Methods of Termination

Methods of termination

- Medical termination in the first trimester (MTOP)
- Surgical termination in the first trimester (STOP)
- Medical termination in the second trimester
- Surgical termination in the second trimester

Medical termination in the first trimester (MTOP)

In 2001 Mifegyne (mifepristone) 200 mg (formerly known as RU486) was approved by MedSafe, the Medicines Assessment Advisory Committee and the Ministry of Health for four indications:

- Early medical termination of pregnancy
- Priming the cervix before a surgical termination
- Second trimester medical termination of pregnancy
- Induction of labour for foetal death in utero

Mifepristone is an anti-progesterone that in pregnancy causes decidual shedding in pregnancies less than nine weeks gestation, sensitizes the myometrium to the contraction-inducing action of prostaglandin and causes cervical ripening.

Misoprostol is a prostaglandin analogue that causes uterine contractions and cervical dilatation.

In New Zealand early medical terminations consist of 200 mg mifepristone orally, followed 24–72 hours later by the vaginal administration of 800 mcg misoprostol (a prostaglandin analogue). This can be followed by smaller doses of oral misoprostol if required.

New Zealand law states that oral mifepristone followed by misoprostol 24 to 48 hours later, depending on the clinical proptocol, must be taken in a licensed institution. If a woman lives close by she may not have to stay in the clinic after taking the medication, but it is important she knows who to call should she have any bleeding.

Medical termination is recommended by the UK RCOG as the method of choice for women up to nine weeks gestation.[4] Medical terminations are associated with less infection and no perforation as compared with surgical termination. Bleeding may be a complication of medical termination.

Medical contraindications for early medical termination and use of Mifepristone.

- No confirmation of pregnancy
- Ectopic pregnancy
- Known bleeding disorder or current anticoagulant medication
- Chronic adrenal failure
- Porphyria
- Anaemia (Hb <100 g/L)
- IUCD in-situ

- Known allergy to either mifepristone or misoprostol
- Severe cardiovascular disease or greater than two cardiovascular risk factors
- Renal or liver failure
- Malnutrition
- Multiple uterine scars or history of uterine rupture
- Long-term steroid medication (mifepristone may make steroids less effective and hence increased doses may be needed)
- Breast feeding (theoretical risk of mifepristone being excreted in breast milk and so women are advised not to breast feed for two to three days after mifepristone)

Social contraindications for early medical termination[5]

- Woman unwilling to proceed to surgical termination if indicated
- Living more than one hour's travelling time from emergency medical services
- Lack of direct telephone access or unable to communicate easily by telephone e.g language difficulties
- Lack of reliable transport i.e. car or money for taxis (for return visits and in the advent of an emergency)
- Unsuitable home environment and/or lack of support
- Woman's inability to cope with cramping and heavy bleeding

Surgical termination in the first trimester (STOP)

Surgical termination is performed under general anesthetic or conscious sedation (fentanyl and midazolam IV). All first trimester surgical operations use suction.

One to three hours prior to surgical termination being performed, misoprostol may be given orally to soften and dilate the cervix.

Second trimester termination of pregnancy

Mifepristone can also be used to induce labour and a termination of pregnancy after 12 weeks gestation. The woman is admitted to a clinic and is given mifepristone followed by repeated doses of misoprostol. This method of second trimester termination is used in some of the larger units in New Zealand.

The interval between the administration of misoprostol and delivery of the products of conception is on average 6-8 hours. This reflects a marked reduction in time to delivery when compared with the past practice of using oxytocin.

Other methods used are laminaria (thin rods of a dried kelp species that are used to slowly dilate the cervix) followed by a surgical termination under general anesthetic, and dilatation and evacuation following mifepristone administration.

Ectopic pregnancy

Mifepristone has **NOT** been shown to be effective in treating ectopic pregnancy. Every effort must be made to exclude an ectopic pregnancy pre-termination, however some will be missed. A pseudo-gestational sac may be present on ultrasound, which may mimic an early intrauterine pregnancy. If no products are seen following a medical or surgical termination, then follow-up to exclude an ectopic pregnancy must be done.