Thematic analysis of 10 unplanned hysterectomies following surgical abortion

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BACKGROUND

Hysterectomy is an uncommon but serious complication of surgical abortion. Since 2015, our complex abortion service has performed 10 emergency hysterectomies following surgical abortion.

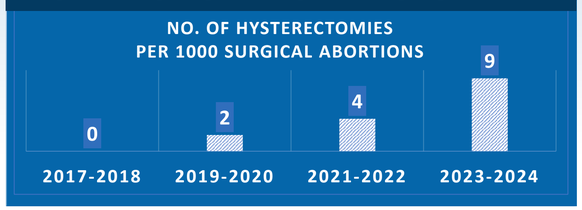
The number of surgical abortions performed per year has remained relatively consistent since 2017 (average 260 per year). However, **50% of the hysterectomies occurred over a single 2-year period** (2023-2024).

We set out to identify any factors that could have contributed to this cluster of cases and identify any opportunities to improve patient care.

METHODS

A retrospective thematic analysis was undertaken as the first step of a quality improvement project. All 10 patients' notes were reviewed in conjunction with the wider service activity data.

INCIDENCE OF HYSTERECTOMY

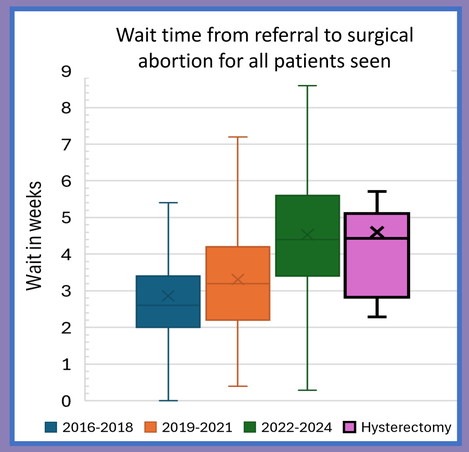


THEMES IDENTIFIED FOR PATIENTS WHO HAD A HYSTERECTOMY

- **Theme 1: Waiting times**

100% waited over 2 weeks from referral to abortion, (NICE standard*) with a mean wait of 4.5 weeks.

The average wait time for all surgical abortions has increased over time and since 2022 has been 4.5 weeks.



- **Theme 2: Patient risk factors**

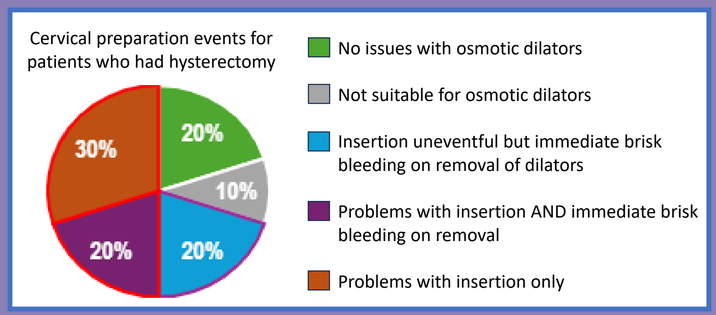
90% had significant risk factors identified pre-operatively. These included:

- Endometrial ablation
- Multiple c-sections with low lying placenta

There has not been a significant change in the overall rate of risk factors seen over the years.

- **Theme 3: Difficulties with cervical preparation**

50% had documented difficulties with osmotic dilator insertion.
This was more common in patients with a BMI >40 and multiple c-sections



- **Theme 4: Placenta accreta Spectrum (PAS)**

40% had PAS confirmed on histology.
All were identified as high-risk prior to the procedure.

DISCUSSION

Our overall rate of 3-4 hysterectomies per 1000 surgical abortions should be interpreted in the context of the complexity of our cohort. Over 95% of patients seen are referred due to risk factors and all patients receiving a surgical abortion have the risk of hysterectomy documented on their consent form.

9 out of 10 patients who had a hysterectomy had significant unmodifiable risk factors, some of which were likely exacerbated by waiting times resulting in higher gestations at treatment.

This analysis was limited by the overall small number of cases seen and documentation.

Our proposed improvements have focused on clinic flow, patient prioritisation and cervical preparation pathways. Further work is required to improve identification and management of placenta accreta spectrum.

CONCLUSION

Key themes identified in the patients who had a hysterectomy included long waits from referral to treatment, complex uterine pathology and challenges with cervical preparation.



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*REF: https://www.nice.org.uk/guidance/ng140/chapter/Recommendations#waiting-times