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Second Trimester Medical Termination Of Pregnancy And Its Outcomes: A Cross Sectional Study

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Abstract: -
Background*: Second-trimester abortion contributes significantly to maternal morbidity and mortality, especially in places where access to safe second-trimester abortion is limited. With the introduction of prostaglandin analogs, the efficacy of medical abortion has improved drastically, and the risk for complications and side effects has been reduced. Among prostaglandins, PGE1 and PGE2 have been used in different doses and by various routes for second-trimester abortion. The method of medically induced abortion has further improved with the usage of mifepristone With mifepristone, the induction-to-abortion interval has shortened and the dose of PG analogs required has reduced. Today, medical abortion has become the method of choice in many centers.*
Materials and Methods*: In this cross sectional study, a total number of 100 patients who underwent second trimester abortion and willing to participate in the study were included in the study. Detailed clinical history, clinical examination and medical termination of pregnancy were done. Induction abortion interval was recorded for each patient.*
Results: *Majority of the study group (50%) belong to the age group of 31 to 40 years, with the fourth Gravida contributing maximum (29%) with single Parity (40%). The majority of the study group (36%) who underwent medical termination of pregnancy were in the 17 to 20 weeks period of gestation Among the study group, 14% had an abortion within 6 hours of induction, 43% had an abortion within 7 to 12 hours of induction, 36% had an abortion within 13 to 18 hours of induction, 6% had an abortion within 19 to 24 hours of induction, and 1% had an abortion within 25 to 30 hours of induction. 36%, had a complete abortion with a dose of misoprostol 800 mcg with a dosing interval of 3 hours. All the patients had complete abortions, and none of them needed post-abortion curettage. The median dose of misoprostol was (1200±800 mcg). These findings were found to be statistically significant (p value <0.05)*
Conclusion*: We conclude that second-trimester medical termination of pregnancy is considered to be a safe, effective, non-invasive regimen with minor complications, short induction–abortion interval (IAI) time and high rate of successful complete abortion.*
Keyword: *Second trimester abortion, Medical abortion, Induction–abortion interval (IAI)*

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I. Introduction

Abortion is defined as "Pregnancy ermination prior to 20 weeks gestation or with a fetus born weighing less than 500 grams." Mid-trimester abortion is the termination of pregnancy between 13 to 28 weeks gestation. With the introduction of prostaglandin analogs, the efficacy of medical abortion has improved drastically, and the risk for complications and side effects has been reduced. Among prostaglandins, PGE1 and PGE2 have been used in different doses and by various routes for second-trimester abortion.The method of medically induced abortion has further improved with the usage of mifepristone. With mifepristone, the induction-to-abortion interval has shortened and the dose of PG analogs required has reduced. This study aims to determine the outcomes of second-trimester medical termination of pregnancy (using Mifepristone and Misoprostol recommended regimens 2017 – FIGO guidelines)

II. Material And Method

This cross-sectional study was conducted in the department of Obstetrics and Gynaecology department, Regional Institute of Medical sciences, Imphal, Manipur from from November 2022 to April 2024 after obtaining approval from Institutional Ethics Committee. A total of 100 patients who underwent medical termination of pregnancy and willing to participate in the study were included.

Study Design: Cross Sectional Study

Study Location: Tertiary care teaching hospital in the Department of Otorhinolaryngology, at Regional Institute of Medical Sciences (RIMS), Imphal, Manipur

Study Duration: November 2022 to April 2024

Sample size: 100 patients.

Sample size calculation: Based on the formula of cross-sectional study, sample size (N) was calculated as: $N = \frac{Z^2PQ}{L^2}$ where, Z = 1.96 @ 95% Confidence Interval, P= Prevalence (Percentage of women who underwent second-trimester MTP out of all MTPs done as per HMIS Annual Report 2019-2028) which is 7%, Q= 100-P. Absolute allowable error (L) was taken as 5% and sample size was calculated to be 100.

Subjects & selection method: The study population was drawn from patients who underwent second trimester medical termination of pregnancy in in the department of Obstetrics and Gynaecology department, Regional Institute of Medical sciences, Imphal

Inclusion criteria:
1.Women who underwent MTP with gestational age more than 13 weeks but less than 24 weeks.
2. Women fulfilling prerequisites of MTP (Amendment) Act 2021.

Exclusion criteria:
1. Grand multipara
2. Hemodynamically unstable
3. Heart disease, uncontrolled hypertension, bronchial asthma, coagulation disorder
4. Hb < 7gm%
5. Inevitable or incomplete abortion following MTP pill ingestion from outside or self-medicated

Procedure methodology:

Informed written consent was obtained from all the participants before including them in the study. A detailed clinical history including age, gravida, parity, gestation period, and previous pregnancy history were recorded. Investigation reports were recorded after reports were available. All the cases were subjected to general, systemic and obstetrics examinations. All the patients underwent medical termination of pregnancy. Induction abortion interval was recorded for all the study participants. Data was collected in pre-designed proforma.

Statistical analysis:

Data collected were checked for completeness and consistency. Data was entered in IBM SPSS version 26 for Windows (IBM Inc. Armonk, New York, USA). Quantitative data like age, gravida, parity, gestation period (in weeks), induction abortion interval, and dose of misoprostol were expressed in mean and standard deviation.

Qualitative data, such as side effects and complications, were expressed in frequency and percentage. The chi-square test was used to check for the association between maternal outcomes and age, gravida, parity, and gestation period (in weeks). Variables of P-value less than 0.2 in univariate analysis were put in the logistic regression model. A P-value of less than 0.05 was considered statistically significant.

III. Result

In the present study, 100 patients who underwent medical termination of pregnancy and fulfilling the inclusion and exclusion criteria were studied. The age group of the patients studied ranged from 18-40years with a mean age of 30.32 years.

Table no 1 shows that the majority of the study group (50%) belong to the age group of 31-40 years, with the fourth Gravida contributing maximum (29%) with single Parity (40%). The majority of the study group (36%) who underwent medical termination of pregnancy were in the 17 to 20 weeks period of gestation.

Table 1 shows demographic details (N=100)

Parameter		**Frequency(n)**	**Percentage (%)**
Age group	18-20	07	07%
	21-30	43	43%
	31-40	50	50%
Gravida	1	20	20%
	2	27	27%
	3	24	24%
	4	29	29%
Parity	0	24	24%
	1	40	40%
	2	15	15%
	3	21	21%
Period of gestation	13-16 weeks	34	34%
	17-20 weeks	36	36%
	21-24 weeks	30	30%

Table 2 shows that the majority (47%) of the indication of MTP was due to unwanted pregnancy, followed by congenital anomalous baby (28%), short pregnancy interval (23%), and severe oligohydramnios (2%).

Table 2 shows Indication for MTP (N=100)

Indication	Frequency(n)	Percentage (%)
Unwanted pregnancy (including unmarried / MLC)	47	47%
Congenital anomaly baby	28	28%
Short pregnancy interval (including post Caesarean section)	23	23%
Severe oligohydramnios	2	2%

Table 3 shows that 14% had an abortion within 6 hours of induction, 43% had an abortion within 7 to 12 hours of induction, 36% had an abortion within 13 to 18 hours of induction, 6% had an abortion within 19 to 24 hours of induction, and 1% had an abortion within 25 to 30 hours of induction. The mean IAI was 12.06 ± 4.56 hours.

Table 3 shows Induction-abortion interval in hours

Induction-Abortion time interval in hours	Frequency(n)	Percentage
≤ 6	14	14%
7-12	43	43%
13-18	36	36%
19-24	6	6%
25-30	1	1%
Mean ± SD	12.06 ± 4.56	
Median ± IQR	12.0 ± 8	
Minimum	5	
Maximum	26	

Table 4 shows that the majority of the study group, 36%, had a complete abortion with a dose of misoprostol 800 mcg with a dosing interval of 3 hours. All the patients had complete abortions, and none of them needed post-abortion curettage. The median dose of misoprostol was (1200±800 mcg).

Table 4 shows Details of MTP procedure

Total no. of doses	Total dose of misoprostol required	Dosing interval	Complete abortion	Incomplete abortion	Frequency	Percentage (%)
2	800mcg	3	36	0	36	36%
3	1200mcg	3	26	0	26	26%
4	1600mcg	3	28	0	28	28%
5	2000mcg	3	8	0	8	8%
6	2400mcg	3	1	0	1	1%
7	2800mcg	3	1	0	1	1%
Mean ± SD				1260 ± 436		

Median ± IQR	1200± 800
Minimum	800
Maximum	2800

Table 5 shows that For women in their first pregnancy (Gravida 1), the majority (55%) had an IAI of 13 to 18 hours, with a smaller proportion experiencing shorter IAIs of ≤ 6 hours (5%) and 7 to 12 hours (20%), and 20% had an IAI of 19 to 24 hours. In contrast, women in their second pregnancy (Gravida 2) had a higher proportion (48.15%) with an IAI of 7 to 12 hours, followed by 25.93% in the 13 to 18 hours interval and a notable 18.52% with IAIs of ≤ 6 hours. For women in their third pregnancy (Gravida 3), 54.17% had an IAI of 13 to 18 hours, and a significant portion (16.67%) experienced IAIs of ≤ 6 hours. Women with four pregnancies (Gravida 4) predominantly had shorter IAIs, with 68.97% in the 7 to 12 hours interval and 13.79% in the ≤ 6 hours interval, and very few having longer IAIs. The Chi-square value of 29.81 and a P-value of 0.001 indicate these differences are statistically significant. As gravida increases, there is a shorter Induction Abortion Interval (IAI) time, which was statistically significant.

Table 5 shows Association of gravida with induction abortion intervals among the study participants

Gravida	Induction Abortion Intervals (IAI - in hours)						Chi square value	P value
	≤ 6	7 – 12	13 – 18	19 – 24	25 – 30	Total		
1	1 (5.0%)	4 (20.0%)	11 (55.0%)	4 (20.0%)	0 (0.0%)	20 (100.0%)	29.81	0.001*
2	5 (18.52%)	13 (48.15%)	7 (25.93%)	1 (3.7%)	1 (3.7%)	27 (100.0%)		
3	4 (16.67%)	6 (25.0%)	13 (54.17%)	1 (4.17%)	0 (0.0%)	24 (100.0%)		
4	4 (13.79%)	20 (68.97%)	5 (17.24%)	0 (0.0%)	0 (0.0%)	29 (100.0%)		
Total	14 (14.0%)	43 (43.0%)	36 (36.0%)	6 (6.0%)	1 (1.0%)	100 (100.0%)		

*- statistically significant by Chi-square test

Table 6 shows that For women with no live births (Parity 0), the majority (54.17%) had an IAI of 13 to 18 hours, followed by 20.83% with an IAI of 7 to 12 hours, and smaller proportions with IAIs of ≤ 6 hours (4.17%), 19 to 24 hours (16.67%), and 25 to 30 hours (4.17%). Women with one live birth (Parity 1) predominantly had IAIs of 13 to 18 hours (42.5%) and 7 to 12 hours (40.0%), with a notable 12.5% experiencing IAIs of ≤ 6 hours and only 5.0% had an IAI of 19 to 24 hours. In the group with two live births (Parity 2), the highest proportion (46.67%) had an IAI of 7 to 12 hours, followed by 33.33% with IAIs of ≤ 6 hours, and 20.0% with IAIs of 13 to 18 hours. Women with three or more live births (Parity 3) mainly had IAIs of 7 to 12 hours (71.43%), with smaller proportions experiencing IAIs of ≤ 6 hours (14.29%) and 13 to 18 hours (14.29%). The Chi-square value of 28.98 and a P-value of 0.001 indicate these differences are statistically significant. The IAI tends to decrease as parity increases, with higher parity groups more likely to experience shorter IAIs.

Table 6 shows Association of parity with induction-abortion intervals among the study participants

Parity	**Induction-Abortion Intervals (IAI) (in hours)**						**Chi square value**	**P value**
	≤ 6	**7 – 12**	**13 – 18**	**19 – 24**	**25 – 30**	**Total**		
0	1 (4.17%)	5 (20.83%)	13 (54.17%)	4 (16.67%)	1 (4.17%)	24 (100.0%)	28.98	**0.001***
1	5 (12.5%)	16 (40.0%)	17 (42.5%)	2 (5.0%)	0 (0.0%)	40 (100.0%)		
2	5 (33.33%)	7 (46.67%)	3 (20.0%)	0 (0.0%)	0 (0.0%)	15 (100.0%)		
3	3 (14.29%)	15 (71.43%)	3 (14.29%)	0 (0.0%)	0 (0.0%)	21 (100.0%)		
Total	14 (14.0%)	43 (43.0%)	36 (36.0%)	6 (6.0%)	1 (1.0%)	100 (100.0%)		

*- statistically significant by Chi-square test

Table 7 shows that For pregnancies between 13 to 16 weeks, a substantial majority (58.82%) had IAIs of 7 to 12 hours, with a notable 41.18% experiencing IAIs of ≤ 6 hours, and no participants had IAIs longer than 12 hours. In the 17 to 20 weeks gestation group, the IAIs were primarily between 7 to 12 hours (55.56%) and 13 to 18 hours (44.44%), with no occurrences of IAIs shorter than 7 hours or longer than 18 hours. For the 21 to 24 weeks gestation group, the majority had IAIs of 13 to 18 hours (66.67%), with 10.0% in the 7 to 12 hours range, and a smaller proportion experienced IAIs of 19 to 24 hours (20.0%) and 25 to 30 hours (3.33%), with no IAIs of

≤ 6 hours. Earlier gestational periods (13 to 16 weeks) are associated with shorter IAIs, predominantly within 12 hours or less. As the gestational period increases, the IAI increases, which is statistically significant.

Table 7 shows that Association of period of gestation with induction abortion intervals among the study participants

Le	Induction Abortion Intervals (IAI) (in hours)						Chi square value	P value
	≤ 6	7 – 12	13 – 18	19 – 24	25 – 30	Total		
13 to 16	14 (41.18%)	20 (58.82%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	34 (100.0%)	75.20	0.001*
17 to 20	0 (0.0%)	20 (55.56%)	16 (44.44%)	0 (0.0%)	0 (0.0%)	36 (100.0%)		
21 to 24	0 (0.0%)	3 (10.0%)	20 (66.67%)	6 (20.0%)	1 (3.33%)	30 (100.0%)		
Total	14 (14.0%)	43 (43.0%)	36 (36.0%)	6 (6.0%)	1 (1.0%)	100 (100.0%)		

*- statistically significant by Chi square test

Table 8 shows that the chi-square value of 32.96 with a P- value of 0.001 indicates that the difference in the distribution of misoprostol across different gravidas is statistically significant. As gravida increases, the dose of misoprostol tends to decrease, which is statistically significant

Table 8 shows Association of gravida with dose of misoprostol among the study participants

Gravida	Dose of misoprostol							Chi square value	P value
	2	3	4	5	6	7	Total		
1	2 (10.0%)	4 (20.0%)	9 (45.0%)	5 (25.0%)	0 (0.0%)	0 (0.0%)	20 (100.0%)	32.96	0.001*
2	12 (44.44%)	8 (29.63%)	5 (18.52%)	0 (0.0%)	1 (3.7%)	1 (3.7%)	27 (100.0%)		
3	7 (29.17%)	4 (16.67%)	10 (41.67%)	3 (12.5%)	0 (0.0%)	0 (0.0%)	24 (100.0%)		
4	15 (51.72%)	10 (34.48%)	4 (13.79%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	29 (100.0%)		
Total	36 (36.0%)	26 (26.0%)	28 (28.0%)	8 (8.0%)	1 (1.0%)	1 (1.0%)	100 (100.0%)		

*- statistically significant by Chi-square test

Table 9 shows that As parity increases, the dose of misoprostol tends to decrease, which was statistically significant (Chi-square value: 27.86, P-value: 0.02).

Table 9 shows Association of parity with dose of misoprostol among the study participants

Parity	Dose of misoprostol							Chi square value	P value
	2	3	4	5	6	7	Total		
0	2 (8.33%)	5 (20.83%)	11 (45.83%)	5 (20.83%)	0 (0.0%)	1 (4.17%)	24 (100.0%)	27.86	0.02*
1	14 (35.0%)	10 (25.0%)	12 (30.0%)	3 (7.5%)	1 (2.5%)	0 (0.0%)	40 (100.0%)		
2	8 (53.33%)	4 (26.67%)	3 (20.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	15 (100.0%)		
3	12 (57.14%)	7 (33.33%)	2 (9.52%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	21 (100.0%)		
Total	36 (36.0%)	26 (26.0%)	28 (28.0%)	8 (8.0%)	1 (1.0%)	1 (1.0%)	100 (100.0%)		

*- statistically significant by Chi-square test

Table 10 shows that As parity increases, the dose of misoprostol tends to decrease, which was statistically significant

Table 10 shows Association of period of gestation with dose of misoprostol among the study participants

Period of gestation	Dose of misoprostol							Chi square value	P value
	2	3	4	5	6	7	Total		
13 – 16	28 (82.35%)	6 (17.65%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	34 (100.0%)	72.50	0.001*

17 – 20	8 (22.22%)	15 (41.67%)	12 (33.33%)	1 (2.78%)	0 (0.0%)	0 (0.0%)	36 (100.0%)		
21 – 24	0 (0.0%)	5 (16.67%)	16 (53.33%)	7 (23.33%)	1 (3.33%)	1 (3.33%)	30 (100.0%)		
Total	36 (36.0%)	26 (26.0%)	28 (28.0%)	8 (8.0%)	1 (1.0%)	1 (1.0%)	100 (100.0%)		

*- statistically significant by Chi-square test

Table 11 shows that Chi square value of 27.91 with a P-value of 0.001 indicates that the differences in the distribution of misoprostol doses across different induction abortion intervals are statistically significant. As the induction abortion interval increases, the dose of misoprostol administered tends to increase, which was statistically significant.

Table 11 shows Association of induction abortion interval with dose of misoprostol among the study participants

Induction abortion interval (hours)	Dose of misoprostol							Chi square value	P value
	2	3	4	5	6	7	Total		
≤ 6	14 (100.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	14 (100.0%)	27.91	0.001*
7 to 12	22 (51.16%)	21 (48.84%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	43 (100.0%)		
13 to 18	0 (0.0%)	5 (13.89%)	28 (77.78%)	3 (8.33%)	0 (0.0%)	0 (0.0%)	36 (100.0%)		
19 to 24	0 (0.0%)	0 (0.0%)	0 (0.0%)	5 (83.33%)	1 (16.67%)	0 (0.0%)	6 (100.0%)		
25 to 30	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	1 (100.0%)	1 (100.0%)		
Total	36 (36.0%)	26 (26.0%)	28 (28.0%)	8 (8.0%)	1 (1.0%)	1 (1.0%)	100 (100.0%)		

*- statistically significant by Chi-square test

IV. Discussion

Worldwide, second trimester abortion constitute about 10-15% of all induced abortions, but it is related to two-thirds of abortion-related complications and morbidities. Medical methods can efficiently and safely promote second-trimester induced abortion. Due to various complications in the second trimester of abortion, it is advised to have it in a center with an operating facility and with blood transfusion. The method of medically induced abortion has further improved with the usage of mifepristone. With mifepristone, the induction-to-abortion interval has shortened, and the dose of Prostaglandin analogs required has reduced. Today, medical abortion has become the method of choice in many centers.

This study recruited 100 patients who fulfilled the inclusion and exclusion criteria. The age group ranged from 18 to 40 years of age. The majority (50%) of the study group were in the age group of 31 to 40 yrs. The majority of the study group who underwent second-trimester medical termination of pregnancy belongs to 4th gravida (29%) with single parity (40%) with 17 to 20 weeks of gestation (36%).

In our study, unwanted pregnancy constitutes the primary indication for medical termination of pregnancy (47%), followed by congenital anomalous baby (28%), short pregnancy interval including post-cesarean section (23%), and severe oligohydramnios (2%).

In this study, all women received 200mg of oral mifepristone followed by 400mcg of vaginal misoprostol after 48 hours of oral mifepristone, and then 400mcg of vaginal misoprostol every 3 hours till abortion. Complete abortion was seen in 100% of our study participants, which was in line with the result reported by Ashok PW et al.in their study. The median dose of misoprostol required was 1200±800 mcg, and the mean induction to an Abortion time interval (IAI) was 12.06 ±4.56 hours, comparable to other studies. Nayak AK et al.[1] in their study also reported that the median dose of misoprostol required was 1128±384mcg. Complete abortion was seen in 92%, and the mean induction abortion interval time was 11.59±2.71 hours. A 100% success rate was also reported by Singh S et al.[2]

In this study, majority (99%) of the participants aborted successfully within 24 hours. Manninen HJ et al.[3] in their study also found that the majority (94%) of women aborted successfully within 24 hours.

In this study, it was found that the induction abortion interval time was shorter when the pregnancy had lasted < 17 weeks (P=0.001), which was also similar to the study conducted by Manninen HJ et al.[3]

The mean induction abortion interval was 12.06 ± 4.56 hours, and nulliparous women took significantly longer time to abort (15.54 hours) compared to 9.81 hours in multiparous women(P<0.001), which was also a similar finding reported by Goh SE and Thong KJ[4] in their study. Manninen HJ et al[3]. in their study also noted

that nulliparous women were more likely to have a longer induction-to-abortion interval time than multiparous women. The induction to abortion interval time, number of misoprostol doses, pain score, and analgesia were found to be increased as gestational age advanced, which was also reported by Louie KS et al.[5] and Nilas et al.[7] in their studies. Manninen HJ et al[3]. in their study also concluded that multiparous women and women with early gestation had complete medical termination faster with a lesser requirement for opiate analgesia, compared to nulliparous women or those with longer gestation time (>17 weeks).

In our study, majority of the women required 2 to 4 doses of misoprostol, the median being 3doses (1200±800 mcg). As multiparous women and women with shorter gestation were more likely to complete the termination faster, they required less misoprostol. Manninen HJ et[3] al in their study also found the decreased need for misoprostol (prostaglandin) in multiparous women

In our study, MTP-related complications encountered were vomiting (48%), diarrhea (24%), and fever (7%). Ngai SW et al.[9] in their study, also reported vomiting(42%), diarrhea (23.2%), and fever (8%) as complications after vaginal administration of misoprostol. In our study, none of our study participants required post-abortion curettage, blood transfusion, uterine rupture, and hysterectomy, which was in line with the study reported by Singh S et al.[2] and Desai GS et al.[8]

It was found that the dose of misoprostol requirement tends to decrease in multigravidas and multiparous women (P=0.001 and P=0.02, respectively). It was also found that misoprostol requirement was lesser in < 17 weeks of gestational age (P=0.001) compared to more extended gestation periods. Manninen HJ et al.[3]in their study, also reported that multiparous women and women with early gestation had complete medical termination faster with a lesser requirement for opiate analgesia, compared to nulliparous women or longer gestation (≥ 17 weeks).

In this cross-sectional study, there were 7 participants with a history of previous cesarean sections and 3 with a history of previous two cesarean sections. Successful complete abortions were seen with no significant complications like excessive bleeding, blood transfusion, post-abortion curettage, uterine rupture or perforation, and undergoing hysterectomy. Kaur M et al.2015[6] in their study, there were seven cases with previous cesarean sections, all of whom had complete abortions without significant complications. They conclude that mifepristone and misoprostol are effective and safe for second-trimester MTP, even in cases of previous cesarean section with close supervision.

V. Conclusion

In this study, all women received 200mg of oral mifepristone followed by 400mcg of vaginal misoprostol after 48 hours of oral mifepristone, and then 400mcg of vaginal misoprostol every 3 hours till complete abortion. The majority of the study group (36%) had complete abortion with a dose of 800 mcg misoprostol. The median dose of misoprostol was 1200±800mcg. The mean induction abortion interval (IAI) time was 12.06 ± 4.56 hours. Complete abortion was seen in 100% of the participants. Therefore, we conclude that second-trimester medical termination of pregnancy is considered to be a safe, effective, non-invasive regimen with minor complications, short induction–abortion interval (IAI) time and high rate of successful complete abortion.

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