Unsafe abortion is one of the major health problems in developing countries and a serious concern for women in their reproductive years. It is estimated that globally about 20 million unsafe abortions take place each year, which is one in ten pregnancies. Around 13% of maternal deaths globally are due to abortion, 95% of these occur in developing countries.

In Pakistan complications of miscarriages/abortion account for 10-12% of maternal deaths. These include spontaneous and induced abortion. The number of women seeking abortions for unwanted pregnancies is also high as evidenced in the survey by Population Council. An estimated 890,000 induced abortions occur annually, which means that 1 out of 6 pregnancies is terminated by induction of abortion mostly in an unsafe manner. Moreover about 197,000 women are treated each year for complications resulting from unsafe induced abortions.

Unwanted pregnancies, poverty, lack of availability and accessibility to contraception and contraceptive failure are some of the factors that account for the rise in the number of women seeking termination of pregnancies in unsafe conditions. The unbelievably high numbers of induced abortions is a possible explanation for the apparent inconsistency between the persistent low levels of contraceptive Prevalence Rate (CPR) and the rapid decline in family size.

Majority of women seeking termination of pregnancy are married and they do it either to limit the family size or space pregnancies. Some seek termination of pregnancy on medical grounds or for socio-economic reasons also. Pregnancy outside of a marriage constitutes a very small component of the total numbers seeking termination of pregnancy. Despite restrictive laws abortionists, trained or untrained, exist in the society. Doctors constitute only a small proportion of the providers who terminate pregnancies on request. Majority of unsafe abortion providers are lady Health visitors, nurse/midwives and dais. This is a point to ponder as almost all Post Abortion Care trainings are given to doctors and not to the actual providers who currently offer this service.

Therefore termination of pregnancy carried out by untrained providers often end up with complications as sepsis, haemorrhage, uterine perforation, visceral injuries, or long term sequelae like infertility with its psychological effects. This results in significant increase in Maternal Morbidity and Mortality.

In addition to the above, women may seek help of health providers for complications following spontaneous miscarriage. This may be incomplete, inevitable, missed and septic abortion. For these women the common method in use is Dilation and Evacuation (sharp curettage).

This surgical method for evacuating the uterus requires special preparation e.g. operating room, presence of an anaesthetist and sometimes blood transfusion. Despite careful and skilled interventions, even in best hands, complications like haemorrhage, incomplete evacuation, perforation, and infection can occur.

Manual Vacuum Aspiration (MVA) may help to reduce these problems to a great extent. The procedure can be done under paracervical block, and the women can go home the same day. Evidence from around the world has shown that it is less painful, acceptable, cost effective, and the incidence of complications is lower when compared to other surgical methods for evacuation.

More recently medical termination of pregnancy is also being used. Misoprostol (prostaglandin E1 analogue) is now a safe option for first and second trimester evacuation of uterus. Although not licensed for this purpose, it is now freely available and is being extensively used.

The change in the legal status of abortion is not known to the general public, policy makers and even majority of health care providers in Pakistan. Till 1997 abortion was permitted only to save the life of a woman. This was amended in 1997 to bring the law in conformity with the injunctions of Islam, as laid down in the Holy Quran and Sunnah. As a result of the amendment of the Penal Code, abortion is allowed in the early stages of pregnancy not only to save the life of the woman, but also for providing necessary treatment. This has widened legal permission for carrying out abortion in the early stages of pregnancy but very few are aware of this change.

Also in 1997 the commission of inquiry for status of women, which was set up to look into the laws to end the inequities towards women and headed by a judge of the Supreme Court recommended "A woman's right to obtain an abortion by her own choice within the first 120 days of pregnancy should be unambiguously declared an absolute..."
legal right."12 This still remains a recommendation.

References

Original Article

Achalasia in a Gastroenterology Unit of Karachi

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Abstract

Objective: To study the presentation of Achalasia and compare the response of pneumatic dilatation with surgery.

Methods: Retrospective analysis of patient's records (January 2000-December 2005) from outpatients department of Pakistan Medical Research Council, Jinnah Postgraduate Medical Centre, Karachi was done. All patients with Achalasia were analyzed. As a protocol endoscopy, esophageal manometry, esophageal transit time and barium swallow was done to establish the diagnosis. Surgery and endoscopic guided pneumatic dilatation were offered to these patients as treatment options. Patients undergoing surgery or pneumatic dilatation were later followed to assess the efficacy and those not responding to second dilatation were also operated and follow up of all these cases were noted.

Results: Forty-six patients (24 males, 22 females) with a mean age of 39.8 ± 15.9 years were analyzed. Dysphagia was the primary symptom in thirty eight patients (83%) followed by vomiting and epigastric pain. Pneumatic dilatation was performed in 32 out of forty-six patients. Out of these cases 22 (69%) had single, and 10 (31%) had two dilatations. Two patients (6%) had perforation, one required emergency surgery, another patient was managed conservatively and recovery was unremarkable. Six patients (19%) later required surgery. Fourteen cases opted for surgery as a primary treatment. Out of 20 patients operated, four (20%) required post operative dilatation and one (5%) developed gastro-esophageal reflux.

Conclusions: Achalasia is prevalent in young age, in both sexes almost equally. Pneumatic dilatation is safe and effective, as it can be managed on outpatient basis with little morbidity and 81 % success rate. Surgery is still an effective procedure with comparable 80 % success rate (JPMA 58:661; 2008).

Introduction

Achalasia is one of the best understood oesophageal motility disorders, derived from Greek terminology meaning “failure to relax”. It was described by Thomas Willis in 16744 and treated by dilatation of the lower oesophageal sphincter with whalebone, which relieved dysphagia and other obstructive symptoms.2 It is characterized by the absence of muscular contractions in the distal two-thirds (smooth muscle) of the esophagus which results in failure of the lower oesophageal sphincter to open/relax and obstructs the passage of food into the stomach. People with achalasia experience a progressive difficulty in eating solid food and in drinking liquids which evolves gradually in a period of years. They often experience regurgitation, and sometimes have spasm-type chest pain.

The reasons for failure of the oesophageal muscles to contract normally in patients with motility disorders,