



Brief communication

Extra-amniotic prostaglandin-E₂ for termination in the second and early third trimesters

A.A. Rouzi^{a,*}, H. Hawasawi^b, H. Abduljabbar^a

^aDepartments of Obstetrics and Gynecology, King Abdulaziz University Hospital, Jeddah, Saudi Arabia

^bKing Fahd Armed Forces Hospital, Jeddah, Saudi Arabia

Received 15 February 1999; received in revised form 10 May 1999; accepted 11 May 1999

Keywords: Pregnancy; Termination; Extra-amniotic; Prostaglandin-E₂

Termination of pregnancy in the second and early third trimesters has always been a common challenge in obstetrical practice. In the United States dilation and evacuation in the second trimester is preferred [1], while in the United Kingdom prostaglandin analogues are favored [2]. Between November 1995 and June 1998, 43 consecutive pregnant women underwent termination of pathological pregnancy in second and early third trimesters according to a protocol using extra-amniotic prostaglandin-E₂ (EAPGE₂) in the Department of Obstetrics and Gynecology at King Fahd Armed Forces Hospital, Jeddah, Saudi Arabia. The protocol was approved by the institution review board. Consent was obtained from all women. Ultrasonography was used routinely to confirm the gestational age. On the day of termination, a 16-French Foley's catheter with a 30-ml balloon was positioned in the internal cervical os

to reach the extra-amniotic space. The rate of infusion of ProstinTM (dinoprostone, UPJOHN, Puurs, Belgium) was 1 ml/h initially. This was increased by 1 ml/h every 2 h until a maximum of 3 ml/h was reached or satisfactory uterine response was accomplished. If abortion did not occur after 12 h or if the catheter fell out before achieving satisfactory response, 40 U of oxytocin in 500 ml of normal saline was started at a rate of 30 mU/min.

The indications for termination of pregnancy are listed in Table 1. The gestational age (mean \pm S.D., range) at the time of termination was 21.2 ± 4.97 , 13–31 weeks. Extra-amniotic PGE₂ was associated with abortion in all women. The mean induction-to-abortion interval was 8.1 ± 7.8 , 1–26 h. Nineteen women needed supplemental oxytocin. Thirteen women underwent surgical evacuation of the uterus after delivery of the fetus. The mean blood loss (clinically estimated) was 145.8 ± 120 ml. There was no major complication related to the use of EAPGE₂. However,

* Corresponding author. Tel.: +966-26772027; fax: +966-25372502.

Table 1
Indications for termination of pregnancy

Indication	Number
Intrauterine fetal death	35
Trisomy 13, 18	2
Lethal fetal anomalies	4
Partial mole	1
Premature rupture of membranes remote from term	1

one woman underwent laparotomy because of perforation of the uterus at the time of evacuation of a retained placenta. Repair of the uterus was done. Fifteen women were given antibiotics (nine women prophylactically and six women for febrile morbidity).

Previous studies have confirmed the safety and effectiveness of EAPGE₂ gel [3,4]. The induction-to-abortion interval with EAPGE₂ gel ranged from 14 to 16.8 h. In our study EAPGE₂ was used as an infusion. This approach was safe, effective, and associated with shorter induction-to-abortion interval. Randomized clinical trials comparing

EAPGE₂ gel with EAPGE₂ infusion are required to confirm our findings.

Acknowledgments

We wish to thank Drs Othman S. Sindi and Bandar Radhan at King Fahd Armed Forces Hospital, Jeddah, Saudi Arabia for their valuable contribution and help to perform this study.

References

- [1] American College of Obstetrics and Gynecologists Technical Bulletin. Methods of mid trimester abortion. 1987;109:1–4.
- [2] Speroff L, Glass RH, Kase NG. Clinical gynecologic endocrinology and infertility. Baltimore: Williams and Wilkins, 1994:710.
- [3] Sorensen S, Heisterberg L, Wolf P. Midtrimester abortion by intracervical prostaglandin E₂. *Eur J Obstet Gynecol Reprod Biol* 1986;21:165–171.
- [4] Hill NCW, Mackenzie IZ. 2308 second trimester terminations using extra-amniotic or intra-amniotic prostaglandin E₂: an analysis of efficacy and complications. *Br J Obstet Gynaecol* 1989;96:1424–1431.