Termination of pregnancy

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Abstract

With at least one in three women in the UK having a termination of pregnancy (TOP) by the age of 45, provision of termination services forms a key part in the role of any obstetrician and gynaecologist. Despite this, there is still stigma attached and formal teaching is frequently missing from the curriculum of trainees. This review aims to explain and discuss the basics of providing termination of pregnancy services, address some of the less frequently encountered difficulties and consider some of the ethical and religious implications that can influence practice.

Keywords abortion, induced; abortion, legal; ethics; informed consent; informed consent by minors; mifepristone; misoprostol; religion; termination of pregnancy; vacuum curettage

Introduction

This article has been produced in a US Presidential Election year. This election has been characterised by having two of the most unpopular candidates ever as the final options for voters. Throughout the campaign however, there has been the familiar rhetoric concerning abortion. As always candidates and hopeful candidates, have been positioning themselves on the ***"pro-choice"*** and ***"pro-life"*** spectrum. This seems strange in a country where almost 50% of the population has personal experience of termination of pregnancy. The lawful ending of a pregnancy is a necessity in any society that does not wish to live with the inevitable consequences that result from illegal termination of pregnancy (TOP). Surely it is time for abortion to become apolitical. At the same time, we must ensure a robust legal framework to protect women requesting TOP, and the practitioners who are prepared to provide this legal and widely required medical service. A framework that requires regular review, and close regulation.

The law

Helen, 42, attends her GP requesting TOP, 8 weeks from her last menstrual period. She explains her family is complete and that she doesn't feel financially or emotionally able to support another child and has no support from her partner; her decision is final. Her GP feels that her reasoning is inadequate and that she would regret her decision in the future, so suggests she takes some time to think about her options. Helen is distraught, embarrassed and unable to get an appointment with another GP for seven weeks by which time she is found to be 16 weeks pregnant and undergoes a medical termination of pregnancy (MTOP) but loses two litres of blood during the procedure. She successfully sues her GP claiming this would not have happened if she had been referred when she initially presented at nine weeks' gestation.

Abortion has been practised throughout history only being made a criminal offence in the UK by The Offences against the Person Act of 1861. It remained illegal under any circumstance until 1929 when the Infant Life Preservation Act amended the law to allow abortion only if being performed to preserve the life of the mother; this was only permitted under 28 weeks' gestation, the age at which the fetus was thought to be viable.

In 1938, Dr Aleck Bourne performed an abortion on a 14-year-old girl who had become pregnant after being raped by five soldiers. This resulted in his arrest and a test case that changed the interpretation of the law when the judge extended the meaning of 'the life of the women' to include her health; "if the doctor is of [the] opinion on reasonable grounds … that the probable consequences … will be to make the woman a physical and mental wreck, the jury are quite entitled to take the view that the doctor … is operating for the purpose of preserving the life of the mother". He was acquitted and the case set a legal precedent that was eventually enacted in the Abortion Act 1967.

This act paved the way to allow legal TOP and the rapid increase in legal abortions noted following the introduction of the Act is often thought to represent not an increase in abortion itself, but a reflection of previously illegal and frequently unsafe abortions being made legal and carried out under medical supervision. A dramatic fall in maternal deaths due to criminal abortion followed.

All legal abortion in Great Britain (excluding Northern Ireland) is carried out under the Abortion Act 1967, satisfying the criteria that two doctors agree in good faith that the request meets one of the criteria stated under the Abortion Act (Table 1). There are two grounds (F and G) for which only one doctor must immediately certify in emergency cases.

In 2015, 98% of all abortions carried out in England and Wales were reported as being performed on Ground C, 99.95% of which were because of a potential risk to the woman's mental health. Any woman is able to legally have a TOP under 24 weeks' gestation based on Ground C of the Abortion Act as the continuation of pregnancy statistically carries a higher risk.

There are myriad opinions and beliefs held by professionals that can influence their wish to provide abortion care. Whilst all professionals have a right to decline to perform abortion, they have a legal responsibility to refer patients to another service that will be able to support them. This must be done without influence or coercion. The GMC's 'Duties of a Doctor' says that doctors must make sure that their "personal beliefs do not prejudice patient care".

In this case, the GP has a conscientious objection to taking part in TOP, but should not have allowed this to influence patient care. This patient needed to be referred without delay onto a colleague who is willing to have a meaningful, non-judgemental discussion with the patient, manage TOP and refer on to the relevant clinic. Due to the delay, this termination carries more risk to the patient as she is at a later gestation.

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Abortion Act 1967 grounds

Ground	Details	% of all cases
A	That the continuance of the pregnancy would involve risk to the life of the pregnant woman greater than if the pregnancy were terminated;	<0.1%
B	That the termination is necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman;	<0.1%
C	That the pregnancy has NOT exceeded its 24th week and that the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of the pregnant woman;	98%
D	That the pregnancy has NOT exceeded its 24th week and that the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of any existing child(ren) of the family of the pregnant woman;	1%
E	That there is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped	1%
F	To save the life of the pregnant woman	Three total cases in
G	To prevent grave permanent injury to the physical or mental health of the pregnant woman	2015

Table 1

Options and procedures for TOP

Beth, 29, attends EPAU at 10 weeks' gestation with a light PV bleed. She has an ultrasound scan which shows she is 11+1 gestation but that the fetus has generalised hydrops with a nuchal translucency measurement of 7 mm. She is seen the next day at the regional fetal medicine centre who confirm hydrops. Given the likely poor outcome she opts for TOP without further testing. She returns to her primary hospital and is offered medical or surgical termination, opting for surgical termination having had a poor experience during previous medical management of miscarriage. However, during pre-operative investigations, she is found to have a history of narrow heart valves. Further investigation reveals this to be pulmonary stenosis and the patient is deemed anaesthetically unfit so is offered manual vacuum aspiration under local anaesthetic, which goes ahead without complication.

Historically, the vast majority of legal terminations of pregnancy were undertaken surgically. The development of antiprogesterones and their use with prostaglandins represented a significant step forward in allowing safe and effective medical abortion and choice for women. Mifepristone, first licensed in the UK in 1991, is a competitive progesterone receptor antagonist that causes endometrial decidual degeneration, cervical softening, release of endogenous prostaglandins and an increased myometrial sensitivity to prostaglandins. Prostaglandin E1 analogues, misoprostol and gemeprost, soften the cervix and promote myometrial contractions. In TOP, mifepristone causes the uterus to reject the pregnancy, misoprostol expels it.

Despite its ubiquitous use misoprostol is not licensed for use in TOP. Gemeprost is the only licensed prostaglandin available in the UK for TOP, however the RCOG guideline development group (GDG) recommended the use of misoprostol based on its cost (<£1 versus £43 per dose), equivalent efficacy and reduced pain characteristics.

The above developments now allow women to choose safely between medical and surgical methods of termination, with few restrictions applicable. Specifically, mifepristone is avoided in severe asthma, renal or hepatic impairment or chronic adrenal failure. Care should be taken with prostaglandins in women with a scarred uterus when used for late medical abortion where half doses are recommended. A variety of specific protocols and methods are used at different gestations as summarised in Table 2 and Figure 1. Currently, 55% of all terminations use medical methods, with 40% undergoing vacuum aspiration and 5% dilatation and evacuation; medical terminations outnumbered surgical for the first time in 2014.

All patients requesting termination of pregnancy should follow a similar set of basic protocols to ensure safe, successful and woman friendly procedures.

Pre-procedure blood tests and vaginal swabs are recommended. Full blood count to ensure normal haemoglobin and platelet counts avoid precipitating unexpected bleeding; a group and save checks whether Rhesus prophylaxis is required. The RCOG recommend that all women undergoing termination have screening for Chlamydia and undergo a risk assessment for other sexually transmitted diseases. Some units forgo this practice by provided universal antibiotic prophylaxis to all patients; a common regime is azithromycin 1 g orally, with metronidazole 1 g PR after termination has taken place.

Despite its use in many centres, paracetamol has been shown to be ineffective at relieving pain associated with termination of pregnancy. NSAID's are effective and some women will require opiate analgesia; this becomes more likely as gestation increases. Analgesia should be prescribed routinely for all women undergoing termination.

In preparing for termination, most practitioners are familiar with the use of misoprostol as a cervical priming agent, but not osmotic dilators which are superior to medical agents in termination of pregnancy over 14 weeks. Two main types are available, laminaria made from compressed stalks of seaweed that expand to four times their dry diameter over 12–24 hours or Dilapan-S®, a synthetic preparation which expands more rapidly and consistently. Both are safe and effective, but care must be taken to avoid inserting too many rods too tightly as the cervix may not dilate and they can become trapped. They are inserted 12 hours prior to second trimester TOP.

The RCOG recommend that fetocide should be performed prior to medical termination at any gestation over 21 weeks and 6 days to ensure that there is no risk of a live birth. An intracardiac injection of potassium chloride is given under ultrasound

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