

1. Introduction and Who Guideline applies to

The aim of this guideline is to inform and advise healthcare professionals an outline and to standardise a safe care process for women requesting abortion at University Hospitals Leicester.

Each year, 22 million unsafe abortions are estimated to take place, resulting in the death of approximately 47 000 women. Some 5 million women suffer injury as a result of complications due to unsafe abortion, often leading to chronic disability. Abortion need not be unsafe. Safe abortion should be and can be available and accessible for all women, to the full extent that the law allows (Abortion Act 1967).

There were 200,608 abortions for women resident in England and Wales in 2018. About 3,000 abortions are funded by the NHS Leicestershire yearly basis.

Abortion is not a complex procedure. A range of providers, including nurses and midwives, have been shown to be competent to deliver abortion services safely in a number of settings. As with many other medical procedures, adherence to best practice standards will ensure that the most effective and the safest services are delivered.

2. Background:

At present UHL provide an abortion care service up to 14 weeks for surgical and up to 16 weeks medical abortion of pregnancy. This document is intended to give a overview of the safe and efficient treatment options available within local and national guidance and by UK law.

3. Related UHL Documents:

- Management of Miscarriage
- Management of pregnancy of unknown location and Ectopic pregnancy
- Anti D prophylaxis
- Sensitive disposal of pregnancy/fetal remains

For Legal aspects of abortion: See Appendix 1.

4. Guideline Standards and Procedures

4.1 Clinic assessment:

- The consultation and assessments should be offered in **sensitive and non-judgemental** manner taking into consideration the confidentiality, privacy and dignity of the women.
- Women who are certain of their decision about abortion do not necessarily need to be counselled further. If a woman is unsure about the decision, then counselling and social services input should be made available, according to her choice.
- Women should be given information about the different methods of abortion appropriate to gestation, the potential adverse effects and complications, and their clinical implications.

4.2 The initial assessment Pro forma includes:

- Detailed medical history and **explore but not challenging** reason (e.g. unplanned, unintended, stress, anxiety) for requesting abortion¹ and previous use of contraception.
- Ultrasound scan: gestational age and location of pregnancy.
 - Non-viable pregnancy/Pregnancy of Unknown Location/suspected ectopic should be referred to Gynaecology Assessment Unit for further management.
- FBC & Rhesus status if unknown - **Anti-D prophylaxis not requires for MTOP up to 10 (ten) weeks gestation.**⁶
- Blood group & save and Haemoglobinopathy screening if clinically indicated.
- *STI self -swab for Chlamydia trachomatis (CT) & Gonorrhoea* screening should be **offered** to all women²
 - If CT positive, the patient will be treated on admission for abortion or earlier.
- A risk assessment for other STIs and offer screening **if appropriate**. (Routine screening for HIV, hepatitis B/C is not recommended)³.
 - For women who test positive for STIs:
 - Inform her (and her partners - **with consent**).
 - Advise her (and her partners) to attend GUM clinic for treatment.

4.3 Contraception: Discuss effective methods of contraception, including long acting reversible contraception (LARC)

- encourage (**but do not coerce**) her to choose a contraceptive option
- A woman's acceptance of a contraceptive method **is not a precondition for providing her an abortion.**

4.4 Clinical assessment outcome: wish to have abortion

- Consent form needs to be completed for medical or surgical abortion as per UHL guideline.
 - Date of the abortion procedure should be offered from the clinic with verbal and written information along with patient information leaflet on abortion care.
 - Sensitive disposal form should be filled in as per trust policy as appropriate.
 - HSA1 form should be completed before treatment
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5. Treatment options:

5.1 Medical abortion (MTOP)

5.1.1 Up to 10 weeks - Early medical abortion (EMA)– minimal hospital stay

5.1.2 Medical abortion at 11-14 weeks gestation – MTOP may be arranged on GAU after discussing with senior medical member of the team and GAU nurse in charge.

5.1.3 MTOP after 14 weeks – **if the woman is not suitable to be treated in BPAS** or private abortion care **due to a medical condition**, MTOP may be arranged **usually up to 16 weeks** as an in-patient on GAU. This should be arranged after discussing with consultant and GAU sister in charge.

5.2 Cautions and Contraindications of MTOP^{1,2,3,4}

5.2.1 Contraindications for MTOP:

- Allergy to Mifepristone or Misoprostol
- Inherited porphyria
- Chronic adrenal failure
- Known or suspected ectopic pregnancy

5.2.2 Caution and clinical review required:

- Long-term corticosteroid therapy (including those with severe asthma).
- On anticoagulation medications
- Haemorrhagic disorder.
- Severe anaemia.
- Pre-existing heart disease or cardiovascular risk factors.
- IUD in place (remove if possible before beginning the regimen).
 - **Ideally the IUD should be removed if threads are visible** whether the woman wishes to have an abortion or continue with the pregnancy.
 - Woman can have MTOP or STOP as per her choice even with IUD in situ.
 - If IUD is not expelled or visible with POC, arrange an X-ray abdomen & pelvis to exclude IUD migration post TOP.

5.2.3 Uterine anomalies or distorted cavity due to fibroid: offer MTOP as first option, as STOP will have higher chance of failure - US guided if performing STOP. Consider follow up scan or serum BHCG to confirm abortion.

5.3 Medical abortion treatment:

5.3.1 Up to 10 weeks (Early MTOP)^{4,5,6:}

- a) Mifepristone 200 mg oral – licenced abortion medicine**
- b) Misoprostol (unlicensed use) after 24 -48 hours:**

800 micrograms given **vaginally** or sublingual/ buccal route

Followed by **400** micrograms (vaginal/sublingual/buccal) in 3-4 hours if abortion has not occurred. Sublingual and buccal misoprostol tablets can be swallowed after 30 minutes as active medicine is absorbed by this time.

5.3.2 Early discharge and self -administration of misoprostol at home^{4,5,6:}

In early MTOP up to and including 10 weeks, at time of taking Mifepristone - it is safe and acceptable for women who wish to leave the abortion unit to complete the abortion at home either:

- Following misoprostol administration (**Early discharge**)
- Following mifepristone administration take home Misoprostol 800 micrograms & 400 micrograms for self- administration at home- **Early medical abortion at home.**

5.3.3 The legal definition of “home” in this case “means the place in England where a pregnant woman has her permanent address or usually resides”.⁴

- **Early discharge / home Misoprostol may be suitable for some women** on request who have support at home, clearly understand the treatment process and will comply with the follow up plan.
- These women should be followed up by telephone/text, low sensitive pregnancy test to confirm completion of abortion within 2-3 weeks.
- They should be given a 24-hour telephone helpline number.
- Written instruction: about pain management, how much bleeding to expect, signs of failed or incomplete abortion, infection, fluid and food intake etc.
- Woman will be informed – may need hospital FU and further treatment
- **symptoms suggesting the need for additional medication:**
 - If they do not bleed within 24 hours of receiving misoprostol
 - If they fail to take the misoprostol as instructed

5.3.4 On the HSA4 form, in section 4d (“name and address of treatment with prostaglandin”) it is sufficient to record the address as “home” or “residence” as long as this is the same as that entered in section 3c (“patients details” – “postcode or complete address”), otherwise enter full details here. Section 4dii (“date of treatment with prostaglandin”) should be recorded as the date on which you advise the patient self-administers misoprostol.⁵

5.3.5 MTOP failed- woman should have options of a STOP or repeat MTOP medication.

5.3.6 MTOP 11-14 weeks^{6:}

- 1) **Mifepristone 200 mg oral** followed by 24-48 hrs
- 2) **Misoprostol 800 micrograms vaginal / sublingual/ buccal route**
- 3) followed by **400 micrograms 3 hourly up to 4 doses** (maximum misoprostol 2400 micrograms in 24 hours - RCOG).

MTOP 14-16 weeks^{3,6}:

- 1) Mifepristone 200mg oral followed by 24 – 48 hrs later
- 2) Misoprostol 800 micrograms PV / SL / Buccal followed by 400 micrograms repeat every 3 hourly if needed (max 2400 mcg.)
- 3) **If there is a concern of uterine scar rupture** due to previous Caesarea section delivery/ uterine surgery or trauma- 1) after 200 mg mifepristone, may consider lower dose misoprostol 200 - 400 micrograms 4 hourly PV or 2 hourly oral. Or 2) mifepristone 200mg daily for 2-3 days (up to 600mg). 3) Discuss in benign gynaecology MDT

5.3.7 If after 24 hours abortion does not occur:

- Repeat Mifepristone 200mg (>3 hrs after last dose of Misoprostol)
- >12 hrs later above Misoprostol course can be repeated.

5.4 Surgical abortion (STOP)^{1,2,3,6}:

5.4.1 Electrical Vacuum Aspiration (EVA) procedure can be performed under General (GA), local Anaesthesia (LA) or conscious sedation up to 13 weeks at UHL. STOP 13 to 14 weeks if safe and after discussing with the surgeon.

5.4.2 Manual vacuum aspiration (MVA) can be performed under LA or conscious sedation usually up to 9 -10 weeks gestation.

5.4.3 Under 7 weeks - additional steps needed to ensure abortion is complete:

US guidance (intra-operative or post-operative scan) should be available **or**

Check products of conception evacuated **or** Serum BHCG follow up.

5.4.4 From 7 weeks to 14 weeks- EVA or MVA usually up to 9-10 weeks

5.4.5 Ultrasound not routinely required for uncomplicated procedures, but should be available

5.5 Cervical priming before surgical abortion up to 14 weeks⁶:

- 400 micrograms sublingual misoprostol suggested one hour before abortion
- 400 micrograms vaginal misoprostol suggested 2-3 hrs before.

If misoprostol cannot be used, consider oral mifepristone 200mg given 24 to 48 hrs before surgery.

5.6 Misoprostol for Cervical preparation on the day of STOP:

- **Suggested for most women** to reduce the risk of trauma to the cervix and inadequate dilation. Particularly for:
 - no previous vaginal birth
 - gestation >10 weeks
- Can be self- administered
- It should be explained to the patient that if the procedure is delayed for any reason, the pregnancy tissue might begin to pass (inadvertent medical abortion).

5.7 Abortion before definitive Ultrasound evidence of an intrauterine pregnancy⁶:

No yolk sac is visible on US scan and by date pregnancy is also under six weeks, no clinic concerns - explain that there is a small chance of an ectopic pregnancy or miscarriage; offer re-scan, if woman strongly wishes to commence Medical abortion-

Explain needs FU with scan or serum HCG after abortion.

Provide 24 hrs emergency contact details to hospital.

5.8 Abortion Complications and risks^{1,2,3}:

5.8.1 **Infection**- less in our unit about 1-5%, usually associated with pre-existing infection (we offer STI swabs and or prophylactic antibiotics) over all up to 10% in literature.

5.8.2 **Severe bleeding** - risk of blood transfusion is low in early abortion occurs 1 in 1000, rising to around 4 in 1000 after 14 weeks.

5.8.3 Intermittent bleeding for 2-3 weeks is common after MTOP, 7-10 days after STOP.

5.8.4 **Uterine rupture** - second-trimester MTOP – risk is < 1 in 1000.

5.8.5 Incomplete Abortion 1-5% - up to 14 weeks as per uterine size.

If Medical management considered: misoprostol 600mcg oral or 400mcg S/L.

Uterine size >14 weeks: oral mifepristone 200 mg + misoprostol 200 mcg

PV/SL/Oral/buccal 6 hrly.

Consider low dosage of misoprostol as above if previous CS delivery or discuss with consultant.

5.8.6 Failed abortion or continuation of pregnancy (less than 1%) - offer STOP or MTOP.

5.9 Relevant to surgical abortion only:

- **Cervical trauma** – no more than 1 in 100, lower for first trimester abortions.
- **Uterine damage:** perforation – the risk is in the order of 1–4 in 1000 and is lower for first- trimester abortions; intrauterine adhesion is very rare with induced abortion of pregnancy.
- Further treatment e.g. blood transfusion, laparoscopy, hysteroscopy, laparotomy or hysterectomy may be required, should one of these complications occur.

[There are no proven associations between abortion and subsequent ectopic pregnancy, placenta- praevia, infertility, breast cancer or psychological problems].

6 Anti-D IgG⁶ – prophylaxis should be given to RhD- negative women within 72 hrs as follows:

6.1 Anti D after 10 weeks abortion

6.2 Anti D after any surgical abortion

6.3 Anti **D not needed** for medical abortion up to 10 weeks.

6.4 Contraception - Women should be advised to start contraception on the day of abortion to prevent future pregnancy or after Mifepristone for MTOP.

IUD/IUS or contraceptive implant can be inserted at time of STOP.

6.5 Post abortion care:

6.5.1 Routine follow up is not always required unless requested by the woman or clinically indicated.

6.5.2 Written and verbal information: including advice on counselling, contraception and what to expect to be given.

6.5.3 Counselling: provision of further counselling as indicated

Appendix 1: Legal aspects of abortion:

Statutory grounds for termination of pregnancy: Abortion is legal in Great Britain if two doctors decide in good faith that in relation to the particular pregnancy; one or more of the grounds specified in the Abortion Act (1967) are met:

- A. The continuance of the pregnancy would involve risk to the life of the pregnant woman greater than if the pregnancy were terminated. Abortion Act 1967 as amended [Section 1(1)(c)].
- B. The termination is necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman. [Section 1(1)(b)].
- C. The pregnancy has not exceeded its 24th week and the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of the pregnant woman. [Section 1(1)(a)].
- D. The pregnancy has not exceeded its 24th week and the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of any existing child(ren) of the family of the pregnant woman. [Section 1(1)(a)].
- E. There is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped. [Section 1(1)(d)].
- F. The Act also permits abortion to be performed in an **emergency** if a doctor is of the opinion formed in good faith that termination is immediately necessary to save the life of the pregnant woman to prevent grave permanent injury to the physical or mental health of the pregnant woman. In this situation,

HSA2 form completed by one doctor only (rare). [Section 1(4)].

Appendix 1: Legal aspects of abortion:

Legal documentation:

HSA1:

HSA1: Two doctors are required to sign the HSA1 form, which is the certificate of opinion before an abortion is performed under Section 1(1) of the Abortion Act. The HSA1 form must be kept for 3 years. **Any medical practitioner** registered with GMC, can sign HSA1. A doctor can sign the HSA1 form **without seeing** the woman, as long as they are satisfied with the patient's medical records and consultation completed by other medical personnel (doctor, Nurse or midwife). It is important to document in the form patient "not seen" and also document in the medical record "patient notes assessed".

HSA2:

In emergency, lifesaving abortion, this form can be completed by one doctor where another doctor is not available to sign HSA1 (uncommon situation).

The form HSA1 or HSA2 is kept for 3 years.

HSA4: Abortion notification form: It is compulsory to send the completed form to the CMO office electronically or by post within 2 weeks after the abortion is completed. HSA4 form should be completed by the doctor in charge of the abortion, usually the doctor performing STOP or prescribing mifepristone (for medical abortion). It is sent to where a surgical or medical **termination has failed** (the fetus has not been expelled) and the procedure is repeated, please complete **one form only with both sets of dates on it, using Page 6** to provide any extra information as necessary. If a form has already been sent and the termination is later found to have failed, please complete a second form and return it with an accompanying letter stating this information.

Appendix 2: Prevention of Infective complications: (NICE)⁶

Offer routine vaginal self -swab for *Chlamydia trachomatis* and treat if positive as per *BASHH guideline*.⁷

Prophylactic antibiotics where swabs negative-

- routine antibiotics not needed for MTOP
- metronidazole 800 mg / doxycycline 200mg orally for STOP

Prophylactic antibiotics where swabs declined or results are not available:

- High risk of STI- doxycycline 100mg BD for 7 days or azithromycin 1gm stat followed by 500 mg/day for next 2 days (BASHH).
- Low risk- doxycycline 100mg BD for 3 days or metronidazole 800mg oral stat.

References:

1. The care of women requesting induced abortion, Evidence –based clinical guideline Number 7. RCOG, Nov 2011.
2. Clinical practice handbook for Safe Abortion, WHO 2014.
3. Best practice in comprehensive abortion care. Best practice paper No 2, RCOG June 2015.
4. Clinical Guidelines for Early Medical Abortion at Home – England. RCOG, FRSH, BSACP. 2019.
5. Approval of Home Use for the Second Stage of Early Medical Abortion 2019. The Abortion Act 1967 - Approval of a Class of Places. Department of Health and Social Care 2019.
6. Abortion care, NICE guideline, September 2019.
7. <https://www.bashh.org/guidelines>

See Appendix 1 for Statutory Grounds for termination of pregnancy

See Appendix 2: Prevention of Infective complications

Dated: May 2019, Updated March 2020 as per NICE Abortion care guideline Sept 2019.

Reviewed by: Miss R Aravindan FRCOG, Miss M Kurni MRCOG

Next review: 2023 or earlier if needed.

3. Education and Training

None

4. Monitoring Compliance

What will be measured to monitor compliance	How will compliance be monitored	Monitoring Lead	Frequency	Reporting arrangements

5. Supporting References (maximum of 3)

If None say NONE

6. Key Words

List of words, phrases that may be used by staff searching for the Guidelines on PAGL. If none – state none.

The Trust recognises the diversity of the local community it serves. Our aim therefore is to provide a safe environment free from discrimination and treat all individuals fairly with dignity and appropriately according to their needs. As part of its development, this policy and its impact on equality have been reviewed and no detriment was identified.

CONTACT AND REVIEW DETAILS	
Guideline Lead (Name and Title) Dr K Raynsford - (ST5/6) Dr A Banerjee - FRCOG, FFSRH	Executive Lead Chief Medical Officer
Details of Changes made during review: Reviewed by:	