bpas
British Pregnancy Advisory Service

# ABORTION IN PRACTICE

## A guide for GPs

# CONTENTS

NO WOMAN EVER WANTS TO NEED AN ABORTION, BUT OVER THE COURSE OF HER REPRODUCTIVE LIFE, ONE IN THREE WILL HAVE ONE. A GENERAL PRACTITIONER WILL OFTEN BE THE FIRST PORT OF CALL FOR A WOMAN CONFRONTED WITH AN UNPLANNED PREGNANCY. SOME WILL ALSO SEEK ADVICE FROM A GP AFTER AN ABORTION. THIS GUIDE IS INTENDED TO ASSIST GPs WITH THIS PROCESS

Established in 1968, the British Pregnancy Advisory Service (BPAS) is now Britain's leading abortion provider. Each year we see over 70,000 women of all ages and personal circumstances with unplanned pregnancies in our consultation centres and clinics throughout the country. Most of the services we provide are on behalf of the NHS. We have considerable experience providing safe and effective clinical care and with managing the psychosocial aspects of women's experiences.

BPAS provides abortion up to 24 weeks' gestation, as well as contraception screening and testing of sexually transmitted infections. Our service is non-judgemental. We talk to women with unplanned pregnancies who subsequently decide to give birth and provide a straightforward, sensitive service for women who decide that abortion is the best option for them.

With around 200,000 abortions taking place each year in England and Wales[1], the vast majority of general practitioners will find themselves consulting women with unplanned pregnancies, referring women for abortion, and caring for women who have had an abortion. *Abortion In Practice: A Guide for GPs* makes use of BPAS' experience to provide clear information about:

- Facts and myths about abortion
- Abortion methods at different gestational ages
- Normal and abnormal signs and symptoms post-abortion
- Helping women prevent unplanned pregnancies in the future

In partnership with the NHS, BPAS is committed to providing a safe, effective, sensitive and cost-effective service for women. General Practitioners play a crucial role in this process.

We hope that you will find this guide helpful.

**Patricia A. Lohr, Medical Director, BPAS**
**April 2014**



# PART ONE
# PRE-ABORTION

BPAS - here if you need us
08457 30 40 30 | five

# IN THIS **SECTION**

- Who can be referred to BPAS?
- How to refer
- Other ways a GP can support a referral to BPAS
- Frequently asked questions
- Conscientious objection
- Treating minors

## WHO CAN BE REFERRED **TO BPAS?**

A GP will often be the first point of contact for a woman with an unplanned pregnancy. She might want to confirm whether she is pregnant, need a referral for an abortion, or want guidance and unbiased counselling about what to do.

*In all of these cases,* a woman can be referred directly to BPAS. We can discuss her options and if she decides on an abortion, we can discuss the different methods and what each entails, perform sexual health screening, and initiate contraception if desired.

## HOW TO **REFER**

Many commissioning organisations allow a woman to refer herself to BPAS for an abortion. In this case, she can simply call us seven days a week on 08457 30 40 30 or visit www.bpas.org. Self-referral is the ideal referral pathway for accessing abortion services as it eliminates barriers to care. It is widely accepted that earlier access to services leads to better clinical outcomes and is more cost-effective than later access.

In some cases, in order to receive NHS funding, a woman needs to be referred by her GP. The specific requirements of the referral process are written into the relevant contract with BPAS.

Some referral pathways require that a woman has a formal letter from her GP as a mode of referral, while others have easier and quicker arrangements.

If you are unsure about how NHS funding for abortion in your area is accessed, telephone us on 08457 30 40 30. A member of our team can take a woman's postcode and some details about her GP to access specific information about the terms of the NHS contract, determine whether she is eligible for NHS funding to be seen at BPAS and, if so, how she should be referred (see page 9). Either the woman herself, or her GP, can call us to obtain this information.

If a written referral is needed, we provide easy-to-complete referral forms that can be used by the GP instead of a letter. These can be obtained via our website, **www.bpas.org**

Information needed to make an appointment at BPAS or determine eligibility for NHS funding and treatment within our clinics.

**Call BPAS 08457 30 40 30**

Be prepared to provide the advisor with the following information:

- Woman's name
- Woman's address/postcode
- GP's name
- GP's address/postcode
- Woman's date of birth
- First day of the last menstrual period (or other estimation of gestational age)
- Woman's height
- Woman's weight
- History of any medical conditions or limitations

## OTHER WAYS A GP CAN SUPPORT **A REFERRAL TO BPAS**

Before a woman's first appointment with BPAS, it is helpful if her GP can:

- Complete a referral form or write a referral letter, if required
- Sign the HSA1 form (Certificate A in Scotland), certifying the GP's opinion that there are grounds for carrying out the abortion (forms available online at www.bpas.org or at www.dh.gov.uk)
- Determine the gestational age of the pregnancy from the first day of the woman's last menstrual period (LMP)

We do appreciate that GPs have many demands on their time. If this is not possible, BPAS can take the woman all the way through the process.

# FREQUENTLY ASKED **QUESTIONS**

A woman seeking abortion may have many questions for her GP about what will happen at her appointments with BPAS. The information here is intended to give a general idea of what happens at a woman's consultation appointment. She can be reassured that BPAS will also address any questions or concerns that she might have at any stage.

**How long will I have to wait for an appointment?**

Guidance from the RCOG[2] states that women should be offered a consultation appointment within five working days of referral and the abortion procedure within five days of the decision to proceed.

**How many appointments will I have?**

In most cases, a woman will have two appointments, one for consultation and one for treatment. Sometimes these occur on the same day.

## WHAT HAPPENS AT CONSULTATION?

The consultation appointment is divided into two parts. First, women are invited to discuss the circumstances of their pregnancy and their choices in an unbiased pregnancy options discussion. If the woman chooses to end the pregnancy the remainder of the consultation is dedicated to establishing her medical history, the gestational age of her pregnancy by ultrasound and making sure the woman is fully informed about the methods available to her. This appointment will be as long or as short as it needs to be but is usually about 1.5 to 2 hours.

**Pregnancy options discussion**

This discussion takes place at the beginning of the consultation process and is between the woman and a BPAS member of staff specifically trained in providing decision-making support. This time is for the woman, if she chooses, to explore her thoughts, feelings and emotions concerning the pregnancy. She is initially seen on her own to ensure there are no safeguarding concerns, after which point her partner or support person is invited to join if she so wishes.

If the woman then decides to end the pregnancy she proceeds to the second part of the consultation, which is concerned with assessing medical suitability for treatment, BPAS treatment options, a screening for infections, and future contraception.

Many of our NHS contracts include a separate telephone-based contraception discussion with an expert contraception nurse to review and discuss all contraception options available, including LARC. We have seen a significant increase in uptake and a general perceived higher level of satisfaction with their choice of contraception. At this point a woman can choose her treatment method and we can have it ready for her at her appointment.

**Your patients' steps at BPAS**

This flow chart will help you guide your patients through their time with BPAS.

1
MAKE A BOOKING

↓

2
CONSULTATION
- Discuss your pregnancy options
- Medical assessment
- Choose your treatment

↓

3
TREATMENT

## PATIENTS WHO ARE DIAGNOSED WITH MISCARRIAGE

Miscarriage occurs in 10 to 20% of pregnancies and will be encountered by women who present to BPAS for an abortion. Where miscarriage is diagnosed, as long as the woman is medically suitable for treatment at BPAS, we can offer to manage the miscarriage if they choose. We can also refer a woman into a local EPAU if the woman would prefer to manage her miscarriage closer to home. We offer three options for miscarriage management

- Surgical management
- Medical management
- Expectant management

## FREQUENTLY ASKED **QUESTIONS CONTINUED**

**Who will I see at BPAS?**

At consultation, a woman will interact with a variety of staff members, all of whom are trained in abortion care:

- An administrative assistant will greet her upon arrival and take some basic identifying information
- A Client Care Co-ordinator will talk her through the process, discuss her feelings about continuing or terminating the pregnancy, and answer any initial questions she may have. A part of this discussion will be on her own to ensure she is not being coerced into a decision about the pregnancy
- A doctor or a nurse will assess the woman medically, perform an ultrasound for gestational age dating, and thoroughly review her options as well as contraception and STI screening

**What method of abortion will I be offered?**

At any gestational age, we aim to offer a choice between a medical and a surgical method. We strive to respect personal preferences in choice of method however, in certain cases, a woman's medical history may make a particular method of abortion inadvisable for her. This will be determined and discussed with her by the healthcare providers at BPAS. The methods of abortion provided by BPAS are detailed on page 20.

**Do I need to take somebody with me?**

A woman does not need to bring a companion on the day of consultation, but she will be advised of the emotional support she may need before, during and after an abortion. For younger clients, particularly those under 16, we strongly recommend the support of a parent or another responsible adult at the consultation. Women under the age of 16 will be told at consultation that on the day of treatment she will need to bring an adult (over the age of 18) with her. If she is unable to identify a suitable adult to take responsibility at discharge, she must let us know at consultation so we can help her find a suitable support person. On the day of treatment, a woman must be accompanied if a general anaesthetic or conscious sedation is to be given.

**When can I start to use contraception?**

All methods of contraception can be initiated on the day of a surgical abortion. Hormonal methods, including the implant and the injection, can be given on the second day of a medical abortion with intrauterine contraception as soon as the abortion is confirmed to be complete. We can also provide a supply of condoms and emergency hormone contraception to take home.

**What about screening for sexually transmitted infections (STIs)?**

At consultation, women are routinely offered a test for chlamydia. BPAS collaborates with the National Chlamydia Screening Programme in many areas, and offers women outside the scope of the programme the opportunity to pay for a test if her local NHS contract with BPAS does not include testing. It makes sense for women to be screened for other STIs, such as gonorrhea, HIV and syphilis, in addition to chlamydia, and many of our NHS contracts allow us to provide them.

**What if I am Rhesus-negative?**

Before the abortion is carried out, a woman will be tested to see if she has Rhesus-negative blood group. Those who do will be given an anti-D immunoglobulin injection on the day of the abortion.

# CONSCIENTIOUS **OBJECTION**

Abortion is an issue that can arouse strong personal, moral and ethical opinions. Some GPs have a conscientious objection to abortion. Guidance produced by the General Medical Council (GMC) states that doctors who have a conscientious objection to abortion must ensure that women can see another doctor for referral, and that conscientious objection to abortion should not affect the care given to a woman before or after abortion. You may be surprised to discover that women still encounter GPs who, as part of their own decision not to refer a woman for abortion services, won't refer them to a GP who will. Many of our NHS contracts ask us to inform them if a woman presents evidence of this practice.

**If carrying out a particular procedure or giving advice about it conflicts with your religious or moral beliefs, and this conflict might affect the treatment or advice you provide[3]:**

- You must explain this to the patient and tell her that she has the right to see another doctor
- You must be satisfied that the patient has sufficient information to enable her to exercise that right
- If it is not practical for a patient to arrange to see another doctor, you must ensure that arrangements are made for another suitably qualified colleague to take over your role
- Where a patient who is awaiting or has undergone a termination of pregnancy needs medical care, she is entitled to be treated just as after any medical or surgical procedure. The same principle applies to the care of patients before or following any other procedure from which you have withdrawn because of your beliefs

# TREATING **MINORS**

The rights of young people to confidentiality in accessing sexual health services are enshrined in law. The General Medical Council Guidance 0-18 years: guidance for all doctors[4] affirms that a doctor or health professional is able to provide contraception, sexual and reproductive health advice and treatment, without parental knowledge or consent, to a young person aged under 16, provided that:

- She/he understands the advice provided and its implications
- Her/his physical or mental health would otherwise be likely to suffer and so provision of advice or treatment is in her best interest

## RCOG ON YOUNG PEOPLE AND ABORTION

In its guideline on abortion, the RCOG notes that: "Doctors have an obligation to encourage a young person to involve her parent(s) or another adult (such as another family member or specialist youth worker) but generally should not override the patient's views.

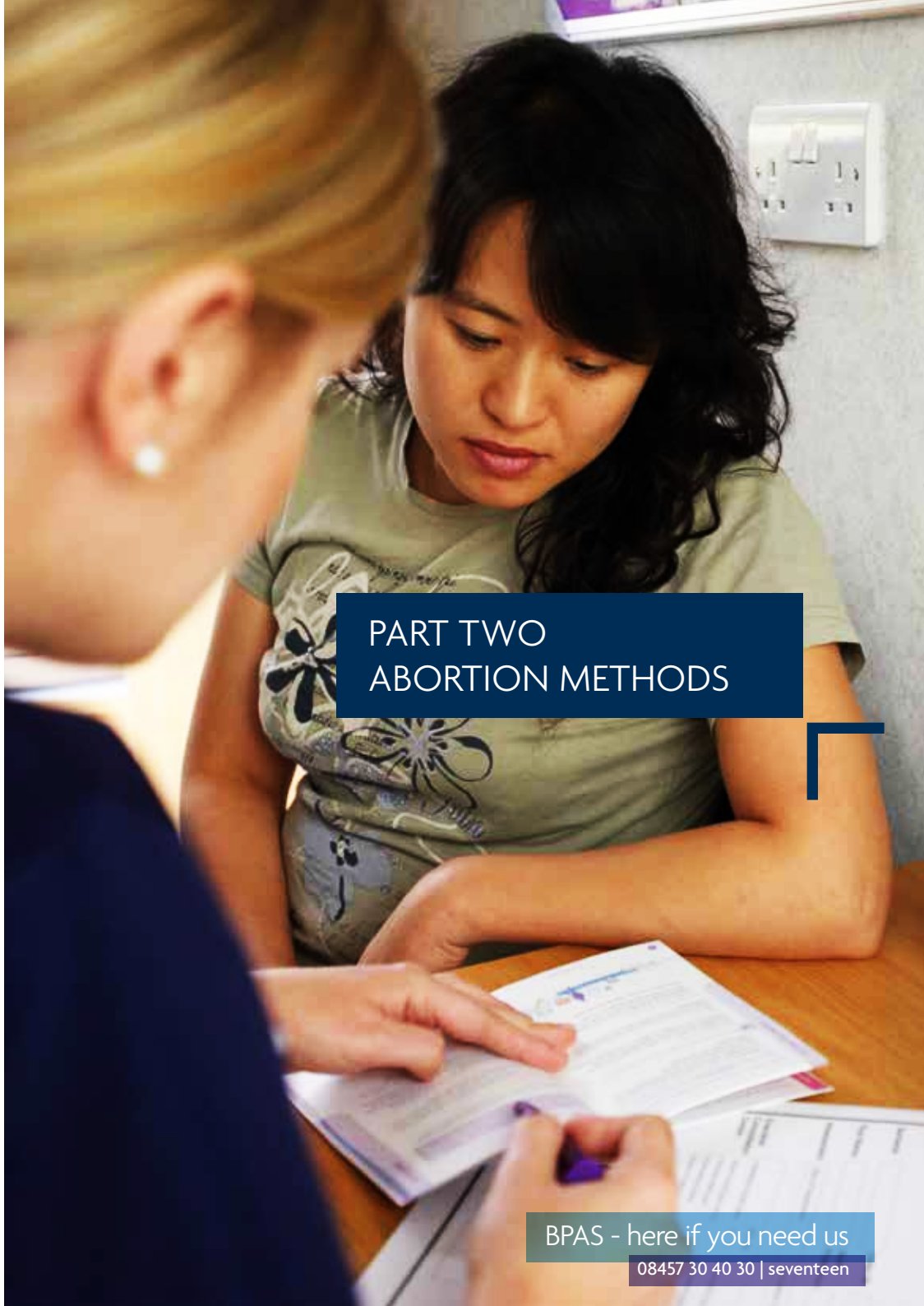
"Only in the most exceptional cases, for example where the pregnancy is thought to have resulted from child abuse, incest or exploitation, may a breach of confidentiality be justifiable. In such cases, the patient must be informed that confidentiality cannot be guaranteed and offered all necessary help and support."[2]

## THE RIGHT OF YOUNG PEOPLE TO CONFIDENTIALITY IN ACCESSING SEXUAL HEALTH SERVICES IS ENSHRINED IN LAW.

BPAS staff also rely on the criteria outlined by Lord Fraser in 1985, commonly known as the Fraser Guidelines:

- The young woman understands the health professional's advice
- The health professional cannot persuade the young woman to inform her parents or allow the doctor to inform the parents that she is seeking contraceptive advice
- The young woman is very likely to begin or continue having intercourse with or without contraceptive treatment
- Unless she receives contraceptive advice or treatment, the young woman's physical or mental health or both are likely to suffer
- The young woman's best interests require the health professional to give contraceptive advice, treatment or both without parental consent





# PART TWO
# ABORTION METHODS

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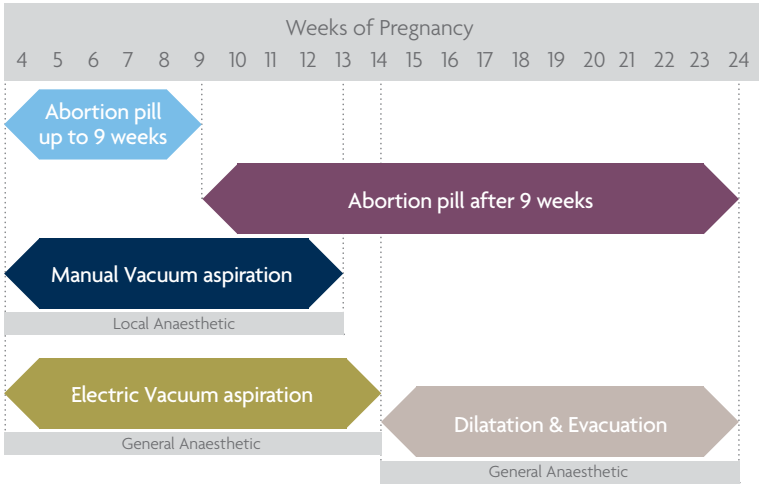
# IN THIS **SECTION**

# ABORTION **METHODS**

The method of abortion offered to a woman depends on gestational age as well as a woman's suitability for treatment. This diagram indicates which methods are available at BPAS, and the anaesthetic options, by gestational age. A detailed description of each method is given in this section.




# MEDICAL **ABORTION**

**Medical Abortion up to 9 weeks (Early Medical Abortion)**

- Offered to 9 weeks' gestation (<63 days).
- Two medicines are given, from six hours to three days apart. An overnight stay is not required.
- At the first visit, the woman swallows one tablet of mifepristone, which blocks the action of the hormone progesterone on the early pregnancy. This stops the growth of the pregnancy, it also causes cervical softening and some uterine contractions. Rarely, side-effects such as light bleeding, nausea, or vomiting, may be experienced before the next medication is administered.
- At the second visit, four tablets of misoprostol, a prostaglandin analogue, are placed in the vagina. This medicine causes the uterus to contract in order to expel the pregnancy. This medication can be taken buccally or sublingually if preferred.
- At BPAS, most women go home immediately after administration of the misoprostol with advice on what to do and expect. Most abortions will happen within four to five hours but pain and bleeding can start at about two hours. All women are given a supply of pain medication and have access to a 24-hour Post-Treatment Support Line that is staffed by nurses with access to consultation by a doctor if necessary.
- Follow-up is required to ensure that a medical abortion was successful. Vaginal bleeding alone does not necessarily mean the abortion is complete and follow-up is important to confirm the medicines have been effective.
- All clients are given either a follow-up appointment for an ultrasound scan or a pregnancy test to perform three weeks after the abortion. They are also advised to contact us immediately if the test is still positive so that an ultrasound scan can be arranged.

Medical Abortion after 9 weeks

- Offered from 9+1 to 24+0 weeks' gestation.
- Two medicines are given 24-48 hours apart. An overnight stay may be required.
- At the first visit, the woman swallows one tablet of mifepristone.
- Women who have a pregnancy of 22 weeks or more will have an additional procedure. The doctor will put a needle into the uterus and inject medicine to induce fetal demise. This may be carried out under local anaesthetic or a light general anaesthetic.
- At the second visit, the woman is admitted to the treatment unit. Four tablets of misoprostol are placed in the vagina to induce labour. Repeated doses of two tablets of misoprostol will be given by vagina or by mouth every three hours until the abortion occurs.
- Medication for pain and other side-effects, such as nausea, vomiting or diarrhoea, will be administered as needed throughout the abortion.
- Many women will have the abortion within eight hours of misoprostol initiation, but for some women a stay of at least one night will be required.



# SURGICAL **ABORTION**

Vacuum Aspiration

- Offered under local or general anaesthetic or conscious sedation up to approximately 14 weeks' gestation. An overnight stay is not required.
- General anaesthetic and conscious sedation procedures are carried out in an operating theatre. Local anaesthetic procedures may be carried out in an operating theatre or a treatment room.
- Local anaesthesia consists of an oral analgesic (typically ibuprofen) and local anaesthetic injected into the cervix before the procedure begins.
- General anaesthesia consists of short-acting medications injected into a vein of the arm or hand.
- After administration of the anaesthetic, a speculum is placed in the vagina and the cervix is gently stretched open using rigid dilators. The uterus is then emptied using a gentle manual or electric vacuum.
- The entire procedure typically takes 10-15 minutes, with the period of uterine evacuation lasting about three to five minutes. Recovery time is 30-45 minutes for local anaesthetic and one to two hours for general anaesthetic.

## ABORTION AFTER **24 WEEKS' GESTATION**

Abortions after 24 weeks' gestation are only permitted by law in cases of fetal anomaly, life-threatening condition or serious injury. Abortions over 24 weeks account for less than 0.1% of all abortions[1]. By law abortions at this stage may only be carried out in an NHS hospital.

**Dilatation & Evacuation (D&E)**

- Offered from 14 to 24+0 weeks' gestation under general anaesthetic or conscious sedation. An overnight stay is not required.
- Prior to a D&E, the cervix is prepared with either misoprostol or osmotic dilators. Misoprostol softens the cervix and dilators are placed inside the cervix to stretch the cervix open slowly. Misoprostol is used two to three hours before the evacuation, whereas dilators are placed 3-24 hours prior to the evacuation. Sometimes dilators and misoprostol are used together.
- Women who have a pregnancy of 22 weeks or more will have an additional procedure carried out the day before the surgery. The doctor will put a needle into the uterus and inject medicine to induce fetal demise. This may be carried out under local anaesthetic or a light general anaesthetic. Women who are aged 16 years or under may have this procedure at lower gestational ages.
- Once the cervix is prepared, forceps are used to remove the pregnancy and any remaining tissue is evacuated using vacuum aspiration.
- Most women leave the clinic within six hours of arriving on the day of surgery.

## SPECIALIST PLACEMENTS TEAM

BPAS has a dedicated team dealing with complex medical cases and placement of clients in the latter phase of the second trimester. Appointments are harder to access the closer a pregnancy is to 24 weeks' gestation. The specialist placements team will use the network of BPAS, NHS hospitals, doctors and other staff to find the most suitable appointment for her anywhere in UK. If you think your patient has a complex case or is having difficulty accessing an appointment for clients over 20 weeks, you can call the team direct on 0845 365 0534.

# WOMEN WITH **MEDICAL CONDITIONS**

Most of BPAS' clinics are not in hospitals and are without immediate access to tertiary care. Therefore, we are unable to routinely treat women with complex medical histories or those that place them at very high risk of complications. Examples of conditions we are unable to manage are;

- Sickle cell disease
- Coagulopathy, including taking anticoagulants
- Severe cardiac, liver or renal disease
- Asthma, diabetes or epilepsy that is currently uncontrolled

For our full suitability criteria please contact us on 08457 30 40 30

PART THREE
POST-ABORTION

# IN THIS **SECTION**

# POST-ABORTION

BPAS offers high quality post-abortion care to the women we have treated. However, in some cases, a woman might present directly to her GP for evaluation. The following guidance is designed to assist GPs in distinguishing between the normal recovery after an abortion, which requires reassurance rather than medical intervention, and complications that merit further action.

**Who do I call if I have a problem after the abortion?**

When a woman has had an abortion, she is given the telephone number of the BPAS clinic where she was treated and of our dedicated 24-hour Post-Treatment Support Line, (0800 247 1122) that she can call should she experience any problems or have concerns. Our Post-Treatment Support Line is staffed by nurses who provide advice based on clearly-defined criteria. Consultation with a doctor is possible if necessary.

ANY WOMAN WITH A SUSPECTED COMPLICATION AFTER AN ABORTION AT BPAS CAN BE REFERRED DIRECTLY TO US FOR EVALUATION BY CALLING THE CLINIC WHERE SHE WAS TREATED OR THE POST-TREATMENT SUPPORT LINE ON 0800 247 1122.

# BPAS POST-TREATMENT **SUPPORT**

**Our post-treatment support includes:**

- A 24-hour dedicated Post-Treatment Support Line: 0800 247 1122
- Follow-up evaluations when required
- Detailed written information on aftercare

Our Post Treatment Support Line is staffed by nurses who use a triage process and clearly-defined criteria to address questions and concerns and identify potential complications. In most cases, issues can be resolved by advice provided over the telephone. If a potential complication is identified the woman may be:

- Referred directly to A&E, with advice to call an ambulance if the problem is judged to be an emergency
- Given an appointment at a BPAS clinic for evaluation
- Referred to an out-of-hours GP, her local GP or Family Planning Clinic, if the problem needs urgent attention, travelling is difficult, or the BPAS clinic that she would like to attend is not open

BPAS post-treatment support (continued)

A routine follow-up evaluation is not required for a woman who has undergone an uncomplicated surgical abortion or a medical abortion where the expulsion has occurred onsite at BPAS. In contrast, a woman who has undergone an EMA at home must have some form of follow-up to ensure that the medications have been successful. Any woman undergoing EMA is provided with a pregnancy test and advised to perform it three weeks after the procedure.

She may also opt to be seen in person in which case an ultrasound is performed to confirm that the abortion is complete. If the test is positive, the woman is told that this could signal a failed medical abortion and that she must return to BPAS for an immediate evaluation.

## VERBAL AND WRITTEN INFORMATION

All women are provided with verbal and written information about the expected and normal recovery process after an abortion, as well as those signs or symptoms, which may indicate a complication. In addition to the number of the Post Treatment Support Line, the phone number of the treatment clinic is always provided, and women are welcomed back for a check-up at any time.

# EXPECTED SYMPTOMS **AFTER ABORTION**

Pain

Following all abortion procedures, women can expect to experience some mild lower abdominal cramping and discomfort for approximately one week as the uterus contracts to its non-pregnant size. This discomfort is typically intermittent and satisfactorily managed with non-steroidal anti-inflammatory drugs, or a locally applied heating pad or hot water bottle.

Managing pain during early medical abortion

Pain is an expected side-effect of an early medical abortion (EMA). Women undergoing EMA at BPAS are allowed to leave the clinic after misoprostol administration, and will likely be in private surroundings by the time the abortion takes place. Most abortions will happen in the following four to six hours, but for some women the process might be faster or slower, and the levels of pain will vary.

Some of our clients have described the pain caused by EMA as 'like a bad period', while others have found it significantly worse. The usual duration of severe pain is one to two hours and is associated with passing the pregnancy. Intermittent cramping may continue after this time but usually resolves over the next week. In most cases, women need reassurance that the pain is normal, and should be managed with pain relief.

Upon discharge from the BPAS clinic, women are offered a prescribed quantity of codeine tablets to take home, and advised on the correct dosages of over-the-counter pain medications, such as ibuprofen. They are also informed about non-medical methods of pain relief, for example, wearing comfortable clothes and using a heating pad.

**It is crucial that women having an early medical abortion do not underestimate the degree of pain relief they may require. 75% of women will need opioid pain relief with an EMA[5] .**

If a woman's pain during an EMA is not controlled with the tablets she has received from BPAS or purchased at the pharmacy, or if she experiences pain for more than one week, she is advised to contact our Post-Treatment Support Line for further management.

**Key questions:**

- How strong is the pain?
- What have you taken for it?
- Are there any other signs or symptoms that may indicate a complication?

LASTING PAIN AND /OR ABDOMINAL TENDERNESS OR PAIN THAT IS NOT CONTROLLED WITH ORAL PAIN MEDICATION TAKEN AT RECOMMENDED DOSES AND INTERVALS MAY INDICATE AN INFECTION OR OTHER COMPLICATION, AND SHOULD BE DEALT WITH PROMPTLY. SEVERE PAIN FOLLOWING A SURGICAL ABORTION MAY INDICATE A SERIOUS COMPLICATION, SUCH AS UTERINE PERFORATION. IN THESE CASES, A TELEPHONE CALL TO THE CLINIC OR TO THE POST-TREATMENT SUPPORT LINE OR DIRECT REFERRAL TO A&E FOR AN EVALUATION IS ADVISED.

**Bleeding**

It is completely normal to bleed following an abortion. After a surgical abortion, a woman can expect bleeding, like a light period, for approximately 7-14 days. Many women also pass small blood clots (smaller than a 50 pence piece). Following administration of misoprostol for an early medical abortion, bleeding will initially be heavy, with the woman passing some large clots along with the pregnancy tissue. Again, in most cases the bleeding like a light period may continue for about 7-14 days, but spotting can continue until the next period.

**Key questions:**

- How heavy is the bleeding (e.g. how many sanitary pads have been soaked hourly)?
- How long has it lasted?
- Are there any other signs or symptoms of a complication?

**Urgent medical attention should be sought if a woman experiences:**

- Bleeding that soaks two or more sanitary pads per hour for two consecutive hours
- Continuous and heavy bleeding
- Symptoms of anaemia, such as dizziness, shortness of breath, tachycardia and fatigue

If these symptoms are present, there is the possibility that the abortion is incomplete which is also known as having retained products of conception (see page 40).

Heavy or brisk bleeding may also be signs that the uterus has not contracted sufficiently (uterine atony) or, after a surgical abortion, may indicate trauma to the cervix or uterus. In such cases, the woman should be evaluated promptly.

**Side-effects of drugs**

A woman undergoing medical abortion may experience side-effects after administration on the day of misoprostol:

- Nausea (37 per 100 women)
- Vomiting (24 per 100 women)
- Diarrhoea (42 per 100 women)
- Headache (7 per 100 women)
- Dizziness (19 per 100 women)
- Flushes/sweats (79 per 100 women)[7]

**These side-effects should not last more than 72 hours.**

If they do, attention should be sought and another source of these symptoms considered.

## GENERAL ANAESTHETIC

A woman who has had a general anaesthetic may experience nausea and vomiting in the immediate post-operative period. Afterward, she may have drowsiness, itching, or headache from the medications used or have pain or bruising where medications were injected. Again, these side-effects are short-lived.

If they do not resolve in the first 24-48 hours following an abortion, evaluation should occur.

A woman who has undergone either a surgical or medical abortion may also experience side-effects from prophylactic antibiotics. All women who undergo surgical abortion at BPAS are treated prophylactically with doxycycline or azithromycin and metronidazole. All women undergoing a medical abortion receive doxycycline or azithromycin. Common side-effects of azithromycin and doxycycline include stomach upset, diarrhoea, nausea, headache, and vomiting. Metronidazole can lead to nausea, headaches, loss of appetite, a metallic taste and, on rare occassions, a rash.

**Emotional upset**

Most women feel relief after an abortion, but some experience short-term feelings of anger, regret, guilt or sadness.

Some women have more serious psychological problems following an abortion. However, these cases are relatively rare and there is no evidence that these problems are actually caused by the abortion. They are often a continuation of problems a woman has experienced before the abortion[2].

BPAS counsellors are trained in dealing with women's feelings about abortion, both before and after the event, and are willing to talk to any woman who requires further support.

Women treated by BPAS are offered free post-abortion counselling and support, no matter how much time has elapsed between the abortion and the time that they seek counselling. Women not treated by BPAS are offered post-abortion counselling for a small fee.

Women seeking post-abortion counselling can call **08457 30 40 30** to book an appointment.

# SOME COMPLICATIONS AFTER ABORTION **AND THEIR TREATMENT**

In addition to continuous heavy bleeding and lasting pain, we advise women to look out for the following unusual signs and symptoms:

- A high temperature (38°C)
- Abdominal tenderness
- Foul smelling or other offensive unusual vaginal discharge
- A general feeling of being unwell

Any of these symptoms may indicate the presence of a complication, which is infrequent but require accurate diagnosis and prompt treatment.

### Infection

Genital tract infection, including post-abortion endometritis or salpingitis, occurs in up to 10% of women after an abortion. The risk is reduced when prophylactic antibiotics are given, or when lower genital tract infection has been excluded by bacteriological screening[2] . All clients who undergo abortion at BPAS are treated with prophylactic antibiotics, however, infection can still occur. Symptoms include:

- Persistent lower abdominal pain
- Pain with intercourse
- Foul-smelling vaginal discharge
- Fever

On pelvic examination the uterus will be tender and there may be cervical motion tenderness as with pelvic inflammatory disease.

### Treatment

Post-abortion endometritis or salpingitis is treated with the same oral antibiotic regimen used for pelvic inflammatory disease. A typical regimen is metronidazole 400mg PO BD for 14 days and ciprofloxacin 500mg PO BD for 14 days. Alternative regimens are given by the British National Formulary (www.bnf.org) and can be advised upon by the BPAS clinic where the woman was treated. Severely ill women will need hospitalisation and intravenous antibiotics. When infection is associated with retained products of conception, urgent surgical evacuation of the uterus is required in addition to antibiotics.

### Retained products of conception

In BPAS' experience only 1% of surgical procedures, and 3-5% of medical abortions, will require an additional vacuum aspiration, which is commonly performed for retained products of conception (RPOC). Symptoms suggestive of RPOC are:

- Prolonged uterine bleeding which may be continuous or intermittent
- Uterine cramping

On pelvic examination the uterus may be tender and enlarged. The cervical os will usually be open to digital examination and active bleeding may be visualised. There may also be blood or blood clots visible in the vaginal vault.

If possible, a woman who reports these symptoms after a medical or surgical abortion should be referred back to BPAS. An evaluation will be conducted, which includes a thorough clinical history, physical examination and, typically, an ultrasound.

### Diagnosing retained products of conception

It is important to remember that the diagnosis of RPOC is a clinical one. A history of prolonged bleeding and/or pain combined with physical findings of blood or blood clots in the vaginal vault, an open internal cervical os, and an enlarged, tender uterus are key diagnostic characteristics. It is important to remember that a pregnancy test can remain positive up to six weeks after an abortion and is not diagnostic of RPOC.

Typical ultrasound findings suggestive of RPOC are a thickened, heterogeneous mass within the uterine cavity. If Doppler ultrasound is performed, the mass with demonstrate vascular blood flow. In contrast, retained blood clots will not demonstrate vascular blood flow.

Several studies have shown that there is no absolute cut-off for endometrial thickness that predicts the need for surgical intervention where the gestational sac has been successfully expelled or removed[8-11]. Thus, while ultrasound can support a diagnosis, it is based primarily on clinical signs and symptoms. It is important to remember to treat the patient and not the ultrasound.

If the diagnosis of retained products of conception is made, BPAS advises women of their options for management. These include:

- Expectant management (watchful waiting)
- Medical management with misoprostol
- Surgical management by vacuum aspiration

Any woman with RPOC may opt for a vacuum aspiration, regardless of the severity of her symptoms. However, if a woman is unstable or bleeding is brisk, urgent surgical evacuation is indicated. If a client is stable and bleeding is light, she may choose expectant management with the anticipation that the residual tissue will be expelled over the next several weeks or during her next menstrual cycle. When bleeding is light to moderate, BPAS offers surgical intervention, or a dose of 800mcg misoprostol administered vaginally or 400mcg sublingually[7].

Women choosing expectant or medical management must be counselled on signs and symptoms that must be addressed urgently, such as bleeding that soaks more than two sanitary pads per hour for two hours in a row. Further follow-up to assess the outcome with either expectant or medical management is also necessary.

## INFECTION

Infection can accompany retained products of conception and at times it can be difficult to ascertain if an infection is present as the uterus will often be tender on examination. If infection is suspected, prompt evacuation of the uterus is recommended along with administration of appropriate antibiotics. These are the same regimens used for pelvic inflammatory disease as described above. If the client has a high temperature, she is assumed to have an infection and needs to be seen as soon as possible.

**Ectopic pregnancy**

Ectopic pregnancy occurs in around 1% of all pregnancies. Its incidence is lower in women seeking abortion than in the general population[12-14]. However, the possibility of ectopic pregnancy should not be disregarded if suspected. All women undergoing abortion at BPAS have an ultrasound to determine gestational age. Where an intrauterine pregnancy cannot definitively be identified on an ultrasound, BPAS healthcare providers are trained to take the possibility of ectopic pregnancy into consideration and refer to an Early Pregnancy Assessment Unit (EPAU) if indicated. Appropriate evaluations at an EPAU would include:

- Serial measurement of serum beta hCG, and;
- Transvaginal ultrasound

The following symptoms should also alert the healthcare provider to the possibility of an ectopic pregnancy:

- Continuing symptoms of pregnancy after an abortion procedure
- Abdominal pain, especially if on one side and severe
- Pain under the ribs or in the shoulders
- Fainting or feeling light-headed

## TREATMENT

Suspected ectopic pregnancy should be referred promptly to a hospital with adequate gynaecological surgical services. Unlike most other complications, women with an ectopic pregnancy should not be referred back to BPAS as we do not have the facilities for appropriate management and treatment should not be delayed.

### Continuing pregnancy

Continuing pregnancy occurs in approximately 2.3 in 1,000 surgical abortions and between 1 and 14 in 1,000 early medical abortions[2]. Pregnancy symptoms should resolve within a week after an abortion. If a woman has symptoms suggestive of a continuing pregnancy, she should be referred directly back to BPAS for evaluation.

It should be kept in mind that a highly sensitive pregnancy test can remain positive for up to six weeks post-abortion. An ultrasound is indicated to look for a continuing intrauterine pregnancy.

Any woman with a continuing pregnancy after a medical or surgical abortion will be offered a surgical evacuation for termination of the pregnancy.

A woman also needs to be aware that she may ovulate within 10 days of her abortion. This reinforces the need for effective contraceptive use immediately following abortion. Recurrent pregnancy symptoms may indicate a new pregnancy. Evaluation with an ultrasound or serial serum beta hCG measurements may be indicated and referral to an EPAU is appropriate.

## REVIEWING COMPLICATIONS

BPAS monitors and regularly reviews complications. If a woman has a complication that is managed outside of BPAS we ask that, with the woman's permission, a summary of the woman's care and any relevant pathology reports are forwarded to us.

Reports and notes can be mailed to:
BPAS, Clinical Department, 20 Timothys Bridge Road, Stratford Enterprise Park, Stratford Upon Avon, CF37 9BF
or sent by fax to: 0845 365 5051.



# CONTRACEPTION

All clients should have a plan for contraception documented before leaving a BPAS consultation centre. As much as possible, these methods should not be delayed as ovulation can occur as soon as 10 days after an abortion.

### Hormonal methods

Oral contraceptive pills, injectables and the contraceptive patch can be started on the same day as a surgical abortion, or on the day on which misoprostol is administered for a medical abortion.

### Long-acting Reversible Contraception

The progestogen-only sub dermal implant can be placed on the day of misoprostol administration in the case of EMA, or late medical abortion, and immediately following surgical abortion[15].

### Intrauterine contraception

Intrauterine contraception is ideally inserted immediately post-abortion, or within the first 48 hours following a surgical or medical abortion. Otherwise, insertion should be delayed until four weeks post-abortion. However, waiting until four or more weeks may put women at risk of pregnancy. After counselling and when intrauterine contraception is the preferred method it can be inserted by an experienced clinician at any time post-abortion if there is no concern that the pregnancy is continuing[16].

# PART FOUR
# FURTHER INFORMATION

BPAS - here if you need us
08457 30 40 30 | forty seven

# IN THIS **SECTION**

# ABORTION:
# MYTHS AND FACTS

**Myth:** Abortion is complicated and dangerous

**Fact:** Improvements in abortion techniques over the decades mean that induced abortion, when managed by trained professionals in countries where abortion is legal, is an extremely safe, quick and effective procedure. In England and Wales in 2012, complications were reported at a rate of about 1 in 700 abortions[1] .
A woman is more likely to die as a result of pregnancy and childbirth than from terminating a pregnancy[17].

**Myth:** Abortion causes breast cancer

**Fact:** Despite persistent claims that induced abortion is associated with breast cancer, a robust body of evidence continues to find no such link. The Royal College of Obstetricians and Gynaecologists' guidance on abortion firmly states 'induced abortion is not associated with an increase in breast cancer risk'[2].

**Myth:** Abortion causes mental illness

**Fact:** Another concern is that abortion damages a woman's mental health. In fact, most women state feelings of relief after an abortion[18]. A recent review by the American Psychological Association found no credible evidence that a single elective abortion of an unwanted pregnancy in and of itself causes mental health problems for adult women[19]. Studies indicate that some women do experience sadness, grief and feelings of loss following an abortion, and some may experience clinically significant psychiatric disorders. However, as the RCOG cautions, it must be kept in mind that these findings do not imply a causal association and may reflect continuation of pre-existing conditions[2].

**Myth:** The 'abortion pill' is like the 'morning after pill'

**Fact:** Mifepristone, one of the drugs used in EMA, is often referred to by the media as 'the abortion pill'. Some people confuse mifepristone with the emergency contraceptive pill (levonorgestrel, often referred to as the 'morning after pill'). These are different drugs. Significantly, emergency contraception will not cause an abortion if a woman is already pregnant and will not damage a pregnancy if one is already established. Early medical abortion, by contrast, is a medical regimen designed for women wishing to end an established pregnancy.

**Myth:** Abortion damages future reproductive outcome

**Fact:** There are no proven associations between induced abortion and subsequent ectopic pregnancy, placenta praevia or infertility. There is conflicting evidence as to whether abortion is associated with a small increase in the risk of subsequent miscarriage or preterm delivery[2].

# ABOUT **BPAS**

BPAS is the UK's leading independent provider of abortion care and offers several other reproductive healthcare services. We have pioneered new developments and innovations in our field and set the standard for good practice in a sensitive area of healthcare. We support reproductive choice by providing high quality, affordable services to prevent or end unwanted pregnancy with contraception or by abortion.

Formed after the passing of the Abortion Act 1967, BPAS is a national organisation with more than 60 locations across England, Scotland and Wales.

## COLLABORATION WITH THE NHS

We have collaborated with the NHS since the early 1970s. Our NHS-funded caseload continues to increase year-on-year, presenting many opportunities for imaginative and innovative partnership arrangements to ensure the best service provision for women seeking abortion. We offer tailored services for organisations that commission our services and a choice of treatments for the women who use them. We currently provide services on behalf of approximately 230 commissioning organisations.

As a registered charity (number 289145), we are a not-for-profit organisation. We exist to provide a vital service and reinvest all profits into the services we provide in the UK.

Choosing BPAS means investing in quality, choice and the security of more than 40 years' experience. We offer:

- A tailored service, flexible enough to meet commissioners' requirements with individually customised packages
- Expertise in our field, demonstrated by the fact that we provide services on behalf of the NHS
- Specialism in abortion in the second trimester and Early Medical Abortion (EMA)
- Real choice for commissioners and their patients, offering the most appropriate procedure, based on information, advice and the woman's needs and wishes
- A caring service, delivered by staff that are sensitive, non-judgemental and focused on the well-being of their patient

A generation on from our formation, the name BPAS is synonymous with a high quality, innovative and professional abortion care.

For further information about commissioning our services please contact:
**development@bpas.org**

# USEFUL ADDITIONAL **READING**

The BPAS website carries a large amount of information for women and for healthcare professionals, including copies of the literature we provide to women who come to us for abortions, as well as detailed information about our local clinics. Please visit:

**www.bpas.org**

**The Royal College of Obstetricians and Gynaecologists (2011): Evidence-based Clinical Guideline Number 7: The Care Of Women Requesting Induced Abortion:**

A comprehensive summary of scientific research on abortion and guidance on best practice. Available online at: **http://www.rcog.org.uk/resources/ Public/pdf/induced_abortionfull.pdf**

**House of Commons Science and Technology Committee (2007): Scientific Developments Relating to the Abortion Act 1967**

A thorough review of scientific developments pertaining to the upper gestational limit for abortion, abortion for fetal abnormality, access and procedures, and the impact of abortion on women's health. Available online at: **http://www.publications.parliament.uk/pa/cm200607/cmselect/cmsctech/1045/1045i.pdf**

**Reproductive Review**

An update of news, commentary and medical developments on abortion and related issues, produced as an educational service by BPAS. Available online at: **http://wwwreproductivereview.org/**

**Abortion Statistics, England and Wales**

The Department of Health's annual bulletin. The 2012 statistics are available online at: **https://www.gov.uk/government/publications/report-on-abortion-statistics-in-england-and-wales-for-2012**

**Abortions (terminations of pregnancy) Statistics for Scotland**

Produced by the Information Services Division. Available online at: **http://www.isdscotland.org/**



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