STUDY ON THE EFFECTIVENESS OF MIFEPRISTONE AND VAGINAL MISOPROSTOL IN LATE FIRST TRIMESTER MEDICAL TERMINATION OF PREGNANCIES,MISSED ABORTIONS AND BLIGHTED OVUM.

DISSERTATION SUBMITTED INFULFILLMENT OF THE REGULATIONS FOR THE AWARD OF

M.D.OBSTETRICS AND GYNAECOLOGY.

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CERTIFICATE

This is to certify that **Dr.G.SOWMIYASREE** has prepared this dissertation entitled "**STUDY ON THE EFFECTIVENESS OF MIFEPRISTONE AND VAGINAL MISOPROSTOL IN LATE FIRST TRIMESTER MEDICAL TERMINATION OF PREGNANCIES, MISSEDABORTIONS AND BLIGHTED OVUM"** under my supervision and guidance in the Institute of PSG Institute of Medical Science and Research, Coimbatore in partial fulfillment of the regulations of Tamilnadu **Dr. M.G.R. Medical University** for the award of **M.D.Degree in Obstetrics and Gynaecology**.

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study on the effectiveness of mifepristone and misoprostol in late first trimester medical termination of pregnancies, missed abortions and blighted ovum

by Sowmiya Sree 20101704 M.D. Obstetrics and Gynaecology

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INTRODUCTION

One of the most common gynecological procedures performed in our country is the termination of pregnancy. One in 6 pregnancies results in miscarriage either blighted ovum, missed abortion or incomplete abortions.[1] Even though surgical abortions are said to be safe with good facilities it is not necessary to be offered to all patients. The women seeking termination of pregnancy or whom with blighted ovum or missed abortion should be given the choice between medical and surgical termination.

Miscarriages and induced abortions although a common scenario and medical abortion though has its own advantage the available evidence on medical abortions are still lacking. Options and ideas regarding medical abortions widely vary among practitioners. This is because various protocols

have been followed for in different type of first trimester abortion and so it is difficult to measure the clinical outcomes. So defining a gold standard regimen in these abortions is challenging.

Unwanted pregnancy is a social stress in all societies. Despite availability of effective contraceptives, abortion remains the only remedy for such pregnancies in significant number of woman. This is because of the lack of awareness and poor acceptability of family planning resources. In India abortion is accessible to all woman since 1972 legalisation and thus safe management of unwanted pregnancy is a right of every woman. This drastically reduced many illegal abortions and septic abortions.

Medical abortions based on the use of mifepristone and misoprostol have shown good efficacy and safety profile in early pregnancy abortion. However no clear recommendations are available for late first trimester termination of pregnancies, blighted ovum and missed abortion. This study

focuses on the success rate of medical abortion and with fewer side effects in late first trimester abortions and making it a good alternative to surgical abortions.

Surgical methods like Dilatation, Suction and Evacuation, Dilatation and Curettage are commonly used procedures in medical termination of pregnancies. But requirement of well-trained surgeon and operation theatre with strict asepsis adds limitation to their availability.

Successful medical termination of pregnancy with mifepristone and misoprostol up to 63 days of gestation is well documented.[1] But there is no proper documentation and recommendation of medical abortion in late first trimester 64 days to 91 days of gestation. This study focuses on the efficacy of mifepristone and misoprostol for pregnancy termination in late first trimester.

AIM OF THE STUDY

PRIMARY OBJECTIVE

To study the effectiveness of medical abortion for the termination of pregnancies in late first trimester for MTP, blighted ovum and missed abortion without the need of surgical termination methods.

SECONDARY OBJECTIVES

Comparing the effectiveness of medical and surgical abortions techniques

- To demonstrate the safety of medical abortions.
- To compare the cost effectiveness of medical and surgical methods.
- To provide the alternative to surgical managment for blighted ovum and missed abortion there by decreasing the need for surgical evacuation and anaesthesia.

REVIEW OF LITERTURE

In population studies, miscarriage was common with 15 % of women reporting at least one miscarriage in their reproductive life span. Dilatation and curettage was commonly used method for uterine evacuation for years. In this century many questions were raised whether surgical intervention is needed for all uncomplicated cases of early pregnancy failure.

Diagnosis of missed abortion is determined by ultrasound identification of fetus or embryo without heart activity. Cut off CRL for detecting cardiac activity by transvaginal sonogram is 4mm and by transabdominal sonogram is 9mm.[2,3]

Missed abortion is also termed as fetal demise or missed miscarriage. Here the fetus is dead and retained inside the uterus for a variable period.

Criteria for silent miscarriage or early fetal demise by RCOG, fetal pole with CRL more than 6mm with no heart beat being demonstrable or

CRL 6mm with no change in 7 days. Later is diagnostic for silent miscarriage. The criteria for abnormal gestational sac criteria includes the Trans abdominal ultrasound fails to detect yolk sac when sac diameter is 20mm or greater or fails to detect embryo with cardiac activity when sac diameter is 25 mm or greater[2]. The measurement reduces to 8mm & 16mm by transvaginal sonogram respectively.[3]

Blighted ovum or anembroyogenic pregnancy refers to gestational sac in which embryo has failed to develop or died at a stage which is too early to be visualized. Diagnosis of blighted ovum is made by absence of embryogenic echoes within gestational sac, whose size is larger enough to suggest a pregnancy age at which structures should be visualized, independent of pattern of menstrual cycle.

If the volume of the sac is less than 2.5 ml and not increasing in size by at least 75% in 1 week, the definition of this pathological condition in early pregnancy is a blighted ovum.

For confirmation of the above finding it should be correlated with other clinical and sonographical data including the visualization of gestational sac with abnormal gestational sac criteria. TVS examination is important in differentiating various miscarriage.

In blighted ovum, the fertilized ovum develops into blastocyst, but the inner cell mass and resultant embryonic pole never develops. The gestational sac with syncytotrophoblast invades the endometrium and act partly like a normally developing pregnancy, producing HCG.

The syncytotrophoblast invades endometrium produce HCG. So pregnancy test is positive and clinical signs of pregnancy occurs. But the gestational sac fails to grow and develop normally and the uterus fails to

develop as expected. In these circumstances the incidence of chromosomal abnormalities is high.

Diagnosis of blighted ovum is done by two ultrasound examinations a week apart when there is an absence of embryo development .

MTP

Medical termination of pregnancy signifies voluntary or willful termination of pregnancy before viability and it is permitted by law. Unsafe or illegal abortions means abortion not provided through approved facilities or persons. MTP act was passed in1971 by Indian parliament with intention of checking the numbers of criminal or illegal abortion to reduce maternal mortality and morbidity. But unsafe abortions are still widely prevalence and estimated 60,000 – 70,000 women die annually of unsafe abortion. In addition hundreds of thousands of women suffer from long-term sequence, which include chronic pelvic pain and infertility.[5]

Use of medication to induce abortion dates back to centuries, but medically proven regimen have evolved over the last 50 years. In 1950 the folic acid antagonist 4-aminopterogyl glutamic acid (aminopterine) was used orally to induce medically indicated abortion with women < 3 months of gestation.[6]

In 1970's researches found that natural PG's like PGE2 and PGF2**α** were effective in inducing abortion in early pregnancy[7]. PG analogues like gemeprost, sulprostone, misoprostol were synthesized from rapid metabolite of natural prostaglandins. They were found to be very effective and less side effects than natural prostaglandins. Administrating gemeprost 1mg intravaginal suppository every 3 hours upto 5 doses resulted in complete abortion in 80 to 97 % of cases within < 56 days of gestation[8]. In women < 49 days gestation the efficacy of 0.5 mg sulprostone administration intramuscularly every 3 hours was comparable to suction and evacuation

(91 % vs. 94% respectively)[9]. Thus many trials have been done and concluded that analogs of prostaglandins were good alternatives to surgical evacuation of early abortion.

Main advantage of misoprostol over other PG analogs is that it does not need refrigeration and it is very helpful in developing countries like India.

Medical abortions has some strong reasons to be a better alternative to suction & evacuation which includes

1. In medical abortions there is no need of anesthesia.
2. It gives a psychological impact that it is more natural as it merges with physiological way of menstruation.
3. It is less invasive procedure.
4. It increases the choice of method to the patient.

MIFEPRISTONE (RU 486):

Mifepristone first came to limelight in 1980 for abortions[11]. This is because many trials have proved that misoprostol when used alone in early abortions the success rate was found to be only 46-60%. By adding Mifepristone the success rate of first trimester abortions increased drastically.[10,11]

FDA approved mifepristone in September 2008. Mifepristone is an anti progesterone which counter acts the action of progesterone in progesterone receptor site and thus inhibits the effect of progesterone.

Progesterone is needed to continue the pregnancy as it prepares the endometrium to implant fertilized ovum. When an anti-progestrone like mifepristone is added it disrupts implantation resulting in abortion.

Mifeprestone binds to progesterone receptor with an affinity five times more than that of progesterone.

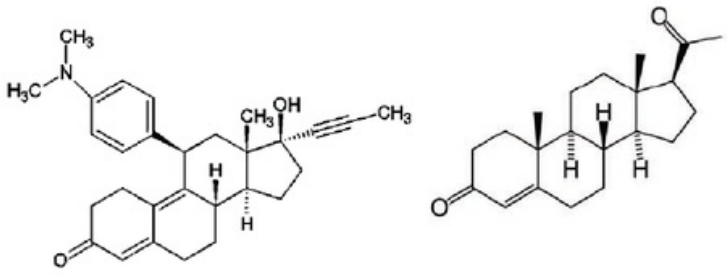


fig.1.structure of mifepristone

Mifepristone acts in 4 ways

Mifepristone causes decidua breakdown resulting in blastocyst detachment, which causes HCG reduction, that in turn decrease progesterone by corpus luteum. This reduction in progesterone again causes breakdown of decidua leading to prostaglandin production.

Affects pituitary gonadotropic cells causes decrease in LH producing leukocytes. Mifepristone reduces Prostaglandin dehydrogenase. This disrupts

the locally produced prostaglandin metabolites, which in turn causes release of PGF2α and PGE2, reaching myometrium and causes uterine contractions.[12]

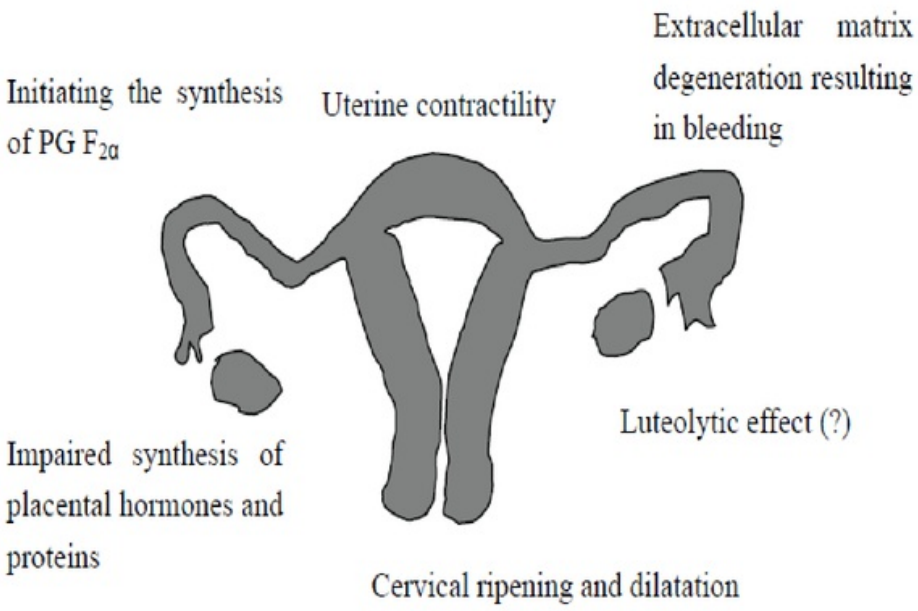


fig.2. Mifipristone – Mechanism of action

It reverses the hyperpolaration of cell membrane and progesterone induced inhibition of gap junction formation[13]. Because of this mechanism gap junction are increases resulting in co ordination contraction of uterus.

It softens the cervix aiding in blastocyst expulsion. Peak plasma concentration is obtained in 10 min and half-life of mifepristone in 18 hrs.

Various dose regimens are available with mifepristone. It is given at a dose of 600 mg orally or 200mg vaginally. Side effects include abdominal cramps, uterine cramps, nausea, vomiting and diarrhea. Mifepristone also has antiglucocorticoid activity. It is also used in postcoital contraception, in endometrious and leiomyoma's and sometimes breast cancer. Cervical ripening of mifepristone has extended its use later in induction of 2nd trimester intra uterine death.

MISOPROSTOL :

Misoprostol was first found in 1991. It is a synthetic 15-deoxy-16 hydroxy-16 methyl analog of prostaglandin E1[17]. As mentioned earlier misoprostol is a prostaglandin analogue. It is economical and readily available. Easily stored, when compared to other prostaglandin analogs. It was initially used for treatment and prevention for peptic ulcer. For treatment of peptic ulcer it is given at a dose of 800mcg in divided doses. When it was used for peptic ulcers it was observed that it caused strong contraction of uterus and cause miscarriage and hence it was contraindicated in pregnant woman. Later its clinical use was extended for pregnancy failure and to induce abortions. It is also used in termination of pregnancy and induction of labor.

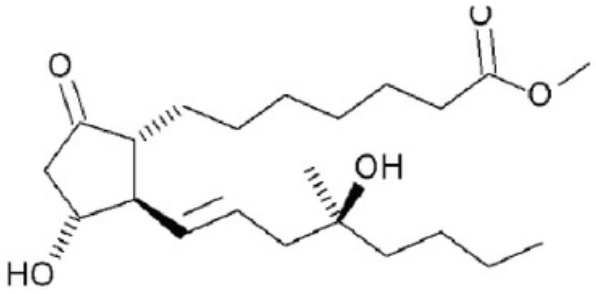


fig.3. structure of misoprostol.

In most of the countries inspite of extensive research on its efficacy it is not approved for abortion. Use of misoprostol for abortions are off –label use. Off label use of these medications are legal and used as a standard of care if evidence based practice are followed.

Misoprostol has become an important part in reproductive health by establishing its usage in induction of abortion, missed abortions and incomplete abortions, usage in cervical softening before suction and evacuation and for labor induction and post partum hemorrhage.[46]

It acts as an uterotonic and also helps in cervix ripening. It is given in various routes like oral, sublingual, vaginal and rectal. Initially misoprostol was used in oral route for termination of pregnancies. Later misoprostol was used by vaginal route as the success rate of abortions were better in vaginal route. When given orally plasma level reaches faster as its abortion is better orally. But the duration of action in uterine contractions is better in vaginal route. Moreover in vaginal route its action causes regular contractions.

In vaginal misoprostol there is a wide individual variation in absorption.[14] Sublingual misoprostol causes stronger contraction initially but its action reduces in 2-3 hours.

It is said that adding water before keeping vaginal misoprostol increases its absorption. But no evidence of confirmation has been seen in various studies. Side effects include diarrhea, nausea, and vomiting, bleeding and abdominal cramps. Misoprostol is a potent teratogen in the first trimester. It may cause limb anomalies and Mobius syndrome with frontal facial set of lesions.

MTP ACT

Medical termination of pregnancy act was passed in 1971. This act as passed with the intention of checking the number of criminal and illegal abortions and to reduce maternal morbidity and mortality. This act was passed to fulfill the following objectives

- The rate of criminal abortions should be brought down.
- To protect the health of pregnant woman.
- To liberalize abortions by including various eugenic, humanitarian and social indications.

MTP act defines

- Indications for which abortions can be done.
- Who can give the consent for MTP.
- By whom MTP can be performed.
- When and where it can be performed.
- Punishment for contravention of the act.

The circumstances under which MTP act can be performed includes

1. The Continuance of the pregnancy causes hazard to the maternal life or her physical or mental status.
2. Eugenic if the child may be born with serious handicap either with physical or mental abnormality.
3. Social-economic where actual or reasonable foreseeable environments could lead to risk of injury to the health of mother.
4. Humanitarian- pregnancy caused as a result of rape
5. Failure of any contraceptive method can be presumes to constitute a grave mental injury to the mother.[15]

The consent of the pregnant woman is necessary for termination of pregnancy. Written consent of the guardian is necessary if the woman is < 18 years or the woman is mentally ill.

The person by whom MTP is done should be a registered Medical Practitioner with adequate qualification and trained to carry out safe MTP with the capability of handling complications. MTP can be done by a Registered Medical Practioner with

- Post graduate qualification in obstetrics and gynecology
- Six month house job in obstetrics and gynecology
- Experience for more than 1 year in a hospital in practice of obstetric and gynecology
- Has assisted any Registered Medical Practioner in 25 MTPS in recognized hospital

MTP can be done in

- Government hospital or in a hospital approved for MTP by government or district level committee (amendment 2002)

- The hospital should have operation table, instruments for abdominal or gynecological surgery, anesthetic equipment's and sterilization and resuscitation equipment's.

MTP can be done by Registered Medical Practioner when the gestational age < 12 weeks. If the gestational age > 12 weeks and < 20 weeks opinion of two Registered Medical Practioner is necessary.

Counselling is necessary in MTP, the counsellar should give the women an opportunity to discuss whether to continue the pregnancy or terminate it. The doctor should provide information and keep the women to decide what is best for her with in the constraints of laws. Some definite maternal indications for abortions are diabetic retinopathy, sickle cell diseases, cardiac diseases NYHA grade 3 and 4, Eiscenmengers syndrome, autoimmune diseases, Psychiatric or neurologic illness taking medications having terotogenic effect.

Some fetal indications includes major congenital abnormalities like anencephaly, or severe neural tube defects.

Contraindications include

- Suspected ectopic pregnancy or any adnexal mass.
- Chronic adrenal failure.
- Any hematological disorder.
- Allergy to the drugs used in abortions.

MEDICAL ABORTIONS

There are certain guidelines in following the medical abortions. The physician treating should be sure of gestational age. Ectopic pregnancy should be excluded. Arrangements for the follow up of incomplete abortions should be made. The patient should be aware of the need to undergo surgical abortion in case of failure of the medical abortion.

Standard FDA regimen

- On day 1 Mifepristone taken orally by the patient.
- On day 3, Misoprostol 400 microgram given orally.
- On day 14, patient returns for follow up and an ultrasound is done. Surgical abortion is recommended if there is retained products of conception.

Trials by Peyron, Aubrey and Spitz demonstrated an efficacy rate of 95% for gestation age < 49days.[18] Various evidence based regimens emerged by reducing the dose of misoprostol, alternative routes of misoprostol administration and raising the gestational age of medication abortion.

These studies led to the use of medical abortion at a greater gestational age with good success rates.

Various trials established that 200 mg mifepristone works as well as 600 mg mifepristone.[19] Mifepristone binds to alpha 1-acid glycoprotein in

serum. Low dose of mifepristone saturates these molecules easily. This change in mifepristone dose lowered the cost drastically. Also vaginal misoprostol increase the efficacy than oral misoprostol. Its onset of action is slow but it has sustained action.

Other regimens include vaginal misoprostol alone 400 microgram or 800 microgram at 4 hours interval. Schaff et al conducted a study comparing the dose of vaginal misoprostol 600 and 800 micro gram and found that higher dose were effective.[20]

Few studies showed continuous administration of vaginal misoprostol 400 microgram at interval of 4 hours continuous for a maximum period of 3 days were effective. 69% had expulsion within 24 hours and 91 % had expelled in 3 days.[21]

A retrospective study by Crenin et al compared 400 microgram with 800 microgram and showed the later dose was more effective.[22] Till date

there is no standard dose limit for misoprostol. Mifepristone and Misoprostol regimen is one of the most widely practiced regimens in medical abortion. Before mifepristone was approved low dose methotrexate was used with misoprostol.[16]

Multicentric trails by World Health Organisation have stated that the effectiveness of 600 mg of mifepristone is equivalent to 200 mg mifepristone followed by a Prostaglandin.[23]

In a study conducted by Hilary and colleagues the regimen of 200 mg mifepristone followed by 800-mcg vaginal misoprostol had high success rate of 90-99% with complete expulsion.[24]

Medical termination of pregnancy with mifepristone and misoprostol has been proved effective up to 9 weeks in various trials[26]. Mifepristone and misoprostol regimen combination has been proved to have a better advantage than other regimen of misoprostol alone or mifepristone alone [25,27].

Study by Ashok and colleagues compared medical abortion with suction and evacuation and found to have an overall efficacy of 94.7 % with mifepristone and misoprostol[28]. The mifepristone and misoprostol regimen is one of the most acceptable regimen.[11] A large scale study of this regime was first reported in 1993 in France.[29]

E1 Rafey et al in his recommended trial found that comparing mifepristone a regimen using oral and intravaginal Misoprostol found that success rate with vaginal was higher than oral (95% vs. 87 %).[30] Intravaginal administration of misoprostol has lower incidence of vomiting, nausea and diarrhea.[31,43]

Following the clinical trials of Peyron, Aubney and Spitz investigators begin to examine ways of improving medication abortion with mifepristone and misoprostol. These studies have led to increased convenience, efficacy at greater gestational age, greater privacy and cost effective.

Medical termination of pregnancy is said to be successful if complete expulsion of product of conception has occurred without the aid of suction evacuation or other surgical procedures.[47] The success rate depends on the period of gestation, route and dose of medication. Numerous studies had proved about the safety and efficacy of medical abortion particularly with mifepristone and misoprostol regimen.[41,42,44]

MATERIALS AND METHODS

This study was conducted in the Department of Obstetrics and Gynecology, PSGIMSR hospitals from January 2011 to June 2012.

STUDY DESIGN

Prospective case control study.

STUDY POPULATION

Study group compressed of women attending in the Department of Obstetrics and Gynecology out patient department in PSGIMSR hospitals seeking termination of pregnancy from 7 weeks to 13 weeks of gestational age for MTP , blighted ovum and missed abortion.

INCLUSION CRITERIA

- Women seeking termination with gestational age 7 weeks to 13 weeks.
- Blighted ovum and missed abortion with gestational age 7 weeks to 13 weeks.

- Women willing for medical abortions.
- Singleton pregnancy.
- General good health.
- No allergy or hypersensitivity to prostaglandins.

EXCLUSION CRITERIA

- Women in first trimester pregnancy with gestational age < 7 weeks.
- Women with gestational age > 13 weeks.
- Severe anemia.
- Multiple gestations.
- Molar pregnancy.
- Undiagnosed adnexal mass.
- Women with increased bleeding or threatened abortions.
- Hypersensitivity to prostaglandins.
- Not willing for medical abortions.

Women who were not willing for medical abortion and who opted for simultaneous tubal ligation were taken as controls and were performed surgical evacuation.

METHODOLOGY

Women seeking termination of pregnancies under gestational age of 7 to 13 weeks were included in the study. Ultrasonography was performed and gestational age was calculated using crown rump length.

Gestational age was assessed on menstrual history and ultrasound examination. Crown rump length and gestational sac diameter measurements were taken wherever needed. Missed abortion was diagnosed when crown rump length was >6 mm and absent fetal heart rate. Blighted ovum was diagnosed when there is no fetal pole with gestational sac diameter > 25 mm.

In those women who wanted to terminate the pregnancy in first trimester due to the reasons falling under MTP act, gestational age was calculated by menstrual history and ultrasonagram.

Women were offered information about both the medical and surgical methods of abortions. An informed written consent from the patient was obtained.

Women who were not willing to undergo medical abortion and those who need tubal ligation concurrently were performed suction and evacuation after a single dose of vaginal misoprostol. These patients were taken in comparison group. Also those women who wanted termination in the first visit to hospital and who were not willing to wait for 48 hours after mifepristone were also taken as controls by giving a single dose of 400 micro gram misoprostol vaginally and performed suction and evacuation 3 hours later.

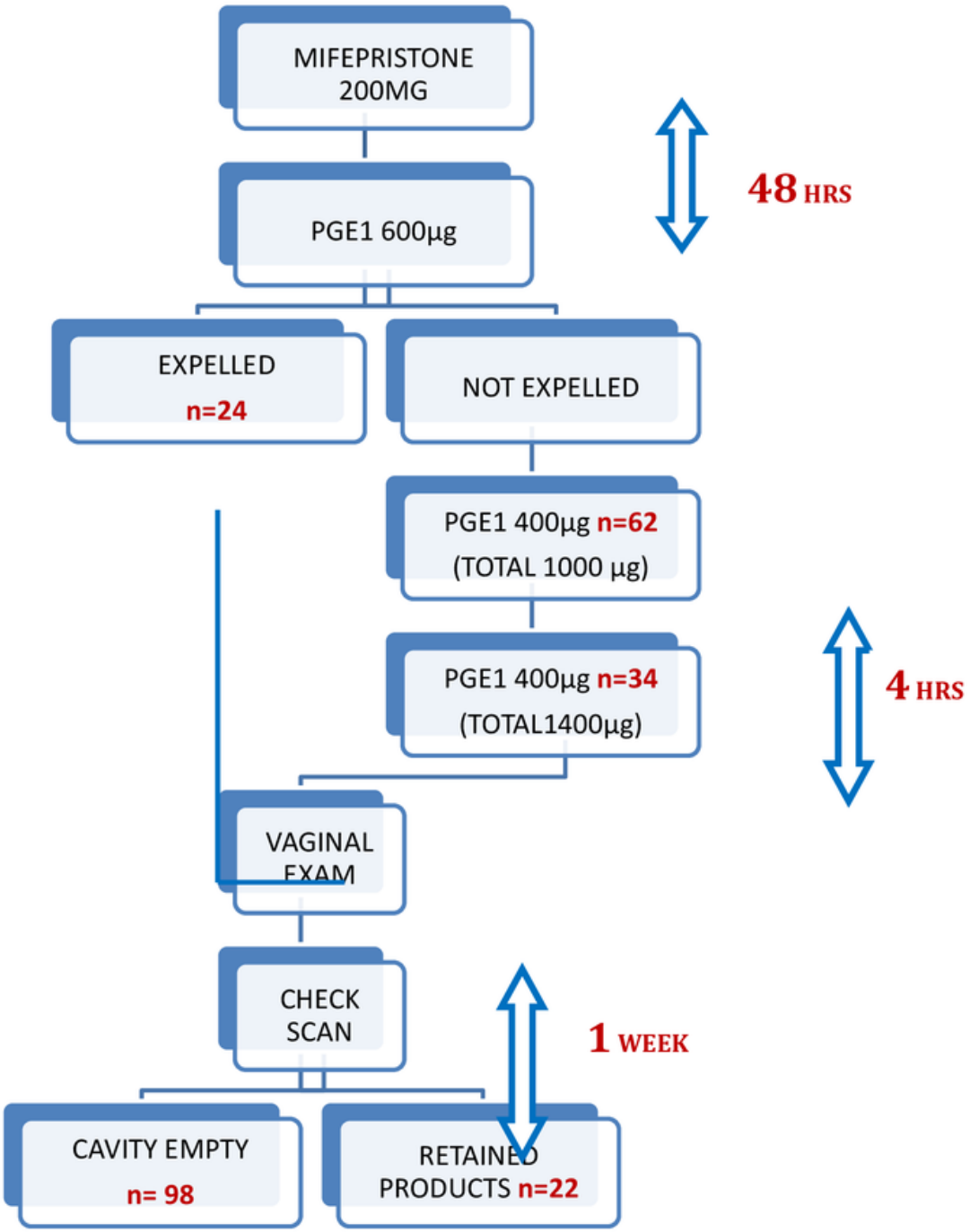
In patient whom the medical abortion has to be performed a detailed history is obtained. Proper assessment of gestational age and clinical examination is done. An ultrasound is performed for accurate assessment of gestational age and also to assess the type of miscarriage. Informed written consent is obtained.

For medical abortion the following things were needed:

1. T. Mifepristone 200mg.
2. T Misoprostol 200 mcg (minimum 2 tablets- maximum 7 tablets).
3. Glove 2 pairs.
4. Sterile cotton, sterile solution.

Tablet Mifepristone 200 mg given orally during the first visit in the out-patient Department. She is asked to come to the hospital after 48 hrs or immediately if she has bleeding or expelled any clots.

MEDICAL PROTOCOL AND THE OUTCOME



During her second visit after checking her vital signs, first dose of misoprostol 600 mcg kept vaginally in the posterior fornix. She is monitored for any expulsion of products of conception or bleeding per vaginam.

If she has not expelled, with in 4 hours, than the second dose of vaginal misoprostol 400mcg kept in the posterior fornix. She is watched for any bleeding or expulsion of products.

If still not expelled in another 4 hours, then third dose of 400 micro gram vaginal misoprostol is kept. The total maximum dose of misoprostol in our study is1400 mcg & the minimum dose is 600mcg.

If there is an increased bleeding between the doses of misoprostol or if the products of conception were not expelled or if there are any retained products then surgical evacuation was performed. If the product of conception expelled between the doses of misoprostol or after the doses of

misoprostol, check scan was performed on the next day or after a week. If retained products found in ultrasound surgical evacuation is performed.

For those patients who wanted tubal ligation along with MTP, or those who were not willing for medical abortions , termination was done by suction evacuation.

Misoprostol 400 micro gram was kept intravaginally for cervical priming. Three hours later surgical evacuation was performed under the following way.

Intravenous opiods inj.Pentazocine 30 mg and inj. Promethazine hydrochloride 25 mg intramuscularly given for analgesia before the procedure.

Instruments required for suction & evacuation

- Sims speculum 2 nos.
- 10% povidine iodine.
- Sterile covering sheet.
- Sponge holding forceps.

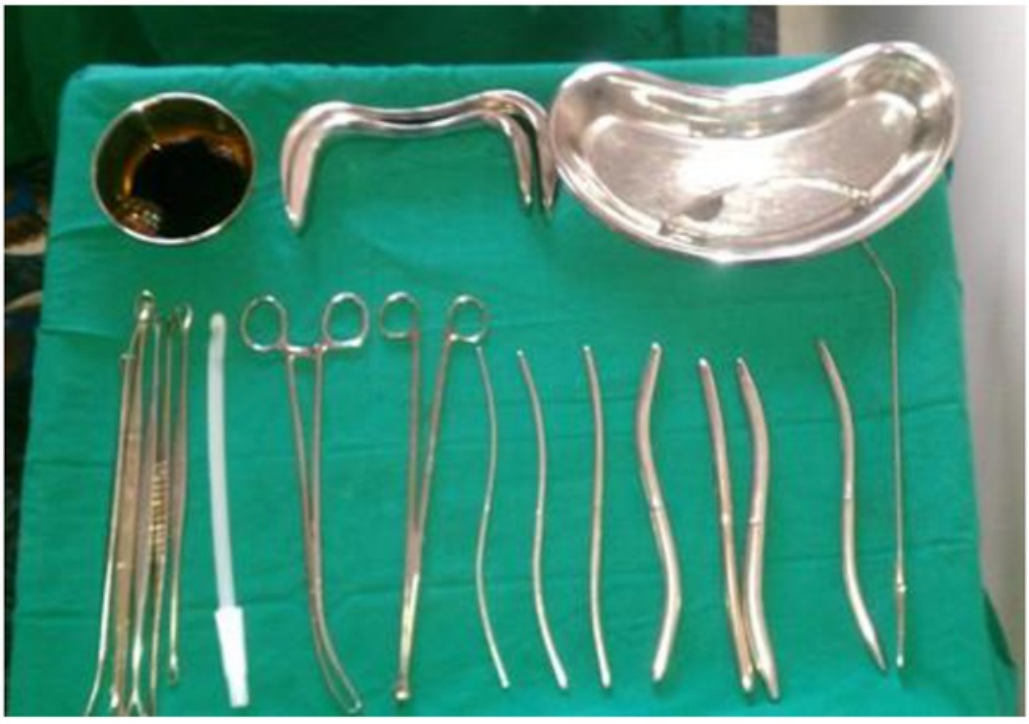


fig.4.suction and evacuation set

- Vulsellum.
- Hegar's dilators of various sizes.
- Karman's cannula.
- Uterine curette.
- Uterine sound.
- Metal catheter.
- Glove 1 pair.
- Suction apparatus.
- 400 mcg misoprostol.

Patient is put in lithotomy position . Vulva and vagina cleaned with 10% povidine iodine solutions. Under aseptic precautions bladder is drained by metal catheter.

Bimanual examination is performed to note the size and position of the uterus. The cervix is caught with vulsellum after placing a vaginal speculum in the posterior aspect . Cervix is examined . Very few patients require dilators to dilate cervix as misoprostol would have primed the cervix. If the cervix has tight internal os, it is dilated with suitable Hegar's dilators.

A uterine sound is passed to measure the uterine size and also its position. It should be passed gently to avoid uterine perforation. Karman cannula of suitable size usually no 6 attached to controlled electric suction apparatus. The suction apparatus provides a negative pressure of 625mm Hg. The assembly need to be checking for airtightness before its insertion.

Karman's cannula is introduced up to the fundus and suction machine is started. The vacuum is created and the cannula is moved against the uterine wall from above downward to internal os in a clockwise manner for

360 degree to evacuate the uterus. The cannula is introduced intermittently till the grating sensation is felt over the whole of uterine cavity.

Bleeding is checked . The vulsellum and speculum are removed . If required check curettage is done. Bimanual examination repeated to be sure that the uterus is smaller than pre procedure.

The products evacuated should be checked in volume, nature and whether consistent with gestational age.

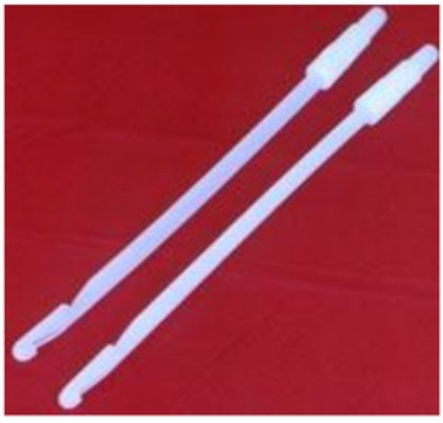


fig.5.KARMAN'S CANNULA

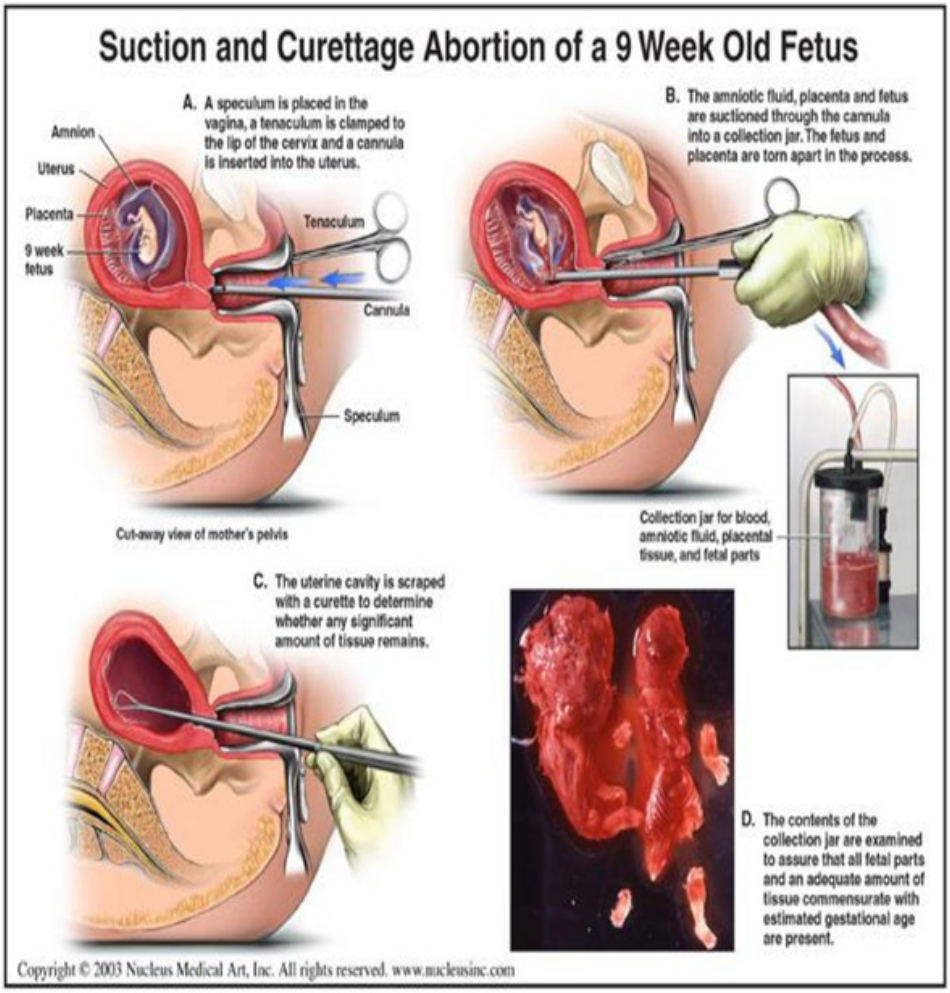


Fig.6. Suction and Evacuation Procedure

Post procedure pulse and blood pressure are checked. Patient is observed for 1-2 hours and checked for increased bleeding and can be discharged with analgesics and antibiotics if needed. Check scan is performed the next day or in a week.

Incase of Rh-negative pregnancy both in medical abortions and surgical abortions Anti-D given to the patient.

All patients undergoing medical abortions were explained about the chance of surgical evacuation if the products were not expelled or if there is increased bleeding or if there are retained products in check scan. While performing medical abortion patient's pulse rate & blood pressure is checked every hourly . She is monitored closely for increased bleeding. If the patient complains of increased abdominal pain analgesics are given. If there is complete expulsion of the products she is discharged the same day. If check

scan is not performed that day she was asked to come 1 week later for ultrasound.

Outcome measures

Primary outcome measured the rate of complete abortion without any surgical intervention. This is mainly assessed by ultrasound and clinical expulsion of products.

Other outcome measures included

- The number of doses.
- Dose to expulsion interval.
- Vaginal bleeding.
- Side effects.
- Cost effectiveness.

Patient who expelled the products of conception and whose check scan showed no retained products were considered to be successful termination. Those whose check scan showed retained products or those who didn't expel with mifepristone and misoprostol regimen were considered as failure and suction and evacuation was performed.

The dosage to expulsion interval was taken from the first dose of misoprostol to expulsion time. Cost of medical abortion and surgical evacuation also compared and side effects noted with medical abortions also were analysed.

RESULTS

The study period included 240 patients. 120 patients had medical abortion and 120 patients had surgical evacuation for termination of pregnancy. The mean age group was 25 years and the mean gestational age was 68.47 days.

	AGE(yrs)	GA (days)
Mean	25.08	68.47
Std.deviation	4.853	13.094
Range	24	50
Minimum	17	41
Maximum	41	91

Table.1. Demographic data

	CHECK SCAN	N	MATERNAL AGE Mean	Std. Deviation
	CAVITY EMPTY	98	23.97	4.685
	REATINED PRODUCTS	22	25.77	4.253

T TEST	t	df	P VALUE
	-1.658	118	.100

Table.2.MATERNAL AGE Vs. OUTCOME

When identifying whether maternal age is influencing the outcome of medical abortion, it was evident that there was no significant difference. Hence age of the patient is not influencing the outcome of medical termination of pregnancy.

The two groups of women were similar with parity and both groups were comparable.

			GROUP		
			CASE GROUP	COMPARISON GROUP	Total
PARITY	PRIMI	Count	57	45	102
		% within PARITY	55.9%	44.1%	100.0%
	MULTI	Count	63	75	138
		% within PARITY	45.7%	54.3%	100.0%
Total		Count	120	120	240
		% within PARITY	50.0%	50.0%	100.0%

Table.3. Distribuation of Parity

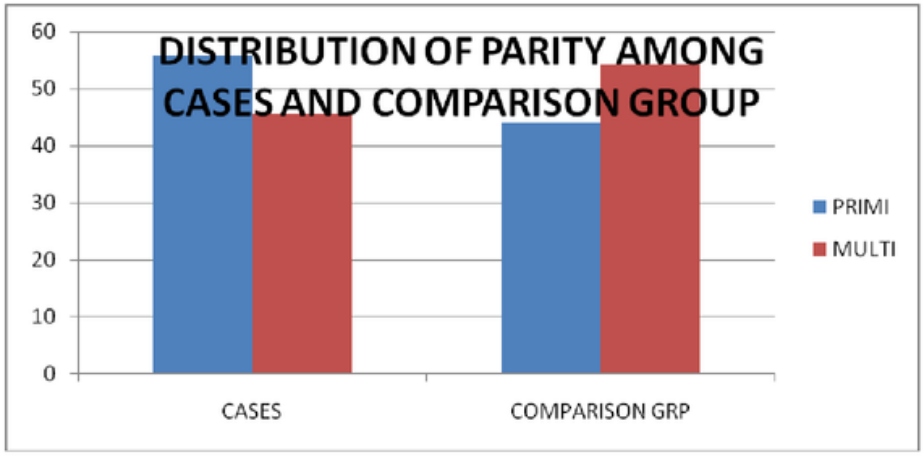


Fig.7.

Both the medical abortion group and surgical evacuation group had similar number of risk factors and were comparable.

Risk factors includes the previous cesarean, medical disorders like hypothyroidism, autoimmune diseases, Rh negative pregnancy and retroviral positive cases.

Table.4. RISK FACTOR * GROUP Crosstabulation

			GROUP		
			CASE GROUP	COMPARISON GROUP	Total
RISK FACTOR	NIL	Count	80	79	159
		% within RISK FACTOR	50.3%	49.7%	100.0%
	PRESENT	Count	40	41	81
		% within RISK FACTOR	49.4%	50.6%	100.0%
Total		Count	120	120	240
		% within RISK FACTOR	50.0%	50.0%	100.0%

RISK FACTORS

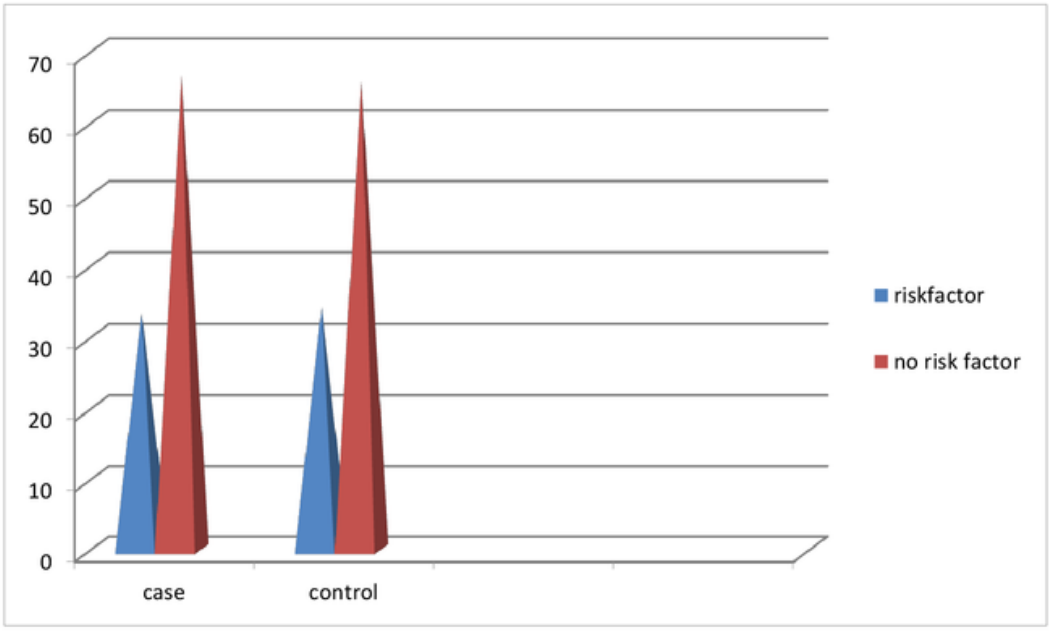


Fig.8.

The main risk factor in both the groups included a history of previous cesarean section.

Table.5. Type of Abortions

			GROUP		
			CASE GROUP	COMPARISON GROUP	Total
USG	SLIUF(MTP)	Count	31	30	61
		% within USG	50.8%	49.2%	100.0%
	MISSED ABORTION	Count	55	61	116
		% within USG	47.4%	52.6%	100.0%
	BLIGHTED OVUM	Count	34	29	63
		% within USG	54.0%	46.0%	100.0%
Total		Count	120	120	240
		% within USG	50.0%	50.0%	100.0%

In medical abortion group 45.83 % comprised of missed abortions, 28.3 % comprised of blighted ovum and 25.8 % comprised of MTP.

The type of abortions was compared in both groups. Both the groups included blighted ovum, missed abortions and MTP.

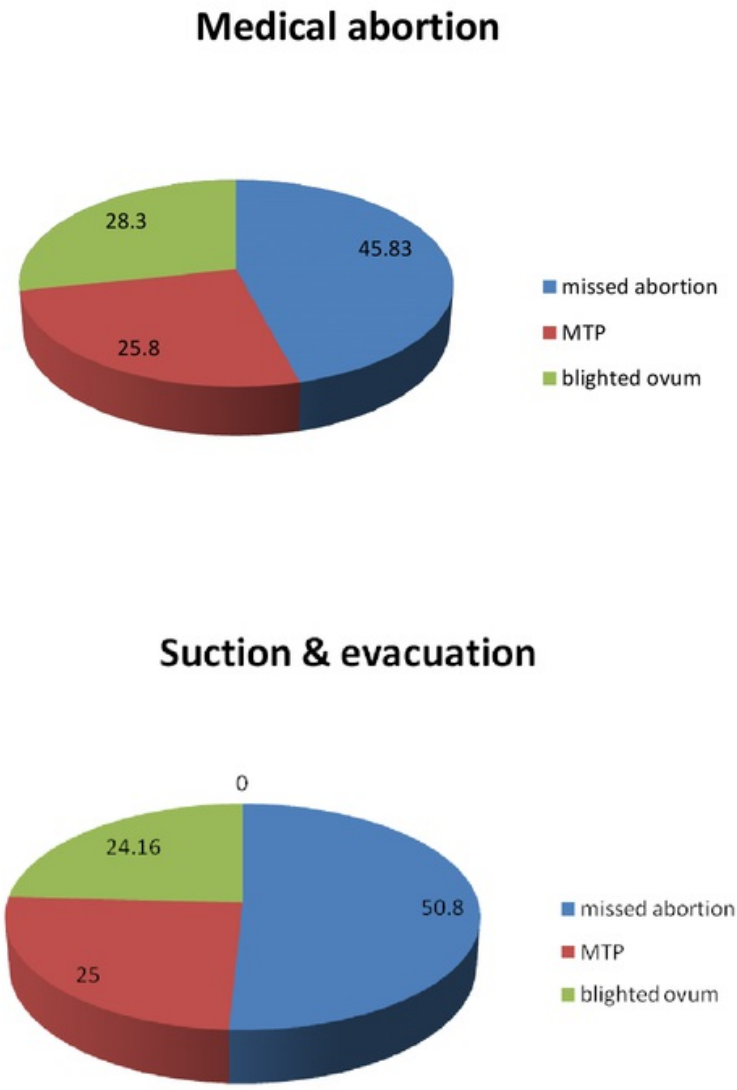

Medical abortion
28.3
45.83
25.8
missed abortion
MTP
blighted ovum
Suction & evacuation
0
24.16
50.8
25
missed abortion
MTP
blighted ovum

fig.9.

Table.6.Number of doses Vs PARITY

			PGE 1			
			600 mcg	1000 mcg	1400 mcg	Total
PARITY	PRIMI	Count	13	29	15	57
		% within PARITY	22.8%	50.9%	26.3%	100.0%
	MULTI	Count	11	33	19	63
		% within PARITY	17.5%	52.4%	30.2%	100.0%
Total		Count	24	62	34	120
		% within PARITY	20.0%	51.7%	28.3%	100.0%

Table.7.Chi-Square Tests

	Value	df	P VALUE
Pearson Chi-Square	.597[a]	2	.742

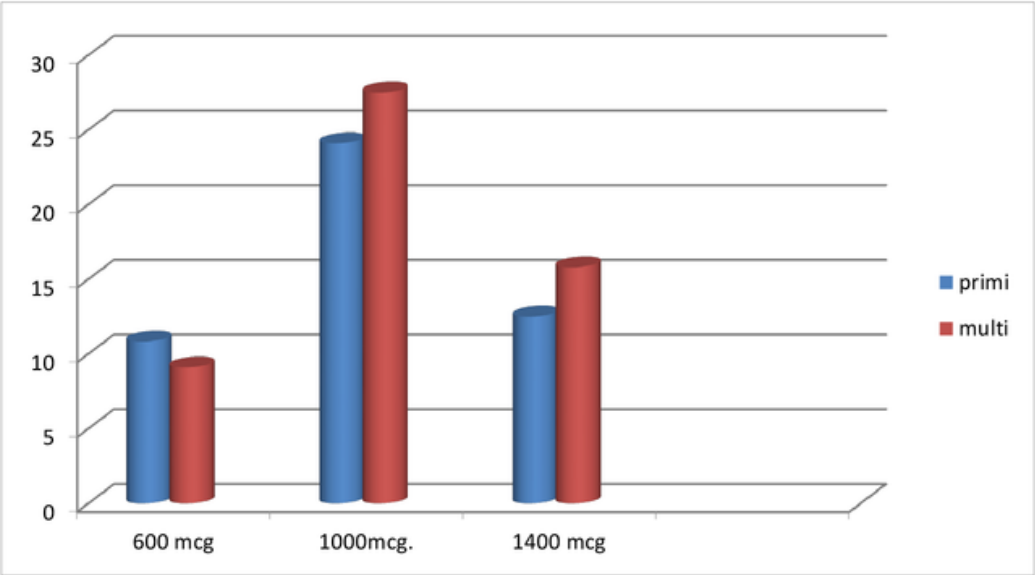


fig.10.

In medical abortion group parity was not influencing the number of doses of misoprostol for the expulsion of products.

p value = 0.74 & it was statistically insignificant. Therefore irrespective of the parity requirement of misoprostol dosage was similar.

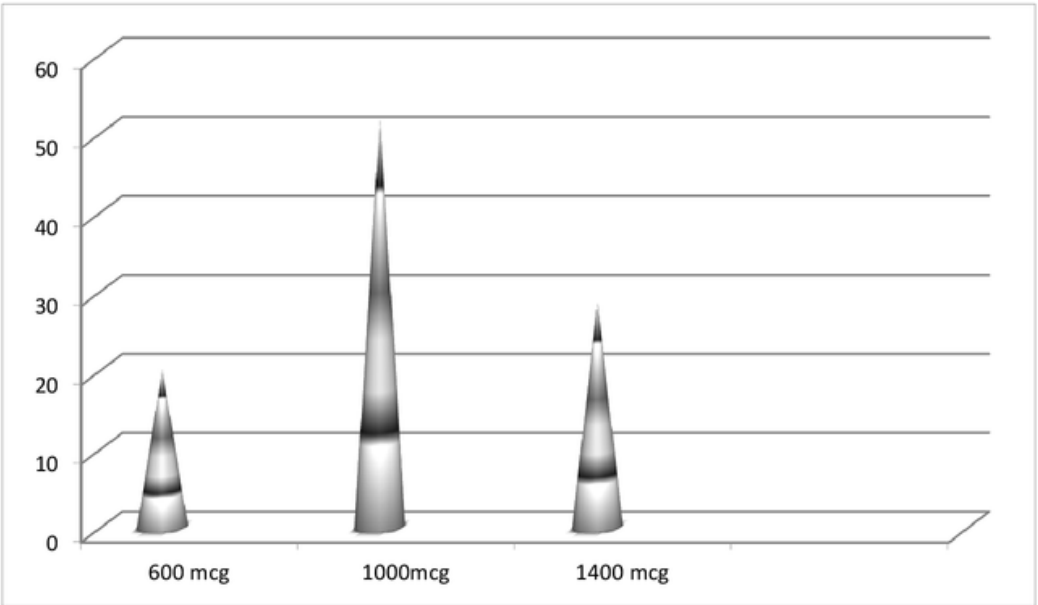


fig.11.

In medical abortion group 20 % of patients required 1 dose of misoprostol, 51.6% required 2 doses of misoprostol and 28.4 % required 3 doses of misoprostol. Thus in this study major group of patients required 1000 mcg of misoprostol to expel the products of conception.

Table.8.Dose Vs Retained Products

			CHECK SCAN		
			CAVITY EMPTY	REATINED PRODUCTS	Total
PGE 1	600 mcg	Count	24	0	24
		% within PGE 1	100.0%	.0%	100.0%
	1000 mcg	Count	57	5	62
		% within PGE 1	91.9%	8.1%	100.0%
	1400 mcg	Count	17	17	34
		% within PGE 1	50.0%	50.0%	100.0%
Total		Count	98	22	120
		% within PGE 1	81.7%	18.3%	100.0%

	Value	df	P VALUE
Chi-Square	32.526[a]	2	.000

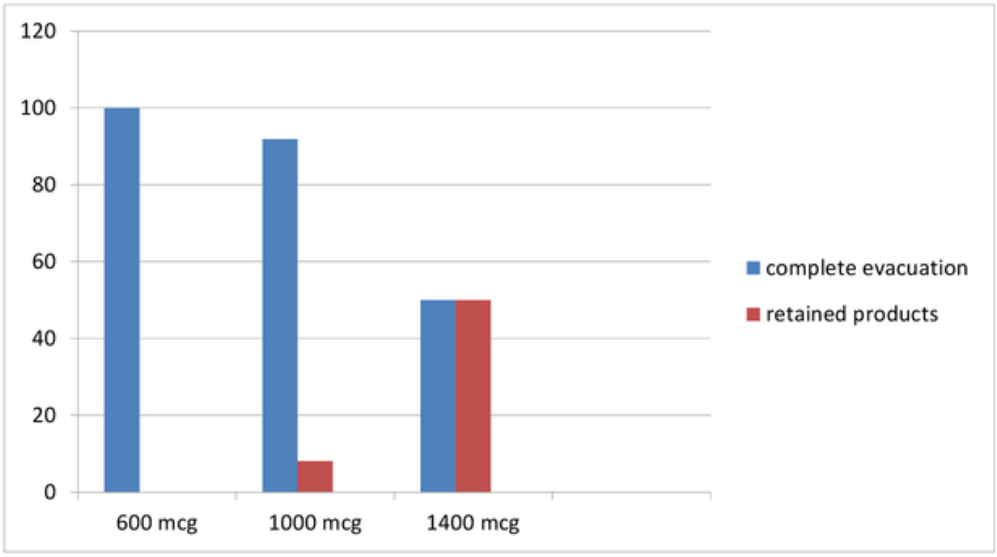


fig.12.

In this study it was found that those who require more doses of misoprostol , the chance of retained products were more. Almost half of the patients who required 3rd dose of misoprostol had to undergo a suction & evacuation for retained products.

There is no statistically significant difference in the gestational age & dosage of misoprostol in the medical abortion group. This shows that the duration of gestational age is not influencing the dose requirement of misoprostol to expel the products of conception.

Table.9. Dose VS Gestational Age.

	GEST AGE (DAYS) MEAN ± SE			
PGE1 DOSE REQ	N	Mean		Std. Error
600 mcg	24	65.50		2.265
1000 mcg	62	69.87		1.812
1400 mcg	34	69.62		2.481
ANOVA	SSB	df	F	Sig.
	353.328	2	.933	.396

Table.10.Gestational Age Vs Retained Products

			CHECK SCAN		
			CAVITY EMPTY	REATINED PRODUCTS	Total
gestational.grp	7 - 9 weeks	Count	43	10	53
		% within gestational.grp	81.1%	18.9%	100.0%
	more than 9 weeks	Count	55	12	67
		% within gestational.grp	82.1%	17.9%	100.0%
Total		Count	98	22	120
		%within GA	81.7%	18.3%	100.0%
Chi-Square Tests					
	Value	Df	p value		
Pearson Chi-Square	.018[a]	1	.893		

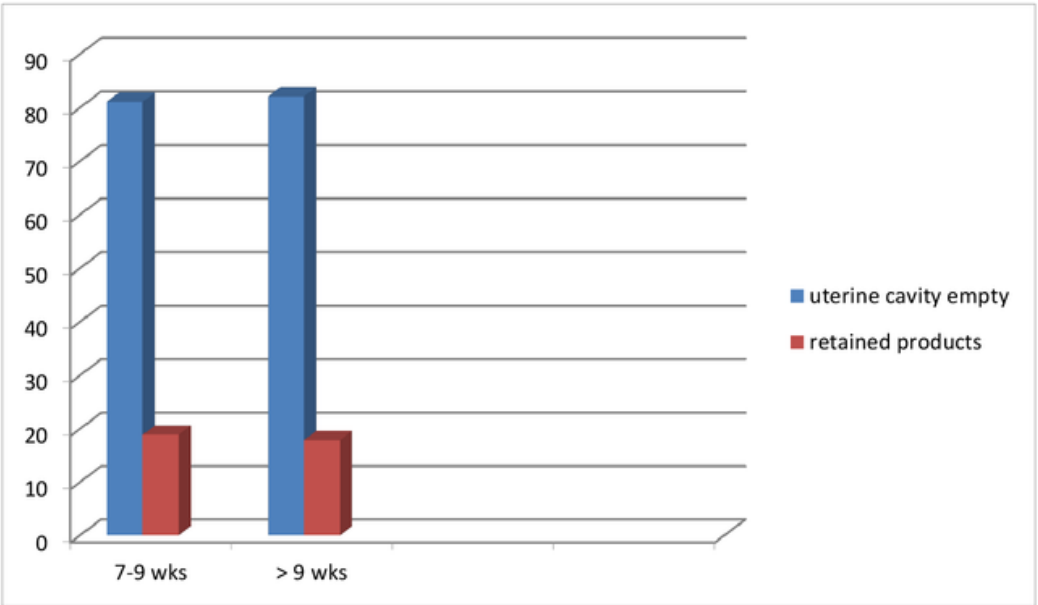


fig.13.

Pregnant females in both early and late trimester has the same failure rate. That means there is no difference in their failure rate in late first trimester abortions.

In this study it was evident that the gestational age in the late first trimester abortions did not determine the dosage of misoprostol & the success rate of medical abortions.

Table.11.SIDE EFFECTS - MEDICAL ABORTION

	NO	PERCENTAGE
BLEEDING	5	4.16
ABDOMINALCRAMPS	8	6.66
RISE IN TEMPERATURE	7	5.8

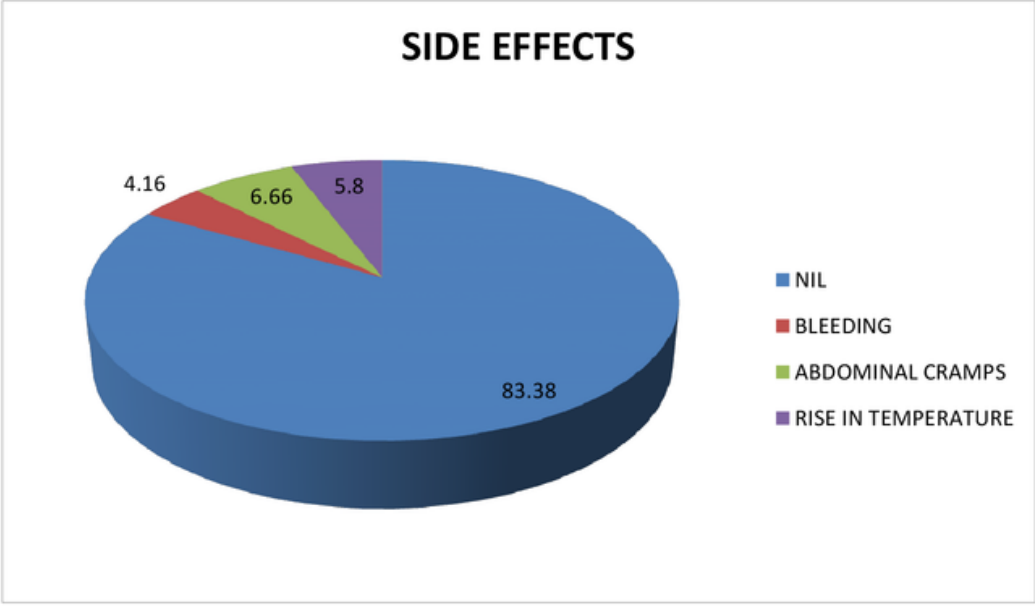


Fig.14.

Very few side-effects were noted in the medical abortion group. Most of the patients had mild menstrual cramps which was well tolerable. 6.66% of patients had abdominal cramps that required analgesics. Rise in temperature of 100 degrees and more were seen in 5.8 % of patients that required antipyretics.

About 4.16 % of patients had increased passage of clots & bleeding that required a surgical evacuation. None of the patients required blood transfusion.

All side-effects were well tolerated by the patients.

COMPARISON OF TIME INTERVAL

Table.12.

Interval (hrs)	Medical abortion. Group 1 (n=120)		Suction & evacuation Group 2 (n=120)	
	No	%	No	%
< 4 hrs	23	19.16	120	100
4-8 hrs	66	55.8	-	-
8-12 hrs	31	25.83	-	-

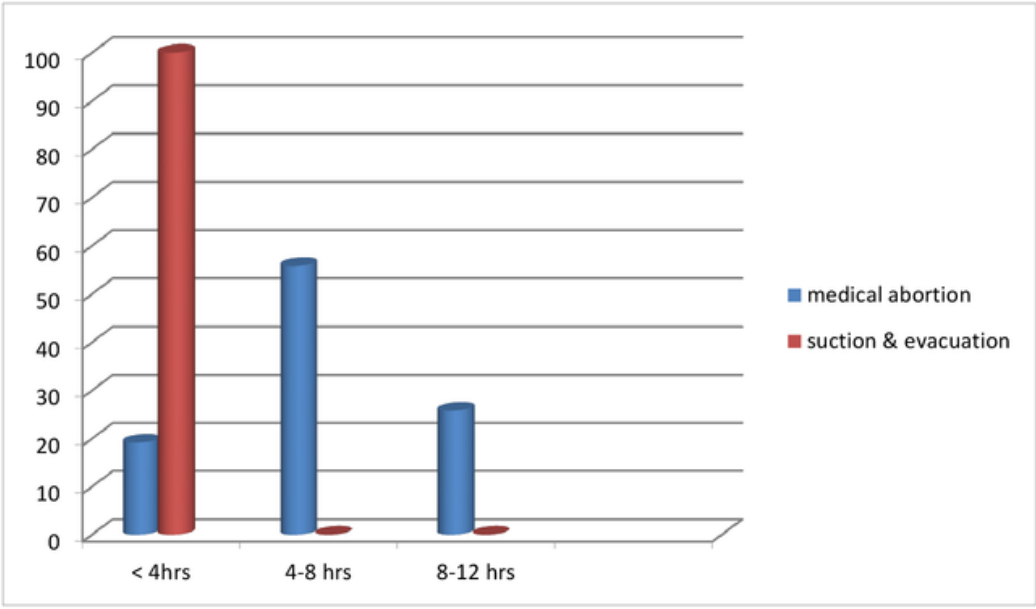


fig.15.

The duration of expulsion was taken from the first dose of misoprostol & not mifepristone. The average duration to expulsion time was 7 hours 30 minutes in medical abortion group. All suction evacuation in comparison group were performed 3 hours after one dose of misoprostol. So the mean duration in surgical evacuation group was 3 hrs.

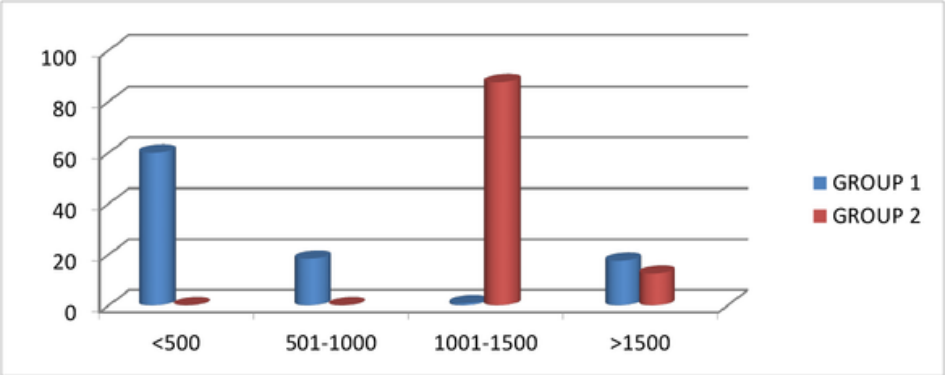
COMPARISON OF COST

COST (Rs)	MEDICAL ABORTION (n=120) - GROUP 1		SUCTION & EVACUATION (n=120) – GROUP 2	
	No	%	No	%
<500	77	60	-	-
501-1000	22	18.33	-	-
1000-1500	1	0.83	105	87.5
>1500	22	17.5	15	12.5

Table.13.

The cost of one tablet of Mifepristone is Rs.380 & misoprostol is Rs 20.The average cost in medical abortion is 679.92 rupees whereas the average cost in suction and evacuation is 1197.08. If the medical abortion fails & only disadvantage is if it is a failed medical abortion the cost increases more than the surgical evacuation.

Fig.16.



COST(IN RUPEES)					
	GROUP	N	Mean	Std. Error Mean	
COST	MEDICAL	120	679.92	42.035	
	SURGICAL	120	1197.08	17.456	
t	df	P VALUE			
-11.362	238	.000			

Table.14.

Direct cost is almost double for the patient undergoing suction evacuation compared to medical abortion & this difference is statistically significant. (p-.000).

SUCCESS RATE IN DIFFERENT ABORTIONS

	Total number	Complete expulsion	Success %
Missed abortion	55	45	81.82
MTP	31	23	75
Blighted ovum	34	30	88.24

Table.15.

Complete successful medical abortions were high in blighted ovum 88.24 % followed by missed abortion which is 81.82 %.

Table.16. FAILURE GROUP Cross tabulation

			GROUP		
			CASE GROUP	COMPARISON GROUP	Total
FAILUREs	NIL	Count	98	118	216
		% within FAILURE	45.37%	54.62%	100.0%
	S&E	Count	22	2	24
		% within FAILURE	91.6%	8.3	100.0%
Total		Count	120	120	240
		% within FAILURE	50.0%	50.0%	100.0%

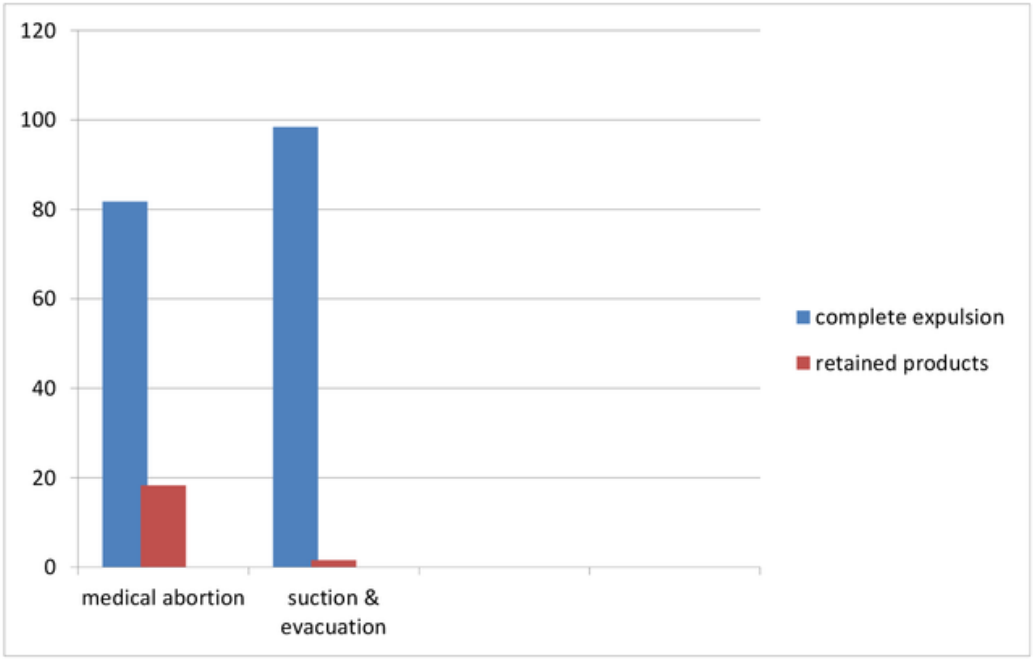


fig. 17.Success rate of medical abortion Vs Suction Evacuation.

The success rate of medical abortion was 81.7% and 98.4% in suction & evacuation group. All patients who did not expel or who had retained product in check scan were considerd to be failed medical abortion. The failure rate was less in suction and evacuation but it is an invasive procedure .

RESULTS

- In medical abortion group 20% required, one dose of 600 micro gram misoprostol, 51.66% required 2 doses of misoprostol and 28.44 % required 3 doses of misoprostol.
- There is no statistically significant difference in the gestational age of both the groups and the different misoprostol doses which shows the duration of gestational age is not influencing the dose requirement of misoprostol to expel the products.
- Parity is not influencing the requirement of PGE1 dose for expulsion of product as it is statistically insignificant (p=0.74).Thus irrespective of parity the requirement of PGE 1 dose is similar.
- Out of medical abortions about 84.2% of women expelled the products of conception with complete expulsion of 81.6 %.

- No retained products were observed in those patients who require one dose misoprostol alone.
- It was observed that those who require more than one dose of misoprostol had retained products and it is statistically significant ($p < 0.05$)
- When compared with suction and evacuation the failure rate was more with medical abortions.
- The success rate of medical abortions was 81.7% in medical group and 98.4% in suction and evacuation group. All patients who didn't expel or had retained products in check scan were considered to be failed medical abortion and it was 18.3% against 1.6% in suction and evacuation group.
- When identifying whether maternal age is influencing the outcome

of medical abortions it is evident that there is no significant difference ,in the age of the mother in the outcome of medical abortion.

- Direct cost is almost double for the patient undergoing suction and evacuation The average cost in medical abortion is 679.92 rupees whereas the average cost in suction and evacuation is 1197.08. the only disadvantage is if it is a failed medical abortion the cost increases.
- The average dose to expulsion time was 7 hours and 37 minutes in medical abortion group and 3 hours in suction and evacuation group.
- There was no significant difference in the failure rate of medical abortion between gestational age of 49 – 63 days and >63 days of gestational age.

DISCUSSION

The study indicates mifepristone – misoprostol regimen as one of the most effective methods of pregnancy termination. Efficacy of the procedure is indicated by the termination of pregnancy with complete expulsion of the products of conception with the need of surgical procedure.[47]

Spitz et al. in a study has reported a higher rate of success up to 98% in medical abortions without the need of suction and evacuation[32]. Similar to our study El-Rafery et al has reported the efficacy of 84% with medical abortion using mifepristone and misoprostol.[33]

The first report on late first trimester abortions using medical regimen was first reported in the Department of Obstetrics and Gynecology, Harkeland

university , Norway in October 2005.[34,45] This study evaluated medical abortion as a good alternative to surgical abortion.

Many studies showed that success rate of medical abortion depend on duration of gestational age.[35]

Few other studies like our study has showed there is no significant difference in gestational age from 49 days to 91 days of gestation. Higher success rate has been reported with advanced gestational age of 9 weeks to 12 weeks.[36] Fielding et al in his study has even mentioned that ultrasound examination is not routinely needed in the first trimester for medical abortion as the duration of gestation does not affect its efficacy.[37]

Our study have highlighted that this regime of mifepristone and misoprostol is an effective method with acceptable side effects. This regimen is a well recognized and widely used method of choice for late first trimester abortions in Haubeland University and mentioned in Norwegian national guidelines.[38]

In the present study it was observed more the number of doses higher the chance of suction and evacuation . This has been supported from the studies of Homoda et al and Ashok et al.[39,40]

In a study conducted in K.E.M Hospital Pune woman with gestational age 64-84 days seeking termination of pregnancy was enrolled in the study. Oral Mifepristone followed by 800 mcg of vaginal misoprostol followed by 400mcg & a maximum dose of 1600mcg was given resulted in success rate of 81 %. .

In a study conducted in Hung Vuong hospital in Pune a maximum dose of 2200mcg misoprostol was given. However in our study the maximum dose of misoprostol used was 1400mcg.

Though suction and evacuation has a good success rate than medical abortions, still medical abortion is a good alternative to surgical evacuation as the later is an invasive procedure with more chance of uterine perforation.

SUMMARY

A prospective case control study was conducted in PSGIMSR Hospitals, in the Department of Obstetrics and Gynecology from January 2011 to June 2012 to study the effectiveness of mifepristone and misoprostol in late trimester abortion.

240 women were included in the study who had blighted ovum, missed abortions or for MTP with gestational age 7 – 13 weeks .

120 women opted for medical abortion with mifepristone and misoprostol

120 women opted for surgical evacuation after single dose of misoprostol.

Those patients who were willing for concurrent tubal ligation and who wants the treatment in one visit opted for suction and evacuation.

Both the group were comparable with parity and both had comparable numbers of missed abortions, blighted ovum and MTPs .

Major percentage of patients required 2 doses of misoprostol (1000 microgram). There was no statistically significant difference in the gestational age and the dosage of misoprostol to expel the products of conception.

Parity is not influencing the requirement of misoprostol for expulsion of products of conception. In medical abortion about 84.2% patients expelled the products partially or completely. The success rate of medical abortion was 81.7% with complete expulsion of products and no retained products in check scan. Age of the patient was not influencing the outcome of medical abortion.

Average dose to expulsion interval 7 hours and 30 minutes in medical group and 3 hours in surgical group. Success rate was more in blighted ovum than missed abortion and MTP.

Side effects were acceptable in medical abortion group. None of the patient require blood transfusion for their bleeding complication. Cost of medical abortion group rupees 679.92 vs 1197.08 in suction and evacuation group. Hence medical abortion is a cost effective method.

CONCLUSION

- Mifepristone and misoprostol is an effective regimen in medical abortion. This study proved that medical abortion with mifepristone and misoprostol is effective also in late first trimester abortion.
- Medical abortions avoids unnecessary surgical intervention with acceptable side effects.
- The dose to expulsion time was more in medical abortion but the cost is much lesser than surgical methods
- Therefore medical abortion is in late first trimester is safer and cost effective alternative to surgical evacuation .

S.NO	NAME	AGE	OP/IP NO	PARITY	GA (wks)	USG	RISK FACTOR	MIFEPRISTONE	PGE 1	RESULT	TIME	SIDE EFFECT	CHECK SCAN	FAILURE	COST
1	Sukanya	21	I11000470	multi	8wks+1day	MISSED ABORTION	NIL	200 mg	600 mcg	expelled	3hr 15 min	nil	cavity empty	nil	410
2	Durgadevi	27	O11001283	multi	8wks+1day	SLIUF (MTP)	HYPOTHYROID	200 mg	1000 mcg	expelled	8hrs20 min	nil	cavity empty	nil	450
3	Krishnaveni	24	I11000523	primi	7wks+6days	BLIGHTED OVUM	NIL	200 mg	1000 mcg	expelled	7 hrs	nil	cavity empty	nil	460
4	Kalamani	28	I11000758	primi	11wks+1day	MISSED ABORTION	NIL	200 mg	1400 mcg	not expelled	14hrs	nil	retained products	S&E	1400
5	Arulselvi	22	O05028787	primi	8wks	BLIGHTED OVUM	NIL	200 mg	1400 mcg	expelled	12hrs	abdominal cramps	cavity empty	nil	515
6	chinthamani	31	I11001960	multi	11 wks	SLIUF (MTP)	PREVIOUS CS	200 mg	1000 mcg	expelled	6 hrs 15 min	nil	cavity empty	nil	475
7	Manimegalai	25	O04003412	multi	7wks+1day	MISSED ABORTION	NIL	200 mg	1000 mcg	expelled	7 hrs 15 min	nil	cavity empty	nil	510
8	Kavitha	21	O0050098	primi	12wks+3days	BLIGHTED OVUM	nil	200 mg	1000 mcg	expelled	8 hrs	fever	cavity empty	nil	480
9	Pushpa	19	O97031167	primi	9wks+4days	BLIGHTED OVUM	nil	200 mg	600 mcg	expelled	3 hrs 30 min	nil	cavity empty	nil	430
10	Santhiya	24	I11004607	multi	10wks	MISSED ABORTION	PREVIOUS CS	200 mg	600 mcg	expelled	3 hrs	fever	cavity empty	nil	430
11	Christiana	23	O01078133	primi	10WKS	MISSED ABORTION	NIL	200 mg	600 mcg	expelled	4HRS	nil	cavity empty	nil	420
12	Banu	29	O11012934	multi	11WKS+3day	SLIUF (MTP)	NIL	200 mg	1000mcg	expelled	6HRS30 MIN	nil	cavity empty	nil	510
13	Krishnaveni	25	I11005152	multi	13WKS	MISSED ABORTION	RH NEGATIVE	200 mg	1400mcg	not expelled	15HRS	nil	retained products	S&E	1540
14	Priyadarshini	32	O08083688	primi	8WKS+3DAYS	SLIUF (MTP)	LUPUS NEPRITIS	200 mg	1000mcg	expelled	9hrs	nil	cavity empty	nil	520
15	Shakila	28	I11003230	multi	13wks	BLIGHTED OVUM	NIL	200 mg	1000mcg	expelled	7hrs 20min	nil	cavity empty	nil	520
16	Sivaneshwari	27	O11019035	multi	13wks	BLIGHTED OVUM	NIL	200 mg	1400 mcg	expelled	10hrs	nil	cavity empty	nil	540
17	Sathyapriya	22	O11020009	primi	7wks+2days	MISSED ABORTION	NIL	200 mg	1400mcg	not expelled	15hrs	abdominal cramps	retained products	S&E	1800
18	Gokilamani	30	O11019383	multi	8wks+5days	SLIUF (MTP)	NIL	200 mg	1400 mcg	not expelled	14hrs	nil	retained products	S&E	1500
19	Priya	29	I11006029	primi	13wks	SLIUF (MTP)	fetal anomaly	200 mg	1400 mcg	not expelled	14hrs	fever	retained products	S&E	1750
20	Sudha	34	I11007521	multi	13wks	BLIGHTED OVUM	NIL	200 mg	1000 mcg	expelled	8hrs20 min	nil	cavity empty	nil	450
21	Maheswari	32	I11009044	multi	11wks	MISSED ABORTION	PREVIOUS CS	200 mg	1000mcg	expelled	7hrs 20min	nil	cavity empty	nil	450
22	Lakshmi	30	O11018651	multi	7wks+5days	BLIGHTED OVUM	HYPOTHYROID	200 mg	1000mcg	expelled	7hrs30 min	nil	cavity empty	nil	450
23	vasanthamani	39	I11010062	multi	12wks+3days	SLIUF (MTP)	autoimmune disease	200 mg	1000mcg	expelled	6HRS30 MIN	nil	cavity empty	nil	480
24	muthulakhmi	21	I11010662	multi	12wks+3days	BLIGHTED OVUM	PREVIOUS CS	200 mg	600mcg	expelled	4hrs	nil	cavity empty	nil	450
25	jeena	22	O11027570	primi	8wks	MISSED ABORTION	NIL	200 mg	1000 mcg	expelled	7 hrs	nil	cavity empty	nil	0

26	arthidevi	24	I11010519	primi	12wks+3days	MISSED ABORTION	NIL	200 mg	1400mcg	expelled	12hrs	nil	cavity empty	nil	510
27	sangeetha	22	O10050204	multi	8wks+1day	MISSED ABORTION	PREVIOUS CS	200 mg	1400 mcg	expelled	12hrs	nil	cavity empty	nil	510
28	selvi	23	I11011497	primi	8wks	MISSED ABORTION	NIL	200 mg	1400mcg	not expelled	11hrs	nil	retained products	S&E	1750
29	Naskewa	23	O11022956	multi	7wks	SLIUF (MTP)	NIL	200 mg	1000mcg	expelled	6HRS30 MIN	fever	cavity empty	nil	450
30	Janani	30	O11024854	multi	7wks+2days	SLIUF (MTP)	DM	200 mg	1000mcg	expelled	6HRS	nil	cavity empty	nil	450
31	Vanaja	29	O11002184	multi	7 wks	SLIUF (MTP)	PREVIOUS CS	200 mg	1000 mcg	not expelled	9 hrs	bleeding	retained products	S&E	1850
32	Meera	28	O04006352	multi	7wks+1day	MISSED ABORTION	PREVIOUS CS	200 mg	1400 mcg	not expelled	10hrs	abdominal cramps	retained products	S&E	1850
33	Anitha	27	O07041184	primi	9 wks	BLIGHTED OVUM	NIL	200 mg	1000 mcg	expelled	6 hrs	nil	cavity empty	nil	470
34	Barkath Nisha	22	O11027816	multi	8wks	MISSED ABORTION	NIL	200 mg	1400 mcg	expelled	10 hrs	nil	cavity empty	nil	530
35	Nirmala	24	I11011600	multi	7wks	SLIUF (MTP)	NIL	200 mg	1400 mcg	not expelled	12 hrs	nil	retained products	S&E	1750
36	Karthikeyani	23	I11011219	multi	7wks	MISSED ABORTION	NIL	200 mg	600 mcg	expelled	3 hrs	nil	cavity empty	nil	430
37	Mythili	21	I11011714	primi	7wks+2days	SLIUF (MTP)	HBsAg +	200 mg	1000 mcg	expelled	5hrs	nil	cavity empty	nil	550
38	Sangeetha	22	O08069492	multi	7wks+4days	MISSED ABORTION	NIL	200 mg	1000 mcg	expelled	6 hrs	nil	cavity empty	nil	440
39	Jennathul	23	O11033354	multi	11wks+2days	SLIUF (MTP)	NIL	200 mg	1000 mcg	expelled	6 hrs 15 min	nil	cavity empty	nil	450
40	Leema Mary	21	O0806690	multi	12wks	SLIUF (MTP)	NIL	200 mg	1400 mcg	expelled	11 hrs	abdominal cramps	cavity empty	nil	510
41	savithiri	22	O11031709	primi	8wks+5days	MISSED ABORTION	NIL	200mg	1000mcg	expelled	7hrs	nil	cavity empty	nil	520
42	Jerine	26	I11012174	multi	11wks+4days	SLIUF (MTP)	NIL	200mg	1000mcg	not expelled	12 hrs	nil	retained products	S&E	1600
43	Lavanya	19	I11014465	primi	11wks+1day	MISSED ABORTION	NIL	200mg	600 mcg	expelled	3hrs	nil	cavity empty	nil	470
44	Punitha	20	O11035664	primi	10 wks	BLIGHTED OVUM	NIL	200mg	1000mcg	expelled	6hrs 20 min	nil	cavity empty	nil	470
45	Kokilameena	35	O11032223	multi	10wks	BLIGHTED OVUM	NIL	200mg	1000mcg	not expelled	5 hrs 35 min	bleeding	retained products	S&E	1600
46	Kaminigala	19	O11041103	primi	8wks+5days	MISSED ABORTION	NIL	200mg	1400mcg	expelled	7 hrs	nil	cavity empty	nil	580
47	Hamsaveni	18	I11016788	primi	9 wks	BLIGHTED OVUM	NIL	200mg	600mcg	expelled	3 hrs 50 min	nil	cavity empty	nil	470
48	Girija	20	I11016788	primi	9wks+1day	MISSED ABORTION	NIL	200mg	1000mcg	expelled	5 hrs 40 min	nil	cavity empty	nil	520
49	Pandiselvi	22	O10024367	multi	9wks+3days	MISSED ABORTION	PREVIOUS CS	200mg	1000mcg	expelled	6 hrs	nil	cavity empty	nil	520
50	Radha	22	O11045468	primi	7 wks+4 days	SLIUF (MTP)	RHD	200mg	1000mcg	expelled	6 hr 50 min	fever	cavity empty	nil	520
51	subha	28	I11016650	multi	8wks+1day	BLIGHTED OVUM	NIL	200mg	600 mcg	expelled	3hrs50 min	nil	cavity empty	nil	410
52	Selvi	20	O07013084	primi	13 wks	SLIUF (MTP)	fetal anomaly	200mg	1000mcg	expelled	6hrs	nil	cavity empty	nil	470

53	Mrithula	23	I11018366	primi	10 wks	MISSED ABORTION	NIL	200mg	1000mcg	expelled	6hrs30 min	nil	cavity empty	nil	470
54	Selvi	24	I11018465	multi	13 wks	MISSED ABORTION	NIL	200mg	1000mcg	expelled	6hrs	nil	cavity empty	nil	470
55	nithya	23	I11019866	primi	12 wks+6days	MISSED ABORTION	NIL	200mg	1000mcg	expelled	6hrs	nil	cavity empty	nil	470
56	Saranya	20	I11020215	primi	10 wks +5days	BLIGHTED OVUM	NIL	200mg	1400mcg	not expelled	10hrs	abdominal cramps	retained products	S&E	1600
57	Esakiammal	28	I11022216	multi	12 wks	MISSED ABORTION	PREVIOUS CS	200mg	1000mcg	expelled	7hrs	nil	cavity empty	nil	470
58	Padmavathy	28	I11022324	primi	12 wks +1 day	BLIGHTED OVUM	NIL	200mg	1000mcg	expelled	7hrs30 min	nil	cavity empty	nil	470
59	Aishwarya	24	I11023108	primi	12 wks +5days	MISSED ABORTION	HYPOTHYROID	200mg	1000mcg	expelled	6hrs	nil	cavity empty	nil	470
60	Meera	35	O08089920	primi	8 wks+1 day	MISSED ABORTION	NIL	200mg	600mcg	expelled	3hrs40 min	nil	cavity empty	nil	410
61	Priya	23	O07321127	multi	9wks	MISSED ABORTION	NIL	200mg	1000mcg	expelled	7hrs	nil	cavity empty	nil	470
62	Mahalakhsmi	32	O11081324	multi	12wks+6days	MISSED ABORTION	NIL	200mg	1000mcg	expelled	7hrs	nil	cavity empty	nil	470
63	jasmine	29	I11024121	primi	12wks	SLIUF (MTP)	fetal anomaly	200mg	1000mcg	not expelled	8hrs	bleeding	retained products	S&E	1600
64	Krishnaveni	29	O02041734	multi	8wks+6days	SLIUF (MTP)	PREVIOUS CS	200mg	1400mcg	expelled	10hrs15 min	nil	cavity empty	nil	520
65	Vasumathi	19	I11024777	multi	10wks	MISSED ABORTION	NIL	200mg	1000mcg	expelled	6hrs20 min	nil	cavity empty	nil	470
66	Baladiviyalakhs	20	O11018114	primi	9wks+1day	MISSED ABORTION	NIL	200mg	1400mcg	expelled	9hrs	nil	cavity empty	nil	520
67	Malarvezhi	23	O11065125	primi	9wks	MISSED ABORTION	NIL	200mg	1000mcg	expelled	7hrs20 min	nil	cavity empty	nil	470
68	Shanmugapriya	22	I11025673	multi	8wks+4days	MISSED ABORTION	PREVIOUS CS	200mg	1400mcg	not expelled	12hrs	fever	retained products	S&E	1600
69	Thangamal	32	I10262943	multi	8wks+6days	MISSED ABORTION	NIL	200mg	600mcg	expelled	3hrs15 min	nil	cavity empty	nil	470
70	Mariyaee	35	O11026185	multi	10wks	BLIGHTED OVUM	NIL	200mg	1000mcg	expelled	6hrs30 min	nil	cavity empty	nil	470
71	Geetha	28	I110127401	primi	9wks+5days	MISSED ABORTION	NIL	200mg	1000mcg	expelled	5hrs30 min	nil	cavity empty	nil	470
72	Neelavathi	23	O11065125	primi	9 wks	MISSED ABORTION	NIL	200mg	1000mcg	expelled	6hrs	nil	cavity empty	nil	470
73	Krithika	20	O0326848	primi	10wks	BLIGHTED OVUM	NIL	200mg	1400mcg	expelled	9hrs30 min	abdominal cramps	cavity empty	nil	520
74	Suriyapriya	24	O11074760	multi	8wks+5days	SLIUF (MTP)	PREVIOUS CS	200mg	600 mcg	expelled	4hrs	nil	cavity empty	nil	410
75	Jothi	23	O07117770	multi	11 wks	SLIUF (MTP)	NIL	200mg	1000 mcg	expelled	7hrs15 min	nil	cavity empty	nil	470
76	Deepa	21	O11076975	primi	7wks+4days	BLIGHTED OVUM	NIL	200mg	1000 mcg	expelled	7hrs	nil	cavity empty	nil	470
77	Pameela mary	21	O10070242	multi	9 wks+6days	SLIUF (MTP)	PREVIOUS CS	200mg	1000mcg	expelled	7hrs 15min	fever	cavity empty	nil	470
78	Velumani	22	I11030316	primi	8wks+3days	MISSED ABORTION	nil	200mg	1400mcg	not expelled	12hrs	bleeding	retained products	S&E	1600
79	Chitra	19	O10097882	primi	7wks+6days	BLIGHTED OVUM	nil	200mg	1000 mcg	expelled	7hrs	nil	cavity empty	nil	470
80	Christy Beula	22	O10324859	primi	12wks+6days	MISSED ABORTION	nil	200mg	1400 mcg	expelled	6hrs 30min	nil	cavity empty	nil	470
81	Nagomi	18	O11055239	primi	11wks+5days	MISSED ABORTION	NIL	200mg	1000mcg	expelled	6hrs	nil	retained products	S&E	1600
82	Deeparani	19	O11077068	primi	9wks	BLIGHTED OVUM	NIL	200mg	1000mcg	expelled	6hrs30 min	nil	cavity empty	nil	470

83	Valithangam	21	I11029265	multi	11wks	MISSED ABORTION	NIL	200mg	1400mcg	expelled	11hrs	nil	cavity empty	nil	520
84	Vasanthapriya	20	I11030203	primi	9wks+3days	MISSED ABORTION	NIL	200mg	600mcg	expelled	3hrs15 min	nil	cavity empty	nil	410
85	Loganakayi	21	O06039718	primi	8wks+5days	BLIGHTED OVUM	NIL	200mg	1400mcg	expelled	11hrs30 min	nil	cavity empty	nil	520
86	Sivakami	28	I11031280	multi	12wks+1day	SLIUF (MTP)	NIL	200mg	1400mcg	not expelled	12hrs	nil	retained products	S&E	1600
87	Lalitha	27	I11031438	multi	12wks+3days	MISSED ABORTION	NIL	200mg	1400mcg	expelled	10hrs15 min	bleeding	retained products	S&E	1600
88	Lakhsmi	23	I11030851	multi	11wks+4days	MISSED ABORTION	PREVIOUS CS	200mg	1000mcg	expelled	7hrs	nil	cavity empty	nil	470
89	Jaisree	26	I11031970	primi	9wks+5days	MISSED ABORTION	NIL	200mg	1400mcg	expelled	9hrs15 min	nil	cavity empty	nil	520
90	Shylarose	24	O10077913	multi	10wks+5days	MISSED ABORTION	HYPOTHYROID	200mg	600mcg	expelled	3hrs30 min	nil	cavity empty	nil	410
91	Kanmani	25	O10082345	primi	8wks	MISSED ABORTION	RH NEGATIVE	200mg	1000mcg	expelled	7hrs20 min	nil	cavity empty	nil	470
92	Swapna	23	I11034231	multi	7wks	BLIGHTED OVUM	nil	200mg	1400mcg	not expelled	12hrs	bleeding	retained products	S&E	1600
93	Sarayana	22	O10002449	primi	7wks+5days	BLIGHTED OVUM	HYPOTHYROID	200mg	600mcg	expelled	3hrs15 min	abdominal cramps	cavity empty	nil	410
94	Renukadevi	24	I11033808	multi	8wks+2days	SLIUF (MTP)	PREVIOUS CS	200mg	600mcg	expelled	4hrs	nil	cavity empty	nil	410
95	Priya	29	O04017332	multi	11wks	BLIGHTED OVUM	nil	200mg	1000mcg	expelled	5hrs30 min	nil	cavity empty	nil	470
96	Raziya	20	O11090236	primi	7wks	BLIGHTED OVUM	nil	200mg	600mcg	expelled	3hrs45 min	nil	cavity empty	nil	410
97	Jeyalakhsmi	18	I11035229	primi	11wks	BLIGHTED OVUM	nil	200mg	600mcg	expelled	3hrs	nil	cavity empty	nil	410
98	Vanitha	17	O09052449	primi	10wks	MISSED ABORTION	nil	200mg	600mcg	expelled	4hrs	nil	cavity empty	nil	410
99	Savitri	18	I12001157	primi	9wks+2days	MISSED ABORTION	nil	200mg	1400mcg	expelled	9hrs	nil	cavity empty	nil	520
100	Manimegai	30	O12007864	multi	11wks+3days	SLIUF (MTP)	PREVIOUS CS	200mg	1000mcg	expelled	7hrs20 min	nil	cavity empty	nil	470
101	HaseenaBegam	20	O09002069	primi	9wks+2days	SLIUF (MTP)	NIL	200mg	1000mcg	expelled	6hrs30 min	nil	cavity empty	nil	470
102	Rathiiswarya	22	I12002473	primi	9wks+4days	BLIGHTED OVUM	NIL	200mg	600mcg	expelled	4hrs	nil	cavity empty	nil	410
103	Swathi	23	O12001956	multi	7wks+2days	MISSED ABORTION	PREVIOUS CS	200mg	600mcg	expelled	3hrs10 min	fever	cavity empty	nil	410
104	Shyamalarose	24	O12002864	multi	7wks	SLIUF (MTP)	NIL	200mg	1000mcg	expelled	8hrs	nil	cavity empty	nil	470
105	Manimehalai	23	O11203218	multi	7wks+2days	MISSED ABORTION	PREVIOUS CS	200mg	1000mcg	expelled	6hrs40 min	nil	cavity empty	nil	470
106	Fahima	22	O12007020	multi	12wks	BLIGHTED OVUM	PREVIOUS CS	200mg	600mcg	expelled	3hrs30 min	nil	cavity empty	nil	410
107	Poonkodi	20	O11029350	multi	11wks+2days	BLIGHTED OVUM	PREVIOUS CS	200mg	1400mcg	not expelled	10hrs15 min	nil	retained products	S&E	1600
108	sabitha	19	O11007315	primi	8wks	MISSED ABORTION	NIL	200mg	1000mcg	expelled	7hrs20 min	nil	cavity empty	nil	470
109	Anitha	18	O10042485	primi	12wks	BLIGHTED OVUM	NIL	200mg	600mcg	expelled	2hrs40 min	nil	cavity empty	nil	410
110	Uma	41	I12009042	multi	12wks+6days	SLIUF (MTP)	PREVIOUS CS	200mg	1000mcg	expelled	6hrs30 min	nil	cavity empty	nil	490
111	Sarithanair	32	I12009124	multi	13wks	SLIUF (MTP)	PREVIOUS CS	200mg	1400mcg	expelled	11hrs	nil	retained products	S&E	1600
112	Poomani	22	O12011123	primi	11wks	MISSED ABORTION	NIL	200mg	1000mcg	expelled	6hrs20 min	nil	cavity empty	nil	470
113	Mohana	23	I12008224	primi	12wks+3days	MISSED ABORTION	NIL	200mg	1000mcg	expelled	7hrs40 min	nil	cavity empty	nil	470

114	Jothimani	22	O12021963	primi	12wks+2days	BLIGHTED OVUM	NIL	200mg	1000mcg	expelled	7hrs30 min	abdominal cramps	cavity empty	nil	490
115	Senaparveen	26	I10900121	multi	8wks	BLIGHTED OVUM	NIL	200mg	1000mcg	expelled	5hrs40 min	nil	cavity empty	nil	470
116	Selvalakhsmi	27	O11034984	multi	9wks	SLIUF (MTP)	HYPOTHYROID	200mg	1400mcg	not expelled	11hrs30 min	nil	retained products	S&E	1600
117	Muthulakhsmi	24	O11321143	multi	8wks	MISSED ABORTION	NIL	200mg	1400mcg	expelled	11hrs	nil	cavity empty	nil	470
118	Priya	20	O11052997	primi	8wks+3days	BLIGHTED OVUM	NIL	200mg	600mcg	expelled	4hrs	nil	cavity empty	nil	470
119	Naseema	23	I12016117	multi	11wks+3days	SLIUF (MTP)	HIV +VE	200mcg	1000mcg	expelled	6hrs20 min	nil	cavity empty	nil	470
120	Nithya	22	I12016503	multi	12wks+3days	MISSED ABORTION	fetal anomaly	200mcg	1400mcg	expelled	7hrs35 min	nil	cavity empty	nil	470

S.NO	NAME	AGE	OP/IP NO	PARITY	GA (wks)	USG	RISK FACTOR	MIFEPRISTONE	PGE1 (mcg)	PROCEDURE	TIME (hours)	SIDE EFFECT	CHECK SCAN	FAILURE	COST(Rs)
1	Sathiya	21	I11003936	Multi	9wks+2days	SLIUF(MTP)	Previous CS	-----	400	S&E + TAT	3	NIL	Cavity empty	Nil	1200
2	Deepa	22	I11000112	Primi	10wks+2days	MISSED ABORTION	Nil	-----	400	S&E	3	NIL	Cavity empty	Nil	1100
3	Vanitha	24	I11013976	Primi	10wks+2days	MISSED ABORTION	Nil	-----	400	S&E	3	NIL	Cavity empty	Nil	1100
4	Anitha	25	I11004340	Multi	8wks	BLIGHTED OVUM	GDM	-----	400	S&E	3	NIL	Cavity empty	Nil	1150
5	Amutha	33	I11002988	Multi	7wks+3days	SLIUF(MTP)	Nil	-----	400	S&E + TAT	3	NIL	Cavity empty	Nil	1200
6	Geetha	34	I11005653	Multi	8wks+2days	SLIUF(MTP)	Bronchial Asthma	-----	400	S&E + TAT	3	NIL	Cavity empty	Nil	1400
7	Gomathy	22	I11005742	Multi	11wks+6days	BLIGHTED OVUM	Nil	-----	400	S&E	3	NIL	Cavity empty	Nil	1100
8	Shobana	20	O11005719	Primi	9wks+6days	MISSED ABORTION	HYPOTHYROID	-----	400	S&E	3	NIL	Cavity empty	Nil	1100
9	Lokanayaki	27	I11008634	Multi	12wks+4days	MISSED ABORTION	nil	-----	400	S&E	3	NIL	Cavity empty	Nil	1100
10	Sowndari	22	O11002486 8	Multi	11wks+2days	BLIGHTED OVUM	Nil	-----	400	S&E	3	NIL	Cavity empty	Nil	1100
11	Manicam	33	I11007476	Multi	7wks+2days	SLIUF(MTP)	RHD+Rh negative	-----	400	S&E + TAT	3	NIL	Cavity empty	Nil	1200
12	Kalyani	31	I11009677	Multi	7wks+2days	SLIUF(MTP)	Previous CS	-----	400	S&E + Laparosterlisation	3	NIL	Cavity empty	Nil	1500
13	Thulasimani	22	I11010031	Primi	9wks+2days	MISSED ABORTION	Previous CS	-----	400	S&E	3	NIL	Cavity empty	Nil	1100
14	Radhamani	30	O08074278	Multi	8wks	BLIGHTED OVUM	Previous CS	-----	400	S&E	3	NIL	Cavity empty	Nil	1100
15	Rajeswari	24	I11001149 7	Multi	12wks+5days	MISSED ABORTION	Nil	-----	400	S&E	3	NIL	Cavity empty	Nil	1100
16	Kalyani	31	O09085890	Multi	7wks+5days	MISSED ABORTION	Previous CS	-----	400	S&E + Laparosterlisation	3	NIL	Cavity empty	Nil	1600
17	Rajameena	33	I11011994	Multi	11wks+1day	SLIUF(MTP)	Post renal transplant	-----	400	S&E + TAT	3	NIL	Cavity empty	Nil	1600
18	Selvi	19	I11011497	Primi	12wks	MISSED ABORTION	Nil	-----	400	S&E	3	NIL	Cavity empty	Nil	1100
19	Vakithabanu	22	I11011525	Multi	8wks	MISSED ABORTION	Nil	-----	400	S&E	3	NIL	Cavity empty	Nil	1100
20	Diviyalakshmi	30	O09106769	Primi	10wks+2days	MISSED ABORTION	Nil	-----	400	S&E	3	NIL	Cavity empty	Nil	1100
21	Suseela	29	I11013649	Multi	9wks	MISSED ABORTION	Previous CS	-----	400	S&E	3	NIL	Cavity empty	Nil	1100
22	Amsaveni	22	O11032192	Primi	10wks+2days	MISSED ABORTION	nil	-----	400	S&E	3	NIL	Cavity empty	Nil	1100
23	Ammla	19	I11013065	Primi	8wks+2days	MISSED ABORTION	Nil	-----	400	S&E	3	NIL	Cavity empty	Nil	1100
24	Ranijacob	31	I11014295	Multi	7wks+6days	SLIUF(MTP)	HYPOTHYROID	-----	400	S&E + Laparosterlisation	3	NIL	Cavity empty	Nil	1600

25	Balkeesh	36	I110113 05	Multi	11wks	MISSED ABORTION	Previous CS	-----	400	S&E	3	NIL	Cavity empty	Nil	1100
26	Poonam	21	i1101339 6	Multi	7wks	BLIGHTED OVUM	Nil	-----	400	S&E	3	NIL	Cavity empty	Nil	1100
27	Mamatha	25	I110137 15	Multi	8wks	MISSED ABORTION	Previous CS	-----	400	S&E	3	NIL	Cavity empty	Nil	1100
28	Maheswari	30	O110356 85	Multi	9wks+5days	MISSED ABORTION	HYPOTHYROID	-----	400	S&E	3	NIL	Cavity empty	Nil	1100
29	Mercy	20	I110151 97	Primi	12wks+1day	MISSED ABORTION	Nil	-----	400	S&E	3	NIL	Cavity empty	Nil	1100
30	Sudha	37	I110204 89	Multi	7wks	SLIUF(MTP)	Cu T conception	-----	400	S&E + Laparosterlisation	3	NIL	Cavity empty	Nil	1600
31	Indragandhi	40	I110253 49	Multi	13wks	SLIUF(MTP)	Nil	-----	400	S&E	3	NIL	Cavity empty	Nil	1100
32	Sharmila	28	I110161 38	Primi	10wks+1day	BLIGHTED OVUM	Nil	-----	400	S&E	3	NIL	Cavity empty	Nil	1100
33	Shanthi	30	O060233 33	Multi	12wks+3days	MISSED ABORTION	Nil	-----	400	S&E	3	NIL	Cavity empty	Nil	1100
34	Umamaheswar	29	I110170 29	Multi	12wks+4days	BLIGHTED OVUM	Previous CS	-----	400	S&E	3	NIL	Cavity empty	Nil	1100
35	Sonali	21	I110182 26	Multi	12wks	MISSED ABORTION	Previous CS	-----	400	S&E	3	NIL	Retained products	PGE	1200
36	Lalitha	24	I110191 81	Multi	9wks+6days	BLIGHTED OVUM	Nil	-----	400	S&E	3	NIL	Cavity empty	Nil	1100
37	Vasanthi	30	I110190 11	Multi	9wks	BLIGHTED OVUM	Nil	-----	400	S&E	3	NIL	Cavity empty	Nil	1100
38	Jennie	22	I110199 24	Multi	10wks	MISSED ABORTION	Nil	-----	400	S&E	3	NIL	Cavity empty	Nil	1100
39	Anushya	28	I110271 65	Multi	7wks+5days	SLIUF(MTP)	Nil	-----	400	S&E + Laparosterlisation	3	NIL	Cavity empty	Nil	1600
40	Kalaivani	25	I110267 78	Multi	12wks+5days	SLIUF(MTP)	Anaemia	-----	400	S&E + TAT	3	NIL	Cavity empty	Nil	1800
41	Yuvarani	22	O110592 46	Primi	13wks	MISSED ABORTION	Nil	-----	400	S&E	3	NIL	Cavity empty	Nil	1100
42	Deepa	25	O090154 43	Primi	8wks	MISSED ABORTION	Nil	-----	400	S&E	3	NIL	Cavity empty	Nil	1100
43	Amutha	30	I110202 66	Multi	9wks+5days	MISSED ABORTION	Previous CS	-----	400	S&E	3	NIL	Cavity empty	Nil	1100
44	Thiyanichitra	22	I110217 51	Primi	11wks+4days	MISSED ABORTION	Nil	-----	400	S&E	3	NIL	Cavity empty	Nil	1100
45	Barkath	32	I110238 34	Multi	8wks	BLIGHTED OVUM	GDM	-----	400	S&E	3	NIL	Cavity empty	Nil	1100
46	Kannaka	28	O100644 39	Primi	13wks	MISSED ABORTION	Nil	-----	400	S&E	3	NIL	Cavity empty	Nil	1100
47	Kavitha	28	I110318 24	Multi	8wks+2days	SLIUF(MTP)	Nil	-----	400	S&E + TAT	3	NIL	Cavity empty	Nil	1200
48	Sangeetha	20	I110245 78	Primi	12wks	BLIGHTED OVUM	Nil	-----	400	S&E	3	NIL	Cavity empty	Nil	1100
49	Muthulakshmi	37	I110337 00	Multi	8wks+2days	MISSED ABORTION	jaundice	-----	400	S&E + TAT	3	NIL	Cavity empty	Nil	1700
50	Julieprabhu	28	O110646 78	Multi	10wks	MISSED ABORTION	Previous CS	-----	400	S&E	3	NIL	Cavity empty	Nil	1100
51	Selvapriya	28	I110264 84	Multi	8wks	BLIGHTED OVUM	Nil	-----	400	S&E	3	NIL	Cavity empty	Nil	1100
52	Balamani	38	I110336 25	Multi	8wks+5days	SLIUF(MTP)	Nil	-----	400	S&E + TAT	3	NIL	Cavity empty	Nil	1200
53	Sanjitha	19	O110123 70	Primi	7wks+4days	BLIGHTED OVUM	Nil	-----	400	S&E	3	NIL	Cavity empty	Nil	1100
54	Umapathi	33	I110358 62	Multi	8wks	SLIUF(MTP)	Nil	-----	400	S&E + TAT	3	NIL	Cavity empty	Nil	1100

55	Priya	30	I110361 94	Multi	9wks	SLIUF(MTP)	HIV +	-----	400	S&E + Lap sterlisa tion	3	NIL	Cavity empty	Nil	2000
56	Marriammal	24	I110266 73	Primi	9wks	MISSED ABORTION	Nil	-----	400	S&E	3	NIL	Cavity empty	Nil	1100
57	Dhanalakshmi	30	O110614 81	Primi	12wks	SLIUF(MTP)	Fetal anomoly	-----	400	S&E	3	NIL	Cavity empty	Nil	1200
58	Manju	22	O070817 25	Primi	10wks	BLIGHTED OVUM	nil	-----	400	S&E	3	NIL	Cavity empty	Nil	1100
59	Geetha	21	O080261 34	Multi	11wks	MISSED ABORTION	nil	-----	400	S&E	3	NIL	Cavity empty	Nil	1100
60	Jeya	20	O110746 79	Multi	11wks+1d ay	BLIGHTED OVUM	Nil	-----	400	S&E	3	NIL	Cavity empty	Nil	1100
61	Raziya	26	I110321 52	Primi	12wks	MISSED ABORTION	HYPOT HYROI D	-----	400	S&E	3	NIL	Cavity empty	Nil	1100
62	Jannai	20	I110281 51	Primi	13wks	MISSED ABORTION	Nil	-----	400	S&E	3	NIL	Cavity empty	Nil	1100
63	Premalatha	27	I110298 63	Primi	9wks	BLIGHTED OVUM	Nil	-----	400	S&E	3	NIL	Cavity empty	Nil	1100
64	Vijayarani	23	I110306 87	Multi	8wks+4da ys	BLIGHTED OVUM	Nil	-----	400	S&E	3	NIL	Cavity empty	Nil	1100
65	Lakhsmi	30	I110308 51	Multi	12wks	MISSED ABORTION	Previou s CS	-----	400	S&E	3	NIL	Cavity empty	Nil	1100
66	Hemalatha	33	I110007 88	Multi	8wks	SLIUF(MTP)	DM	-----	400	S&E + Lap sterlisa tion	3	NIL	Cavity empty	Nil	1600
67	Radhamani	32	I110024 26	Multi	9wks+2da ys	SLIUF(MTP)	Nil	-----	400	S&E + Lap sterlisa tion	3	NIL	Cavity empty	Nil	1600
68	Estherrani	24	I110375 36	Multi	9wks	SLIUF(MTP)	Fetal anomoly	-----	400	S&E	3	NIL	Cavity empty	Nil	1100
69	Sangeetha	20	I110320 60	Primi	8wks	MISSED ABORTION	Nil	-----	400	S&E	3	NIL	Cavity empty	Nil	1100
70	Sinduja	29	I120035 49	Multi	7wks+2da ys	SLIUF(MTP)	Previou s CS	-----	400	S&E + TAT	3	NIL	Cavity empty	Nil	1200
71	Manonmani	24	I110328 04	Primi	7wks+6da ys	MISSED ABORTION	nil	-----	400	S&E	3	NIL	Cavity empty	Nil	1100
72	yashodha	30	I110333 73	Multi	11wks+1d ay	BLIGHTED OVUM	nil	-----	400	S&E	3	NIL	Cavity empty	Nil	1200
73	Poonuerulayee	24	I110337 6	Multi	12wks	SLIUF(MTP)	Previou s CS	-----	400	S&E	3	NIL	Cavity empty	Nil	1100
74	Iyyammal	20	O100475 18	Multi	13wks	MISSED ABORTION	Nil	-----	400	S&E	3	NIL	Cavity empty	Nil	1100
75	Vidhya	18	I110344 01	Primi	9wks	MISSED ABORTION	Nil	-----	400	S&E	3	NIL	Cavity empty	Nil	1100
76	Parameswari	26	I120054 63	Multi	11wks	SLIUF(MTP)	Nil	-----	400	S&E + TAT	3	NIL	Cavity empty	Nil	1100
77	Yuvarani	20	I110350 27	Primi	9wks	MISSED ABORTION	Nil	-----	400	S&E	3	NIL	Cavity empty	Nil	1100
78	Parvathi	25	O110835 78	Primi	12wks+3d ays	MISSED ABORTION	Nil	-----	400	S&E	3	NIL	Cavity empty	Nil	1100
79	Sulochana	25	I120004 7	Multi	12wks+5d ays	MISSED ABORTION	Nil	-----	400	S&E	3	NIL	Cavity empty	Nil	1100
80	Kavitha	24	I120072 41	Primi	8wks+4da ys	MISSED ABORTION	Anaemi a	-----	400	S&E	3	NIL	Cavity empty	Nil	1400
81	Saraswathi	33	O110337 41	Multi	8wks+2da ys	BLIGHTED OVUM	Nil	-----	400	S&E + Lap sterlisa tion	3	NIL	Cavity empty	Nil	1700

82	Kalpana	19	O12014249	Primi	9wks	MISSED ABORTION	Nil	-----	400	S&E	3	NIL	Cavity empty	Nil	1100
83	Kalaimani	20	O12014772	Primi	10wks	BLIGHTED OVUM	HYPOTHYROID	-----	400	S&E	3	NIL	Cavity empty	Nil	1100
84	Pavithra	26	O09019575	Multi	9wks	MISSED ABORTION	Nil	-----	400	S&E	3	NIL	Cavity empty	Nil	1100
85	Ruba	22	I12004742	Primi	7wks+5days	BLIGHTED OVUM	Nil	-----	400	S&E	3	NIL	Cavity empty	Nil	1100
86	Sasikala	23	I12005935	Multi	7wks+3days	SLIUF(MTP)	Nil	-----	400	S&E + TAT	3	NIL	Cavity empty	Nil	1600
87	Mohana	30	I12008224	Primi	12wks+3days	BLIGHTED OVUM	Nil	-----	400	S&E	3	NIL	Cavity empty	Nil	1100
88	Maheswari	25	I12008997	Multi	10wks	MISSED ABORTION	Nil	-----	400	S&E	3	NIL	Cavity empty	Nil	1100
89	Ayyammal	23	I12010498	Primi	8wks	MISSED ABORTION	Nil	-----	400	S&E	3	NIL	Cavity empty	Nil	1100
90	Ashaaganthiya	26	I12010792	Multi	12wks+5days	SLIUF(MTP)	Previous CS	-----	400	S&E + TAT	3	NIL	Cavity empty	Nil	1400
91	Nagasawari	32	I12013945	Multi	7wks+5days	MISSED ABORTION	Previous CS	-----	400	S&E + TAT	3	NIL	Cavity empty	Nil	1400
92	Nagajothi	26	I12015206	Multi	7wks+6days	SLIUF(MTP)	Nil	-----	400	S&E + TAT	3	NIL	Cavity empty	Nil	1200
93	Mridula	20	O10321546	Primi	11wks	BLIGHTED OVUM	Nil	-----	400	S&E	3	NIL	Cavity empty	Nil	1100
94	Kuppathal	22	O11018054	Multi	9wks+5days	MISSED ABORTION	Previous CS	-----	400	S&E	3	NIL	Retained products	PGE	1300
95	Subhapriya	25	O10112956	Multi	10wks	BLIGHTED OVUM	Nil	-----	400	S&E	3	NIL	Cavity empty	Nil	1100
96	Selvi	30	O11475132	Primi	9wks	MISSED ABORTION	Nil	-----	400	S&E	3	NIL	Cavity empty	Nil	1200
97	Geetha S	28	I12016646	Multi	11wks+3days	SLIUF(MTP)	Nil	-----	400	S&E + Laparosterlisation	3	NIL	Cavity empty	Nil	1600
98	Arthi G	30	O12115421	Primi	11wks	MISSED ABORTION	Nil	-----	400	S&E	3	NIL	Cavity empty	Nil	1100
99	Vishnupriya	25	i12012241	Primi	11wks+2days	MISSED ABORTION	Nil	-----	400	S&E	3	NIL	Cavity empty	Nil	1100
100	Mythli	28	I12011655	Multi	9wks	SLIUF(MTP)	Nil	-----	400	S&E + TAT	3	NIL	Cavity empty	Nil	1200
101	Pondiselvi	20	I12032887	Primi	9wks+2days	BLIGHTED OVUM	Nil	-----	400	S&E	3	NIL	Cavity empty	Nil	1100
102	Samundeshwa	24	I12014161	Primi	10wks	MISSED ABORTION	Nil	-----	400	S&E	3	NIL	Cavity empty	Nil	1100
103	Ponamammal	28	I12013481	Multi	9wks+2days	MISSED ABORTION	Previous CS	-----	400	S&E	3	NIL	Cavity empty	Nil	1200
104	Princey	22	O11052997	Multi	8wks+3days	MISSED ABORTION	Nil	-----	400	S&E	3	NIL	Cavity empty	Nil	1100
105	Mohana	35	I12021339	Multi	7wks+3days	BLIGHTED OVUM	Previous CS	-----	400	S&E + Laparosterlisation	3	NIL	Cavity empty	Nil	1600
106	Nithiyalakshmi	28	O11038124	Multi	10wks	BLIGHTED OVUM	Nil	-----	400	S&E	3	NIL	Cavity empty	Nil	1100
107	Praveena	20	O12015793	Primi	11wks	MISSED ABORTION	HYPOTHYROID	-----	400	S&E	3	NIL	Cavity empty	Nil	1100
108	Sindu	24	O11042184	Multi	11wks+1day	MISSED ABORTION	Nil	-----	400	S&E	3	NIL	Cavity empty	Nil	1100
109	Saranya	19	O07325549	Primi	7wks+5days	MISSED ABORTION	Nil	-----	400	S&E	3	NIL	Cavity empty	Nil	1100
110	Anandhi	22	O06544321	Primi	8wks	MISSED ABORTION	Nil	-----	400	S&E	3	NIL	Cavity empty	Nil	1100

111	Jabarani	24	O12037484	Multi	10wks	BLIGHTED OVUM	Previous CS	-----	400	S&E	3	NIL	Cavity empty	Nil	1100
112	Sundari	24	O11032935	Multi	8wks	MISSED ABORTION	Nil	-----	400	S&E	3	NIL	Cavity empty	Nil	1100
113	Poongodi	22	O12037022	Primi	8wks+5days	MISSED ABORTION	Nil	-----	400	S&E	3	NIL	Cavity empty	Nil	1100
114	Chamundeswa	25	O12035716	Multi	7wks+3days	MISSED ABORTION	Nil	-----	400	S&E	3	NIL	Cavity empty	Nil	1100
115	Indumathi	22	O12039155	Primi	8wks	BLIGHTED OVUM	Nil	-----	400	S&E	3	NIL	Cavity empty	Nil	1100
116	Rosemary	24	O00700250	Multi	8wks+1day	SLIUF(MTP)	Nil	-----	400	S&E	3	NIL	Cavity empty	Nil	1200
117	Manimegalai	22	O10821154	Multi	10wks	MISSED ABORTION	Nil	-----	400	S&E	3	NIL	Cavity empty	Nil	1100
118	Sindhusajan	35	I12006207	Multi	7wks+2days	SLIUF(MTP)	Nil	-----	400	S&E + Laparosterlisation	3	NIL	Cavity empty	Nil	1600
119	Nithiya	22	I12016503	Multi	12wks+3days	SLIUF(MTP)	Fetal anomoly	-----	400	S&E	3	NIL	Cavity empty	Nil	1200
120	Manoranjithum	20	O12011384	Primi	9wks+3days	MISSED ABORTION	Nil	-----	400	S&E	3	NIL	Cavity empty	Nil	1100

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ABBREVIATIONS

MTP - Medical Termination Of Pregnancy.

CRL - Crown Rump Length.

ACOG - American College Of Obstetricians & Gynaecologists.

RCOG - Royal College of Obstetricians & Gynaecologists.

RMP - Registered Medical Practitioner.

HCG - Human Chorionic Gonadotropin.

USG - Ultrasonogram

TVS - Trans-Vaginal Sonogram.

PG - Prostaglandin

FDA - Food & Drug Administration.

mcg - microgram.

NYHA – New York Heart Association.

TAS - Trans Abdominal Sonogram.

STUDY ON EFFECTIVENESS OF MIFEPRISTONE & MISOPROSTOL IN LATE FIRST TRIMESTER ABORTION & MTP

NAME : AGE: SEX PARITY:

LMP: GA: NO:

DIAGNOSIS:

USG:

RISK FACTORS

CASE / CONTROL:

T.MIFEPRISTONE 200 mg	T.MISOPROSTOL 600 mcg	T.MISOPROSTOL 400 MCG	SUCTION & EVACUATION

CHECK SCAN:

PULSE: BP: TEMP: BLEEDING:

REMARKS:

STATISTICAL ANALYSIS

Mean value & standard deviation were computed for continuous variables. Changes over time were evaluated by student paired t-test. Comparison of groups done by chi-square test. Differences were considered significant if p value <0.05. Values expressed as mean value with standard deviation.