

South Australian Perinatal Practice Guideline

Termination of Pregnancy in the First Trimester

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Note:

This guideline provides advice of a general nature. This statewide guideline has been prepared to promote and facilitate standardisation and consistency of practice, using a multidisciplinary approach. The guideline is based on a review of published evidence and expert opinion.

Information in this statewide guideline is current at the time of publication.

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Health practitioners in the South Australian public health sector are expected to review specific details of each patient and professionally assess the applicability of the relevant guideline to that clinical situation.

If for good clinical reasons, a decision is made to depart from the guideline, the responsible clinician must document in the patient's medical record, the decision made, by whom, and detailed reasons for the departure from the guideline.

This statewide guideline does not address all the elements of clinical practice and assumes that the individual clinicians are responsible for discussing care with consumers in an environment that is culturally appropriate and which enables respectful confidential discussion. This includes:

- The use of interpreter services where necessary,
- Advising consumers of their choice and ensuring informed consent is obtained,
- Providing care within scope of practice, meeting all legislative requirements and maintaining standards of professional conduct, and
- Documenting all care in accordance with mandatory and local requirements

Explanation of the aboriginal artwork:

The Aboriginal artwork used symbolises the connection to country and the circle shape shows the strong relationships amongst families and the Aboriginal culture. The horse shoe shape design shown in front of the generic statement symbolises a woman and those enclosing a smaller horse shoe shape depicts a pregnant women. The smaller horse shoe shape in this instance represents the unborn child. The artwork shown before the specific statements within the document symbolises a footprint and demonstrates the need to move forward together in unison.



Australian Aboriginal Culture is the oldest living culture in the world yet Aboriginal people continue to experience the poorest health outcomes when compared to non-Aboriginal Australians. In South Australia, Aboriginal women are 2-5 times more likely to die in childbirth and their babies are 2-3 times more likely to be of low birth weight. The accumulative effects of stress, low socio economic status, exposure to violence, historical trauma, culturally unsafe and discriminatory health services and health systems are all major contributors to the disparities in Aboriginal maternal and birthing outcomes. Despite these unacceptable statistics the birth of an Aboriginal baby is a celebration of life and an important cultural event bringing family together in celebration, obligation and responsibility. The diversity between Aboriginal cultures, language and practices differ greatly and so it is imperative that perinatal services prepare to respectively manage Aboriginal protocol and provide a culturally positive health care experience for Aboriginal people to ensure the best maternal, neonatal and child health outcomes.

Purpose and Scope of Perinatal Practice Guideline (PPG)

The purpose of this guideline is to provide clinicians with information on the management of termination of pregnancy in the first trimester using either medical or surgical methods. It includes possible complications, risks, indications, contraindications, procedural information and information for women as printable Fact Sheets.



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Summary of Practice Recommendations

Health services that are unable to provide medical and/or surgical termination of pregnancy services must have defined clinical protocols to support staff in the prompt referral of the woman requiring these services.

If a woman presents for a first trimester abortion but investigations demonstrate a pregnancy over 12 weeks, she can be referred to second trimester abortion service for her care.

Medical practitioners wishing to prescribe mifepristone and misoprostol must be registered with and certified by MS Health.

Ensure that the woman's request for a termination of pregnancy is not made under coercion. It is good practice to perform a brief screen for domestic violence as part of care.

Haemoglobin, Rhesus status, sexually transmitted disease screen (chlamydia and gonorrhoea) & β -HCG quantification are recommended investigations.

An intrauterine sac must be confirmed prior to commencement of termination of pregnancy.

Medical termination of pregnancy (with mifepristone and misoprostol) is only an option up to 63 days (9+0 weeks) gestation due to TGA approval.

Cervical preparation with misoprostol prior to surgical termination of pregnancy reduces the need for mechanical cervical dilatation as well as reducing the risk of an incomplete evacuation.

Follow up of the abortion to exclude a continuing pregnancy is important and if the pregnancy is indeed continuing, then a repeated abortion is advised due to fetal exposure to Misoprostol.

Administer Anti-D (Rh immunoglobulin) 250 IU to women who are Rh negative.

Signs and symptoms of complications and when to seek professional advice should be discussed with the woman and given as written information.

Provide contraception for use immediately after completion of termination of pregnancy following discussion with the woman regarding appropriate options.

Abbreviations

COCP	Combined oral contraceptive pill
D&C	Dilatation and curettage
g	Gram(s)
Hb	Haemoglobin
IU	International units
IUCD	Intrauterine contraceptive device
IV	Intravenous
kg	Kilogram(s)
LLETZ	Large loop excision of the transformation zone
LMP	Last menstrual period
LSCS	Lower segment caesarean section
microg	Microgram(s)
mg	Milligram(s)
mL	Millilitre(s)
NSAIDs	Non-steroidal anti-inflammatory drugs
Quant β -HCG	Quantitative Beta-HCG
Rh	Rhesus
S/L	Sublingual
STOP	Surgical Termination of Pregnancy
TGA	Therapeutic Goods Administration
TOP	Termination of Pregnancy

Termination of Pregnancy In the First Trimester

Definitions

Termination of pregnancy	Refers to a procedure, whether medical or surgical, that results in expulsion of the products of conception
First trimester termination of pregnancy	Refers to pregnancies ended before 12 ⁺⁶ weeks of gestation
Second trimester termination of pregnancy	Refers to pregnancies ended after 13 ⁺⁰ weeks of gestation

Background

It is estimated that approximately half of all pregnancies in Australia are unplanned. A large Australian survey¹ showed the following outcomes for women faced with an unplanned pregnancy:

- > Motherhood 56 %
- > Terminate pregnancy 29 %
- > Offer the baby for adoption: 2 %
- > Miscarriage 13 %

In South Australia, approximately 18 % of recorded pregnancies end in termination of pregnancy²

At the time of publication of this guideline, South Australian legislation^{3,4} requires the following:

- > The woman has been resident in the State for at least two months before the termination
- > The termination is performed in a prescribed hospital by a qualified medical practitioner
- > A second medical practitioner confirms that the termination is legally justified

The procedural requirements are waived in emergency situations, where the termination is immediately necessary to save the pregnant woman's life, or to prevent grave injury to her physical or mental health³.

There is also a reporting requirement for each woman undergoing termination whereby the completed COR-19 form needs to be forwarded to the Pregnancy Outcome Unit⁴.

Medical Termination of Pregnancy

Background

Mifepristone is a progesterone antagonist which binds to progesterone and glucocorticoid receptors. By preventing the effects of progesterone in the uterus it interferes with implantation and placental development resulting in fetal demise. It also increases uterine sensitivity to prostaglandins and softens and dilates the cervix making its use in conjunction with misoprostol very effective (> 96 %) in bringing about termination in early pregnancy⁵.

Misoprostol is a prostaglandin E-1 analogue which induces uterine contractions, cervical dilatation and ripening. When used alone without mifepristone in the first trimester it is reported to be > 83 % effective in expelling the products of conception from the uterus⁵.

Misoprostol in the first trimester of pregnancy has been shown to double the risk of congenital malformations⁶. For this reason women should be informed of the importance of follow-up and in the rare event of ongoing pregnancy are recommended to undertake further abortion procedure when either medical or surgical abortion has failed.

Mifepristone is TGA approved for use with misoprostol to terminate pregnancy up to 63 days (9⁺⁰ weeks) gestation^{7,8}.

Mifepristone and misoprostol are both listed on the PBS for the medical termination of a developing intrauterine pregnancy up to 63 days of gestation.

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Medical practitioners wishing to prescribe mifepristone and misoprostol must be registered with and certified by MS Health via the secure healthcare professional website <https://www.ms2step.com.au/> (for more information see *Standards for the Management of Termination of Pregnancy in SA* available at www.sahealth.sa.gov.au/perinatal)⁹

Note: Registered medical practitioners with a Fellowship of the Royal Australian New Zealand College Obstetricians Gynaecologists will not have to complete the training but are still required to register with MS Health as part of the medical termination of pregnancy Risk Management Plan⁹.

Indication

Women seeking termination of pregnancy who are less than 63 days (9 weeks) from the first day of their last menstrual period as confirmed by ultrasound assessment of gestation.

Contraindications to mifepristone / misoprostol

- > Bleeding conditions or concomitant administration of anticoagulants
- > Inherited porphyria
- > Chronic adrenal failure
- > Chronic corticosteroid use (as mifepristone suppresses adrenal function for 3-4 days due to its competitive antagonism at glucocorticoid receptors)
- > Hypersensitivity to mifepristone and/or misoprostol
- > Intrauterine device in situ
- > Pelvic infection
- > Known or suspected ectopic pregnancy

Caution to mifepristone / misoprostol

- > Severe anaemia
- > Pre-existing heart conditions / cardiovascular risk factors

Assessment

Health services that are unable to provide medical and/or surgical termination of pregnancy services must have defined clinical protocols to support staff in the prompt referral of the woman requiring these services⁹.

Clinical history

- > Date of last menstrual period
- > Pregnancy test: type and timing
- > Course of the current pregnancy
- > Symptoms of pain and bleeding
- > History of previous pregnancies
- > Any medical conditions and allergies

Social Considerations

Assess the woman on her own at some point in the consultation to establish that her request for a termination of pregnancy is not made under coercion, especially by someone accompanying her.

It is good practice to perform a brief screen for domestic violence with referral to Social Work for extra support if she screens positive.



Perinatal service providers need cultural sensitivity within a non-judgemental environment when planning care for the Aboriginal woman.



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Women over the age of 16 with decision making capacity have the right to **consent** or refuse to **consent** to their own medical treatment and/or healthcare. In the young woman (under 16 years of age), 2 doctors need to have seen and assessed the competency of the patient to ensure that she has sufficient understanding and intelligence to enable her to fully understand what is proposed, including all possible adverse consequences, outcomes and risks¹⁰.

Investigations

- > Ultrasound or vaginal examination to assess the site and gestation of the pregnancy
- > Haemoglobin, Rhesus status, sexually transmitted disease screen (chlamydia and gonorrhoea) & β -HCG quantification

If no pregnancy is identified in the uterus, ectopic pregnancy needs to be considered (see *Bleeding and Pain in Early Pregnancy* PPG, available at www.sahealth.sa.gov.au/perinatal). Correlation with a quantitative β -HCG is recommended in this situation. An intrauterine sac should be visible on transvaginal ultrasound at 5+ weeks gestation and/or with a β -HCG of >1,500 IU. Mifepristone administration should be delayed until an intrauterine sac is confirmed and visible on ultrasound.

Management

Medication

- > Obtain written consent from the woman after full explanation of possible risks
- > Administer a single dose of mifepristone 200 mg orally
- > Discharge the woman with an oral antiemetic in case of nausea / vomiting. Ask her to return to the hospital / clinic for a further dose if she vomits within 1 hour of mifepristone administration. For women who are already very nauseous 4 mg to 8 mg ondansetron or 10 mg metoclopramide can be given to reduce the chance of vomiting.
- > The woman should be instructed to pre-medicate herself with an oral antiemetic (either 4 mg to 8 mg ondansetron tablet / wafer OR 10 mg metoclopramide tablet orally) and a non-steroidal anti-inflammatory medication (NSAID) (either 400 mg ibuprofen OR 50 mg to 100 mg diclofenac orally) prior to returning to the hospital / clinic after 36 to 48 hours.
- > 36 to 48 hours post-administration of mifepristone, administer 800 micrograms (4 x 200 microg tablets) misoprostol buccally or sublingually.
- > Give an oral analgesic such as paracetamol 500 mg / codeine phosphate 30 mg.
- > Administer Anti-D (Rh immunoglobulin) 250 IU to women who are Rh negative (see *Anti-D Prophylaxis* PPG available at www.sahealth.sa.gov.au/perinatal).
- > Discharge the woman home with regular oral analgesia (i.e. 50mg diclofenac every 8 hours) or if pain is severe, two paracetamol 500 mg / codeine phosphate 30 mg tablets every 4 to 6 hours (up to 8 tablets in 24 hour period).

Information for women

- > Women should be given written information on what to expect, timing for medication and appointments and under what circumstances she should seek additional medical assistance (see [appendix 1](#)).



- > *Aboriginal women should be referred to an Aboriginal Health Professional to support their care*

- > Misoprostol usually acts quickly and the majority of women can expect to pass products of conception within the next 24 hours, but bleeding usually continues for several weeks.
- > The woman needs to have adequate support for the process, including a support person to drive her home and / or return to the hospital (via car or ambulance) in the case of profuse bleeding necessitating urgent treatment.
- > It is recommended that the woman has access to a 24 hour phone line in case health triage and advice is needed (e.g. Marie Stopes After Care line, Telephone: 1300 515 883)
- > Written information must be provided to the woman. She should be advised not to use tampons and to abstain from intercourse for 7 days to reduce the risk of infection.

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- > The woman must be advised that, if she has heavy bleeding (usually on the day of the misoprostol administration) – i.e. Soaking more than 1 pad / hour for 2 or more hours, she must present to the Emergency Department for assessment. Urgent dilatation and curettage may be required.
- > The woman should be advised that if she is still bleeding as much or more than the normal first day of her period seven days after using misoprostol or has stop /start bleeding, she should contact the doctor / hospital for review. This is generally an indication that there may be retained products of conception. Check by ultrasound, if there is doubt.
- > Women need to agree to undertake the follow-up process (see below) to ensure all products of conception have been expelled.

Follow-up

Follow up is recommended to ensure that the pregnancy is not ongoing. Symptoms of retained products of conception and infection should also be reviewed and treated accordingly.

The following indicate that the pregnancy has been successfully terminated:

1. Pregnancy symptoms subside (i.e. nausea)
2. The next menstrual period is expected within 5 weeks. This may be absent where Etonogestrel implant (Implanon®) or medroxyprogesterone depot (Depo Provera®) is used.
3. Falling β -HCG levels. Quantitative β -HCG level between day 7 and 14 can be compared to the initial value. A pathology order form for quantitative β -HCG level can be given at the woman's initial consultation with verbal request to attend a community collection centre 10-20 days later. A decrease of $\geq 70\%$ of the initial β -HCG levels (day of mifepristone) is suggestive of success^{12,13}.
4. A negative urine β -HCG test. It may take some time after the termination procedure before levels fall below 15-25 IU (the usual level at which a urine test is positive). Urine pregnancy tests may remain positive for at least 4 weeks after termination of pregnancy

Note: β -HCG values correlate poorly with retained products of conception. Clinical assessment of symptoms and signs is recommended to assess for retained products of conception +/- ultrasound

Management of complications

Haemorrhage

Severe haemorrhage is a complication occurring in about 0.1 %⁵. It needs ready access to dilatation and curettage facilities.

Less heavy but persistent bleeding is better managed with further home medication with buccal misoprostol and avoidance of surgery where possible.

Ongoing pregnancy

Continuing symptoms of pregnancy or a rising β -HCG suggest a continuing pregnancy. This should be confirmed with ultrasound (to exclude molar pregnancy) before commencing any further procedures to terminate the pregnancy.

Surgical management with suction curette if > 9 weeks gestation. If < 9 weeks gestation repeat doses of mifepristone and misoprostol could be an alternative option to surgical management and the woman should be counselled about both options.

Retained products of conception

Management depends on the amount of bleeding, symptoms / signs of infection and the woman's preference:

- > Medical management with further misoprostol (800 microg stat buccally followed by 400 microg buccally every 3 hours up to a maximum of 1600 microg i.e. 4 doses) **OR**
- > Surgical management with dilatation and curettage

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Infection

Severe infections after medical termination are rare. In Australia there has been one reported case of death (less than 0.01 % prevalence) in the last 10 years since the introduction of mifepristone into Australia. This was due to Group A Streptococcal sepsis in a woman 9 days after medical termination. Despite fever and flu-like symptoms she had not sought medical help¹⁴.

Medical practitioners assessing a woman after medical termination should, therefore, be alert to the rare possibility of severe infection. In the case of sepsis, inpatient management with appropriate IV antibiotics is recommended.

Routine antibiotic prophylaxis is not indicated but could be considered for women deemed to be at high risk of infection.

Less severe infection still remains uncommon with a rate of suspected or proven infection of 0.2 %¹². Infection is often related to retained products of conception and assessment and treatment for this is also recommended concurrently

Contraception

Provide contraception for use immediately after completion of termination of pregnancy following discussion with the woman re preferred option.

Fertility returns very quickly after medical termination of pregnancy. On average ovulation occurs on day 20 after mifepristone¹¹, but can occur as soon as 8 days after mifepristone.

Etonogestrel implant (Implanon®), medroxyprogesterone depot (Depo Provera®), progestogen only pill, or combined oral contraception should be initiated on the day of misoprostol administration.

IUCD insertion should be booked for around 2 weeks afterwards to ensure complete expulsion of the products of conception before IUCD insertion.

Surgical Termination of Pregnancy

Indication

Women seeking termination of pregnancy at a gestational age of 12 weeks or less. The alternative is medical termination with mifepristone / misoprostol if < 9 weeks.

Vacuum aspiration involves evacuation of the uterus under local or general anaesthesia and has well proven success and safety record.

Assessment

> Clinical history:

- date of last menstrual period
- symptoms of pain and/or bleeding

> Maternity and/or gynaecology history:

- previous pregnancies
- previous gynaecological surgery, in particular LSCS, LLETZ, cone biopsy
- known variation in uterine anatomy such as bicornuate uterus

> Medical conditions, surgical history, drug history and allergies

Social Considerations

Assess the woman on her own at some point in the consultation to establish that her request for a termination of pregnancy is not made under coercion, especially by someone accompanying her.



Perinatal service providers need cultural sensitivity within a non-judgemental environment when planning care for the Aboriginal woman.

It is good practice to perform a brief screen for domestic violence with referral to Social Work for extra support if she screens positive.

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Women over the age of 16 with decision making capacity have the right to **consent** or refuse to **consent** to their own medical treatment and/or healthcare. In the young patient (aged 16 and under), 2 doctors need to have seen and assessed the patient to ensure that she has sufficient understanding and intelligence to enable her to fully understand what is proposed, including all possible adverse consequences, outcomes and risks¹⁰.

Investigations

- > Ultrasound to assess the site and gestation of the pregnancy
- > Haemoglobin, Rhesus status and sexually transmitted disease screen (chlamydia and gonorrhoea)

If no pregnancy is identified in the uterus, ectopic pregnancy needs to be considered (see *Bleeding and Pain in Early Pregnancy* PPG, available at www.sahealth.sa.gov.au/perinatal). Correlation with a quantitative β -HCG is recommended in this situation. An intrauterine sac should be visible on transvaginal ultrasound at 5+ weeks gestation and/or with a β -HCG of >1,500 IU. An intrauterine pregnancy should be confirmed before suction aspiration. If a fetal pole is not yet identified before surgery, additional investigations will be required to exclude ectopic pregnancy and to confirm a completed abortion. If there is any doubt at the time of surgery, products of conception may need to be sent for histopathology or follow up with β -HCG instituted.

Management

- > Obtain written consent from the woman after full explanation and understanding of the possible risks of the procedure.
- >  *Aboriginal women should be referred to an Aboriginal Health Professional to support their care*
- > Women should be given written information on what to expect, timing for fasting, medication and appointments and under what circumstances she should seek additional medical assistance (see [appendix 2](#)).
- > Discuss contraception for after the termination of pregnancy is completed. Note: Etonogestrel implant (Implanon®) or IUCD can be inserted at the time of the surgical termination of pregnancy.
- > The risk of expulsion of an IUCD increases with increasing gestational age at the time of termination (due to greater cervical dilatation) but there are no other increased risks. Therefore, it is not necessary to avoid insertion given that it is an opportune time to insert efficacious long-acting contraception¹⁵. Screening for chlamydia should be undertaken before insertion of an IUCD.

Preoperative preparation

- > Fast from food for six hours (clear fluids 2 hours) before the procedure
- > Administer pre-operative misoprostol for cervical preparation
- > Cervical preparation reduces the need for mechanical cervical dilatation¹⁶ as well as reducing the risk of an incomplete evacuation¹⁷
- > Dose of misoprostol is dependent on gestational age (see below)
- > Ideally, women can take misoprostol at home orally 2-3 hours before the procedure
- > Women should have made a clear decision before taking misoprostol. In the event of abortion not proceeding or a continuing pregnancy it is important to note that misoprostol in the first trimester of pregnancy has been shown to double the risk of congenital malformations⁶. For this reason women should be informed of the importance of follow-up and in the rare event of ongoing pregnancy, are recommended to undertake further procedure for termination when either medical or surgical termination of pregnancy has failed
- > Antiemetics are given to women who need more than two doses of misoprostol because of the increased incidence of vomiting

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- > Osmotic dilators (e.g. Dilapan) should be considered as an alternative for pre-surgical cervical preparation in patients where misoprostol is contraindicated.
- > Mifepristone use for cervical priming is off-label

Table 1: Misoprostol regimen for cervical priming in first trimester surgical abortion

GESTATION	RECOMMENDED PRE-MEDICATION
5-9 weeks	Misoprostol 200 micrograms sublingually or orally 2-3 hours before surgery
10 weeks	Misoprostol 200 micrograms sublingually or orally 2-3 hours before surgery AND Misoprostol 200 micrograms sublingually or orally at least 30 minutes before surgery
11 weeks	Misoprostol 200 micrograms sublingually or orally 2-3 hours before surgery AND Misoprostol 400 micrograms sublingually or orally after 30 minutes (at least 30 minutes before surgery)
12 weeks	Misoprostol 200 micrograms sublingually or orally 2-3 hours before surgery THEN Misoprostol 400 micrograms sublingually or orally after 30 minutes THEN misoprostol 400 micrograms sublingually or orally after another 30 minutes (at least 30 minutes before surgery)

Procedure

- > Bimanual examination is used to assess uterine position
- > The woman is prepared in the lithotomy position
- > Povidone-Iodine (Betadine®) or chlorhexidine solution to the pubic area, vulva, perineum and vagina
- > Drape with sterile sheet
- > Insert Sims speculum to expose cervix
- > Two Vulsellum forceps are applied to the anterior lip of the cervix to control the position of the cervix
- > Inject cervical local anaesthetic:
 - Inject just lateral to the cervical os at each side (3 o'clock and 9 o'clock positions) with half the local anaesthetic at each site. An appropriate dose (a total of 7 mL at < 8 weeks gestation and 14 mL at ≥ 8 weeks gestation) of lidocaine (lignocaine) 2 % with epinephrine (adrenaline) 1:200,000 should be given to achieve cervical anaesthesia
 - The maximum safe dose of 7 mg / kg of lidocaine should not be exceeded
 - Epinephrine should be omitted when gestation is less than 6 weeks due to the risk of prolonged uterine artery vasospasm. The maximum safe dose of 5 mg / kg of lidocaine should not be exceeded
- > Dilate cervix with Hegar or Hawkin / Ambler dilators to a size appropriate for gestation and parity. See table 2 below:

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Table 2: Dilator size appropriate for gestation and parity for surgical abortion

Gestation in weeks	Dilatation in millimetres
6 and less	6
7	7 or 8
8	8 or 9
9	9 or 10
10	10 or 11
11	11 or 12
12	12

- > Choose appropriate suction curette and attach to the tubing. Either flexible or rigid suction catheters are used. Insert into the uterus up to the fundus with the suction hole open. Then, apply suction and move the curette with a circular motion while slowly withdrawing it until the uterus is empty. Curved rigid suction curettes are useful for accessing cornual angles and the fundus of acutely flexed uterine bodies.
- > Caution needs to be exercised with sharp curette use as there is a potential increased risk of perforation and Asherman's Syndrome with vigorous use.
- > Check with ultrasound that no pregnancy sac or retained products of conception remain.
- > Consider the use of misoprostol 200 microg into the posterior fornix of the vagina/ per rectum to increase uterine tone and reducing bleeding.
- > Consider the use of NSAIDs (such as indometacin 100 mg) per rectum for analgesia.
- > Check swab count is correct.
- > Administer Anti-D (Rh immunoglobulin) 250 IU to women who are Rh negative (see *Anti-D Prophylaxis* PPG available at www.sahealth.sa.gov.au/perinatal)
- > There is no benefit from prophylactic administration of oxytocin or ergometrine in the first trimester.

Post-operative management

- > Record baseline temperature, pulse, blood pressure and vaginal blood loss on return from theatre
- > Repeat temperature, pulse, blood pressure and vaginal loss after one hour or sooner if indicated
- > Offer a light meal and fluids when fully awake

Discharge criteria

The woman should be informed that she will not be able to drive or drink alcohol for 24 hours after the procedure if she had general anaesthesia. Arrangements will need to be made in advance for her transport home after discharge.

The following criteria need to be met:

- > Vital signs stable for at least one hour
- > Woman is orientated to time, place and relevant people
- > Adequate pain control with oral analgesics
- > Minimal nausea, vomiting or dizziness
- > Minimal bleeding
- > Has passed urine
- > Has a responsible adult to take her home (if she had general anaesthesia)

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Instructions should be given to the woman to return to an emergency service should she have large vaginal blood loss or develop symptoms of infection such as fever, sweating, rigors, myalgia, vaginal discharge or escalating abdominal pain.

Contraception

Provide contraception for use immediately after completion of termination of pregnancy following discussion with the woman re preferred option

Fertility returns very quickly after surgical termination of pregnancy.

IUCD, Etonogestrel implant (Implanon®), medroxyprogesterone depot (Depo Provera®) contraception should be inserted on the day of surgical termination. Progestogen only pill, or combined oral pill should be initiated within 2 days of surgical termination.



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Termination of Pregnancy In the First Trimester

Useful guidelines:

Royal College of Obstetricians and Gynaecologists (UK).

The Care of Women Requesting Induced Abortion. Evidence-based Clinical Guideline Number 7, 2011.

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International Planned Parenthood Federation. First trimester Abortion Guidelines and Principles. 2008.

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Fact Sheet

Medical Abortion

A medical abortion (termination of pregnancy) involves taking two medications to interrupt and expel a pregnancy and resembles a natural miscarriage. It can be undertaken between 5 and 9 weeks of pregnancy. Medical abortion is successful for 96-98% of women.

How it works

The first medication (tablet), **mifepristone**, works by blocking the effect of the hormone progesterone which supports the pregnancy. This changes the lining of the uterus, causing the pregnancy to detach. Mifepristone also opens the cervix and increases the sensitivity of the uterus to the second medication. The second medication (tablet), **misoprostol**, is taken 48 hours later. It causes the uterus to contract and expel the pregnancy.

Note: These 2 medications will not stop an ectopic pregnancy from growing. An ultrasound to confirm that the pregnancy is inside the uterus is required prior to a medical abortion.

Why you might choose to have a medical abortion

- > More privacy as clinic attendance is only for the medication
- > No general anaesthetic or risks associated with surgery (even though these are small)
- > The process may feel more natural than a surgical abortion

Who should not have a medical abortion?

- > Women diagnosed with an ectopic pregnancy
- > Women who have an allergy to either mifepristone or misoprostol
- > Women who live more than an hour away from emergency services
- > Women who do not have a support person who can stay with them from the time of the second medication until the pregnancy is expelled
- > Women who are more than 9 weeks (63 days) pregnant
- > Some medical conditions may also mean that medical abortion is not an option

Possible side effects and risks

After the first medication, mifepristone

Some bleeding or spotting is normal, but it is rare for the pregnancy to abort after mifepristone alone. You may experience nausea, mild cramping, hot flushes, headache or shivering. The symptoms are usually mild and do not last long.

After the second medication, misoprostol

Cramping and Pain usually starts between 1 and 6 hours after you take the misoprostol. Pain can vary from mild period type pain to severe and disabling pain. For most women, the pain can be managed by pain relieving medication, heat packs and/or massage.

Bleeding also usually starts within 6 hours of taking the misoprostol. It can vary from light spotting to a very heavy flow with clots and pregnancy tissue. Bleeding similar to your normal period can last up to 7 days, with most women experiencing spotting for 2 to 6 weeks after the medication.

Other symptoms such as headache, diarrhoea, nausea, vomiting, dizziness, flushing, shivering and chills may also occur for some women.

What are the more serious risks of a medical abortion?

- > Heavy bleeding requiring hospitalisation or blood transfusion (1 in 250 women)
- > Infection requiring antibiotics (1 in 100 women)
- > Incomplete abortion requiring a surgical procedure (2 to 5 in 100 women)
- > Continuing pregnancy requiring a follow-up surgical procedure (1 in 100 women)



Steps for medical abortion

Day 1: At the health facility – administration of mifepristone

Date:/...../..... Time:am / pm

Day 3: At the health facility or home – administration of misoprostol

Date:/...../..... Time:am / pm

Day 14: Follow-up blood test

Date:/...../.....

Your health facility will receive the results of your blood test. If the hormone levels indicate a continuing pregnancy or an incomplete abortion, you will be contacted by telephone as you may require further treatment.

General advice for women undergoing medical abortion

- > Regular pain relief will help during the process. Panadol (paracetamol) and nurofen (ibuprofen) can be used alone or together. Using heat packs or massage will also help
- > Use sanitary pads (tampons should not be used for 7 days after an abortion)
- > Eat light meals and drink plenty of fluids. Avoid alcohol until abortion is complete
- > Avoid swimming, baths and sexual intercourse for 7 days after the abortion
- > You will require 1-2 days off work and will need to rest
- > Medical abortion does not reduce the chance of becoming pregnant again. You can become fertile from 2 weeks following the abortion. You need to consider contraception as soon as the current pregnancy is over

When to contact your health facility or 24 hour health provider

- > **Bleeding:** Soaking a pad every hour or passing large clots
- > **Bleeding:** If still bleeding as much or more than a heavy period on day 10
- > **Bleeding:** If stop/start pattern of bleeding continues after day 10
- > **Pain:** Not relieved by your pain medication
- > **Fever:** Temperature more than 38°Celsius
- > If you feel generally unwell or have other concerns related to the procedure
- > If you do not feel that the pregnancy was expelled by the end of day 4

Resources

Marie Stopes International (available 24 hours a day, 7 days a week)

Telephone: 1300 515 883

Pregnancy Advisory Centre (available Monday to Friday, 9am to 4pm)

Telephone: 8243 3999 or 1800 672 966 (for country callers)

Health Direct (available 24 hours a day, 7 days a week)

Telephone: 1800 022 222

Counselling

The vast majority of research on emotions after an abortion indicates that women feel positive and relieved about their decision and are able to move forward with their lives. Sometimes these positive feelings can be mixed with feelings of sadness, loss, anger, regret or guilt. If you are unsure or unhappy with your level of coping after your abortion, please contact the health facility that you went to for the abortion, your GP or other counselling service.

For more information

SA Health and Wellbeing
Women's & Children's Health Network
72 King William Road
North Adelaide SA 5006

www.sahealth.sa.gov.au

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Surgical Abortion

A surgical abortion (termination of pregnancy) in the first trimester (before 13 weeks of pregnancy) is a day procedure that involves a light general anaesthetic and use of a suction tube to remove pregnancy tissue from the uterus (dilation and curette). The suction tube is inserted through the cervix into the uterus so no cuts are made on the skin. Surgical abortion is successful for 98% of women.

How it works

You will be given a medication (tablet), called misoprostol, to take 2-3 hours before the surgery. You may need to take more tablets closer to your scheduled surgery time depending on how far into the pregnancy you are. Misoprostol helps to prepare the cervix by softening and opening it, making it easier for the suction tube to be passed into the uterus to remove the pregnancy.

Notes: Fasting from food and fluids is necessary prior to the surgical procedure

An ultrasound to confirm that the pregnancy is inside the uterus is required prior to a surgical abortion.

Why you might choose to have a surgical abortion

- > The procedure is completed within 10-15 minutes
- > There is a shorter period of bleeding when compared to early medication abortion
- > Pain is generally only mild after the procedure

Who should not have a surgical abortion?

- > Women diagnosed with an ectopic pregnancy
- > Women who do not have a support person who can stay with them for 24 hours after the procedure

Possible side effects and risks

- > **Cramping and Pain** may occur after the operation and for up to a week after the abortion
- > **Bleeding** similar to your normal period can last up to 2 weeks after the abortion
- > Misoprostol may cause cramping, bleeding, diarrhoea, nausea, vomiting, dizziness and shivering
- > General anaesthetic may cause nausea, vomiting, headache and affect your judgement for 24 hours

What are the more serious risks of a surgical abortion?

- > Infection requiring antibiotics (1 in 200 women)
- > Incomplete abortion requiring a further surgical procedure or misoprostol tablets to remove the remaining pregnancy tissue (2 in 100 women)
- > Asherman's syndrome where there is scarring inside the cervix and uterus. This may reduce future fertility (1 in 1000 women)
- > Uterine perforation (puncture) (1 in 1000 women)
- > Heavy bleeding requiring blood transfusion (1 in 5000 women)



Steps for surgical abortion in the first trimester

Fasting:

No food or fluids other than water from: Date:/...../..... Time:am / pm

No water from: Date:/...../..... Time:am / pm

At home: Self-administration of misoprostol tablet(s):

1st dose: Tablet(s) of misoprostol Date:/...../..... Time:am / pm

2nd dose: Tablet(s) of misoprostol (if needed) Time:am / pm

3rd dose: Tablet(s) of misoprostol (if needed) Time:am / pm

Admission to health facility:

Report to: Date:/...../..... Time:am / pm

(Do not wear any make-up, jewellery, nail polish or body piercings)

- > A nurse will see you to prepare you for the operation and answer any questions.
- > An anaesthetist will meet with you (if not seen at your first appointment), obtain relevant health information and answer any questions prior to you going to theatre.
- > When you wake up from the surgery you may have an intravenous drip. The nursing staff will watch you carefully and give you medication to help with nausea or pain if needed.
- > You will be ready to go home when you are medically stable, have adequate pain control, can tolerate light food and fluids and are awake and oriented with a responsible adult to take you home (usually within 4 hours of the operation).

General advice for women undergoing surgical abortion

- > A general anaesthetic will affect your judgement for about 24 hours. During this time you must not drive a vehicle, operate machinery, drink alcohol or use illicit substances
- > Period-type pain may last for a few days and can generally be managed with Panadol (paracetamol), nurofen (ibuprofen) or naprogesic (naproxen)
- > Use sanitary pads (tampons should not be used for 7 days after an abortion)
- > Avoid swimming, baths and sexual intercourse for 7 days after the abortion
- > You will require 1-2 days off work and will need to rest
- > Surgical abortion does not reduce the chance of becoming pregnant again. You need to consider contraception as soon as the current pregnancy is over. Oral contraceptive pills should be started within 2 days of the abortion

When to contact your health facility or 24 hour health provider

- > **Bleeding:** Soaking a pad every hour or passing large clots
- > **Bleeding:** If stop/start pattern of bleeding continues after day 7
- > **Pain:** Not relieved by your pain medication
- > **Fever:** Temperature more than 38°Celsius
- > If you feel generally unwell or have other concerns related to the procedure

Resources

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Health Direct (available 24 hours a day, 7 days a week)

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For more information

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Termination of Pregnancy In the First Trimester

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Termination of Pregnancy In the First Trimester

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