Does a past abortion affect my chances of getting pregnant?

Expert Answers The BabyCenter Editorial Team

www.babycenter.com/404_does-a-past-abortion-affect-my-chances-of-getting-pregnant_6148.bc

Probably not. However, in rare cases, multiple dilations and curettages (the cleaning out of the uterus, also known as a D&C) can cause some scarring at the top of the cervix or inside the uterus. A procedure called hysteroscopy (when a small camera is placed through your cervix into your uterine cavity) can be used to check for this problem and can usually repair the scar tissue at the same time. But even if that's not the case for you, you should know that any procedure that dilates the cervix (a necessary step during most abortions) can weaken it. So if you've had more than one abortion and you get pregnant again later on, you may find that you have what's known as an incompetent cervix — a cervix that starts dilating prematurely. This can sometimes be treated with a stitch to keep the cervix closed, called a cerclage. On the bright side, having conceived before proves that you ovulate and that your fallopian tubes are open.

With the help of Robert Jansen, a clinical professor of reproductive medicine at the University of Sydney in Australia. Dr. Jansen is also head of the Department of Reproductive Endocrinology & Infertility at Royal Prince Alfred Hospital in Sydney, the medical director of Sydney IVF, one of Australia's leading fertility clinics, and the author of ***Overcoming Infertility: A Compassionate Resource for Getting Pregnant****. You can learn more about the book or search Dr. Jansen's extensive glossary of infertility terms at* http://www.jansen.com.au

From Michigan Dept of Community Health – Informed Consent for Abortion

www.mi.gov/mdch/0,1607,7-132-2940_4909_6437_19077-46287--,00.html (April, 2010)

Risk Factors for Mifepristone Abortion

According to the U.S. Food and Drug Administration, early pregnancy means that your doctor has confirmed through a valid and reliable manner that your pregnancy began 49 days (seven weeks) or less from the beginning of your last menstrual period.

There are some risks and complications that can occur with this abortion procedure. Not all risks may pertain to all patients. This procedure should be discussed with your doctor for information on the risks that apply to you.

As noted earlier, vaginal bleeding and uterine cramping will occur in almost all patients. In some cases, bleeding can be very heavy. You should expect to experience bleeding or spotting for an average of nine to 16 days. Some women experience bleeding for 30 days or more. In some cases, excessive bleeding may require blood transfusions, treatment with medication, surgery, and/or saline transfusions. Commonly reported side effects included nausea, vomiting and diarrhea.

Medication-Induced Abortion

This is a procedure generally used after 16 weeks of a pregnancy. This procedure will generally require a hospital stay of one to two days. The skin on the abdomen is numbed by a pain-killer. A needle is used to inject a substance drop by drop through the abdomen into the amniotic fluid in the uterus which surrounds the fetus.

Generally one of three substances is used:

- a salt solution (saline)
- a drug (prostaglandin)
- or a chemical compound (urea).

Other medicines may be given to cause contractions to begin.

Risks and Complications:

Following is a list of some of the risks which in the past have been associated with this type of

abortion procedure. Not all of these risks may pertain to any one patient. This procedure should be discussed with your physician for information regarding risks which may apply to you.

Complications may include infection, heavy bleeding, and perforation of the uterus (a hole or tear in the wall of the womb).

The risks of uterine perforation and laceration are slightly greater at this stage of pregnancy than they are in an abortion done earlier due to the larger fetus and thinner uterine walls.

Other complications could include cervical incompetence (a condition in which the cervix opens up too early, increasing the risk of a miscarriage in future pregnancies) and injury to the cervix. Repeated abortions could increase the possibility of premature delivery or a low birth weight infant in future pregnancies.

Dilation and Evacuation (D&E)

This is a procedure generally used after 12 weeks of pregnancy. The procedure will generally be done on an outpatient basis but may sometimes require hospitalization. The physician will often use ultrasound to determine how far along you are in your pregnancy.

Risks and Complications:
Following is a list of some of the risks which in the past have been associated with this type of abortion procedure. Not all of these risks may pertain to any one patient. This procedure should be discussed with your physician for information regarding risks which may apply to you.

Complications may include infection, heavy bleeding, and perforation of the uterus (a hole or tear in the wall of the womb). The risks of uterine perforation and laceration are slightly greater at this stage of pregnancy than they are in an abortion done earlier due to the larger fetus and thinner uterine walls.

Other complications could include cervical incompetence (a condition in which the cervix opens up too early, increasing the risk of a miscarriage in future pregnancies) and injury to the cervix.

Repeated abortions could increase the possibility of premature delivery or a low birth weight infant in future pregnancies.

Suction Curettage

This is a procedure generally used in the first 12 weeks of a pregnancy (the first trimester). Unless there are unusual complications, this procedure is done on an outpatient basis and may be done in a physician's office or a clinic.

Risks and Complications Associated with this type of Abortion:
Following is a list of some of the risks which in the past have been associated with this type of abortion procedure. Not all of these risks may pertain to any one patient. This procedure should be discussed with your physician for information regarding risks which may apply to you.

Complications may include infection, heavy bleeding, perforation of the uterus (a hole or tear in the wall of the womb), cervical incompetence (a condition in which the cervix opens up too early in future pregnancies, increasing the risk of a miscarriage in future pregnancies), and injury to the cervix.

Repeated abortions could increase the possibility of premature delivery or a low birth weight infant in future pregnancies.

Risks and Complications associated with Pregnancy and Delivery

For every 100 hospitalizations for delivery there are approximately 22 hospitalizations for pregnancy complications.

Some of the complications of pregnancy which may result in death or hospitalization include heavy bleeding or **infection**, preeclampsia and eclampsia (characterized by seizures, swelling and high blood pressure), blood clots, **ectopic pregnancies** (fertilized eggs growing outside the womb),

miscarriage, death of the fetus or newborn, premature labor, urinary tract infection, excessive vomiting during pregnancy, and diabetes.

What causes an ectopic pregnancy? (www.webmd.com/baby/tc/ectopic-pregnancy-topic-overview)

An ectopic pregnancy is often caused by damage to the fallopian tubes. A fertilized egg may have trouble passing through a damaged tube, causing the egg to implant and grow in the tube.

Things that make you more likely to have fallopian tube damage and an ectopic pregnancy include:

- Smoking. The more you smoke, the higher your risk of an ectopic pregnancy.
- **Pelvic inflammatory disease (PID).** This is often the result of an **infection** such as chlamydia or gonorrhea.
- **Endometriosis,** which can cause scar tissue in or around the fallopian tubes.
- Being exposed to the chemical DES before you were born.

Some medical treatments can increase your risk of ectopic pregnancy. These include:

- Surgery on the fallopian tubes or in the pelvic area.
- Fertility treatments such as in vitro fertilization.

Preventing pelvic infection after abortion.

(http://www.ncbi.nlm.nih.gov/pubmed/8547409)

Stevenson MM, Radcliffe KW. Int J STD AIDS. 1995 Sep-Oct;6(5):305-12.

Abstract

Pelvic infection is the commonest complication of legal abortion. The presence of lower genital tract infections increases the risk of complications, and women requesting abortion are at significant risk of harbouring sexually transmitted diseases (STD). Prophylactic antibiotic treatment can decrease the rate of post-abortal sepsis, but the optimum regime is unclear. In particular, patients with Chlamydia trachomatis infection, and bacterial vaginosis would appear to be at increased risk, and detection and treatment of these conditions can lower this risk. The opportunity to screen and treat for STD presents itself in this setting, allowing patients and their sexual contacts to benefit, with a decrease in the infected pool in the community.

PIP: Induced abortion is one of the most frequent surgical procedures in the UK. Even though it is considered safe, it sometimes has complications and long-term sequelae. Pelvic inflammatory disease (PID) is the most prevalent complication and can lead to chronic pelvic pain, pain during intercourse, infertility, and a higher risk of ectopic pregnancy. Chlamydia trachomatis is perhaps the leading etiologic agent for PID among women who have undergone induced abortion and who develop PID. Gonorrhea is another major etiologic agent for PID. Strategies used to try to reduce pelvic infection revolve around administration of antibiotic prophylaxis based on demographic features and on the presence of certain organisms in the genital tract that may increase their risk (e.g., C. trachomatis and Neisseria gonorrhoeae) and universal antibiotic prophylaxis for all women undergoing abortion. Most of the literature suggests that antibiotic prophylaxis does provide some protection against PID but does not clearly indicate who should be screened and for which pathogens and who should be treated and with which antibiotics. Demographic features useful for identifying who should receive antibiotic prophylaxis are: a history of PID, single status, nulliparity, and youth (especially reliable for chlamydial infection). Screening for bacterial vaginosis involves diagnosis based on 3 of 4 criteria: characteristic vaginal discharge, positive amine test, raised vaginal pH, and the presence of clue cells on microscopy of wet or stained preparations of vaginal discharge. Since C. trachomatis is the most important pathogen, drugs sensitive to it should be administered: tetracyclines and erythromycin. Screening women seeking

abortion for sexually transmitted diseases (STDs) provides an opportunity to educate them about STDs and treatment compliance and to contact their partners for investigation, treatment, and contact-tracing to reduce the STD-infected pool in the community.

PMID: 8547409 [PubMed - indexed for MEDLINE]

Abortion, Complications (http://emedicine.medscape.com/article/795001-overview)

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Contributor Information and Disclosures

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Introduction

Background

Complications of spontaneous miscarriages and therapeutic abortions include the following:

- Complications of anesthesia
- Postabortion triad (ie, pain, bleeding, low-grade fever)
- Hematometra
- Retained products of conception
- Uterine perforation
- Bowel and bladder injury
- Failed abortion
- **Septic abortion**
- Cervical shock
- Cervical laceration
- Disseminated intravascular coagulation (DIC)

The term "septic abortion" refers to a spontaneous miscarriage or therapeutic/artificial abortion **complicated by a pelvic infection.**

Pathophysiology

Postabortion complications develop as a result of 3 major mechanisms as follows: incomplete evacuation of the uterus and uterine atony, which leads to hemorrhagic complications; infection; and injury due to instruments used during the procedure.

In septic abortion, infection usually begins as **endometritis** and involves the endometrium and any retained products of conception. If not treated, the infection may spread further into the myometrium and parametrium. Parametritis may progress into peritonitis. The patient may develop bacteremia and sepsis at any stage of septic abortion. **Pelvic inflammatory disease (PID) is the most common complication of septic abortion.**

Frequency

United States

Frequency of complications depends on gestational age (GA) at the time of miscarriage or abortion and method of abortion. Complication rates according to gestational age at the time of abortion are as follows:

- 8 weeks and under - Less than 1%
- 8-12 weeks - 1.5-2%
- **12-13 weeks - 3-6%**
- **Second trimester - Up to 50%, possibly higher**

Mortality/Morbidity

Mortality and morbidity depend on gestational age at the time of miscarriage or abortion. In the United States, **mortality rates per 100,000 abortions are as follows: fewer than 8 weeks, 0.5%; 11-12 weeks, 2.2%; 16-20 weeks, 14%; and more than 21 weeks, 18%**.

Septic abortion was once the leading cause of maternal death around the world. The condition remains a primary cause of maternal mortality in the developing world, mostly as a result of illegal abortions. According to the World Health Organization, about 68,000 women die each year due to complications from unsafe abortions, with sepsis as the main cause of death.[1] In the United States in 2005, 7 women reportedly died from complications of legal induced abortion.[2]

In the United States, mortality from septic abortion rapidly declined after legalization of abortion. Death now occurs in less than 1 per 100,000 abortions. Figures for most European countries are similar to US rates.

The risk of death from septic abortion rises with the progression of gestation.