Management of **side effects and complications**

The data on complications due to terminations performed in New Zealand is incomplete. Approximately 30% of women return to their referring general practitioner for follow-up therefore there are no reliable figures available. The follow up visit is important to ensure that both the physical, and psychological health is maintained and contraception organised.

Managing early medical termination in the community

Pain: It is very common for women to experience abdominal cramps in the hours following prostaglandin intake, but the severity varies from patient to patient. The peak of pain and bleeding occurs at the expulsion of the gestation sac. Pain is modified by such factors as fear and anxiety. Full preliminary information and support during the procedure can modify the pain.

Usually a hot water bottle and oral analgesics (paracetamol, NSAIDs, codeine) will be sufficient to control the pain in most women. Some women may also require anti-nausea medication.

Bleeding is a normal consequence of the termination process but may exceed a woman's previous experience of menstrual bleeding. As with pain management, informing the patient in advance of what to expect is essential.

The heaviest bleeding usually occurs at the time of expulsion of the gestational sac which for 5% of women will be before misoprostol administration. Bleeding after a medical termination is commonly more erratic than after a surgical termination and may still be present several weeks after the procedure.

- 77% of women describe their bleeding as "spotting" at 15 days
- 9% continue to have some bleeding at 30 days
- 1% continue to have some bleeding at 60 days

Women should be told to initiate contact if bleeding soaks through two thick full-size sanitary pads per hour for two consecutive hours. The size of the clots and the accompanying symptoms (such as dizziness, weakness) must be factored into the assessment.

Depending on these variables, a doctor may advise admission to hospital for evaluation.

Surgical intervention for excessive bleeding is required in less than 1% of first trimester medical terminations. The woman should have been given her clinic contact number and advice can be sought here first.

Temperature: Hot flushes and fever are also fairly common side effects of high dose misoprostol. These symptoms are usually short-lived and resolve spontaneously.

A post termination temperature greater than 38°C that persists for several hours warrants evaluation for infection as would be done after miscarriage. This includes endocervical swabs for Chlamydia and Gonorrhea and a standard high vaginal swab. A FBC and CRP can also be helpful.

Infection: Endometritis is a rare complication of medical termination, especially patients screened and treated for STIs. Persistent pelvic pain in the days after a termination

should be evaluated for possible endometritis or incomplete termination. Either condition may cause the uterus to feel slightly enlarged, softened and tender.

A seven day course of a broad-spectrum antibiotic (such as amoxycillin with clavulanic acid or erythromycin) may be used for treatment of infection, while awaiting swab results to further guide treatment.

Uterine/cervical trauma: Cervical and uterine trauma does not occur in early medical terminations.

Failed termination: 10 out of 1000 medical terminations may fail to achieve expulsion of the pregnancy. If there is any doubt about a continuing pregnancy, two serum HCGs taken two days apart will be helpful. If hormone levels are not dropping appropriately, then the woman should be immediately referred to your local gynecology clinic for scan and assessment for ongoing pregnancy including ectopic.

Managing Surgical terminations in the Community

Fever, bleeding and pain are all signs which can signify infection or retained products of conception and these need to be checked at follow-up. If an IUCD has been inserted at the time of the termination, it is often not necessary to remove it as symptoms can often be managed without having to remove the device. However if the clinical condition of the woman warrants it, removal may be necessary. The woman must then be informed she is no longer protected from pregnancy and other contraception will need to be arranged.

Pain: It is usual to experience some crampy abdominal pain for a short while following the procedure. This often responds well to simple analgesia (paracetamol, NSAIDs) and reassurance.

Bleeding: Bleeding usually settles in the first week to ten days after a surgical termination. Fresh bleeding, clots or prolonged bleeding may be a sign of retained products of conception, a failed termination or infection. Heavy bleeding should be managed as for a miscarriage.

Prolonged light bleeding will often settle with a course of antibiotics such as amoxycillin with clavulanic acid or erythromycin. If bleeding persists, arrange an ultrasound scan. Consider the role of contraception such as Depo Provera in causing persistent bleeding.

Infection: Post-termination infection can range from a low grade endometritis to, rarely, a full-blown pelvic inflammatory disease with septicaemia. Prophylactic antibiotics reduce the subsequent incidence of infection and are used routinely in New-Zealand clinics. If there is no temperature and fresh bleeding is minimal , but you suspect a low grade infection on clinical grounds, such as pain on pelvic examination, then a trial of a broad spectrum antibiotic (such as amoxycillin and clavulanic acid or erythromycin) may deal with low-grade infections without the need for more invasive interventions.

Uterine/cervical trauma: The advent of misoprostol as a pre-op medication has significantly reduced the incidence of cervical trauma. **Trauma at the tenaculum site may sometimes be seen at follow-up examination, and conservative management is recommended. Uterine trauma will usually have been identified at operation or in the immediate post-operative period and managed at the clinic. If in doubt a gynaecological opinion can be sought.**

Failed termination: There is approximately one failure per 1000 surgical terminations. Bear the possibility in mind if the woman tells you she still feels pregnant at the post-op check up. If there is any doubt about a continuing pregnancy, two serum HCGs taken two days apart will be helpful. If hormone levels are not dropping appropriately, then the woman should be immediately referred to your local gynaecology clinic for scan and assessment to determine if there is an ongoing and possibly ectopic pregnancy.