Hampton Park
Women's Health Care

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COMPLICATIONS OF SURGICAL TERMINATION OF PREGNANCY

This list is provided to help you understand what the possible risks are of having a surgical pregnancy termiation, to help inform you. Over the past decade, measures have been implemented to help minimise these risks and because of the ability to reduce these risks, some of the quoted statistics are higher than what we are seeing in practice today. It is commonly known that legally performed surgical pregnancy termination with a trained professional is 10 -14 times safer than childbirth.

1. RETAINED OR REMAINING PRODUCTS OF CONCEPTION (1: 500)

This complication arises due to some of the pregnancy tissue or placental site remaining after the surgery. This complication can cause heavy or prolonged bleeding e.g. for longer than 2 + weeks, often associated with lower abdominal cramping. To minimise this risk the doctor will perform a postoperative vaginal ultrasound whilst you are still under anaesthetic to check that your uterus is empty. Further suction can be performed at this time to further empty the uterus. If there is any concern regarding tissue that cannot be removed, then you will be given tablets to help the uterus naturally expel this tissue. The risk of remaining tissue seen is approximately 1 in 500 patients. Prior to the surgery you will be given a medication which softens your cervix and has been shown in studies to reduce the likelihood of leftover tissue.

2. INFECTION (<1: 200)

It is stated that the risk of developing an infection of the uterus is 5 % and the risk of developing in infection effecting the fallopian tubes is 1 in 200 or 0.5 %. This is not reflected in our observations, perhaps due to regular screening for Chlamydia and other potentially harmful bacteria which live in the vagina or cervix. All patients are given antibiotics on the day of the surgery and a script of antibiotics for after the surgery.

3. EXCESSIVE BLEEDING. (1: 5,000)

Very rarely heavy bleeding occurs at the time of the operation requiring admission to hospital. Statistically this occurs in 1:5000 patients however thus far in our practice it has occurred < 1; 10,000 patients.

4. UTERINE PERFORATION. (1: 1000)

Very rarely during surgery, one of the instruments can go through the wall of the uterus. Statistically this occurs 1 in 1000 patients. Often, if this has occurred and the pregnancy has been removed, antibiotics and careful observation are required either in hospital or with your doctor. Rarely this requires formal surgery to repair the uterine wall. Over the past decade we have had a risk rate much lower than 1 :1000 patients.

5. CONTINUING PREGNANCY.

Very rarely, particularly if the operation is performed very early in the pregnancy e.g.< 5 weeks pregnant, the pregnancy might not be removed. To avoid this occurring the doctor will perform a vaginal ultrasound at the end of the surgery (before you wake up) and will send all the tissue removed to the pathology laboratory with your consent, to confirm that the pregnancy was identified. If extra reassurance is required, the surgeon will organise a pregnancy level to be taken at the time of your surgery and you will be asked to have a follow up blood test, to make sure that your pregnancy levels are dropping as expected. If asked, please have the second blood test.

6. BLOCKAGE OF THE CERVIX

Rarely after surgery the cervix can block blood passing from the uterus. This normally occurs in the first 24 hours after surgery causing unusual abdominal pain that radiates through to the rectum. Some patients feel that their lower abdomen feels fuller. This is treated by gentle repeat dilation (to stretch open the cervix), allowing the blood in the uterus to pass. This instantly relieves symptoms.

7. ASHERMAN'S SYNDROME

Is a very **rare** complication, which might occur when a patient has required multiple operations – often over a short period of time. Scar tissue develops over 2 – 3 months with the gradual **absence** of menstrual bleeding but **increase** in period pain.
If left untreated this can affect future fertility. Treatment involves a 'hysteroscopy', when an instrument is used to look into the uterus and 'diathermy', to burn away the scar tissue, allowing the lining of the uterus to regrow. Please report any such symptoms as early intervention has a better outcome.

8. ECTOPIC PREGNANCY (1: 200)

An ectopic pregnancy is not a complication of the surgery however, is a pregnancy that is not growing in the uterine cavity. Most commonly it is found within one of the Fallopian Tubes. This occurs 1 in 200 pregnancies. Symptoms **if** present, include lower abdominal pain (often to one side or the other) and a history of irregular bleeding during the pregnancy. If there is no pregnancy seen on your initial pregnancy ultrasound, then this will need close monitoring with blood tests and further ultrasounds. If suspected, you must go directly to hospital as rupture of a Fallopian Tube can be life threatening.

9. EXCESSIVE BLEEDING (< 1: 5000)

Occasionally very heavy bleeding occurs at the time of the operation and this rarely necessitates admission to hospital (< 1 in 5,000 patients.)
Prolonged (e.g. > 2 weeks) or troublesome bleeding may occur after the termination of pregnancy which requires no specific treatment (1 in 200 patients.)

10. NEGATIVE EMOTIONAL REACTION

For a couple of weeks your hormone levels decline but remain in the body. Some women feel a bit up and down during this time. Some people experience emotions of grief, regret, sadness and guilt. Many people feel a sense of relief. These emotions are normal; however, we encourage anyone feeling negative thoughts to seek emotional professional support if your symptoms worsen or do not improve. Women with a history of mental illness such as Depression are more at risk.
Follow up counselling might help you to understand your feelings and maintain your sense of wellbeing.
Often women make difficult choices during difficult circumstances and that in itself deserves compassionate understanding.

11. OTHER COMPLICATIONS

These include allergic reactions to any medicines given, for example to the anaesthetic medications. It is important to check and inform our nurses and doctors of any allergies you are aware of and to provide us with an accurate and full medical history.
It is important to inform us if you have any serious medical conditions, have a BMI of 40 or over, have had gastric bypass surgery, or are taking any oral blood thinning agents.
Please follow the instructions regarding "**NO FOOD OR FLUID FOR** "for 6 hours prior to your appointment". If there is food or fluid in your stomach, then you can potentially vomit whilst under anaesthetic and this can pass into your lungs. This risk is greater for patients that have had Laparoscopic Gastric Banding Surgery.

Your referring doctor will be sent a letter of your attendance, with all the results of any tests performed. It can take **2 weeks** for your bleeding to settle and pregnancy test to go negative so please go for your post-operative check-up.

I MRS /MS _____D/ O/ B _____/_____/_____ Have read and understand the risks stated above.

I DR / RN _____have helped discuss these risks and believe that my patient has good understanding of what has been listed.