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Septic abortion, an infected abortion, complicated by fever, endometritis and parametritis,¹ remains one of the most serious threats to women's health worldwide. Although morbidity and mortality from septic abortion are rare in countries where induced abortion is legal, suffering and death from this process are widespread in many developing countries where abortion is either illegal or inaccessible. Septic abortion is a paradigm of preventive medicine, pertaining to all levels of prevention - primary, secondary and tertiary.² In the past, obstetricians/gynecologists have often been experts in the treatment of sepsis. However, those who have been trained where abortion is legal may have little experience with septic abortion, so management is considered in some detail. A 1973 United States report by a prestigious medical journal described a teenager being hospitalized in a major Boston training hospital with what turned out to be an incomplete septic abortion. Evacuation of the uterus was carried out only a few days after hospitalization, as this diagnosis was not initially entertained. The patient died despite mass antibiotic therapy and intensive medical management.³ Tragedies of this kind are now rare in the US. The most important public health legalization effect of abortion is the near-elimination of deaths from illegal abortions in the United States. Illegal abortion deaths disproportionately due to infection.⁴ 5 In a 1994 U.S. survey, 62% of illegal abortion deaths and 51% of spontaneous abortion deaths were from infection, while only 21% of legal abortion deaths were from infection.⁶ Later breakdowns by cause of death are not available due to the rarity of legal abortion deaths. The risk of death from post-abortion sepsis is greatest for young women and unmarried women, and it is more likely with procedures that do not directly evacuate the contents of the uterus.⁷ With more advanced pregnancies, the risk of perforation and tissue preservation increases.⁷ Delay in treatment allows progress to bacteremia, pelvic abscess, pelvic shews, common intravascular coagulopathy, septic shock, renal failure, and mortality from all causes has been steadily declining since 1940.⁹ Mortality from abortion was manifested in three phases: an initial decline to 1950, a plateau from 1951 to 1965, and then a very rapid decline from 1965 to 1976 (faster than maternal mortality from other causes), as legal abortion became more accessible (Figure 1). In 2009, the last year for which full data are available, eight abortion deaths were reported by the U.S. Centers for Disease Control.¹⁰ The rate of fatality in 2003-2009 0.67 per 100,000 induced abortions.¹⁰ For comparison, in the 1940s, before the legalization of abortion, more than 1,000 women a year were known died from abortion in the United States.⁵ The fatality rate in 1973-1977 (immediately after the legalization of abortion in the United States) was 2.09.¹⁰ The Council of the American Medical Association for Scientific Affairs explained the marked decline in abortion deaths in this century by the introduction of antibiotics to treat sepsis. The widespread use of effective contraception since the 1960s, which reduced the number of unwanted pregnancies, and more recently the transition from illegal to legal abortion.¹¹ Serious complications have also become rare. A large series from Planned Parenthood of New York City describes 170,000 outpatient abortions performed in outpatient settings by a small group of practicing experts. Deaths have not occurred, and only 121 hospitalizations due to complications occurred, 0.71 per 1,000 abortions.¹² Approximately 3.2 million unintended pregnancies occur each year in US¹³ and with an ongoing attack on legal abortion services¹⁴, 15 and ongoing barriers to access,¹⁶ demand leads abortions to revive illegal self-induced abortions. Recent case reports from the US include a 24-year-old woman who posed after attempting to cause a 24-week abortion with a coat hanger stuck through her own cervix. She experienced severe hooiaamionitis and systemic sepsis after a full abdominal hysterectomy and bilateral osophorectomy.¹⁷, 18, 19 pic. 1. Maternal mortality rates per 100,000 live births, excluding abortion deaths and abortion deaths, in the United States in 1940-1976. The maternal mortality rate from abortion is equal to maternal mortality, minus the mortality rate from abortion per 1 million live births. The mortality rate from abortion is equal to the mortality rate from abortion per 1 million live births. Data from United States life statistics, National Center for Health Statistics, 1940-1976. (Cates W Jr, Rochat RW, Grimes DA et al: Legalized Abortion: Influence on National Trends in Maternal Mortality and Abortion-Related Mortality (1940-1976). Am J Obstet Gynecol 132:211, 1978). Western Europe and the former Soviet Union Experience in Western Europe was very similar to the experience in the United States, with legal abortion becoming widely available and very low abortion deaths are being reported. Overall, maternal mortality from legal abortion in Europe is less than 1 in 100,000 procedures.²⁰ Mortality is slightly higher in the former Soviet Union, where there was a particular problem of induced abortion as the primary method of family planning. Recently, the Russian parliament has tightened restrictions on abortion, which can lead to an increase in illegal abortions.²¹ In developing countries, unsafe abortion remains the leading cause of maternal mortality in developing countries. WHO defines abortion as unsafe, they are carried out by people who do not have the necessary skills, or in meet minimum medical standards, or both. In 2008, an estimated 49 per cent of the world's 44 million abortions were considered unsafe, while 98 per cent of unsafe abortions were in developing countries. In developing countries, 56% of abortions were unsafe, compared with 6% in developed countries.²⁰ WHO estimates that 47,000 deaths from unsafe abortions occur worldwide each year. Worldwide, it is estimated that 5 million women are hospitalized annually for abortion-related complications such as hemorrhage and sepsis.²² About 1 in 8 maternal deaths worldwide are associated with unsafe abortion.²³ Most of these maternal deaths occur in underdeveloped countries with the highest burdens in Africa, Latin America and the Caribbean.²² The proportion of maternal mortality that is the result of unsafe abortion is likely to be significantly higher than the estimated. Where abortion is illegal, women and health professionals are reluctant to report that abortion was caused by a private personal dialogue with women through training, empathetic workers show that a higher proportion of induced abortions.²⁵ Preventable morbidity and mortality from septic abortions are staggering and well documented.²⁶ Guinea's 1992 report, in West Africa, reported on the investigation of all maternal deaths in the capital from July 1, 1989 to June 30, 1990. The most common causes were hypertension (20%), postpartum haemorrhage (19%) and hypertension (19%). Sepsis was the most common cause of death.²⁷ A study at five hospitals in Kampala, Uganda, in East Africa, between 1980 and 1986 showed 20% of maternal deaths are related to abortion.²⁸ A Nigerian study reported that 35% of maternal deaths in hospitals were related to abortion, with sepsis the most common cause of death.²⁹ 7-year-old abortion review at University College Hospital in Ibadan, Nigeria, reported that abortion complications accounted for 77% of all emergency gynecological hospitalizations.³⁰ In rural Bangladesh, there were 387 maternal deaths between 1976 and 1985 (555 per 100,000 live births), the causes of death were postpartum hemorrhage (20%), abortion (18%), and pregnancy-induced hypertension/eclampsia (12%).³¹ In 1990, 36 hospitals and medical schools from four Latin American countries participated in a multinational study of all women of all women during this time, 14,501 abortion admissions were registered and 8,871 were investigated. At the same time, 113,714 births were registered in participating hospitals. Fifteen percent were classified as septic tanks upon admission. Forty-three of the 8,871 women in need of a hysterectomy and 36 women died, resulting in an abortion rate of 406 per 100,000 women admitted to abortion. Although hemorrhage was the most common abortion abortion Seventy-five per cent of deaths were in women who were admitted as septic tanks. In some areas, the problem may escalate. In the 10-day survey, the survey taken in Rio de Janeiro, abortion-related mortality accounted for 47% of total mortality.³³ As shown in all these studies, abortion deaths are mainly caused by sepsis. More recent reports from many countries confirm the same gloomy conclusions. A 10-year study published in 2001 in rural India found that 41.9 per cent of all maternal deaths were septic abortions, and the overall maternal mortality rate is extraordinary (785 per 100,000 live births), which is about 100 times the maternal mortality rate in developed countries.³⁴ A WHO report showed a decline in maternal mortality worldwide from 546,000 deaths in 1990 to 358,000 in 2008 and a parallel reduction in deaths from unsafe abortions from 69,000 to 47,000 over the same interval. However, the proportion of maternal deaths from unsafe abortions remains the same at 13 per cent. The actual number of unsafe abortions worldwide increased from 19.7 million in 2003 to 21.6 million in 2008 due to the growing population of women of childbearing age.²⁰, 35 Prime prevention avoids disease or injury.² Primary prevention of septic abortion includes access to effective and acceptable contraception; Access to safe, legal abortion if contraceptives are refused; and proper medical management of abortion. Avoiding unintended pregnancies Pregnancy puts women at risk for illness and death. This risk can be gladly taken with the desired pregnancy. Unwanted pregnancies put a woman at additional risk if she seeks an abortion and safe services are not available.³⁶, 37 Reducing unwanted pregnancies is a goal to which both sides in the abortion dispute can agree, though the means to do so diverge. The prerequisite for preventing unwanted pregnancies - in all countries - is social equality: increasing the status of women so that they can avoid forced sexual relations and use contraceptive methods that they consider safe and free from side effects.³⁶ In the United States, the age rates of abortion make it clear that women at greatest risk of unwanted pregnancies are both young adults.¹⁰ Marriage and intentional childbearing are delayed, but there is no sexual activity. National surveys consistently show that 11-12 per cent of women of reproductive age are sexually active without contraception.³⁸ State-funded contraceptive services do not reach everyone who needs them. For more than a decade, there has been no increase in funding for public services the 11th U.S. Congression tried to remove all federal funding for Planned Parenthood clinics. Sex education is often not informed about contraception due to that such education about contraception encourages sexual experimentation. In fact, teens entering family planning clinics tend to be sexually active long before receiving services.³⁹ Education about biology is not enough. Actual services should be made easily accessible and affordable (table 1). Table 1. Components of Safe Surgical Abortion Services: Pressure diagnosis of pregnancy with urine test Provide nonjudgmental counseling Space patient in active disease, which can complicate the procedure or choice of anesthesia, and evaluate the allergy/Perform physical examination with attention to the size and position of the uterus, other pelvic pathologies Anni ultrasound examination, if the duration of pregnancy is uncertain, there is a discrepancy between the length, there is pelvic mass, or gestational age goes beyond the early midtrimester/Perform minimal laboratory testing - blood group and Rh status/Provide prophylactic antibiotics (e.g. doxycycline 100 mg PO, two doses before or immediately after the procedure)/Evening local anesthesia: paracemic block/Dile of the cervix with cervical extenders (Pratt or similar) or use hyposcopic extenders (kelonar or synthetic alternatives to Dilapan or misoprostol 400 micrograms per buccal or sublingual routes 3 hours before) Using vacuum buzzards corresponding diameter one less than estimated gestational age in weeks) Perform a fresh examination of tissues to rule out incomplete or unsuccessful abortion, ectopic and molya pregnancy/Alternatively, to provide medical abortion with mifepristone and misoprostol, or misoprostol only if mifepristone is not available/Provide access to a 24-hour follow-up service Active to track high-risk patients of Philadelphia, JB Lippincott, 1984; and Stubblefield PG: Pregnancy interruption. In Gabbe SG, Niebly JR, Simpson JL (eds): Obstetrics: Normal and Troubled Pregnancy, page 1303-1332. 2nd o. New York, Churchill Livingstone, 1991/Access to safe abortion services The need for safe, legal abortion is nowhere more clearly shown than in the Romanian experience. When abortion was outlawed in the 1960s, the rate of maternal mortality associated with abortion increased tenfold. An estimated 10,000 women have died from the policy in the 23 years it was introduced.⁴⁰ The death rate has only fallen when abortion has been re-legalized. The public health message of this strange natural experiment is clear: when abortion is legal and affordable, women's health improves, and vice versa. There is no evidence to support the claim that restricting abortion reduces the number of abortions performed. Abortion rates and rates are equally high or higher in countries where abortion is fully than in countries where it is legal and readily available.⁴¹ The need for safe legal abortion abortion once again shown in nepal's experience. Between 1996 and 2006, maternal mortality fell sharply from 539 to 281 deaths per 100,000 live births. This sharp decline is due to the legalization of abortion in Nepal in 2002. Safe abortion services are available in all 75 counties, and more than 400,000 women benefited from the increase in safe abortion services between 2002 and 2010.⁴² Between 1994 and 1998-2001, after the legalization of abortion in 1997, abortion deaths decreased by 91 per cent. Access is particularly a problem for disadvantaged women, including the young, who in many jurisdictions have to obtain their parents' consent for an abortion but who may continue to have a pregnancy, a much more dangerous course in themselves.⁴⁴ The technology of first-trimester abortion is not complicated (table 1). In the first trimester and early midtrimester, abortion is easily performed by vacuum curettage in outpatient or office setting.⁴⁵, 46 Preventive antibiotics reduce the risk of feverish morbidity after abortion.⁴⁷ Inth preventative requires early detection and treatment, in order to stop the disease process.² Secondary prevention of septic abortion entails rapid diagnosis and effective treatment of endometritis, to avoid more serious infections. The diagnosis of septic abortion should be suspected when any woman of reproductive age presents with vaginal bleeding, lower abdominal pain, and fever. A common theme in reported deaths from septic abortions is delay: young or unmarried women often conceal abortions and delay seeking help until they die. In this environment, a sensitive pregnancy test (capable of detecting 20-50 mIU/mL beta-human chorionic gonadotropin (beta-HCG) will usually be positive, because it takes 4-6 weeks for beta-HCG to become undetectable after a complete evacuation of the uterus. The abortion provider should be contacted to determine the details of the procedure - whether complications were suspected at the time, duration of pregnancy, and the number of pregnancy tissue removed, results of any screening of bacteriological studies, and pathological examination of interrupted tissue. Perforation and tissue preservation. Perforation significantly increases the risk of serious sepsis.⁷ Illegal abortion by injecting hard foreign objects increases the risk of perforation.⁴⁸ Intrauterine soap burying poses a particular danger to uterine necrosis renal failure.⁴⁹ Abdominal and pelvic examinations deserve special attention. The expert should note abdominal tenderness, protection and rebound, and whether the tenderness is limited to the lower abdomen (pelvic peritonitis) or present throughout the abdomen (generalized peritonitis). Are there vaginal or cervical lacerations? Is there a bad smell? Are the products of conception or foe visible in the cervical OS? Is the uterus enlarged and tender? Is there an adnexal mass? If perforation is suspected, radiographic studies of the abdomen can help determine free air or other body. Some women develop mild illness, with a turn-based triad of symptoms: low-grade fever, mild lower abdominal pain and moderate vaginal bleeding. Patients suffering from these symptoms typically have either an incomplete or unsuccessful abortion (continued pregnancy) or a haematometer (preserved rolled up and liquid blood).⁵⁰ The ideal management is an immediate evacuation to an outpatient clinic or emergency room. It can be easily achieved safely and humanely through vacuum treatment with local anesthesia and intravenous sedation. In a large U.S. series, 3.5 patients per 1,000 were re-evacuated at an abortion clinic, which undoubtedly contributed to the surprisingly low hospitalization rate of authors for septic abortion, 0.21 per 1000.⁵¹ Bacteriology of septic abortion, usually polymicrobial, derived from normal vaginal flora and endocervix, with the important addition of sexually transmitted pathogens.⁵² Grampaol and gram-negative aerobics and teachers or mandatory anaerobics, Neisseria gonorrhoea, and Chlamy trachomatis all possible pathogens.⁸ 46 In the United States, Clostridium perfringens infection is largely associated with illegal abortions.⁸ Recently Clostridium sordellii has been the cause of death in a small number of women treated with mifepristone and vaginal misoprostol for early medical abortion.⁵³ In developing countries, tetanus contributes to deaths from septic abortion.²⁶ due to various bacterial agents found in abortion. No antibiotic agent is ideal. Recommended centers of Disease Control and Prevention schemes for outpatient treatment of pelvic inflammatory diseases are suitable for patients with an early post-abortion infection limited to the uterine cavity in addition to the evacuation of the uterus. One such regimen is ceftriaxone 250 mg by intramuscular injection (or other third-generation cephalosporin, such as cefaxitine, ceftizoxime, or cefotaxim) plus doxycycline 100 mg orally twice a day for 14 days, with or without metronidazole 500 mg orally twice a day for 14 days.⁵⁴ Due to the spread of quinolone-resistant gonococci, quinolones are no longer the first choice for outpatient inflammatory pelvic disease in the U.S.⁵⁴ Terthian prevention minimizes harm harm 2 Tertiary prevention of septic abortion is aimed at avoiding serious consequences of infection, including hysterectomy and death. Systemic inflammatory syndrome (SIRS) is an inflammatory reaction. SIRS is characterized by fever of zgt:38 degrees Celsius, tachycardia of zgt:90 b/s, tachypneir RR zgt:20, white blood cells of zgt:12,000 or zlt:4000, or gt:10% immature forms. Septic shock involves SIRS plus suspected or present infection. Severe sepsis includes SIRS plus evidence of organ dysfunction.evidence of organ dysfunction in the conditions of bacteremia.⁵⁵ Septic shock is suggested by tachycardia (qgt:110), respiratory failure, oliguria, altered mental state and hypotension, despite adequate reuse of fluid.⁸, 50, 55 Patients with a more established infection, as evidenced by fever (arbitrarily defined as zgt:38 degrees Celsius), pelvic peritonitis or a more serious disease, should be hospitalized for parenteral antibiotic therapy and uterine evacuation. Bacteremia is more common in septic abortion than in other pelvic infections: septic shock and adult respiratory distress syndrome (ARDS) can result.⁴⁸ Managing severe sepsis requires early aggressive resuscitation volume, Eradicating infection and supporting care for the cardiovascular system and other participating infection control systems and supporting care for the cardiovascular system and other participating organ systems.⁸, 56 For a detailed review of the management of severe sepsis, the reader refers to the publication of the Sepsis Survival Campaign, an international collaboration that currently includes 30 organizations around the world. The campaign has been developing expert recommendations based on evidence for more than a decade.⁵⁷ It is necessary to develop a culture of blood infection, adopt a culture of urine and cervix, and start intravenously taking high-dose antibiotics. A sample of endometrial or tissue biopsy obtained during uterine aspiration provides a better pattern for culture than cervical excretion. Studying gram-colored materials can guide early management. One-time regimen for severe pelvic sepsis is penicillin (5 million units intravenously IV every 6 hours) or ampicillin (2 g IV every 6 hours) in combination with gentamicin (2 mg/kg load dose, followed by 1.5 mg/kg every 8 hours or 5 mg/kg every 24 hours depending on the level of renal and blood status). Added either clindamycin (900 mg IV every 8 hours) or methanidazole (15 mg/kg, followed initially by 7.5 mg/kg every 8 hours). The rapid use of broad-spectrum antibiotics is key to favorable result. Cleaning the uterus Remaining pregnancy tissue should be evacuated without delay as soon as antibiotic therapy and fluid resuscitation have begun. Doctors' indecision to evacuate the uterus is because of the lack of time. Poor patient condition is a common theme in fatal septic abortions in the United States.⁷ Vacuum curettage is easily performed with a patient under local anesthesia with minimal intravenous sedation, and if necessary, it can be performed in the bed ICU. Saved fetus from midtrimester miscarriage presents a special challenge. The uterus can usually be easily evacuated through the curettage procedure, promoted by ultrasound guide, if a practitioner experienced with midtrimester enlargement and evacuation abortion is available. Otherwise, medical means are needed to evacuate the uterus. Although there is little information about its use in the context of septic abortion, misoprostol, the analogue of prostaglandin E1 is widely used for induction of abortions in the first and second trimesters, probably the drug of choice for this purpose. Misoprostol has fewer side effects than old prostaglandins and is inexpensive, stable at room temperature, and is widely available.⁵⁸ Vaginal or sublingual doses of 400 micrograms at 3 hourly intervals are highly effective for inducing abortions in midtrimester.⁵⁹ Alternately, high doses of oxytocin can be used. Fifty units of oxytocin are given in 500 ml 5% dextrose and normal saline solution during a 3-hour period (approximately 278 mU/min). This is followed by a 1-hour rest and repeats, adding 50 additional units to the next infusion of 500 ml, and continuing with 3 hours of infusion and 1 hour of rest. It is repeated until the patient interrupts or the final decision of 300 U oxytocin in 500 ml is reached (1.667 MU / min 60 If none of these remedies are available, Another option is metreuryner. The Foley catheter is placed in the lower uterus and the balloon is inflated to 50-75 ml. One kilogram of thrust from the orthopedic weight at the foot of the bed is then attached to the catheter. Other signs are uterine perforation with suspected bowel damage, pelvic abscess and clostridial myometritis.⁵⁰ In clinically stable diagnostic laparoscopy the patient may be evaluated for possible uterine perforation, causing damage to adjacent organs such as the intestines or bladder. In critically ill women with severe post-abortion sepsis, a hysterectomy is likely to be necessary in addition to draining any abscess. Discolored, woody appearance of the uterus and adnexa, suspected clostridial sepsis, crepitation in pelvic tissues, and radiographic evidence of air in the uterine wall, are signs for general hysterectomy and possible removal of both Operational cultures must be obtained. Abundant irrigation recommended plying material and abdominal drainage with closed suction systems. In the absence injury, a leak of fecal fluid in enterostomy is necessary. The closure of the abdominal cavity should be interrupted by an internal stay (Smead-Jones or similar) or running a mass ligature including abdominal, rectal muscles, and straight fascia. The subcutaneous subcutaneous and skin remain open with seams placed to delay the initial closure, and the wound is packed. Supportive care for patients with severe sepsis and septic shock should be managed in intensive care in collaboration with doctors and nurses trained in critical care medicine. However, care should be delayed as soon as possible, rather than delaying until the transport is complete. Management principles are aggressive control of sources with antibiotics and early hemodynamic resuscitation. Cardiovascular support is trying to restore tissue perfusion with fluid and inotropic therapy. The principles of management of post-abortion septic shock do not differ from the principles of tissue perfusion. This approach is known as an early goal of targeted therapy, and has been shown to improve mortality when initiated within the first 6 hours of presentation.⁵⁵ Central venous catheters (CVC) and central venous oxygenoglobin saturation (ScvO2) should be used, if any. Treatment using CVC and ScvO2 has been shown to reduce mortality in septic shock conditions. CVP targets 8-12 mm Hg. Art and ScvO2 zgt:70% should be used.⁵⁶ Average blood pressure of 65 mmHg, art,0.5 ml/kg per hour, and lactate clearance are clinical signs of reperfusion. These measures can be useful in under-resourced settings where central monitoring is not always available. The liquid should be injected into the fast large 500-1000 ml boluses, and patients are likely to need at least 2 litres and up to 5 litres of crystalloid in the first 6 hours. Hydroxyethyl starches (HES) are not recommended for fluid resuscitation in treatment The administration properly targeted antibiotics during the first hour of presentation has also been shown to improve results. Vasopressors are added if the patient is a patient hypotensive, despite sufficient resuscitation or in patients who develop cardiogenic pulmonary edema, limiting the amount of resuscitation efforts. Norepinephrine must be the first-line agent used to control fire-resistant hypotension in septic shock conditions. Norepinephrine is used at 2-20 micrograms/min. Epinephrine is added or replaced by norepinephrine when an additional agent is needed to maintain adequate blood pressure. Dopamine is no longer recommended regularly.⁵⁷ In a recent systematic review of randomized controlled dopamine trials against norepinephrine, there was no statistically significant hospital or 28-day mortality among patients with septic shock.⁶² Dopamine, however, is associated with an increased risk of arrhythmia.⁶³ Inotropic therapy with dobutamine is recommended for patients with low heart disease sepsis. Anemia should be corrected with packed red blood cells of hemoglobin 7 g/dL. Fresh frozen plasma, platelets or cryoprecipitate should only be used when there is clinical or laboratory evidence of coagulopathy.⁶⁴ ARDS pulmonary complications management will develop in 25-50% of patients with septic shock.⁵² The cornerstone of treatment in ARDS management is low tidal ventilation to prevent further damage. When using mechanical ventilation, the tidal volume should be set to 6 ml/kg (calculated on the ideal body weight) with the pressure plateau of the target less than 30. The principle of limiting tidal volume is to avoid further injury to lung volume and the need to limit plateau pressure to avoid barotrauma. Additional treatments for high-dose corticosteroid therapy are no longer recommended, after two randomized trials failed to find a benefit.⁶⁵, 66 compared to placebo. Hydrocortisone led to faster shock treatment, but due to an increase in secondary infections, mortality was not improved.⁶⁷ External cooling (to a core body temperature of 36.5-37 degrees Celsius) in patients with septic shock requiring vasopressors, ventilation and sedation may have the benefit of mortality⁶⁸, but this practice requires further study before it becomes standard. Nine deaths occurred in the U.S., and one in Canada, from Clostridium sordellii sepsis in women who had an early abortion induced with mifepristone and vaginal misoprostol. The mortality rate from C. sordellii sepsis with medical abortion in the U.S. is estimated as 0.58 per 100,000 medical abortions.⁶⁹ This body has also caused a number of deaths in childbirth, spontaneous abortion, injecting in prohibited drugs, and in traumatic injury or surgery.⁷⁰ Patients are presented in an unusual way, with severe pelvic pain, without but with severe, producing very high hematocrit and leukomoid reaction, and then quickly developed the shock associated with Swelling. All patients died despite vigorous and prompt treatment in the hospital, including a hysterectomy. Death appeared to be linked to a deadly toxin developed by this bacterium.⁶⁹ Lee's earlier diagnosis, based on this unique presentation, confirmed by Gram spot endometrial biopsy showing characteristic Gram positive rods and treatment for a hysterectomy will improve the results, unknown. Deaths and serious complications associated with an abortion-related infection are almost entirely preventable. Unfortunately, preventing death from abortion remains a political rather than a medical problem. While international health leaders have repeatedly drawn attention to the complications of abortion and maternal mortality, many governments and health institutions still lack the moral courage to address this problem.⁶⁹ For health workers, ethical issues have been made clear: we must reaffirm our own commitment to the values of health care. We have an obligation to put health first, to respect the best available scientific evidence and to be frank when we shift such evidence to other considerations, whether moral, religious, economic or simply appropriate. ⁷¹, ⁷² We are grateful to Sajid Shahul, M.D., an anesthesiology and critical care instructor at Harvard Medical School and Beth Israel Diacones Medical Center in Boston, Massachusetts, for his critical reading of the manuscript. Manuscript.

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