

Late termination of pregnancy



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Since antiquity, women have requested or desired to end pregnancies before the time when there would be a live birth. Prior to the introduction of modern methods of termination of pregnancy within legalised frameworks, this was fraught with dangers to the life of the woman.

Where termination of pregnancy is legal and conducted by trained people, abortion is not associated with maternal death and serious morbidity is very rare.¹ In developed countries, most abortions occur by the end of the first trimester of pregnancy, but there are a number of reasons, some obvious, why abortion may be considered later on in gestation.² What constitutes a 'late' abortion will vary from place to place but the issues around

timing may be more legal and emotional rather than medical or ethical. Certain jurisdictions, for example in New Zealand, have been careful not to attempt to define viability because this may change over time due to medical-neonatal paediatric care. In considering any abortion, live birth is to be avoided. This is important when considering the reasons why abortions may be done at any gestation and why it is simplistic to think that fetal abnormality differs fundamentally for other maternal issues which lead to the request to end the pregnancy.

Indeed, in New Zealand, after 20 weeks gestation, the indications for termination of pregnancy remain similar to those before that gestation but with a 'higher' level of harm to the mother from continuing (or benefit to be gained by not continuing) than before 20 weeks. In the UK, similarly, there is no time limit on abortion where two doctors agree that a woman's health or life is gravely threatened by continuing with the pregnancy or that the fetus is likely to be born with severe physical or mental abnormalities.³ As in many countries, such statements leave a great deal to the interpretation of the medical attendants, even where termination of pregnancy is occurring within the local legal framework. In the UK, under the revised act of 1991, 24 weeks became the time limit for certain sections of the Act, but not others.

In Australia, the legal situation is complex because abortion remains subject to State not National law. While there are similarities between many of the State laws, only in the Australian Capital Territory is abortion decriminalised. Western Australia, the Northern Territory and South Australia have time limits, though in practice other States may apply a limit as well. Gestation is important not only for legal reasons but also when considering procedures associated with termination of pregnancy.

The RCOG has produced statements on the acceptability of not providing life support to fetuses at the 'threshold' of viability, noting that, 'It is extremely important to distinguish between physiological movements and signs of life, as well as being aware that observed movements may be of a reflex nature and not necessarily signs of life or viability'⁴. This type of statement may assist in clarifying the situation for caregivers involved in looking after women undergoing late termination for any reason where there is a likelihood that such

'movements' would occur after birth. It may be better however to undertake procedures such that no movements occur.

Indications for late termination

Careful reading of the many legislations from different countries would suggest that the law is more vague about indications than the interpretations put on such legislation by the healthcare professionals. Ultimately, except when it is obvious that a woman may be dying because of the pregnancy, all other reasons why a pregnancy may be interrupted before term delivery relate to the woman's perception of the adverse effect that continuing would have on her long-term health. In this construct, it can be seen that the view of the woman may relate to either a fetal problem or her own situation. There are many reasons why women present after the first trimester of pregnancy.² Lack of knowledge, continuing menses, cultural barriers, failed diagnosis of pregnancy and late diagnosis of fetal abnormality are all frequent reasons for late presentations, yet the indications for termination of pregnancy may be just as or more valid as in early request for abortion.

Methods of late termination

There are no randomised trials to guide decision-making as to the best methods of terminating a pregnancy in the second trimester. A proposed trial comparing mifepristone-misoprostol versus dilatation and evacuation was abandoned due to slow recruitment.⁵ However, there are concerns about the use of surgical methods, due not only to blood loss but also trauma to the cervix and uterus with subsequent implications for future pregnancy.

Some epidemiological data would suggest increased risks of preterm birth after second trimester termination but the issue is contentious.⁶

Accepted regimens such as mifepristone in a dose of 200mgm (which seems as efficacious as 600mgm), followed 24 to 48 hours later by 800mcg of misoprostol vaginally, then 400mcg administered buccally or sublingually (not orally) every three hours will achieve expulsion of the fetus and placenta in over 97 per cent of cases, within five doses and with a mean of six to nine hours.⁷

The surgical method involves pre-surgical cervical treatments with prostaglandin analogues or 'mechanical dilators', such as DilapanR, then dilatation and evacuation of the conceptus. In addition to availability of theatres and acceptability to theatre staff, there is likely to be a decreasing number of surgeons skilled in the required techniques, making this a less safe and less available procedure than 'medical abortion'. Medical abortion does permit the parents to see the fetus, which may well be an advantage where the abortion is done for fetal reasons. There is no evidence that grief resolution is different after termination of pregnancy by either

method in a previously wanted pregnancy.⁸ Data are less clear where the pregnancy had been unplanned and unwanted.

Where there is a likelihood that the fetus will be delivered with movement, consideration must be given to performing fetocide. This will reduce difficulties for staff as well as the woman following delivery, while fetocide cannot be insisted upon due to issues of consent, nevertheless, staff have rights as well, and in practice it is a straightforward procedure technically which simplifies many decisions during the abortion care process.

Staff training

Awareness that abortion is a women's health issue and that the provision of safe abortion is fundamental to women's rights, reducing maternal mortality and morbidity are essential parts of training in obstetrics and gynaecology. Training in the provision of abortion services is important and there is a critical need for this in many places. This requires a supportive environment and involves not only doctors but all the healthcare workers who participate. Decriminalisation and integration of abortion services within gynaecological services may be the best way to achieve better service provision and avoid very undesirable practices such as women travelling to Australia, due to lack of trained staff and services in New Zealand.

From abortion to contraception

Discussion about and provision of effective contraception is essential after any abortion. As a College and as a society at large, we have an obligation to encourage moves away from abortion towards effective fertility control.

Summary

There will always be a need to provide safe abortion services and not only in the first trimester. While the decisions around indications and procedures become more complex the later the gestation is,

in essence these are a continuum. Whatever the outcome of a request for late abortion, women need ongoing support and help to avoid such a situation again. This applies, whatever the reasons for abortion, whether the reasons are due to fetal anomaly or other factors. Abortion is part of women's health and fetal medicine and will always be within the scope of this College's activities.

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Fellows and Diplomates

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