UNIT 5 MEDICAL TERMINATION OF PREGNANCY

Structure

5.0 OBJECTIVES

By the end of this unit, you should be able to:

- define MTP;
- describe the rules and regulations involved in the MTP Act;
- list the methods of 1st and 2nd trimester pregnancy terminations and describe the methods for first trimester termination in a particular woman;
- enumerate the complications, their prevention and management; and
- provide post MTP follow-up services.

5.1 INTRODUCTION

In this unit, you will learn all about the medical termination of pregnancy, MTP Act, rules and guidelines to do an MTP. You will also know the details about the various methods of MTP and the problems you are likely to face during the procedure.

Pregnancy termination or induced abortion particularly for a normal pregnancy is associated with emotional change, superstition and religious taboos. It involves social, political and economical issues in every country. Termination of pregnancy has been practiced since historical time. Because of its greater safety as compared to the child birth, abortion has obtained tremendous popularity in the last few years to get rid of unwanted children. It also has great impact on population control. It is never recommended as a method of contraception. Let us now go into the further details about MTP.

5.2 HISTORY AND DEFINITION

From the historical times, termination of pregnancy has been practised with or without legal and social sanctions as a solution for unwanted pregnancies. Maternal morbidity and mortality due to complications of unsafe or illegal abortions constituted a major public health problem.

Hence, in India, Shantilal Shaw Committee formed in 1964 recommended liberalisation of abortion law in 1966. In 1971, MTP Act was passed by Indian Parliament, and implemented in 1972. In 1975 October MTP rules were notified. These rules were further amended in 1977.

What is meant by induced abortion or termination of pregnancy?

Induced abortion defined as willful termination of pregnancy before viability i.e. before 20 weeks of pregnancy.

5.3 GUIDELINES FOR MTP

Now we will go into the details of MTP Act and rules. The MTP Act specified three conditions:

- Time when a pregnancy can be terminated
- Person who can perform MTP and
- Place where MTP can be done.

When can pregnancy be terminated?

a) If pregnancy endangers the life of the pregnant woman i.e. if mental or physical health of the woman is affected by the pregnancy.

b) If baby is to be born with serious physical or mental abnormalities.

c) Pregnancy caused by rape.

d) Pregnancy due to failure of contraception.

Who can perform termination of pregnancy?

a) Up to 12 weeks of pregnancy MTP can be performed by a registered medical practitioner having experience in Obstetrics and Gynaecology only.

b) If the pregnancy exceeds 12 weeks and is not more than 20 weeks, the opinion of 2 registered medical practitioners is necessary to terminate the pregnancy.

Where can abortion be done?

a) A hospital established and maintained by government.

b) A place or hospital approved for this purpose by government.

Abortion services are provided in hospitals in strict confidence. The name of the abortion seeker is kept confidential.

MTP Rules, 1975

The conditions specified in the MTP Act were altered in 1975 to make MTP services more readily available. These changes have occurred in three administrative areas.

- Approval by Board. Under the new rules the Chief Medical Officer of the District is empowered to certify that a doctor has the necessary training to do MTP.
- Qualification required to do abortion.
  a) Six months housemanship in Obstetrics & Gynaecology.
  b) A post graduate degree in Obstetrics & Gynaecology.
  c) Three years of practice in obstetrics and gynaecology for those doctors registered before the 1971 MTP Act.
  d) One year of practice in obstetrics and gynaecology for those registered on or after the date of commencement of act.
  e) The new rules also allow the medical practitioners to qualify through spot training. To qualify; the practitioner must assist 25 cases of MTP in an approved institution.

f) The place where abortion is performed. Under the new rules of 1975 non-governmental institutions may also take up abortion services if they obtain a licence from the Chief Medical Officer of the district.

Consent for MTP Prescribed in MTP Act

A written consent of woman desiring MTP is taken. In case the girl is below 18 or the woman is mentally unsound a written consent from the guardian is necessary.

Community Awareness

In India about 6 million abortions occur every year. Out of these 4 million are induced abortions, but very few of these are reported and the remaining are done illegally. This is either due to lack of awareness in the community of due to lack of easy availability.

Hence, methods like mass media or simple posters in regional languages are advocated for the awareness of community. The media must emphasize the easy availability and confidentiality of free, safe and legalized abortion services.

MTP and Contraception

After an abortion, about 75% women ovulate within 20 days. Approximately 6% of women will conceive in 4 to 6 weeks after abortion. Hence, proper contraceptive must be given at the time of abortion. The couple will be highly receptive at that time. Best method of contraceptive is sterilization if woman has 2 or more children. Suppose the woman has one child, temporary methods of contraception are recommended.

Counselling

Proper counselling in women coming for MTP is very important. It is important to answer queries and to remove apprehensions and mis-conceptions. The psychological preparation of woman leads to better cooperation. Counselling is done concurrently for contraception. Privacy and confidentiality is to be assured at every stage.

Check Your Progress 1

1) Define induced abortion.

.....

.....

.....

.....

2) When was termination of pregnancy act passed and when was it implemented?

.....

.....

.....

.....

3) Define the indications for MTP as prescribed in MTP Act.

.....

.....

.....

.....

4) Tick (3) the correct answer in the following:

i) For MTP in a girl of 16 years:

a) girl's consent is taken

b) consent of two medical practitioners is necessary

c) no consent is necessary.

ii) Regarding qualifications required to do abortion all of the following are true except:

a) If a registered medical practitioner has assisted in 25 cases of MTP in an approved institution

b) 6 months of housemanship in Obst. & Gynae.

c) A post graduate qualification in Obst. & Gynae.

d) Any registered medical practitioner.

iii) Promotion of post MTP contraception is very important because:

a) the couples are highly receptive

b) risk of ovulation within 20 days

c) conception can occur within 4 to 6 weeks

d) all of the above are correct

5.4 SELECTION OF A PATIENT

In induced abortion period of gestation is the most important factor. Only women who are less than 10 weeks pregnancy should be considered for out patient termination and MTP beyond 10 weeks must be done in a place where facilities are available to treat complications.

History

The important points that you must enquire about are:

a) present or past history of any major disease

b) any previous surgery

c) menstrual history and date of last menstrual period

d) obstetric history with special enquiry regarding any previous caesarean section

e) previous MTP

Physical Examination Including Vaginal Examination

General physical examination is very essential. This includes recording of temperature, pulse, B.P. and systemic examination. You must look for anaemia. A thorough pelvic examination is very essential. This will help you in:

a) evaluating the size of the uterus

b) to rule out any pelvic inflammatory disease or neoplasm (like fibroids or ovarian tumors)

c) to detect any local infection.

Investigations

You must do routine investigations like Hb% and urine examination for albumin and sugar. One more important investigation is blood grouping and Rh typing.

Special investigations like urine for pregnancy test and Ultrasonography are done whenever necessary. Urine for pregnancy test is done only in cases of doubt about pregnancy. Ultrasonography is done to rule out associated pathology. After these investigations the patient is ready for MTP.

5.5 METHODS OF FIRST TRIMESTER PREGNANCY TERMINATION

The methods for first trimester pregnancy termination is discussed under medical methods and surgical methods.

5.5.1 Medical Methods

The following medical methods can be used for 1st trimester pregnancy—PGE_2 and $PGF_2\alpha$

The induction of abortion can be done by Prostaglandin E_2 (PGE_2) and Prostaglandin $F_2\alpha$ ($PGF_2\alpha$) administered as vaginal pessaries or IM injections.

The drawback of the use of Prostaglandin in 1st Trimester are:

- incomplete evacuation in 3-15% requiring evacuation
- excess uterine cramps (33%)
- gastrointestinal side effects like vomitings and diarrhoea in 30 to 50% of cases in spite of antiemetics and antidiarrhoeals
- bleeding which lasts for 10 to 12 days.

Prostaglandins have not yet been able to replace vaccum suction for 1st Trimester MTP due to higher rates of side effects and less successful results.

RU486 (Mifepristone)

It is an antiprogestational agent. It competes with progesterone for the receptors in the uterus so that the progesterone is displaced and pregnancy can not be sustained. Thus it acts as a abortifacient. For the process to be complete, prostaglandins are given after RU486 is taken. Prostaglandin cause uterine contraction and complete the abortion. It is effective upto 6 to 8 weeks only. The procedure takes several days and may require 2 or more visits to service providers. Bleeding or spotting may last upto 8 to 10 days. Cramping, nausea and diarrhoea may occur. Heavy bleeding may occur in 2% of women and failed procedure need backup. It is approved by Drug Controller of India and is marketed in some states at present. To use RU486, backup facilities to complete abortion must be available. Success rate is claimed to be 90%.

5.5.2 Surgical Methods

a) **Menstrual Regulation (MR)**

Menstrual regulation is done for delayed menstrual period upto 14 days that is the period of ammenorrhoea less than 6 weeks. Remember that MR can be done at any time after 35 days and before 45 days from the 1st day of last menstrual period. MR is safe and easy A Karman's cannula. No.4 along with a 50 ml menstrual regulation syringe is used to do MR. Patient is put in lithotamy position — vagina and cervix are cleaned properly with an antiseptic solution like Betadine. No. 4 cannula is inserted into the uterine cavity through the cervix. A negative pressure is created with the menstrual regulation syringe. This causes separation of the functional layer of the decidua/endometrium, which is aspirated into the syringe. For further details of technique and instruments used please refer practical manual.

Complications of MR are grouped into immediate and delayed:

- Immediate complications that you can anticipate are, uterine perforation, syncopal attack, severe uterine cramps, cervical lacerations and haemorrhage.
- Delayed complications are persistent bleeding, incomplete evacuation and pelvic infection, ectopic pregnancy which has been missed and continuation of pregnancy.
- You must ask the patient to come for follow up examination after 2 weeks and earlier if she gets:

— excessive bleeding

— bleeding persists after 1 week

— if she experiences severe lower abdominal pain

— if pregnancy symptoms persist and also if she does not have menstruation within 4 to 5 weeks after the procedure is done.

b) **Suction Evacuation or Vacuum Aspiration**

MTP up to 8 weeks of pregnancy can be done safely as an out patient procedure even in PHCs. Safest period for MTP is between 6-8 weeks. Complication rate rises by 15-30% beyond 8 weeks. MTP between 10-12 weeks should be performed only at a place where full facilities to deal with emergencies are available.

Suction evacuation is done under intravenous analgesia and local anaesthesia. General anaesthesia is needed in nervous patients.

The procedure of SE consists of dilation of cervix and aspiration of products.

Different vaccum pumps or suction machines are available. There are electrically or manually operated. The pump should be capable of delivering a consistent negative pressure of not less than 600 mm of mercury. The cannulae used are made of either metal or plastic. The metal cannulae can be sterilized and used repeatedly. The plastic one are presterilized and disposable. The choice of thickness of cannula is determined by the duration of pregnancy and usually corresponds to the gestation in weeks. For example 8 weeks of pregnancy, 8 mm cannula is used. For 10 weeks, 10 mm cannula is used.

First dilate the cervix to the extent so as accommodate the chosen cannula. Then introduce the cannula to the full depth of the uterine, cavity and apply suction (see Fig. 5.1). Move the cannula back and forth rotating through 180° side ways both clock and anticlock wise. within the uterus and the products are sucked out. Stop when you have a gritty feel then you do a curettage by a blunt curette. Do not do too vigorous a curettage.

Fig. 5.1: Suction evacuation

Post Operative Care and Follow Up

- Administration of routine antibiotics following SE and D & E are debatable.
- You should administer antibiotics if there is excessive bleeding during the procedure or you suspect local infection or if the procedure has taken a long time.
- After observing the patient for few hours you can send her home. At the time of discharge, inform the patient that she can become pregnant even after 7 to 14 days. Hence, advise her to use suitable contraceptive measures. If patient is willing, an IUD (CuT) can be introduced at the end of MTP. Ask the woman to report for routine check up after 2 weeks. But advise her to come earlier if she develops any of the following symptoms:
  - — acute pain in abdomen
  - — rise of temperature or persistent pain for more than 7 days
  - — heavy or persistent fresh bleeding
  - — persistent pregnancy symptoms

- In case of acute pain suspect ectopic or acute pelvic infection. Examine her with these in mind and start appropriate treatment immediately after the diagnosis is made.
- In case there is persistent bleeding or continuation of pregnancy do repeat SE and curettage.
- During routine follow up visits after 2 weeks, besides routine examination, do a pelvic examination and rule out continuation of pregnancy, incomplete abortion, pelvic infection and to check for Cu - T if it has been inserted along with MTP.

Complications and their Treatment

Complications of SE and D & E depend on operators skill, available facilities, gestational age, type of anaesthesia, patients' age, parity, socio-economic status and pre-existing disease. The major complication rate is less than 1 in 100 procedures. The risk of mortality from these procedures is eleven times lower than the risk of dying from pregnancy and child birth.

The following complications may be met during suction evacuation :

i) ***Uterine Haemorrhage :*** It is usually due to incomplate evacuation of products of conception. It occurs more often when the gestational age is more than 8 weeks and when general anaesthesia is used. It can be reduced to a great extent by the use of oxytocic drugs (5-0 units of syntocinon in 5% dextrose as IV drip) during the procedure and by prior use of laminaria tents for effective dilation of cervix when the size of uterus is 10 to 12 weeks.

Laminaria Tents are made from seaweed dried and rounded into stick shape. These are intensely hygroscopic. When placed in a moist environment such as cervical canal it gradually swells up to several times its original diameter.

These are available in three diameters — small 3-5 mm, medium 6-8 mm and large 8-10 mm. A thread is placed at one end to facilitate removal. The laminaria tents are inserted into cervical canal. Care must be taken that the distal tip of the tent be inserted through the internal OS and proximal tip remains outside the cervical OS. The tent is kept for 6-12 hours and removed. You can either do SE or evacuation after removal of laminaria tent.

One of the drawbacks of laminaria tent is infection. Hence, always use prophylactic antibiotics.

ii) ***Pelvic Infection:*** It occurs in 0.1 to 1% of cases mostly due to incomplete evacuation and improper aseptic technique. The symptoms usually appear on the 2nd or 3rd day but may be delayed upto 10 days. The woman has fever, foul smelling discharge, abdominal pain, pelvic tenderness, subinvolution of uterus and bleeding per vagina. The infection can be controlled by the use of antibiotics and reevacuation if the abortion is incomplete. Cases of peritonitis and septic shock should be referred to higher centre.

iii) ***Cervical Injury:*** Incidence is 0.1 to 1 % occurs more often with D & E in advanced gestational age and in nulliparous women. This can be avoided to a great extent by the use of laminaria tents prior to evacuation.

iv) ***Uterine Perforation:*** It is the most dangerous complication. Incidence is 0.1 to 0.28%. This can be further minimized by use of laminaria tents. When perforation is suspected keep the patient under observation. But if perforation has occurred or if injury to the omentum or intestines is suspected laparotomy followed by the necessary procedure should be performed.

v) ***Retained Products:*** These are seen in 2-4% of cases. It can be reduced by check curettage after SE. These cases need repeat SE and antibiotics.

vi) ***Continuation of Pregnancy:*** Incidence is less than 1 %. Diagnosis is by routine follow up and asking patient to report if pregnancy symptoms continue or ammenorrhoea continues for more than 4 weeks after MTP. Repeat SE is needed.

Maternal Mortality and Morbidity

Morbidity is lowest between 6-8 weeks of pregnancy. Risk of complications rises by 15-30% for each week of delay. Mortality is very rare. Incidence being 1.3/1 lakh procedures.

Note: Morbidity and mortality rates increase steeply after 8 weeks of gestation.

Long Term Complications

The WHO study showed an increased chance of future abortions specially in the mid trimester and preterm labour. The cause may be cervical incompetence. Also remember that the chances of sterility and ectopic pregnancy are more, may be because of infection, adherent placenta and rupture of uterus due to previous undiagnosed perforation during MTP. Hence, strict aseptic precautions are to be taken while doing an MTP.

c) **Manual Vacuum Aspiration**

The Manual Vacuum Aspiration (MVA) Technique is a safe and simple technique for termination of early pregnancy and also for evacuation of inevitable and incomplete abortion.

The MVA Technique

The MVA is performed using a syringe that can hold vacuum and an appropriate sized flexible plastic cannulae (Karman's). The vacuum produced in the syringe is approximately 25-26 inches / 600-650 mm of Mercury (Hg), which is the same as the level of vacuum in an electric suction machine. The termination of pregnancy is performed by aspirating the products of conception using the cannula and the syringe. The technique is described in detail in Practical Manual (MMEL-102).

Advantages and disadvantages of MVA

Advantages

i) It is a simple technique that has proven to be safe and effective in termination of early pregnancy (as well as in management of incomplete abortion and inevitable abortion).

ii) It is not dependent on availability of electricity.

iii) It can be performed in any facility with basic facilities for minor surgery/normal delivery.

iv) It can be performed without any anaesthesia. In selected cases, local infiltration may be required.

v) It is one of the effective techniques of surgical intervention for termination of pregnancy up to eight weeks of gestation.

vi) Its effectiveness in completely evacuating the uterus is reported to be more than 98%.

vii) Its complication rate is low. Results of comparative studies of various techniques for termination of pregnancy, done in three hospitals in Delhi, have reiterated the fact.

viii) It is easy to inspect the aspirate for products of conception as tissue remains more or less intact.

Disadvantages

i) The main disadvantages related to the equipment are that the MVA syringe needs to be replaced after doing .....procedures (number of procedures) and the cannulae needs to be replaced after doing .....procedures (number of procedures).

ii) The MVA can cause serious complications such as the following, which may be encountered with any of the surgical methods of intervention for terminating pregnancy. However the complication rate is lower in the case of MVA. The serious complications are:

- Haemorrhage
- Infection
- Perforation

With careful selection of clients and care during procedure, the above can be avoided.

Indications and contra-indications for use of the MVA

Indications

Termination of pregnancies up to eight weeks of gestation.

Although the MVA can be used for termination of pregnancy up to 12 weeks by specialists, it is not recommended for medical officers as the risk of complications is high. The MVA can also be used for evacuation of uterus in inevitable and incomplete abortions.

Contra-indications

In the following conditions, the MVA should not be used in PHCs and in facilities with no emergency back up:

- Uterine size more than eight weeks (even if the reported duration of pregnancy is less than eight weeks) as the risk of complications is high.
- Septic shock
- Severe tenderness of lower abdomen and distension
- Suspicion of perforation (from a previous interference)
- Suspicion of ectopic pregnancy
- Pregnancy with fibroid uterus
- History of caesarean section or uterine surgery
- Severe cervical stenosis
- Medical disorders such as:
  - Anaemia with haemoglobin below 8 gms.
  - Bleeding disorders
  - Hypertension
  - Heart disease
  - Renal disease
  - Diabetes mellitus

i) The MVA should be used carefully in the following conditions after ensuring arrangements for immediate referral:

- Young adolescent
- Nulliparous women

ii) In case of clients with purulent discharge per vagina, treat the infection first before doing the procedure.

Complications

i) ***Immediate***

- Complication due to local anaesthesia
- Excessive bleeding
- Uterine perforation
- Fainting

ii) ***Delayed complications***

1) *Incomplete evacuation*

This is the commonest complication. Patient usually presents with excessive or prolonged bleeding per vagina, fever or pain in the abdomen, usually within two weeks of the procedure. The condition is preventable by using the correct technique of evacuation and checking the quantity of the evacuated material.

- Counsel and refer such cases to a higher facility. Manage bleeding (as above) if there is heavy bleeding.

2) *Continuation of pregnancy*

Pregnancy may continue due to failure to terminate the pregnancy due to the following:

- Early pregnancy that makes it difficult to suck out the embryo as it is too small and is lying near the cornua of the uterus.
- Presence of fibroids that distort the uterine cavity and block the suction of the embryo.
- Failure to suck effectively due to small sized cannula, partially blocked openings and ineffective suction pressure.
- Counsel and refer to a higher facility.

3) *Infection*

The symptoms of infection generally appear within two to three days after the procedure.

Infection should be prevented by taking utmost care while performing the procedure by ensuring that all the instruments used are properly sterilised and that 'no touch technique' is observed. The parts of instruments that will be introduced in the uterus should not touch objects or surfaces that are not sterile, including the vaginal wall, before being inserted. Initiation of antibiotic therapy before the procedure is another critical step in preventing infection. The signs of infection are fever, abdominal pain, pelvic tenderness or sub-involution of uterus and bleeding per vagina. In severe cases patient may present with signs of peritonitis or septic shock.

- Manage as follows:
  - Give a dose of Doxycycline 100 mg. and Metronidazole 400 mg. orally.
  - Refer

Remote Complications

i) Complications may occur during future pregnancies, example, adherent placenta and uterine rupture due to previous undiagnosed perforation in MVA.

ii) Psychosomatic Symptoms

Depression may be seen sometimes, especially if the termination has been carried out for medical reasons or has been enforced by the women's husband or family members. Counselling has a critical role to play in preventing such problems.

iii) Recurrent mid-pregnancy abortions

Recurrent mid-pregnancy abortions can occur due to cervical incompetence as a result of injury to the cervix.

iv) Ectopic pregnancy

v) Infertility

vi) Amenorrhoea due to Ashermann's syndrome (uterine synechae)

Check Your Progress 2

1) Describe the minimum investigations that you do before doing a 1st Trimester MTP.

.....

.....

.....

2) Mention the various types of 1st Trimester MTP procedure and mention which is the best.

.....

.....

.....

3) Enumerate the complications of SE.

.....

.....

.....

4) Choose the correct answer:

i) MTP is safe:

a) before 4 weeks

b) between 6-8 weeks

c) between 12-14 weeks

d) between 18-20 weeks

ii) Death rate following legally induced abortion is:

a) 1.3/1 lakh of procedures

b) 3/lakh of procedures

c) 4.4/lakh of procedures

5.6 METHODS OF SECOND TRIMESTER PREGNANCY TERMINATION

Second trimester pregnancy termination is done either by induction of abortion by uterine stimulation or by surgical methods.

Induction of abortion is done by injecting drugs into intra or extra amniotic space and introducing devices like LT or catheters. Surgical methods include hysterotomy and hysterectomy. The methods could be classified as mentioned below:

1) Extra/intra amniotic instillation of drugs

- Ethacredine lactate (emcredil)
- Prostaglandins ($PGF_2\alpha$)
- Urea 40%

2) Introduction of devices through cervix to induce abortion

- Laminaria tent
- Catheters

3) Surgical method

- Abdominal hysterotomy
- Abdominal hysterectomy

Ethacredine Lactate

Ethacredine is the most commonly used drug for 2nd trimester MTP. This drug is given by extra-amniotic route. Amount instilled is 10 ml of 0.1 % ethacredine for every week of gestation upto a maximum of 150 ml. Its mode of action is by producing prostaglandin from decidua.

Intravenous oxytocin drip is started after 12-24 hours to accelerate abortion. Induction abortion interval is approximately 30 hours. 86% of patients abort within 72 hours. If the patient does not abort within 72 hours, reinstillation of ethacredine can be done. With reinstillation, the success rate is almost 100%.

It has no contraindication and is safe. For midtrimester abortion, extramniotic instillation of ethacredine lactate is good, because it is safe. Complications and very rare, failure rate is about 5-6% where reinstillation is required.

Late Sequelae of MTP

Incompetent cervical os, anaemia, menstrual disturbance, secondary amenorrhoea, Asheman's syndrome, infertility, psychological disturbances and Rh isoimmunization. Rh isoimmunization can be prevented by giving 150 mg of Rh immunoglobulin to Rh negative women.

Check Your Progress 3

1) Mention the commonly used methods for 2nd trimester abortion.

.....

.....

.....

.....

.....

2) Choose the correct answer.

The common method used for 2nd trimester abortion is:

a) Extra amniotic injection of Ethacredine Lactate

b) D & E

c) Hysterotomy

d) Hysterectomy

5.7 LET US SUM UP

In this unit, we have learned about medical termination of pregnancy. Here are the main points of this unit:

- Medical Termination of Pregnancy Act was introduced in India in 1971 and further rules were amended in 1975 and 1977.

- MTP or induced abortion is defined as willful termination of pregnancy before viability (i.e. before 20 weeks of pregnancy).
- We learned the guidelines for MTP i.e. where, when and who can perform abortion.
- Proper channel, counselling and patient selection is very important for safe MTP.
- We learned in detail the methods of 1st Trimester pregnancy termination.
- 1st Trimester MTP is safest when performed before 8 weeks.
- Safest and best method of 1st Trimester MTP is MVA and SE.
- We have learned in detail the complications and their prevention and management.
- We learnt about the methods of 2nd Trimester MTP by extra amniotic injection of Ethacredine lactate.
- We also discussed about the importance of contraceptive advice along with MTP.

5.8 KEY WORDS

Cx : Cervix

D & E : Dilatation and Evacuation

Hb% : Haemoglobin Percentage

IUD : Intrauterine Contraceptive Device

IV : Intravenous

LT : Laminaria TentsIU

MR : Menstrual Regulation

MTP : Medical Termination of Pregnancy

MVA : Manual Vacuum Aspiration

PG : Prostaglandin

PHC : Primary Health Centre

SE : Suction Evacuation

5.9 ANSWERS TO CHECK YOUR PROGRESS

Check Your Progress 1

1) An induced abortion means willful termination of pregnancy before viability.

2) MTP Act was passed in 1971 and was implemented from April 1972.

3) a) If pregnancy can endanger the life of pregnant woman.

   b) If baby will be born with severe abnormalities.

   c) Pregnancy caused by rape.

   d) Pregnancy due to failure of contraception.

4) i) b)

ii) d)

iii) b)

Check Your Progress 2

1) Minimum investigations before 1st Trimester MTP are Hb% urine routine and microscopic and if possible blood grouping with Rh typing.

2) a) Use of Prostaglandin, b) SE, c) D & E, d) MR.

Of these suction evacuation is the best.

3) Complications of suction evacuation: a) Uterine haemorrhage, b) Pelvic infection, c) Uterine perforation, d) Cervical injury, e) Retained products, f) Continuation of pregnancy

4) i) b ii) a

Check Your Progress 3

1) a) Ethacredine lactate

b) Abdominal Hysterotomy

c) Aspirotomy

2) a)

5.10 FURTHER READINGS

Chaudhari, S.K., *Practice of Fertility Control.*

Registrar General of India: *Survey of Causes of Death. A*nnual Report, 1997 (Data on abortion related maternal mortality).

Government of India: *Manual for Medical Termination of First Trimester of Pregnancy*. Department of Family Welfare, Ministry of Health and Family Welfare, 1995.

Winkler J. Oliveras E and McIntosh N: *Postabortion Care*. *A Reference Manual for Improving Quality of Care.* Postabortion Care Consortium, 1995.

Greenslade F.C., Leonard A.H., Benson J., *et al: Manual Vacuum Aspiration. A Summary of Clinical and Programmatic Experience Worldwide.* IPAS, 1993.

MOHFW and PSS: *National Conference on Making Early Abortion Safe and Accessible, October 11-13, 2000.*

Government of India: *Guidelines for IUCD Insertion for Medical Officers.* Department of Family Welfare. Ministry of Health and Family Welfare, 2001.

Dear learner,

While going through this block, you might have found certain portions of the text to be difficult to comprehend and some scope to improve them. We wish to know your difficulties and suggestions in order to improve the quality of the course. We, therefore, request you to fill up and send us the following questionnaire, which pertains to this block. If you find the space provided insufficient, kindly use a separate sheet.

Please mail the filled in questionnaire to: **Programme Coordinator, PGDMCH Programme, School of Health Sciences, IGNOU, Maidan Garhi, New Delhi-110 068.**

Questionnaire

Enrolment No. | | | | | | | | | |

Section A: Unit Specific Comments

Unit 1: Diagnosis of Pregnancy and Antenatal Care

1. How many hours did you need to study this unit? .....
2. Please grade the unit on the following items by putting a tick (3) mark:

Item	Grade				
	Excellent	**Very Good**	**Good**	**Satisfactory**	**Poor**
Presentation Quality					
Language and Style					
Illustrations (Diagram, Tables etc.)					
Conceptual Clarity					
Check Your Progress Questions					
Answers to Check Your Progress					

3. Do you find all the sections to be relevant for this course? .....
   If not, please list the section/sub-section.
   .....
   .....

Unit 2: Maternal Nutrition in Pregnancy and Lactation

1. How many hours did you need to study this unit? .....
2. Please grade the unit on the following items by putting a tick (3) mark:

Item	Grade				
	Excellent	**Very Good**	**Good**	**Satisfactory**	**Poor**
Presentation Quality					
Language and Style					
Illustrations (Diagram, Tables etc.)					
Conceptual Clarity					
Check Your Progress Questions					
Answers to Check Your Progress					

3. Do you find all the sections to be relevant for this course? .....
   If not, please list the section/sub-section.
   .....
   .....

Unit 3: Aneamia in Pregnancy

1. How many hours did you need to study this unit? .....
2. Please grade the unit on the following items by putting a tick (3) mark:

Item	Grade				
	Excellent	**Very Good**	**Good**	**Satisfactory**	**Poor**
Presentation Quality					
Language and Style					
Illustrations (Diagram, Tables etc.)					
Conceptual Clarity					
Check Your Progress Questions					
Answers to Check Your Progress					

3. Do you find all the sections to be relevant for this course? .....
   If not, please list the section/sub-section.
   .....

Unit 4: Medical Disorders Complicating Pregnancy

1. How many hours did you need to study this unit? .....
2. Please grade the unit on the following items by putting a tick (3) mark:

Item	Grade				
	Excellent	**Very Good**	**Good**	**Satisfactory**	**Poor**
Presentation Quality					
Language and Style					
Illustrations (Diagram, Tables etc.)					
Conceptual Clarity					
Check Your Progress Questions					
Answers to Check Your Progress					

3. Do you find all the sections to be relevant for this course? .....
   If not, please list the section/sub-section.

   .....

Unit 5: Medical Termination of Pregnancy

1. How many hours did you need to study this unit? .....
2. Please grade the unit on the following items by putting a tick (3) mark:

Item	Grade				
	Excellent	**Very Good**	**Good**	**Satisfactory**	**Poor**
Presentation Quality					
Language and Style					
Illustrations (Diagram, Tables etc.)					
Conceptual Clarity					
Check Your Progress Questions					
Answers to Check Your Progress					

3. Do you find all the sections to be relevant for this course? .....
   If not, please list the section/sub-section.

   .....

Section B: Block Specific Comments

1. List the subject areas of relevance to Maternity and Child Health that you feel should have been incorporated in this Block.

   .....

   .....

2. Any other suggestions:

   .....

   .....