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Original Research Article

Medical termination of pregnancy beyond 24 weeks: preliminary observations from a tertiary care institute in Northern India

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ABSTRACT

Background: Despite increase in legally prescribed limit of gestational age to 24 weeks for medical termination of pregnancy (MTP) in India, a reasonable number of women request for MTP beyond 24 weeks of gestation. We present preliminary observations on women who underwent MTP beyond 24 weeks of gestation at our institute.

Methods: Current study included 32 women who underwent MTP beyond 24 weeks of gestation (after obtaining permission from permanent medical board) at our tertiary care institute in Northern India. Gestational age was calculated by menstrual history as well as ultrasonographic findings.

Results: Mean age was 28±4.8 years. Mean gestational age at time of MTP was 28 weeks and 2 days. Eight (25%) women were primigravida while 24 (75%) were multigravida. Nine (28.1%) women had past history of abortion. The most common indications for MTP were neurological defects (28.1%) followed by cardiac (21.9%), renal (18.8%) and musculoskeletal (15.6%) defects. Two women underwent surgical intervention while pregnancy was terminated medically in 30 (87.5%) women. All women were healthy at discharge.

Conclusions: MTP beyond 24 weeks of gestational age is safe. Future studies on reasons for delayed presentation may help us in further streamlining of MTP services.

Keywords: 24 weeks, Abortion, Birth defect, MTP, Neural defects

INTRODUCTION

Government of India published “Medical Termination of Pregnancy (Amendment) Act, 2021” in Indian Gazette on 25th March, 2021. This provided more autonomy and safety to Indian women and was welcomed by obstetricians across the country.¹ However, a significant number of women still continue to present beyond 24 weeks of gestation for MTP. In our institute we have a permanent medical board (PMB) since April 2021 for Abortion beyond 24 Weeks of Gestation, which was

constituted in accordance with orders of Government of India.

While initially abortions recommended by medical board required permission from honourable High Court, subsequently its powers were increased so that abortions could be carried out based solely on its recommendations. Accordingly, now carry out abortions beyond 24 weeks of gestation after obtaining permission from PMB of our institute. Main aim of current study is to present our data on MTP beyond 24 weeks of gestation at the institute.

METHODS

Current study is a prospective observational study conducted from 1st July 2024 to 31 December 2024 in department of Gynecology and Obstetrics at a tertiary care institute (Postgraduate Institute of Medical Education and Research, Chandigarh) in Northern India. During this period all the women (n=32) who requested abortion beyond 24 weeks of gestation were enrolled. After obtaining permission from permanent medical board of our institute, these women were planned for MTP at our institute. Gestational age was calculated based on menstrual history which was further corroborated by ultrasonographic findings. In case of any discrepancy, decision regarding gestational age was reached by consensus.

Once enrolled, all the women underwent detailed clinical and laboratory evaluation including detailed hemogram, biochemistry (including blood sugars, renal, liver and thyroid function tests, serum electrolytes, coagulation profile, etc) urine microscopy and screening for human immunodeficiency virus, hepatitis B and C viruses. All the women underwent MTP as per standard protocol being followed in our institute (Mifepristone (200mg on 1st and 2nd day in our outdoor patient department)), On 3rd day, they are admitted and based on their clinical picture and risks they are given either Misoprostol or oxytocin). All relevant clinical, laboratory therapeutic and outcome data were recorded meticulously.

RESULTS

Current study enrolled 32 women. Mean age was 28±4.8 years (range:20-39 years). Mean gestational age (GA) at

time of MTP was 28 weeks and 2 days (range: 24.5 to 32.2 days). Eight (25%) women were primigravida while 24 (75%) were multigravida. 4 (12.5%) has two living children at time of MTP, 18 (56.3%) has one living child while 10 (31.3%) women (including 8 primigravida) did not have any living child. Nine (28.1%) women had past history of abortion. The most common indication for abortion was neural defects (9; 28.1%; 7-isolated; 2 as part of multiple congenital anomalies), followed by cardiac (7; 21.9%; isolated 6; as part of multiple congenital anomalies-1)), renal (6, 18.8%; isolated-5) and musculoskeletal (5; 15.6%; isolated-4) in that order.

Despite adequate antenatal check-up (100%), fetal aneuploidy screen was done in only 8 (25%) while 5 (15.6%) women underwent amniocentesis and genetic testing after admission in our institute. Foetal intracardiac potassium chloride (KCl) was given to 24 (75%) women; Mifepristone was used in 28 (87.5%) women; Among four women, where it was not used, two came in spontaneous labour following KCL injection, one underwent caesarean section (as gestational age was 32.2 weeks with previous two caesareans sections) and one underwent hysterotomy (previous two caesareans' sections).

Among the 28 women who received mifepristone, Bishop score was less than 4 in 26 (92.9%) while 2 (7.1%) came in spontaneous labour. 23/28 (82.1%) women required misoprostol (mean±SD= 191.3±104.1 µg) while 3 (10.7%) received oxytocin. Thirty (93.7%) women were discharged within one day, 1 (3.1%) after 2 days and 1 (3.1%) after 4 days. There was no complication in any of the women and all were healthy at time of discharge. No postprocedural complications were seen in any patient. These data are summarized in Table 1.

Table 1: Clinical and demographic data of study population.

Parameter	Value (n=32)
Mean (±SD) age in years	28±4.8 (range: 20-39 years)
Mean gestational age	28 weeks 2 days (range: 24.5 to 32.2 days)
Indication for medical termination of pregnancy	Number of patients (percentage) (n=32)
Neural (Arnold Chiari Malformation type II: 4; Anencephaly-1; Ventriculomegaly-1; lissencephaly-1; as part of multiple congenital anomalies-2)	9 (28.1%)
Cardiac (Tricuspid atresia-1; Single atrioventricular canal-1; Double outlet right ventricle with atrial septal defect and pulmonary stenosis-1; Single ventricle-1; hypoplastic heart-1; complex cardiac anomaly-1; as part of multiple congenital anomalies-1)	7 (21.9%)
Renal (Renal agenesis-5; As part of multiple congenital anomalies)	6 (18.8%)
Genetic/ chromosomal defects (Trisomy 18-1; Noonan syndrome-1; Pittochi Shaffer syndrome-1; DiGeorge syndrome-1; I cell disease-1)	5 (15.6%)
Musculoskeletal (arthroposis-3; skeletal hypoplasia-1; as multiple congenital anomalies-1)	5 (15.6%)
Lungs (As part of multiple congenital anomalies)	2 (6.3%)
Multiple affecting > 1 organs (Acrania, spinal defects, congenital diaphragmatic hernia-1; Sacral meningomyelocele with congenital diaphragmatic hernia-1; skeletal dysplasia with pulmonary hypoplasia-1; gross hydronephrosis with lung hypoplasia-1; Hypoplastic heart with renal malrotation-1)	5 (15.6%)

Continued.

Parameter	Value (n=32)
Parity	
Primigravida	8 (25%)
Multigravida (G ₂ -11; G ₃ -7; G ₄ -5; G ₅ -1)	24 (75%)
Past history of abortions	
None	22 (64.7%)
One	6 (18.8%)
Two	3 (9.4%)
Three	1 (3.1%)
Past history of caesarean section	
None	25 (78.3%)
One	5 (15.6%)
Two	2 (6.3%)
Living children	
None	10 (31.3%)
One	19 (59.4%)
Two	3 (9.4%)
Use of potassium chloride	
Yes	24 (75%)
No	8 (25%)
Drug/ procedural intervention	
Misoprostol	23 (71.9%)
Oxytocin	3 (9.4%)
Caesarean section	1 (3.1%)
Hysterotomy	1 (3.1%)
Spontaneous labour	4 (12.5%)
Sex of baby	
Girl	18 (56.3%)
Boy	11 (34.4%)
Could not be determined- fused genitalia	3 (9.4%)
Any procedural/ postprocedural complication	None
Duration of stay	
24 hours	30 (93.8%)
2 days	1 (3.1%)
4 days	1 (3.1%)

DISCUSSION

For more than 70 years after independence, legally prescribed limit of GA for MTP in India was 20 weeks, though many countries did not have any legal limit for GA for MTP.² Last five years have witnessed remarkable changes in MTP act of India. Firstly, legal MTP was allowed up to 24 weeks of gestation. Further it is also mentioned in latest amendment that length of the pregnancy shall not apply when MTP is indicated for substantial foetal abnormality. Accordingly, beyond 24 weeks of gestational age, abortions were done after obtaining necessary permission from honourable courts based on recommendations from permanent medical boards constituted in states and union territories of India (created in our institute in 2017). Later on, permanent medical board in our institute was given powers to recommend abortion without permission from Honourable high court in order to avoid procedural delay. All these changes have provided more autonomy and safety to women requesting MTP.^{1,3,4} In current study we evaluated the causes and outcome of women undergoing MTP after

24 weeks of gestational age. Most common cause for MTP in the study was presence of fetal anomalies which is similar to that reported previously.^{5,6} The most common fetal anomalies in the cohort were neurological defects which is similar to that reported previously.⁷⁻⁹ However, the results contrasted from other studies which reported cardiac defects and chromosomal anomalies as main reasons for MTP.^{4,10,11} The reason for this discrepancy is likely related to the fact that genetic testing being costly is not done for many of our patients (15.6% in present study) despite past history of abortion, while ultrasonographic scanning is done routinely and is relatively cheaper. Another reason for above discrepancy is related to possibility of progression of anomaly after initial ultrasound. This is consistent with the fact that neural defects (26-39.7%) top the reason for MTP in late pregnancy.¹²⁻¹⁴ Overall, approximately 17% (32/189) of MTPs in the institute were beyond 24 weeks of GA. This is much higher than previous reports of 0.9% and 6% respectively but similar to 15% reported by another study.^{9,12,15} One possible explanation for this discrepancy is that one GA is beyond 24 weeks, all the women are

referred for MTP to the center as opinion of PMB (as per legal regulation) is needed for MTP in these women. In current study, 12.5% of women has two living children at time of 3rd pregnancy. Though the number is relatively small, we need to implement two child policy of our government even more robustly. All women in the study (except two who underwent caesarean section and hysterotomy), could be discharged within 24 hours. Both the women who underwent surgical produces had past history of two caesarean sections. There was no procedural or post-procedural complication in any of woman.

Main strengths of the study are continuous cohort and a uniform methodology. The main limitations include relatively small sample size and the fact that we did not evaluate reasons for delay of presentation in current cohort.

CONCLUSION

To conclude, our data suggest that MTP beyond 24 weeks of gestational age done for fetal malformations is safe and provides more autonomy to women. Future studies evaluating socioeconomic and other factors which lead to delayed presentation will further help us in streamlining MTP services.

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Ethical approval: The study was approved by the Institutional Ethics Committee

REFERENCES

1. Datar N. MTP After 20 weeks: When & How. *J Obstet Gynaecol.* 2021;71(4):357-60.
2. Paintin D. Abortion after 24 weeks. *Br J Obstet Gynaecol.* 1997;104(4):398-400.
3. Bagga R, Singh R, Bansal Y, Singh T, Mukhopadhyay K, Shah R, et al. Legal abortion limit raised up to 24 weeks of gestation for substantial foetal anomalies or for rape victims: a welcome step for women and health providers in India. *Asian Bio Rev.* 2021;14(1):5-8.
4. Hern WM. Fetal diagnostic indications for second and third trimester outpatient pregnancy termination. *Prenat Diag.* 2014;34(5):438-44.
5. Dogru S, Akkus F, Atci AA, Erdogan AC, Acar A. Pregnancy termination indications and outcomes before 24 weeks of gestation—a case series. *Cesk Gynecol.* 2023;88(6):428-34.
6. Ozyuncu O, Orgul G, Tanacan A, Aktoz F, Guleray N, Fadiloglu E, et al. Retrospective analysis of indications for termination of pregnancy. *J Obstet Gynaecol.* 2019;39(3):355-8.
7. Bolluk G, Bakirci IT, Cok M, Karakus HT, Sengonul K. Evaluating pregnancy termination decisions for fetal anomalies: a retrospective study in a tertiary referral center. *Rev Assoc Med Bras.* 2024;70(5):1118.
8. Corbacioglu A, Aslan H, Aydin S, Akbayir O, Ersan F, Alpay V, et al. Trends in fetal indications for termination of pregnancy between 2002 and 2010 at a tertiary referral centre. *J Turk Ger Gynecol Assoc.* 2012;13(2):85-90.
9. Dogan Y, Karatas S, Turhan MA, Kockaya E, Eser MD, Babaoglu A. Termination of pregnancy for medical indications: A 14-year analysis from a tertiary referral center. *Int J Gynaecol Obstet.* 2025;171(3):1205-11.
10. Terece C, Turan G, Uckan HH, Eser A, Ozler MR, Gunbay S, et al. The analysis of pregnancies terminated before and after the limit of viability: A medicolegal view. *J Forensic Leg Med.* 2023;95:102491.
11. Friedman CF, Chasen ST. Abortion for fetal indications: Timing of prenatal diagnosis and abortion for structural and genetic abnormalities. *Contraception.* 2020;101(5):293-5.
12. Game E, Khoshnood B, Loane M, Boyd P, Dolk H. EUROCAT Working Group. Termination of pregnancy for fetal anomaly after 23 weeks of gestation: a European register-based study. *BJOG.* 2010;117(6):660-6.
13. Dathan-Stumpf A, Kern J, Faber R, Stepan H. Prenatal and Obstetric Parameters of Late Terminations: A Retrospective Analysis. *Geburtshilfe Frauenheilkd.* 2021;81(7):807-18.
14. Muin DA, Otte P, Scharrer A, Kasprian G, Husslein PW, Kiss H, et al. Temporal changes in epidemiological profile and fetal indications for late termination of pregnancy: a retrospective single-center study. *Arch Gynecol Obstet.* 2021;304(4):935-42.
15. Kortsmit K, Nguyen AT, Mandel MG, Hollier LM, Ramer S, Rodenhizer J, et al. Abortion Surveillance - United States, 2021. *MMWR Surveill Summ.* 2023;72(9):1-29.

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