Treating Spontaneous and Induced Septic Abortions

David A. Eschenbach, MD

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Questions have been written by:
Tamara Fuller-Eddins, MD
University of South Dakota
Department of Obstetrics and Gynecology
Sioux Falls, South Dakota

Responses have been written by:
David A. Eschenbach, MD
University of Washington
Department of Obstetrics and Gynecology
Seattle, Washington

Question 1:

What recommendations regarding early diagnosis of septic abortion would you make for the new ob–gyn practitioner?

Response from Dr. Eschenbach:

The early diagnosis of septic abortion needs to be considered as part of the differential diagnosis when a pregnant patient at less than 20 weeks of gestation has evidence of infection based on a fever, usually with vaginal bleeding, and other signs, symptoms, or laboratory evidence of sepsis.

Question 2:

Safe surgical environments are not always immediately available in low resource settings. Other than parenteral antibiotics and intravenous medications, are there other treatment modalities that would be helpful until evacuation of the uterus is available?

Response from Dr. Eschenbach:

Unsafe abortion environments include unsterile conditions in which either patients themselves or other untrained people attempt to perform an abortion, or when the environment does not meet minimum medical standards. Thus, safe surgical environments should always be available where physicians practice medicine. The prompt evacuation of the uterus is the first and main treatment of a septic abortion. All obstetrician-gynecologists should have the equipment and skill to complete an incomplete abortion. This skill will usually suffice to treat septic abortion in all but those at a very advanced gestational age. There are no other vital treatment modalities in this emergency situation besides the prompt removal of infected tissue; antibiotic therapy has minimal effect without the removal of infected tissue.
Question 3:

How would you counsel successfully treated patients regarding future pregnancies?

Response from Dr. Eschenbach:

There are no good data on whether an uncomplicated septic abortion confers any added risk to future pregnancies, including infertility from the uterine infection. Although not well studied, it is unlikely that the risk of a subsequent septic abortion is increased following septic abortion.

Question 4:

What counsel would you give to obstetricians–gynecologists who are reluctant to terminate the pregnancy when cardiac activity is still present?

Response from Dr. Eschenbach:

A septic abortion is defined as sepsis occurring in a previable pregnancy. Clearly, a prompt delivery is required in a viable pregnancy with sepsis from the placenta. Clearly, septic abortion is an emergency condition where prompt pregnancy evacuation is also required; the baby cannot be “saved” in this case. The physician’s first duty is to treat the woman; a failure to do so, irrespective of fetal cardiac activity, puts the pregnant woman at risk for sepsis serious enough to cause organ failure, the need for a hysterectomy, and even maternal death. Such serious delays are well documented. An especially public case occurred in Ireland (see Wikipedia, “Death of Savita Halappanavar”).

Question 5:

When starting antibiotics before culture results are available, which antibiotic regimen do you use for treatment of septic abortion? Following evacuation of the uterus for a septic abortion, is there ever a role for follow-up human chorionic gonadotropin (hCG) levels?

Response from Dr. Eschenbach:

Given that maternal bacteremia is common, particularly with anaerobic bacteria, combination antibiotic regimens are recommended as listed in Box 3 of the article. I have no personal recommendation for any particular antibiotic regimen; again, antibiotics are of secondary importance to prompt uterine evacuation. Follow-up hCG determinations are not necessary, providing that complete removal of all pregnancy tissue occurs (this is mandatory for effective treatment), and pregnancy tissue was present (excluding an ectopic pregnancy).

Question 6:

Will widespread medical abortion and increased use of intrauterine devices yield an increase in incidence of septic abortions?

Response from Dr. Eschenbach:

Medical abortions do leave pregnancy and placental tissue in the uterus for a longer time than a surgical abortion. However, the incidence of septic abortion following a medical abortion is low, and prompt surgical removal of infected tissue remains the necessary treatment. Although intrauterine pregnancy with an
Question 7:

Do you recommend any changes in the U.S. obstetrics and gynecology residency program curriculum with regard to clinical recognition and treatment of patients with septic abortions?

Response from Dr. Eschenbach:

I recommend that we ensure that all U.S. obstetrics and gynecology residencies teach all residents surgical techniques necessary to complete an incomplete abortion. Such residencies should ensure that all residents know the emergency nature of septic abortions, the need to promptly remove infected tissue, and the potential serious consequences. An added benefit would be to learn the additional skills gained through the performance of induced abortion.

intrauterine device (IUD) in place is unusual, if the string is visible the IUD should be removed to reduce the increased rate of spontaneous abortion and preterm delivery if the IUD remains in place. The rate of septic abortion among women using an IUD is sufficiently low that good data are not available to know the effect of increased IUD use on septic abortion.