Clinical Guidelines for Early Medical Abortion at Home – England

Rationale and Scope

The recommendations in this guideline represent the view of the Royal College of Obstetricians & Gynaecologists (RCOG) expert abortion group, chaired by the president of the RCOG and comprising representatives from the specialist society representing providers caring for women needing abortion (BSACP) and the Faculty of Sexual and Reproductive Healthcare (FSRH), with clinical experts from the NHS and charitable providers, nursing and GP representatives. The working group included representation from the Department of Health and Social Care (DHSC). The guidelines were subject to peer review and consultation.

When exercising their judgement, professionals and practitioners are expected to take this guideline into account, alongside the individual needs, preferences and values of their patients or the people using their service. The guideline does not override the responsibility of clinicians to make decisions appropriate to the circumstances of the individual, in consultation with them and their families and carers or guardian.

This guidance is a summary of best practice and does not replace other published, detailed and authoritative guidance such as that available from the RCOG[1;2], WHO[3;4], the CQC[5] and other national and international organisations. Providers are expected to keep their own policies up to date based on the best available evidence. New NICE guidance on abortion is expected to be published in September 2019.

This guidance relates to early medical abortion at home (EMA) up to and including 9 weeks 6 days gestation when the first medication is administered. The second part of the treatment regimen is either administered in hospital or clinic settings with the woman then returning home to complete the abortion, or where the woman administers the medication at home herself.

Introduction

The government has amended the approval for the class of place where abortion drugs can be administered for the second stage of early medical abortion to include the place in England where a pregnant woman has her permanent address or usually resides. This guidance summarises best practice for early medical abortion at home, whether medication is administered in a hospital or clinic setting as was universal under the previous approval or, as is now permitted under the updated approval, in the woman's home.

Outline of Early Medical Abortion

Over 100,000 women in England have early medical abortions each year, with medical abortion accounting for 65% of all abortions[6]. Almost all women have their early medical abortion at home, but women have been required to administer the medications within licenced premises before returning home. Expert consensus is that it is safer, more effective and better tolerated for women to administer the drugs in the privacy of their own residence – this avoids the risk of distressing bleeding and pain on the journey home and removes the need for an extra visit to a clinic or hospital[7]. There is no medical justification for drugs to be taken in a hospital or clinic setting.

The process of early medical abortion involves taking a tablet of mifepristone followed by misoprostol taken vaginally (as pessaries), dissolved under the tongue (sub-lingual) or dissolved in the mouth between the cheek and gum (buccal). The combination of the two drugs cause the womb (uterus) to contract to expel the pregnancy in a process equivalent to that of a natural miscarriage.

Recommendations for Best Practice

Women should be given the abortion method of their choice. Safe options include early medical abortion with medication taken at home, medical abortion with medication administered in hospital or clinic settings, or surgical techniques using local anaesthetic, sedation or general anaesthetic (surgical techniques are beyond the scope of this guideline). [RCOG 2011, 6.6].

Before Treatment

Information Provision and Informed Consent

Information should be given in a non-judgemental and supportive way. [RCOG 2015]

Women should be informed about their pregnancy options so that they can make an informed choice about their preferred course of action. [RCOG 2015]

Women should be reassured that abortion is a safe procedure for which major complications and mortality are rare at all gestations. [RCOG 2015]

The following information should be provided to women requesting abortion, with an emphasis on the overall safety of the procedure and in a way that women can understand: [RCOG 2015]

- the choice of abortion method available and the characteristics of each
- the side effects, risks and complications associated with each available abortion method
- what will happen during and after the abortion
- symptoms likely to be experienced both during and after the abortion (e.g. menstrual-like cramps, pain and bleeding)
- how long it is likely to take for the abortion to be completed
- what pain management will be made available
- follow-up care
- the range of emotions commonly experienced after having an abortion

clinic. Providers should ensure that their policies do not deny women the option of administration at her residence other than on the grounds of safety, patient choice or need to comply with the law.

Advise women that bleeding and cramping can start quickly after misoprostol administration.

^‰](] Z }uu v š]}v• ÁZ Œ u]•}‰Œ}•š}o]• u]v]•š Œ residence

Ensure that the woman understands how to administer the medication.

Ensure that the woman knows who to contact in case she changes her mind and continues the pregnancy, or if her circumstances significantly alter or should unexpected difficulties arise.

When completing the Abortion Notification (HSA4) form]v • š]}v ð ~^v u v Œ ••}(šŒ šu vš Á]šZ ‰ Œ}•š Po v]v]•š Œ }Œ šZ as long as this is the same as that entered in section 3c ‰ š] vš• ^‰]•o} complete address, otherwise enter full details here. š]}v ð]• šŒ šu vš Á]šZ ‰ Œ}•š Po v]v should be recorded as the date on which you advise the patient self-administers misoprostol.

References

1. Royal College of Obstetricians and Gynaecologists. The Care of Women Requesting Induced Abortion. 7. 2011. London, Royal College of Obstetricians and Gynaecologists. Evidence-based Clinical Guideline. www.rcog.org.uk/globalassets/documents/guidelines/abortion-guideline_web_1.pdf

2. Royal College of Obstetricians and Gynaecologists. Best practice in comprehensive abortion care. RCOG. 2015. London, Royal College of Obstetricians & Gynaecologists. Best Practice Paper No. 2. https://www.rcog.org.uk/globalassets/documents/guidelines/best-practice-papers/best-practice-paper-2.pdf. Date accessed: 1-10-2018

3. World Health Organisation. Safe abortion: technical and policy guidance for health systems. World Health Organisation. Second edition. 2012. Geneva, World Health Organisation. http://extranet.who.int/iris/bitstream/10665/70914/1/9789241548434_eng.pdf?ua=1. Date accessed: 7-5-2018

4. World Health Organisation. Clinical practice handbook for safe abortion. Geneva: World Health Organisation, 2014. http://apps.who.int/iris/bitstream/handle/10665/97415/9789241548717_eng.pdf?sequence=1

5. Care Quality Commission. Core service (or single specialty): Termination of pregnancy. v2.01. 9-2-2018. London, Care Quality Commission. Inspection framework: independent acute hospitals (and single specialty). https://www.cqc.org.uk/sites/default/files/inspection-framework-independent-hospitals-termination-pregnancy.pdf. Date accessed: 30-9-2018

6. Department of Health. Abortion Statistics, England and Wales: 2017. 2018. London, Department of Health. Summary information from the abortion notification forms returned to the Chief Medical Officers of England and Wales. https://www.gov.uk/government/statistics/abortion-statistics-for-england-and-wales-2017. Date accessed: 1-10-2018

7. Lord, J, Regan, L, Kasliwal, A, Massey, L, and Cameron, S. Early medical abortion: best practice now lawful in Scotland and Wales but not available to women in England. *BMJ Sex Reprod Health* 2018;**44**:155.http://jfprhc.bmj.com/content/44/3/155.abstract

8. Lohr, P. A., Starling, J. E., Scott, J. G., and Aiken, A. R. A. Simultaneous Compared With Interval Medical Abortion Regimens Where Home Use Is Restricted. *Obstet.Gynecol.* 2018;**131**:635-41.PM:29528933