

# THERAPEUTIC APPROACH IN THE UTERINE EVACUATION PROCESS

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## ABORDAGEM TERAPÊUTICA NO PROCESSO DE ESVAZIAMENTO UTERINO

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## ENFOQUE TERAPÉUTICO EN EL PROCESO DE VACIACIÓN UTERINO

Cassiana Pinheiro de Araújo<sup>1</sup>  
Adélia Cristina Vieira de Rezende Dornelas<sup>2</sup>  
Antônio Manuel Sousa<sup>3</sup>

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**Objectives:** identify the therapeutics used in the uterine evacuation process and outline the obstetric profile of the women attended in this process. **Method:** quantitative, retrospective, exploratory and descriptive research, consisting of 466 records of women hospitalized for uterine evacuation between June 2015 and June 2016. **Results:** ages ranged between 14 and 43 years. The main diagnosis was incomplete abortion, responsible for 44.85% of the hospitalizations. The most used initial therapy was misoprostol (57.71%) and the length of hospitalization before the uterine evacuation ranged between 0.20 and 137 hours. **Conclusion:** the obstetric profile of women who experience gestational loss does not differ from the profile found in Brazil; curettage was the most used final therapy, in addition to some unfavorable outcomes, such as longer hospitalization and excessive exposure to medication.

**Descriptors:** Women's health. Abortion. Therapeutic approaches. Delivery of Health Care.

*Objetivos:* identificar a terapêutica utilizada no processo de esvaziamento uterino e traçar o perfil obstétrico das mulheres assistidas nesse processo. *Método:* pesquisa quantitativa, retrospectiva, de caráter exploratório-descritivo, constituída por 466 prontuários de mulheres internadas para esvaziamento uterino, no período de junho de 2015 a junho de 2016. *Resultados:* a idade variou entre 14 e 43 anos, o principal diagnóstico foi o aborto incompleto, responsável por 44,85% das internações, a terapêutica inicial mais utilizada foi o misoprostol (57,71%) e o tempo de internação até o esvaziamento uterino variou entre 0,20 e 137 horas. *Conclusão:* o perfil obstétrico da mulher que vivencia a perda gestacional não difere do encontrado nacionalmente; a curetagem foi a terapêutica final mais utilizada acrescida de alguns desfechos desfavoráveis, como maior tempo de internação e exposição excessiva a medicação.

*Descritores:* Saúde da mulher. Abortamento. Métodos terapêuticos. Assistência à saúde.

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<sup>1</sup> RN. Obstetric Nursing Specialist. Manaus, Amazonas, Brazil. cassianapinheiro@gmail.com

<sup>2</sup> RN. Obstetric Nursing Specialist. Master's student in Health Sciences at Universidade de São Paulo. Professor in the Nursing Program at Escola Superior da Saúde, Universidade do Estado do Amazonas. Manaus, Amazonas, Brazil.

<sup>3</sup> Biologist. Microbiology Specialist. M.Sc. in Epidemiology. Ph.D. in Collective Health. Adjunct Professor at School of Health Sciences, Universidade do Estado do Amazonas. Manaus, Amazonas, Brazil.

*las internaciones, la terapéutica inicial más utilizada fue el misoprostol (57,71%) y el tiempo de internación hasta el vaciamiento uterino varió entre 0,20 y 137 horas. Conclusión: el perfil obstétrico de la mujer que vive la pérdida gestacional no difiere de lo encontrado nacionalmente; el curetaje fue la terapia final más utilizada, sumada de algunos resultados desfavorables, como mayor tiempo de internación y exposición excesiva a la medicación.*

*Descriptores: Salud de la mujer. Aborto. Métodos terapéuticos. Prestación de atención de salud.*

## Introduction

From the medical point of view, the concept of abortion is the interruption of pregnancy until the 20th or 22nd week of gestation and with the product of the conception weighing less than 500 g. Abortion is the product eliminated in the miscarriage<sup>(1)</sup>. To replace the medical terminology, in order to minimize the psychological, social and legal stigmas inherent in the terms “abortion” and “miscarriage”, since 1997, the Royal College of Obstetricians and Gynaecologists (RCOG) has been recommending the term gestational loss but, in Brazil, the Health Department does not recognize this term yet<sup>(2)</sup>.

The prevalence of gestational loss varies globally between 15 and 20% of clinically confirmed pregnancies, most of which occur before the 12th week of gestation<sup>(3)</sup>. It is a common event among Brazilian women. According to the National Abortion Survey (NAP) held in 2016, approximately one in five women have experienced this event. Like the PNA 2010, the PNA 2016 shows a higher frequency among younger women, ranging from 18 to 29 years old (51.8%), with almost half of this population (48%) requiring hospitalization to complete the abortion. Considering that most of these events are illegal and performed beyond the health units, gestational loss remains one of the major public health problems in Brazil, either because of the health risks for those who experience it or because of the costs of the health system to provide care<sup>(4)</sup>.

In Brazil, the North and Northeast stand out with the highest rates of abortion and the lowest reduction rates. Maternal mortality is only a fraction of this problem, which also involves the

deficit in the quality of sexual and reproductive health care for women, difficulty in accessing health services, low levels of education and low income. In addition, the data on the hospitalization are factors that surround this issue and contribute to its magnitude<sup>(5)</sup>.

Several aspects influence the therapeutic decision making towards gestational loss, such as defined gestational age, complications, infections and some contraindications. Therefore, the need for care and quality care is imperative<sup>(2-3)</sup>.

Uterine evacuation treatment ranges from the active to the expectant conduct. The first includes the pharmacological methods, such as oral, sublingual or vaginal misoprostol associated or not with oral mifepristone, depending on the time of gestation; and surgical, such as manual intrauterine aspiration, vacuum or electric, for pregnancies up to 12 to 14 weeks of gestation<sup>(3-6)</sup>; and uterine curettage, widely used for uterine evacuation at more advanced gestational ages<sup>(7)</sup>. The World Health Organization (WHO) considers this an obsolete procedure, which should be replaced by vacuum aspiration or pharmacological methods<sup>(6)</sup>. The interval of the expectant behavior, which results in the complete expulsion of the product of the conception, varies until the expulsion, presenting the risk of infection and hemorrhagic complications as worrying factors<sup>(3,7)</sup>. Deciding on the best course of treatment for gestational loss is still a major challenge for prescribers today though, reflecting the lack of evidence-based information that permits safe and effective behavior<sup>(3)</sup>.

This study aimed to identify the therapy used in the uterine evacuation process and to outline

the obstetric profile of the women assisted in this process.

## Method

Quantitative, retrospective, exploratory-descriptive study conducted at a public maternity hospital in the city of Manaus, Amazonas, Brazil. It is one of the reference units for obstetrical care in the state, including for high-risk pregnancy care. Approval for the research was obtained from the Research Ethics Committee (CEP) at *Universidade do Estado do Amazonas* (UEA), CAEE n. 60896616.5.0000.5016, in December 2016, Opinion 1.871.349.

The sample consisted of the medical records of patients admitted to the institution for gestational loss from June 2015 to June 2016. The following inclusion criteria were used: gestational age up to 22 weeks, according to the date of last menstruation (DLM) or ultrasound (US), diagnosis of fetal/embryonic death, incomplete abortion, molar pregnancy, ongoing abortion, legal/induced abortion, anembryonic pregnancy and all ages. The medical records of women who did not present evidence of gestational age were excluded, as well as cases in which the concept weighed more than 500 g, records with illegible data, clinical data not compatible with diagnosis, conflicting information, patients transferred or evaded prior to uterine evacuation, and indigenous women, due to the lack of time to attend to the whole bureaucratic process required in the surveys carried out with indigenous people.

The number of medical records included in the study was based on the number of admissions performed in 2015 and 2016 for uterine evacuation. Then, the medical records were identified directly in the files of the Medical and Statistical Archive Service (SAME) of the institution, based on the diagnosis of hospitalization, constituting a population of 782 medical records. Subsequently, those that met the inclusion and exclusion criteria were selected, totalizing a sample of 466 selected records, based on a sample reliability rate of 99.9%.

To collect the data, the researchers constructed a form, which was completed with data extracted only from the medical record and contained the following variables: obstetric data, hospitalization diagnosis, therapeutic management, need for surgical treatment, patient complaints, need for medication, time until uterine evacuation, length of hospital stay, complications.

The data analysis was performed through descriptive analysis, with the support of Epi Info version 7. The results were presented in frequency distribution tables.

In accordance with National Health Council Resolution 466, dated December 12, 2012<sup>(8)</sup>, on research involving human beings, the waiver of the Free and Informed Consent Form (TCLE) was requested, being a retrospective research using data from the medical records.

## Results

Of the 466 women included, 191 (40.99%) lived with a fixed partner, 141 (30.26%) were single, 101 (21.67%) were married and only one (0.21%) was divorced. In 32 (6.87%) medical records, this information was ignored. As to the place of residence, 447 (95.92%) lived in the city of Manaus, 18 (3.87%) lived in the interior of the state and one (0.21%) in another Brazilian state.

Of the women attended, 180 (38.63%) were hospitalized with some cervical dilation, 245 (52.58%) without dilatation and, in 41 (8.80%) medical records, this data was not reported. Regarding prenatal follow-up, 296 (63.52%) had no follow-up, 63 (13.52%) had at least one visit and 107 (22.96%) records contained no information.

The ages ranged from 14 to 43 years, with a mean age of 26.8 years (SD = 7.35). Regarding the obstetric data, 370 (79.40%) presented gestational age less than 13 weeks, with a mean gestational age of 10.2 weeks (SD = 3.63); 338 (72.53%) had no previous abortion and 128 (27.47%) women had already had a previous abortion. It was not investigated whether these abortions were triggered or spontaneous. The

number of pregnancies ranged from one to 13; 214 (45.93%) women attended were between the second and third gestations, had between

one and 8 vaginal deliveries and one to three caesarean sections (Table 1).

**Table 1** – Distribution of the women attended in uterine evacuation process according to age range, gestational age, number of gestations, delivery, abortion and type of birth. Manaus, Amazonas, Brazil – 2015-2016 (N = 466)

Variable	Frequency		Mean	Standard Deviation
	n	%		
<b>Age range</b>	<b>466</b>	<b>100.00</b>		
14 – 16	24	5.15	26.75	7.35
17 – 19	71	15.24		
20 – 22	65	13.95		
23 – 25	69	14.81		
26 – 29	74	15.88		
30 – 34	72	15.45		
35 – 39	62	13.30		
≥ 40	29	6.22		
<b>Gestational age</b>	<b>466</b>	<b>100.00</b>		
≤ 12.6 weeks	370	79.40	10.20	3.63
13 to 22 weeks	96	20.60		
<b>Number of abortions</b>	<b>466</b>	<b>100.00</b>		
0	338	72.53	0.36	0.68
1 – 2	121	25.97		
≥3	7	1.49		
<b>Number of gestations</b>	<b>466</b>	<b>100.00</b>		
1	114	24.46	2.93	1.91
2 – 3	214	45.93		
≥ 4	138	29.61		
<b>Number of vaginal births</b>	<b>466</b>	<b>100.00</b>		
0	211	45.28		
1	103	22.10	1.22	1.54
2 – 3	114	24.47		
≥ 4	38	8.15		
<b>Number of cesarean births</b>	<b>466</b>	<b>100.00</b>		
0	346	74.25	0.35	0.65
≥ 1	120	25.75		

Source: Created by the authors.

Among the diagnoses for hospitalization, incomplete abortion was the main diagnosis, accounting for 209 (44.85%) hospitalizations for uterine evacuation, followed by fetal death, with 163 (34.98%). Molar pregnancy and infected abortion were the least cited reasons, each responsible for three (0.64%) and four (0.86%) hospitalizations, respectively. Regarding the therapy chosen, misoprostol was the most

used (59.01%), followed by curettage (37.55%), both used in association or not. Expectant conduct was indicated for 38 (8.15%) women. It is worth mentioning that expectant conduct was considered to be the method without pharmacological or surgical intervention for uterine evacuation, with women undergoing this method remaining hospitalized (Table 2).

**Table 2** – Distribution of the reason for hospitalization and therapy used for uterine evacuation. Manaus, Amazonas, Brazil – 2015-2016 (N = 466)

Variable	Frequency	
	n	%
<b>Reason for hospitalization</b>	<b>466</b>	<b>100.00</b>
Ongoing abortion	52	11.16
Incomplete abortion	209	44.85
Infected abortion	4	0.86
Anembryonic pregnancy	35	7.51
Molar pregnancy	3	0.64
Fetal/embryonic death / retained abortion	163	34.98
<b>Therapeutic indication</b>	<b>523</b>	
Manual Intrauterine Aspiration	35*	7.51
Curettage	175*	37.55
Misoprostol	275*	59.01
Expectant conduct	38*	8.15
<b>Misoprostol associated with surgical treatment</b>	<b>275</b>	<b>100.00</b>
No	13	4.73
Manual Intrauterine Aspiration	48	17.45
Curettage	213	77.46
Manual Intrauterine Aspiration + curettage	1	0.36
<b>Expectant conduct associated with other therapeutic method</b>	<b>38</b>	<b>100.00</b>
No	12	31.58
Manual Intrauterine Aspiration	1	2.63
Curettage	20	52.63
Misoprostol	5	13.16

Source: Created by the authors.

\* Associated therapeutic methods.

As pharmacological therapy, only misoprostol was used, and 19 different prescribed therapeutic regimens were found, ranging from one to five administered doses, with an average of 1.35 (SD = 0.93; CV = 68.89%), irrespective of the therapeutic regimen used. Of the women submitted to this therapy, 212 (76.26%) used between one and two doses and 30 (10.79%) received three or more doses. Of the prescribed doses, 12.95% were not administered and at least three women used more than one pharmacological regimen.

Regarding the need for surgical treatment associated with the initial therapy, 262 (95.27%) women who used the drug therapy and 26

(68.42%) of those who started with the expectant conduct required some type of surgical treatment.

The time of hospitalization until the uterine evacuation ranged from 0.20 min to 137 hours. The length of hospitalization until hospital discharge varied between 4.30 and 220 hours.

Among the complaints presented, 215 (46.14%) women cited moderate bleeding, 176 (37.77%) reported pain and 175 (37.55%) reported mild bleeding, 20 (4.29%) had bleeding, four (0.86%) presented vomiting, two (0.43%) women had fever, malaise, hypotension, chills, diarrhea, weakness each being cited only once, and 42 (9.01%) did not present any complaints.

**Table 3** – Distribution of mean time for uterine evacuation and hospitalization according to therapy used. Manaus, Amazonas, Brazil – 2015-2016 (N = 466)

Variable	Time (h) uterine evacuation			VC	Time (h) hospitalization			VC
	Mean	Minimum-maximum	Standard Deviation		Mean	Minimum-maximum	Standard Deviation	
Manual Intrauterine Aspiration	21.53	1.00-75.00	5.79	27.14	43.28	4.30-96.00	6.73	15.55
Curettage	15.55	0.20 -86.00	8.07	51.90	44.32	6.4-201.25	16.09	36.64
Misoprostol	36.13	2.00-137.00	16.52	45.72	63.30	16.15-220.00	21.11	33.56
Expectant conduct	28.22	0.20-91.00	6.71	24.12	67.02	13.00- 211.37	12.85	19.29

Source: Created by the authors.

VC = Variation coefficient.

Regarding the need for medication according to the therapy used, as shown in Table 4, 19 (54.29%) patients who underwent manual intrauterine aspiration used analgesics, 69 (39.43%) for curettage, 114 (41.45%) for misoprostol and 20 (52.63%) for expectant conduct. The need for antibiotics was observed in four (11.43%) patients for manual intrauterine aspiration, 37 (21.14%) for curettage, 41 (14.91%) for misoprostol and nine (23.68%) for expectant conduct. Fifteen (42.86%)

patients who used manual intrauterine aspiration used uterotonic medication, 130 (74.29%) of those who underwent curettage, 182 (66.18%) for misoprostol and 28 (73.68) for expectant conduct. Hemoderivatives were used in seven patients (4.00%) who underwent curettage, five (1.82%) who underwent misoprostol and three (7.89%) who started with expectant conduct; for those who performed manual intrauterine aspiration, it was not necessary.

**Table 4** – Distribution of need for medication used according to therapeutic indication. Manaus, Amazonas, Brazil – 2015-2016 (N = 466)

Therapy	Analgesic		Antibiotic		Uterotonic		Hemoderivative	
	Medication need							
	n	%	n	%	n	%	n	%
Expectant conduct	20	52,63	9	23,68	28	73,68	3	7,89
Manual Intrauterine Aspiration	19	54,29	4	11,43	15	42,86	0	0,00
Curettage	69	39,43	37	21,14	130	74,29	7	4,00
Misoprostol	114	41,45	41	14,91	182	66,18	5	1,82

Source: Created by the authors.

The correlation between the types of treatment offered and the occurrence of complications (Table 5) showed that all of them presented these complications, associated or not. The complications were: persistent bleeding, hemorrhage, endometritis, ovary remnants, uterine cervix hematoma and uterine perforation,

totaling 8 (1.72%) cases. The misoprostol procedure presented the most complications, with five cases. Of the nine complications, four women had to undergo a new surgical procedure, including: exploratory laparotomy (two cases) and curettage (two cases).

**Table 5** – Frequency distribution of therapeutic indications according to complications presented. Manaus, Amazonas, Brazil – 2015-2016 (N = 466)

Therapeutic indication	Complication after the therapy used				Total
	No		Yes		
	n	%	n	%	
<b>Total</b>	<b>513</b>		<b>8/10</b>		<b>523</b>
Manual Intrauterine Aspiration	34	97.14%	1	2.86%	35
Curettage	172	98.29%	3*	1.71%	175
Misoprostol	270	98.18%	5*	1.82%	275
Expectant conduct	37	97.37%	1*	2.63%	38

Source: Created by the authors.

\* Associated therapeutic methods.

## Discussion

In total, 665 hospitalizations for uterine evacuation happened at the maternity under study in 2015. In 2016, this number reached 526 hospitalizations, with a drop by 20.90% in this service compared to the previous year and abortion accounting for 7% of the institution's total hospitalizations. Post-abortion uterine evacuation ranked second on the Brazilian list of obstetric surgical procedure in 2015. In the state of Amazonas, this is the third most accomplished procedure at public maternity hospitals, according to the Hospitalization System of SUS (SIH/SUS)<sup>(9)</sup>.

According to the latest National Abortion Survey, conducted in Brazil in 2016, through a household survey of literate women aged 18-49 years, in which 2,002 female volunteers were interviewed, 251 (13%) had already had an abortion in some phase of their life, 102 (40.64%) were between 20 and 29 years old – characterized by a higher frequency among younger women and dropping in older women –, 163 (60%) were married or lived with a fixed partner<sup>(4)</sup>.

A research was carried out in Recife (PE), at the Center for Women's Care (CAM) of the *Instituto de Medicina Integral Professor Fernando Figueira* (IMIP), in the period of 2005-2006, involving 160 women in this same age group, aiming to investigate the sociodemographic and reproductive characteristics of women hospitalized for abortion. Seventy-eight (48.9%)

of the participants were between 20 and 30 years of age, 144 (90.1%) had a partner, 89 (55.7%) had at least one child, 116 (72.5%) had no previous abortions, 89 (55.7%) had an early abortion and nine (5.6%) had no known gestational age<sup>(10)</sup>.

The obstetric profile of women attended at the institution studied did not differ from the Brazilian profile of women who had experienced abortion, with the highest incidence occurring during the period with the greatest reproductive activity, ranging from 20 to 30 years of age. One notable fact was the significant percentage of obstetric and clinical evaluation data ignored. This lack complicates the characterization of the real scenario and even the evaluation of the conduct the women who experienced gestational loss took.

A clinical trial conducted at *Santa Casa de Misericórdia de Sobral* (CE) in 2006, involving 41 patients with interrupted gestation between seven and 12 weeks of gestation, evaluated the efficacy of vaginal misoprostol in replacement of uterine curettage using a single dose of 800 mcg. This procedure achieved a success rate of 80.5%, with an average time to evacuation of approximately 13 hours, and was more significant when used at a gestational age below eight weeks (96.2%). Historically, it was believed that all gestational losses should be considered incomplete, with the need for a surgical procedure to remove placental tissues in order to avoid complications<sup>(3)</sup>. The results of the trial suggested that misoprostol,

compared with other prostaglandin analogues, at a dose of 800 mcg administered through the vaginal route, was a safe and effective alternative to uterine curettage though<sup>(7)</sup>.

This study is in line with the other studies, presenting a success rate of only 4.69% for the use of misoprostol, although the comparative study was carried out with women of gestational age up to 12 weeks. This may be related to the different therapeutic schemes used, although the Health Department launched specific protocols. Another factor to be considered is overcrowding at the health institution, the number of non-administered doses (12.95%) and the lack of beds for administration of the medication, reported in the medical records. It can be concluded, analyzing the success of the pharmacological treatment, that the construction of standardized conducts is of great importance with a view to effective treatment, thus reducing the risks of complications<sup>(3)</sup>.

An analytical-descriptive study performed at the Obstetric Center of the *Hospital Universitário de Santa Maria* (RS), involving 30 pregnant women with up to 12 weeks gestation and diagnosis of incomplete abortion, compared efficacy, complications, blood loss and hospitalization time between curettage procedures and manual intrauterine aspiration. The time to evacuation was on average 12.4 hours for curettage and 8.0 hours for manual intrauterine aspiration, with no significant difference in the duration of the surgical procedure. In that study, the length of hospitalization for patients undergoing curettage was, on average, 18 hours, against 10.7 hours for the group that underwent manual intrauterine aspiration. Both groups were equally effective, with no need for a new surgical procedure. Although no statistically significant difference was found for the blood loss between the two groups, the women submitted to manual intrauterine aspiration presented lower variation of the hematimetric parameters<sup>(11)</sup>.

Uterine curettage was the second most observed treatment, responsible for 175 (37.55%) indications of this therapy. The number of

women who used this treatment reached 409 (87.77%) when the final evacuation procedure was assessed, being associated with expectant conduct and misoprostol, when this method was 99.27% effective. Three (0.735) cases of complications for this method were found, with one (0.25%) patient needing new surgical treatment (exploratory laparotomy) due to uterine perforation.

Manual intrauterine aspiration was responsible for 85 (18.24%) indications of uterine evacuation, although 370 (79.40%) had presented early abortion. According to the literature, it is indicated in pregnancies under 12 weeks in function of the uterine size<sup>(2)</sup>. The mean time until uterine evacuation was superior to the time found for curettage, but the mean length of hospitalization until discharge was approximately 43 hours, corresponding to the shortest hospitalization time among the therapies used and the smallest need for uterotonic and antibiotic drugs and blood derivatives.

The efficacy of surgical treatment for uterine evacuation remains higher in relation to the other methods used for uterine evacuation in case of gestational loss, but its use is not risk-free<sup>(3)</sup>. According to the literature comparing surgical treatments for gestational loss, the advantage of manual intrauterine aspiration in relation to curettage is: shorter hospitalization time, which contributes to a reduction in hospital costs; replacement of general anesthesia or spinal block by analgesics, which may or may not be associated with para-cervical block; does not require the presence of the anesthesiologist and is associated with a low risk of complications such as uterine perforation, laceration of the cervix and genital hemorrhage. This is also the preferred technique for infected abortion and is recommended by the WHO and the International Federation of Gynecology and Obstetrics (FIGO). A review of the Cochrane Library reveals that aspiration is a faster, less painful method with less blood loss and safer than curettage<sup>(12)</sup>. It is important to remind that WHO considers uterine curettage an obsolete method for uterine



evacuation, recommending the use of vacuum aspiration<sup>(6)</sup>.

Despite the availability of the intrauterine aspiration method, curettage is still predominant, not only in this study, but in Brazil. The choice of this method may be related to the high cost of the vacuum aspirator and the need for professionals qualified for that procedure<sup>(3)</sup>, which may also be reflected in the length of hospitalization until uterine evacuation of the women who underwent manual intrauterine aspiration in the current research, which was 43.28 hours, in addition to exposing them to greater risks of infection due to the hospital stay and the costs of the hospitalization time itself. Nevertheless, this study points to manual intrauterine aspiration as a safe method, with less time variation among the active methods (surgical and pharmacological) until the uterine evacuation and also in the hospitalization time, among all the methods available at the institution.

Expectant conduct was the least used therapeutic method (8.15%) and, overall, it was initially associated with the diagnosis of ongoing abortion. Twenty-six (68.42%) patients submitted to this method required some associated treatment for uterine evacuation though. The women who used this therapy were those most in need of uterotonics, antibiotics and blood derivatives. Regarding the occurrence of complications, one case (2.63%) was found that required a surgical procedure for correction.

When expectant conduct was compared with surgical and pharmacological treatment, on average, it was 73% effective in the treatment of gestational loss. Regarding the occurrence of bleeding and complications, it presents the highest rates in relation to the surgical treatment when levels of hemoglobin, amount of bleeding and need for transfusion were compared. As to pelvic infection, no evidence of a difference among the available methods was found<sup>(3)</sup>.

Despite lower success rates, this study corroborates data from the literature regarding complaints and need for medication and blood derivatives and associated treatment. The success

of expectant management as a therapeutic method depends on a careful evaluation of the time of pregnancy, type of loss, follow-up time and characteristics of the material found. For this reason, the efficiency of this method for uterine evacuation can reach 90%<sup>(3)</sup>.

No alternative therapeutic methods have been found for treatment in case of uterine evacuation at the institution studied, such as acupuncture, despite the existence of international studies that point to this method as an effective alternative. Also, no study was available at the Brazilian level on the use of acupuncture for uterine evacuation, evidencing that this practice is not yet available and accessible in public health institutions that attend to women in gestational loss<sup>(5)</sup>.

The main limitations of the study were the incomplete filling of the participants' medical records, regarding the age, defined gestational age, diagnosis and therapy used, lack of valid writing, procedures performed and complications presented, which resulted in a sample lower than initially estimated, resulting in data even lower than the exact scenario of women experiencing gestational loss.

## Conclusion

The profile of the women attended at the public health service in Amazonas, with a diagnosis of gestational loss, does not differ from that found in Brazilian, being the main age group affected between 20 and 30 years of age and presenting more than one gestation.

Despite the occurrence of early gestational loss, the conduct corroborates that applied in other regions of the country, and curettage is the main therapeutic method used for uterine evacuation. Some unfavorable outcomes were observed, such as longer hospitalization and excessive exposure to medication. These can be related to logistic, budgetary and professional qualification factors and not only to the therapy used. It could be concluded that the obstetric profile of the women experiencing gestational loss does not differ from that found in Brazil;

curettage was the most used final treatment, in addition to some unfavorable outcomes, such as longer hospitalization and excessive exposure to medication. Overcrowding and lack of standardization of the care provided, for example, negatively affect the therapeutic process, suggesting the need for further research to confirm these associations. Thus, the question can be raised whether the therapy used for gestational loss in public health services offers complete and high-quality care to the female population and if the use of alternative therapeutic methods could not be adopted to minimize the length of hospitalization and excessive medication use, mitigating the suffering of women submitted to uterine evacuation therapy.

### Collaborations:

1. conception, design, analysis and interpretation of data: Cassiana Pinheiro de Araújo, Adélia Cristina Vieira de Rezende Dornelas and António Manuel Sousa;

2. writing of the article and relevant critical review of the intellectual content: Cassiana Pinheiro de Araújo, Adélia Cristina Vieira de Rezende Dornelas and António Manuel Sousa;

3. final approval of the version to be published: Cassiana Pinheiro de Araújo, Adélia Cristina Vieira de Rezende Dornelas and António Manuel Sousa.

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