University Hospitals of Derby and Burton NHS Foundation Trust

Pregnancy Advisory Clinic - Full Clinical Guideline
Service only available location RDH

Gynae/01:24/T1

Contents

1. Introduction

This document provides guidance for doctors and nurses looking after women considering and/or having a termination of pregnancy (TOP).

2. Purpose and Outcomes

To ensure that a woman's rights to privacy, dignity and confidentiality are respected at all times.

To ensure that the request for termination of pregnancy lies within the terms of the Abortion Act 1967 and modifications introduced by the Human Fertilisation and Embryology Act 1990.

To ensure that termination of pregnancy is provided as an integral part of broader sexual health services.

3. Abbreviations

ßhcg	-	Beta Human Chorionic Gonadotrophin
BP	-	Blood Pressure
CNS	-	Clinical Nurse Specialist
COCP	-	Combined Oral Contraceptive Pill
C & S	-	Culture and Sensitivity
FEPS	-	Fertility & Early Pregnancy Scan
GA	-	General Anaesthesia
GOPD	-	Gynaecology Out-Patient Department
GAU	-	Gynaecology Assessment Unit
GP	-	General Practitioner
HIV	-	Human Immunodeficiency Virus
iCM	-	iSoft Clinical Manager
LA	-	Local Anaesthesia
MTOP	-	Medical Termination of Pregnancy
MVAC	-	Manual Vacuum Aspiration (STOP under local anaesthetic)
POC	-	Products of Conception (Preferred term is pregnancy tissue)
PR	-	Per Rectum
POP	-	Progesterone Only Pill
PV	-	Per Vagina
STI	-	Sexual Transmitted Infection
STOP	-	Surgical Termination of Pregnancy
TOP	-	Termination of Pregnancy
VTE	-	Venous Thromboembolism

4. Key Responsibilities and Duties

All staff caring for these women have a responsibility to ensure care and dignity is given in all circumstances. Healthcare professionals should not allow their personal beliefs to delay access to abortion services.

When caring for women who are having an abortion, be aware of:

- The anxiety they may have about perceived negative and judgemental attitudes from healthcare professionals.
- The impact that verbal and non-verbal communication may have on them.

Services should be sensitive to the concerns women have about their privacy and confidentiality, including their concerns that information about the abortion might be shared with healthcare professionals not directly involved in their care.

5. Making an Appointment for counselling in The Pregnancy Advisory Clinic

Women can be referred into the clinic by:

- Internally e.g GAU / ANC through the PAC team
- Their G.P or Allied Healthcare professional
- Independent Service Provider e.g BPAS, NUPAS, MSI
- Contraception and Sexual Health Service (CASH) and/ or GUM services
- School Nurses
- SV2 - Supporting Victims of Sexual Assault
- Drug and alcohol Services
- Self Referrals (If not registered with a GP or do not wish to disclose to their GP). In these instances, please contact the pregnancy nurse mobile on 07788388412.

The referrer must send a referral letter accompanied by a signed Abortion Act 1967 Certificate HSA1, to facilitate prompt treatment for the woman. Appointments are to be made via;

i) Choose and Book system

ii) Email to dhft.gynaecology@nhs.net .This referral will then be triaged by the appointments team for allocation to a PAC appointment.

iii) Internal trust referrals can be emailed to the PAC team uhdb.top@nhs.net or discussed with the PAC Nurse on 07788388412

For all Urgent problems (e.g. Patient has complex medical problems) please contact Gynaecology Consultant on-call.

The Gynaecology outpatients team will contact the woman by telephone taking into account any special instructions detailed in their referral information (e.g. a request for no correspondence to be sent to a home address). Patients from out of area are encouraged to bring in any information regarding past medical history from different Healthcare providers.

Patients under 16 years of age must attend a consultant clinic (*see section 10 on Special Patient groups).*

Referral to Treatment Pathway
To minimise delay, service arrangements are that:

- An appointment to PAC should be offered within one week of referral.
- Termination should be provided one week of their decision to proceed.
- Same day treatment is available for patients suitable for the Early medical at home pathway or Surgical management under local anaesthetic (Wednesday clinic)
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- Women requiring abortion for urgent medical reasons should be seen as a priority.

For women who would prefer to wait longer for an abortion, help them to make an informed decision by explaining the implications, including:

- the legal limit for abortions, as stated in the Abortion Act
- that delaying the abortion will affect their options for treatment and may increase the risk of complications, although the overall risk is low.

6. Initial Consultation- Counselling Women Considering Termination of Pregnancy

On arrival to their appointment the patient will be asked to complete a self-assessment medical questionnaire to record her past obstetric, gynaecological and medical history.

Routine observations including pulse, blood pressure, height and weight (BMI) and temperature will be taken.

Ultrasound scan will be carried out on all patients attending and this will exclude the possibility of an ectopic pregnancy. (check above paragraph)

Abortion before definitive ultrasound evidence of an intrauterine pregnancy

Consider abortion before there is definitive ultrasound evidence of an intrauterine pregnancy (a yolk sac) for women who do not have signs or symptoms of an ectopic pregnancy.

For women who are having an abortion before there is definitive ultrasound evidence of an intrauterine pregnancy (a yolk sac):

- explain that there is a small chance of an ectopic pregnancy.
- explain that they may need to have follow-up appointments to ensure the pregnancy has been terminated and to monitor for ectopic pregnancy.
- provide 24-hour emergency contact details, and advise them to get in contact immediately if they develop symptoms that could indicate an ectopic pregnancy.

6. 1 Establishing the gestation

- Check date of last menstrual period
- Ultrasound scan to establish gestational age. Women should be informed a transvaginal examination may be required. If the patient has already undergone a scan through GAU, a recognised independent provider (BPAS) or another NHS trust a further scan is not required unless the clinical picture has changed.

Gestation of pregnancy will have some influence over the method of Termination of pregnancy (see individual sections for eligibility criteria).

TOP is available up to 17^{+6} weeks at the Royal Derby Hospital. For gestations beyond this the patient will need to self-refer to an alternative provider e.g. British Pregnancy Advisory Service (03457304030 or email at info@bpas.org)

6.2 Document the following medical history (initially completed by the patient and confirmed by clinician)

- Obstetric, gynaecological, medical and anaesthetic history.
- Medication history and any known allergies.
- VTE risk assessment (anti-coagulation may need to be prescribed pre & post TOP)
- Assess smoking status, plus any alcohol and/or drug consumption.
- Assess for the risk of domestic abuse or any child protection concerns.

6.3 Exploring their request for termination of pregnancy

Counselling is the process of enhancing a patient's ability to assess and understand her situation, evaluate her options, to make an informed choice or decision.

- What the pregnancy means to the woman, e.g. planned, unplanned, ambivalence
- Reason for request for termination of pregnancy and what stage of decision-making the woman has reached, e.g. certain, very unsure.
- Available support network

  The options available (e.g. termination, continue with pregnancy, adoption) and also the medical, social, financial and cultural implications and sources of help available.
- Women are not required to have compulsory counselling or compulsory time for reflection before the abortion. Provide or refer women for support to make a decision if they request this. (referred to: 'Talk it over Derby')

- Methods of termination available and the potential complications and risks. Provide information about the differences between medical and surgical abortion (including the benefits and risks), taking account of the woman's needs and preferences. Do this without being directive, so that women can make their own choice.

6.3.1 Patient information

Reassure women that having an abortion is not associated with increased risk of infertility, breast cancer or mental health issues.

- For women who would prefer to wait longer for an abortion, help them to make an informed decision by explaining the implications, including:
    - the legal limit for abortions, as stated in the Abortion Act
    - that delaying the abortion will increase the risk of complications, although the overall risk is low.
    - Provide information in a range of formats as required.
    - Provide women with information about the different options for management and disposal of pregnancy remains.
      For women having a TOP for fetal anomalies, explain to her that there may not be any physical signs of a fetal anomaly.

6.4 Offer women the option to discuss contraception

- Method(s) used in the past and contraceptive failures.
- Future pregnancy plans E.g. Long-term family planning.
- Advise women the ability to conceive can return within 5 days of a TOP.
- Establish a firm plan for contraception and document.
- Prescribe agreed contraception & discuss a bridging method if unable to provide LARC.
- Advise additional use of condoms to protect against sexually transmitted infections.
- Ensure woman aware of emergency contraception (including IUCD) and how to access it.
- Nexplanon insertion is currently only provided if a trained clinician is available.

6.5 Investigations

STI screening

Check previous history of sexually transmitted infection (STI) and whether symptomatic or receiving treatment. Refer all asymptomatic ladies to SH:24 website to access self-swabbing for chlamydia, gonorrhoea and bacterial Vaginosis. If symptomatic, refer patients to Derbyshire integrated sexual health service (GUM) for a comprehensive STI screen and partner notification programme.

Pre Procedure investigations

A FBC is only required in the following circumstances:
- in patients known to have a history of anaemia
- those at high risk of bleeding (known bleeding disorder or on high dose anticoagulants)
- those whom have had a baby within the last 12 months.

A Group & save is only require for
1.Rhesus status

-For surgical treatment (either local or general anaesthesia)
-For medical treatment at gestation > 10 weeks
Historical Blood group from our ePR (e.g from previous treatments or pregnancies) can be used

For those known to be Rhesus Negative a current sample is needed for Anti-D to be issued.

2. Where there is a bleeding risk concern:
Medical TOP >13 weeks gestation up to 17+6.
History of Anaemia or Hb < 100
High bleeding risk

Arrange additional investigations if clinically indicated or relevant to patient's medical history e.g. ECG or LFTs. Inform anaesthetist (Via anaesthetic office) in advance if high risk patient attending for surgery. Inform the Gynaecologist consultant on call if high risk patient is attending for inpatient medical termination.

6.6 Discussion with patient regarding consent for Sensitive disposal

This document is NOT required for ladies having early medical management of TOP at home.

i) Sensitive disposal form
(Triplicate form: White – Case notes, Yellow-Mortuary, Pink – Patients personal records)

In the UK the disposal of pregnancy tissue is regulated by the Department of Health with guidance from the Human Tissue Authority. The Lord Bonomy's Infant Cremation Commission Report (see references) requires documented consent for the disposal of all pregnancy loss up to and including 23^{+6} days gestation, irrespective of cause or origin (e.g. includes elective termination of pregnancy.

Women should be made aware of their options for sensitive disposal and given verbal or written information. The trust's standard procedure is that the mortuary sends all PREGNANCY TISSUE for shared cremation at Markeaton Crematorium. "Shared Cremation" is the preferred term for discussing collective disposal in a crematorium with patients.

The information provided to patients should still include an explanation for disposal even if the woman:

i) does not wish to make a decision.

ii) prefers the hospital to perform our standard procedure

Some women may not wish to know and may decline the information, but this should still be documented. Patients should be advised that pregnancy tissue is respectfully held by the mortuary for 14 days after the termination should they need some time to make a decision of change their preference.

If a woman prefers to make her own sensitive disposal arrangements e.g. burial arrangements, the "sensitive disposal paperwork" must still be completed and signed by the patient and the clinician. Women are allowed to take their pregnancy tissue home with them if they wish to make their own arrangements.

Please note the "Sensitive Disposal form"

- In PAC is different to that used by GAU when a woman attends with a miscarriage (See Appendix B)

- Does not include a request for histopathology – this is rarely needed for a TOP and therefore would need to be separately requested by the clinician.

ii) Application form for shared cremation form (Carbon book)
This form does not require a signature from the patient. The consultant signs the shared form to confirm that a patient has consented to sensitive disposal (by completing the above paperwork). It also allocates a "batch number" and is completed by staff in:

- Theatre (GA STOP)
- GOPD (MVAC)
- 209 (Late MTOP)
- Day case 209 (MTOP)

6.7 Paperwork

- Explain their chosen method of TOP and discuss risks involved. This must include discussion of symptoms to expect after the termination and how to seek advice. Complete the pathway booklet and prescribe drugs and contraception and include on consent form.

- Ensure Sensitive disposal form discussed and signed by patient.

- Sign Abortion Act Form HSA1 (2 signatures required)

The first signature is usually the PAC clinician. The notes are then reviewed by a second doctor who must document in the notes that they have done so and to support the patient's request for termination.
The EMA1 (Certificate C) will also need to be completed by the original clinician if EMAH < 10 /40 has been decided
A completed HSA received from the Independent Sector can also be used

Complete VTE Risk assessment and prescribe anticoagulation therapy if clinically indicated. Click here for link to VTE in pregnancy guideline

Waiting list form if patients are being listed for STOP under general anaesthesia.

The HSA4 form (yellow form) is now completed online and will be completed by the operating surgeon for MVAC/STOP or by the medical secretaries for MTOP once the procedure has been completed.

7. Medical Termination of Pregnancy

Contra-Indications / Caution for mifepristone / misoprostol
Mifepristone and misoprostol should be used with caution in certain conditions:

Absolute contra-indications

- Inherited porphyria
- Chronic adrenal failure
- Known or suspected ectopic pregnancy.
- Uncontrolled severe asthma
- Previous allergic reaction to one of drugs involved.

Caution required in the following circumstances (discuss with senior medical staff)

- Woman on long-term corticosteroids
- Asthma (avoid if severe)
- Haemorrhagic disorder or anticoagulant therapy
- Prosthetic heart valve or history of endocarditis
- Pre-existing heart disease
- Hepatic or renal impairment
- Severe anaemia
- Severe inflammatory bowel disease e.g. Crohns
- IUCD in place (remove pre procedure)
- Smokes more than 20/day and over 35 years of age.
- ≥ 3 previous Caesarean sections or Caesarean section < 6months.

From August 2022 the legal status of Mifepristone has been changed following the Covid-19 Pandemic. This means a patient's home is now "licensed for Mifepristone use" (previously had to be an improved healthcare setting) where the gestation is LESS 10 weeks.

7.1 Early Medical Abortion at Home (EMAH) Up to 9 weeks and 6 days

Evidence has clearly demonstrated that home self-administration of misoprostol is a safe method of TOP, with no higher risk of complications than medical TOP as a day case. (1) This offers additional choice to women requesting a TOP and, in addition to practical and logistical benefits, enables women to complete treatment in an environment where they feel most comfortable. Women meeting the inclusion criteria will be given the option to take Mifepristone after their consultation appointment. The majority of women will be able to go home to self-administer misoprostol 24 to 48 hours later to pass the pregnancy.

Ensure the woman fully understands what to expect with regards to pain and vaginal bleeding during and after the termination. The woman must have a responsible adult at home for support.
Ensure that the woman understands:

- that they may see the products of pregnancy as they are passed
- what the products of pregnancy will look like

For women who are having a medical abortion at home, explain how to be sure that the pregnancy has ended (see follow-up after medical abortion up to and including 9+6 weeks).

Inclusion Criteria

- Certain of decision to have a TOP and wishes to pass the pregnancy at home.
- Fulfils the criteria set out in the Abortion Act 1967
- ≤ 9 weeks + 06 days confirmed pregnancy on the day of mifepristone administration.
- 16 years of age or above, unless considered clinically appropriate.
- Adult to be at home with them following the self-administration of misoprostol.
- No significant medical conditions or contraindications to medical TOP (see above)
- If patient is unable to speak English please ensure they have someone at home to support them through the process who has a good understanding of English and is able to interpret information as required.
- No cause for concern regarding wellbeing at home.
- Fully understands the need to perform a home pregnancy test 3 weeks post procedure for confirmation of successful termination.

Mifepristone administration

This is likely to occur following the clinic consultation with the clinician.
For women who are having a medical abortion up to and including 9+6 weeks' gestation, give them the choice of having mifepristone and vaginal misoprostol at the same time, but explain that:

- the risk of ongoing pregnancy may be higher, and it may increase with gestation.
- it may take longer for the bleeding and pain to start.

1. Confirm that patient is certain of decision to proceed with TOP, including the vaginal self-administration of misoprostol at home.

2. Check that patient will have an adult at home with them after they self-administer misoprostol. If there is no adult available to be at home with the patient, then treatment as EMAH should not proceed. Patient to be offered another date for day case treatment or for EMAH (if criteria for EMAH can be fulfilled on the new date).

3. Discuss contraception options and provide on-going contraception in line with national guidelines (2)

4. Administer 200 mg mifepristone orally.

5. Dispense take–home pack of misoprostol tablets, Analgesia (Codeine), Anti-emetic and 3 month supply of Progesterone only pill, pregnancy test. Traditional administration of misoprostol has been by the vaginal route, but sublingual route and buccal routes are as effective, and the patient should be advised on how to self-administer by the preferred route.

    a. If vaginal administration is unacceptable to the patient, then the same dose of misoprostol may be administered sublingually or buccally with similar efficacy. Please note oral administration (swallowing) of misoprostol is not recommended as has a lower efficacy and higher incidence of Gastro-intestinal side effects. Oral administration should only be used if the pregnancy is < 7 weeks gestation and if vaginal, sublingual or buccal routes of administration of misoprostol are unacceptable to the patient.

    b. The patient should be made aware that administration by sublingual or buccal route is associated with higher likelihood of headache. Misoprostol tablets administered buccally or sublingually may take approximately 20 minutes to dissolve, may not dissolve fully and are associated with an unpleasant taste in the mouth.

9. The patient should be advised of the standard dosing interval between mifepristone and misoprostol is 24-48 hrs, based upon efficacy. Misoprostol should thus normally be administered 24 to 48 hrs after mifepristone.

10. Check VTE score and ensure LMWH (Clexane) has been prescribed and patient understands how to self- administer using Pregnancy VTE assessment click here for full guideline

11. Complete Medical termination of pregnancy pathway, detailing patient understanding of treatment and provide patient information with advice on what to expect at home.

12. Please ensure patient understands they MUST perform a pregnancy test according to instructions as part of follow up

13. Advise patient on signs and symptoms that should warrant re-attendance to hospital as an emergency .

14. Advise patient that they should contact the clinic- PAC Mobile 07788388412 in office hours or 01332 788209 if they have any of the following as the procedure may not have been effective:

    - If they fail to take the misoprostol as instructed
    - If they do not bleed within 24 hours of receiving misoprostol tablets
    - If they have less than 4 days of bleeding
    - If they still ‘feel’ pregnant at the end of one week or have symptoms of pregnancy such as sore breasts, sickness, tummy growing etc.
    - If the next period does not come one month after treatment
    - If they remain concerned that they may still be pregnant

14. Ensure the patient has been provided with:
    - Complete medication regime (TTO PACK)
    - Emergency contact information
    - Patient information leaflet
    - Contraception of their choice
    - Clexane (If appropriate using Maternity VTE assessment click here for full guideline
    - Advice about how and when to perform the supplied pregnancy test kit
    - Copy of discharge letter

Ensure the woman has adequate pain relief at home should she require it. If Depo-Provera is requested please administer prior to discharge.

The woman must sign the relevant section in the pathway which ensures she is aware of possible risks, what to expect, the follow up arrangements **including a urine pregnancy test 3 weeks after the procedure and also sign the self assessment agreement** for home medical management to say she has received and understands the information for follow up.

Ensure the visit is coded appropriately and the note returned to the secretaries for GP letter and HSA4 completion.

Please ensure when completing the online HSA4 form (Notification of Abortion) that you record the location of the place of treatment. The section on prostaglandins administration should record the patients address. It is sufficient to record the address as 'place of residence' or 'home' as this must be recorded on the first page of the form. Type of premises should be recorded as home. 'Date of administration of prostaglandins' should be recorded as the date on which you advise the patient self-administers misoprostol.

As the patient is completing the termination at home, we are unable to confirm the termination is confirmed. Thus the box should be left blank. If subsequently it is found that the pregnancy has not ended, a letter must be sent to the Chief Medical Officer and the HAS 4 form will be cancelled.

7.2 Medical Termination of Pregnancy (10+0 to 13+6 weeks of pregnancy)

This is performed on ward 209. A bed must be booked through the nurse in charge on 209. Mifepristone can NOT be given as a TTO when the patient is 10+0 pregnant. The patient must return to hospital 36-48hours before admission to take this 1st stage. This appointment will be arranged through GOPD or ward 209. Where possible Mifepristone should be given on the same day as the patient's clinic consultation, assuming the second stage of treatment can be facilitated in the next 48hours.

Medication regimen - If no allergies, prescribe medication**:**

- Mifepristone 200 mg orally

Followed 36-48 hours later by:

- Misoprostol 800 micrograms PV.
- Paracetamol 1g oral x1 dose if required.
- Codeine phosphate 30-60 mg oral x1 dose if required.
- Pethidine 50 mg SC x1 dose if required.
- Cyclizine 50mg SC x1 dose if required.
- Syntometrine 1 mL IM x1 dose if required.

1st stage – Mifepristone to be taken in GOPD or Ward 209 / daycase

Check!

- She still wishes to go ahead with the termination
- Consent form for the procedure is signed
- HSA1 Form is completed and signed by two medical practitioners

Prepare for procedure and carry out mandatory checks.

Ensure no contraindications and administer mifepristone 200 mg oral.

Check future contraception prescribed and give emergency contact numbers. Ensure woman understands 2nd visit arrangements: to return to the ward at approximately 07:30 – 08:00 hours (i.e. 36-48 hours after the mifepristone). Discharge home and advise the woman to return to the hospital if there is vomiting within one hour, a repeat dose of mifepristone 200mg should be given.

2nd stage - Attending Ward 209 / daycase

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Check blood group. Arrange for Anti D if required click here for full guidance

Confirm woman understands procedure & check allergy status.

Patient or Nursing staff to administer misoprostol 800 micrograms PV into posterior vaginal fornix as prescribed. Please note other routes of administration are buccal or sublingual.

While awaiting passage of pregnancy tissue on the ward:

- Measure BP and pulse rate when clinically indicated (e.g. excessive bleeding +/- severe pain).
- Administer prescribed analgesia and anti-emetic as required and assess effectiveness.
- Assist patient with elimination needs and observe for the passage of pregnancy tissue.

Pregnancy tissue is usually passed within 4 hours. For women at 10^{+0} weeks to 13^{+6} weeks gestation, if abortion has not occurred 4 hours after administration of misoprostol, a second dose of misoprostol 400 micrograms may be administered vaginally or buccal/ sublingual (depending upon preference and amount of PV bleeding).

Pregnancy tissue must undergo sensitive disposal as per the patient's wishes (See section 6.6). For the majority this will be shared cremation via the mortuary. Ensure Sensitive disposal form discussed and signed by patient, a yellow copy must accompany the pregnancy tissue to the mortuary. The relevant paperwork for sensitive disposal should be sent to the mortuary – including the yellow copy of sensitive disposal form with pregnancy tissue and put patient's details on the "Application for shared cremation" form.

If pregnancy tissue is <u>not</u> seen or excessive PV bleeding / pain,
ask Gynae Registrar on-call to review.

Discharge for Home

- Allow a minimum time of 1-hour following complete passage of pregnancy tissue, i.e. gestation sac and fetus identified.
- Assess pain and quantity of vaginal bleeding.
- Ensure symptoms have settled, food and drink are tolerated and woman feels well.
- Ensure observations post procedure are normal.
- The woman should be advised that bleeding can be moderately heavy for 3-4 days after medical TOP, occasionally with passage of small clots. The bleeding may take up to 3 weeks to settle completely.
- Check and administer anti-D if Rh D negative if applicable click here for full guidance
- Ensure contraception has been fully explained & administer Depo-Provera if required

If all of the above are satisfactory with minimal bleeding and pain, the woman can be discharged home.

- Reinforce instructions and answer any questions.
- Give emergency contact number.
- Recommend a follow-up visit with GP / Contraception and Sexual Health Service in 2 weeks to discuss contraception needs.
- Check VTE score (using Pregnancy VTE assessment click here for full guideline), and ensure LMWH (Clexane) has been prescribed and patient understands how to self- administer
- Information should be given to the patient that in the event the STI screen results show positive GUM/ DISH will automatically contact her for follow up treatment and partner notification.

Inform the patient that she <u>must perform a home urine pregnancy test 3 weeks after the procedure</u> and contact us immediately if this remains positive.

- Complete TOP summary proforma for secretary to generate discharge letter.
- Ensure the visit is coded appropriately and the note returned to the secretaries for GP letter and HSA4 completion.

7.3 Late Medical Termination of Pregnancy (14 – 17^{+6} Weeks gestation)

The gestational age was increased in June 2016 to 17^{+6} weeks to enable the PAC service to offer local treatment to our women and avoid the need to travel long distances at a time of great stress to another provider. In exceptional circumstances a termination may be provided beyond this gestation, but this must be discussed with a PAC team consultant first.

This service is completely separate from Fetal Medicine patients undergoing TOP for fetal abnormalities or obstetric complications (e.g. extreme PROM or late miscarriage). There are different pathways, consent forms and sensitive disposal processes for PAC and fetal medicine.

These cases require inpatient beds so must be arranged with the Ward 209 coordinator as to when best to accommodate them.

Medication regimen - If no allergies, prescribe medication**:**

- Mifepristone 200 mg orally

Followed 36-48 hours later by:

- Misoprostol 800 micrograms PV (Initial dose)
- Misoprostol 400 micrograms PV every 3 hours alt. buccal/ sublingual (maximum of x4 doses after initial dose)
- Paracetamol 1g oral x1 dose if required.
- Codeine phosphate 30-60 mg oral x1 dose if required.
- Pethidine 50 mg SC x1 dose if required.
- Cyclizine 50mg SC x1 dose if required.
- Syntometrine 1 mL IM x1 dose if required.

Offer women the option to have a shorter interval between mifepristone and misoprostol if the woman prefers this, but explain that it may take a longer time from taking the first misoprostol dose to complete the abortion.

7.3.1 1st stage: as per MTOP Guidance (section 7.2)

7.3.2 2nd stage - Attending Ward 209

Obtain result of full blood count and blood group.

Confirm woman understands procedure & check allergy status, then administer misoprostol 800 micrograms PV into posterior vaginal fornix as prescribed. Some women prefer to insert the tablets themselves. Ensure woman is aware of need to rest on the bed for 1 hour following administration to allow absorption.

While awaiting passage of products of conception (pregnancy tissue) on the ward:

- Measure BP and pulse rate when clinically indicated (e.g. excessive bleeding +/- severe pain).
- Administer prescribed analgesia and anti-emetic as required and assess effectiveness.
- Assist patient with elimination needs and observe for the passage of pregnancy tissue.

Pregnancy tissue is usually passed within 6 hours but for later gestations this could be longer. In a minority of procedures, the placenta does not pass spontaneously, and the patient should be reviewed by the on-call Gynae registrar as surgical management may be required to remove the pregnancy tissue. If concerns e.g. excessive bleeding, pain not relieved by analgesia or low BP, ask Gynae Registrar on-call to review.

When the pregnancy tissue has been passed this must undergo sensitive disposal as per the patient's wishes (See section 6.6). For the majority this will be shared cremation via the mortuary. The relevant paperwork for sensitive disposal should be sent to the mortuary – including the yellow copy of the sensitive disposal form with pregnancy tissue and put patient's details on the "Application for shared cremation" form. This is the same sensitive disposal form as per all methods of termination for gestations up to 17^{+6} in women using the PAC service (See

Appendices). This paperwork is NOT to be used for patients referred via the Fetal Medicine Unit – *See separate Bereavement pathway*.

If PREGNANCY TISSUE not seen:

- Ask Gynae Registrar on-call to review. If after medical review confirms the termination has not occurred, mifepristone can be repeated 3 hours after the last dose of misoprostol. 12 hours later the misoprostol regime may then be recommenced.

Discharge for Home as per MTOP (section 7.2)

8. Surgical Termination of Pregnancy

8.1 Manual Vacuum Aspiration under Local Anaesthesia ≤9^{+6} / 40

The MVAC clinic (Code GYNMV) is alternate Monday mornings and every Wednesday afternoon and alternates between JRA and JLH. *See MVAC SOP.*

8.1.1 Patient selection criteria

All patients may be considered suitable for an MVA unless there are contra-indications (see below).

Contraindications to MVA are no different to those for surgical TOP under general anaesthesia plus:

- Gestation > 10 weeks

Cautions with MVA

- Patients who have excessive anxiety about the procedure, speculum examination or local anaesthetic techniques.
- Allergy to local anaesthetic
- Congenital or acquired uterine or cervical anomalies - may require ultrasound guidance during the procedure and it may be more difficult to dilate the cervix or cannulate the uterus leading to a longer or more painful procedure.
- Cardiac conditions where continuous monitoring may be required in case of vaso-vagal with MVAC. These patients could be considered for MVAC under LA but on a STOP list to allow additional monitoring.

Patients are to be prescribed medications for cervical priming as a TTO to be administered 1hour prior to their appointment time.

Patient Information

Explain to women that cervical priming:

- reduces the risk of incomplete abortion for women who are parous.
- makes dilation easier for women who are parous or nulliparous.
- may cause bleeding and pain before the procedure.

Medication regimen - If no allergies, prescribe medication**:**

Cervical priming:

- Misoprostol 400 micrograms PV (1 hour pre-op).
- If misoprostol cannot be used, consider cervical priming with 200 mg oral mifepristone, given 24 to 48 hours before the abortion.

- Antibiotic prophylaxis: click here for guideline

8.1.2 Pre-appointment Instructions

Vacuum aspiration uses gentle suction to remove the pregnancy and takes about 5-10 minutes from start to finish. The patient should be advised to:

- Take their medication as prescribed 1 hour prior to their appointment time.
- Take simple analgesia prior to the procedure – Ibuprofen and paracetamol.
- To eat a light breakfast or lunch and drink as - normal.

- That they may drive themselves to and from the appointment
- They should expect to be in the department for up to 2hours.
- They do not need an escort to take them home.
- They can return to normal duties after their procedure.
- They can return to work the day after their procedure if they feel able to
- All forms of LARC can be fitted at the same time as their MVAC.

8.1.3 MVAC Visit

Click here for MVAC SOP

8.2 Surgical Termination of Pregnancy under General Anaesthetic (8- < 14^{+6} Weeks Gestation)

Surgical Termination of pregnancy is only available up to 14^{+6} weeks. Women presenting for STOP who are > 13/40 must be discussed with the individual surgeon performing the list prior to booking the patient.

Preference is given to patients >10 weeks or medically not suitable for MTOP

Attending Gynae Day case Unit

Discuss plan of care. Prepare for procedure and carry out mandatory checks.

Check!

- She still wishes to go ahead with the termination
- Consent form for the procedure is signed
- HSA1 Form is completed and signed by two medical practitioners
- Contraception choice & confirm on consent form
- Check VTE score and ensure LMWH (Clexane) has been prescribed and patient understands how to self- administer using Maternity VTE assessment click here for full guideline

Obtain blood group and request Anti D if required click here for full guidance

Ensure that:

- rhesus status testing and anti-D prophylaxis supply does not cause any delays to women having an abortion.
- anti-D prophylaxis is available at the time of the abortion.

Medication regimen - If no allergies, prescribe medication**:**

- Cervical priming: Misoprostol 400 micrograms PV (1-2 hours pre-op)
- Antibiotic prophylaxis: click here for guideline

Routine care and observations post operatively.

Check and administer anti-D if Rh D negative if required click here for full guidance

Administer Depo-Provera to the woman if requested.

Reinforce instructions and answer any questions. Check discharge arrangements (i.e. adult to take woman home). Discharge home after a minimum of 1 hour post -anaesthetic if well, vaginal bleeding minimal and pain minimal. Give emergency contact number.

- Advise woman **she must perform a home urine pregnancy test 3 weeks** after the procedure and to contact us immediately if this is positive.

Pregnancy tissue must undergo sensitive disposal as per the patient's wishes (See section 6.6). For the majority this will be shared cremation via the mortuary. The relevant paperwork for sensitive disposal should be sent to the mortuary – including the yellow copy of sensitive disposal form with the pregnancy tissue and put patient's details on the "Application for shared cremation" form.

Surgeon to complete:

- Online HAS form 4 (Abortion Notification Form)
- Dictate TOP summary letter for referrer and case notes record.

9. Aftercare for all PAC patients

Follow up is only undertaken in hospital if the woman is unwilling to return to the referring agency or a specific need has been identified at discharge.

- The woman may self-refer to GAU / Ward 209 at any time following the administration of mifepristone. She should be advised to telephone the unit first rather than 'walk-in'.

- The woman may self-refer to GAU / Ward 209 within 72 hours of misoprostol administration if she has any concerns. Thereafter she should contact her GP.

- The woman may self-refer to GAU / Ward 209 within 72 hours of a surgical termination of pregnancy (either STOP or MVAC).

- Provide or refer women for counselling if requested. And provide emotional support if required.

- Advise women to seek support if they need it, and how to access it (if relevant). This could include:
    - support from family and friends or pastoral support.
    - peer support, or support groups for women who have had an abortion.
    - counselling or psychological interventions.

If the clinical history / ultrasound scan / βhCG are suggestive of retained products of conception / ongoing intrauterine pregnancy / ectopic pregnancy, discuss with on-call Gynae Registrar or Consultant immediately with regards to further management. If necessary, arrange readmission.

If additional counselling post-termination or if the patient has any general queries refer to Clinical Nurse Specialist/ PAC Mobile in office hours 07788388412.

For women whom remain to have a positive test 3 weeks following on from the termination of pregnancy, dependent on symptoms, these ladies will be offered a TV Ultrasound scan or blood tests and followed up in the gynae assessment unit.

10. Special patient groups

10.1 Patients under 16 years of age

Consider if there are any safeguarding issues, refer to Safeguarding Policy.
Advice and treatment on contraception, termination of pregnancy and sexually transmitted infections can be provided to girls under 16 years of age provided:

- They understand all aspects of the advice and its implications.
- You cannot persuade the young person to tell her parents or to allow you to tell them.
- In relation to contraception and STIs, the young person is very likely to have sex with or without such treatment.
- Their physical or mental health is likely to suffer unless they receive such advice or treatment.
- It is in the best interests of the young person to receive the advice and treatment without parental knowledge or consent.

The above risk assessment must be documented in the patient's notes. For advice and support please contact the DTHFT Safeguarding team:

- Non-urgent queries call 01332 (7)87547 (24 hour secure answerphone)
- Email dhft.safeguarding@nhs.net
- For urgent case related queries-Please call the Duty phone on 07471140537 (This number is available 9am-5pm Monday-Friday)

10.2 The Care of Women seen in the Pregnancy Advisory Clinic with Non-Viable or Possible Ectopic Pregnancies

If uterus empty on ultrasound scan in Pregnancy Advisory Clinic, check urine pregnancy test.

If negative:

The patient is no longer pregnant and can be discharged. The patient should be given advice on STI screening and offered a discussion on contraception in order to reduce the risk of a future unplanned pregnancy.

If positive:
PAC team to take blood sample for serum ßhcg. If clinical history, examination or investigations are suggestive of Ectopic pregnancy or Pregnancy of unknown location (PUL) please refer to GAU for medical review. Please see separate guideline for *Ectopic Pregnancy & Pregnancy of Unknown Location*

If asymptomatic: arrange for woman to attend the GAU for repeat serum ßhcg 48 hours later.

GAU will communicate results to the woman.
- If results suggest non-viable pregnancy or ectopic pregnancy, they will need to liaise with the on-call team for further management.
- If results suggest an on-going intra-uterine pregnancy, GAU will arrange for woman to be seen with repeat ultrasound scan in Pregnancy Advisory Clinic approximately 10-14 days later to plan further treatment.
- If viability is uncertain, inform the woman.
-
- If appearances on ultrasound scan suggest on-going intra-uterine pregnancy, but it is too early to see fetal heart movement, many women are still ok to go ahead with TOP even if inevitable miscarriage may seem likely. Some may prefer to wait to see if miscarriage is confirmed, however this may incur a delay to facilitate the second scan.

The key issue is to make sure an ectopic pregnancy is not missed, (see ectopic pregnancy guideline (E1)

11. Contraception in complex patient groups

The UK Medical Eligibility Criteria for Contraceptive Use (UKMEC) offers guidance to providers of contraception regarding who can use contraception safely. These evidence based guidelines do not take into account the best method for a woman nor do they take into account efficacy (includes drug interactions and absorption problems). The recommendations allow for consideration of possible methods that could be used safely by individuals who have other medical problems (e.g. hypertension) or specific patient characteristics (e.g. Age) to prevent unintended pregnancy.

http://mag.digitalpc.co.uk/fvx/fsrh/ukmec/2016/

Most contraceptive users are medically fit and can use any available contraceptive method safely. However some medical conditions are associated with potential or theoretically increased health risks when certain contraceptives are used either because the method adversely affects the condition or because the medical condition or its treatment affects the safety of the contraception.

Further information is available through the Faculty of Sexual and Reproductive Healthcare website under the guidelines section. www.fsrh.org.uk

13. Monitoring Compliance and Effectiveness

Monitoring requirement	• Time interval from original referral to termination of pregnancy. • Percentage of women having TOP under local anaesthesia (manual vacuum aspiration), general anaesthesia and medication termination of pregnancy. • Percentage of Rh D negative women who received anti-D immunoglobulin as per guideline

	• Contraception uptake and method chosen. • Percentage of women requiring readmission within 28 days of procedure.
Frequency of report	As per agreed Audit forward programme

14. References

http://www.medscape.com/viewarticle/755739 Comparison of Unscheduled Re-attendance and Contraception at Discharge, Among Women Having the Final Stage of Early Medical Abortion at Home and Those Remaining in Hospital - Hannah Astle, Sharon T Cameron, Anne Johnstone)
https://www.fsrh.org/news/new-fsrh-guideline--contraception-after-pregnancy/
Guidance for completing the Notification of Abortion form

RCOG. The Care of Women Requesting Induced Abortion. Evidence-based Clinical Guideline Number 7. London: RCOG Press, 2011

RCOG. Abortion Care - information for you. London: RCOG Press, 2012

GMC. 0-18 Years: Guidance for all doctors. GMC, London, 2007

Department of Health. The National Strategy for Sexual Health and HIV. London: HMSO; 2001

National Committee on Infant Cremation 2015 Annual Report. Guidance on the Disposal of Pregnancy Losses up to and Including 23 Weeks and 6 Days Gestation
http://www.scotland.gov.uk/Publications/2014/06/8342/0

DoH Detailed guidance note for completing the abortion notification form HSA4 for abortions performed in England and Wales: Electronic form

Appendix A

Pregnancy Advisory Clinic – 21 Day Referral-To-Treatment for Termination of Pregnancy (TOP)

PATIENT ID STICKER	**CONTACT No:** …… **Consents to messages:** **YES** ☐ **NO** ☐

Referral Date ……

Referred By (Please circle) GP SELF OTHER (Provide Details)

……

↓

Date of First Pregnancy Advisory Clinic Appointment ……
Date of Additional Appointment if required …….. (tick reason below)
Required more time to consider options ☐
Required further investigations as too early ☐
DNA/Cancelled Appointment ☐
Other ……

↓

First Available TOP date suitable for the gestation:
MTOP (Medical) …….. **LATE MTOP……..**
STOP (Surgical) …… **MVAC (Manual Vacuum Aspiration) ……**

↙ ↘

PATIENT DECLINES ABOVE DATE (INDICATE REASON BELOW)
More time required to consider options ☐
Requests alternative method of TOP to First Available option ☐
Cannot attend date offered (social reason) ☐
Other ☐
PLEASE STATE ……

PATIENT ACCEPTS ABOVE DATE *
Confirmed procedure method ……
Date given ……

→

PATIENTS' *NEW* CHOSEN DATE *
Confirmed procedure method ……
Date given ……

- **N.B. IF EITHER DATE IS MORE THAN 21 DAYS FROM ORIGINAL REFERRAL PLEASE ENSURE REASON IS STATED ON LORENZO FOR 21 DAY RTT TARGET**

SPECIAL NOTES e.g. BMI / Allergies: **OVERNIGHT ADMISSION REQUIRED? (PLEASE CIRCLE)** **NO / YES REASON IF YES:**	**NURSE SIGNATURE** **PRINT NAME**

Suital

Self-Assessment Agreement for Home Medical Management

I understand that:	✓
I am taking responsibility for performing my own post-treatment assessment to make sure that I am no longer pregnant.	
The signs that treatment may not have worked and that I still may be pregnant, are: • If I do not bleed within 24 hours of having the misoprostol tablets • If I have less than 4 days of bleeding • If I still 'feel' pregnant at the end of 1 week or have symptoms of pregnancy such as sore breasts, sickness, tummy growing, etc.	
I should contact the clinical nurse specialist in office hours and leave a message on 07788388412 if I have any of those signs, as I may require more treatment. (alt. 01332 785061 or 01332 785170)	
I will NOT be contacted by Royal Derby Hospital to find out if my treatment has worked, but understand the need to do a home pregnancy test to confirm this. I need to perform the urine pregnancy test 3 weeks after treatment on / / The urine test must be performed using only my first morning urine (first urine passed when I wake up).	
If the pregnancy test is positive, or invalid, or I am not sure, or my next period does not come by 4 weeks after treatment I must contact the clinic as soon as possible, as I might still be pregnant.	
If the treatment fails and I am still pregnant, we cannot guarantee a healthy pregnancy	
I can fall pregnant again almost immediately after a termination, and therefore understand the need to have my plan for contraceptive already in place.	
Serious complications have warning signs. You should start to feel better each day after the abortion. Contact the us straight away if you have: - Heavy bleeding that soaks through 2 sanitary pads an hour, for 2 hours or more in a row - Abdominal pain or discomfort that is not helped by medication, rest, a hot water bottle, or a heating pad - A fever of 38°C or higher - An unpleasant-smelling discharge from your vagina - Signs that you are still pregnant - No bleeding 24 hours after using misoprostol	

Patient Signature:……
Print Name……
Date……

Nurse Signature:……
Print Name……
Date……..

UNIVERSITY HOSPITALS OF DERBY AND BURTON NHS FOUNDATION TRUST

PREGNANCY ADVISORY CLINIC – CONSENT FOR DISPOSAL OF PREGNANCY REMAINS

ID Label or Hospital Number .....

Name: .....

Address: .....

.....

Date of Birth: .....

NHS Number .....

What happens to the pregnancy remains?

In the UK the disposal of pregnancy remains is regulated by the Department of Health with guidance from the Human Tissue Authority. Under these regulations we are required to discuss disposal of pregnancy remains with you; we certainly do not wish to cause you any distress.

The pregnancy tissue removed at operation or expelled following a medical termination of pregnancy can be dealt with respectfully by the hospital. Royal Derby Hospital will arrange a shared cremation at Markeaton Crematorium. Many women prefer the hospital to handle this sensitive matter - and you simply confirm this with us.

Alternatively, you may wish to be involved in a decision about other options for the pregnancy remains, in which case please ask about this. It is best to ask before the termination takes place but the pregnancy remains are held for 14 days after the termination so you do have some time to make a decision or change your wishes.

Your choice for disposal of the pregnancy remains; Please choose one of the following options:

1. I have read the above information and I do not wish to be involved in the decision and request that Royal Derby Hospital handles the matter. I have been made aware that further information is available on the disposal options and do not wish to have this. ☐

Signature of the Patient _____ Date Signed _____.

Signature of the Consultant _____ Date Signed _____.

Signature of Interpreter _____. Date Signed _____.

or

2. I have read the above information and I have had the opportunity to discuss alternative arrangements for my pregnancy remains. Following this I would prefer to make my own arrangements. Please be aware you will need to meet any costs of this yourself. If the remains are not taken home on discharge for some reason, the Trust will notify you when they are ready for collection. I am aware that I will need to collect within 6 weeks of being notified and that if I choose not to do so, the Trust will respectfully deal with them and arrange a shared cremation. ☐

Signature of the Patient _____ Date Signed _____.

Signature of the Consultant _____ Date Signed _____.

Signature of Interpreter _____. Date Signed _____.

Distribution: White – Patient records; Yellow – Mortuary; Pink – Patients copy

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For mortuary use only: MT number: _____ Date of collection: _____

Collected by:_____ Signature: _____.

Released by: _____. Signature: _____.

Derby campus WPH2216 lgtd
January 2019

Appendix D

Application By Royal Derby Hospital for Communal Cremation of Fetal Remains at Markeaton Crematorium, Derby.

(Applicant*).....…….....

This application must be signed by the person authorised by the Medical Director of the Derby Teaching Hospitals NHS Foundation Trust to make an application for cremation.

(Address): Obstetrics and Gynaecology, Royal Derby Hospital, Uttoxeter Road, Derby, DE22 3NE

(Position).....…….....

As the authorised and designated person, I declare that I hold paperwork relating to each of the fetal remains listed, signed by the medical practitioner/registered nurse/whose name is shown, and that the paperwork includes a declaration that the fetal remains were:

a) Of a gestation up to and including 23 weeks and 6 days

b) Showed no signs of life

AND

c) The parent(s) have been made aware that a Communal Cremation is to be carried out and that any cremated remains recovered following the process will be scattered together around the Children's Memorial Garden in the Gardens of Remembrance at Markeaton Crematorium

Accordingly, I hereby apply to Markeaton Crematorium to cremate the fetal remains detailed below:

Hospital No:	Date	Name of medical practitioner / registered nurse

I DECLARE that all the information given in this application is correct, that no material particular has been omitted and that authorisation/consent for the communal cremation has been obtained.

Signature of Applicant.…….....Date.....

Mortuary use only

Transfer of Batch to Mortuary

Received by……

Date……..

Recording of Batch in Mortuary

Batch no ……

No. in batch……

…….. of ……

Recorded by……

Released from Mortuary to …….. Funeral Directors

Released by……

Taken by…….

Date…….

Documentation Control

Reference Number: Gynae/01:24/T1	**Version: 5.1**		**Status: FINAL**	
Version / Amendment	Version	Date	Author	Reason
	1	Dec 2013	Mr J Allsop Consultant Obstetrician / Gynaecologist, Mrs C Wardle, Clinical Specialist Nurse	Replaces: • Early medical termination of pregnancy (under 63 days – 9 weeks) (T1) • Post TOP Counseling (T2) • Flow chart (T3) • STI & TOP (T4) • Medical Termination <12 weeks (T5) • MTOP aftercare (T6) • Post MTOP flow chart (T7) • MVA under LA (T8) • STOP under GA (T9) • PAC-non viable/ectopic preg (T10)
	2	Aug 2016	As above	To include MTOP at home
	2.1	Aug 2017	Maternity Guideline Group Julia Lacey – Lead Pharmacist	Synchronised with Antibiotics guideline
	3	Dec 2018	Mr J Allsop – Consultant Obstetrician & Gynaecologist	Reflecting recent amendment to current clinical practice
	4	Apr 2019	Mr J Allsop – Consultant Obstetrician & Gynaecologist / Mrs C Wardle, Clinical Specialist Nurse	Review
	5	June 2020	Miss Heslop – Consultant	Review
	5.1	June 2023	Joanna Harrison-Engwell - Lead Midwife for Guidelines, Audit and Quality Improvement	Amendments to section 7.2 regarding TTO and Covid advice. Agreed with Susi Dumbleton and Claire Wardle
	6	Jan 2024	Jen Heslop - Gynaecology consultant	Review and update
Intended Recipients: All staff within the Gynaecology Service				
Training and Dissemination: Cascaded electronically through lead sisters/midwives/doctors; Published on Intranet, NHS mail circulation list. Article in business unit newsletter				
Consultation with:	Gynaecology staff			
Business Unit sign off:	08/01/2024: Gynaecology Guidelines Group: Miss B Purwar – Chair 31/01/2024: Gynaecology Development & Governance Committee: Mr V Asher – Chair			
Divisional sign off of governance process followed:	31/01/2024			
Implementation date:	31/01/2024			
Review Date:	January 2027			

Key Contact:	Joanna Harrison-Engwell