PIPADOR REVISION

MRCOG Part 1 Revision Notes

Termination of Pregnancy

CLINICAL MANAGEMENT • LECTURE 493

VISUAL EXAMINATION REVISION NOTES

2026 Edition

493

MRCOG PART 1 REVISION NOTES | CLINICAL MANAGEMENT

Termination of Pregnancy

Legal framework, methods by gestation, aftercare and complications of abortion (Abortion Act 1967, NICE NG140)

≈ 250,000	Ground C	≤ 9+6 wk	Anti-D
Abortions/year (England & Wales)	> 95%	Home medical abortion (telemed.)	If RhD− and > 10 weeks

■ KEY FACTS: Learning objectives

- Define induced abortion, medical and surgical abortion and the legal framework (Abortion Act 1967).
- Describe assessment and the choice of method by gestation (NICE NG140).
- Describe aftercare: anti-D, contraception, STI screening, complications and follow-up.

493.1 Key definitions

Term	Definition
Induced abortion (termination of pregnancy)	Deliberate ending of a pregnancy
Early medical abortion (EMA)	Mifepristone followed by misoprostol up to 9+6 weeks — can be taken at home after telemedicine consultation (England, Wales, Scotland)
Surgical abortion	• Vacuum aspiration (MVA or electric) up to ≈ 14 weeks • Dilatation and evacuation (D&E) from ≈ 14 weeks
Cervical priming	Misoprostol (or mifepristone/osmotic dilators) before surgical abortion
Feticide	Induced fetal asystole (intracardiac KCl) before medical abortion from 21+6 weeks
HSA1 / HSA4 forms	Certificate of opinion signed by two doctors / notification to the Chief Medical Officer

■ IN PLAIN ENGLISH: Termination of pregnancy

Abortion is a common, safe procedure when provided early by trained staff. Care should be **prompt, non-judgemental and woman-centred**, offering a choice of method and planning contraception.

493.2 Legal framework

Abortion Act 1967 (amended 1990) — grounds (England, Wales, Scotland)

A	B	C (≤ 24 wk)
Risk to life of the woman greater than if pregnancy terminated	Prevent grave permanent injury to physical/ mental health	Risk to woman's physical or mental health greater than if terminated — > 95% of abortions

D (≤ 24 wk)	E	F & G
Risk to health of existing children	Substantial risk that the child would have serious physical/mental abnormalities — no upper gestation limit	Emergency: save life / prevent grave injury — one doctor, no prior second signature

Figure 493.1 — Grounds for abortion (Abortion Act 1967)

- Two registered medical practitioners must certify in good faith (except emergencies); nurses/midwives can administer abortion medication.
- Northern Ireland: abortion decriminalised (2019) — on request to 12 weeks; Scotland follows the 1967 Act.
- Conscientious objection: doctors may object to participating, but must refer and must provide emergency care.
- Recent parliamentary changes (England & Wales) have addressed criminal liability for women ending their own pregnancies — check current legislation.

493.3 Methods (NICE NG140)

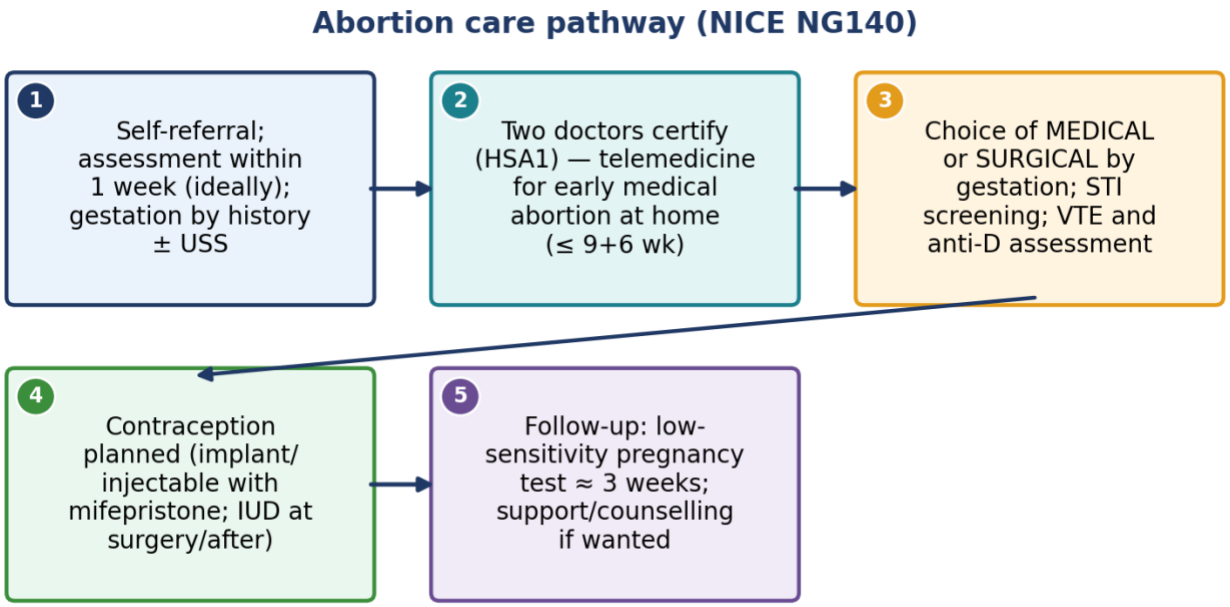


Figure 493.2 — Abortion care pathway

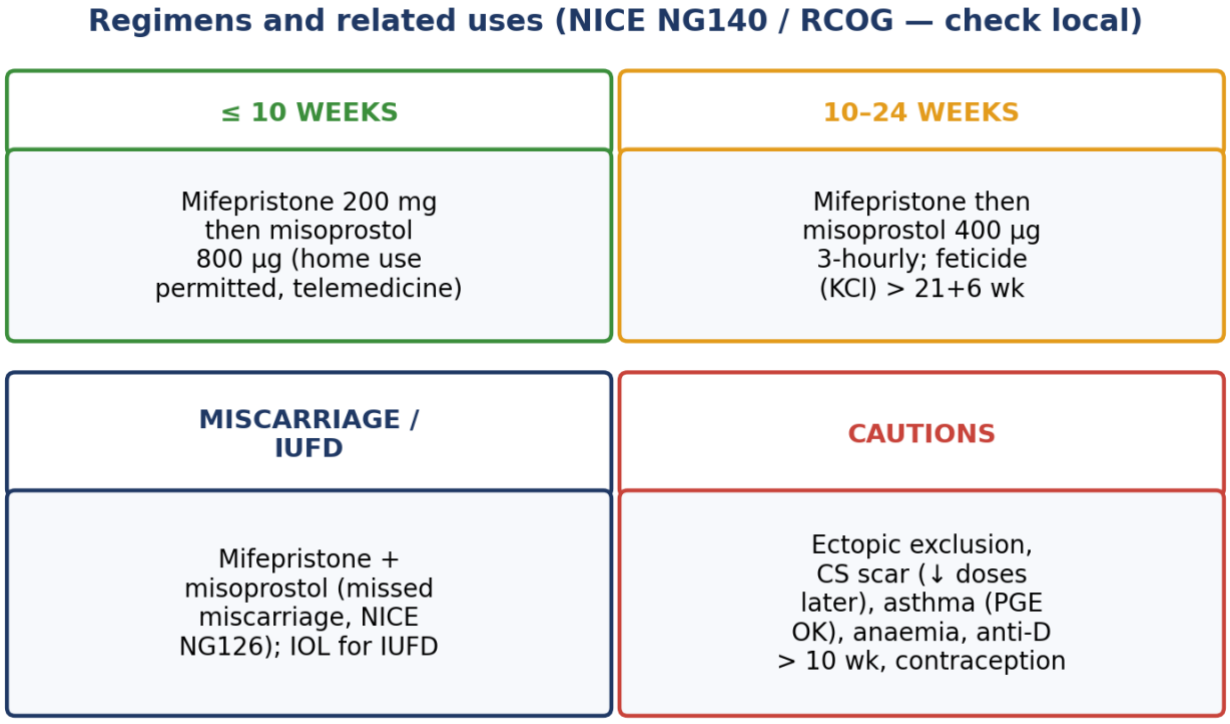


Figure 493.3 — Medical regimens

Gestation	Options
Up to 9+6 weeks	• EMA: mifepristone 200 mg, then misoprostol 800 µg 24–48 h later (or simultaneously) — at home • Or surgical vacuum aspiration (local/sedation)
10+0 – 13+6 weeks	Medical (mifepristone then misoprostol 800 µg then 400 µg every 3 h) or surgical vacuum aspiration with cervical priming

Gestation	Options
14+0 – 23+6 weeks	• Medical (mifepristone, then misoprostol 400 µg every 3 h) or surgical D&E with cervical priming • Feticide from 21+6 weeks for medical abortion
Ectopic exclusion	USS not mandatory before EMA if no risk factors/symptoms — but required if any doubt about gestation or location

493.4 Aftercare

Topic	Recommendation
Anti-D	Offer to RhD-negative women having an abortion after 10+0 weeks (not needed before 10+0 for medical abortion)
STI	• Test for chlamydia/gonorrhoea • Antibiotic prophylaxis for surgical abortion
VTE	Risk assessment, particularly for later surgical/medical abortion
Contraception	• Discuss before • Implant/injectable can be given with mifepristone • IUD/IUS at surgical abortion or after medical abortion is complete • CHC/POP start day of misoprostol
Pain relief	NSAIDs (do not reduce efficacy), paracetamol, ± opioids
Follow-up	• Low-sensitivity urine pregnancy test at ≈ 3–4 weeks for EMA • Seek help for heavy bleeding, fever, pain, continuing pregnancy symptoms
Support	Access to counselling if wanted; safeguarding where indicated

- **Complications**: haemorrhage (≈ 1 in 1,000; more later)
  - Infection (≈ 1 in 10 — reduced by prophylaxis)
  - Incomplete abortion/continuing pregnancy (≈ 1–2% medical)
  - Uterine perforation (surgical ≈ 1–4/1,000)
  - Cervical injury (rare)
  - No proven association with future infertility, breast cancer or mental illness.

■ COMMON PITFALLS

Delaying care (risks rise with gestation).

Giving anti-D unnecessarily before 10 weeks or forgetting it after.

Not planning contraception at the time of abortion.

493.5 Must-know summary

■ EXAM TIP

- Abortion Act 1967: 2 doctors; ground C (> 95%) to 24 wk; E (abnormality) no limit; emergency F/G.
- EMA ≤ 9+6 wk at home (mifepristone 200 mg → misoprostol 800 µg); surgical vacuum aspiration to ≈ 14 wk, D&E after.
- Anti-D if RhD-negative after 10+0 wk; STI testing; contraception planned; pregnancy test at 3–4 weeks.
- Complications: bleeding, infection, incomplete abortion, perforation; no ↑ infertility.

■ MNEMONIC / MEMORY AID

Abortion aftercare — 'Anti-D, Antibiotics/STI, Analgesia, Avoid pregnancy (contraception)'.