Frimley Health NHS Foundation Trust

Termination for fetal abnormality

Key Points

- The method of termination available at Frimley Health is limited and dependant on gestation.
- Termination of pregnancy following fetal abnormality: Management options will depend on which site patient is booked and the availability of specialist doctors with the maternity service.

Version:	3.0
Date Issued:	07/10/2024
Review Date:	01.10.2027
Key words:	Termination, abortion, stillbirth, late fetal loss, induction of labour, funeral arrangements, mifepristone, misoprostol, postmortem.

Abbreviations

ARC	Antenatal results and choices
BPAS	British Pregnancy Advisory service
CVS	Chorionic villus sampling
ERPC	Evacuation of retained products of conception
MEOWS	Modified early obstetric warning score
NACARDS	National Congenital Anomaly and Rare Disease Register
PCA	Patient controlled analgesia
PM	Post-mortem
PN VTE	Postnatal venous thromboembolism
PV	Per vagina
SANDS	Stillbirth and neonatal death charity
SMM	Surgical management of miscarriage
SROM	Spontaneous rupture of membranes

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Contents

1. Introduction

This guideline is to support the management and care required for women who have made the difficult decision to terminate a pregnancy following diagnosis of a fetal abnormality, or when a decision is made on a clinical basis, e.g. rupture of membranes prior to viable gestation.

Women undergoing termination of pregnancy following a diagnosis of fetal structural, chromosomal or genetic abnormality, should be managed in a sensitive and non-judgemental manner.

Staff who have conscientious objections to termination of pregnancy should make these known to the co-ordinator on labour ward or the consultant lead for each individual case. They are not required to administer the drugs that terminate the pregnancy. However, in an emergency situation, every midwife or doctor has a duty of care to these women and their families.

The method of termination available at Frimley Health is limited and dependant on gestation. Women should be aware of the services we can provide at Frimley Health and if requested can self-refer to Marie Stopes International (MSI) if their chosen method of termination cannot be supported on either site at Frimley Health. A choice between medical and surgical termination should be offered up to 23+6 weeks gestation.
If requested, the maternity service will support women with transfer to an alternative abortion service and continue ongoing support which may include transfer of further information about the anomaly to another provider, but women must be made aware that a surgical option will not allow for a post-mortem examination.

Prior to late termination of pregnancy (>21+6/40) feticide is advised to prevent the baby being born with signs of life. Refer to the trust Feticide guideline.

Although very rare, failures of feticide have been reported. If the feticide procedure has been performed off site at a tertiary referral centre, an ultrasound scan by someone competent in scanning, should be performed to confirm there is no fetal heart activity prior to giving any medication to initiate the termination.
All consent forms should be reviewed to ensure they are complete if patient returns from a tertiary centre following fetocide, including completed form HSA1.

2.0 Termination of Pregnancy

Decision to terminate will be made with the support of the fetal medicine consultants, the tertiary referral centre if appropriate & the specialist midwives in the screening team.
In most cases the fetal medicine consultant will assume the lead responsibilities for women when a fetal abnormality is identified.

2.1 Surgical termination of pregnancy for fetal anormality/SROM < 17 weeks

Availability on both the Wexham Park and Frimley Park site for surgical termination of pregnancy is limited to women where fetal abnormality or spontaneous rupture of membranes has occurred up to 16+6 weeks of pregnancy and only provided by specific obstetric consultants.

The fetal medicine consultants and screening team will make every effort to coordinate a surgical procedure. Theatre availability can be identified from their existing theatre lists or from the surgical management of miscarriage (SMM) spaces that are allocated each day. Early Pregnancy unit will

assist with booking an SMM slot this is called a ‘golden slot’ on the Wexham site. Once possible theatre space has been identified liaising with the specific consultants will be coordinated by the screening team.

Alternatively, women will be supported to contact external termination services.

The screening team are responsible for counselling and supporting the woman with her decision. External termination services as commissioned through the Frimley ICB. The screening teams will have the referral details and will support women to self-refer. For advice /referral Marie Stopes international can be contacted on 0345 300 8090

2.2 Surgical Termination of pregnancy request up to 17 weeks for other reasons.

At FHFT, surgical termination of pregnancy is only available for women with fetal abnormality or spontaneous rupture of membranes in the second trimester up to 17 weeks gestation. Women requesting termination of pregnancy for other reasons need to be referred through their GP to external termination services who can facilitate a surgical termination of pregnancy up to 23 weeks.
Patients can self-refer to Marie Stopes international (MSI) Tel 0345043700360. Information and support can be provided by the screening teams. Patients with medical complexity may not be suitable to have their care with external services, but still need to be referred through MSI as they will coordinate referral to another NHS provider or advise an alternative pathway where the surgical termination is for social reasons or under Clause C of the 1967 Abortion Act.

In the event of a patient over 17 weeks requesting surgical termination for a fetal abnormality or SROM in the second trimester, the fetal medicine consultant or on call consultant obstetrician can obtain direct support from the team at Imperial College Healthcare (St Mary’s Hospital London).

If a patient is requesting a social termination outside of the fetal abnormality pathway or if a GP requires support for a women requestion termination with additional complex needs, MSI referral still needs to be initiated as FHFT does not hold a contract for this pathway.

See appendix 4 for Information and contact details for referring to Imperial College Health care.

See

Appendix 2 SOP for surgical process

Appendix 3 Pre op check list Surgical termination of pregnancy.

Appendix 4 Referral and contact details for Imperial College Healthcare

2.3 Medical termination of pregnancy less than 16 weeks.

Individual patient discussion is required to explore a request for medical termination less than 16 weeks. There are no longer specialist gynaecology inpatient beds or skilled inpatient nurses to support this pathway at Frimley Health, but if a woman is requesting medical termination of pregnancy, this request should be explored with the consultant and inpatient teams. In exceptional circumstances labour ward may be able to accommodate a specific request.

2.4 Consent process

- The screening team will arrange for the woman to attend at an agreed time and place.
- Care will be taken to ensure a full discussion has taken place and all questions answered prior to commencing the consent process.

- **Form HSA1 Blue Abortion Act 1967**: two signatures required; the first signature should be the lead consultant. The obstetric registrar or admitting consultant can complete the second signature and ensure the patient consent process is complete. The second signature must be completed prior to the administration of Mifepristone. Once completed this form must be scanned on to woman's EPIC record under the media tab.
- **Patient consent form**: the correct consent template for termination of pregnancy should be selected from EPIC. Surgical termination of pregnancy or medical termination of pregnancy and should be signed by the woman. If unable to complete EPIC consent form than a paper consent can be completed and scanned onto the patient's media section on their EPIC record.
- The drug regime should be prescribed on the EPIC medical administration record (MAR) as per protocol (See Appendix 1). Mifepristone 200mg or 600mg will be administered orally by the medical practitioner 24-48 hours ahead of the admission.
- **Form HSA4: Yellow abortion notification form**: It is the responsibility of the consultant who first counsels and consents the women to complete this form and ensure it is returned to the Department of Health within 14 working days. All doctors should now be using the electronic HSA4 portal. Please contact Screening team if electronic access required.
- Provide women with information about the different options for management and sensitive disposal of pregnancy remains and complete the correct documentation. Paper version must be signed by the women and scanned onto the media tab. Electronic sensitive disposal consent to be built into the EPIC consent process.
- Screening team will provide women with information on signs and symptoms that indicate they need medical help after the procedure and who to contact if they do.
- The screening team are responsible for ensuring all arrangements are in place for the woman to return 24-48 hours later for the termination of pregnancy procedure. Contact number for screening team to be given for additional support if required.

- A written information booklet (Blue ARC booklet) entitled 'Handbook to be given to parents when an anomaly is diagnosed' is available for parents which contains comprehensive information to support parents through the termination process and following discharge.

3.0 Medical Termination of Pregnancy

3.1 Admission to Labour Ward

Ideally, use the Bereavement Suites. Rowan Suite (FPH) or Willow Suite (WPH).

On admission the obstetric registrar should review the woman and assess any relevant obstetric or medical risk factors.

Women with uterine scar, grand multipara, impaired liver function should be discussed with the obstetric consultant for management.

The midwife looking after the woman should use the appropriate checklist/bereavement pack for fetal loss **(loss up to 23+6 weeks)** available on EPIC.

If **gestation is > 24 weeks** the Epic checklist/bereavement pack for stillbirth/TOP after 24 weeks should be used**.**

See Appendix 1 – Protocol for Mifepristone/Misoprostol

Misoprostol may be given vaginally, sublingually, buccal (between gum and cheek) or orally. Side effects (diarrhoea, vomiting, shivering, pyrexia) are more common when used orally. The sublingual or buccal route is preferrable as better absorption is achieved via these two routes of administration. The misoprostol tablets should be divided using the pill cutter provided on the Labour Ward if dose required is under 200mg.

Partogram

Commence the partogram at the first administration of misoprostol, and use to record all maternal observations, uterine activity and any PV loss. Observations should be undertaken three hourly, unless indicated earlier due to medical condition.

Vaginal examinations may be performed to assess progress following discussion with the woman, although it is not absolutely necessary. Cervical dilation should be recorded on the partogram should vaginal examinations be carried out.

Any vaginal loss (e.g. SROM/PV bleeding) should be recorded.

Completion of regime

After 5 doses of misoprostol, if delivery has not yet occurred, no further misoprostol should be given until ongoing management has been discussed with the obstetric consultant.

3.2 Analgesia

All pain relief options should be discussed. Epidural analgesia can be offered as a form of pain relief. Consider patient controlled analgesia (PCA) with morphine or remifentanil as these agents have the advantage over pethidine of a longer duration of action and of greater analgesic effect. PCA observations must be recorded appropriately on EPIC. Entonox, pethidine and morphine sulphate solution (Oromorph) are also available for pain relief.

3.3 Birth

The baby and the placenta may be delivered together but occasionally, there is delay between delivery of the baby and the placenta. The cord must always be clamped and cut as soon as the baby has delivered provided the woman's condition is stable and there is no excessive bleeding, The woman may be observed for a period up to two hours whilst awaiting placental delivery. If a further dose of misoprostol is due during this time it should be given as prescribed. If the woman feels unusual pain or feels faint, or becomes tachycardic and/or hypotensive, she should be reviewed by an obstetrician urgently as occasionally there is concealed uterine bleeding with retained placenta.

If bleeding is excessive follow the postpartum hemorrhage guidance. If the placenta has not been expelled after two hours, a speculum examination should be performed by an obstetrician ST2 or above as the placenta may be in the upper vagina. If this is not the case, inform the labour ward co-ordinator, obstetric anaesthetist and theatre staff to make arrangements for evacuation of retained products of conception (ERPC). **Inform theatre staff that there has not been a live birth to avoid inappropriate comments.** If bleeding is excessive give ergometrine 500 micrograms by intramuscular injection (unless contraindicated) which is the first line drug at this gestation.

3.4 Post Birth

The attending midwife should give the woman and her partner the opportunity to see and hold the baby. If a woman is reluctant her preferences should be respected and no pressure to view her baby should be exerted. The woman's wishes should be documented in the notes.
Consideration should be given if LW have supported a medical termination less than 16 weeks gestation. In this situation the woman's wishes after she has delivered should be documented in her Epic record, either by the fetal medicine doctors or the screening team. Sensitive disposal of

the pregnancy tissue can be arranged by the hospital laboratory and the chaplaincy team but any specific requests by the patient should be supported if legally possible including taking the pregnancy products home assuring that the correct documentation is completed. Sensitive disposal of products of conception form. Paper copies are available, and the mother must sign 2 copies. 1x signed copy should accompany the sample to the lab and 1x signed copy should be scanned into the media section of the patient's EPIC record.

A cold cot or cuddle cot should always be used to ensure the baby is kept at an appropriate temperature when they are not being held by family. Cold cots can be placed in the room with the parents if they wish.

Further care post delivery

- Maternal observations of temperature, pulse and blood pressure should be recorded and documented on Epic.
- Ensure the uterine fundus is well contracted and bleeding is not excessive.
- A postnatal (PN) VTE assessment needs to be completed and actioned appropriately. Low molecular weight heparin should be prescribed if indicated.
- Offer the parents the opportunity to see a specialist bereavement midwife if not already met.
- The obstetric consultant or registrar must see the woman prior to discharge.
- If the woman is Rh negative, take maternal blood for a Kleihauer test and administer Anti – D immunoglobulin (1500 international units) within 72 hours of delivery. IM injection into deltoid muscle. Patient with a bleeding disorder should have subcutaneous administration of the injection.

The midwife should examine the baby and record:

- Fetal weight
- Gender. It may be difficult to determine the sex of a baby at early gestation. If there is uncertainty and a postmortem is planned the result of gender can be expedited. It is recommended to check this with another midwife if unclear, do not assume or guess the

gender in this case and gently inform the parents. If no postmortem is planned, the parents may like the opportunity to determine the gender of their own baby.

- Presence or absence of abnormalities
- Number of blood vessels in umbilical cord
- The appearance of the placenta

The midwife should complete:

- The Epic bereavement checklist ensuring all tasks are completed before discharge including the Care after Death for the baby.
- All original paperwork accompanying baby to the mortuary needs to be scanned and emailed to the bereavement midwives at FPH or WPH using the shared email. This includes but is not limited to post-mortem consent or decline form, photography request form, Crem 3 form and Crem 9 form.

3.5 Post-mortem

If prenatal diagnosis through amniocentesis or CVS has been confirmed, then postmortem may not be indicated. Please check antenatal documentation carefully for any specific instructions from the tertiary referral centre or geneticist.

Taking consent

Post-mortem examination should always be discussed by a consultant obstetrician or a midwife who has undergone recent training in consent taking. The SANDS consent form should be completed if the family would like a post-mortem examination. Please refer to the “local information for consent takers” folder for more guidance if needed.

If genetic studies are indicated a specific referral should be completed and appropriate fetal tissue or placenta should be sent dry in a labelled laboratory container to Viapath Genetics at Guys and St Thomas. The screening teams can support with additional information, samples required, referral forms etc. In certain circumstances the bereavement team can support with the placenta only being sent to the Oxford post mortem service .

Changing your mind section

The SANDS consent form includes a “Changing your mind” section, which must be completed. The woman should be advised that she may contact the named individual by the specified time if she has changed her mind. The post-mortem examination will not take place until that date has passed, and it must be completed. The discussion and the woman’s wishes must be recorded in her Epic record.

3.6 Protocol for transfer to the mortuary
Frimley Park Hospital

Send the baby in a body bag in a specialised cardboard box together with the placenta (dry) in a pathology laboratory container with 2 patient labels on the lid and side of the container with the accompanying post-mortem consent and request forms. Please provide as much information as possible on the request forms and include copies of relevant scans to give the pathologist as much information as possible. Please ensure that the baby is dressed as they will not be accepted for PM without this. The baby must have two name labels. If the gestation is less than 24 weeks the labels must have the mother’s details to include-name, DOB, hospital number and NHS number. There must, also, be two completed Baby Loss Identification labels - one goes in the window of the bag and the other on top of the coffin. If the gestation is more than 24 weeks one label should have the mother’s details and other with the baby’s details - to include name, DOB, hospital number and NHS number. There must also be two Baby Loss Identification labels - one goes in the window of the bag and the other on top of the coffin. The mortuary staff will forward the forms to Oxford Hospitals mortuary if a post-mortem examination is requested. If a post-mortem is declined, please ensure the ‘decline form’ is completed.

Wexham Park Hospital

Commence the Bereavement pack.

Baby should be dressed and labelled clearly with two name labels, prior to the transfer with the mother's name, MRN, date of delivery and home address.

The placenta should be dry in a specimen pot, clearly labelled and sent with the baby to the mortuary for transfer if going for post-mortem.

The post-mortem pack should be photocopied and left for the bereavement midwives, alternatively, the paperwork accompanying baby can be emailed to wphbereavementmidwives@nhs.net.

Any belongings should be clearly marked with the mothers' details and sent with the baby in the appropriately sized body bag.

The baby should be transferred to the mortuary with two members of staff, all paperwork referred to in the checklist should be transferred with the baby and placed in the mortuary box, next to the register.

It is the midwife's responsibility to ensure all paperwork is complete and correct before transferring to the mortuary. Failure to do this is a breach of HTA legal requirements. The midwife is responsible for completing the mortuary register when baby is safely received – not the porters. If there are any outstanding actions, they should be handed over to the bereavement midwives or labour ward coordinator on the next shift.

4. Communication

If there are communication issues (e.g. English as a second language, learning difficulties, blindness/partial sightedness, and deafness) staff will take appropriate measures to ensure the patient (and her partner, if appropriate) understand the actions and rationale behind them. Please make use of, the hospital translating service, or a member of staff.

5. Patient Leaflets Appendix 5 And 6

Screening team can consider additional patient leaflets,

- Patient information for treatment of medical termination of pregnancy with Mifepristone and Misoprostol
- Information for women facing interruption of pregnancy for fetal abnormality. (Surgical procedure)

6. Monitoring Compliance

All mid-trimester terminations of pregnancy are monitored through the perinatal mortality audits locally and regionally. Any baby born alive following midtrimester termination of pregnancy will be subject to case review via Patient Safety and Quality team review. An electronic referral to the Coroner will need to be submitted explaining the circumstances so that a death certificate can be issued (Bereavement team will assist in this process). Be aware that the local Child Death Overview Panel (CDOP) may contact clinician for further details at a later date.

Details of fetal anomalies identified antenatally will be shared with NACARDS (National Congenital Anomaly and Rare Disease Register

7. References

https://www.rcog.org.uk/guidance/browse-all-guidance/other-guidelines-and-reports/termination-of-pregnancy-for-fetal-abnormality-in-england-scotland-and-wales/

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https://www.nmc.org.uk/standards/code/conscientious-objection-by-nurses-and-midwives/

https://www.hta.gov.uk/guidance-professionals/regulated-sectors/post-mortem/guidance-sensitive-handling-pregnancy-0

https://www.sands.org.uk/sites/default/files/Position%20statement%20Disposal%20of%20Fetal%20Remains%20April%202015.pdf

https://www.sands.org.uk/professionals/sands-post-mortem-consent-package

Appendix 1: Protocol For Administration of Mifepristone & Misoprostol

WARNING : Staff who are or may become pregnant should not handle crushed, broken or dispersed tablets.

Misoprostol tablets are dispensed as 200 microgram tablets, the tablets may be cut with a pill cutter if smaller dose required. Sublingual or buccal administration of misoprostol is advised as this improves absorption and bioavailability.

Protocol for administration of Mifepristone (Mifegyne 200 mg) & Misoprostol (Cytotec 200 micrograms) drug regimes for termination of pregnancy or induction of labour following intrauterine fetal death

Caution with women who have a uterine scar or are a grand multipara and be aware that the uterus is more sensitive to misoprostol as pregnancy advances so risk of uterine rupture increases.

DRUG	GESTATION	DOSE	FREQUENCY
Mifepristone	**>12 weeks – all cases**	**200 mg orally (consider 600mg if weight >100kg and /or nulliparous**	**Once**
Misoprostol (36 - 48 hours interval post Mifepristone)	**12 - 24+6 weeks**	**1st dose 800 mcg PV Thereafter at 3 hourly intervals 400 mcg sublingual/buccal**	**3 hourly until delivery (consider 12hr break after 5 doses)**
	25-27+6 weeks	**1st dose 400 mcg PV Thereafter at 4 hourly intervals 200 mcg sublingual/buccal**	**4 hourly until delivery (consider 12hr break after 4 doses)**
	> 28 weeks	**1st dose 200mcg PV Thereafter at 6 hourly interval 100mcg sublingual/buccal**	**6 hourly until delivery**

NICE 2019 - Only give antibiotic prophylaxis to women who are having a medical termination of pregnancy if they have an increased risk of sexually transmitted infections. For women who are having antibiotic prophylaxis, start the antibiotic on the same day they take the mifepristone. Consider: • a 7-day course of twice-daily 100 mg oral doxycycline or • 1 g oral azithromycin as a single dose, followed by 500 mg once daily for 2 days

3. EFFICACY & SAFETY

Regimen	Failure rate	Time to expulsion	Major adverse events
Mifepristone + Misoprostol	At 36 hours: <1%	6-9 hours	<1%
Misoprostol only (Alternative regimen if mifepristone not available)	At 48 hours: <10%	12-18 hours	<1%

Risks	Failure rate
Failed induction	<1 in 100
Retained placenta or retained products of conception	5-8 in 100
Need for further intervention to complete the procedure	13 in 100
Infection	<2 in 100
Severe bleeding requiring transfusion <20 weeks	<1 in 1000
Severe bleeding requiring transfusion >20 weeks	4 in 1000
Uterine rupture	<1 in 1000

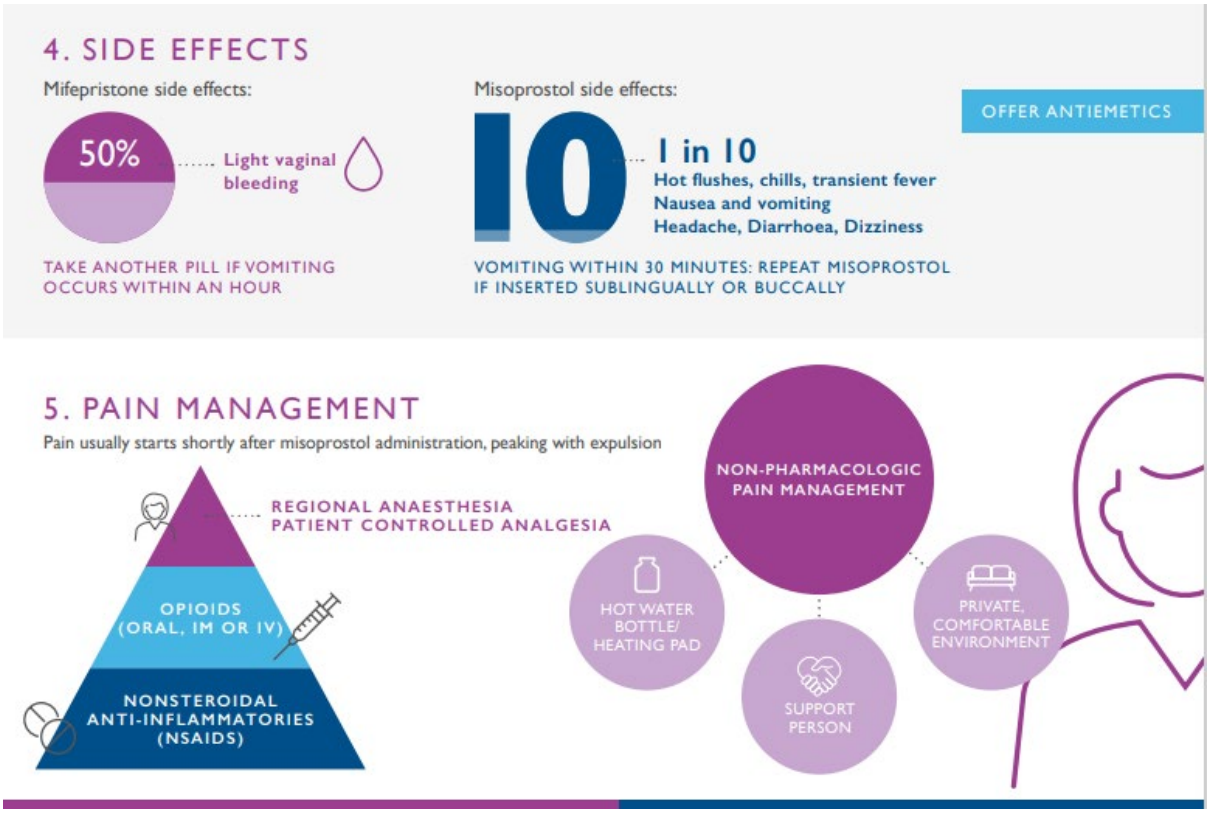
Without previous caesarean deliveries: **1 in 10,000**

With previous caesarean deliveries: **2.8 in 1,000**

Women undergoing VBAC should be closely monitored for signs of scar rupture - fetal heart rate abnormality, usually the most common sign of early scar dehiscence, does not apply in this circumstance. Other clinical features include maternal tachycardia, atypical pain, vaginal bleeding, haematuria and maternal collapse.

Misoprostol can be safely used for induction in women with a single previous Caesarean Section and an Intrauterine Fetal Death/TOP. Women with 2 or more previous Caesareans or an atypical scar should be advised that the safety profile is not known but reasonable to proceed with caution.

In the context of ruptured membranes – intravenous oxytocin is less effective than Misoprostol which demonstrates a reduced induction to delivery interval. Gestations <27 weeks will not have effective oxytocin receptors and PV/sublingual or buccal Misoprostol is preferred. For gestations >27 weeks oxytocin can be considered after discussing with a consultant obstetrician (Misoprostol is usually first line).



If delivery has not occurred following the above regimes, a consultant review must be undertaken prior to further management.

References

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2. Late Intrauterine fetal death & still birth (Greentop No 55) RCOG 2017
3. Misoprostol in Obstetrics & Gynaecology – International Journal of O&G
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Appendix 2: SOP Surgical termination of pregnancy for Fetal abnormality Frimley Health

- Identify theatre slot with support from antenatal screening team and/or specific surgeon. Ideally a theatre slot is found on a routine list, but if necessary to use SMM Golden patient slot on CPOD list.

- Screening team to arrange date and time for patient to attend for consent /Mifepristone medication.

- The HSA1 Abortion Act form (blue form) must be completed and signed prior to taking any cervical ripening medication.

- The consent form for sensitive disposal of early pregnancy tissue must be completed.

- Electronic consent must be taken prior to administration of Mifepristone (on EPIC).

- Mifepristone 200mg or 600mg dose orally should be prescribed as a Clinic Administered Medicine (CAM) on EPIC by the responsible clinician.

- Mifepristone 200 micrograms will be administered orally by the medical practitioner 12-48 hours ahead of the procedure. FPH site this needs to be dispensed from Pharmacy on the day of the consultation and it is the responsibility of the screening team to collect this medication. If collected before the appointment, this will need to be stored in the locked drug cupboard in ANC. WPH site this can be signed out from LW controlled drugs cupboard and book signed as per protocol.

- Mifepristone is being administered as a cervical ripening agent in order to soften the cervix to facilitate the termination which is being carried out by surgical means on the day of the procedure. If the patient is being seen and consented more than 48 hours prior to her operation, the consultant surgeon can consider allowing the patient to take the mifepristone at home 12-48 hours pre-operation. In this circumstance an outpatient order should be placed for the Mifepristone for the named patient and collected from pharmacy by the antenatal screening team.

- Screening Midwife will complete STOP pre-operative checklist with the patient and take bloods for FBC and Group & Save.

- If the woman is blood group Rh negative; FPH site Anti –D immunoglobulin (1500 international units) will be ordered by the screening team and taken to Day Surgery 1 prior to the procedure date. WPH site the EPU team will order the anti-D immunoglobulin and liaise with the surgeon following the procedure to ensure administered appropriately.

- Following the surgical procedure, the patient should be prescribed azithromycin 1g orally prior to discharge home on the day of the procedure as per national guidance for surgical termination of pregnancy.

- VTE assessment will follow the antenatal assessment on EPIC and, if identified as moderate or high risk on the STOP pre op check list, this will be discussed with the

consenting doctor. It is the responsibility of the doctor performing the surgical procedure to prescribe low molecular heparin if indicated.

Appendix 3: Pre-Op Check List: Surgical Termination of Pregnancy (Illustration only).

PATIENT DETAILS: (Or addressograph label) Name: DOB: MRN Lead Consultant	**PATIENT NEXT OF KIN:** Name: DOB: Address: Telephone NO.

PROCEDURE: **DATE OF PROCEDURE:** Booked on Theatre list Responsible surgeon Admission location confirmed with patient. Preadmission information given	**Consent forms signed**. Yes/No **HSA1 Abortion Act form (blue form) completed with 2 signatures** Yes/No **Sensitive disposal form completed** Yes/No

Current Medication **Allergies** **Blood group** **Anti D immunoglobulin required Yes/No** **Anti-D immunoglobulin ordered Yes/No**	**Mifepristone 200mg given orally** **Date** **Time** **Blood group & save.** **FBC : date taken**

PATIENT'S BMI:	**VTE RISK ASSESSMENT** (use antenatal risk assessment tool) LOW □ MEDIUM □ HIGH □ *If moderate or high risk discuss with Consultant and document if anti-coagulants regime required post-surgery*

RELEVANT MEDICAL/OBSTETRIC HISTORY:

Appendix 4: Referring A Patient to Imperial College Healthcare Pregnancy Termination services.

You may refer a patient and book her appointment via the contact details below. It would be very helpful if you could email a brief letter indicating your patient's request for an abortion along with her details and her medical history. If you are also able to include a signed HSA that would be very helpful, though it is not necessary.

Ideally, make the contact with one of the consultants gynaecologists who work in the unit at St Mary's, Dr Vinita Nair or Dr Clare Ross.

Phone: 020 3312 1525

Mobile: 077 1766 7899

Email: imperial.TOP@nhs.net

Patients who wish to self-refer to this service may call directly.

Phone: 020 3312 1093

Appendix 5: Patient information for treatment of medical termination of pregnancy with Mifepristone and Misoprostol

Pt information Medical TOP.pdf

Appendix 6: Patient Information following interruption of pregnancy.

Information for women facing interup

Full version control record

Version:	3
Guidelines Lead(s):	Monica Eve, Hannah Hawkett, Anna Kemsley, Cassie Appleton, Anne Deans, Lead Fetal Medicine Katharine Franks ANNB Screening lead Catherine McPadden, Lorna Beecher screening coordinators
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Library check completed:	07.08.2024
Ratified at:	Cross site obstetric clinical governance meeting, 01.10.2024
Date Issued:	07/10/2024
Review Date:	01.10.2027
Pharmaceutical dosing advice and formulary compliance checked by:	Ruhena Ahmad, 02.09.2024
Key words:	Termination, abortion, stillbirth, late fetal loss, induction of labour, funeral arrangements, mifepristone, misoprostol, postmortem.

This guideline has been registered with the Trust. However, clinical guidelines are guidelines only. The interpretation and application of clinical guidelines will remain the responsibility of the individual clinician. If in doubt, contact a senior colleague or expert. Caution is advised when using guidelines after the review date.

This guideline is for use in Frimley Health NHS Foundation Trust hospitals only. Any use outside this location will not be supported by the Trust and will be at the risk of the individual using it.

Version History

Version	Date	Guideline Lead(s)	Status	Comment
1.0	September 2016	Mid trimester Termination for Fetal Abnormality	Final	
2.0	December 2019	M. Eve, C. Litchfield, K. Franks, J. Cox, C. McPadden, C. Holt	Final	Reviewed and updated
3	October 2024	Monica Eve, Anna Kemsley, Kathy Franks Cassie Appleton, Anne Deans	Final	Scheduled review, ratified at cross site obstetric clinical governance meeting 01.10.2024

Related Documents

Document Type	Document Name
Guideline	Feticide guideline
Guideline	Intrauterine death (>24 weeks of gestation) trust guideline
Guideline	Late fetal loss (16 weeks to 23+6 weeks gestation)