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THE INCIDENCE OF ABORTION AT THE JUBILEE HOSPITAL, BELFAST

For my presidential address to the Society I have chosen a subject which, although having a certain suggestion of impropriety, is none the less of such importance that I have no hesitation in enlisting your interest in it.

Over the last number of years the incidence of abortion shows a steady increase. In the Gynaecological Flat of our Belfast Union Infirmary, in which there are forty-seven beds, the number of our abortion cases in the year has increased from under four hundred (in 1926) to over one thousand. As one of the nursing sisters remarked to me a few days ago, abortion is certainly our "big line." This state of affairs to us at present engaged in a great war is one of considerable gravity; compare for a moment the loss in still-birth and neo-natal death. In 1939 in the Maternity Flat there were 1,508 births: 96 infants were still-born; there were 55 neo-natal deaths, a total of 151. The most frequent causes of still-births and neo-natal deaths were extreme prematurity – little removed from abortion, maternal toxaemia, malformations, and development defaults. From abortion in 1939 we had an immediate total loss of 1,020. Allowing for considerable further losses of children before they reach adult life, it is still evident that the greatest loss of potential citizens of the country occurs from abortion; a still-birth or neonatal death is regarded as a major disaster; it should be realised that an abortion at the third month is not a detail to be scarcely worth mentioning, but has the same significance as a neo-natal death – the loss of a potential citizen.

In this address I shall consider two types of abortion only:–

1. Those induced – the criminal abortion.
2. Those due to some pelvic or general pathology.

The criminal abortion, that is an induced one, is diagnosed by direct evidence of injury – lacerations, perforations, or foreign bodies in the cervix, or by definite history of operation, interference, or

drug-taking. It is surprising how many of these women will give to a discreet and kindly nurse a complete history of the details and cost of an abortionist's operation, or the nature and dosage of a drug taken. I think this is due to the fact that they have no sense of wrong-doing in the matter. Just as it is not unusual for a young woman, normally pregnant, to present herself at the hospital to be operated on for her condition, and expresses much surprise that her request is not granted.

Special enquiry is always made in any case of abortion admitted with a temperature – the infected case is always a suspect.

The methods of induction are with drug or instrumental induction. The most popular drugs are –

1. QUININE – stated to be infallible, if taken in sufficiently massive doses. One patient who had used this drug successfully on several occasions stated that she took the drug until she had temporary paralysis of arms and legs: at that stage she aborted.

2. SMITH'S ERGOPIOL – Taken three or four times daily – three tablets t.i.d., three or four tablets t.i.d., four tablets t.i.d. four-hourly: alleged to be successful

in most cases.

3. LEAD PLASTER – One case aborted, but developed acute lead-poisoning.

4. PUL. FERRI ET ALOIS – With a permanganate of potash tablet at night. Method, two pills daily with pot pessary at night.

5. PENNY ROYAL AND STEEL – Dr. Martin's female pills.

Transition stage – slippery elm bark as a pack in vaginal vault, alleged to dilate cervix and start contractions, or a piece of bark inserted in cervix has same action as sea tangle tent.

The operations of the abortionist here seem to be limited to two methods: passing a sound into the uterus, or injection of soap and water through the cervical canal. These individuals must be possessed of considerable manipulative skill, as in cases where the history is very definite, obvious trauma is rare, and the cervix does not even show the marks of a volsullum, so this very essential instrument in intra-cervical manipulations is not used.

To do anything of a deterrent nature about these things is incredibly difficult. I have been in touch with the C.I.D. people here over very many cases: indeed, I will tell you presently of some illustrative cases in the law in Northern Ireland. It seems to me that there is no chance of a conviction unless several policemen and a couple of reputable doctors are actual witnesses of the crime.

When acutely ill and afraid, I have known very many of these women give meticulous and convincing evidence of their operation. When questioned by the police, they will completely deny their former story, attributing it to the delirium of their illness. Even if they do repeat their story to the police, with unsupported evidence – and so often in the absence of trauma, unconvincing medical evidence – conviction seems impossible. For instance, a young woman who consulted a midwife, who was a recognised abortionist, for the treatment of a short period of amenorrhoea, was treated by the nurse by intra-uterine injection. Unfortunately the pregnancy was in the fallopian tube, which ruptured after the second treatment.

After operation, the patient in her convalescence gave details of her case to the police. The nurse was duly arrested and came before the Grand Jury. The defence offered was that the nurse had been consulted re douching for leucorrhoea, a proper treatment, and no suggestion of pregnancy. The Crown exhibits were a Higginson syringe, fitted with a long, narrow vaginal nozzle. Evidence supported the patient's statement, insomuch as there had been an infection of the pelvis and pelvic abscess drained through posterior fornix. The Grand Jury returned no bill, so that the nurse was never brought to open court.

Another case showing difficulty of obtaining evidence is as follows: A young married woman of thirty years of age, thought to be suffering from a ruptured tubal pregnancy, was admitted to hospital. She had all the signs of this condition, and was very desperately ill. At operation, two large perforations of the fundus of the uterus were observed, with an ovum herniating through one of them. The uterus was removed, and the woman made a rapid recovery. The police were notified by the hospital authorities, and on repeated occasions questioned the woman; on all occasions she definitely and very firmly denied any form of operative treatment, and stated that the trouble was due, not to operation, but to the fact that she had strained herself lifting a tub. If you are willing to accept this story of the extraordinary effect of strain on the pregnant uterus, you can see the specimen in the museum at Queen's University.

At times, too, one sees examples of extraordinary determination on the part of a very crude abortionist. I have removed from the uterus of a five-months pregnancy a piece of lath eight inches long and half an inch broad. The cervix was apparently uninjured, and after abortion the patient never had a temperature. No history could be elicited.

One other story of the abortionist, this time of poetic justice. A lady who for many years had run a lucrative practice as abortionist here, had the misfortune to be convicted, and served a term of imprisonment. On her release, in the ordinary course of nature she missed a couple of periods – her age was the mid-forties. Just to make sure, she passed an instrument on herself, perforated her uterus, and died of an acute septicaemia. She was not pregnant. This time the mills of the Lord ground exceeding small.

Considering the tendency to the increase of the conditions, I wonder if the existence of this hospital may not be to some extent responsible for this. The abortionist has only to induce the condition, have the matter so arranged that the patient is sent to hospital, and the responsibility of her recovery, or the reverse, rests on us – an unpleasant thought, but with some degree of fact. We have had very many cases investigated by the police. Quite a number of known abortionists are kept under police observation, but the difficulties of evidence have made the convictions few, but we still have hope.

The second group – due to some general or pelvic pathology – should present a more

encouraging outlook. In the social class to which Poor-law patients belong, the conditions of life as to housing, food, and overcrowding, must be a strong predisposing factor. Abortion does not occur in any comparable proportion in countrywomen or in the well-fed and well-cared-for higher social grades. A constant diet of white bread and tea, deficient in the vitamins, so essential in reproduction, with any other predisposing conditions, will make abortion very likely. The most common of the predisposing factors are rapidly repeated pregnancies, especially if associated with any degree of kidney toxaemia, or nephritis. Syphilis as a predisposing factor is of recent years negligible; not a half per cent. of our cases show a positive Wasserman reaction. Predisposing causes are deep cervical lacerations with chronic cervical infection, and retroflexion with vault prolapse, causing congestion of veins. The most important of these conditions is without doubt the cervix. For the safer development of a pregnancy it is essential that there should be no gross interference with its integrity. I have noticed in cases who have had a high amputation of cervix, and subsequently became pregnant, that abortions may be considered inevitable. In deep lacerations there is the same loss of protection, and the outlook cannot be improved by the presence of chronic infection.

As to the question of endocrine deficiency, I have no doubt it is a factor; its estimation is difficult, and its treatment by endocrine expensive and experimental, and the results in a small series of cases unconvincing.

TREATMENT.

In a case of haemorrhage without dilation of the cervix, absolute rest is the essential treatment. Small doses of morphia or bromide may help. I have not found vitamin E or lutine extract makes any appreciable difference. If bleeding stops, the treatment is rest for one week after it has stopped. One pregnancy in ten of these cases will go on to term. Although immediate results are good, we find that many of the cases are readmitted after a few weeks, with abortion inevitable. If in addition to haemorrhage the cervix is dilated, or any part of an ovary enlarged, the uterus is at once emptied, by use of a flushing curette. I consider digital emptying insufficient, as it leaves the patient liable to further bleeding, and with increased risk of sepsis. Where infection is present, the patient is at once put on prontosil treatment. This we have found of very greatest value; indeed, since its adoption there has been a striking drop in the death-rate of our septic cases.

In 1936 (474 cases) – we had 58 septic cases: 22 severe: 6 died.

In 1937 (637 cases) – 59 septic cases: 15 severe: 5 died.

In 1938 (742 cases) – 60 septic cases: 3 only severe: 1 died.

It was in 1938 that prophylatic prontosil treatment was started.

It is the practice of, I think, the majority of gynaecologists not to subject any patient with a septic abortion, and with a raised temperature, to any form of operation procedure. I cannot persuade myself that it is a good thing to leave indefinitely in the uterus a mass of stinking and infected tissue; better I think is the chance of recovery from a single dissemination from curettage, than in continued absorption for many days or weeks. This opinion of mine I fear will fill the souls of my colleagues with indignation, but it is my considered opinion based on many years experience.