Impacts and experiences of surgical termination of pregnancy due to fetal abnorma...

IMPACTS AND EXPERIENCES OF SURGICAL TERMINATION OF PREGNANCY DUE TO FETAL ABNORMALITY. A review of the literature.

Abstract:

Surgical termination of pregnancy (STOP) can have long-lasting significant impacts. Studies revealed that the manifestation of complication is obvious, and many women accounts different experiences inversely. During STOP procedures, operating department practitioners (ODP) are deeply involved and play an integral role in all aspects of STOP. As a result of knowing the consequences of STOP due to foetal abnormality (FA), ODPs can practice professionally, ethically, efficiently, offer abetter care and promote their work. This review has critically identified those experiences and the relational impacts of STOP.

Key words: lived experiences, abortion, foetal abnormality, and theatre practitioners.

Introduction:

This paper has engaged both systematic and critical review considering the best available evidence of STOP. Pregnancy terminations for FA have been increased due to advanced methods in antenatal screening and delayed maternal age (Department of Health, 2011). The Royal College of Obstetricians and Gynaecologists (2009) pointed out that more couples delayed starting a family, thus increasing the risk of foetal abnormalities happening. According to the department of health (2012), from the year 2011 surgical termination from foetal abnormalities represented 1% of all

terminations. Since then the number of such terminations has risen significantly, which brings mixed experiences to many families and practitioners, (Department of Health, 2015).

Once FA is diagnosed pregnant women are presented with two options. The first possibility is that of medical induction of labour, usually using the drugs named mifepristone and misoprostol to induce uterine contractions which causes the passage of the foetus and placenta intact (Department of Health, 2012). The second possibility is that of STOP, typically involves instrumental removal of the foetus and placenta in small pieces through an artificially dilated cervix. The search on this paper has sorely concentrated on STOP and little venture on the option of medical induction. The drive of this review is not to assume that all women who have pregnant termination due to FA have negative impact. However, this review has focused to scrutinise the relational and individual experiences that women associate with the decision to go ahead with such termination of pregnancy. According to Department of Health (DH) data England and Wales (2013), STOP for FA is six to eleven times safer than that of medical induction.

Theatre practitioners play an integral role in all aspects of surgical termination of pregnancy Singh (2012). ODPs duty are practically spread from all aspects of perioperative environment and well involved in STOP. For this reason, this paper seeks to shed some light from those women opting STOP might undergo and what circumstances are the most likely to happen. This will eventually equip ODPs to become better cares, providing best support and promote the profession.

Method of search strategy:

The database namely CINAHL, PubMed and Medline were searched using the Sheffield Hallam University (SHU) library gateway. Words such aslived experiences, abortion, foetal abnormality, theatre practitionerswere used in the search. Key terms were searched employing Boolean operators in the ‘ Title’ field to uphold the focus of the study. Eradication steps were taken to reduce the number of articles but using a combination of words, removing articles which contains quantitative data, retaining qualitative articles with a limitation to English language only. The adjustment of the tittle and abstract were undertaken progressively. The time frame was left open in order to have a wide appraisal in the articles.

Result:

A total of 808 articles were retrieved in the initial search, however this was reduced to 488 articles on removal of replicas. Remained titles were screened for relevant leading to 18 articles. Only 8 articles were identified to be relevant to the topic, hence meeting inclusion criteria for this literature review. The studies in these articles were ethical as they were conceded out after approval from the Institutional Review Boards of the prospective hospitals. The credibility and validity of the studies, researchers involved in the collection of data were blinded to the studies to prevent bias or tampering with the data.

Discussion:

The termination of the pregnancy process is undoubtedly a traumatic event, which can lead to feelings of loss and sorrow, Smith et al., (2009). Some parents do show slight or significant distress at one stage of the pregnant termination process and not experience difficulties in any other stages, whereas some parent may have multiple challenges before and after the pregnant termination event (Marshall and Raynor, 2002).

On their research Pickering et al, 2012 revealed that, women who decided to go ahead with STOP have this procedure often under local anaesthesia (LA). In 2008, 44. 5% of all foetal abnormalities termination procedures in the UK were performed with (LA), about 32. 9% under general anaesthesia (GA) and 9. 7% were done under sedation. Throughout these procedures, an ODP was fully involved as part of the team in the care and supporting patient, Association for Perioperative Practice (AfPP), 2011.

The investigations carried out in various studies have found out that women opting STOP do experiencefear foranaesthesia and surgerymainly because of lack of understanding, Green and Statham (2007). The emotions that arise from this affects the body leading to anxiety and it is important to address the issue of anxiety by providing enough preoperative information (AfPP , 2011) this reduces the need for analgesics, anaesthetic drugs but it also speeds up recovery. In their study of 40 patients, Blackmore et al. (2014) looked at how psychological interventions through effective communication can significantly reduce anxiety levels during anaesthesia phase. They found out that direct psychological intervention through effective communication can reduce the activity of the sympathetic nervous system and restore the balance of the parasympathetic nervous system which in turn reduces

perioperative anxiety. As supported above, well informed ODPs can be instrumental to calm down patients by the way of supporting and assurance throughout the STOP procedure.

Impacts:

Uterine perforation occurrence; uterine perforation is an infrequent but potentially serious complication of uterine manipulation during removal ofretained products of conception(Royal College of Obstetrics and Gynaecology, 2011). During STOP, surgeons employ variety of tools inside the uterus in order to eliminate the retained products of conception. Throughout the procedure there is a possibility to puncture the uterus and other surrounding organs, henceforth causing haemorrhage. Most ofgynaecologistshave perforated a uterus during STOP procedures, hence resulting in the early recognition of uterine injury so there is less risk of the unsafe use of suction grasping forceps in the abdominal cavity. However, two studies have signposted that, uterine perforation are now performed by junior trainees. These studies which were undertaken in the United Kingdom suggested that, uterine perforation performed by inexperiencedgynaecologistsdoes not bear better outcome compared with that of experienced gynaecologists (Statham 2007).

Another impact reported was cervix laceration; during STOP procedure the cervix or the entrance to the uterus, can be torn or slashed. This is known as a Cervix Laceration. This performance can lead to blood loss and the necessity to patch-up the tear with stitches, occasionally it remains undiagnosed and could be potentially challenging in a future pregnancy.

Several cases have been described of women dying from haemorrhage due to a cervical tear, following STOP (Royal College of Obstetricians and Gynaecologists, 2004).

Infection caused by incomplete termination of pregnancy was also reported; this occurs when the evacuation procedure is incomplete, with the possibility of retaining products of conception inside the uterus. This sort of cases is potentially life threatening since the remains of products of conception can cause a life-threatening infection to a woman involved. The management of incomplete STOP remains a problem and can bring a huge impact to the patient. Studies indicated that each year, several millions of women who underwent STOP also bear this kind of consequence (Department of Health (2012).

Experiences:

There have been only a few of good wide-rangingstudieson the emotional effects of STOP on women due to foetal abnormalities. The investigations carried out in various studies have found out that women opting STOP do experience both short- and long-term emotional consequences. Blackmore et al. (2008) executed that STOP is not beneficial to a lady’s mental health. Three different studies also have indicated that regardless of whether a woman opting a surgical or chemical pregnancy termination, the likelihood to experience depression, abuse substances is imminent. Pregnant women opting STOP are more likely to indulge in suicidal behaviour according to Coleman (2011). Those studies have determined that women undergoing

STOP can experience depression, anxiety, suicidal tendencies and abuse substances like alcohol and drugs after STOP.

Resounding the conclusions in the literature by Larkin, M and Thompson (2012) many mothers experienced anxiety after STOP, these women usually struggled to cope after the incidence. Findings from. Coping with such a traumatic event was a personal issue, consequently, what was adaptive for some was not necessary for others. Nonetheless, Blackmore (2014) argued by insisting that the grieving process from foetal abnormalities STOP was different compared with that of stillbirth.

Furthermore, Paul et al., 2009 indicated that, immediately after STOP due to foetal abnormalities 86% of those women feel some positive emotion, generally a big relief and return of confidence. The same findings submitted the fact that around 2 in 5 women they experienced negative emotions, usually some sort of sadness or guilt. Those ladies who reported having spiritual concerns in line of STOP due to foetal abnormalities had very negative sentiments e. g. ashamed of what they consented for, sadness feeling and full of guilt. A spiritual concern was directed to the belief that abortion decision was either partially or completely approving that the act is equivalent to killing the baby.

Over 85% of women reported at least one of these adverse responses with a third reporting five or more of these feedbacks. Britton et al. 2010, concluded that women with strong beliefs in personal efficacy tended to show greater adjustment in terms of mood stability and general physical health. However, Statham et al., 2001 specified that, those mothers who

were assigned to a brief counselling intervention prior and after their STOP, they improved immensely in their self-efficacy.

The above findings advocated that some women benefited from additional emotional support related to the termination of pregnancy. Numerous emotional and spiritual providers usually offer pre- and post-abortion counselling and referral sessions. The forecast of having both positive and negative emotions after having STOP due to FA was detected, proposing that complex and conflicted feelings are common for those women undergoing such an incidence (Paul et al., 2009). This was evident that women who went through STOP with a foetal anomaly appeared to have more difficulty coping after the procedure.

On their paper, Coleman et al., 2005 contended that, any termination of pregnant is incomparable traumatic experience since it involves a human death experience specifically, the intentional destruction of unborn child. Nevertheless, Adler et al., 1992 argued that STOP due to FA can be a way of resolving stress associated with such a pregnancy and, hence, can lead to a big relief.

Acknowledged coping mechanism:

There were few coping strategies emphasized by two different articles. The papers were more specific targeting women’s experiences due to FA. Among of those strategies includes the following; getting support from perioperative healthcare professionals as well as from their spouses, acknowledging the baby and focusing on the task rather than thinking about its meaning. The

consistency of the above strategies yielded the significance input and offered good outcome.

For instance in their review of 100 coping assessments, Skinner and colleagues (2003) advocated that, getting support was number one essential coping strategy existed throughout the STOP due to FA process. The point was accelerated by Geerinck-Vercammen and Kanhai (2003) when they expressed that health professionals, especially those who work in perioperative environment e. g. ODP’s, theatre nurses, anaesthetist, surgeons etc., when offered emotional support to women undergoing STOP due to FA managed well compared to those who did not receive such support. These support was sorely both during and after the procedure.

Subsequently, in their study Statham and Green (2007) established that, participants or women who received support from healthcare professional in perioperative environment scored very well for relieving more distress. The study went on to highlight that the post-perioperative care though was habitually poor. Statham et al., 2001 though insisted that partner support was critical to these group of women and was considered second to none. It was stretched that the support from partners was critical because women only fully shared these experiences with their spouses. This concept of support, i. e. support from partners involved two separate activities, one was receiving it and the other was providing it.

The second coping structure was acknowledging the baby or acceptance; the occurrence was achieved in different ways. Mothers opted to see their remains of their baby after STOP due to FA found this comforting and

experienced liberation bringing closure. Women engaged in this type of rituals and symbolic acts coped well (Hughes et al., 2002). Those women who tried not to think about the procedure as well as the baby tended to block the pain hence acquiring a short-term gain but long-term loss. Though a minority of those mothers opted this rituals found it very disturbing (Geerinck-Vercammen and Kanhai, 2003).

Alternative experienced coping mechanism was to focusing on the task rather than thinking about its meaning. The approach was used solely during the procedure as resounded by McDonald et al., 2004 that preoperative information were more beneficial in reducing levels of anxiety prior to surgery. In post – termination i. e. right from post-anaesthesia care unit (PACU) women had a strategy of looking to the future. This involved a return to normality and aiming on another pregnancy, and thus reflected a drive to restore equilibrium and move forward. However, Rillstone and Hutchinson (2001) offered their judgement by stating that the last strategy engendered mixed feelings to many women and their spouses.

Conclusion:

The notion of aborting the baby due to FA is particularly complex, given that the pregnancy in most cases is not desirable. Advanced methods in antenatal screening has enabled many pregnant women to come up with such conclusion. Delayed maternal age due to different reasons like financial security, legally accepted operation etc. has contributed for these procedure to happen regularly. Consequently, when women recalling their termination due to FA to some extent they might justify their decision by rationalizing it.

Categorically, women should post rationalize the impacts and coping processes in light of the decision they about to make. The impacts and experiences above findings has clearly indicated that, anybody involved in caring those patients like that of the ODP role should be familiar with the consequences and experiences of STOP due to FA. Upon doing so, ODPs can practice professionally, ethically, efficiently, acting autonomously, offer a better care and promote their work. Due to its complexity of this topic it might be reasonable to highlight that more exploration and research should be implemented.

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