ABORTION: THE INSIDE STORY

SHOULD WE 'ABHOR A VACUUM'?

THIS IS NOT AN INSTRUCTION LEAFLET ON DO-IT-YOURSELF ABORTION, AND TO USE IT AS SUCH COULD BE DISASTROUS. ITS AIM IS TO PROVIDE INFORMATION ON THE TECHNIQUE - SPECIALISED BUT NOT IMPENETRABLY MYSTERIOUS - OF 'MENSTRUAL EXTRACTION'. WHAT IS IT ABOUT ? WHAT ARE THE SNAGS ? WHERE CAN ONE FIND OUT MORE ?

Irrespective of what happens in Parliament, the struggle to control our own bodies, ourselves, must and will continue. If certain laws make it easier rather than (as usual) more difficult, that's fine. But the matter is too important to be left to politicians or to governments. It is also too important for us to abdicate control, or the right to relevant knowledge, and to put ourselves unreservedly and unquestioningly in the hands of the 'experts'.

Of course there is a need for skills and special knowledge, and plenty of it. We are not against expertise. But we are against its monopolisation and against anyone making a fetish of it. Experts, even medical ones, can and do make mistakes. Moreover their decisions may be influenced by non-medical considerations. Responsible ordinary people can make themselves experts, if they choose to, in matters that concern them very closely.

One area where we may have to learn more for ourselves, instead of putting pressure on others to do things for us, is that of simple, safe, early abortion. Basing themselves on existing experience, and collaborating with each other and with sympathetic, well-informed health workers, women in France and in the USA have developed their own health-care facilities, ready to undertake procedures on the borderline of legality. This, incidentally, proved a most effective way of getting the law changed.

In this country the chances of having a very early abortion done on the NHS are slim and probably getting slimmer. If we want to make sure it is and remains one of our options, the only way may be for increasing numbers to get together with gynaecologists and other doctors, midwives and nurses and train systematically to do it themselves. Where this has been done with care and commitment, results have been encouraging. In fact they have at times been better than those obtained in more formally structured clinical trials conducted by high-powered professionals. In one American clinic (Karman, 1972) where ex-abortion patients volunteered to help, 21 out of 45 persevered through an 18-week training course and achieved a high level of proficiency. These women had no previous medical training: their educational backgrounds ranged from 2 years in high school to a master's degree in social work.

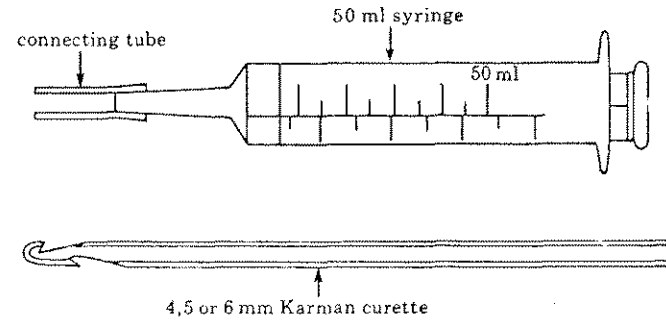
This example shows what can be done under optimum conditions, with the involvement of highly-motivated people including some professionals, willing to learn and with open minds. It may not always be that easy. Any such project must be approached in a responsible way and in full awareness of the possible risks if it is not to result in a list of self-managed horror stories (or at least cautionary tales).

THE KARMAN TECHNIQUE

In a classic paper on the subject, Dr. Harvey Karman (of the Dept. of Medical Research, San Vicente Hospital, Los Angeles, California) stressed that 'although the public had been conditioned to think of abortion as a major operation involving considerable risk, it was obviously absurd to compare an 8-week gestation (which can be aspirated without dilation in 30 seconds on a conscious patient) with a 13-week D and C (dilation of the cervix and curettage) or a 16-week hysterotomy (incision of the uterus)'.

Karman felt that many common assumptions regarding the dangers of abortion proved, on re-examination, to be an indictment of the techniques used or of available equipment. 'It was obvious, for instance, that if a way could be found to avoid the use of tenacula (forceps for grasping the cervix), cervical laceration would be substantially reduced or prevented. Since metal sounds, dilators and curettes would inevitably cause a certain percentage of perforations, these instruments were considered unacceptable'. Karman's first task was to design instrumentation that could safely lend itself to more widespread use. 'Indispensable to this objective was the discovery that cervical dilation was unnecessary in most cases because of the fluidity of embryonic tissue'. Later in pregnancy, of course, this changes.

'For early terminations a small bore, flexible cannula was designed to serve simultaneously as sound, suction wand and blunt curette'. Although 'verbal anaesthesia' proved quite adequate in the majority of cases, each patient was told that a local anaesthetic was available to carry out a 'cervical block'. A short film demonstrating the procedure was screened for those interested in a detailed preview. This proved very helpful. Patients were all carefully interviewed beforehand with a view to discovering those with gynaecological or other disorders, who might have to be referred for more specialised help.



The pregnancies were of about 6-8 weeks' duration (i.e. the menstrual period was from 10-28 days overdue). The patient was not starved or shaved but simply removed her undergarments and lay down on her back with heels drawn up and knees separated (the lithotomy position). Some authorities recommend that the vulva be cleansed with cetavlon and most suggest that the vagina and cervix be swabbed with a povidone-iodine solution. A paramedic first 'evaluated the uterus bimanually for size and configuration'. Any abnormalities were noted, as probably requiring the attention of a physician. The purpose was to exclude the presence of any pelvic mass other than the gravid uterus and to ensure that the womb was not bigger than it should be for the stated duration of the pregnancy. A plastic (non-metallic) speculum of the right size was then chosen to gain good visibility of the cervix and inserted into the vagina. The 'blades' were separated just enough to provide easy access.

A sterile, flexible plastic cannula, slightly precurved manually to fit each patient's uterine outline, was then inserted through the os (the opening of the cervix), using the no-touch technique. The cannula was used to gently 'sound' the uterine cavity. 'If the sounded depth indicates a gestational size consistent with a palpational estimate of 8 weeks' gestation or less, a (self-locking) 50 ml vacuum syringe is attached directly to the cannula. The piston is then slowly withdrawn and locked in position to maintain a negative pressure. Rotative action of the cannula tip near the site of implantation, accompanied by gentle stroking movements to create contact with the entire lining of the womb, is usually sufficient to evacuate the conceptus painlessly in 45 seconds'. The volume fits easily into a 50 ml syringe. Karman had stressed in an earlier paper (1972) how vitally important it was never to thrust the plunger of the syringe inwards when it was attached to a cannula in the uterus. If even a small amount of air was injected a very dangerous complication called air embolism might follow. 'Should the cervix not admit the cannula readily or tend to retract, it is gently grasped by blunt forceps to stabilise its position'.

Following the procedure a medicated tampon was inserted in the vagina. Most of Karman's patients could leave within half an hour. Post-operative instructions were minimal: 'Contact the clinic any time you have a question, a fever above 101.4°F, or bleeding or cramping in excess of normal menstruation'. Fever implies infection and excessive bleeding usually implies that the evacuation was not complete. These are the most likely complications. They are usually not serious but require skilled care.

In experienced hands (paramedical with medical supervision) the complication rate has been as low as 1.3% of 774 patients (Scotti and Karman, 1976). The risk of more serious complications is slight but not non-existent. Women must not be constrained to suppress potentially serious symptoms for fear of making trouble for the health collective.

Equipment should be disassembled, cleansed in soap and water and sterilised for 30 minutes in an antiseptic solution. Ideally, a Karman-type cannula should be used only once. If re-used it should be cold-sterilised - not in iodine or formalin but, for instance, in a 1 in 750 aqueous solution of benzalkonium chloride. It should be examined closely for signs of collapse or tearing at the tip and discarded if defective. Scrupulously clean hands (with or without sterile surgical gloves) are of course essential.

WHO CAN DO IT?

Even orthodox medics acknowledge that clinical experience, rather than academic qualification, counts in making people good at doing all this safely and effectively. Anyone taking on the responsibility should know what she is doing as thoroughly as possible, but commitment to the project and sympathy for the patients are also important. Contacts should be made with those who have already had adequate training (theoretical and practical). Training should include basic anatomical knowledge as well as a programme of observation, assisting, examining and talking with patients. Groups of trainees may practice on each other, extracting menses. It should be obvious, however, that no woman need feel duty-bound to participate in a collective doing this kind of work if it goes against her inclinations, however strong her sympathies with the project. By the same token no woman who is one week overdue need feel that she has to undergo this procedure immediately.

ADDRESSES

International Planned Parenthood Federation : 18 Regent Street, SW1. Tel.: 01 839 2911

International Pregnancy Advisory Service (for information on obtaining kits) : NCNB Plaza, Suite 300, Chapel Hill, North Carolina 27514, USA.

Graves Medical Audiovisual Library : P.O. Box 99, Holly House, Chelmsford CM2 9BJ. Tel.: 0245 83351.

THE LAW

Legal risks, like medical ones, must be consciously faced. As things stand, it is illegal in Britain to attempt (the intention is enough) to terminate a pregnancy except under the terms of the 1967 Abortion Act, i.e. it must be done by a qualified medical practitioner and with the proper certificates. Even if there was no actual pregnancy, an offence has been committed if an unqualified person tried to end one.

There is an area of possible ambiguity. It could be claimed that menstrual extraction or regulation was carried out routinely, or for diagnostic or therapeutic reasons rather than to terminate pregnancy. However, we do not advise anyone to pin their faith on this dodgy 'loophole'.

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