Abortion – procedure for foetus up to 9 weeks

For a foetus up to 63 days (9 weeks) gestation the type of abortion a patient would receive is a medical abortion, or a surgical abortion.

The use of medical abortions for pre-9 weeks has increased since the availability of MS-2Step. It is anticipated that this will continue to increase given the TGA restrictions have been lifted due to the reduced risk profile of MS-2Step.

The patient is not required to attend hospital and usually takes the medication at home. Medical abortion offers an alternative to surgical abortion in the early weeks of pregnancy. It is a low-risk, non-invasive way to terminate a pregnancy.

Oral medication is prescribed (currently by a GP or abortion provider; the Bill will allow other registered health practitioners). Medical abortion uses a combination of two medications to end a pregnancy.

The first tablet (mifepristone) blocks a pregnancy hormone. To complete the abortion, the patient take a second tablet (misoprostol) 36 to 48 hours later. This causes the uterus (womb) lining to break down and the patient will start to bleed, usually within two hours. The pregnancy ends with bleeding or clotting similar to a miscarriage. This usually happens within four to six hours of taking the second tablet but may be quicker or take longer.

If, for any reason, this treatment does not work, the patient may require a surgical termination. The abortion service will provide the patient with information and contact details to access help if there are any complications.

Abortion – procedure for foetus after 9 weeks

After 9-weeks' gestation, abortions may be surgical or a combination of medication and surgery, or a medical procedure to induce labour.

Post 9 weeks abortions are only available in licensed day surgery clinics and in hospitals.

Currently in WA, post 20 weeks are only performed in KEMH or Broome. In other States post 23/24 weeks would be done in hospitals

Surgical methods include vacuum aspiration, curettage, dilation and evacuation and may differ across service providers.

Up to 14-16 weeks, aspiration techniques and curettage can generally be used. The procedure is generally performed under anaesthetic and/or maternal conscious sedation.

For gestations over 14-16 weeks, a slightly different process is used to ensure all the products of pregnancy are removed, called dilation and evacuation involves the dilation of the cervix and surgical evacuation of the uterus. This may involve curettage and surgical dissection and removal of the pregnancy tissue.

Inducing labour is a non-surgical abortion method that usually occurs post 13 to 14 weeks, and may be preceded by a feticide process at gestations from 22 weeks.

Surgical techniques (eg. vacuum aspiration, curettage, dilation & evacuation) may be required for the uncommon situation where a non-surgical abortion provided does not result in foetal expulsion.

There are different methods of conducting a feticide process. Feticide is usually performed for gestations greater than 22 weeks. It is not clinically necessary prior to 22 weeks as the fetus is fragile and will not survive the labour process.

At King Edward Memorial Hospital feticide generally involves the injection of potassium chloride directly into the foetus under ultrasound guidance. The foetal cardiac activity and signs of life are monitored in utero, until it is confirmed that the foetus is no longer alive. Only then, is labour induced. The medical staff in the room (minimum of two) monitor the real-time ultrasound image and confirm that there is no foetal heartbeat. Sedation is administered to the woman, which flows on to the fetus.

KEMH routinely performs feticide for non-lethal anomalies, such as where an abortion is performed for maternal health reasons.

Prior to 2017, KEMH did not always conduct feticides for postnatal lethal conditions for foetus over 22 weeks gestation, such as anencephaly and Trisomy 18.

In 2017, a policy of universal feticide for terminations above 22 weeks was introduced to avoid the situation of transient livebirth after termination and the potential for a coronial review, which could further increase distress of the woman and her family.