

Simplifying early surgical abortion

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13th FIAPAC Conference

14-15 September 2018

Nantes, France

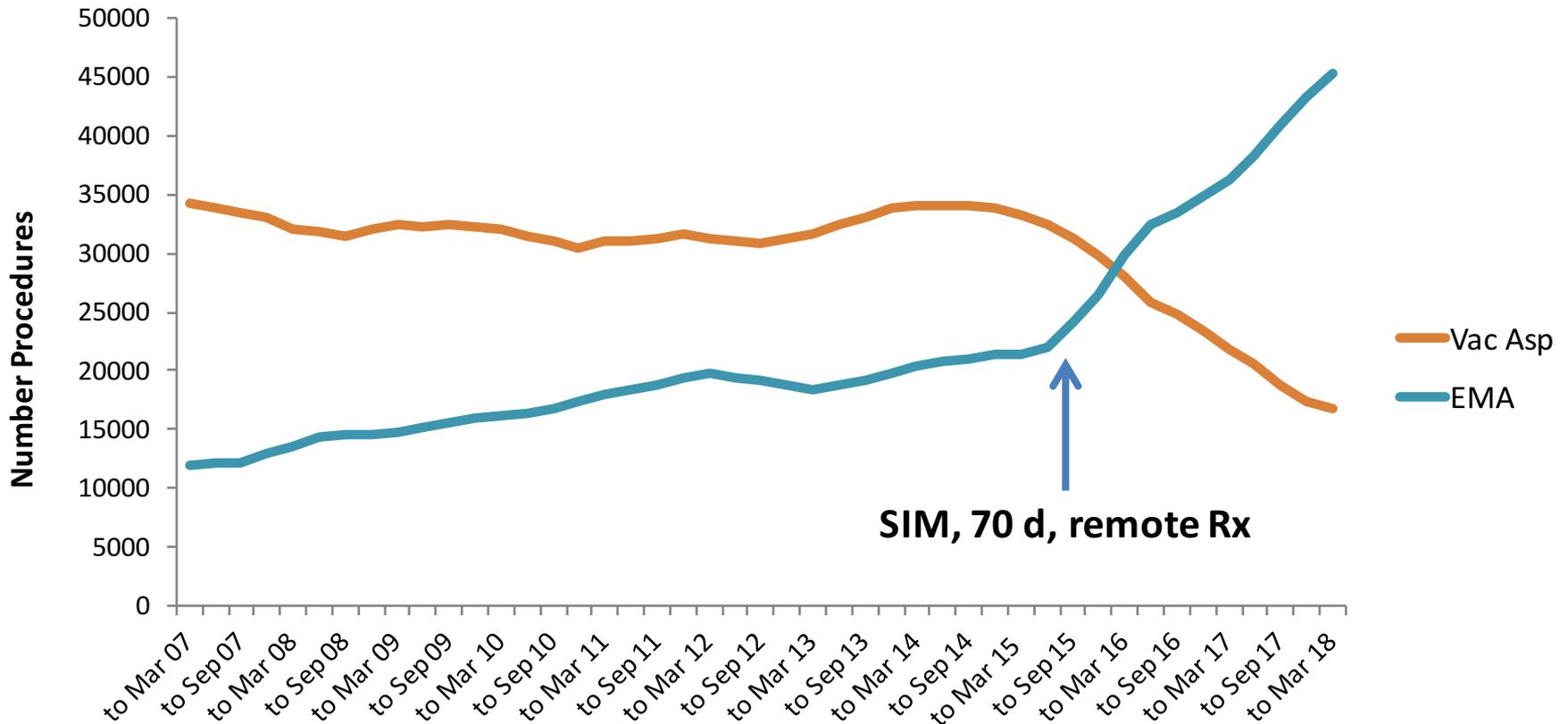
Disclosures

- I am Medical Director of British Pregnancy Advisory Service (BPAS) and I will be presenting some BPAS data
- I have no commercial disclosures

Early medical abortion: a vision

- In last decade, bpas implemented vision for delivering medical abortion
- Based on what women told us they wanted and what we believed possible in our setting
 - Local services
 - Self-referral with single access point
 - Rapid entry into and through treatment
 - Fewest clinic visits possible

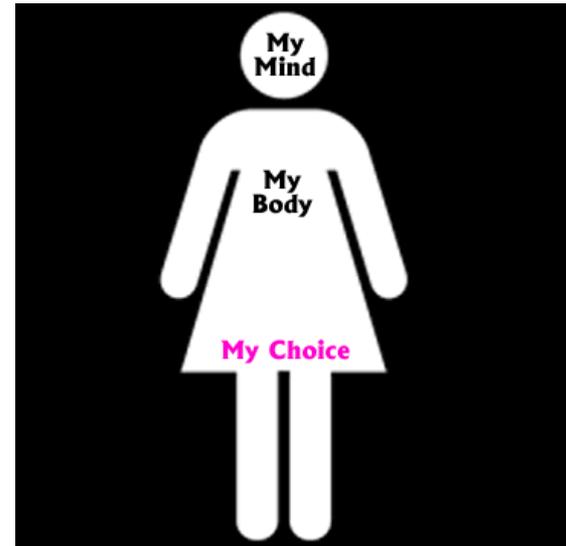
The vision realised





Arguments for retaining method choice

- Ethics
 - Self-determination
 - Informed consent
- Effectiveness
 - Surgical > medical
- Experience
 - Preferences
 - Satisfaction
 - The impact of gestational age



Partial preference RCT medical vs. surgical: short and mid-term acceptability

- Mifepristone/misoprostol vs. vacuum aspiration under general anaesthesia at 6-14 weeks' gestation
- Proportion who would choose method again measured at **2 weeks** and **3 months** post-treatment

	2 weeks (%)	3 months (%)
Prefer surgical (n=488)	97	96
Prefer medical (n=565)	81	79
Randomised surgical (n=134)	94	95
Randomised medical (n=123)	69	65

Partial preference RCT medical vs. surgical: short and long-term acceptability

- Mifepristone/gemeprost vs. vacuum aspiration under general anaesthesia up to 9 weeks' gestation
- Proportion who would choose method again assessed at **2 weeks**; f/u study on in **2 years**

	2 weeks (%)	2 years (%)
Prefer surgical (n=84/36)	90	89
Prefer medical (n=72/27)	95	89
Randomised surgical (n=95/38)	87	87
Randomised medical (n=94/39)	74	64

69%: choice 'extremely important'

Willing to pay median £311 to have options

Partial preference RCT medical vs. surgical: subsequent abortion

- Follow-up of partial preference RCT population (original n=1,033) + 346 cases from year prior (total n=1,497)
- In period up to 2005, 24% (n=330) had ≥ 1 further abortion
- Method choice of next and any further abortion compared to index/prior

Method prior (s)	Subsequent medical (%)	Subsequent surgical (%)	p
Medical (n=171)	49	51	ns
Surgical (n=159)	13	87	<.01
Both (n=125)	37	63	<.01

Medical vs. surgical: preference by gestation

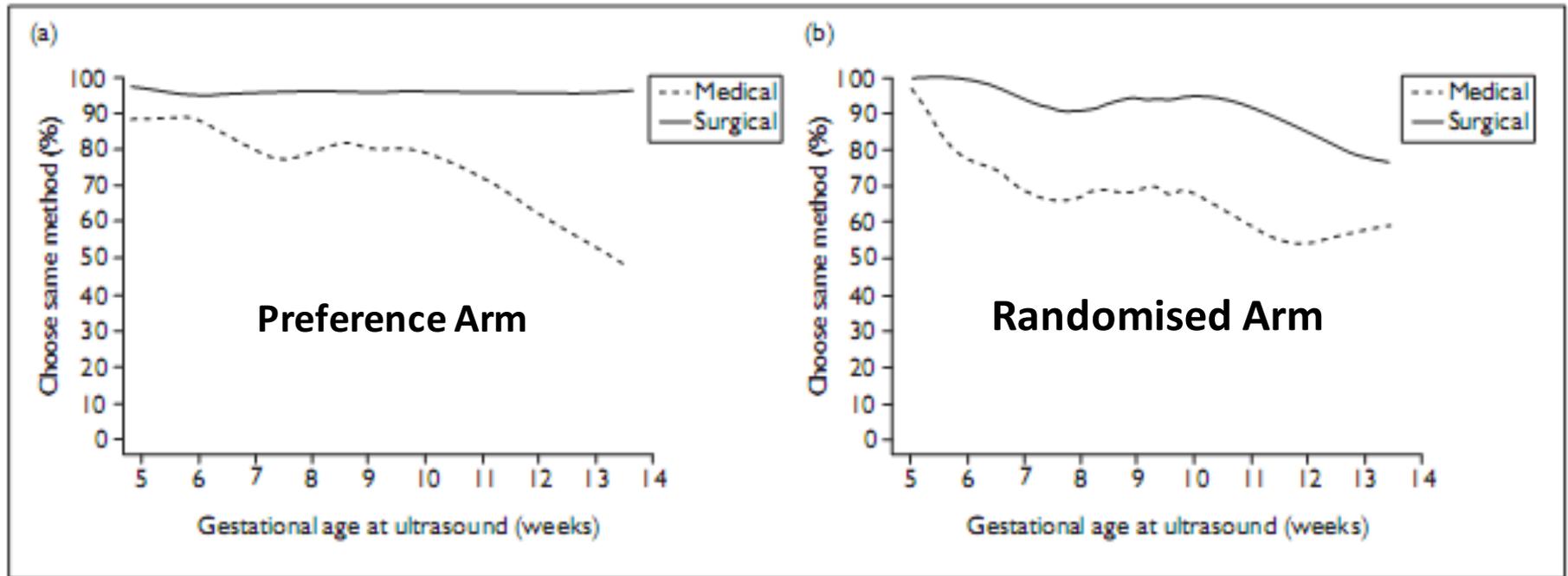
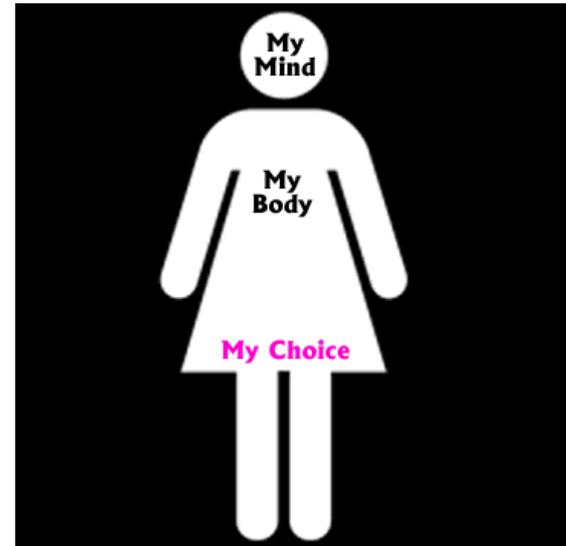


FIGURE 4 Acceptability by gestation at 2 weeks post termination: (a) comparing preference arms; and (b) comparing randomised arms.

Arguments for retaining method choice

- Ethics
- Effectiveness
- Experience
- Eligibility
- Skills



Robson SC et al HTA 2009, Rorbye C et al Hum Reprod 2005,
Ashok PW et al Contraception 2005, Henshaw RC et al BMJ 1993,
Howie FL et al BJOG 1997

Reduce clinic visits: same day or remote assessment

I have 2 youngsters and would have struggled to travel with them



Lovely to relax in my own home in private, this whole situation has been traumatic

Enabled me to attend work and take time out in a private room

Service is brilliant... I live miles from anywhere

Task share with nurses/midwives

- General Medical Council: doctor can delegate obtaining consent to someone else, provided the delegate:
 - is suitably trained and qualified
 - has sufficient knowledge of the proposed investigation or treatment, and understands the risks involved
 - understands, and agrees to act in accordance with, [GMC guidance]
- Royal College of Nursing: role of nurses in abortion pre-assessment includes obtaining consent and assessment of competence to consent
- Training is essential as are job aides to consent.

Move treatment out of theatre

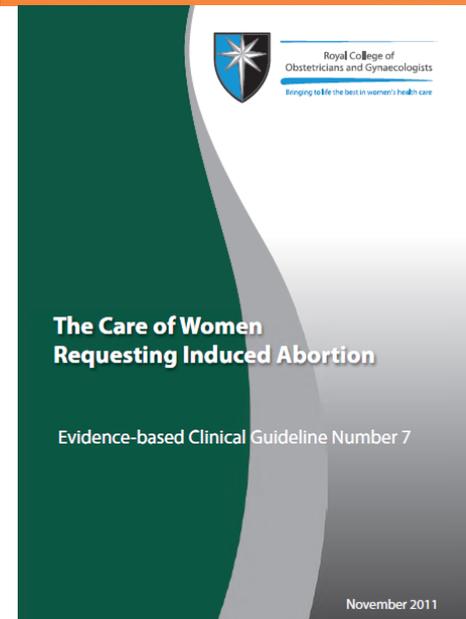
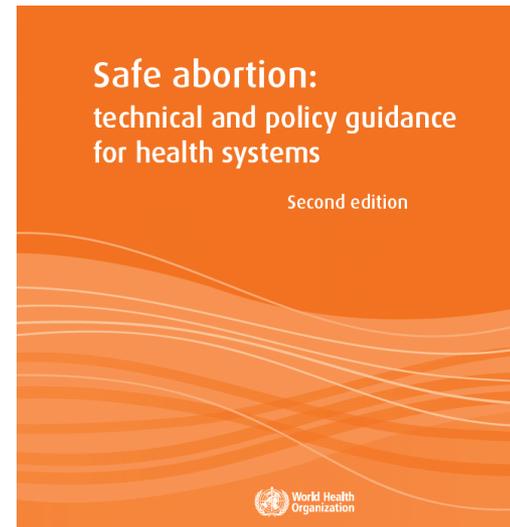
- Cost to set up/run 2 lists/week from treatment room for 1 year: £28,000
 - Procedure room had scan machine, gynae couch, light; needed dilators, theatre clothes
 - Contraceptive costs: £235/session
- Within 4 months: 1 theatre list per week replaced saving £92,000
- Manual vacuum aspiration and disposable instruments aide treatment in smaller spaces



Reduce use of general anaesthesia

WHO: General anaesthesia is not routinely recommended for abortion procedures, and increases the clinical risks...and costs for both the health care facility and the woman

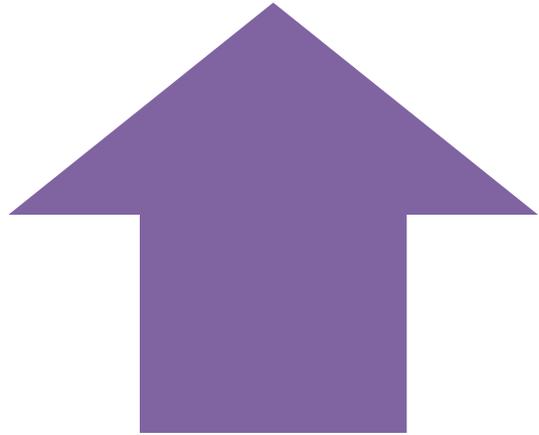
RCOG: Services should be able to provide surgical abortions without resort to general anaesthesia



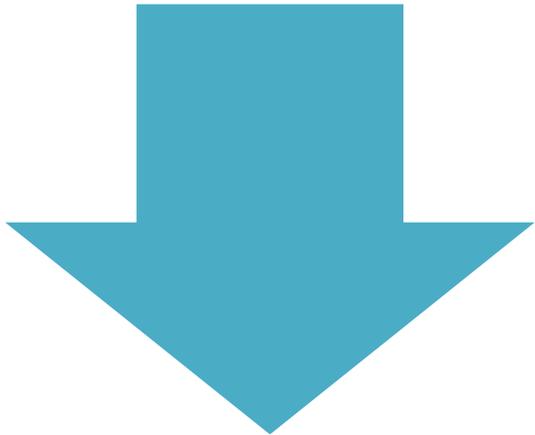
Quality of life with office-based evacuations under local anaesthesia

- Sub-study of multicentre trial comparing misoprostol to vacuum aspiration for miscarriage
- Women randomised to surgical had either
 - EVA under general/sedation/spinal in theatre (n=68)
 - MVA in office with local anaesthesia (n=89)
- Lower quality of life with theatre-based model
 - Need to cut down on work or other activities OR 2.8 (1.4, 5.8)
 - Accomplished less than you would like OR 2.6 (1.2, 5.3)
 - Missed school or work OR 3.2 (1.5, 6.5)
 - Need help from family/friends OR 3.9 (1.9, 8.1)
- Pain scores higher in local anaesthesia group

Understand what influences abortion pain



Young age
Fewer prior pregnancies
History dysmenorrhoea
Anxiety
Depression



Older age
More prior pregnancies
Shorter operative time
Increased provider experience

Remember: effective pain management begins at “hello”

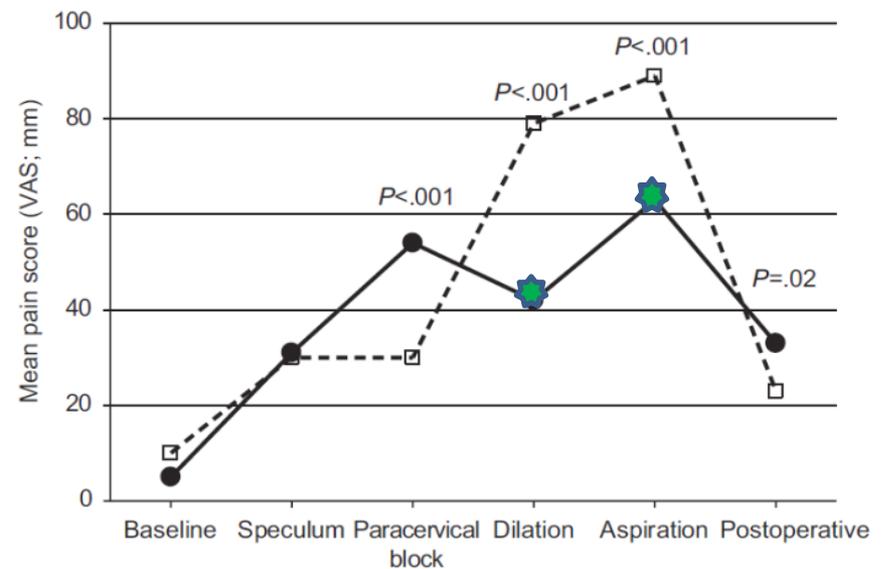
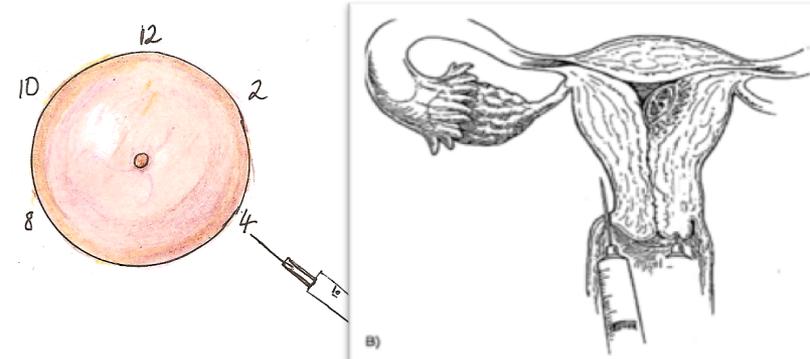
- Respectful, informed, supportive staff
- Warm, friendly environment
- Good patient preparation
- Women’s involvement in the pain management plan
- Gentle but quick technique
- Effective pain medications



Give an effective para-cervical block

- 20 ml buffered 1% lidocaine
- Tenaculum site + 4 point block
- Deep (3cm) injections
- Given slowly
- 3 minute wait
- Reduced pain at dilation and aspiration vs. sham ($p < 0.001$)

Renner R Obstet Gynecol 2012



● — ● = Paracervical block

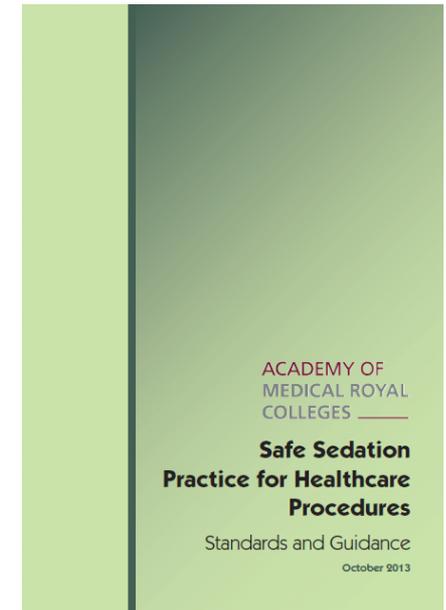
◆ - - ◆ = Sham

Use adjuncts that work

- Oral NSAIDs (IM effective but injection is painful)
- What does not work to reduce pain
 - Demand flow 50/50 nitrous/oxygen
 - Oral opioids or oral benzodiazepines
 - Paracetamol as post-procedure pain prophylaxis
 - Cervical priming (but may make procedure faster)
- Non-pharmacologic interventions: vocal local, doulas, music may improve experience but no, limited, or conflicting evidence for pain reduction

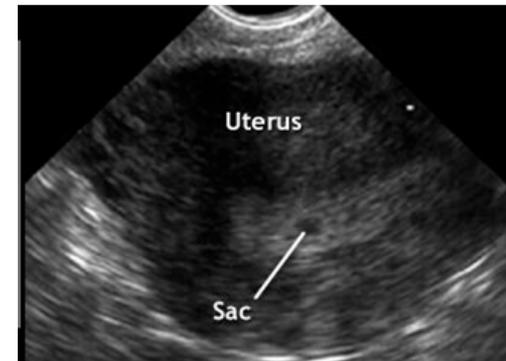
Consider conscious sedation

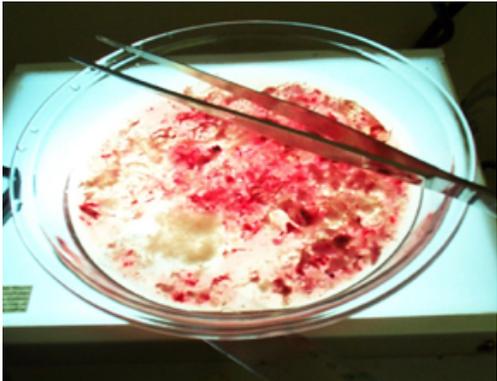
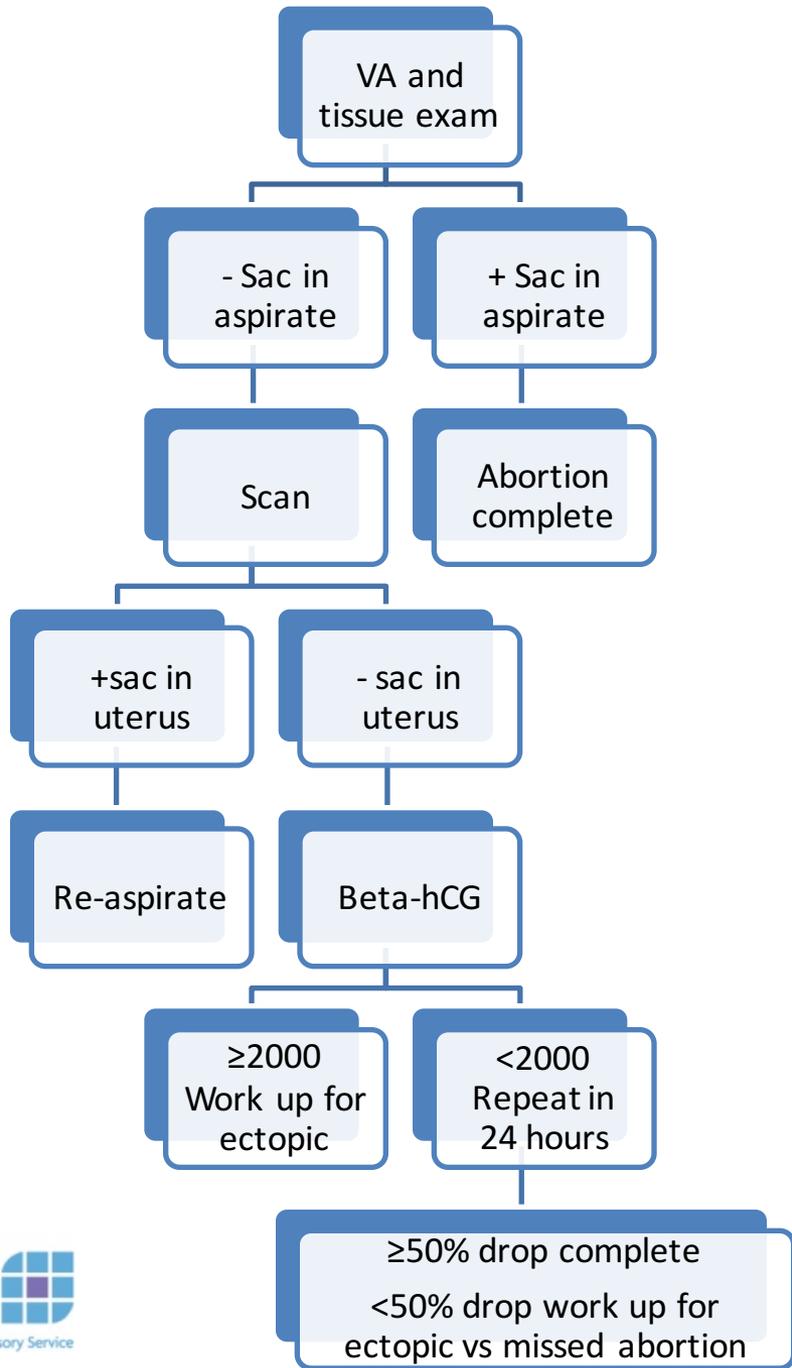
- Compared to local anaesthetic, low dose intravenous midazolam and fentanyl associated with
 - Reduced procedural pain among self-selectors
 - Increased satisfaction in women randomised
- Operator-delivered, outpatient model safe to 18 weeks' gestation
- Standards for safe staffing, training, infrastructure available



Offer abortion as early as necessary

- Positive pregnancy test
- No concern for ectopic
- Undesired pregnancy
- Inconclusive scan (no sac, sac but no yolk sac)
- Can adhere to follow-up protocol with beta-hCG if required





5 week sac*



6 week sac*

*Images courtesy C. Fiala

Very early surgical abortion outcomes

- Cohort of 2,399 MVAs at < 6 weeks gestation
 - 99% effective
 - 94% had immediate verification of a gestational sac
 - 49% with no sac on scan had sac visualised in the aspirate
 - 6 repeat aspirations (0.25%)
 - 14 ectopic pregnancies (0.6%) diagnosed & treated
- Trial of 500 cases < 6 weeks randomised to MVA or EVA
 - 98-99% effective with either device
 - 36% with sac size $\leq 3\text{mm}$ had sac visualised in aspirate

Summary

- Large shifts toward medical abortion can threaten ability of services to continue offering surgical abortion
- Retaining choice of methods important as principle of abortion provision, to ensure an optimal abortion experience, maintenance of skills
- Sustainable, effective, acceptable surgical abortion can be delivered by changes to service model (treatment room, task sharing), rationalising use of general anaesthesia, providing effective local anaesthesia +/- conscious sedation, offering parity in gestational ages at which surgical and medical abortion are offered

Thank you for your attention.

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Understand pain with abortion under local anaesthesia

- Mean pain scores 4-7 (10 point scale)
- Pain management has improved over time

	1979 (%)	1999 (%)
None	3	30
Mild	17	25
Moderate	46	29
Severe	32	14
Very severe	2	-