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Induced Abortion After Previous Caesarean Section: A Scoping Review

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ABSTRACT

Background: Previous caesarean section (CS) is increasingly common among women undergoing induced abortion.

Aims: To map and analyse existing literature on abortion safety, outcomes and management in those with previous CS.

Materials and Methods: Four databases were systematically searched from inception to July 2024. Primary human studies in English reporting on outcomes, safety or management of first- or second-trimester medical (MToP) or surgical (SToP) abortion in women with previous CS were included. Uterine rupture incidence was analysed cumulatively in the first and secondtrimesters by the number of CS and the type of prostaglandin used. Data on the efficacy and safety of MToP and SToP, including studies reporting on the management of abortion in the setting of abnormal placentation, were collected and analysed by theme.

Results: In total, 164 articles met inclusion criteria. Incidence of uterine rupture in first-trimester MToP was 0 of 2194 cases, in second-trimester misoprostol MToP in those with 1 previous CS was 0.5% (10/1910) and 2.2% (18/835) in women with ≥2 CS ($p < 0.001$). Mifepristone priming did not increase the rupture rate in second-trimester MToP ($p = 0.77$). Previous CS was a modest risk factor for retained products after MToP across both trimesters (OR 1.48, CI 1.29–1.70).

Conclusion: Medical and surgical abortion in the first and second trimester appears safe in women with prior CS; however, risks include uterine rupture, need for surgical intervention and haemorrhage from undiagnosed placenta accreta. Further research and guidance are needed on managing abortion after previous classical CS, ≥3 previous CS and those with abnormally invasive placenta.

1 | Background

Caesarean section (CS) rates continue to rise internationally [1], and in Australia climbed from 32% to 38% between 2009 and 2021 [2, 3]. Furthermore, the majority (88%) of Australian women who have a CS will have their subsequent birth by CS [3], leading to an overall increasing trend in women with more than one previous CS. There are at least 80,000–90,000 induced abortions per year in Australia, and approximately a quarter of pregnancies end in induced abortion [4]. Thus, it is common for an individual undergoing induced abortion to have had one or more CS. CS carries specific risks to future pregnancies, including abnormal placentation, caesarean scar pregnancy (CSP) and uterine rupture, which also have the potential to affect abortion safety [5, 6].

The incidence of uterine rupture during second-trimester MToP has been reported to be lower than in term vaginal birth in those with previous CS [7] (0.3%–0.43% in previous systematic reviews) [6, 8], a recent meta-analysis published in 2023 reports a 1.1% incidence with mifepristone-misoprostol [9]. Current guidelines acknowledge the small risk of rupture with second-trimester MToP, some offering consensus-based low-dose misoprostol regimens for women with previous CS [10–12]. These regimens are heterogeneous between institutions, and there is little guidance regarding SToP safety and optimal abortion care for those with >1 previous CS or previous vertical uterine incision (classical CS). Importantly, previous reviews have included low numbers of individuals with >1 previous CS, making it difficult to accurately draw conclusions about rupture rates in this group.

With rising CS rates, related sequelae including placenta accreta spectrum (PAS) and CSP are increasingly reported [13, 14]. Abnormal placentation, with associated obstetric risks, can also be a reason for seeking abortion; and there is minimal guidance on optimising the safety of abortion in these cases.

Given the scope of the research questions and heterogenous nature of available evidence, the exploratory approach of a scoping review was chosen [15]. This scoping review covers a broader topic than previously published reviews and includes both first and second-trimester abortion and varying methods of medical and surgical abortion.

2 | Materials and Methods

2.1 | Protocol and Registration

This review was performed according to Joanna Briggs Institute methodology [16] using the Preferred Reporting Items for Systematic Reviews and Meta-Analyses Extension for Scoping Reviews (PRISMA-ScR) [17] (Table S1). The protocol was registered with Open Science Framework (OSF.IO/AH79V).

2.2 | Identification of Research Questions

The objectives of the review were as follows:

- To summarise and analyse existing literature on abortion after prior CS, including risks of complications.
- To map the current evidence on recommended management of abortion after CS.
- To identify knowledge gaps and guide further research into abortion care for those with previous CS.

2.3 | Search Strategy

We systematically searched four online databases (MEDLINE (Ovid), CINAHL, SCOPUS and EMBASE) from inception to July 2024. The search strategy was developed using keywords and MeSH terms related to outcomes, complications and management of abortion after prior CS (Appendix S1). References of included articles were hand-searched to identify additional relevant articles.

2.4 | Study Selection

Title and abstract screening were performed independently by three reviewers (ND, VG and BV), followed by full-text review (ND and VG) to determine eligibility. Conflicts between the two initial reviewers were resolved by a third (CD).

Articles meeting eligibility criteria were included (Table S2). Studies were included if they reported on outcomes (safety; complete abortion rates; complication rates, prevention or management) of first or second-trimester abortion in individuals with ≥1 previous CS. Studies only involving participants with miscarriage or intrauterine fetal death, and those that did not report outcomes for participants with previous CS, were excluded. Studies involving women undergoing treatment of known CSP were excluded, as this would have yielded papers regarding management of this condition, outside the scope of this review. However, studies and case reports of women undergoing abortion with undiagnosed CSP that became apparent after commencement of the abortion process were included, as this is an increasingly common challenge facing abortion care clinicians. Studies were also included if they involved participants undergoing second-trimester abortion with PAS and previous CS.

Inclusion was limited to articles published in English, involving humans, with no date limitations. Primary descriptive, observational, and interventional studies were included, as were case reports. Secondary sources of evidence including systematic reviews, opinions, book chapters, letters to the editor, protocols and guidelines were excluded.

2.5 | Data Extraction and Analysis

Data variables are summarised in Table S3. Risk of bias was assessed by two reviewers using the Cochrane Risk of Bias for Randomized Trials Tool version 2.0 (RoB 2.0) [18] for randomised controlled trials, ROBINS-I [19] for non-randomised interventional studies and ROBINS-E [20] for observational studies.

Results were grouped and analysed according to themes:

- Safety and efficacy of MToP in first-trimester
- Safety and efficacy of MToP in second-trimester
- Safety and outcomes of SToP in first- and second-trimester
- Abortion after previous classical CS
- Abortion in the context of abnormal placentation

Descriptive statistics were used and cumulative meta-analyses of rupture rates in the setting of first- and second-trimester

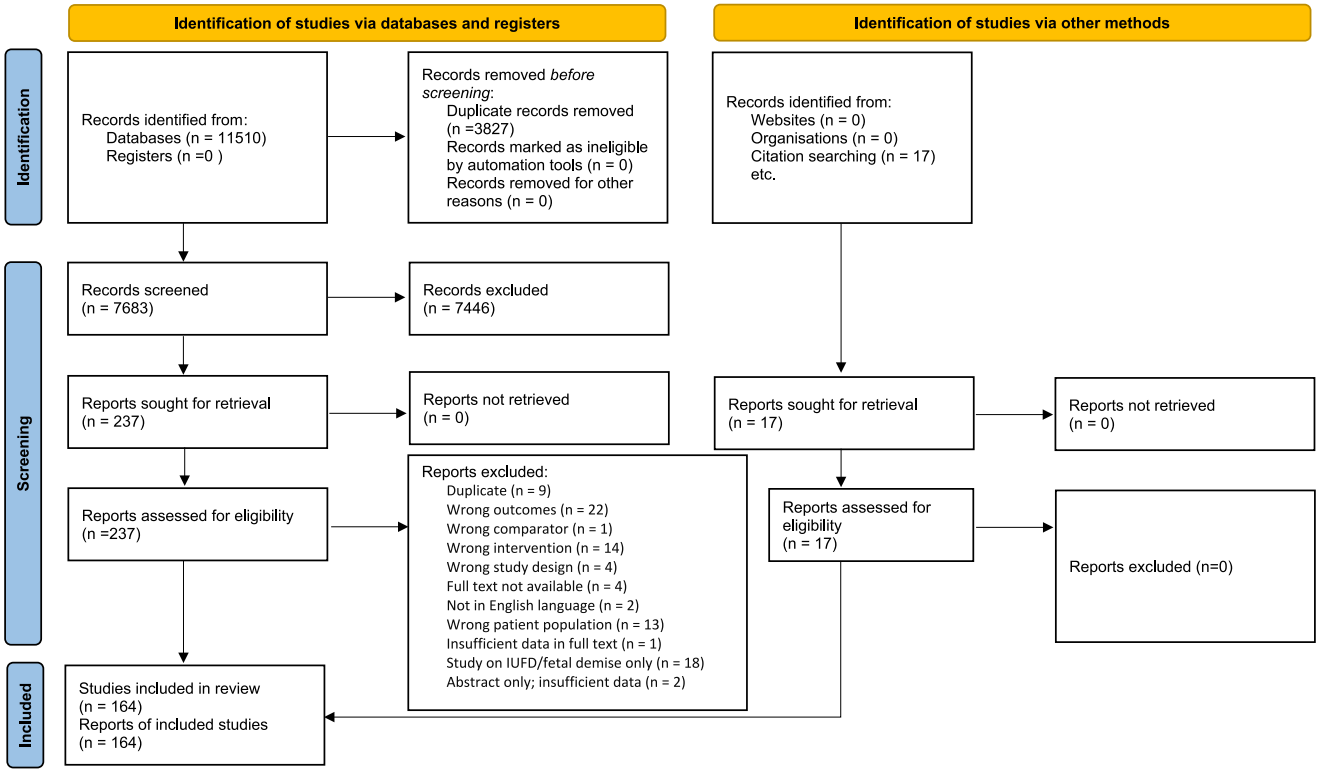

FIGURE 1 | PRISMA flow diagram. *Source:* Page et al. [22]. For more information, visit: http://www.prisma-statement.org/.

MToPs, and for cervical priming prior to SToP, were performed. Confidence intervals (CI) were calculated using the adjusted Wald method [21]. Data analysis of the efficacy of first- and second-trimester MToP, and outcomes of first- and second-trimester SToP, was performed using Review Manager (Revman) 5.4.1 with risk ratios and CI given using a random effects model. Results were considered statistically significant when $p < 0.05$.

2.6 | Definitions

First trimester is defined as < 13 weeks gestation and second trimester 13–28 weeks; however, several studies included in the analysis defined the second-trimester as beginning at 12 + 0, and these were included in the second-trimester analysis if these data were unable to be extracted separately. Classical CS refers to a vertical incision on the uterus, as opposed to lower segment CS, in which a transverse lower segment incision is made. Hysterotomy refers to operative abdominal delivery with uterine incision for a non-viable pregnancy.

2.7 | Patient and Public Involvement

Patients and the public were not involved in the design or conduct of this scoping review.

2.8 | Ethics Statement

Not applicable.

3 | Results

In total, 164 articles were included: 46 case reports in 39 articles (Table S4), and 125 original articles (Table S5). Figure 1 shows the PRISMA diagram of study inclusion.

Table 1 summarises the characteristics of included studies.

3.1 | Safety of MToP After Previous Caesarean

There were 23 case reports of uterine rupture complicating either MToP or during cervical ripening before SToP [23–41]. Twenty (87.0%) cases occurred in the second trimester, and reported blood loss was 200–3000 mL; 4(17.4%) required hysterectomy. Laparotomy was the most common method of surgical intervention for uterine rupture, but four authors described a laparoscopic approach and one reported transvaginal approximation of the defect [27, 32, 34, 39, 41].

Despite three reports of uterine rupture in the first trimester [24, 33, 40], seven observational studies reported no cases of rupture amongst 2194 women undergoing first-trimester MToP [42–48] (Table 2).

Table 3 synthesises articles reporting on rupture rates with second-trimester MToP using prostaglandins [8, 49–88, 90–113, 115–117]. Studies were excluded if ruptures occurred in the context of intravenous oxytocin use [66, 118–121], included data from participants of unclear gestation (≤ 28 weeks vs. > 28 weeks), or did not specify a rupture rate [120, 122–130].

TABLE 1 | Summary of characteristics of included studies.

Characteristics	Values	Number (%) of articles
Year of publication	1981–1990	1 (0.6%)
	1991–2000	11 (6.7%)
	2001–2010	52 (31.7%)
	2011–2020	69 (42.1%)
	2021–2024	31 (18.9%)
Continent of conduct	Africa	12 (7.3%)
	Asia	65 (40.0%)
	Europe	43 (26.2%)
	North America	36 (21.9%)
	Oceania	8 (4.9%)
Design	Case reports	39 (23.8%)
	Case series/ descriptive	12 (7.3%)
	Case–control	2 (1.2%)
	Cohort	95 (57.9%)
	Non-randomised controlled	1 (0.6%)
	Randomised controlled	15 (9.1%)
Gestation	First trimester (<13 weeks)	24 (14.6%)
	Second trimester (13 + 0–28 + 0 weeks)	121 (73.8%)
	Both	18 (11.0%)
Type of abortion	Unspecified	1 (0.6%)
	MToP	118 (72.0%)
	SToP	39 (23.8%)
	Both	7 (4.3%)

Sixty-six studies (5604 women) with previous CS undergoing second-trimester prostaglandin MToP were included in the analysis: 69 ruptures occurred (1.23%, 95% CI 1.00%–1.56%), 45 of 4512 with misoprostol use (1.00%, CI 0.75%–1.33%) and 24 of 1093 with gemeprost (2.20%, CI 1.48%–3.26%; $p = 0.001$). Of the 69 ruptures, the mean gestation was 21 weeks (SD 3.8), and 53 (76.8%) were managed with closure of the defect by laparoscopy or laparotomy without hysterectomy.

Rupture rates were also calculated by number of previous CS where data was available (Table 3), demonstrating a rupture rate of 10 of 1910 (0.52%, CI 0.28%–0.97%) after 1 previous CS, and 18 of 835 (2.16%, CI 1.36%–3.40%) after ≥2 previous CS ($p < 0.001$).

There was no difference in rupture rates between misoprostol alone (1.0%) compared with the use of mifepristone and misoprostol (1.1%; $p = 0.77$). However, numerous studies reported a reduction in abortion time with the addition of mifepristone 24–48 h prior to misoprostol [54, 81, 96, 106, 115]. There were significant variations in misoprostol dosage, timing and route of administration. Where dosage data were able to be extracted and categorised into low-dose only (≤200 μg) and >200 μg increments, studies that used low-dose increments only [49, 50, 56, 58, 63, 69, 70, 75, 82, 85, 92, 93, 107, 108, 112, 115] did not have significantly lower rupture rates than those using >200 μg [51, 52, 59–61, 64, 67, 68, 71, 74, 76–79, 81, 84, 85, 90, 95, 97, 98, 101, 103, 105, 106, 109, 111, 113, 115, 117, 131] (8/843 (0.95%) and 11/1963 (0.56%) respectively, $p = 0.08$).

3.2 | Efficacy of MToP After Previous Caesarean

Thirty-eight studies reported on the efficacy of MToP in 12,177 women with and 95,122 without previous CS [42, 48, 50–52, 58, 61, 63, 65, 72, 75, 77, 80, 84–86, 88, 90, 94, 98, 102, 103, 109, 110, 112, 117, 118, 120, 125, 127, 131–137]. Across both trimesters, the risk of failed MToP/need for surgical intervention was higher in women with previous CS (OR 1.48, CI 1.29–1.70) (Figure S1). This was still significant when analysed separately for the first (OR 1.88, CI 1.14–2.52) or second trimester (OR 1.32, CI 1.11–1.56).

Two studies examined the ability of ultrasound of CS scar thickness to predict the outcome of MToP. A retrospective review of 183 women with previous CS undergoing first trimester MToP found that a CS scar defect on transvaginal ultrasound, where residual myometrial thickness was <30% of the adjacent myometrial thickness, had an increased chance of needing surgical intervention (OR 3.32, CI 1.64–6.75) with an overall risk of 57.1% if myometrial thickness ratio <30% [138]. A small study including 66 women demonstrated that a lower uterine segment thickness <3 mm was associated with uterine rupture (OR 94, CI 4.2–2106) [95].

3.3 | Safety of SToP After Previous Caesarean

There were two case reports of perforation through CS scar during SToP [139, 140].

Eight studies, including 542 women with and 10,979 women without previous CS, reported on the safety and efficacy of cervical priming prior to SToP [141–148]. Laminaria and/or misoprostol in doses varying from 100 to 800 μg were used with no cases of uterine rupture.

Eleven studies including 2760 women with previous CS reported on adverse events during SToP [141, 146, 149–157]. Adverse outcomes were more common across both trimesters amongst women with previous CS (OR 2.43, CI 1.56–3.78). Only one retrospective cohort study reported on outcomes of first-trimester SToP, demonstrating an increased risk of complications associated with previous CS (OR 1.9, CI 1.1–3.4) [150]; all other studies included second-trimester procedures or a combination of first- and second-trimester cases.

TABLE 2 | Incidence of first-trimester rupture during MToP in included studies.

Authors/publication date	# participants with previous CS	Method of MToP	Gestation	1 CS	≥2CS	≥3CS	Type of previous CS	Ruptures
Au et al. [48] (2024)	140[a]	600 mg mifepristone followed by 600 μg misoprostol	<13 weeks	75	65		Unspecified	0
Chien et al. [42] (2009)	122	600 mg mifepristone followed by PO misoprostol 48 h later	<8 weeks	60	62		Unspecified	0
Gao et al. [43] (1999)	213	150 mg mifepristone in divided doses followed by 600 μg PO misoprostol day 3	4–9 weeks	N/A	N/A	N/A	Unspecified	0
Gautam et al. [44] (2003)	66	50 mg IM MTX followed by 800 μg PV misoprostol 2–3 days later	<9 weeks	46	20		LSCS	0
Wang et al. [45] (2010)	668	150 mg mifepristone in divided doses followed by 600 μg PO misoprostol day 3	<7 weeks	589	79		LSCS	0
Xu et al. [46] (2001)	35	150 mg mifepristone in divided doses followed by 600 μg PO misoprostol day 4	<49 days	35	0	0	Unspecified	0
Young et al. [47] (2022)	950	200 mg PO mifepristone followed by 800 μg PV or SL misoprostol	<10 weeks	N/A	N/A	N/A	Unspecified	0
Totals (%)	2194			805	226			0 (0%)
[95% CI]								[0.00–0.00]

Abbreviations: CS, caesarean section; LSCS, lower segment caesarean section; MToP, medical termination of pregnancy; N/A, not available.
[a]Participants with miscarriage excluded.

TABLE 3 | Rupture rates by prostaglandin and number of CS in second-trimester MToP.

Author/ publication date	Number of participants	Method of abortion	Gestation	Number of participants with 1 prior CS[a]	Number of participants with 2(+) prior CS[a]	Number of participants with 3(+) prior CS[b]	Number of ruptures amongst those with 1 prior LSCS	Number of ruptures amongst those with ≥ 2 prior LSCS	Number of ruptures in those with prior classical CS	Rupture rate overall
Abou Elela [49] (2022)	50	50 μg PV misoprostol every 4 h	13–26 weeks	50			0			0 of 50
Aydin et al. [50] (2019)	85	50 μg PV misoprostol every 6 h until regular contractions	19.19 ± 2.63 weeks[c]							1 of 85
Bahar et al. [51] (2021)	128	Misoprostol 800 μg PV followed by 400 μg PO 3 hourly; max of 4 PO doses (IV oxytocin used after 3-h interval if abortion not complete after misoprostol regimen)	13–26 weeks	99	15	14	1	0		1[d] of 128
Basu et al. [52] (2009)	47	400 μg PV misoprostol every 8 h for up to 48 h; MVA following successful abortion prior to discharge	16 ± 2 weeks[c]							0 of 47
Berghella et al. [8] (2009)	17	100–800 μg PV misoprostol every 4–6 h	16–28 weeks	13	2		0	0	1 of 2	1 of 17
Bhattacharjee et al. [53] (2007)	80	200–400 μg PV/SL misoprostol every 4 h; max 24 h	13–26 weeks							0 of 80
Bhuvaneswari et al. [54] (2020)[e]	50	(1) Foley catheter + 200–400 μg PV misoprostol every 4 h; max 5 doses or	13–26 weeks	50			0			0 of 50
Bhuvaneswari et al. [54] (2020)[e]	50	(2) 200 mg mifepristone followed by 200–400 μg PV misoprostol every 4 h; max 5 doses	13–26 weeks	50			1			1 of 50
Brouns [55] (2010)	12	200 mg mifepristone followed by 200 μg or 400 μg PV misoprostol every 4 h	14–24 weeks							0 of 12

(Continues)

TABLE 3 | (Continued)

Author/ publication date	Number of participants	Method of abortion	Gestation	Number of participants with 1 prior CS[a]	Number of participants with 2(+) prior CS[a]	Number of participants with 3(+) prior CS[b]	Number of ruptures amongst those with 1 prior LSCS	Number of ruptures amongst those with ≥ 2 prior LSCS	Number of ruptures in those with prior classical CS	Rupture rate overall
Cetin et al. [56] (2016)	77	(1) misoprostol 100 μg PV misoprostol every 4 h (2) misoprostol 200 μg SL every 3 h; max 5 doses	12–24 weeks	48	29		0	1		1 of 77
Chen [57] (2023)	204	200 mg PO mifepristone followed by various doses of PV/PO misoprostol ± cervical ripening balloon	14–27 weeks							1 of 204
Choudhary et al. [58] (2011)[f]	29	200 μg PV misoprostol every 4–6 h; max 24 h ± mifepristone	12–20 weeks							1 of 29
Daponte et al. [59] (2006)	85	400 μg PV misoprostol followed by 200–400 μg every 6 h; max 1600 μg	14–20 weeks	85			0			0 of 85
Daponte et al. [60] (2007)	21	400 μg PV misoprostol followed by 200 μg every 6 h; max 800 μg	1st and 2nd trimester[c,g]		19	2		0		0 of 21
Daskalakis et al. [61] (2005)	108	400 μg PO misoprostol + 400 μg PV misoprostol followed by 400 μg PV misoprostol every 6 h; max 5 doses	17–24 weeks	96	11	1	0	0		0 of 108
Davey et al. [62] (1997)	22	600 mg mifepristone followed by 1 mg PV gemeprost every 3 h; max 5 doses	12–24 weeks							1 of 22
Dickinson et al. [63] (2005)	101	200 μg PV misoprostol every 6 h	14–28 weeks	78	19	4	0	0		0 of 101
Dickinson et al. [64] (2010)[e]	39	(1) 400 μg PV misoprostol every 6 h; max 48 h	14–28 weeks							0 of 39
Dickinson et al. [64] (2010)[e]	42	(2) 200 mg mifepristone followed by 800 μg PV misoprostol then 400 μg PO misoprostol every 3 h; max 5 doses	14–28 weeks							0 of 42

(Continues)

TABLE 3 | (Continued)

Author/ publication date	Number of participants	Method of abortion	Gestation	Number of participants with 1 prior CS[a]	Number of participants with 2(+) prior CS[a]	Number of participants with 3(+) prior CS[b]	Number of ruptures amongst those with 1 prior LSCS	Number of ruptures amongst those with ≥ 2 prior LSCS	Number of ruptures in those with prior classical CS	Rupture rate overall
Dickinson et al. [65] (2023)[h]	304	200 mg PO mifepristone followed by 200–600 μg PV misoprostol every 3–4 h	14–28 weeks	241	62		3	1	0 of 1	4 of 304
Domrose et al. [66] (2012)[i]	100	1 mg gemeprost PV every 6 h	14–28 weeks	88	12		N/A[l]	N/A[l]		1 of 100
Elasy [67] (2022)	79	400 μg PV misoprostol followed by 200 μg misoprostol every 4 h	14–24 weeks							3 of 79
El-Sayed [68] (2023)	28	400 μg PV misoprostol every 3–4 h	13–18 weeks	28			0			0 of 28
El Sharkwy et al. [69] (2019)	78	(1) 100 μg PV misoprostol 6 hourly (2) Intracervical Foley catheter with 30 mL Normal Saline + 100 μg PV misoprostol every 6 h	20–27 weeks		36	42		0		0 of 78
Ercan et al. [70] (2016)	144	(1) 200 μg PV misoprostol then 200 μg SL misoprostol every 4 h (2) 200 μg PV misoprostol with weighted intracervical Foley catheter 2 h later; if undelivered at 24 h 200 μg misoprostol every 4 h	14–24 weeks							0 of 144
Erturk et al. [71] (2022)	137	(1) 400 μg PV/SL misoprostol every 3–6 h (2) 400 μg PV/ SL misoprostol followed by 200 μg every 3–6 h	14–24 weeks	79	58		0	1		1 of 137
Fawzy et al. [72] (2010)	31	200 μg PV misoprostol every 6 h; 400 μg PV misoprostol every 6 h beyond 24 h	13–26 weeks			31		1		1 of 31

(Continues)

TABLE 3 | (Continued)

Author/ publication date	Number of participants	Method of abortion	Gestation	Number of participants with 1 prior CS[a]	Number of participants with 2(+) prior CS[a]	Number of participants with 3(+) prior CS[b]	Number of ruptures amongst those with 1 prior LSCS	Number of ruptures amongst those with ≥ 2 prior LSCS	Number of ruptures in those with prior classical CS	Rupture rate overall
Garofalo et al. [73] (2018)	141	SToP or MToP depending on patient preference and clinical expertise; MToP > 16 + 0 600 mg mifepristone followed by 1 mg gemeprost every 3 h	< 22 weeks[c]							6 of 141
Gomez et al. [74] (2010)	28	200 mg PO mifepristone followed by 800 μg PV misoprostol then 400 μg misoprostol every 3 h	12–23 weeks							0 of 28
Gulec et al. [75] (2013)	86	200 μg PV misoprostol 4 hourly; max 1200 μg	14–26 weeks	60	26		0	3		3 of 86
Henkel [76] (2020)	5	200 mg PO mifepristone followed by 400 μg buccal misoprostol every 3 h	15–27 weeks							0 of 5
Herabutya et al. [77] (2003)	56	600–800 μg PV misoprostol every 6–12 h	14–26 weeks	45	8	3	0	0		0 of 56
Hou et al. [78] (2010)	5	200 mg PO mifepristone followed by 400 μg PO misoprostol every 6 h	13–16 weeks							0 of 5
Jacques et al. [79] (2020)	13[j]	200 mg mifepristone followed by 400 μg PV or SL misoprostol	14–24 weeks							0 of 13
Jamali et al. [80] (2020)	431	100–400 μg misoprostol PV every 4–6 h	14–24 weeks	218	213		3	7		10 of 431
Kapp et al. [81] (2007)	3	200 mg PO mifepristone followed by 400 μg buccal misoprostol then 200 μg buccal misoprostol every 6 h	18–23 weeks							0 of 3
Kiley et al. [82] (2022)	3	Feticide followed by 200 μg misoprostol every 4 h	23–26 weeks	3			0			0 of 3

(Continues)

TABLE 3 | (Continued)

Author/ publication date	Number of participants	Method of abortion	Gestation	Number of participants with 1 prior CS[a]	Number of participants with 2(+) prior CS[a]	Number of participants with 3(+) prior CS[b]	Number of ruptures amongst those with 1 prior LSCS	Number of ruptures amongst those with ≥ 2 prior LSCS	Number of ruptures in those with prior classical CS	Rupture rate overall
Koh et al. [83] (2018)	339	(1) Gemeprost PV 1 mg or (2) misoprostol PO 400 μg every 4 h; max 5 doses	14–23 weeks							7 of 339[k]
Latta et al. [84] (2023)[e]	77	800 μg misoprostol then 400 μg PV/SL every 3 h	14–24 weeks	55	22		0	2	0 of 11	2 of 77
Latta et al. [84] (2023)	32	PO mifepristone followed by 800 μg misoprostol then 400 μg PV/SL every 3 h	14–24 weeks	22	10		0	0		0 of 32
Liaquat et al. [85] (2006)	5	50 μg PV misoprostol every 4 h; max 4 doses; followed by syntocinon if abortion not complete	14–26 weeks							0 of 5
Marinoni et al. [86] (2007)	62	1 mg PV gemeprost every 3 h; max 5 doses	13–23 weeks	52	8	2	N/A[l]	N/A[l]		0 of 62
Masse et al. [87] (2020)	51	200 mg mifepristone[m] then 200–400 μg misoprostol; various routes and frequencies	14–24 weeks							1 of 51[n]
Mazouni et al. [88] (2006)	50	15–34 weeks: 600 mg mifepristone followed by 200–400 μg PV misoprostol every 3 h; or > 34 weeks mifepristone followed by Prostin E2 gel	> 15 weeks[c]							2 of 50
Meaidi [89] (2020)	236	200 mg mifepristone followed by 400 μg PV misoprostol every 3 h	13–23 weeks							2 of 236
Mobusher [90] (2013)	100	400 μg PV misoprostol every 6 h; max 5 doses	14–24 weeks	95	4	1	0	0		0 of 100
Morra et al. [91] (2019)	340	1 mg PV gemeprost every 3 h; max 5 doses ± 200 mg PO mifepristone prior	13–24 weeks							9 of 340

(Continues)

TABLE 3 | (Continued)

Author/ publication date	Number of participants	Method of abortion	Gestation	Number of participants with 1 prior CS[a]	Number of participants with 2(+) prior CS[a]	Number of participants with 3(+) prior CS[b]	Number of ruptures amongst those with 1 prior LSCS	Number of ruptures amongst those with ≥ 2 prior LSCS	Number of ruptures in those with prior classical CS	Rupture rate overall
Munir et al. [92] (2014)[o]	50	5× doses 200 μg PO misoprostol every 6 h	13–26 weeks							0 of 50
Naguib et al. [93] (2010)	50	200 μg PV misoprostol 4 hourly	16–26 weeks	50			0			0 of 50
Obata-Yasuoka et al. [94] (2009)	26	Laminaria 4 hourly for 2 days; on day 3 removal of laminaria + 1 mg PV gemeprost every 3 h; max 4 doses	12–21 weeks	19	7		N/A[l]	N/A[l]		0 of 26
Peng et al. [95] (2015)[p]	32	200 mg PO mifepristone followed by 600 μg misoprostol then 200 μg PV misoprostol every 3 h; max 1800 μg daily	13–16 weeks							1 of 32
Petca [96] (2019)	7	200 mg mifepristone followed by 400 μg PV misoprostol then 50 μg SL and 50 μg PV every 6 h	16–24 weeks							0 of 7
Pongsatha et al. [97] (2011)	64	400–800 μg PV/PO misoprostol every 3–12 h	20.9 ± 3.9[c]							0 of 64
Pongsatha at al [98] (2024)	80	400 μg PV misoprostol every 6 h	14–28 weeks							1 of 80
Pourhouseini et al. [99](2023)	104	(1) letrozole 2.5 mg every 6 h total of 6 doses prior to misoprostol (2) various doses of PV misoprostol	< 20 weeks[c]							0 of 104
Reehan [100] (2024)	100	100–400 μg PV misoprostol every 3 h	13–26 weeks		60	40		2		2 of 100
Reischer [101] (2023)	139	600 mg PO mifepristone followed by 400 μg PO misoprostol every 3 h; feticide if > 22 weeks	14–24 weeks							0 of 139

(Continues)

TABLE 3 | (Continued)

Author/ publication date	Number of participants	Method of abortion	Gestation	Number of participants with 1 prior CS[a]	Number of participants with 2(+) prior CS[a]	Number of participants with 3(+) prior CS[b]	Number of ruptures amongst those with 1 prior LSCS	Number of ruptures amongst those with ≥2 prior LSCS	Number of ruptures in those with prior classical CS	Rupture rate overall
Scioscia et al. [102] (2005)[q]	63	1 mg PV gemeprost every 3 h; max 3 doses per day	13–23 weeks	55	5	1	N/A[l]	N/A[l]		0 of 63
Shammas et al. [103] (2006)	63	400 μg PV misoprostol followed by 200 μg PV misoprostol every 6 h	15–28 weeks	38	15	10	0	0		0 of 63
Shantikumar et al. [104] (2021)	20	200 mg mifepristone day 1 and repeat dose day 2, followed by 200–400 μg PV misoprostol 6 hourly	13–20 weeks	20			0			0 of 20
Sharma et al. [105] (2020)	6	200 mg PO mifepristone followed by 400 μg SL every 3 h	13–28 weeks	6			0			0 of 6
Shay et al. [106] (2022)[e]	15	200 mg mifepristone followed by 400–600 μg PV misoprostol every 3–6 h	14–28 weeks							0 of 15
Shay et al. [106] (2022)[e]	35	400–600 μg PV misoprostol every 3–6 h	14–28 weeks							0 of 35
Stewart et al. [107] (2022)	72	200 mg mifepristone followed 25–200 μg misoprostol PV or PO; max 4 doses	≥20 weeks (average 23 weeks; IQR 22–26) [c]	50	22	3	2	0	0 of 1	2 of 75
Tarim et al. [108] (2005)	12	200 μg PO misoprostol hourly; max 6 doses	2nd trimester[c]	12			0			0 of 12
Torriente et al. [109] (2017)	268	800 μg PV misoprostol followed by 200 μg every 2 h; max 1400 μg	13–20 weeks	231	37		0	0		0 of 268
Turgut et al. [110] (2013)	56	50–600 μg PV misoprostol every 4–6 h	13–24 weeks							3 of 56
van Bogaert [111] (2007)[r]	18	400 μg SL misoprostol + 800 μg PO misoprostol	< 20 weeks[c]							0 of 18
Velipasaoglu et al. [112] (2018)	104	200 μg PV misoprostol every 4 h; if cervix not favourable at 24 h then Foley catheter inserted	14–22 weeks	88	16		0	0		0 of 104

(Continues)

TABLE 3 | (Continued)

Author/ publication date	Number of participants	Method of abortion	Gestation	Number of participants with 1 prior CS[a]	Number of participants with 2(+) prior CS[a]	Number of participants with 3(+) prior CS[b]	Number of ruptures amongst those with 1 prior LSCS	Number of ruptures amongst those with ≥ 2 prior LSCS	Number of ruptures in those with prior classical CS	Rupture rate overall
Vlad et al. [113] (2022)	9	200 mg PO mifepristone followed by 400 μg PV misoprostol every 4 h	13–24 weeks							0 of 9
Totals	5604			2124	708	154	10 of 1910 (0.52%)[a]	18 of 835 (2.16%)[a]	1 of 15 (6.66%)	69 of 5604 (1.23%)
[95% CI]							[0.28%–0.97%]	[1.36%–3.40%]	[1.00%–44.28%]	[1.00%–1.56%]
Misoprostol alone	3198									31 of 3198 (0.97%)
[95% CI]										[0.68–1.38]
Mifepristone + misoprostol	1313									14 of 1314 (1.07%)
[95% CI]										[0.63–1.79]
Gemeprost	1093									24 of 1093 (2.20%)
[95% CI]										[1.48–3.26]

Abbreviations: CI, confidence interval; CS, caesarean section; IV, intravenous; LSCS, lower segment caesarean section; MToP, medical termination of pregnancy; MVA, manual vacuum aspiration; PO, per oral; PV, per vagina; SL, sublingual; SToP, surgical termination of pregnancy.

[a]Data on the number of prior CS were not provided in many of the articles; where these data were provided, it has been entered into this table. Due to missing data, total ruptures for those with 1 prior and 2 prior CS do not equal the total rupture rates provided, which include the majority of participants for whom the number of prior CS was not reported.

[b]There was insufficient available data on ruptures amongst those documented to have had 3+ prior CS; however, the number of included participants [114] is included in the table and highlights the lack of data in this subgroup.

[c]Exact gestational range not provided.

[d]Rupture was in the misoprostol group.

[e]Data from study separated into two different treatment groups for analysis.

[f]Excluded women managed with oxytocin or planned hysterotomy [58].

[g]Unable to exclude first trimester cases.

[h]Dickinson et al. (2014) not included in this analysis as it captures the same cases of rupture.

[i]Excluded women in the study who were in the third trimester.

[j]Numbers not clear from data provided in article; however, data obtained from Henkel et al. 2023 systematic review paper.

[k]All cases of rupture received gemeprost.

[l]Only misoprostol MToP is included in the analysis of rupture by number of previous CS; studies using gemeprost were excluded.

[m]Only 2.1% of this cohort used mifepristone.

[n]This patient had not used mifepristone prior to misoprostol.

[o]Excluded women who underwent instillation abortion and oxytocin (100 additional women with no ruptures); unable to separate out numbers on women with 2 and 3+ prior CS from the group that received misoprostol, however this study included in total: 66 with 1 prior CS, 49 with 2 prior CS and 35 with 3+ prior CS.

[p]Only 32 women received mife/miso, and these were included in the analysis; others received ethacridine lactate and were excluded from the analysis.

[q]Includes 2 women with previous transmural myomectomy.

[r]Only 18 women in the second trimester.

3.4 | Termination of Pregnancy After Previous Classical Caesarean

Fifteen women with previous classical CS were identified within the original research papers, among whom only one experienced rupture (6.66%, CI 1.00%–44.28%). See Table 3.

3.5 | Termination of Pregnancy in the Context of Abnormal Placentation

Eleven case reports described undiagnosed CSP or PAS encountered during abortion (6–18 weeks gestation) [36, 114, 158–164]. One report described an undiagnosed arteriovenous malformation (AVM) at the site of a CS scar in a woman with four previous CS; this was diagnosed with angiography after large haemorrhage during a 12-week SToP [165]. In all cases, ultrasound had been used, failing to recognise abnormal implantation of trophoblastic tissue. In 8 of 11 reports of undiagnosed CSP/PAS, hysterectomy was required to control haemorrhage; 5 of 11 reported massive blood loss.

Eight case reports of second-trimester abortion with known PAS were identified [32, 166–171], describing several management techniques. In five cases, magnetic resonance imaging (MRI) confirmed the diagnosis. Surgical management included gravid hysterectomy, D&E or planned hysterotomy. Adjunct methods to improve safety included methotrexate and/or uterine artery embolisation (UAE) [166, 168]. Three cases describe medical management alone using either feticide and methotrexate, mifepristone/misoprostol or gemeprost [32, 166, 170]. All three cases required surgical intervention and described significant complications.

Nine original studies (160 women) described abortion in those with previous CS and either PAS or placenta praevia [172–180]. One series of seven women with undiagnosed PAS at D&E requiring hysterectomy to control bleeding [176] affirms case reports demonstrating a high risk of haemorrhage and emergency hysterectomy. In another study, four cases of undiagnosed PAS during first-trimester SToP experiencing haemorrhage were successfully managed with uterine artery embolisation (UAE) with uterine preservation [174]. There was successful use of UAE prior to MToP or hysterotomy in 12 patients undergoing mid-trimester abortion with PAS, showing a reduction in mean blood loss from 1533 to 383 mL [178]. Seven cases of mid-trimester hysterotomy and internal iliac ligation with accreta are reported, with prophylactic UAE; all experienced massive haemorrhage and almost half required emergency hysterectomy [172]. The largest study identified on this topic is from China and describes the management of 51 people with PAS undergoing mid-trimester MToP; 31 had UAE followed by MToP and 20 had UAE followed by planned hysterotomy [173]. Two thirds having MToP required curettage for abnormally adherent placental tissue; however, only 7.8% required hysterectomy and there was no difference between MToP and hysterotomy in terms of blood loss, transfusion, hospital stay duration or need for hysterectomy [173]. Placenta praevia without PAS was significantly associated with the need for emergency UAE and intensive care admission in one study with 34 cases for abortion in the setting of placenta praevia [180]. Adjunct measures described in these studies to reduce blood loss include internal iliac ligation, intrauterine balloon tamponade and adjunct methotrexate.

3.6 | Critical Appraisal

Results of the risk of bias and quality appraisal of original studies are presented in Appendix S2.

4 | Discussion

4.1 | Main Findings

This review summarises the large and rapidly growing body of evidence regarding the management of induced abortion in people with previous CS. Uterine rupture is rare during the first trimester, with only three case reports identified [24, 33, 40], and no ruptures in observational studies [42–48]. Perdue et al. recently reviewed 61 cases of first-trimester rupture reported in the literature, of which 30% required hysterectomy; however, none were in the setting of induced abortion [181]. The findings of this scoping review support the safety of first-trimester MToP outside hospital settings for women with previous CS.

In contrast, CSP is increasingly reported [14], and has the potential for significant morbidity if undetected prior to abortion. In 1995, Rashbaum reported the incidence of undiagnosed accreta encountered at second trimester SToP to be 0.04% [176]; however, the current incidence is likely considerably higher, given the incidence of PAS rose fourfold 1994–2002 [182]. Most case reports of undiagnosed CSP occurred during the first trimester; associated morbidity was high, with a significant risk of haemorrhage and a need for hysterectomy. Ultrasound is not always reliable for identifying abnormal placentation in early pregnancy, when reported sensitivity and specificity for PAS are 41% and 88%, respectively [183]; thus, the optimal imaging modality for ruling out CSP/PAS prior to abortion remains unclear. MRI has not reliably been shown to have improved sensitivity or specificity compared to ultrasound in diagnosing PAS but can be a useful adjunct to ultrasound, the latter still considered first line [184]. Pre-abortion ultrasound, including assessment for CSP/PAS, should be recommended for all women undergoing pregnancy termination on the background of a prior caesarean section. Detection rates vary depending on gestation and operator experience and are higher when performed by experts. Due to the relatively uncommon nature of the condition and the absence of specific sonographer credentialling in PAS [184], it would seem reasonable for expert/tertiary ultrasound to be sought prior to abortion for women at significantly increased risk, such as those with ≥ 3 previous CS, or in cases where ultrasound demonstrates a gestational sac sitting low or near the CS scar [185]. Furthermore, failed MToP or ongoing bleeding after SToP in those with prior CS should alert the clinician to the possibility of CSP [114, 159, 163].

This review contains the largest cumulative meta-analysis of uterine rupture rates during prostaglandin MToP to date. In 2009, two systematic reviews of misoprostol MToP reported similarly low rupture rates of 0.28% and 0.43% (among 722 and 507 women with previous CS) [6, 8]. At this time, available

studies only included a total of 46 women with two previous CS, making it difficult to draw conclusions about the risk of rupture in this group [8]. A recent systematic review by Henkel et al. reported a rupture rate of 1.1% among 876 women undergoing second-trimester MToP with mifepristone and misoprostol [9]. Our review similarly shows a higher rupture rate (1.0%) with misoprostol regimens in the second trimester than that published in earlier meta-analyses, but our review suggests that mifepristone-misoprostol compared to misoprostol alone shortens abortion time without increasing the risk of rupture. This updated rupture rate is closer to term induced vaginal birth after one previous CS [7]; however, in the context of an abortion, fetal hypoxia is not of concern. There remains a risk of significant maternal haemorrhage, and uterine rupture should be treated as an emergency; however, it is reassuring that a majority (76%) of ruptures were managed without hysterectomy, and that laparoscopic techniques for repair are being reported.

Owing to the rise in CS rate and the large numbers of studies published on this topic since previous reviews, our review included significantly more women with ≥2 previous CS ($n=835$) than previously published; this reveals that a history of ≥2 previous CS is associated with increased risk of rupture compared to women with a single prior CS. It is likely that women with ≥3 CS are at increasingly higher risk of rupture, although available evidence remains insufficient for accurate analysis. This requires further research and raises the question of whether surgical termination is safer than medical termination in women with multiple previous CS.

There was significant heterogeneity in relation to dose, intervals and mode of administration of misoprostol for second-trimester MToP. Most studies used vaginal or sublingual administration, which is associated with fewer side effects and better absorption than oral [186, 187], and Dickinson found that 400 μg shortened abortion time compared with 200 μg doses [115]. Sublingual or buccal administration has similar pharmacokinetics to vaginal and was used in some studies [188]. Further research is required to determine whether there is benefit to reduction in dose of misoprostol in women with prior CS, as recommended by some guidelines [12].

Gemeprost was associated with a higher rupture rate than misoprostol (2.20% vs. 1.00%, $p<0.001$). Furthermore, Le Roux showed mifepristone-misoprostol to be significantly more effective at achieving complete abortion compared to gemeprost (94% vs. 68%, $p=0.02$) [126]. Misoprostol is the most commonly used prostaglandin for abortion and should be the preferred choice.

To our knowledge, this is the first data synthesis showing previous CS was associated with moderately increased risk of retained products of conception and/or need for surgical intervention. Mifepristone shortens abortion time and is routinely used in many countries prior to misoprostol for MToP [128]; it appears safe in both first and second trimesters, decreases abortion time and may reduce the incidence of incomplete abortion [64].

The absence of rupture amongst 542 women with mechanical and/or prostaglandin ripening prior to D&E is reassuring. Although uncommon, rupture in this setting is possible, as highlighted by the four individual case reports of uterine rupture from cervical ripening prior to D&E [23, 34, 38]. The largest study in the first trimester showed a significant reduction in the need for mechanical dilatation with the use of low dose misoprostol [144]. Hern published a non-blinded controlled clinical trial of feticide and laminaria with and without additional misoprostol prior to late D&E, showing that adding misoprostol reduced procedure length and blood loss; however, previous CS was a risk factor for haemorrhage ($p<0.0001$) [143]. A smaller retrospective study found no difference in efficacy between overnight osmotic dilators and misoprostol 1-h prior to D&E [147]. Importantly, Ben-Ami and associates found that previous CS was a significant risk factor for inadequate dilation prior to D&E [189]. Given that difficult or inadequate dilatation is a risk factor for complications such as perforation, further clarification on optimal ripening pre-procedures for women with previous CS is warranted.

Classical CS is known to increase rupture risk with subsequent labour compared to LSCS [190], and is considered a contraindication to a trial of labour at term [191]. Seto's case report is accompanied by a comprehensive literature review on MToP after classical CS, reporting only 16 cases ever published, two of which were complicated by rupture [192]. Several of these reports were regarding spontaneous mid-trimester labour, fetal death, or instillation abortion and hence are not included in our review [193–197]. Our review includes 15 women with previous classical CS, with one uterine rupture. It remains unclear whether surgical abortion is a safer option for women with prior classical CS, and evidence is likely to remain predominantly based on case reports and expert consensus given the infrequency of classical CS.

There is a paucity of literature on the management of abortion for women with PAS. The available evidence, largely from case series, describes various techniques including medical and surgical (hysterotomy), with adjunctive UAE to reduce blood loss and the need for hysterectomy. There remain theoretical concerns regarding the reduction in uterine vascularity and the risk of growth restriction in pregnancies following UAE; however, subsequent successful pregnancies at term have been reported [198]. Additionally, important is the risk of recurrence of PAS in subsequent pregnancies [14], counselling is required and for those who do not desire future fertility, gravid hysterectomy with or without prophylactic UAE could be considered. Further evidence is required on this topic, and management should be individualised.

This review is limited by the exclusion of non-English articles; however, it was broadened by having no date limitations. Regardless, it captures data from across the globe (31 countries). Due to the heterogeneity of methodology and aims of available research, some data were unavailable for extraction. Despite excluding papers only including women with miscarriage and IUFD, some included papers contained both abortions and pregnancy loss cases, and abortion-only data were unable to be extracted separately.

This scoping review offers insights into the increasingly important topic of abortion complexities after previous caesareans and provides avenues for further research. Prior caesarean delivery increases the risk of adverse maternal outcomes in women

having abortion. In particular, second-trimester abortion care should be provided by experienced health care providers with the knowledge and available infrastructure to provide high-level care if difficulties are encountered.

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Conflicts of Interest

The authors declare no conflicts of interest.

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Supporting Information

Additional supporting information can be found online in the Supporting Information section.