

# SPECIALIST GYNAECOLOGY CENTRES

ABN 153 524 150-92

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## **After Care....management of your patient after pregnancy termination**

All patients are given a written account of the symptoms they may experience and a list of those that would make an urgent medical consultation necessary. They are given a 24 hour help-line telephone number to use if they feel worried about pain, bleeding or high temperature. Urgent clinical advice and emergency gynaecological assessment is available when necessary.

A follow-up appointment with either Specialist Gynaecology Centres or referral back to you within two weeks of the procedure is recommended to each patient following the abortion. In some cases, where the patient has no medical practitioner, a letter is given that provides information about the procedure to allow another practitioner elsewhere to deal with any complications.

### **At follow-up check for.....**

**Bleeding:** After the procedure, significant bleeding occurs for only a few hours while the remaining tissue is expelled and haemostatic mechanisms establish. Bleeding then rapidly diminishes until decreasing  $\beta$ hCG levels cause the remaining decidua to separate by Day 3-4. A heavier loss and occasionally sheets of decidua are expelled (described as "tissue" or "skin") & sometimes accompanied by mild uterine cramps. This heavier bleeding may last for a few days and is best managed expectantly with reassurance. Unnecessary repeat curettage can be avoided by managing excessive bleeding clinically not by an ultrasonic examination which will show heterogenous appearances in 80% within the first week. Ensure that there are no signs of PID (lower abdominal tenderness, adnexal or uterine tenderness, pyrexia and leucocytosis).

Repeat curettage is indicated for excessive (continued passage of clots, heavier than a heavy period) or prolonged (bright red bleeding for more than 14 days) bleeding. Persistent slight bleeding, dark bleeding or brown discharge may be due to the progestogenic effect of OCP or other contraception commenced at the time of the abortion (Depo-Provera).

**Pregnancy Symptoms:** Persistent nausea, breast tenderness and enlargement, abdominal distension. Although  $\beta$ hCG levels halve every 12 hours, a qualitative urine pregnancy test is a very sensitive measure of  $\beta$ hCG and may still be positive for 2-3 weeks after the procedure. After complete evacuation of trophoblast,  $\beta$ hCG levels should be less than 500 IU at 14 days. Nausea should subside within 24-48 hours but breast tenderness may take 2 weeks to subside if breast tissue is substantial and the pregnancy was more advanced.

All tissue is examined macroscopically and histologically after the procedure to confirm normal trophoblast (intrauterine pregnancy) thereby excluding ectopic pregnancy and hydatidiform molar pregnancy. If trophoblast is present histologically, it is extremely unlikely that a continuing pregnancy can occur. If trophoblast is not identified, we will consider this to be an ectopic pregnancy and will initiate pelvic sonography, serial  $\beta$ hCG assay and review with clinical examination. We do not routinely send you a copy of the histology report.

**Post-abortion infection:** Chlamydial PCR is performed on every patient and antibiotic therapy should be commenced within 48 hours if the PCR is positive. We recommend azithromycin 1g (two 500mg tablets Zithromax). If symptoms of mild PID are present at the time of diagnosis doxycycline 100mg 12 hourly for 14 days (for chlamydia) plus metronidazole 400mg orally 12 hourly for 14 days (for secondary organisms) is advised. For non-compliant patients, add azithromycin 1g on Day 1 and Day 8. Gonococcal PCR is performed on all patients who have a positive chlamydial PCR. We will notify you of these results. Severe PID requires IV antibiotics indicating hospital admission.

Apart from chlamydia, bacterial vaginosis is a risk factor in the development of PID because of the high prevalence (BV occurs in 10-30% of patients). We use prophylactic metronidazole (2g orally) if BV is clinically apparent at the time of the abortion. BV commonly occurs as a secondary infection in association with Monilia because of an underlying Papillomavirus infection.

**Depression:** Emotional lability is fairly common for first few weeks after termination of pregnancy. This usually resolves spontaneously and only rarely will a patient require further counselling. We use a comprehensive questionnaire as well as pre-operative counselling to minimize this problem.

**Persistent Amenorrhoea:** The next normal period is expected 4-6 weeks after the abortion. If the pill is started immediately after the procedure (active tablet the next day), the next period is expected a few days after the patient reaches the next inactive tablets. Without OCP, the next period may not come until after 6 weeks. If no period occurs by this time, repeat the pregnancy test (UCG) and ensure that adequate contraception is being used. A positive UCG may mean another pregnancy because of inadequate contraception.

If the pregnancy test is negative, amenorrhoea is most commonly due to endometrial hypoplasia (rarely intrauterine adhesions). There may be a history of light periods or amenorrhoea in the past. If spontaneous regeneration does not rapidly occur, an estrogenic OCP will induce endometrial growth.

Hypomenorrhoea or amenorrhoea with dysmenorrhoea is usually due to a progestational effect of OCP or Depo-Provera rather than cervical stenosis or intrauterine adhesions. Dysmenorrhoea with amenorrhoea in the first week may be due to clot retention without retained tissue and evacuation of the clot by suction curettage will be necessary.

### Complications .....

**Haemorrhage** at the time of abortion is rare. It complicates around 1.5/1000 abortions overall and the rate is lower for early abortions (1.2/1000 at <13 weeks; 8.5/1000 at >20 weeks).

**Uterine perforation** at the time of surgical abortion is rare. The incidence is of the order of 1-4 per 1000. The rate is lower for abortions performed early in pregnancy and performed by experienced clinicians.

**Cervical trauma:** the rate of damage to the external cervical os at the time of surgical abortion is no greater than 1%. The rate is lower when abortions are performed early in pregnancy and when they are performed by experienced clinicians.

**Failed abortion/on-going pregnancy:** all methods of first trimester abortion carry a risk of failure to terminate the pregnancy, thus necessitating a further procedure. The rate for surgical abortion is around 2.3/1000 and for medical abortion around 6.0/1000.

**Post-abortion infection:** genital tract infection of varying degrees of severity, including pelvic inflammatory disease, occurs in some series in up to 10% of cases. The risk is reduced to less than 2% when prophylactic antibiotics are given or when lower genital tract infection has been excluded by bacteriological screening. We perform routine Chlamydia PCR on all patients (about 5% positive). We aim for best practice and value feedback from you if complications occur.

**Breast cancer risk:** there is no evidence on an association between induced abortion and breast cancer.

**Future reproductive outcome:** There are no proven associations between induced abortion and subsequent infertility or preterm delivery.

**Psychological sequelae:** only a small minority of women experience any long-term, adverse psychological sequelae after abortion. Early distress, although common, is usually a continuation of symptoms present before the abortion. Conversely however, long-lasting negative effects on both mothers and their children have been reported where abortion has been denied. We advise referral for further counselling for the small minority of women who experience long-term post abortion distress. Risk factors are ambivalence before the abortion, lack of a supportive partner, a psychiatric history or membership of a cultural group that considers abortion wrong.

**Rh iso-immunisation:** Anti-D IgG (250 IU below 12 weeks and 625 IU 12 weeks or after) is given to all non-sensitised Rh-D negative women following abortion.

### Contraception Advice...

Before your patient is discharged, future contraception is discussed and contraceptive advice offered if required. The chosen method of contraception should be initiated as soon as possible following abortion.

We usually recommend...

Barrier methods: when appropriate especially in short term relationships.

OCP: especially with previous history of cycle irregularity. Intermenstrual bleeding may occur in the first few cycles due to a progestational effect on the thin regenerating endometrium. Not used without an end-point in mind especially after the family is complete or in the older woman.

IUD: usually only in multiparous woman and especially after the family is completed. An IUD may be inserted in the first 10 days or about 7 days after the first period. With menorrhagia, a Mirena rather than a Copper IUD is preferred. Expect irregular bleeding in the first few months if using Mirena and advise the patient about the development of amenorrhoea (30-40%).

Depo-Provera: Best given after the decidua has been shed and before endometrial regeneration commences (Day 5) otherwise wait until Day 3-5 of the next cycle. Irregular persistent and occasionally heavy bleeding may otherwise occur due to decidualisation and later shedding of the endometrium. We will refer the patient to you earlier than usual if Depo-Provera is planned.

Implanon: As with Depo-Provera, progestational effects are similar. Implanon must be inserted by Day 5 or wait until Day 1-5 of next cycle. We generally do not recommend Implanon in teenager or nulliparous.

### Appointments and 24 hour advice:-

Telephone Hobart (03) 6224 5888 Launceston (03) 6331 8333