

# Early medical abortion without ultrasound

## Protocol

### Background

Early medication abortion (EMA) to 63 days gestation using a combination of mifepristone and misoprostol (in Australia marketed as MS2Step) is safe and effective. An ultrasound scan (USS) prior to abortion has previously been regarded as standard practice to confirm gestational age and location of pregnancy.

Evolving research and guidelines support the practice of early medical abortion without ultrasound. Aiken (2021) shows that a no-test telehealth abortion is safe in appropriately selected patients who meet eligibility criteria. In this cohort, the risk of ectopic pregnancy was 0.2% and was not different when comparing the two groups - standard care (USS prior to abortion) and the intervention group (no-test abortion; USS only if screen positive). Of note, 39% of patients in the intervention group required an ultrasound after eligibility screening.

Brandell (2024) found that early initiation of medical abortion, prior to confirmation of an intrauterine pregnancy, was non-inferior to standard treatment initiated after confirmed intrauterine pregnancy with respect to complete abortion. Reasons for failed abortion differed between the two groups, with a higher incidence of surgical intervention for incomplete abortion after standard treatment and a higher incidence of ongoing pregnancy after early initiation.

RANZCOG Abortion Care Guidelines (2023) recommend that gestational age be determined prior to abortion, either by clinical means (history, date of last menstrual period) or ultrasound.

Early medical abortion without ultrasound includes both patients with early pregnancy (where an intrauterine pregnancy is not yet visible on ultrasound, often <6/40), or patients who choose not to or are unable to access an ultrasound. The advantages include early access to timely care and may contribute to less pain and bleeding and may reduce complications following the procedure.

The safety of early medical abortion without ultrasound relies on screening, risk assessment and safety netting strategies to identify and respond to an ectopic pregnancy.

This protocol has been developed in conjunction with international research and guidelines to accurately determine gestational age and screen for risk of ectopic pregnancy.

## Criteria for EMA without ultrasound

### It is important to:

- Establish gestational age by clinical history i.e. last normal menstrual period and/or certainty of the date of conception.
  - In addition, a quantitative serum  $\beta$ -hCG can be used to correlate findings.
- Identify risk factors and screen for an ectopic pregnancy.
- Offer to individuals able to provide informed consent and be active in follow up care.

### Eligibility screening for medical abortion without USS

History:	Ultrasound required if:
<p><b>Targeted menstrual history</b></p> <ul style="list-style-type: none"> <li>• <b>Is date of the LMP certain?</b> <ul style="list-style-type: none"> <li>◦ Use first day of proper bleeding (do not count light spotting prior to full period)</li> </ul> </li> <li>• <b>How frequent are periods?</b></li> <li>• <b>Was last period 'normal' (not lighter or heavier flow)?</b> <ul style="list-style-type: none"> <li>◦ If particularly heavy, repeat pregnancy test and take date of last normal period</li> </ul> </li> <li>• <b>When was the date of the first positive pregnancy test?</b></li> </ul>	<ul style="list-style-type: none"> <li>• LMP is unknown or more than 8 weeks ago</li> <li>• Periods are irregular <b>OR</b> <ul style="list-style-type: none"> <li>◦ less than 21 or more than 35 days between cycles <b>OR</b></li> <li>◦ if LMP was especially light or just spotting</li> </ul> </li> <li>• The quantitative <math>\beta</math>HCG is inconsistent with dates</li> </ul>
<p><b>Hormonal contraception</b></p> <p>In the last 8 weeks, has any form of hormonal contraception been used, including EC?</p>	<ul style="list-style-type: none"> <li>• Any hormonal contraception used in the past 8 weeks</li> </ul>
<p><b>Breastfeeding</b></p> <p>Is currently breastfeeding? Are the cycles regular for at least 3 months?</p>	<ul style="list-style-type: none"> <li>• If breastfeeding and amenorrhea <b>OR</b></li> <li>• irregular cycles for past 3 months</li> </ul>
<p><b>Ectopic risk factors</b></p> <ul style="list-style-type: none"> <li>• Any history of previous ectopic pregnancy, fallopian tube surgery, tubal scarring or damage?</li> <li>• Past or current pelvic inflammatory disease</li> <li>• If an IUD was in place at the time of conception, EMA is not suitable unless the IUD is removed prior to MS2Step.</li> </ul> <p><b>Since pregnancy diagnosis:</b></p> <ul style="list-style-type: none"> <li>• Had pelvic pain, especially more on one side than the other</li> <li>• Shoulder tip or rectal pain</li> <li>• Vaginal bleeding or spotting</li> </ul>	<ul style="list-style-type: none"> <li>• Any risk factor for ectopic identified</li> </ul>

## Counselling points for medical abortion without USS

- Early medical abortion is safe.
- Ectopic pregnancy is rare (0.2% if the above screening is negative). For patients who have been screened with the above methodology, the incidence of ectopic pregnancy is lower than the general population.
- Ectopic pregnancy has not been definitively excluded. EMA will not treat an ectopic pregnancy.
- Follow up is essential to ensure safety, wellbeing and resolution of the pregnancy.
- Provide advice on when to seek medical help i.e. no response to medication, no bleeding, significant unilateral pelvic pain, shoulder tip or rectal pain, collapse or loss of consciousness.
- All other counselling points for routine EMA apply, as per the Women's [EMA Clinical Guideline](#).
- Follow-up for EMA without USS is as per usual EMA practice.
- While there is no evidence to support a lower gestational limit for early medical abortion, failure rates (ongoing pregnancy) may be higher at less than 5 weeks gestation. Close follow-up is recommended.

### Early medical abortion without ultrasound is suitable for women and pregnant people who:

- have met the above criteria
- estimated to be less than 9 weeks with no indication for a scan
- have provided informed consent
- are able to be active and engage in follow up care.

### Adapted from:

1. Aiken, A.R.A., Lohr, P.A., Lord, J., Ghosh, N. and Starling, J., 2021. Effectiveness, safety and acceptability of no-test medical abortion (termination of pregnancy) provided via telemedicine: a national cohort study. *BJOG*, 128, pp. 1464-1474.
2. Brandell, K., 2024. Randomized Trial of Very Early Medication Abortion. *New England Journal of Medicine*, 391, pp. 1685-1695.
3. RANZCOG, 2023. Clinical Guideline for Abortion Care: An evidence-based guideline on abortion care in Australia and Aotearoa New Zealand. Royal Australian and New Zealand College of Obstetricians and Gynaecologists.
4. RCOG, 2024. Decision aid for early medical abortion without ultrasound. London: Royal College of Obstetricians and Gynaecologists.
5. Queensland Health. 2024. Queensland Clinical Guidelines. Termination of pregnancy. Guideline No. MN24.21- V10-R29. Available at: <http://www.health.qld.gov.au/qcg>. (Accessed 30 July 2025).

### For more information:

The Women's Sexual & Reproductive Health Clinical Champion Network  
**P:** (03) 8345 2135

**Further reading:** [The Women's Early Medical Abortion clinical pathway](#).



# Decision flowchart

## Eligibility criteria for medical abortion without ultrasound

