Termination of pregnancy
Queensland Clinical Guideline: Termination of pregnancy

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Endorsed by: Queensland Clinical Guidelines Steering Committee
Statewide Maternity and Neonatal Clinical Network (Queensland)
Contact: Email: Guidelines@health.qld.gov.au
URL: www.health.qld.gov.au/qcg

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The guideline is not a substitute for clinical judgement, knowledge and expertise, or medical advice. Variation from the guideline, taking into account individual circumstances, may be appropriate.

This guideline does not address all elements of standard practice and accepts that individual clinicians are responsible for:

- Providing care within the context of locally available resources, expertise, and scope of practice
- Supporting consumer rights and informed decision making, including the right to decline intervention or ongoing management
- Advising consumers of their choices in an environment that is culturally appropriate and which enables comfortable and confidential discussion. This includes the use of interpreter services where necessary
- Ensuring informed consent is obtained prior to delivering care
- Meeting all legislative requirements and professional standards
- Applying standard precautions, and additional precautions as necessary, when delivering care
- Documenting all care in accordance with mandatory and local requirements

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Flow Chart: Summary of termination of pregnancy

**Clinical assessment**
- Confirm pregnancy
- Medical history
- Psychosocial history
- Pregnancy circumstances
  - Refer as appropriate
  - Discuss fetal autopsy if clinically indicated
- If < 18 years, consider risk of harm and mandatory reporting requirements

**Examination/Investigations**
- Determine gestational age
- Consider ectopic pregnancy
- Routine antenatal bloods
- Consider cervico-vaginal swabs
- Offer opportunistic health care:
  - Pap smear
  - Sexual health check
  - Rubella titre
  - Smoking cessation advice

**Information**
- Provide accurate, non-judgemental, easy to understand information on:
  - Options for the pregnancy
  - Methods of termination
  - Post termination care

**Coordinate referrals**
- Offer confidential non-judgemental counselling
- Offer formal mental health referral if required
- Refer to other services as required (e.g. private service providers)

**Documentation**
- Document the decision making process

**Conscientious objection**
- Disclose if termination healthcare requested
- Transfer care to other service/providers without conscientious objection

**Legal requirements ToP Act 2018**

**Less than or equal to 22+0 weeks**
- A medical practitioner may perform a termination upon request

**At or after 22+1 weeks**
- A medical practitioner may perform a termination if they consider that in all the circumstances, the termination should be performed
- The medical practitioner must seek agreement from another medical practitioner
- Circumstances both must consider:
  - All relevant medical circumstances
  - The woman’s current and future physical, psychological and social circumstances
  - Professional standards and guidelines relevant to the practitioners in relation to termination

**Pre-termination assessment**
- Confirm pregnancy
- Medical history
- Psychosocial history
- Pregnancy circumstances
  - Refer as appropriate
  - Discuss fetal autopsy if clinically indicated
- If < 18 years, consider risk of harm and mandatory reporting requirements

**Surgical or medical procedure**
- Consider:
  - Gestation of pregnancy
  - Clinical indications
  - Preferences of the woman
  - Service level capability and expertise

**Consent**
- Consider issues of capacity
- Consider adequacy of information provision and counselling
- If < 14 years:
  - Involve paediatric services
  - Assess mandatory reporting requirements

**Coordinate referrals**
- Consider referrals for specialist care, termination procedure, psychological support/counselling

**Follow-up**
- Arrange follow-up
- Discuss contraception

**Considerations**
- Histopathology
- RhD immunoglobulin
- Analgesia requirements
- Provide after care advice
- Discuss contraceptive options
- Provide advice on accessing psychological care
- Ensure follow-up
- Refer as required

---

ToP: termination of pregnancy; ≤: less than
Flowchart: Medical termination with MS-2 Step

**Woman requests termination healthcare**
- Offer non-directive pregnancy related counselling (1)
- Urinary pregnancy test (2)
- USS is recommended
- Counsel about termination options

### Clinical assessment for MToP (3)
- Review history
- Exclude contraindications
- Obtain consent
- Remove IUD
- Routine antenatal bloods
  - If Rh D -ve, Rh D immunoglobulin required
- Consider cervico-vaginal swabs
- Offer opportunistic health care
  - Pap smear
  - Sexual health check
  - Rubella titre
  - Smoking cessation advice

### MS-2 step
- Provide instructions for self administration
- Advise on:
  - Pain management
  - Expected bleeding
  - Possible complications
  - Accessing emergency care
  - Sex and fertility
  - Need for follow-up

### MBS Item Numbers
1. 4001 with required training or use time-based item number
2. 73806
3. No specific MBS item number exists. Use time-based item number (e.g. 44)

### Flowchart:

- **Confirmed IUP?**
  - Yes
    - Pregnancy \(\leq 63\) days?
      - Yes
        - Woman chooses MToP?
          - Yes
            - Are you a registered MToP provider?
              - Yes
                - Perform clinical assessment for MToP
              - No
                - Refer to surgical termination provider
          - No
            - Refer to registered MToP provider
      - No
        - Refer to surgical termination provider
    - No
      - Consider ectopic, PUL or unknown viability
      - Refer to QCG EPL and its flowchart Assessment of location and viability

### Further follow-up (as indicated)
- If bleeding continues (even lightly) check ceased in further 2–3 days
- USS
- Consider referral for:
  - Surgical intervention or
  - Further misoprostol dose

### Follow-up
- Face to face or remote consult
- Confirm wellbeing
  - \(\beta\)-hCG (expect 80% drop)
  - Bleeding ceased
  - USS if indicated
- Offer contraception (e.g. oral, implanton, IUD)
  - Can commence immediately

### Conscientious objection
- Disclose if termination healthcare requested
- Transfer care to other service or to provider who does not have conscientious objection

### β-hCG:
beta human chorionic gonadotrophin; EPL: early pregnancy loss; IUD: intrauterine device; IUP: intrauterine pregnancy; MBS: medical benefit schedule; MToP: medical termination of pregnancy; PUL: pregnancy of unknown location; QCG: Queensland Clinical Guidelines; RhD: Rhesus D; USS: ultrasound scan; ≤: less than or equal to
### Abbreviations

<table>
<thead>
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<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>ARTG</td>
<td>Australian Register of Therapeutic Goods</td>
</tr>
<tr>
<td>β-hCG</td>
<td>Beta human chorionic gonadotropin</td>
</tr>
<tr>
<td>BP</td>
<td>Blood pressure</td>
</tr>
<tr>
<td>GP</td>
<td>General Practitioner</td>
</tr>
<tr>
<td>HHS</td>
<td>Hospital and Health Services</td>
</tr>
<tr>
<td>LAM</td>
<td>List of Approved Medicines (Queensland Health)</td>
</tr>
<tr>
<td>Rh</td>
<td>Rhesus</td>
</tr>
<tr>
<td>TGA</td>
<td>Therapeutic Goods Administration</td>
</tr>
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### Definition of Terms

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complex case</td>
<td>A complex case may be one in which: In the judgement of the treating health professional(s), there are circumstances that complicate the decision-making process and/or care and management of a woman requesting termination of pregnancy. This may include (but is not automatically a requirement of or limited to) issues related to a woman’s medical, social or economic circumstances, capacity to consent, mental health, age or gestation of pregnancy at which termination of pregnancy is requested.</td>
</tr>
<tr>
<td>Conscientious objector</td>
<td>Conscientious objector is a registered health practitioner who refuses to provide or participate in a lawful treatment or procedure because it conflicts with their own personal beliefs, values or moral concerns.¹</td>
</tr>
<tr>
<td>Live birth²</td>
<td>The complete expulsion or extraction from its mother of a baby, irrespective of the duration of the pregnancy, which after such separation, breathes or shows any other evidence of life, such as beating of the heart, pulsation of the umbilical cord or definite movement of voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached. Each product of such a birth is considered live born.</td>
</tr>
<tr>
<td>Obstetrician</td>
<td>Local facilities may as required, differentiate the roles and responsibilities assigned in this document to an “Obstetrician” according to their specific practitioner group requirements; for example, to gynaecologists, general practitioner obstetricians, specialist obstetricians, consultants, senior registrars and obstetric fellows.</td>
</tr>
<tr>
<td>Registered health practitioner</td>
<td>In Australia, health practitioners are registered under the Health Practitioner Regulation National Law. This sets out a framework for the registration and discipline of registered health practitioners and establishes National Boards that set standards, codes and guidelines that registered health practitioners must meet. The ToP Act defines a registered health practitioner as a person registered under the Health Practitioners Regulation National Law to practise a health profession, other than as a student.</td>
</tr>
</tbody>
</table>
| Routes of misoprostol administration³ | Oral: pills are swallowed immediately  
Buccal: pills are placed between the cheek and gums and swallowed after 30 minutes  
Sublingual: pills are placed under the tongue and swallowed after 30 minutes  
Vaginal: pills are placed in the vagina fornices (deepest portions of the vagina) and the woman is instructed to lie down for 30 minutes |
| Termination healthcare      | In this document termination healthcare refers to the provision of healthcare by a registered health practitioner that supports a woman to terminate a pregnancy. Includes  
• Referral for termination services  
• Making a decision on whether a termination should be performed on a woman at or after 22+1 weeks pregnant  
• Advising about the performance of termination  
• Performing or assisting with a termination procedure  
  o Includes feticide, surgical procedures and dispensing, supplying or administering a termination drug on a medical practitioner’s instruction |
| Young person                | In this document a young person refers to a woman aged less than 18 years |
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1 Introduction
Termination of pregnancy as used in this document refers to the deliberate ending of a pregnancy. The purpose of this guideline is to assist health professionals to provide care to women requesting termination of pregnancy.

1.1 Background
Prior to 3 December 2018, it was unlawful under the Criminal Code Act 1899, to administer a drug or to perform a surgical or other medical procedure intending to terminate a pregnancy unless such conduct was authorised, excused, or justified by law. Case law was relied on to provide an excuse from criminal responsibility and justify a termination where a surgical or medical treatment (where the intention was to adversely affect the pregnancy) was provided:
- In good faith and
- With reasonable care and skill and
- It was to preserve the mother’s life and
- Performing the operation or providing the medical treatment is reasonable, having regard to the patient's state at the time and to all the circumstances of the case

2 Queensland law
As of 3 December 2018 the Termination of Pregnancy Act 20184 (the ToP Act) applies to termination of pregnancy in Queensland. Termination performed by a registered medical practitioner, is no longer a criminal offence under the Criminal Code; nor is it a criminal offence for a woman to consent to, assist in or perform a termination on herself.

The purposes of the ToP Act are to:
- Enable reasonable and safe access by women to termination
- Regulate the conduct of registered health practitioners in relation to terminations

2.1 Medical practitioner responsibilities
The legal responsibilities for the medical practitioner in relation to termination, are specified according to the gestational age of the woman's pregnancy.1

Table 1. Medical practitioner responsibilities

<table>
<thead>
<tr>
<th>Aspect</th>
<th>Lawful action</th>
</tr>
</thead>
</table>
| Context | Queensland Crown Law advise in relation to the ToP Act:  
| | o “Not more than 22 weeks” means less than or equal to 22+0 weeks  
| | o “More than 22 weeks” means at or after 22+1 weeks  
| | Use clinical judgement when determining gestational age in individual circumstances |
| Less than or equal to 22+0 weeks gestation | A medical practitioner may perform a termination on a woman upon request |
| At or after 22+1 weeks gestation | A medical practitioner may perform a termination if:  
| | o They consider that in all the circumstances, the termination should be performed and  
| | o They have consulted with another medical practitioner who also considers that, in all the circumstances, the termination should be performed  
| | Both medical practitioners must consider:  
| | o All relevant medical circumstances  
| | o The woman’s current and future physical, psychological and social circumstances  
| | o The professional standards and guidelines that apply to the practitioner in relation to the performance of the termination  
| | Consultation1  
| | o The second medical practitioner is not required to examine the woman but may wish to do so  
| | o Between medical practitioners, consultation in person is not required and may occur by telephone or video-conference as is required to facilitate access to termination services |
2.2 Registered health practitioners assisting
Assisting in the performance of a termination includes dispensing, supplying or administering a termination drug on the medical practitioner’s instruction.\textsuperscript{5} Refer to Definition of terms: Registered health practitioner.

Table 2. Assisting with a termination

<table>
<thead>
<tr>
<th>Aspect</th>
<th>Lawful action</th>
</tr>
</thead>
</table>
| Registered health practitioners\textsuperscript{5} | • The following registered health practitioners may assist a medical practitioner in the performance of a termination  
  o Another medical practitioner  
  o Nurse  
  o Midwife  
  o Pharmacist  
  o Aboriginal and Torres Strait Islander health practitioners  
  o Other registered health practitioner prescribed by regulation  
  • Does not apply in relation to a termination the assisting practitioner knows or ought reasonably to know, is being performed by the medical practitioner other than in accordance with the ToP Act |
| Students                | • Student health practitioners are not permitted to assist in the performance of a termination  
  o A student health practitioner is a person enrolled in an approved program of study or who is undertaking clinical training and is registered as a student with their respective National Board\textsuperscript{6} |

2.3 Conscientious objection
If a person asks a registered health practitioner for termination healthcare [refer to Definition of terms: Termination healthcare] and the health practitioner has a conscientious objection to the performance of the termination [refer to Definition of terms: Conscientious objector], the conscientious objection requirements under the ToP Act apply.

Table 3. Conscientious objection

<table>
<thead>
<tr>
<th>Aspect</th>
<th>Lawful action</th>
</tr>
</thead>
</table>
| Disclosure of objection\textsuperscript{5} | • Registered health practitioners must disclose their conscientious objection to a person asking for termination healthcare  
  • For example:  
    o If a medical practitioner asks for assistance from a nurse who holds a conscientious objection, the nurse is required to disclose this to the medical practitioner  
    o If a woman requests termination healthcare from a medical practitioner who holds a conscientious objection, the medical practitioner must disclose this to the woman  
  • Refer to Definition of terms Termination healthcare |
| Referral or transfer of care\textsuperscript{5} | • If a woman requests termination healthcare, a registered health practitioner who has a conscientious objection to termination healthcare must refer the woman or transfer her care to:  
  o Another registered health practitioner whom they believe can provide the requested termination healthcare and who does not have a conscientious objection OR  
  o To a health service provider at which, in the practitioner’s belief, the requested service can be provided by another registered health practitioner who does not have a conscientious objection |
| Objection only in certain circumstances | • Where a registered health practitioner has a conscientious objection only in certain circumstances (e.g. a request beyond X weeks gestation) conscientious objection requirements apply only in that circumstance (i.e for requests beyond X weeks gestation) |
| Care that is not a matter for conscientious objection | • The conscientious objection provision does not extend to\textsuperscript{1}:  
  o Administrative, managerial or other tasks ancillary to the provision of termination healthcare  
  o Hospitals, institutions or services as the right to conscientiously object is a personal and individual right |
2.4 Emergency care involving termination

Table 4. Emergency care

<table>
<thead>
<tr>
<th>Aspect</th>
<th>Lawful action</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medical practitioner</strong></td>
<td>• In an emergency, a medical practitioner may perform a termination if they consider it is necessary to save the woman’s life or the life of another unborn child</td>
</tr>
<tr>
<td></td>
<td>• If the pregnancy is at or after 22+1 weeks, they may perform the termination:</td>
</tr>
<tr>
<td></td>
<td>o Without consulting another medical practitioner</td>
</tr>
<tr>
<td></td>
<td>o Without considering all relevant circumstances</td>
</tr>
<tr>
<td>Practitioners assisting¹</td>
<td>• In an emergency, a registered health practitioner may assist a medical practitioner performing a termination in the circumstances outlined above</td>
</tr>
<tr>
<td>Conscientious objectors¹</td>
<td>• Conscientious objection does not limit any duty owed by a registered health practitioner to provide a service in an emergency at any gestation of pregnancy</td>
</tr>
<tr>
<td></td>
<td>• As for other health emergencies, the medical practitioner is required to consider what assistance they can provide based on their own safety, skills and what other options are available</td>
</tr>
</tbody>
</table>

2.5 Safe access zones

The purpose of safe access zones is to protect the safety and well-being and respect the privacy and dignity of women and other persons accessing premises where termination healthcare is provided (termination services premises).¹

Table 5. Safe access zone

<table>
<thead>
<tr>
<th>Aspect</th>
<th>Lawful action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safe distance¹</td>
<td>• Unless otherwise prescribed by regulation, the prescribed distance is 150 metres from the entrance to the termination services premises</td>
</tr>
<tr>
<td></td>
<td>• A pharmacy is not included in the definition of termination services premises</td>
</tr>
<tr>
<td>Prohibited conduct¹</td>
<td>• Conduct in a safe access zone is prohibited if it relates to terminations (or could be reasonably be perceived to be so) and:</td>
</tr>
<tr>
<td></td>
<td>o Would be visible or audible to another person entering or leaving the premises and</td>
</tr>
<tr>
<td></td>
<td>o Would be reasonably likely to deter a person from entering or leaving the termination services premises, requesting or undergoing a termination, or performing or assisting with the performance of a termination</td>
</tr>
<tr>
<td></td>
<td>• The conduct may be prohibited whether or not another person sees or hears the conduct or is actually deterred</td>
</tr>
<tr>
<td></td>
<td>• It is also an offense to make an audio or visual recording that contains information that could identify a person entering or leaving a termination services premises without the person’s consent, or to publish or distribute a recording without the person’s consent</td>
</tr>
</tbody>
</table>
### 2.6 Non-compliance with the ToP Act

Table 6. Non-compliance

<table>
<thead>
<tr>
<th>Aspect</th>
<th>Lawful action</th>
</tr>
</thead>
</table>
| **Offences**                  | • Termination is considered a health matter  
                                 • No penalty or offence is specified in the ToP Act for a health practitioner’s failure to comply with the requirements of the law including the conscientious objection provision  
                                 • The following apply as for other healthcare procedures:  
                                    o Professional and legal consequences of non-compliance  
                                    o Laws for duty of care, reasonable skill and care  
                                    o Civil or criminal responsibility for harm that results from a failure to act with reasonable skill and care |
| **Professional conduct**      | • Non-compliance with relevant registration and accreditation standards, professional standards (including codes of ethics, codes of conduct and competency standards) policies and guidelines is subject to the same professional and legal consequences as for other healthcare |
3 Clinical standards

Where service level capabilities, as defined in the Clinical Services Capability Framework\(^7\), are insufficient to provide termination healthcare, establish referral and transfer systems with other service level facilities\(^8\) in accordance with the Clinical Services Capability Framework\(^8\).

Table 7. Clinical standards

<table>
<thead>
<tr>
<th>Aspect</th>
<th>Good Practice Point</th>
</tr>
</thead>
</table>
| Access                    | - Women requesting termination require assessment by a medical officer who is not a conscientious objector  
  - Where termination healthcare is not locally available, support women to access the service as would occur for any specialist procedure as per local HHS policy for consultation and referral  
  - Provide documented information to consumers, external service providers and support agencies within the local HHS on the choices available within the service, and on routes of access to these services  
  - Facilitate access to termination services as early as possible in the pregnancy to reduce the likelihood of associated health risks\(^3\)  
  - Ideally, offer an assessment appointment within 5 days of referral\(^9\)  
  - Provide dedicated clinic time for the assessment appointment\(^9\) separate from antenatal clinics where feasible  
  - Ideally, provide termination within 2 weeks of the decision to proceed being agreed\(^8\)  
| Referral                  | - Document referral pathways within and between HHSs (e.g. between departments within a facility, between facilities and between a facility and external agencies and GPs)  
  - Consider engagement with statewide external service providers and agencies in the development of referral pathways and mechanisms  
  - Provide documented referral pathways to external service providers, agencies and GPs  
  - Inform health care professionals in contact with women seeking termination (e.g. emergency departments, GPs) about referral pathways  
  - If conscientious objection to termination healthcare, act in accordance with Table 3. Conscientious objection  
  - Where the woman considers but does not proceed to termination, provide information and access to appropriate referral pathways (e.g. access to a social worker, referral for antenatal care)  
| Local service delivery    | - Determine the local service delivery mechanisms and administrative reporting requirements within each service  
  - Where there are complex issues present [refer to Definition of terms: Complex case], consider a case review (as for other complex healthcare) to assess the complexities specific to the individual case  
| Care setting              | - A multidisciplinary and coordinated approach is required so as to avoid unnecessary delay in the provision of care  
  - The most appropriate care setting for termination is dependent on the:  
    - Method of termination chosen  
    - Gestation of the pregnancy\(^3\)  
    - Preferences of the woman and her care provider  
    - The service capabilities of the facility\(^8\)  
  - Ensure there are local arrangements for the safe and sensitive handling, storage and disposal of fetal tissue\(^10\)  
| Workforce                 | - Educate providers and referrers about the service, the pathways, any service limitations and their professional responsibilities  
  - For health professionals involved in the provision of termination healthcare:  
    - Provide ongoing training and education\(^3\)  
    - Offer counselling and debriefing support
4 Individual case considerations

The decision to provide termination healthcare is made in partnership with the woman (and her family, where appropriate) and her health care professional. It is led by the woman's health needs and concerns. Health practitioners providing termination healthcare are advised to familiarise themselves with their legal responsibilities under the ToP Act. Refer to Section 2 Queensland law.

4.1 Consent

Table 8. Consent

<table>
<thead>
<tr>
<th>Aspect</th>
<th>Consideration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consent</td>
<td>• Follow usual consent processes and standards including:  &lt;br&gt;   o Assessment of capacity  &lt;br&gt;   o Discussion of available methods of termination  &lt;br&gt;   o Risks and complications of each method of termination</td>
</tr>
<tr>
<td>Capacity to consent</td>
<td>• The legal test for capacity in adults is found in Schedule 3 of the Powers of Attorney Act 1998 (Qld), namely that the person:  &lt;br&gt;   o Understands the nature and effect of decisions about the matter  &lt;br&gt;   o Freely and voluntarily makes decisions about the matter and  &lt;br&gt;   o Communicates the decisions in some way</td>
</tr>
<tr>
<td>Adults who lack capacity</td>
<td>• The Queensland Civil and Administrative Tribunal may consent for an adult who lacks capacity to undergo a termination &quot;only if the Tribunal is satisfied that it may be performed by a medical practitioner under the Act&quot;  &lt;br&gt;   • Termination of a pregnancy of an adult is considered to be &quot;special health care&quot; under the Guardianship and Administration Act 2000 (Qld)  &lt;br&gt;   • A legal guardian or substitute decision-maker cannot provide consent.</td>
</tr>
<tr>
<td>Gillick competent young person</td>
<td>• A young person (less than 18 years of age) is considered Gillick competent when she achieves a sufficient understanding and intelligence to enable her to understand fully what medical treatment is proposed (^\text{11})  &lt;br&gt;   • A Gillick competent young person can give consent to medical procedures as would an autonomous adult  &lt;br&gt;   • The law leaves the decision about whether a young person is Gillick competent to the individual practitioner  &lt;br&gt;   • Consider additional elements of informed consent when obtaining consent from a Gillick competent young person (e.g. the ability to freely and voluntarily make decisions without coercion)  &lt;br&gt;   • Routinely explore and where appropriate, encourage the young person to involve her parents/guardians in decision-making and consultation  &lt;br&gt;   • The law requires that when a competent young person refuses to include her parents/guardians in consultation, this must be respected and her confidentiality not breached  &lt;br&gt;   • Involve paediatric and mental health services for assessment of Gillick competency, psychosocial assessment and family court matters where clinically indicated</td>
</tr>
<tr>
<td>Young person not Gillick competent</td>
<td>• For a young person deemed not Gillick competent, the Supreme Court in its parens patriae jurisdiction may authorise the termination  &lt;br&gt;   • The Supreme Court must act in the best interests of the young person  &lt;br&gt;   • A young person's parents/guardian cannot provide consent to a termination  &lt;br&gt;   • Involve paediatric and mental health services for assessment of Gillick competency, psychosocial assessment and family court matters where clinically indicated  &lt;br&gt;   • Escalate these cases the Executive Director of Medical Services or equivalent (e.g. Medical Superintendent) for urgent attention</td>
</tr>
</tbody>
</table>
4.2 Young person less than 14 years

Table 9. Young person less than 14 years

<table>
<thead>
<tr>
<th>Aspect</th>
<th>Consideration</th>
</tr>
</thead>
</table>
| Young person less than 14 years | • Each HHS determines its capability to provide termination healthcare for young people less than 14 years  
                                   • Involve social worker support  
                                   • Involve paediatric and mental health services for assessment of Gillick competency, psychosocial assessment and family court matters  
                                   • Provide pre-termination psychological counselling from an appropriately qualified health care professional [refer to Section 5 Psychological support]  
                                   o Include documented evidence of the pre-termination counselling in the medical record                                                                 |

4.3 Suspicion of child abuse

Table 10. Suspicion of child abuse

<table>
<thead>
<tr>
<th>Aspect</th>
<th>Consideration</th>
</tr>
</thead>
</table>
| Reporting requirements  | • Report any reasonable suspicions of child abuse and neglect to Child Safety Services in the Department of Child Safety, Youth and Women\(^8,12,13\)  
                                   • Sexual activity in a young person under 14 years is a mandatory report to the Department of Child Safety, Youth and Women for Queensland Health employees\(^14\) |

4.4 Documentation of decisions

Table 11. Documentation

<table>
<thead>
<tr>
<th>Aspect</th>
<th>Consideration</th>
</tr>
</thead>
</table>
| Less than or equal to 22+0 weeks | • Standard documentation principles apply  
                                   • Refer to Queensland Clinical Guideline: Standard care\(^15\)                                                                                     |
| At or after 22+1 weeks and/or complex case | • Both medical practitioners document:  
                                   o Clinical opinion as regards the relevant medical circumstances  
                                   o Clinical opinion as regards the woman's current and future physical, and psychological and social circumstances  
                                   o Individual clinical assessment of the woman                                                                                                     |

4.5 Birth registration

Table 12. Registration requirements

<table>
<thead>
<tr>
<th>Gestation/Birth weight</th>
<th>Signs of life</th>
<th>Requirement</th>
</tr>
</thead>
</table>
| Less than 20 weeks AND less than 400 grams | Not live born | • Birth registration not required  
                                   • Death certificate not required  
                                   • Burial/cremation not required                                                                 |
| Less than 20 weeks AND less than 400 grams | Live born     | • Birth registration required  
                                   • Death certificate required  
                                   • Burial/cremation required                                                                 |
| Greater than 20 weeks OR more than 400 grams | Not live born  | • Birth registration not required  
                                   • Death certificate not required  
                                   • Burial/cremation not required                                                                 |
5 Psychological support

Involves social worker support in the care of women requesting and accessing termination healthcare.

Table 13. Information and counselling

<table>
<thead>
<tr>
<th>Aspect</th>
<th>Good practice points</th>
</tr>
</thead>
</table>
| Information | • Support the decision-making process by providing accurate, impartial and easy to understand information\(^3\) including\(^{16,17}\):
  - Options to continue the pregnancy and parent the child
  - Options to continue the pregnancy and place the child for foster care/adoption
  - Information about methods of termination\(^{17}\)
  - Post-termination considerations including contraceptive options and counselling support
  - Discuss birth registration requirements |
| Counselling | • Offer confidential, non-judgemental support and counselling\(^3,18,19\):
  - Counselling should be provided by someone (e.g. social worker, psychologist, counsellor) who:
    - Is appropriately qualified and/or trained\(^3\)
    - Is familiar with the issues surrounding termination
    - Has no vested interest in the pregnancy outcome\(^{16}\)
  - Where feasible, offer counselling ‘close to home’ to aid the establishment of longer term counselling support
  - Consider the requirement for formal mental health referral especially if there is a history of mental illness\(^{20}\) |

Table 14. Mental health considerations

<table>
<thead>
<tr>
<th>Considerations</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>• There are significant limitations in the evidence examining the relationships between unwanted pregnancy, termination, birth and mental health(^{21})</td>
<td></td>
</tr>
<tr>
<td>• For the majority of mental health outcomes, there is no statistically significant association between pregnancy resolution and mental health problems(^{21})</td>
<td></td>
</tr>
<tr>
<td>• An unwanted pregnancy may lead to an increased risk of mental health problems, or other factors may lead to both an increased risk of unwanted pregnancy and an increased risk of mental health problems(^{21})</td>
<td></td>
</tr>
<tr>
<td>• When a woman has an unwanted pregnancy, rates of mental health problems will be largely unaffected whether she has a termination or goes on to give birth(^{21})</td>
<td></td>
</tr>
<tr>
<td>• Women with a past history of mental health problems are at increased risk of further problems after an unintended pregnancy(^9)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Offer referral to a mental health service where there is a pre-existing mental health problem(^{21})</td>
<td></td>
</tr>
<tr>
<td>• Consider the need for support and care for all women who request a termination, because the risk of mental health problems increases whatever the pregnancy outcome(^{21})</td>
<td></td>
</tr>
<tr>
<td>• Involve social worker support where feasible</td>
<td></td>
</tr>
</tbody>
</table>
6  Pre-termination assessment

Offer pre-termination assessment including counselling and psychosocial support services [refer to Section 5 Psychological support] ‘close to home’ where feasible. Components of the pre-termination clinical assessment are outlined in Table 15.

Table 15. Assessment prior to termination

<table>
<thead>
<tr>
<th>Aspect</th>
<th>Good practice points</th>
</tr>
</thead>
</table>
| Circumstances of pregnancy     | • Obtain a full picture of the circumstances leading to the request for termination\(^{10}\)  
  o Offer referral to other services as appropriate – especially where risk factors are identified (e.g. young women, women with physical or intellectual disabilities, mental illness, rape or sexual assault, domestic violence, fertility issues and cultural beliefs/values\(^{3,10}\))  
  • Offer fetal autopsy if clinically indicated (e.g. if there is fetal abnormality)  
    o Usual consent processes and counselling are required [refer to Guideline: Stillbirth care\(^{22}\)] |
| Medical history                | • Date of last menstrual period\(^3\)  
  • Gynaecological, obstetric, and sexual health history\(^3\)  
  • Past and current medical history\(^{3,18,23}\) |
| Clinical exam and investigations | • Physical exam as indicated by medical history and symptoms including:  
  o Vital signs: temperature, blood pressure (BP), pulse\(^{23}\)  
  • Confirm the diagnosis of pregnancy\(^{23}\) and location by ultrasound, urinary or serum β-hCG assay\(^{16,18}\)  
  • Determine gestational age\(^{3,18,23}\) as this may impact on choice of termination method  
    o Consider ultrasound to confirm gestation\(^{17}\) and obtain in all cases of second trimester procedures\(^{16}\)  
    • Consider ectopic pregnancy and evaluate further if clinically indicated\(^{17,23}\)  
    • Consider cervico-vaginal swabs to allow treatment of bacterial infections prior to termination\(^{24}\)  
      o If bacterial vaginosis suspected/confirmed treat with Metronidazole before the termination\(^{16}\)  
  • Routine antenatal screening  
    o Haemoglobin\(^{16,17}\)  
    o Blood group and Rh status to identify Rh negative women for administration of Rh D immunoglobulin\(^{16,18,23}\) |
| Opportunistic health care      | • Consider opportunistic health screening or advice. For example:  
  o Pap smear\(^{3,16}\)  
  o Sexual health check  
  o Rubella titre  
  o Smoking cessation advice\(^{18}\) |
| Referral coordination          | • Consider the requirement for timely referral and coordination with other facilities/disciplines/agencies.\(^{10,24}\) For example:  
  o Specialist medical assessment (e.g. cardiologist, clinical genetics services, tertiary imaging)  
  o Psychosocial counselling/support  
  o Mental health support/treatment  
  o Termination procedure  
  • Arrange a follow-up appointment to facilitate\(^{18,23}\):  
    o Assessment of physical recovery  
    o Confirmation of procedure success\(^{23}\)  
    o Discussion of ongoing contraception\(^{25}\)  
    o Consideration of emotional issues and counselling as necessary |
| Contraception                  | • Promote and facilitate commencement of contraception at the time of termination or immediately after\(^{3,16}\):  
  o Intrauterine devices may be inserted immediately post-termination if clinically appropriate\(^{26}\) |
### 6.1 Other pre-termination considerations

**Table 16. Pre-termination considerations**

<table>
<thead>
<tr>
<th>Aspect</th>
<th>Good practice points</th>
</tr>
</thead>
</table>
| **Method of termination** | • A pregnancy may be terminated using a medical or surgical approach or a combination of the two\(^\text{18}\)  
• The choice of method may be dependent on local clinician expertise and service capabilities as well as availability of pharmacological agents\(^\text{18}\) and the woman’s preference  
• There is limited evidence that examines the acceptability and side effects of medical compared to surgical first trimester termination\(^\text{27}\)  
• Prostaglandins used alone seem to be less effective and more painful compared to surgical first trimester termination\(^\text{27}\)  
• Discuss complications and risks in a way the woman can understand and emphasise the overall safety of the procedure\(^\text{9}\) |
| **Selective/non-selective reduction** | • If selective reduction or non-selective reduction in multiple pregnancy is required, consider individual circumstances on a case by case basis conforming with the principles outlined in preceding sections |
| **Feticide**            | • Usually for gestations greater than 22+0 weeks  
• Refer the woman to the closest Level 6 facility with the capability to provide this service\(^\text{8}\)  
• If feticide is clinically indicated this will normally be undertaken by injection of intracardiac potassium under ultrasound guidance  
• Post feticide, a woman may be transferred to another facility for birth if this is considered clinically safe and there is a robust referral process and comprehensive documentation |
| **Live birth**          | • Consider the potential for a live birth and discuss with the woman if appropriate:  
  o Ensure there are local procedures for the management of live birth  
  o Offer counselling and support services if live birth occurs |
7 Medical termination

Medical termination is one where drugs are used to induce the termination.\(^\text{16}\) It may be considered at all gestations of pregnancy. Mifepristone (RU486) in combination with other agents is frequently cited in international literature as the preferred regimen for medical termination.\(^\text{3,10,17,23,28,29}\) However, misoprostol alone is also common, especially in settings in which mifepristone is not available.\(^\text{30}\) Gemeprost may also be used for second trimester terminations\(^\text{3}\) at the discretion of the treating obstetrician.

Where local protocols are not well established or do not exist, suggested protocols are provided in:

- Section 7.5 MS-2 Step for gestations less than or equal to 63 days
- Appendix B Mifepristone and Misoprostol protocol
- Appendix C Misoprostol alone protocol
- Appendix D 2nd trimester misoprostol protocol for increased risk of uterine rupture

Refer to the Australian product information for complete drug information.

7.1 Precautions for medical termination

Medical methods of termination have been shown to be safe and effective.\(^\text{3,28}\) Uterine rupture is a rare complication associated with later gestational age and prior uterine surgery.\(^\text{3,31-33}\) Although causality has not been established, serious infections and bleeding occur very rarely following use of Mifepristone for medical termination.\(^\text{34}\) Bacterial infection may present without fever or abdominal pain.

Table 17. Contraindications and cautions for medical termination

<table>
<thead>
<tr>
<th>Aspect</th>
<th>Good practice points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contraindications</td>
<td>• Known hypersensitivity or allergy to prostaglandins or any component of the product(^\text{30})&lt;br&gt;• Suspected or confirmed ectopic pregnancy(^\text{30})&lt;br&gt;• Gestational trophoblastic disease(^\text{30})&lt;br&gt;• Intrauterine device (must be removed prior to termination)(^\text{30})&lt;br&gt;• Obstructive cervical lesions (e.g. fibroids)(^\text{35})&lt;br&gt;• High suspicion of placenta accreta&lt;br&gt;• High risk of uterine rupture(^\text{30}) (consider individual circumstances(^\text{36}), may still be suitable in women with history of caesarean section or multiple pregnancies or who have uterine abnormalities(^\text{37}))</td>
</tr>
<tr>
<td>Cautions</td>
<td>• Cardiovascular disease – monitor cardiovascular status closely as prostaglandins may cause transient BP changes(^\text{38})&lt;br&gt;• If membranes are ruptured consider IV oxytocin (syntocinon) due to the increased risk of infection</td>
</tr>
</tbody>
</table>

7.2 Outpatient care

The most appropriate setting for medical termination requires consideration of the local service capabilities and the individual circumstances of the woman including geographic distances to be travelled if emergency care is required. Involve social worker support where appropriate. May be suitable for women who:

- Are less than or equal to 9 weeks gestation
- Are accompanied by a support person, who has been adequately informed about what to expect, until the termination is complete\(^\text{28}\)
- Have immediate access to transport and telephone
- Can communicate by telephone (e.g. have an interpreter available if required)
- Have the capacity to understand and follow instructions
- Can access a healthcare facility
- Have follow-up arrangements in place
7.3 Mifepristone

Table 18. Mifepristone considerations

<table>
<thead>
<tr>
<th>DRUG</th>
<th><em>MIFEPRISTONE</em> (Antiprogestosterone and antiglucocorticoid)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indications</td>
<td>• Termination of first or second trimester pregnancy with misoprostol</td>
</tr>
</tbody>
</table>
| Contraindications     | • Refer to Table 17 for cautions and contraindications to medical termination  
                        | • Contraindicated in:  
                        |   o Adrenal failure/insufficiency  
                        |   o Severe hepatic failure  
                        |   o Some gynaecological conditions (e.g. serious pelvic infection)  
                        |   o Some haematological conditions (e.g. inherited porphyria)  
                        |   o Concurrent anticoagulants  
                        |   o Potential for serious Cytochrome P450 (CYP) drug interactions |
| Precautions           | • Renal or hepatic impairment (dosage adjustment recommended)  
                        | • Severe anaemia, haemostatic disorders or hypocoagulability  
                        | • May reduce efficacy of long term corticosteroids for 3–4 days after use |
| Approval for use      | • In August 2012 Marie Stopes International Australia successfully applied to register mifepristone with the Therapeutic Goods Administration (TGA) and is the sponsor of the medicine  
                        | • Queensland Health approves the use of mifepristone by specialist obstetric and gynaecology staff who are registered with the MS-2 Step Prescribing Program for use in the termination of an intra-uterine pregnancy, in sequential combination with misoprostol as per the Queensland Maternity and Neonatal Clinical Guideline for termination of pregnancy |
| Presentation          | • Tablet 200 milligrams (mg) |
| Dosage                | • The effect of mifepristone is not decreased by lowering the dose from previously recommended 600 mg to 200 mg when combined with at least 400 micrograms of misoprostol  
                        | • Refer to Appendix B or C for suggested protocol |
| Administration        | • Oral |
| Efficacy              | • A combination regimen with a prostaglandin analogue is more effective than use of either medication as a single analogue agent  
                        | • The failure rate of first trimester medical termination with mifepristone and misoprostol is slightly higher (2–7%) than that for surgical termination |
| Adverse effects       | • Side effects are dose dependent and are frequently reported in combination with misoprostol use. They most commonly include:  
                        |   o Nausea, vomiting diarrhoea  
                        |   o Headache, dizziness, fatigue  
                        |   o Thermoregulatory (hot flushes, low grade temperature)  
                        | • Abdominal pain and cramps  
                        | • Prolonged vaginal bleeding  
                        | • Adrenal insufficiency, bacterial infection, hypokalemia and QT interval prolongation have been reported |

*Caution: refer to the Australian product information for complete drug information
### 7.4 Misoprostol

#### Table 19. Misoprostol considerations

<table>
<thead>
<tr>
<th>DRUG</th>
<th><em>MISOPROSTOL (Prostaglandin E1 analogue)</em></th>
</tr>
</thead>
</table>
| **Indications** | To ripen the cervix before surgical termination of first or second trimester pregnancy\(^{38}\)  
Termination of second trimester pregnancy\(^{28}\)  
Medical termination of first or second trimester pregnancy with mifepristone\(^{38}\) |
| **Precautions** | Refer to Table 17 for cautions and contraindications to medical termination  
Asthma, Chronic Obstructive Pulmonary Disease – prostaglandins may cause bronchospasm\(^{38}\)  
Predisposition to diarrhoea (e.g. inflammatory bowel disease)\(^{38}\)  
Epilepsy\(^{40}\) |
| **Approval for use** | In August 2012 *Marie Stopes International Australia* successfully applied to register misoprostol with the TGA and is the sponsor of the medicine  
Queensland Health approves the use of misoprostol for obstetric/gynaecologic indications when\(^{39}\):  
o Prescribed by a specialist for the termination of a pregnancy (or the management of missed abortion)  
o Informed consent that includes awareness of the TGA status of the drug has been obtained |
| **Presentation** | Tablet 200 micrograms\(^{42}\) |
| **Dosage** | The optimal dosing regimen is uncertain\(^{16,25,28,31,43}\). Select dose and dosing interval so as to generate sufficient and sustained uterine activity while minimising adverse effects\(^{30}\).  
The sensitivity of the uterus to prostaglandins increases with gestational age therefore decreasing amounts of misoprostol may be required with increasing gestational age\(^{30,41}\). Adjust dose based on clinical experience and judgement  
Refer to Table 21 and Table 22 for cervical priming regimens  
Refer to Appendix B, C or D for relevant termination protocols |
| **Administration** | Oral  
Buccal/sublingual  
Vaginal (oral tablets are administered intravaginally) |
| **Efficacy** | Vaginal misoprostol is more effective than oral misoprostol with fewer side effects\(^{17,44}\).  
Sublingual or buccal misoprostol are similarly effective to vaginal misoprostol however they have higher rates of side effects\(^{28}\).  
Misoprostol is as effective as other preparations in effecting vaginal birth within 24 hours\(^{43,44}\).  
In comparison to other prostaglandin preparations (gemeprost, prostaglandin E\(_2\) and prostaglandin F\(_2\) alpha), misoprostol, is more cost effective, more stable at room temperature and has fewer side effects\(^{31,36,43}\) |
| **Adverse effects** | Adverse effects increase with gestational age\(^{45}\).  
Side effects are dose dependent\(^{41}\) and most commonly include:  
- Nausea, vomiting diarrhoea\(^{17,28}\)  
- Headache\(^{17}\)  
- Thermoregulatory\(^{17,25}\) (hot flushes, low grade temperature)  
- Abdominal pain and cramps\(^{35}\) |

*Caution: refer to the Australian product information for complete drug information*
## 7.5 MS-2 Step (less than or equal to 63 days gestation)

MS-2 Step composite pack is suitable for termination at less than or equal to 63 days gestation.

<table>
<thead>
<tr>
<th>Aspect</th>
<th>Consideration</th>
</tr>
</thead>
</table>
| **MS-2 Step composite pack**<sup>46</sup> | • Consists of:  
  o Mifepristone 200 mg (1 tablet containing 200 mg)  
  o Misoprostol 800 micrograms (4 tablets, each tablet containing 200 micrograms) |
| **Clinical efficacy**<sup>46</sup> | • For women with gestational age less than 49 days:  
  o Efficacy 97.4%  
  o Incomplete termination requiring aspiration 2.3%  
  o Rate of ongoing pregnancy 0.3%  
  • For women with gestational age 49 to 63 days:  
  o Efficacy 95.2%  
  o Incomplete termination requiring aspiration 4.8%  
  o Rate of ongoing pregnancy 0.6% |
| **Approval for use** | • In June 2014 Marie Stopes International Australia successfully applied to register MS-2 Step with the TGA and is the sponsor of the medicine<sup>46</sup>  
  • Prescribers must register online with the MS-2 Step Prescribing Program  
  • Queensland Health approves the use of MS-2 Step for specialist obstetric and gynaecology staff who are registered with the MS-2 Step Prescribing Program for use in the termination of an intra-uterine pregnancy as per the Queensland Maternity and Neonatal Clinical Guideline for termination of pregnancy<sup>39</sup> |
| **Pre-dose care** | • Perform a pre-termination assessment  
  o Refer to Section 6 Pre-termination assessment  
  • Obtain informed consent  
  o Refer to Section 4.1 Consent  
  • Exclude contraindications and review cautions  
  o Refer to Section 7.1 Precautions for medical termination  
  • Provide written information about what the woman can expect to experience including bleeding, pain, and when to seek emergency care  
  o Refer to Appendix E: Aftercare advice  
  • Provide written information to the woman regarding the process of self-administration  
  • Supply a script for analgesia and antiemetics  
  • Confirm review appointment for 14–21 days post termination |
| **Dose**<sup>46</sup> | **Initial dose:**  
  • Mifepristone 200 mg oral  
  • Check BP 15 minutes after mifepristone administration  
  • Administer Rh D Immunoglobulin to Rh negative women  
  **Subsequent dose:**  
  • 36–48 hours after mifepristone  
  o Misoprostol 800 micrograms buccal or sublingual |
| **Follow-up**<sup>46</sup> | • Follow-up 14–21 days after administration of mifepristone  
  • Confirm expulsion complete  
  o Clinical examination  
  o Serum β-hCG assay (expect 80% drop)  
  o Ultrasound scan if indicated  
  o Vaginal bleeding stopped completely—if persistent (even light bleeding) confirm cessation within another 2–3 days  
  • Referral for surgical procedure or other follow-up if required |
8 Surgical termination
Surgical curettage is generally suitable for gestations of pregnancy up to 14 weeks. If the pregnancy is between 14 and 16 weeks gestation, the procedure should only be performed by experienced practitioners\textsuperscript{3}. The procedure may be preceded by cervical priming\textsuperscript{3,18}.

8.1 Cervical priming

- Cervical preparation decreases the length of the termination procedure\textsuperscript{47}. It may also\textsuperscript{16,47}:
  - Reduce complications of uterine perforation and cervical injury
  - Make the procedure easier to perform
  - Make the procedure more comfortable for the woman
- Routine cervical preparation is recommended\textsuperscript{3,31}:
  - For women less than 18 years of age
  - For nulliparous women
  - After 12–14 weeks of gestation (although may be considered at any gestational age)\textsuperscript{3,19}
- Cervical priming can be accomplished using\textsuperscript{3,16,23,47}:
  - Osmotic dilators (e.g. Laminaria—not included in the Queensland Health List of Approved Medicines (LAM))
  - Pharmacological agents:
    - Refer to Table 21. Misoprostol alone for cervical priming or
    - Refer to Table 22. Mifepristone and misoprostol for cervical priming prior to surgical termination
    - Gemeprost may also be used at the discretion of the treating obstetrician\textsuperscript{3}

8.1.1 Misoprostol alone regimen

Table 21. Misoprostol alone for cervical priming prior to surgical termination

<table>
<thead>
<tr>
<th>MISOPROSTOL alone regimen</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Precautions</strong></td>
</tr>
<tr>
<td>Refer to Table 17. Contraindications and cautions for medical termination</td>
</tr>
<tr>
<td>Refer to Table 19. Misoprostol considerations</td>
</tr>
<tr>
<td><strong>Dosage</strong></td>
</tr>
<tr>
<td>3–4 hours prior to surgery\textsuperscript{3,9}</td>
</tr>
<tr>
<td>400 micrograms\textsuperscript{47} inserted into the posterior fornix of the vagina</td>
</tr>
<tr>
<td>OR</td>
</tr>
<tr>
<td>2–3 hours prior to surgery\textsuperscript{3,9,47}</td>
</tr>
<tr>
<td>400 micrograms oral, sublingual or buccal</td>
</tr>
</tbody>
</table>

*Caution: refer to the Australian product information for complete drug information
8.1.2 Mifepristone and misoprostol regimen

Table 22. Mifepristone and misoprostol for cervical priming prior to surgical termination

<table>
<thead>
<tr>
<th><strong>MIFEPRISTONE and MISOPROSTOL regimen</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Precautions</strong></td>
</tr>
<tr>
<td>• Refer to Table 17. Contraindications and cautions for medical termination</td>
</tr>
<tr>
<td>• Refer to Table 18. Mifepristone considerations</td>
</tr>
<tr>
<td>• Refer to Table 19. Misoprostol considerations</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Day 1: Pre-dose care</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• May occur as an outpatient</td>
</tr>
<tr>
<td>• Baseline maternal observations (temperature, Blood Pressure (BP) and pulse)</td>
</tr>
<tr>
<td>• If BP greater than 140/90 on two consecutive readings 15 minutes apart then withhold mifepristone and seek obstetrician review</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Day 1: Dosage</strong> (24–36 hours prior to procedure)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Mifepristone 200 mg oral$^{34,35}$</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Day 1: Post-dose care</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Check BP 15 minutes after mifepristone administration</td>
</tr>
<tr>
<td>• Observe for one hour post mifepristone administration in case of nausea and vomiting</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Day 2</strong> (Day of procedure)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• <strong>If less than 14 weeks gestation:</strong></td>
</tr>
<tr>
<td>• Misoprostol 400 micrograms, oral, sublingual or buccal 2 hours prior to procedure</td>
</tr>
<tr>
<td>• <strong>If greater than 14 weeks gestation:</strong></td>
</tr>
<tr>
<td>• Misoprostol 400 micrograms, oral, sublingual or buccal, 4 hours prior to the procedure and then again 2 hours prior to procedure</td>
</tr>
</tbody>
</table>

*Caution: refer to the Australian product information for complete drug information

Adapted from Royal Brisbane and Women’s Hospital Work Unit Guideline: Administration of mifepristone and misoprostol in medical induction of labour at less than 28 weeks gestation where a live birth is not the expected outcome
### 8.2 Considerations for surgical curettage

#### Table 23. Considerations for surgical termination

<table>
<thead>
<tr>
<th>Aspect</th>
<th>Good practice points</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Indications</strong></td>
<td>• Generally for gestations up to 14 weeks</td>
</tr>
<tr>
<td><strong>Prophylactic antibiotics</strong></td>
<td>• Perioperative prophylactic antibiotics are recommended[3,16,23]</td>
</tr>
<tr>
<td><strong>Anaesthesia</strong></td>
<td>• The method chosen may depend on service capabilities and the woman’s choice[18] \  • The procedure may be performed with or without oral or intravenous tranquilliser.[18] \  • Generally analgesics, local anaesthesia and/or mild sedation are sufficient[3]</td>
</tr>
<tr>
<td><strong>Oxytocic agents</strong></td>
<td>• May decrease the risks of haemorrhage but not routinely recommended for vacuum aspiration[3,9]</td>
</tr>
<tr>
<td><strong>Ultrasound</strong></td>
<td>• May be used to check completeness \  • Routine use not required[9] at less than 12 weeks</td>
</tr>
<tr>
<td><strong>Examination of tissue</strong></td>
<td>• Examination of the products of conception by the surgeon may assist with recognition of gestational trophoblast and exclude ectopic pregnancy[3,18] \  • Histopathology if clinically indicated</td>
</tr>
<tr>
<td><strong>Effectiveness of procedure</strong></td>
<td>• Highly effective but failure does occur[18] \  • Continuing pregnancy rate reported to be 2.3 per 1000 women[18]</td>
</tr>
<tr>
<td><strong>Side effects</strong></td>
<td>• Pain: analgesia is usually required (e.g. Non-steroidal anti-inflammatory drugs)[3] \  • Bleeding: expected duration 5–18 days[18] \  • Nausea: usually related to prostaglandins or anaesthetic drugs[18]</td>
</tr>
<tr>
<td><strong>Risks and complications</strong></td>
<td>• Serious complications are rare[18] \  • Risk rises with[23,31]: \  o Operator inexperience \  o Gestational age \  • Refer to Appendix A for specific risks and complications</td>
</tr>
</tbody>
</table>
9 Post-termination care
Most serious complications are detectable in the immediate post-procedure period. Appropriate and accessible follow-up care is essential.

Table 24. Post-termination care considerations

<table>
<thead>
<tr>
<th>Aspect</th>
<th>Good practice points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Histopathology</td>
<td>• Consider histopathological examination of tissue obtained during termination procedures if clinically indicated</td>
</tr>
</tbody>
</table>
| Rh prophylaxis | • Recommend Rh D immunoglobulin (anti-D) to all non-sensitised Rh D negative women within 72 hours following termination[^23]  
• Less than 13 weeks gestation 250 IU Rh D immunoglobulin via intramuscular injection[^3,^48]  
• 13 or greater weeks gestation 625 IU Rh D immunoglobulin via intramuscular injection[^3,^48] |
| Analgesia | • Individually determine analgesia requirements after surgical termination or during and after medical termination as requirements vary[^31]  
• Offer medication for pain management[^3]  
• Clinical surveillance is required as pain may be indicative of uterine perforation or clot retention[^3] |
| Post-procedural care | • Provide routine post-procedural care including assessment of vital signs, consciousness and observation of vaginal loss[^3] |
| Discharge | • Determine timing of discharge on an individual basis  
• Consider routine discharge criteria (e.g. vital signs stable, recovery from effects of sedation/anaesthesia) |
| Aftercare advice | • Refer to Appendix E: Aftercare advice  
• Provide written information regarding possible symptoms and emergency care[^3,^30]  
• Document the provision of aftercare advice[^23] |
| Follow-up | • Refer to Section 5 Psychological support  
• Promote continuity of care to facilitate the development of longer term support opportunities  
• Offer or advise the woman to obtain a follow-up appointment[^25] within 6–8 weeks of the procedure. This may be within the termination service or with the referring service  
• Schedule an appointment for provision of pathology results (where appropriate), especially where there was histopathology/autopsy for fetal abnormality  
• Provide a letter that gives sufficient information about the procedure to allow another practitioner elsewhere to deal with any complications[^9]  
• Offer referral for further counselling, especially where risk factors for long-term post-termination distress are evident (e.g. ambivalence before the termination, lack of a supportive partner, a psychiatric history or membership of a religious or cultural group that considers termination wrong[^9])  
• Provide information on accessing support agencies/organisations appropriate to individual circumstances (e.g. general practitioner, grief counselling or support groups)  
• Offer information and assistance as appropriate regarding birth registration and funeral arrangements  
• Offer referral to medical specialists as clinically appropriate (e.g. clinical genetics services) |
References


35. Spitz IM, Zieman M, editor. Mifepristone for the medical termination of pregnancy. [online]: UpToDate; 2010 [cited 2012 February 15].


45. Micromedex ® 2.0. Misoprostol.


### Appendix A: Complications of termination of pregnancy

<table>
<thead>
<tr>
<th>Complication</th>
<th>Comments</th>
</tr>
</thead>
</table>
| Retained products of conception    | • Uncommon following surgical termination  
• Requirement for surgical evacuation of retained products increased following medical termination                                                                                                     |
| Infection                           | • Risk reduced if:  
  o Prophylactic antibiotics are given  
  o Lower genital tract infection has been excluded by bacteriological screening                                                                                                                   |
| Cervical trauma                     | • Rates vary. Risk of damage to the external cervical os at the time of surgical termination is no greater than 1 in 100  
• Decreased risk with:  
  o Experienced clinician  
  o Use of preoperative cervical priming  
  o Earlier gestations                                                                                                                                  |
| Haemorrhage                         | • May be more common following medical termination (bleeding may persist up to 45 days) but evidence is not conclusive  
• Risk is lower at earlier gestations  
  o Less than 13 weeks: 0.88 in 1000 terminations  
  o Greater than 20 weeks: 4 in 1000 terminations                                                                                                          |
| Uterine perforation                 | • Risk at the time of surgical termination is 1–4 in 1000  
• Decreased risk of uterine perforation associated with:  
  o Experienced clinician  
  o Use of pre-operative cervical priming  
  o Earlier gestations                                                                                                                                     |
| Uterine rupture                     | • Uterine rupture has been rarely reported in association with mid-trimester medical terminations  
• More frequently associated with later gestational ages and previous uterine scar  
• Risk is less than 1 in 1000 terminations                                                                                                                      |
| Maternal mortality                  | • Estimated at 0.6 per 100,000 terminations  
• First trimester procedures are safer than second trimester procedures  
  o 0.1–0.4 deaths per 100 000 first trimester  
  o 1.7–8.9 deaths per 100 000 second trimester procedures  
• Suction curettage has the lowest rate of any surgical pregnancy termination method                                                                         |
| Psychological sequelae              | • Emotional responses following termination are complex and may change over time  
• Risk factors for post-termination psychological problems may include: previous or concurrent psychiatric illness, coercion, increasing length of gestation, ambivalence and lack of social support, poor relationships with others or religious affiliation  
• Adverse psychological sequelae are no more likely following termination than following continuation of the pregnancy                                                                 |
| Failure to achieve termination of the pregnancy | • All methods of first trimester termination carry a small risk of failure to terminate  
  o Surgical method – approximately 2.3 in 1000  
  o Medical method – risk increases with gestation  
• More likely following early rather than late termination of pregnancy  
• Failed termination of pregnancy while uncommon may lead to fetal anomalies if the pregnancy persists                                                                 |
| Future pregnancies                  | • Conflicting results have been reported about the risk of low-birth weight, premature delivery or spontaneous miscarriage in subsequent pregnancies for women who have had a prior termination  
• There are no proven associations between termination of pregnancy and subsequent ectopic pregnancy, placenta praevia or infertility                                                                 |
Appendix B: Mifepristone and misoprostol protocol after 63 days gestation

Adapted from World Health Organization (2012). "Safe abortion: technical and policy guidance for health systems."

<table>
<thead>
<tr>
<th>Caution: refer to the Australian product information for complete drug information</th>
</tr>
</thead>
</table>

### Day 1: Protocol – all gestations

**Pre-dose care**
- Provide written information to the woman regarding the process of medical termination to be followed
- Take baseline maternal observations (temperature, BP and pulse)
  - If BP greater than 140/90 on two consecutive readings 15 minutes apart then withhold mifepristone and seek medical review
- Confirm review appointment arranged if indicated

**Dose**
- Mifepristone 200 mg oral
- Check BP 15 minutes after mifepristone administration
- Observe for one hour post mifepristone administration in case of nausea and vomiting

### Day 2: Follow protocol according to gestational age

#### 9–12 weeks (64–90 days)
- 36–48 hours after mifepristone*
  - Misoprostol 800 micrograms vaginal
  - Followed by misoprostol 400 micrograms vaginal or sublingual every three hours up to a maximum of four further doses
- If fetus undelivered, consider additional misoprostol dose or surgical procedure
- Administer Rh D immunoglobulin to Rh negative women
- Day 3: Perform ultrasound scan to ensure termination successful

#### 13 weeks to 24 weeks (91–174 days)
- 36–48 hours after mifepristone*
- Misoprostol 800 micrograms vaginal OR misoprostol 400 micrograms oral
- Followed by misoprostol 400 micrograms vaginal or sublingual every three hours up to a maximum of four further doses

#### Greater than 24 weeks
- For pregnancies greater than 24 weeks reduce the dose of misoprostol due to increased sensitivity of the uterus to prostaglandins
- Consider individual circumstances
- Seek expert advice from a higher level service as required

*Misoprostol may be given 24 hours after mifepristone if required
Appendix C: Misoprostol alone protocol
Where mifepristone is not available the following misoprostol alone protocols are recommended. Adapted from World Health Organization (2012). *Safe abortion: technical and policy guidance for health systems.*

<table>
<thead>
<tr>
<th>Pre-care (all gestations)</th>
<th>Pre-care (all gestations)</th>
</tr>
</thead>
</table>
| **Caution:** refer to the Australian product information for complete drug information | • Provide written information to the woman regarding the process of medical termination to be followed  
• Confirm review appointment arranged as indicated  
• Ensure Queensland Health prescribing requirements met [refer to the List of Approved Medicines]  
• Baseline observations: temperature, BP, pulse, vaginal loss, pain level prior to commencement  
• If there is a risk of uterine rupture refer to Appendix D: 2nd trimester misoprostol protocol for increased risk of uterine rupture |

<table>
<thead>
<tr>
<th>Protocol for gestations 12–24 weeks (84–174 days)</th>
<th>Protocol for gestations 12–24 weeks (84–174 days)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Care requirements</strong></td>
<td><strong>Care requirements</strong></td>
</tr>
</tbody>
</table>
| • IV access is recommended  
• Consider cervical priming especially in nulliparous women  
• Observations  
  o Following initial dose of misoprostol – (½ hourly for one hour)  
    § BP, pulse, vaginal loss, contractions, assess pain  
  o Following each subsequent dose of misoprostol (one set)  
    § Temperature, BP, pulse, vaginal loss, contractions, assess pain  
• Offer analgesia  
• Offer antiemetics if required  
• Vaginal examination as clinically indicated  
• Bed rest for 30 minutes after each dose but may mobilise freely at other times  
• If the placenta is not spontaneously delivered within 60 minutes of the fetus (or earlier if excessive bleeding occurs) consider operative removal |

<table>
<thead>
<tr>
<th>Dose</th>
<th>Dose</th>
</tr>
</thead>
</table>
| • Misoprostol 400 micrograms vaginal or sublingual  
• May be repeated every three hours up to a maximum of four further doses |

<table>
<thead>
<tr>
<th>Protocol for gestations greater than 24 weeks (&gt; 175 days)</th>
<th>Protocol for gestations greater than 24 weeks (&gt; 175 days)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gestations greater than 24 weeks</strong></td>
<td><strong>Gestations greater than 24 weeks</strong></td>
</tr>
</tbody>
</table>
| • Reduce the dose of misoprostol due to increased sensitivity of the uterus to prostaglandins  
• Consider individual circumstances  
• Seek expert advice from a higher level service as required |
Appendix D: 2\textsuperscript{nd} trimester misoprostol protocol in cases with increased risk of uterine rupture

<table>
<thead>
<tr>
<th>Aspect</th>
<th>Good practice points</th>
</tr>
</thead>
</table>
| Pre-care | • Ensure Queensland Health prescribing requirements met [refer to the List of Approved Medications (LAM)]  
• Baseline observations: temperature, BP, pulse, vaginal loss, pain level prior to commencement  
• IV access is recommended  
• Consider cervical priming especially in nulliparous women |
| Observations | • Following initial dose – (½ hourly for one hour)  
  o BP, pulse, vaginal loss, contractions, assess pain  
• Following each subsequent dose of misoprostol  
  o Temperature, BP, pulse, vaginal loss, contractions, assess pain |
| Care requirements | • Offer analgesia  
• Offer antiemetics if required  
• Vaginal examination as clinically indicated  
• Bed rest for 30 minutes after each dose but may mobilise freely at other times  
• If the placenta is not spontaneously delivered within 60 minutes of the fetus (or earlier if excessive bleeding occurs) consider operative removal |

Caution: refer to Australian pharmacopeia for complete drug information

### Dosing for previous uterine surgery

**Initial dose:**
- Misoprostol 200 micrograms inserted into the posterior fornix of the vagina

**Subsequent doses:**
- If undelivered at 4 hours after initial dose, then misoprostol 200 micrograms inserted into the posterior fornix of the vagina every 4 hours for 4 doses
- If undelivered at 24 hours after initial dose, then commence misoprostol 400 micrograms inserted into the posterior fornix of the vagina every 6 hours for a maximum of 4 doses
- If undelivered at 48 hours after initial dose, then review by an obstetrician is indicated. Options may include:
  - Continue with misoprostol 400 micrograms 6 hourly or
  - Rest day then recommence or
  - IV Oxytocin is most effective if some effacement and dilation has occurred
  - Surgical delivery

*Adapted from Royal Brisbane and Women’s Hospital Work Unit Guideline: Administration of mifepristone and misoprostol in medical induction of labour at less than 28 weeks gestation where a live birth is not the expected outcome*
## Appendix E: Aftercare advice

<table>
<thead>
<tr>
<th>Aspect</th>
<th>Good practice points</th>
</tr>
</thead>
</table>
| Vaginal bleeding          | • Use sanitary pads rather than tampons to limit the risk of infection  
• Bleeding may occur with or without clots  
• Bleeding may last for up to 2 weeks after a surgical termination and up to six weeks after a medical termination  
• Bleeding generally decreases over the weeks  
• If bleeding is continuous and heavy (e.g. more than one pad soaked per hour for more than three hours) seek urgent medical attention |
| Pain                      | • Over the counter pain medicines (analgesia) such as Ibuprofen can be used  
• Hot packs or hot water bottles may provide relief for abdominal cramps |
| Infection                 | • If there are signs of infection seek medical attention  
• Signs of infection include fever, lethargy, offensive vaginal discharge, excessive pain |
| Ectopic pregnancy         | • There may be a possibility of ectopic pregnancy – especially if the pregnancy site was not confirmed by ultrasound scan before the procedure  
• If there is increasing pain and/or a reoccurrence of vaginal bleeding seek medical assistance |
| Breast discomfort         | • Can persist for two weeks (especially after mid trimester terminations)  
• Lactation can occur (at later gestations)  
• Advise physiological management of breast discomfort (not stimulating, firm supportive bra, cold packs, analgesics)  
• Consider pharmacological lactation suppression with caution 52 |
| Sexual intercourse        | • Avoid sexual intercourse while still bleeding to limit the risk of infection |
| Future fertility          | • Fertility can return immediately so contraception can be initiated immediately if having sexual intercourse  
• Urine pregnancy tests are not reliable until at least 4–6 weeks post-termination because human chorionic gonadotropin levels may still be discernible and distort test results |
| Menstruation              | • May commence within 3 weeks of termination but in some cases can take up to 9 weeks  
• If menstruation has not commenced within 4–6 weeks post-termination, perform a pregnancy test |
Acknowledgements
The Queensland Clinical Guidelines gratefully acknowledge the contribution of Queensland clinicians and other stakeholders who participated throughout the guideline development process.

Working Party Members
The multidisciplinary working party for the guideline *Termination of pregnancy* included representatives from the following professions and disciplines:

- Obstetrics
- Midwifery
- Mental Health
- Allied Health
- Pharmacology
- Maternal Fetal Medicine
- Law
- Medical Health Administration
- Consumer
- Ethicist

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