CLINICAL GUIDELINE

This document is intended to guide clinical care without changing the responsibility of the health care team or the patient.
It never replaces clinical judgment and individualized care.

Developed and endorsed by SASOG as part of the BetterGYN® programme

TERMINATION OF PREGNANCY

Definition

Termination of pregnancy (TOP) refers to medical or surgical interference with an existing pregnancy which results in an abortion. In South Africa TOP is legal and is regulated by Act 92 of 1996 and its amendments. Termination of pregnancy can effectively and safely be performed by trained health care workers in approved medical facilities and in all 24-hour delivery facilities. For the first 12 weeks of a pregnancy, the law allows nurse practitioners to perform TOPs. After 12 weeks however only medical doctors may perform TOPs.

Impact

Some of the numerous factors linked to unplanned pregnancy or the non-use / failure of contraceptives are: poverty; lower education levels; unplanned sexual relations; multiple disruptive life events; and health care service delivery challenges. For the first 12 weeks of pregnancy, TOPs require only the request and permission of the pregnant woman herself, even if she is a minor.

Women seek termination of pregnancy for a variety of medical and social reasons. A patient may present later than the first trimester due to a delay in diagnosis of pregnancy, or because of delays in obtaining referrals or to the appropriate service centre. Between 13 and 20 weeks TOP is offered by a medical doctor. The doctor must hold the professional opinion that the continuation of pregnancy will threaten the health or socio-economic situation of the pregnant woman, or it is a result of rape or incest. After 20 weeks of pregnancy TOP is permitted only if continuation will threaten the health of mother or result in the birth of a severely handicapped child.

Safe termination of pregnancy should contribute to prevent the severe morbidity and mortality associated with unsafe termination practices and the social catastrophe of unwelcome children.

Clinical assessment

Women should be carefully counselled and should fully understand the consequences of their choice. If there is any doubt about their decision, the procedure is postponed. Counselling should include a discussion of: decision to have an abortion; available and recommended methods; exact administration of drugs; side effects; teratogenic potential of misoprostol (anomalies of frontal and temporal bones, limbs, mobius syndrome); complications; time; pain and bleeding; success rates; and the need for follow-ups and contraception (which can be started immediately).

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Gestational age is a critical factor within the legal framework for counselling, choice of method and outcome. Gestational age should be accurately determined before treatment, preferably by transvaginal ultrasound in the first trimester, or via transabdominal ultrasound after 12 weeks. Ultrasound also rules out ectopic pregnancy and can be repeated after medical termination to confirm complete expulsion of products.

Treatment options for medical termination

Mifepristone is a derivative of norethindrone which binds to the progesterone receptor with an affinity greater than progesterone, but does not activate the receptor, thereby acting as anti-progestin. In the uterus, it causes decidual necrosis, cervical softening, increased uterine contractility and prostaglandin sensitivity.

Misoprostol is a prostaglandin E_1 analogue which is used for induction of labour, treatment of early pregnancy loss, prevention and treatment of post-partum haemorrhage and for cervical priming before uterine procedures.

- **Metotrexate** is an antimetabolite, cytotoxic drug which acts by slowing cell growth of the product of conception, thereby enhancing success rates of medical methods.

Treatment options for the first trimester – up to 12 weeks

Medical regimens are used and are effective for medical termination without surgical evacuation. The younger the gestational age, the less likely the need for surgical evacuation becomes. Misoprostol is more effective if used via the vagina, sublingually or buccal, than orally. Misoprostol alone is less effective than in combination regimens. Mifepristone 200mg saves cost and is as effective as the higher dose regimens. The follow-up ultrasound to confirm expulsion of products after receiving medical treatment is very important.

1. Mifepristone 200mg PO followed by Misoprostol 800mg PV after 24-48 hours: up to 9 weeks >90% effective.
2. Methotrexate 50mg/m^2 IMI followed by Misoprostol 600mg PV after 24-48 hours: up to 9 weeks >90% effective.
3. Mifepristone 600mg PO followed by Misoprostol 400mg PV after 48hrs: up to 7 weeks > 90% effective.
4. Misoprostol 800mg PV/SL alone: up to 8 weeks only about 85% effective but the cheapest regimen.

Suction evacuation by curettage is also safe and effective as a primary method during the first trimester, or can follow an incomplete medical abortion. It is performed using sedation and analgesia with an appropriately sized curettage point on a manual vacuum aspiration syringe. Cervical dilatation is less traumatic after softening with prostaglandin.

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Treatment options for the second trimester – 13-24 weeks

Medical termination after 12 weeks is possible, but complete abortion is less frequent and some women will need evacuation. Pain treatment and anti-Rh(D) Ig must be given to Rh negative women within 72 hrs of the first treatment. The most commonly used regimen is:

- Misoprostol 800ug PV, repeated after 4 hours and after 7 days if no response.

  After previous caesarean: 400ug PV, repeated 8 hourly and after 7 days.

  Women are followed to passage of products of conception which must be within 7-14 days.

Primary uterine evacuation must be used with great caution and combined with cervical ripening after 12 weeks. It is not recommended due to the significant risks for injury from fetal parts and incomplete removal of products.

Women with previous caesarean sections are at increased risk of uterine rupture and adequate counselling is mandatory prior to initiation of the procedure. Termination must be done in a facility with skilled personnel on hand to perform a hysterectomy in case of uterine rupture. Although all methods are relatively safe, uterine rupture can follow any method. Alternatives to misoprostol include Foley's catheter, intracervical hyaluronidase and prostagladin E_2.

Prognosis

TOP in medical facilities is very safe and effective and the psychosocial outcomes are much better than that of an unwelcome pregnancy. It must not be an alternative to offering contraceptive services.

References:

1. EL- Halwaggy S.S; Dawood AS.A. Second trimester pregnancy termination in previous caesarean section patients with unfavourable cervix; A randomised controlled clinical trials comparing three different methods 2017; 3(4) 1-5.
2. McQuoid – Mason DJ; S. Afri Med. J 2018(9)721-723. Termination of pregnancy; cultural practices; the choice on termination of pregnancy; Act and the constitutional rights of children.
3. Dudley C. 2017 Government Gazette No 40970. Choice of termination of pregnancy Amendment bill.
4. Green-top Guidelines No17 April 2011. The investigation and treatment of couples with recurrent first trimester and second trimester miscarriages
5. Practice Bulletin 2013; Reaffirmed 2017; 135.- The American College of Obstetricians and Gynecologists.

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