Termination of Pregnancy

Disclaimer

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Background

About Termination of Pregnancy (TOP)

Medical and surgical procedures described in this pathway will terminate an intra-uterine pregnancy. Other procedures are required to treat an ectopic pregnancy.

The Victorian Abortion Law Reform Act 2008 allows a woman to access abortion up to a gestational limit of 24 weeks. After that point two medical practitioners must agree that an abortion is appropriate in all the circumstances.

Assessment

1. Record the date of the last menstrual period and confirm the pregnancy by urine or serum BhCG. Determine gestation by dates (if certain) or ultrasound.

2. If any symptoms of abdominal pain or bleeding, consider an ectopic pregnancy.

3. Consider the possibility of reproductive coercion or sexual violence.

4. Investigations:
   - Arrange an ultrasound to site the pregnancy and confirm the gestational age

Ultrasound

- Transvaginal ultrasound is preferred. To ensure sensitivity by the ultrasonographer, indicate on the ultrasound referral that the patient may not continue the pregnancy and may not wish to view the images.
- Ultrasound scans less than 5 weeks are unreliable at detecting intra-uterine pregnancy.
- If ultrasound is unhelpful or inconclusive, order BhCG.
- If BhCG less than 2500 units, wait one week before repeating – a low reading may indicate that the pregnancy is early, non-viable, or ectopic.

- Perform:
  - Blood group and Rh antibodies to determine if rhesus negative blood group and requirement for anti-D
  - Cervical screening test if appropriate
  - Sexually transmitted infection (STI) screen if appropriate

Management

1. If ectopic pregnancy is suspected, manage as per Early Pregnancy Bleeding.

2. If an intrauterine contraceptive device (IUCD) is present, consider removing only after careful discussion with the patient about her intentions not to proceed with the pregnancy. Removing an IUCD increases the risk of miscarriage.
3. If a positive pregnancy test, document and discuss options. Available options include continuation, adoption, and abortion.

- Provide or refer the patient for non-directive pregnancy counselling services.

### Counselling services

**1800 My Options**

Statewide information line for advice about contraception, pregnancy options and sexual health in Victoria.

*Phone: 1800-696-784*

*Website: [1800 My Options](#)*

**Family Planning Victoria**

Information resource

*Phone: 1800-013-952*

*Web: [Family Planning Victoria](#)*

**Fertility Control Clinic**

Counselling service

*Phone: (03) 9419-2922*

*Web: [Fertility Control Clinic](#)*

**Marie Stopes Australia**

Telephone counselling service

*Phone 1300-003-707*

*Web: [Marie Stopes Australia](#)*

**National Pregnancy, Birth and Baby Helpline**

*Phone: 1800-882-436*

*Web: [Pregnancy, Birth and Baby Helpline](#)*

**Other**

- Local psychologists or counsellors – consider if a local therapist or counsellor might be appropriate, accessible, or affordable for the patient. Ensure that the counselling service is able to provide independent and unbiased counselling approach.

- Better Health Channel – [Pregnancy – Unplanned](#)

- Australian Government – [Translating and Interpreter Services](#)

- See [pregnancy options counselling](#) information.

- See [a woman-centred decision-making guide](#).
• Consider **training** to provide pregnancy advice and support (including assessment), and to be able to claim MBS item 4001.

**Training**
- Training is available for general practitioners to claim MBS item 4001.
- This training is also available to psychologists, social workers, and mental health care nurses.
- Rebates are available for 3 non-directive pregnancy support counselling services per patient per pregnancy.
- Training is available through RACGP, takes 4 hours to complete, and provides eight category 2 points.

4. If high-risk, complex, or late gestation, refer for urgent or routine gynaecology assessment or discuss with **1800 My Options**.

**1800 My Options**
1800 My Options is an independent sexual and reproductive health information service, including medical and surgical termination of pregnancy for both public and private services.

Patients may call this number and seek information about services directly, or health professionals may call on their behalf. Operators of the service will provide patients with impartial information about services that are most appropriate to them depending on location, gestation, and other social factors.

- Phone: **1800-696-784**
- Website

5. If termination of pregnancy is indicated, discuss **medical** and **surgical** options. Phone or refer the patient to **1800 My Options**.

**Medical abortions**
- Medical abortion is the administration of a composite pack of medications (mifepristone 200 mg *1 and misoprostol 200 micrograms *4 – “MS-2 Step”) to end a pregnancy. Practitioners must be registered to prescribe and pharmacists must be registered to dispense it. Australian general practitioners can become prescribers by completing the **online training** which takes 3 to 4 hours.
- Contraindications to mifepristone and misoprostol:
  - Known allergy to mifepristone or prostaglandins
  - Porphyria, chronic adrenal failure, severe uncontrolled asthma, use of oral corticosteroids (long term or current)
  - Inhaled corticosteroid therapy for women with severe asthma
- Exercise caution for women who:
  - are older than 35 years and smoke more than 10 cigarettes a day.
  - have heart disease, hypertension, or renal failure.
  - have liver disease, adrenal failure, or uncontrolled inflammatory bowel disease.
  - have an IUD with strings not visible and unable to be removed.
➢ Are on anticoagulants.

➢ In Australia there is TGA approval and PBS availability from diagnosis of pregnancy up to 63 days completed gestational age.

➢ Can cause strong cramps and heavy bleeding so good support is mandatory:
  o Patient should not be alone when undergoing this procedure.
  o The patient and practitioner need an agreed plan to access backup medical services and the location of the nearest emergency department in the unlikely event of very heavy bleeding.
  o This is particularly relevant for rural women.

➢ Up to 5% of women having medical termination in the first trimester will need subsequent surgical intervention for symptoms.

➢ Complication rates are similar to surgical abortions.

➢ For pregnancies up to 63 days misoprostol (a prostaglandin analogue) and mifepristone (a synthetic anti-progesterone) are used.
  o The first dose, 200 mg mifepristone, can be:
    ▪ administered at an abortion clinic, hospital-based service, or by a general practitioner registered to prescribe it.
    ▪ self-administered at home.
    ▪ commenced in the clinic in cases of reproductive coercion where the prescriber and patient agree on a plan.
  o The second dose, 800 microgram misoprostol, is taken at home 24 to 48 hours later. Buccal administration is recommended.
  o The abortion usually starts 4 to 5 hours after the misoprostol.
  o Advise the patient to expect bleeding and cramping generally up to twice as heavy as what may be experienced with their usual menstrual pattern.
  o On average, bleeding lasts from 16 to 28 days. Bleeding and cramping usually diminishes once the pregnancy is expelled.
  o Advise the patient that heat packs and NSAIDs (e.g. ibuprofen), or paracetamol and codeine are recommended for pain relief (paracetamol alone has not been found to be effective). Ensure she has contact numbers if complications arise.
  o Rhesus negative women should be given anti-D within 72 hours of the termination.
  o A review visit at 10 to 14 days is recommended. Consider checking a quantitative hCG to confirm it is falling. Expect an 80% decline in BhCG levels between day of misoprostol administration to day 7.
  o Registered general practitioner prescribers must complete administration and follow-up procedures outlined on the MS website.

Surgical abortions

➢ The cost to patient may be more than medical terminations. Access to public services is very limited.

➢ Can be performed up to 24 weeks in the public health system. Availability to publicly-funded abortion services up to 24 weeks is extremely limited. Suggest discussing with 1800 My Options.
➢ Sedation is required and instrumentation is involved. General anaesthesia may also be used.

➢ The vast majority are done as a day procedure. For early termination up to 12 weeks, a short procedure is followed by approximately 2 hours in recovery. Later terminations can take several hours longer as prostaglandin, usually given as misoprostol buccally or vaginally, may have to be used to soften the cervix before dilatation occurs.

➢ Rhesus negative patients should be given anti-D within 72 hours of the termination.

➢ Risks:
  o Uterine perforation occurs in 1 to 4:1000 cases.
  o Cervical trauma occurs in up to 1:100 cases.
  o Laparoscopy, laparotomy, and blood transfusion may be required if these complications occur.

6. Discuss post-termination contraceptive options – see Faculty of Sexual and Reproductive Healthcare – UK Medical Eligibility Criteria 2016 Summary Sheets.

**Contraceptive options**

- Encourage use of long acting contraception after abortion:
  - Etonorgestrel 68 mg implant (Implanon NXT) or levonorgestrel 52 mg intrauterine system (Mirena) can be inserted once a medical abortion is complete.
  - Medroxyprogesterone 150 mg/mL injection (Depo-Provera or Depo-Ralovera) will be suitable for selected patients.
  - Patients choosing combined oral contraceptive pill (COCP) can be counselled as to the quick start method, after termination of pregnancy.

- Start the patient immediately on an active pill:
  - If started 5 days or less post-procedure the patient is covered immediately.
  - If started more than 5 days post-procedure it will require 7 active tablets, taken consecutively, to obtain contraceptive cover. Additional condom use is required over this time.

*If the patient starts hormonal contraception immediately after miscarriage or termination, bleeding may take longer to settle.*

7. Arrange follow up with the patient.

- If medical termination: 10 to 14 days after termination, by which time discharge and pain should have settled.
- If surgical termination: after 6 weeks.
- If symptomatic (pain, heavy bleeding or discharge, psychological distress): follow-up at any stage.
Referral

- Refer for suitable community-based services when possible – contact 1800 My Options.
- Consider urgent or routine gynaecology referral if:
  - surgical termination of pregnancy at later gestations.
  - high risk or complex pregnancy.
  - surgical termination of pregnancy where medical termination is no longer appropriate and services cannot be accessed outside of a public health service.

Information

For health professionals

Further information

- Children by Choice – Resources for Patients and Clients
- The Royal Women's Hospital:
  - Termination of Pregnancy: Medication Drugs and Dosage Regimens up to 13 Weeks Gestation
  - Termination of Pregnancy: Choice of Method
  - Termination of Pregnancy: Assessment
- RACGP – GP Learning
- RANZCOG:
  - Guidelines for the Use of RH(D) Immunoglobulin (Anti-D) in obstetrics in Australia
  - Termination of Pregnancy

For patients

- 1800 My Options
- Family Planning Victoria:
  - Abortion Overview
  - Abortion: Emotional Issues and Counselling
  - Medical Abortion (Abortion Pill)
- Marie Stopes Australia:
  - Abortion
  - Reproductive Coercion
  - Understanding Your Options: Surgical Abortion vs Medical Abortion
- Pregnancy Advisory Centre, South Australia – Abortions

References

Select bibliography


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