

MODIFIED REGIMEN FOR MID-TRIMESTER MEDICAL TERMINATION: ASSESSMENT OF SAFETY AND EFFECTIVENESS

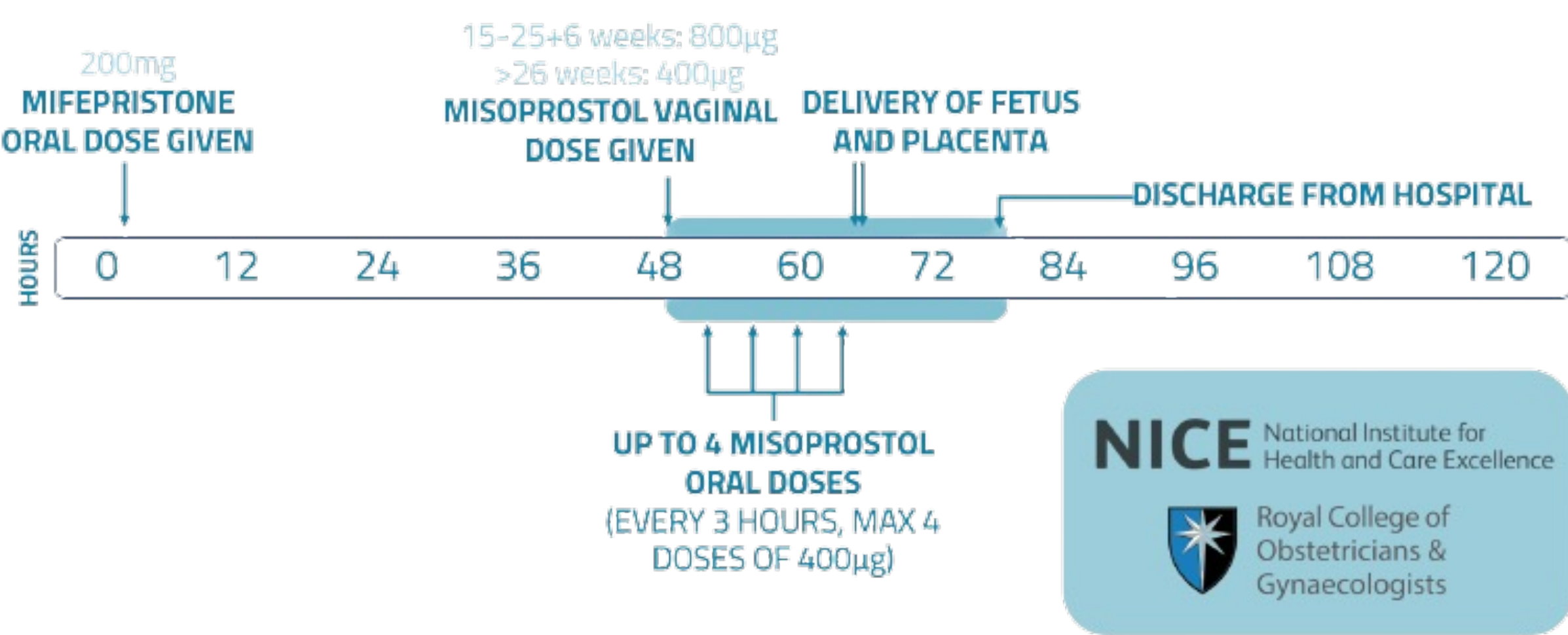
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BACKGROUND

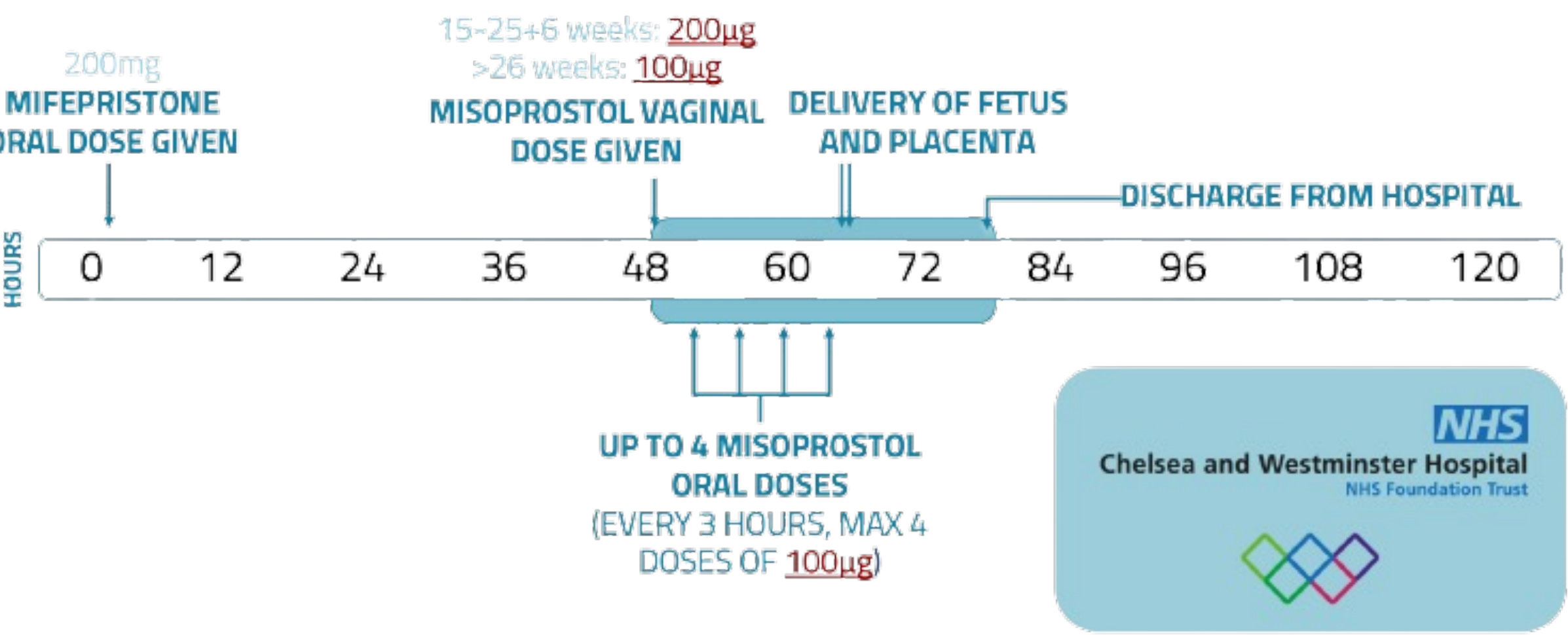
Up to one in six terminations of pregnancy occur beyond the first trimester, often due to fetal anomalies¹. Given the significant psychological and physiological impact of terminations², particularly beyond the first trimester, there is a **need for an effective, safe and streamlined process**. The current protocol for medical terminations recommended by RCOG/NICE^{3,4} is 200mg of mifepristone orally, followed by 800µg misoprostol vaginally and up to four subsequent doses of 400mg of misoprostol orally. Concerns regarding the risk of uterine rupture (1 in 1000) at these high misoprostol doses have prompted the consideration of lower doses¹. The aim of this study is to review the safety and effectiveness of a modified regimen for mid-trimester medical terminations at Chelsea and Westminster Hospital NHS Foundation Trust.

following fetocide. The remaining 79 patients were started on a regimen of 200mg of mifepristone orally, followed by 200µg of misoprostol vaginally (100µg in women with previous c-sections or beyond 26 weeks gestation) and then up to four 100µg misoprostol doses. Where one cycle was unsuccessful, a consultant review occurred. Data on demographics, pregnancy-related factors, adherence to protocol and outcomes was collected.

Protocol recommended by NICE/RCOG^{2,3}

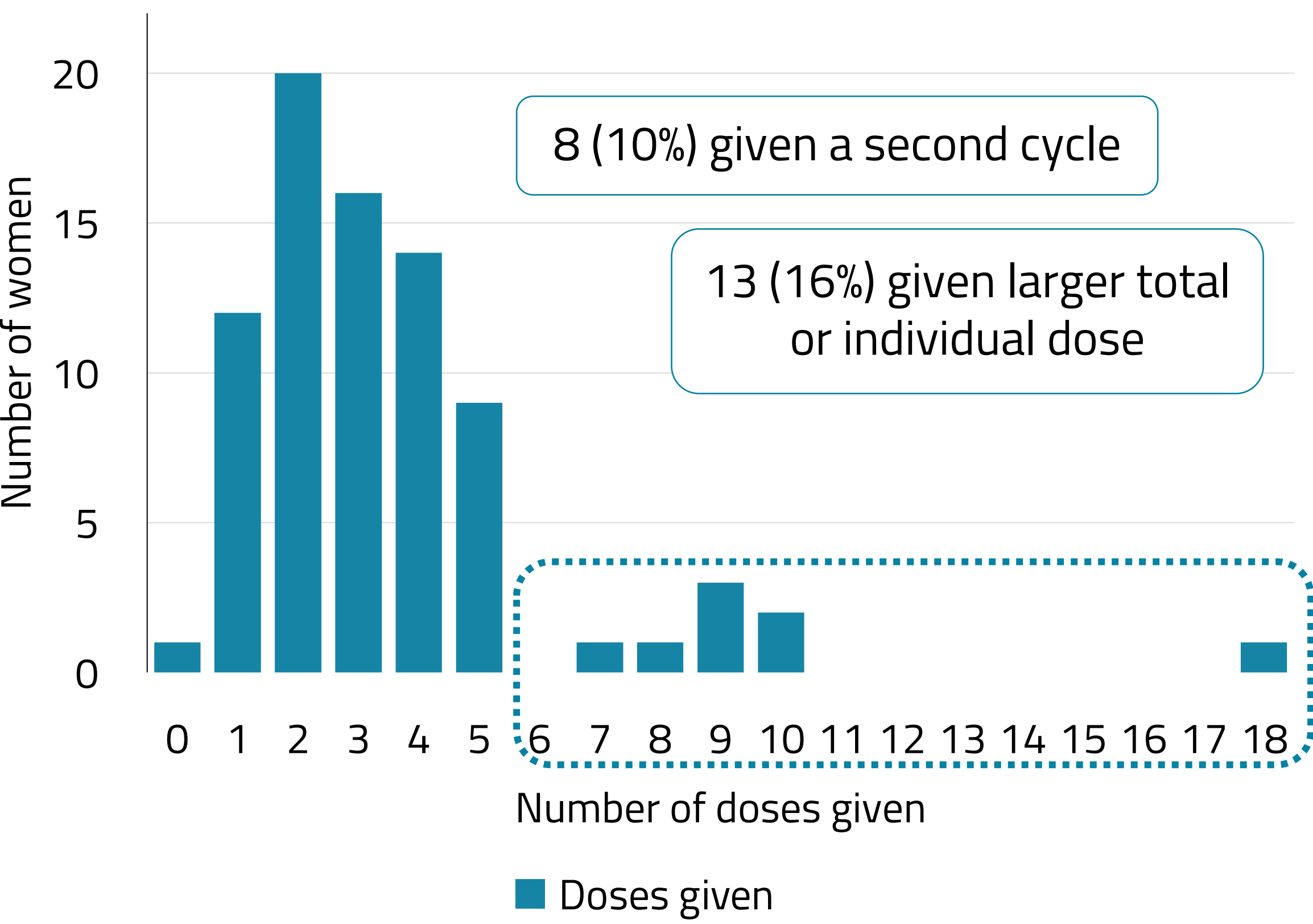


Protocol at Chelsea and Westminster Hospital



Results

One woman delivered following mifepristone alone. Of the 78 women given misoprostol, **93% (n=73) delivered within 48 hours** and 97% (n=76) within 72 hours of the first dose. Two women took over three days to deliver, involving multiple cycles with rest times. A total of **23% of women (n=18) required surgical intervention**, with 89% (n=16) of these for retained placental tissue. 36% of women (n=28) experienced side effects or adverse events, however most were known side effects of misoprostol. The median blood loss was 150ml. There were **no cases of uterine rupture**. These results are comparable to the outcomes achieved using current RCOG/NICE recommendations.



DOSES OF MISOPROSTOL	1	2	3	4	5	>5	TOTAL
Number of women (n=78)	12 (15%)	20 (25%)	15 (19%)	14 (18%)	9 (12%)	8 (10%)	n/a
Cumulative (%)	16	41	60	78	90	100	n/a
Surgical intervention (n=18)	4 (33%)	4 (20%)	2 (13%)	2 (14%)	2 (22%)	5 (63%)	18 (23%)

Conclusion

The implementation of a modified regimen demonstrated comparable clinical effectiveness and a reduced risk of major complications compared to regimens using higher misoprostol doses.

However, it was associated with prolonged hospital stay and the need for additional cycles in some women. This study shows that **use of a modified regimen is an effective and safe option** that could be offered to women and can be continued in our trust.

References

- (1) World Health Organisation (WHO). Abortion. Available from: https://www.who.int/health-topics/abortion#tab=tab_1
- (2) Soet, Brack, Dilorio. (2003) Prevalence and predictors of women’s experience of psychological trauma during childbirth. *Birth*.
- (3) RCOG. (November 2011) The Care of Women Requesting Induced Abortion. Evidence-based clinical Guideline Number 7.
- (4) NICE. (April 2019). Guideline: Termination of Pregnancy.

Methodology

Design: A retrospective study of all women undergoing medical termination of pregnancy between 1st January 2019 and 31st April 2022 under clause E.

Methods: A total of 82 women fulfilled the inclusion criteria. Three women aborted spontaneously