MEDICAL TERMINATION OF PREGNANCY FOR FETAL ABNORMALITY AND FETOCIDE

INTRODUCTION
- Obtain written informed consent, together with written agreement of two certified medical practitioners who have signed HSA1 form (Abortion act 1967 revised 1991)
- Guidance from Royal College of Obstetricians and Gynaecologists on termination of pregnancy for fetal abnormality stresses that a legal abortion 'must not be allowed to result in a live birth' www.rcog.org.uk/search/node/termination. Therefore, method of termination of pregnancy after 21 weeks, should ensure fetus is born dead
- Where termination is planned >21+6 weeks for abnormalities that are not lethal, consultant in fetal medicine must discuss fetocide with woman
- If woman refuses fetocide, document clearly in notes that it has been offered and declined

Recommended drug regimen

Initial drug dose
- Mifepristone (Mifegyne RU 486) 200 mg oral is administered by senior obstetrician on licensed premises and a healthcare professional must observe woman take tablet
- Inform woman of possibility of abdominal discomfort and/or a small amount of bleeding
- Reassure that this is normal and can be treated with regular paracetamol at home
- Ask woman to remain on premises for 1 hour to observe side effects
- If vomiting occurs, repeat dose
- Induction may commence at this point or, should the woman wish, she may go home and return the following day
- Provide telephone numbers for delivery suite with instructions to call if she has any concerns while at home

Further drug regimen
- No more than 24–72 hr after initial dose of mifepristone 200 mg oral, give misoprostol:
  - <26 week’s gestation: 100 microgram vaginally 6-hrly – maximum 4 doses
  - >27 week’s gestation: 25–50 microgram vaginally 4-hrly – maximum 6 doses

In previous caesarean section or uterine surgery, where the cavity has been breached (e.g. myomectomy, uterine perforation) use 25–50 microgram dosage

Side effects/complications associated with misoprostol
- Pyrexia
- Diarrhoea
- Retained placenta
- Hypovolaemic shock
- Ruptured uterus
- Extra vigilance in women with:
  - severe asthma
  - previous operative delivery
  - cardiovascular insufficiency
  - previous caesarean section
  - anticoagulant treatment
  - renal/hepatic failure
  - long-term corticosteroid therapy
- Advise woman she may experience flu like symptoms e.g. feeling febrile or rise in temperature

Management of third stage
- Once fetus and placenta delivered, give 1 mL syntometrine IM
- If woman hypertensive, give 10 units syntocinon IM or 5 units by slow IV bolus
• If delay in delivery of placenta, see Retained placenta guideline or follow local procedure for management of retained placenta
• In general, woman should be cared for as if she had experienced any other fetal loss (see Fetal loss guideline)

Notifying Department of Health
• Doctor responsible for commencing termination of pregnancy is required, by law, to notify Department of Health by submitting relevant (yellow HSA4) form

FETOCIDE
Definition
• Intracardiac injection of potassium chloride to induce fetal death before termination of pregnancy

Informed consent
• Counsel woman about reasons for carrying out fetocide and explain legal position and ethical implications should baby be born alive

Pre-termination assessment
• Carried out by trained staff who will provide counselling and support
• Perform ultrasound scan immediately before procedure to confirm presence of fetal abnormalities and select suitable site for needle entry
• For fetus with chromosomal abnormality, scan features may not be present. Laboratory report must be available to consultant before fetocide performed

Procedure
• Identify suitable entry site and clean abdomen and probe with antiseptic solution
• Anaesthetise skin and subcutaneous tissues with lidocaine 1% 5–10 mL
• Draw 1.5 g in 10 mL potassium chloride 15% (KCl) into a new syringe
• Place aqueous gel onto probe to facilitate scanning
• Under ultrasound guidance, insert 21 gauge echo tip needle into fetal heart
• Using a 5 mL syringe, withdraw a small volume of fetal blood to confirm correct placement of needle. If required, send blood for cytogenetic analysis
• Slowly inject 2–3 mL KCl solution into fetal heart until cardiac activity stops
• Remove and discard into sharps container
• Allow mother to rest for 5–10 min before performing a confirmatory scan to check fetal cardiac activity has not resumed
• Transfer mother to delivery suite to complete termination