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Royal College of  
Obstetricians and Gynaecologists

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# **The Care of Women Requesting Induced Abortion: Summary**

Evidence-based Clinical Guideline Number 7

November 2011

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# Introduction and methodology

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## The guideline topic

Induced abortion is common: over 200 000 procedures are performed each year in Great Britain<sup>3,4</sup> and at least one-third of British women will have had an abortion by the time they reach the age of 45 years.<sup>5</sup> In a legal setting where sterile facilities are available, abortion is a safe procedure for which major complications and mortality are rare at all gestations. Abortion accounts for a significant proportion of the workload of many gynaecologists. The RCOG views induced abortion as a healthcare need as well as an important public health intervention, and reiterates the recommendation of the RCOG Working Party on Unplanned Pregnancy (1991)<sup>6</sup> that 'health authorities should accept responsibility for the abortions needed by women resident in their districts'.

Over 98% of induced abortions in Britain are undertaken because of risk to the mental or physical health of the woman or her children.<sup>3,4</sup> This guideline has been developed in relation to the care of women seeking abortion on such grounds. Separate RCOG publications address legal, ethical and service issues relating to the minority of abortions undertaken because of fetal abnormality.<sup>7</sup>

Data on abortion rates in relation to age, gestation, grounds for abortion and so on are routinely collected and published annually in Great Britain. These data are available for England and Wales from the DH<sup>8</sup> and for Scotland from the Information Services Division.<sup>9</sup>

In Chapter 3 of this guideline, legal issues directly relevant to the context of service provision are summarised. In 2007, the RCOG provided evidence to the House of Commons Science and Technology Committee, which was undertaking an inquiry into the scientific developments relating to the Abortion Act 1967.<sup>1</sup> A number of issues were highlighted for Members of Parliament to consider. Those relevant to the recommendations made in this guideline and to the provision of services included:

- the case for removing the need for the signature of two doctors authorising the abortion
- recommendations allowing greater responsibility for nurses already involved in service provision
- the recommendation that there were no reasons of safety, efficacy or acceptability for not allowing women to undergo the second stage of medical abortion at home.

Although the House of Commons chose not to amend the law relating to induced abortion in any of the above respects, the RCOG would still support these changes should any change in the regulations allow them to take place.

There are large geographical variations in access to NHS-funded abortion. In Scotland almost all abortions take place in NHS hospitals,<sup>4</sup> while in England and Wales the NHS has funding arrangements with the independent sector. In 2009, 94% of abortions were funded by the NHS; of which over half (60%) took place in the independent sector under NHS contract.<sup>3</sup> Notably, too, the independent sector undertakes the majority of abortions at late gestations. Thus, the clinical management of women requesting abortion spans a number of care sectors involving a range of professionals; these guidelines are written with this in mind.

The RCOG acknowledges the substantial role that nurses now take in the provision of abortion services and recognises the lack of a national standard for training for this role. The RCOG recommends that the RCN gives thought to developing and implementing specialist training programmes for nurses working in abortion care.

### **Aim of the guideline**

Clinical guidelines have been defined as systematically developed statements which assist clinicians and patients in making decisions about appropriate treatment for specific conditions.

The aim of this guideline is to ensure that all women considering induced abortion have access to a service of uniformly high quality. It is hoped that this guideline will be implemented across all relevant healthcare sectors and will promote a consistent standard regardless of the sectors in which an individual woman is managed.

The guideline does not cover prevention of unintended pregnancy other than to recommend robust arrangements for contraceptive provision after abortion. Counselling to assist individuals in making the decision to have an abortion, rather than to continue the pregnancy, is not discussed in detail. The starting point of this guideline is the point at which a woman presents to a health provider requesting induced abortion of an unintended/unwanted pregnancy.

### **For whom is the guideline intended?**

The guideline has been developed under the auspices of the RCOG for its Fellows and Members practising in Great Britain. The guideline is also intended for other professional groups who share in caring for women considering abortion: primary care teams, sexual health services, gynaecology nurses, staff participating in non-NHS assessment centres and clinics and all those professionals providing abortion counselling. Those with responsibilities for planning and/or commissioning abortion services, for example directors of public health, local government, NHS trust managers and managers of primary care groups, may also find the guideline helpful.

In this guideline, the term 'clinician' is used to refer to all healthcare professionals who participate in direct clinical patient care. Thus, the term includes doctors, nurses and midwives.

The guideline has been developed taking into account abortion legislation and available resources in Great Britain. The guideline may be used for reference in other countries, but readers should bear in mind that legislation, resources and facilities will be different.

The content of the guideline falls naturally into a number of chapters documenting the process of managing induced abortion. The text in each chapter gives supporting evidence for the recommendations. Inevitably, there is considerable overlap between chapters, and referring to one single recommendation out of context of the guideline in its entirety may lead to misinterpretation.

## Local protocol development

It is anticipated that this national guideline will be used as the basis for the development of local protocols or guidelines which will take into account local service provision and the needs and preferences of the local population. Such local adaptation should take place in a similar multidisciplinary group in consultation with all stakeholders affected by the recommendations. It is essential that commissioners of health care, as well as general practitioners (GPs), specialists and service users, take part in such a process.<sup>10</sup>

## Methods used in the development of the guideline

### Literature search strategy

The aim of the literature review was to identify and synthesise relevant evidence within the published literature, thus enabling clinical practice recommendations to be based on evidence wherever possible.

In developing the earlier versions of this guideline, searches were carried out for each topic of interest. The electronic database MEDLINE (Ovid version including foreign language publications) was searched for the period January 1966 to September 2003. The searches were performed using relevant medical subject headings (MeSH) terms and text words. In addition, the electronic database EMBASE was searched between 1974 and September 2003 to identify publications, usually European, not indexed on MEDLINE. The Cochrane Library was searched to identify systematic reviews, meta-analyses and controlled clinical trials. Reference lists of non-systematic review articles and studies obtained from the initial search were trawled and journals in the RCOG library were hand-searched to identify articles not yet indexed. There was no systematic attempt to search the 'grey literature' (conferences, abstracts, theses and unpublished trials).

In developing this edition, similar literature searches were carried out covering the period 2003 to February 2011.

Rather than undertaking a new search, where available, systematic reviews were used, including those undertaken for the revision of the WHO guidelines for safe abortion.<sup>2</sup> These reviews are listed in Appendix 2 together with the tables of evidence used in the absence of appropriate published reviews. For WHO, Cochrane systematic reviews including randomised clinical trials (RCTs) were the primary source of evidence. Relevant Cochrane systematic reviews were identified and the need for updating these was determined. Relevant and possibly relevant Cochrane systematic reviews were identified and those that were considered outdated were updated using their specific, standard search strategies. Additionally, three systematic reviews were conducted outside of the Cochrane Database of Systematic Reviews and were published in peer-reviewed journals. The search strategies and the specific criteria for including and excluding trials identified by the search are provided in the corresponding systematic review.

### Sifting and reviewing the literature

For both the original and updated literature searches, a preliminary scrutiny of titles and abstracts was undertaken and full papers were obtained if they were relevant to the topic. Articles not relevant to the subject in question were rejected, as were articles where relevant outcomes were not reported. For all the subject areas, published systematic reviews or meta-analyses were used, if available. If these did not exist, RCTs were sought. For subject areas where a body of systematic

review or randomised trial evidence was available, studies of less robust design were not systematically sought. Where there were no relevant published RCTs, other appropriate experimental or observational studies were sought.

### Synthesising the evidence

Identified articles were assessed methodologically and the best available evidence was used to form and support the recommendations. If a good systematic review, meta-analysis or RCT existed in relation to a topic, studies of a weaker design were ignored. The evidence was synthesised using qualitative methods. These involved summarising the content of identified papers in the form of evidence tables and agreeing brief recommendation statements that accurately reflected the relevant evidence. Quantitative techniques (meta-analyses) were not performed by the GDG because of time constraints and the difficulty of combining studies of various designs.

### Forming and grading the recommendations

The definitions of the types of evidence used in this guideline originate from the US Agency for Health Care Policy and Research (Table 1.1).<sup>11</sup> Recommendations were based on, and explicitly linked to, the evidence that supports them. Recommendations were derived from available research evidence using consensus methods. Where there were areas without available research evidence, consensus was again used.

As part of the consensus process, the recommendations published in the 2004 guideline were circulated to members of the GDG. For each recommendation, members were asked to indicate whether they thought that the recommendation should be included as it stood, included with modifications or excluded, and whether any new recommendations should be developed. This approach ensured that all Group members had an equal opportunity to express their views on recommendations. The Group used an informal consensus process to agree modified recommendations.

The recommendations were then graded according to the level of evidence upon which they were based. The grading scheme used was formulated by the Clinical Outcomes Group and recommended by the NHS Executive.<sup>12</sup>

The strength of the evidence on which each recommendation is based is shown in Table 1.2. It is accepted that, in this grading system, the evidence itself is not graded according to quality, although it is discussed narratively in the text supporting each recommendation. It is also accepted that RCTs may not always be the most appropriate study design (for example, to investigate diagnostic tests).<sup>11</sup> Similarly, there may be clinical questions that cannot easily be answered by experiment but nevertheless represent good practice. Such recommendations will automatically be graded C or ✓.

**Table 1 Levels of evidence**

Level	Evidence
Ia	Evidence obtained from meta-analysis of randomised trials
Ib	Evidence obtained from at least one randomised controlled trial
IIa	Evidence obtained from at least one well-designed controlled study, without randomisation
IIb	Evidence obtained from at least one other type of well-designed quasi-experimental study
III	Evidence obtained from well-designed non-experimental descriptive studies, correlation studies and case studies
IV	Evidence obtained from expert committee reports or opinions and/or clinical experience of respected authorities

**Table 2 Forming recommendations**

Grade of recommendation	Evidence level
A	Requires at least one randomised controlled trial as part of a body of literature of overall good quality and consistency addressing the specific recommendation ( <i>evidence levels Ia, Ib</i> )
B	Requires the availability of well-conducted clinical studies, but no randomised clinical trials on the topic of the recommendation ( <i>evidence levels IIa, IIb, III</i> )
C	Requires evidence obtained from expert committee reports or opinions and/or clinical experience of respected authorities; indicates an absence of directly applicable clinical studies of good quality ( <i>evidence level IV</i> )
Good practice points ✓	Recommended best practice based on the clinical experience of the Guideline Development Group

The validity of some grade C and ✓ recommendations may be questionable, as they are not based upon incontrovertible evidence. However, the views of the 2010/2011 GDG, combined with comments from extensive peer review, as detailed below, suggest that the recommendations with this grading are acceptable to a wide body of expert opinion.

### Scope and methods of peer review

Successive drafts of the original guideline were written and discussed by the GDG until a formal peer review process was undertaken. Members of the Group suggested names of individuals or organisations from the area of practice that they represented and the draft guideline was sent to individuals chosen by the DH and the RCOG. The draft was also posted on the RCOG website and comments were invited from any member of the public. Comments received were reviewed by the development team and changes were made to the document where necessary. Equal consideration was given to comments made by the nominated peer reviewers and members of the public, and all comments were taken into account when finalising the document.

### Implementation and review









This updated guideline was published in 2011. The RCOG will maintain a watching brief on the need to review recommendations in the light of new research evidence.

# Summary of recommendations



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## Commissioning and organising services


### Access to services

-  4.1 Commissioners and providers of abortion services should have local strategies in place for providing information for women and healthcare professionals on routes of access, including self-referral.
-  4.2 Commissioners should ensure that women have access to abortion services locally.
-  4.3 Services should have arrangements which facilitate access without delay for referrals from a wide range of sources.
-  4.4 Where services have no on-site provision for emergency care, there must be robust and timely pathways for referral.
-  4.5 Commissioners should ensure that abortion providers do not restrict access on the grounds of age, ethnicity, religious beliefs, disability or sexual orientation.
-  4.6 Commissioners should ensure that access is not restricted on the grounds of marital status or the number of previous abortions.
-  4.7 Professionals who are ethically opposed to abortion have a duty of care to refer onward women requesting abortion without delay.
-  4.8 Services should facilitate access for all women, particularly those who traditionally have difficulties accessing health services.

### Tailored care

-  4.9 Services should make sure that a female member of staff is available if requested.
-  4.10 Services should be culturally sensitive and professional interpreters should be available if required.

### Information provision

-  4.11 Services should make sure that written, objective, evidence-guided information is available for women considering abortion to take away before the procedure. Information should be available in a variety of languages and formats.



- ✓ 4.12 Services are encouraged to adapt nationally developed patient information for local use.
- ✓ 4.13 Staff providing abortion services should provide up-to-date evidence-guided information, supported by local data where robust, about complications and sequelae of abortion.
- ✓ 4.14 Women should have access to objective information and, if required, counselling and decision-making support about their pregnancy options.
- C 4.15 Information for women and providers should emphasise the duty of confidentiality.

### Initial assessment

- ✓ 4.16 There should be a pathway to tertiary medical care for women with significant medical conditions.
- C 4.17 Women who decide to continue with the pregnancy should be referred for antenatal care without delay.
- ✓ 4.18 Women who have a non-viable pregnancy require appropriate management, not forgetting contraception and sexual health care.
- C 4.19 Services should identify issues which make women particularly vulnerable (for example, child protection needs and domestic abuse/gender-based violence) and refer/signpost them on to appropriate support services in a timely manner.
- ✓ 4.20 The assessment (including support services such as ultrasound) should be provided within a dedicated time and space and by a team committed to women requesting abortion, specifically separate from miscarriage and antenatal services.
- C 4.21 Elements of the assessment consultation can be provided via the telephone and/or the internet. However, women should be able to access face-to-face consultation, if preferred.

### Arrangements for the procedure

- ✓ 4.22 A system should be in place to ensure that doctors within the abortion service complete form HSA1 (Certificate A in Scotland) if a woman refers herself, or if the referring doctor is not willing to support the abortion.
- C 4.23 With respect to the method used to induce the abortion, service arrangements should be such that:
  - Services should be commissioned for all women requesting induced abortion at all gestations.
  - If a service cannot offer an abortion by any method after a specific gestation, timely onward referral must be ensured.
  - All services should be able to offer abortion by at least one of the recommended methods for each gestation band.
  - All services should be able to offer a **choice** of recommended methods for each gestation band.
  - Services should provide surgical abortion under both local and general anaesthesia.

- C** 4.24 To minimise delay, service arrangements should be such that:
- Referral to an abortion provider should be made within 2 working days.
  - Abortion services must offer assessment within 5 working days of referral or self-referral.
  - Services should offer women the abortion procedure within 5 working days of the decision to proceed.
  - The total time from seeing the abortion provider to the procedure should not exceed 10 working days.
  - Women requiring abortion for urgent medical reasons should be seen as soon as possible.
- ✓** 4.25 Women should be informed that they have a right to delay or cancel appointments and/or the procedure should they wish.
- ✓** 4.26 Upon referral, women should be given the service provider's contact details.
- C** 4.27 Inpatient services, provided in an appropriate centre and clinical setting, should be available for women who are unsuitable for or who do not desire home or day case care.
- ✓** 4.28 Services should have a protocol in place allowing early discharge after misoprostol for women undergoing medical abortion up to 9 weeks of gestation.
- ✓** 4.29 The setting for abortion should be sensitive and responsive to women's needs, and should respect the need for privacy and dignity.
- 4.30 Commissioners should ensure that services meet the recommendations relating to:
- B Contraception after the abortion
  - A and C Antibiotic prophylaxis
  - B Screening for sexually transmitted infections (STIs)
  - C Information provision after the abortion
  - C Counselling after the abortion

### **Adverse effects, complications and sequelae of abortion: what women need to know**

- B** 5.1 Women should be informed that abortion is a safe procedure for which major complications and mortality are rare at all gestations.
- ✓** 5.2 Complications and risks should be discussed with women in a way that they can understand and should emphasise the overall safety of the procedure.
- ✓** 5.3 Services should provide women with information about the physical symptoms and sequelae that may be experienced after abortion.
- ✓** 5.4 Service providers should inform women about the range of emotional responses that may be experienced during and following an abortion. Providers should be aware that women with a past history of mental health problems are at increased risk of further problems after an unintended pregnancy.

## Abortion complications

- B** 5.5 Women should be informed of the following rare but serious complication that may occur:
- Uterine rupture has been reported in association with medical abortion at late gestations. The risk is less than 1 in 1000.
- B** 5.6 Women should be informed of the uncommon complications that may occur and of their possible clinical consequences. These may include:
- Severe bleeding requiring transfusion; the risk is lower for early abortions, occurring in less than 1 in 1000, rising to around 4 in 1000 at gestations beyond 20 weeks.
  - Uterine perforation (surgical abortion only); the risk is in the order of 1–4 in 1000 and is lower for early abortions and those performed by experienced clinicians.
  - Cervical trauma (surgical abortion only); the risk of damage to the external os is no greater than 1 in 100 and is lower for early abortions and those performed by experienced clinicians.
  - Women must be informed that, should one of these complications occur, further treatment in the form of blood transfusion, laparoscopy or laparotomy may be required.

## Failed abortion and continuing pregnancy

- B** 5.7 Women should be informed that surgical and medical methods of abortion carry a small risk of failure to end the pregnancy (less than 1 in 100) , necessitating another procedure.
- C** 5.8 Women should be informed that there is a small risk (usually much less than 5%) of the need for further intervention, such as surgical intervention following medical abortion or re-evacuation following surgical abortion.

## Post-abortion infection

- B** 5.9 Women should be informed that infection of varying degrees of severity may occur after medical or surgical abortion and is usually caused by pre-existing infection. Prophylactic antibiotic use and bacterial screening for lower genital tract infection reduces this risk.

## Breast cancer

- A** 5.10 Women should be informed that induced abortion is not associated with an increase in breast cancer risk.

## Future reproductive outcome

- B** 5.11 Women should be informed that there are no proven associations between induced abortion and subsequent ectopic pregnancy, placenta praevia or infertility.

## Preterm birth

- B** 5.12 Women should be informed that induced abortion is associated with a small increase in the risk of subsequent preterm birth, which increases with the number of abortions. However, there is insufficient evidence to imply causality.

### Psychological sequelae

- B** 5.13 Women with an unintended pregnancy should be informed that the evidence suggests that they are no more or less likely to suffer adverse psychological sequelae whether they have an abortion or continue with the pregnancy and have the baby.
- B** 5.14 Women with an unintended pregnancy and a past history of mental health problems should be advised that they may experience further problems whether they choose to have an abortion or to continue with the pregnancy.

### Pre-abortion management

- ✓** 6.1 Prior to referral, pregnancy should be confirmed by history and a reliable urine pregnancy test.

### The abortion decision

- C** 6.2 Healthcare staff caring for women requesting abortion should identify those who require more support in the decision-making process.
- C** 6.3 Women who are certain of their decision to have an abortion should not be subjected to compulsory counselling.
- ✓** 6.4 Pathways to additional support, including counselling and social services, should be available.
- ✓** 6.5 Women should be given information about the different methods of abortion appropriate to gestation, the potential adverse effects and complications, and their clinical implications.
- ✓** 6.6 Where possible, women should be given the abortion method of their choice.

### Blood tests

- C** 6.7 Pre-abortion assessment should always include:
  - determination of rhesus blood status.Where clinically indicated, pre-abortion assessment should also include:
  - determination of blood group with screening for red cell antibodies
  - measurement of haemoglobin concentration
  - testing for haemoglobinopathies.
- B** 6.8 It is not cost-effective or necessary to routinely cross-match women undergoing induced abortion.

### Venous thromboembolism risk assessment

- ✓** 6.9 All women undergoing an abortion should undergo a venous thromboembolism (VTE) risk assessment.

## Cervical cytology

- ✓ 6.10 Women who have not had cervical cytology screening within the recommended interval should be offered screening within the abortion service, or advised on when and where to obtain it.

## Ultrasound scanning

- B 6.11 Use of **routine** pre-abortion ultrasound scanning is unnecessary.
- C 6.12 Ultrasound scanning must be available to all services as it may be required as part of the assessment.
- ✓ 6.13 Ultrasound scanning should be provided in a setting and manner sensitive to the woman's situation.
- C 6.14 Before ultrasound is undertaken, women should be asked whether they would wish to see the image or not.

## Prevention of infective complications

- A  
C 6.15 Services should offer antibiotic prophylaxis effective against *Chlamydia trachomatis* and anaerobes for both surgical abortion (evidence grade: A) and medical abortion (evidence grade: C).
- C 6.16 The following regimens are suitable for peri-abortion antibiotic prophylaxis:
  - azithromycin 1 g orally on the day of abortion, **plus** metronidazole 1 g rectally or 800 mg orally prior to or at the time of abortion

**OR**

  - doxycycline 100 mg orally twice daily for 7 days, starting on the day of the abortion, **plus** metronidazole 1 g rectally or 800 mg orally prior to or at the time of the abortion

**OR**

  - metronidazole 1 g rectally or 800 mg orally prior to or at the time of abortion for women who have tested negative for *C. trachomatis* infection.

## STI screening

- B 6.17 All women should be screened for *C. trachomatis* and undergo a risk assessment for other STIs (for example, HIV, gonorrhoea, syphilis), and be screened for them if appropriate.
- C 6.18 A system for partner notification and follow-up or referral to a sexual health service should be in place.
- ✓ 6.19 Services should make available information about the prevention of STIs and offer condoms for STI prevention to women undergoing abortion.

## Contraception

- C 6.20 All appropriate methods of contraception should be discussed with women at the initial assessment and a plan agreed for contraception after the abortion.

### Feticide

- C** 6.21 Feticide should be performed before medical abortion after 21 weeks and 6 days of gestation to ensure that there is no risk of a live birth.

## Abortion procedures

### Surgical methods

#### *Vacuum aspiration*

- B** 7.1 Vacuum aspiration is an appropriate method of surgical abortion up to 14 weeks of gestation.
- A** 7.2 Either electric or manual vacuum aspiration may be used as both are effective and acceptable to women and clinicians.
- B** 7.3 Vacuum aspiration under 7 weeks of gestation should be performed with appropriate safeguards to ensure complete abortion, including inspection of aspirated tissue.
- A** 7.4 Vacuum aspiration may be performed from 14 to 16 weeks of gestation; large-bore cannulae and suction tubing may be required to complete the procedure without the use of forceps to remove larger fetal parts.
- ✓** 7.5 During vacuum aspiration, the uterus should be emptied using the suction cannula and blunt forceps (if required) only. The procedure should not be routinely completed by sharp curettage.
- C** 7.6 Access to ultrasound during vacuum aspiration is recommended but not routinely required for uncomplicated procedures.

#### *Dilatation and evacuation*

- A** 7.7 Surgical abortion by dilatation and evacuation (D&E), preceded by cervical preparation, is appropriate for pregnancies above 14 weeks of gestation.
- B** 7.8 Continuous ultrasound guidance during D&E is recommended to reduce the risk of surgical complications.

#### *Cervical preparation for surgical abortion*

- B** 7.9 Cervical preparation should be considered in all cases.
- B** 7.10 The following regimens are recommended for cervical preparation up to 14 weeks of gestation:
- Misoprostol 400 micrograms administered vaginally 3 hours prior to surgery or sublingually 2–3 hours prior to surgery.
- B** 7.11 Vaginal misoprostol can be administered either by the woman herself or by a clinician.
- B** 7.12 After 14 weeks of gestation, osmotic dilators provide superior dilatation to medical methods; however, misoprostol is an acceptable alternative up to 18 weeks of gestation.
- A** 7.13 Use of medications containing oxytocin or ergometrine is not recommended for prophylaxis to prevent excessive bleeding at the time of vacuum aspiration.

## Pain relief for surgical abortion

### Anaesthesia

- B** 7.14 Services should be able to provide surgical abortions without resort to general anaesthesia.
- C** 7.15 If conscious sedation is used during surgical abortion, it should be undertaken only by trained practitioners and in line with DH guidance.

### Analgesia

- B** 7.16 Women should routinely be offered pain relief such as non-steroidal anti-inflammatory drugs (NSAIDs) during surgical abortion.
- A** 7.17 Prophylactic paracetamol (oral or rectal) is ineffective in reducing pain after surgical abortion and is not recommended.

## Medical methods

- B** 7.18 Medical abortion regimens using 200 mg oral mifepristone and misoprostol are effective and appropriate at any gestation.

### Medical abortion at ≤ 63 days of gestation (early medical abortion)

- B** 7.19 The following regimens are recommended for early medical abortion:
  - at ≤ 63 days of gestation, mifepristone 200 mg orally followed 24–48 hours later by misoprostol 800 micrograms given by the vaginal, buccal or sublingual route
  - at ≤ 49 days, 200 mg oral mifepristone followed 24–48 hours later by 400 micrograms of oral misoprostol.
- B** 7.20 For women at 50–63 days of gestation, if abortion has not occurred 4 hours after administration of misoprostol, a second dose of misoprostol 400 micrograms may be administered vaginally or orally (depending upon preference and amount of bleeding).

### Place of misoprostol administration

- ✓** 7.21 It is safe and acceptable for women who wish to leave the abortion unit following misoprostol administration to complete the abortion at home. There must be an adequate support strategy and robust follow-up arrangements for these women.

### Medical abortion at 9–13 weeks of gestation

- A** 7.22 The following regimen is recommended for medical abortion between 9 and 13 weeks of gestation:
  - mifepristone 200 mg orally followed 36–48 hours later by misoprostol 800 micrograms vaginally. A maximum of four further doses of misoprostol 400 micrograms may be administered at 3-hourly intervals, vaginally or orally.

### *Medical abortion at 13–24 weeks of gestation*

- A** 7.23 The following regimen is recommended for medical abortion between 13 and 24 weeks of gestation:
- mifepristone 200 mg orally, followed 36–48 hours later by misoprostol 800 micrograms vaginally, then misoprostol 400 micrograms orally or vaginally, 3-hourly, to a maximum of four further doses.
  - If abortion does not occur, mifepristone can be repeated 3 hours after the last dose of misoprostol and 12 hours later misoprostol may be recommenced.
- B** 7.24 Surgical evacuation of the uterus is not required routinely following medical abortion between 13 and 24 weeks of gestation. It should be undertaken only if there is clinical evidence that the abortion is incomplete.

### *Pain relief for medical abortion*

- B** 7.25 Women should routinely be offered pain relief (for example, NSAIDs) during medical abortion.
- A** 7.26 Oral paracetamol has not been shown to reduce pain more than placebo during medical abortion and is not recommended.
- B** 7.27 Some women may require additional narcotic analgesia, particularly after 13 weeks of gestation.

## Histopathology

- C** 7.28 Routine histopathological examination of tissue obtained at abortion procedures is not recommended.

## Gestational trophoblastic neoplasia

- C** 7.29 Routine screening of women for gestational trophoblastic neoplasia (GTN) at the time of abortion is not recommended; providers should be aware of the signs and symptoms and, where appropriate, facilitate referral into a GTN monitoring programme.

## Care after the abortion

### Rhesus prophylaxis

- B** 8.1 Anti-D IgG should be given, by injection into the deltoid muscle, to all non-sensitised RhD negative women within 72 hours following abortion, whether by surgical or medical methods.

### Information after abortion

- ✓** 8.2 On discharge, all women should be given a letter providing sufficient information about the procedure to allow another practitioner elsewhere to manage any complications.



- ✓ 8.3 Following abortion, women should be provided with verbal and written information about:
  - symptoms they may experience, emphasising those which would necessitate an urgent medical consultation
  - symptoms suggestive of continuing pregnancy.
- ✓ 8.4 Independent providers of abortion services should have arrangements in place for referring women into NHS services for emergency assessment/admission.
- ✓ 8.5 A 24-hour telephone helpline number should be available for women to use after abortion if they have any concerns.

### Follow-up after abortion

- B 8.6 There is no medical need for routine follow-up after surgical abortion or after medical abortion if successful abortion has been confirmed at the time of the procedure.
- ✓ 8.7 Women having a medical abortion in whom successful abortion has **not** been confirmed at the time of the procedure should be offered follow-up to exclude continuing pregnancy.
- ✓ 8.8 All women having an abortion should be able to choose to return for routine follow-up if they so wish.
- ✓ 8.9 Referral should be available for any woman who may require additional emotional support or whose mental health is perceived to be at risk.
- ✓ 8.10 All women should be advised where to seek help if they have any concerns or if they need further contraceptive advice or provision.
- C 8.11 Ultrasound examination should not be used routinely to screen women for incomplete abortion.
- C 8.12 The decision to evacuate the uterus following incomplete abortion should be based on clinical signs and symptoms and not on ultrasound appearance.

### Contraception after abortion

- B 8.13 Abortion services should be able to provide all methods of contraception, including long-acting methods, immediately after abortion.
- B 8.14 Women should be advised of the greater effectiveness of long-acting reversible methods of contraception.
- B 8.15 Before she is discharged, future contraception should have been discussed with each woman and contraceptive supplies should have been offered.
- B 8.16 The chosen method of contraception should be initiated immediately.
- B 8.17 Intrauterine contraceptives can be inserted immediately following medical and surgical abortion at all gestations as long as it is reasonably certain that the woman is not still pregnant.
- ✓ 8.18 Women who choose not to start a contraceptive method immediately should be given information about local contraceptive providers in addition to their GP.

- ✓ 8.19 Abortion services should have an agreed pathway of care to local community sexual health services.

### Sterilisation

- B 8.20 Sterilisation can be safely performed at the time of induced abortion, although this may be more likely to be associated with regret and failure.

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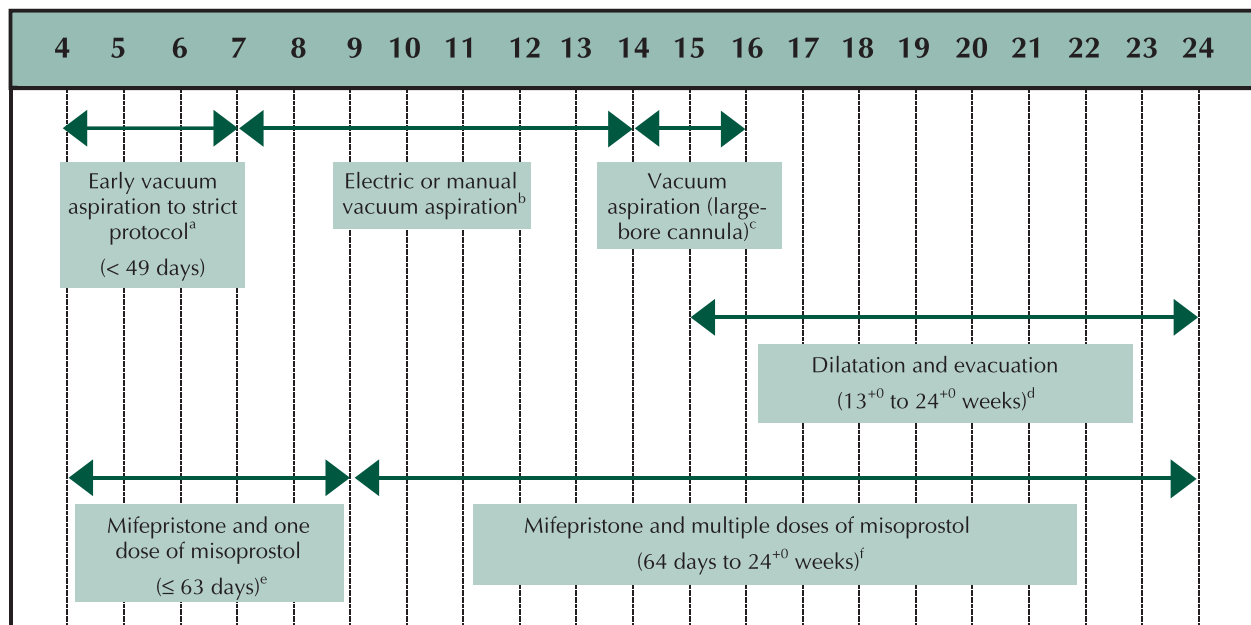
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# Appendix: Recommended methods of abortion for different gestations

**Table A** Clarifying gestation

Completed weeks	0	1	2	3	4	5	6	7	8	9	10	11	12
Days	0–6	7–13	14–20	21–27	28–34	35–41	42–48	49–55	56–62	63–69	70–76	77–83	84–90
Completed weeks	13	14	15	16	17	18	19	20	21	22	23	24	
Days	91–97	98–104	105–111	112–118	119–125	126–132	133–139	140–146	147–153	154–160	161–167	168–174	

**Figure A** Summary of abortion methods appropriate for use in abortion services in Great Britain by gestational age in weeks



- Surgical abortion by means of vacuum aspiration at gestations below 7 weeks. To increase confidence that the gestation sac has been removed, protocols should include safeguards such as examination of the aspirate for the presence of the gestational sac and follow-up serum human chorionic gonadotrophin estimation if needed.
- Surgical abortion using electric or manual vacuum aspiration. The uterus is emptied using a suction cannula. Sharp curettage is not recommended.
- Surgical abortion using vacuum aspiration which may require large-bore suction cannula and tubing.
- Surgical abortion using a combination of vacuum aspiration and specialised forceps.
- Medical abortion using a single oral dose of the antiprogesterone mifepristone, followed by a single dose of a prostaglandin analogue.
- Medical abortion using a single oral dose of the antiprogesterone mifepristone, followed by multiple doses of a prostaglandin analogue.



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