

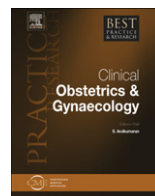


ELSEVIER

Contents lists available at ScienceDirect

Best Practice & Research Clinical Obstetrics and Gynaecology

journal homepage: www.elsevier.com/locate/bpobgyn



9

Late termination of pregnancy and foetal reduction for foetal anomaly

Raffaele Napolitano, MD, Clinical Fellow, Basky Thilaganathan, MD FRCOG, Professor *

Fetal Medicine Unit, 4th Floor, Lanesborough Wing, St. Georges University of London, Cranmer Terrace, London SW17 0QT, UK

Keywords:

pregnancy
late termination
second trimester
foetal anomaly
selective termination

Late termination of pregnancy is a relatively rare procedure accounting for approximately 1% of all registered terminations in England and Wales; however, with improving detection rates for foetal anomalies, this number is increasing. Surgical dilation and evacuation (D&E) appears to be a safe and cost-effective procedure as long as the clinical expertise exists to provide this service. Medical termination appears equally safe and is best undertaken with the combined use of mifepristone and misoprostol. Foeticide, when required, should be performed from 22 weeks' gestation using strong KCl administered either by cardiocentesis or by cordocentesis. All women should be offered a post-mortem and any other appropriate investigation to allow accurate counselling regarding future pregnancies. The issue of late selective foetal reduction for foetal abnormality is complicated by the need to balance the risks to the healthy co-twin of expectant management versus selective termination.

© 2010 Elsevier Ltd. All rights reserved.

Incidence

Second-trimester abortion comprises 10–15% of the 42 million abortions that occur worldwide each year. According to surveillance data from the Center for Disease Control and Prevention (CDC), 12% of abortions occur at or after 13 weeks' gestation, with 1.3% being performed from 21 weeks' gestation.¹ Induced abortion is one of the most commonly performed gynaecological procedures in Great Britain, with around 186 000 terminations performed annually in England and Wales and around 11 500 in

* Corresponding author. Tel.: +44 20 8725 0071; Fax: +44 20 8725 0079.

E-mail address: basky@pobox.com (B. Thilaganathan).

Scotland. Termination of pregnancy for foetal anomalies constituted less than 1% of all registered termination during 2001 in England and Wales and is therefore a rare procedure, both in terms of the total number of pregnancies and the total number of abortions.²

Ethics and the law

The ethics of termination of pregnancy covers many religious and social aspects of life, leading to highly emotional and heated public debate, an issue that is beyond the scope of this article. Termination of pregnancy is legal in Great Britain if two doctors decide in good faith that a particular pregnancy is associated with factors that satisfy one or more of five grounds specified in the Regulations of the Abortion Act and Section 37 of the Human Fertilisation and Embryology Act 1990.^{3–5} In England and Wales in 2002, the vast majority of abortions were undertaken under grounds C and D, with grounds A, B and E together accounting for just over 2% of abortions. Between 2000 and 2004, approximately 100 terminations per annum were carried out under ground E annually in UK beyond 24 weeks, making up ~5% of all those conducted for foetal abnormality.⁶

Definition of late termination

Abortion is defined as termination of pregnancy by any means before the foetus is viable. Viability is now considered to be reached at 24 weeks of gestation, as the Abortion Act infers in grounds C and D. To terminate the pregnancy after this gestation, the pregnancy must represent either a risk to the woman's life or the foetus needs to have 'a substantial risk' of being 'seriously handicapped'. Second or mid-trimester is a period that could range from 13 to 28 weeks' gestation. In this review, late termination is defined as a termination performed after the 13th gestation week, irrespective of foetal viability.

Indications for late terminations

Advances in medical ultrasound technology and the introduction of routine prenatal screening allow the diagnosis of various foetal abnormalities (including structural, chromosomal and genetic) throughout the different stages of pregnancy.⁷ Antenatal detection of foetal malformations relies on accurate detection of the disorder from screening programmes. The Royal College of Obstetricians and Gynaecologists (RCOG) Working Party on Ultrasound Screening for Foetal Abnormalities and National Institutes for Clinical Excellence (NICE) Guidelines for Routine Antenatal Care state that pregnant women should routinely be offered an ultrasound scan to screen for structural anomalies, ideally between 18 and 21 weeks' gestation.^{8,9} The detection rates for foetal malformations vary greatly with some abnormalities being diagnosed almost universally (e.g., anencephaly) and some malformations being diagnosed in less than 50% (e.g., congenital heart defects) of cases.¹⁰ In addition, some foetal malformations are not apparent at the 20-week anomaly scan but are more apparent at later gestations (e.g., hypoplastic left heart syndrome and cerebral ventriculomegaly). The incidence of foetal malformations has been evaluated from 17 European population-based registries of congenital malformations (EUROCAT) for the period 1995–1999.¹¹ Although the overall prenatal detection rate for major foetal abnormality was 64%, just 68% of these occurred before 24 weeks of gestational age.

Because of the relatively high sensitivity of the anomaly scans, most late terminations are performed before 24 weeks gestation.¹² The Cochrane Review on Ultrasonography after 24 weeks failed to demonstrate any evidence of reduced perinatal mortality, but this review was limited by a paucity of information on long-term substantive outcomes such as neurodevelopment.¹³ Screening for foetal structural abnormalities is mostly restricted to the options of continuing versus terminating the pregnancy when a diagnosis is made. Vaknin et al. reviewed all 84 late terminations performed in a referral centre for foetal abnormalities, diagnosed before or after 23 weeks. Interestingly, the incidence of structural abnormalities (excluding genetic problems or infections) diagnosed after 23 weeks

Download English Version:

<https://daneshyari.com/en/article/3907905>

Download Persian Version:

<https://daneshyari.com/article/3907905>

[Daneshyari.com](https://daneshyari.com)