INTRODUCTION
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Population explosion is a global problem. Every three seconds, there are two more mouths to feed. More than 74 million individuals are added to world population every year. This problem is particularly very acute in a developing country like India. India adds to its population every year total population of Australia. Population explosion leads to poverty, illiteracy, unemployment, and epidemic diseases spread easily leading to increased morbidity in the population. So to bring down this birth rate, various family limitation and spacing methods are available free of cost at family welfare centers all over the country. If any method of contraception fails then there is provision for providing facilities for medical termination of pregnancy.

Abortion is the termination of pregnancy by any means before the foetus is sufficiently developed to survive (Williams, 20th edition). The age of viability is usually taken to be 20 wks in developed countries, and 24-28 weeks in developing countries. Since antiquity, the practice of abortion is in existence. Every year, an estimated 40-60 million abortions are performed worldwide, majorities of which are from the developing countries Abortion was legalized in India on broad socio-medical grounds through the medical termination of pregnancy (MTP) Act (act number 34 of 1971), 1971 legalized by the parliament on August 10, 1971, and enforced across the country from April 1, 1972. The objectives of MTP were,

1. Protection of people from quacks.
2. Protection against economic hazards.
3. Protection against health hazards.
According to section 3 (subsection-2) of the act, a pregnancy exceeding 12 weeks but not exceeding 20 weeks requires the opinion of not less than two medical practitioners. Therefore, any induced abortion performed beyond 20 weeks is unprotected by the umbrella of MTP act. It is considered an illegal abortion, unless it is necessary to save maternal life, according to section 5 of the same act. However, there is an appeal from the MTP committee of FOGSI to increase this duration of pregnancy up to at least 22 weeks to cope up with the increased demand of second trimester termination resulting from recent advances in prenatal diagnosis.

It is paradoxical that despite the promulgation of medical termination of pregnancy (MTP) act more than 30 years back, a significant portion of these abortions in India, are still performed illegally and are unsafe. This leads to considerable maternal morbidity, mortality and erosion of national health budget.

The most important reason for liberalization of abortion law is high rate of maternal mortality and morbidity due to illegal and unsafe practices. The termination of pregnancy is neither safe nor simple as to advocate abortion on demand. It has been studied that abortion whether spontaneous or induced, always brings with it hazards resulting in maternal morbidity or mortality. The degree varies with the place and method of abortion and necessary skilled help and ancillaries available.

Due to increased awareness of abortion facilities in hospital, more and more women are taking advantage of termination in first trimester of pregnancy. However, a good percentage of women still come for termination in 2\textsuperscript{nd} trimester. In England and Wales only 10.8 percent of all abortions are performed beyond 12 weeks and in US,
second trimester abortions account for 10 percent of all abortions. The number is higher in developing countries like India. Moreover, the tragedy is that even these relatively smaller number of second trimester abortions are responsible for two-thirds of all abortions related major complications and more than half of the maternal deaths associated with abortion. Unmarried girls and rape victims are late presenters due to social stigma. Non-availability and non-awareness of medical facilities at early gestation due to staying in remote areas is also one of the reasons for resorting to mid-trimester abortion. Another group of patients presenting in mid-trimester are females with diagnosed congenitally malformed foetuses. Thus, formulating a cost and time effective and safe mid-trimester abortifacient is the need of hour for most obstetricians.

First trimester abortions are almost universally performed by surgical evaluation. Surgical evaluation is not safe in mid-trimester and various agents tried for inductions of second trimester abortion are not very promising. Unfortunately, there is no consensus of opinion as regards to the best method for termination of second trimester pregnancy.

The available methods for second trimester abortion are –

1. **Gestation between 13-15 weeks**
   - Dilatation and evacuation.
   - Oxytocics.
   - Prostaglandins.
   - Transcervical intra-amniotic instillation of hypertonic saline (20%) or extra-amniotic instillation of 0.1% ethacrydine lactate is used with limited success.
• To allow the pregnancy to continue up to 16 weeks, when the available intra-uterine instillation techniques can be employed.

2. Gestation between 16-20 weeks.
• Intra-amniotic instillation of hypertonic saline (20%) or hypertonic urea (40%) or mannitol.
• Foreign bodies in the form of catheters and laminaria tents.
• Extra-amniotic instillation of 0.1% ethacrydine lactate.
• Oxytocics.
• Prostaglandins.
• Dilatation and evacuation.
• Aspirotomy.
• Hysterotomy.

In modern obstetrics, there are only two classes of drugs which are considered in induction of labour and abortion i.e. oxytocin and prostaglandins. Oxytocin alone has been used in field of obstetrics for induction of abortion & labour very widely, as it is cheap, easily available but has proven ineffective in quite a number of cases and then usually supplemented by surgical induction, may be evacuation of products per vaginum or hysterotomy.

So, we are still in search of a better alternative in which medical induction may be done with no failure and avoid surgical supplementation.

To improve the safety of the abortion procedure and expedite expulsion, prostaglandins are considered to be the best. Prostaglandins are extensively used because of their uterotonic
effects, cervical ripening effect. Prostaglandins are comparatively safe, effective and rapidly metabolized if accidentally pass into general circulation. Until now dinoprostone, a PGE$_2$ analogue has been the traditional protocol. Recently, newer drugs are under trial in search of a more effective and safer abortifacient and to overcome the obstacles in wide use of previous prostaglandins namely high cost and difficult storage requirements.

Mid-trimester termination can be physically and psychologically traumatic for the patient (Iles, 1989). A high degree of patients' involvement is required and can be stressful.

Considering the increased incidence and severity of complications associated with surgical methods of termination and the relative lack of adequately trained personnel for second trimester termination of pregnancy by dilatation and evacuation. The need for an alternative and safe methods was more importantly felt than ever.

Misoprostol is a synthetic prostaglandin analogue (15 deoxy-16-hydroxy methyl PGE$_1$) that has been approved by the food and drug administration (FDA) to be taken orally for the prevention and treatment of gastric ulcers associated with the use of nonsteroidal anti-inflammatory drugs (NSAIDs). It has also become an important drug in obstetrical practice because of its uterotonic and cervical-ripening actions. It is widely being used in combination with mifepristone for medical termination of early pregnancy.

Use and dosage of misoprostol in mid-trimester abortion has not been widely studied. This study was therefore so designed to evaluate efficacy, safety and tolerance of intra vaginal misoprostol compared to traditional intracervical dinoprostone in mid-trimester abortion.
Misoprostol has edge over traditional dinoprostone and has several advantages namely –

(i) Misoprostol is stable at room temperature, requires no refrigeration, needles or syringes for its storage and administration.

(ii) It is cheaper (cost 1.25% of PGE₂ analogue).

(iii) Is easily stored (shelf-life 2 years).

(iv) It is effective both orally and vaginally.

(v) It has no bronchoconstrictive action and has slight bronchodilatory action.

(vi) Can be safely used in hypertensive patients.

(vii) Its application is technically easy as it is put in the vagina and not intra-cervically (Mundle & Young, 1996).

(viii) It is readily accessible.

(ix) It has lesser side effects by intra-vaginal route.

If the abortion is legalized on demand, the society must accept some responsibility for whatever follows both to the patients and her surroundings. The stress should be laid on the public of all the risk and complications of termination of pregnancy before term. The many delayed complications, physical as well as emotional should not be neglected and therefore complete long term follow up of patients is obligatory.