NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Guideline

Termination of Pregnancy

Draft for consultation, 12 April 2019

This guideline covers termination of pregnancy for women of any age. It aims to improve the organisation of services to make it easier for women to access a termination. Detailed recommendations on conducting terminations at different gestational stages are also included, to ensure that women get the most effective care possible.

Who is it for?

- Healthcare professionals
- Commissioners and providers
- Those responsible for training curriculums
- Women requesting a termination of pregnancy

This draft guideline contains:

- the draft recommendations
- recommendations for research
- rationale and impact sections that explain why the committee made the recommendations and how they might affect practice
- the guideline context.

Information about how the guideline was developed is on the guideline's page on the NICE website. This includes the evidence reviews, the scope, and details of the committee and any declarations of interest.

Contents

1 Recommendations

People have the right to be involved in discussions and make informed decisions about their care, as described in your care.

Making decisions using NICE guidelines explains how we use words to show the strength (or certainty) of our recommendations, and has information about prescribing medicines (including off-label use), professional guidelines, standards and laws (including on consent and mental capacity), and safeguarding.

Note that, for medical termination of pregnancy, misoprostol only has a UK marketing authorisation for use of 400 micrograms orally up to 49 days, or 800 micrograms vaginally. All other uses recommended in this guideline are unlicensed. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented. See the General Medical Council's Prescribing guidance: prescribing unlicensed medicines for further information.

Note that, for termination of pregnancy, mifepristone only has a UK marketing authorisation for:

- 200 mg orally for medical termination or cervical priming for surgical termination
- 600 mg orally for medical termination.

All other uses recommended in this guideline are unlicensed. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented. See the General Medical Council's Prescribing guidance: prescribing unlicensed medicines for further information.

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1.1 Service organisation

Making it easier to access services

1.1.1 Commissioners and providers should work together to:

- make information about termination of pregnancy services (including how to access them) widely available
- ensure that women are promptly referred onwards if a service cannot provide a termination of pregnancy after a specific gestational age or by the woman's preferred method.

1.1.2 Commissioners and providers should allow women to self-refer to termination of pregnancy services.

1.1.3 Healthcare professionals should not allow their personal beliefs to delay access to termination of pregnancy services.

1.1.4 Commissioners should consider upfront funding for travel and accommodation for women who:

- are eligible for the NHS Healthcare Travel Costs Scheme **and/or**
- need to travel to a service that is not available locally.

Waiting times

1.1.5 Commissioners should work with providers to ensure termination of pregnancy services have the capacity and resources to deliver the range of services needed with minimal delay.

1.1.6 Ensure minimal delay in the termination of pregnancy process, and ideally:

- provide the assessment within 1 week of the request
- provide the termination of pregnancy within 1 week of the assessment.

1.1.7 For women who would prefer to wait longer for a termination of pregnancy, explain the implications[1] so they can make an informed decision.

1.1.8 Do not require women to have compulsory counselling or compulsory time for reflection before the termination of pregnancy.

Location of services

1.1.9 Consider providing termination of pregnancy consultations by phone or video call, for women who prefer this.

1.1.10 Consider providing termination of pregnancy services in a range of settings (including in the community and in hospitals), according to the needs of the local population.

Workforce and training

1.1.11 Termination of pregnancy providers should maximise the role of nurses and midwives in providing care.

1.1.12 Trainee healthcare professionals who may care for women who request a termination of pregnancy (for example nurses, midwives, and GPs) should have the chance to gain experience in termination of pregnancy services during their training.

1.1.13 For specialities that include training in termination of pregnancy as part of the core curriculum:

- ensure all trainees have the training, unless they opt out due to a conscientious objection
- include practical experience of termination of pregnancy services and procedures in the curriculum.

[1] This includes information about the legal limit stated in the Abortion Act, and that delaying a termination of pregnancy will increase risk, although the overall risk is low.

1.1.14 If a trainee's placement service does not provide termination of pregnancy, the trainee should gain experience with whoever is providing this service (either in the NHS or in the independent sector).

Complex comorbidities

1.1.15 Commissioners should ensure that specialist centres are available as locally as possible, to reduce delays and travel times for women with complex needs or significant comorbidities.

1.1.16 Providers should develop pathways for women with complex needs or significant comorbidities to:

- refer them to specialist centres if needed
- minimise delays in accessing care
- avoid the need for women to repeat key steps (such as returning to their GP for referral, or repeated assessments or investigations).

Avoiding stigma

1.1.17 When caring for women who are having a termination of pregnancy, be aware of:

- the anxiety they may have about perceived negative and judgemental attitudes from healthcare professionals
- the impact that verbal and non-verbal communication may have on them.

1.1.18 Services should be sensitive to the concerns women have about their privacy and confidentiality, including their concerns that information about the termination of pregnancy will be shared with healthcare professionals not directly involved in their care.

To find out why the committee made the recommendations on service organisation and how they might affect services, see rationale and impact.

1.2 Providing information

1.2.1 Reassure women that having a termination of pregnancy does not increase their risk of long-term health problems (such as infertility, cancer or mental health issues).

1.2.2 Provide information about the benefits and risks of medical and surgical termination of pregnancy (see table 1). Do this without being directive, so that women can make their own choice.

Table 1: Factors influencing a woman's decision between medical and surgical termination of pregnancy[2]

Medical and surgical termination of pregnancy are both highly effective and safe. The effectiveness and safety of both methods is similar, so if both are suitable the method used will depend on the woman's preference.

	Medical	Surgical
Procedure	***For all stages of gestation***	***For all stages of gestation***
	Women take a mifepristone tablet, followed by some misoprostol tablets. Mifepristone is swallowed. Misoprostol is left to dissolve under the tongue, inside the vagina or between the cheek and gum. Misoprostol is usually taken 1 to 2 days after mifepristone. Depending on the circumstances, gestational age and the woman's preference, the medical procedure may take place at home or in a clinic or hospital.	An operation that involves inserting a suction tube or instruments into the womb to remove the pregnancy. Depending on circumstances and the woman's preference, the operation may be performed using local anaesthesia (to numb the area), sedation with local anaesthesia (to numb the pain and make her drowsy), or deep sedation or general anaesthesia (to make her fall asleep). Takes place in a clinic or hospital.

[2] This table will form the basis of the decision aid that we intend to publish alongside the guideline and therefore will not appear in the final version of the guideline.

<table>
<tr><th></th><th colspan="2">Medical</th><th colspan="2">Surgical</th></tr>
<tr><td></td><td colspan="2">Avoids the need for surgery and an anaesthetic.

The woman is awake and aware of the process, and may see the pregnancy as it passes.

If performed in a clinic or hospital, the woman can usually go home on the same day.

An inpatient stay may sometimes be necessary.</td><td colspan="2">The woman will not usually see the pregnancy, unless she chooses to do so.

The woman can normally go home on the same day, but will need someone to accompany her if she has had sedation or general anaesthesia.

An inpatient stay may sometimes be necessary.</td></tr>
<tr><td></td><td>Before 10+1 weeks</td><td>After 10+0 weeks</td><td>Before 14+0 weeks</td><td>Between 14+0 weeks and 23+6 weeks</td></tr>
<tr><td></td><td>Based on the woman’s preference, misoprostol can be taken at home (before 10+0 weeks), following an outpatient appointment, or at the hospital or clinic.

Most women pass the pregnancy within 4 to 6 hours of taking the misoprostol.</td><td>Additional doses of misoprostol might be needed until the pregnancy is passed, and the woman will need to stay in the clinic or hospital after taking misoprostol.</td><td>Women will be given misoprostol tablets to help open their cervix and make the operation easier to perform.

Misoprostol is taken 1 to 3 hours before the operation, and is left to dissolve under the tongue, inside the vagina or between the cheek and gum. This may cause bleeding and pain</td><td>Osmotic dilators (medicated sticks) are carefully placed in the opening of the cervix several hours before the operation. The dilators swell in size by absorbing fluid from the cervix. This opens the cervix and makes the operation easier to perform. The dilators are inserted at an examination either on the same day as the termination or the day before.

As an alternative to osmotic dilators, some women may be asked to swallow</td></tr>
</table>

	Medical		Surgical	
			before the operation. As an alternative to misoprostol, some women may be asked to swallow a mifepristone tablet 1 to 2 days before the operation.	a mifepristone tablet the day before the operation, or take misoprostol (see 'before 14^{+0} weeks'). Some women may receive a combination of osmotic dilators and mifepristone.
Pain and bleeding	***For all stages of gestation***		***For all stages of gestation***	
	The degree of pain experienced varies and depends upon factors including the stage of the pregnancy, the use of pain relief and the individual woman's perception of pain. In general, women tend to bleed for more days after a medical termination than after surgery, although the overall total blood loss is similar with both methods.		The degree of pain experienced varies and depends upon factors including the stage of the pregnancy, the use of pain relief and the individual woman's perception of pain. In general, women tend to bleed for fewer days after a surgical termination than after a medical procedure, although the overall total blood loss is similar with both methods.	
Follow-up	***Before 10^{+1} weeks***	***After 10^{+0} weeks***	***For all stages of gestation***	
	No routine follow-up is necessary. However if the woman has chosen to go home to pass the pregnancy, she will need to do a special type of pregnancy test after about 2 weeks to confirm that	No routine follow-up is necessary.	No routine follow-up is necessary.	

	Medical		Surgical	
	the pregnancy has ended.			
Chance of complications	***Before 13+0 weeks***	***Between 13+0 weeks and 23+6 weeks***	***Before 13+0 weeks***	***Between 13+0 weeks and 23+6 weeks***
	On average, if 1000 women have a medical termination of pregnancy: • about 72 will need surgery to empty the womb; about 928 will not need surgery at all[3] • less than 1 will have severe bleeding or sepsis.[4]	On average, if 1000 women have a medical termination of pregnancy: • about 130 will need surgery to empty the womb; about 870 will not need surgery at all[5] • about 14 will have severe bleeding that requires a transfusion; about 986 will not have severe bleeding[5] • about 43 will have infection; about 957 will not have infection.[5]	On average, if 1000 women have a surgical termination of pregnancy: • about 36 will need further surgery to empty the womb; about 964 will not need further surgery[6] • about 1 will have severe bleeding, uterine perforation or sepsis; about 999 will not have severe bleeding, uterine perforation or sepsis.[7]	On average, if 1000 women have a surgical termination of pregnancy: • about 28 will need further surgery to empty the womb; about 972 will not need further surgery[8] • about 70 will have severe bleeding that requires a transfusion; about 930 will not have severe bleeding[8] • about 14 will have injury to the cervix; about 986 will not have injury to the cervix.[8]

[3] Figures are for women up to 13+6 weeks gestation and taken from Say, L, Brahmi, D, Kulier, R, Campana, A, Gülmezoglu, A M (2002) Medical versus surgical methods for first trimester termination of pregnancy. Cochrane Database of Systematic Reviews 4

[4] Figures are for women up to 12 completed weeks gestation and calculated from Abortion Statistics for England and Wales: 2017 (Available from https://www.gov.uk/government/statistics/abortion-statistics-for-england-and-wales-2017 [Accessed 19/03/2019])

[5] Figures taken from evidence review K: Medical versus surgical termination of pregnancy between 13+0 and 24+0 weeks' gestation

[6] Figures are for women up to 13+6 weeks gestation and taken from Say, L, Brahmi, D, Kulier, R, Campana, A, Gülmezoglu, A M (2002) Medical versus surgical methods for first trimester termination of pregnancy. Cochrane Database of Systematic Reviews 4

[7] Figures are for women up to 12 completed weeks gestation and calculated from Abortion Statistics for England and Wales: 2017 (Available from https://www.gov.uk/government/statistics/abortion-statistics-for-england-and-wales-2017 [Accessed 19/03/2019])

	Medical		Surgical	
		Fewer than 1 in 100 women having a medical termination of pregnancy will have: • uterine rupture (usually only occurs in women who have had a previous caesarean section).[5]		Fewer than 1 in 100 women having a surgical termination of pregnancy will have: • uterine perforation • infection.[8]
Immediate access to long-acting reversible contraceptives	***For all stages of gestation***		***For all stages of gestation***	
	Women can choose to have a depot medroxyprogesterone acetate (DMPA) injection or contraceptive implant fitted when they take the mifepristone tablet. Women may have an intrauterine contraceptive device fitted after they have passed the pregnancy.		Women can choose to have a DMPA injection or a contraceptive implant or intrauterine contraceptive device fitted at the same time as the procedure.	

1.2.3 As early as possible, provide women with detailed information to help them prepare for the termination of pregnancy. Cover:

- what it involves and what happens afterwards
- how much pain and bleeding to expect.

1.2.4 Provide information in a range of formats, for example video or written information. Include information based on the experiences of women who have had a termination of pregnancy.

[8] Figures taken from evidence review K: Medical versus surgical termination of pregnancy between 13^{+0} and 24^{+0} weeks' gestation

1.2.5 For more guidance on providing information and helping women to make decisions about their care, see enabling patients to actively participate in their care in the NICE guideline on patient experience in adult NHS services.

1.2.6 Ask women if they want information on contraception, and if so provide information about the options available to them.

1.2.7 For women who are having a medical termination of pregnancy, explain:

- that they may see the pregnancy as they pass it
- what the pregnancy will look like
- whether there may be any movement.

1.2.8 For women who are having a medical termination of pregnancy at home, explain how to be sure that the pregnancy has passed.

1.2.9 Provide women with information on signs and symptoms that indicate they need medical help after a termination of pregnancy, and who to contact if they do.

1.2.10 Provide women with information about the different options for handling fetal remains.

Information for women who are having a termination because of fetal anomaly

1.2.11 If termination of pregnancy for fetal anomaly cannot be provided in the maternity setting, establish a clear referral pathway with ongoing communication between services so that women can:

- easily transfer to the termination service
- get more information about the anomaly.

1.2.12 Explain to women that the fetus may not look abnormal despite there being a fetal anomaly.

To find out why the committee made the recommendations on providing information and how they might affect practice, see rationale and impact.

1.3 Anti-D prophylaxis

1.3.1 Offer anti-D prophylaxis to women who are having a termination of pregnancy after 9^{+6} weeks' gestation and are rhesus D negative.

1.3.2 For women who are having a medical termination of pregnancy, do not offer rhesus status testing or anti-D prophylaxis before 10^{+0} weeks' gestation.

1.3.3 For women who are having a surgical termination of pregnancy and are rhesus D negative, consider anti-D prophylaxis before 10^{+0} weeks.

1.3.4 Providers should ensure that:

- anti-D prophylaxis is available at the time of the termination of pregnancy
- rhesus status testing and anti-D prophylaxis supply does not cause any delays to women having a termination of pregnancy.

To find out why the committee made the recommendations on anti-D prophylaxis and how they might affect practice, see rationale and impact.

1.4 Antibiotic prophylaxis

Medical termination

1.4.1 Only give antibiotic prophylaxis to women who are having a medical termination of pregnancy if they have an increased risk of sexually transmitted infections.

1.4.2 For women who are having antibiotic prophylaxis, start the antibiotic on the same day they take the mifepristone. Consider:

- a 7-day course of twice-daily 100 mg oral doxycycline **or**

- 1 g oral azithromycin as a single dose, followed by 500 mg once daily for 2 days.

1.4.3 Do not routinely offer metronidazole in combination with another broad-spectrum antibiotic such as doxycycline for women having a medical termination of pregnancy.

Surgical termination

1.4.4 Offer antibiotic prophylaxis to women who are having surgical termination of pregnancy.

1.4.5 For women who are having a surgical termination of pregnancy and antibiotic prophylaxis, consider:

- a 7-day course of twice-daily 100 mg oral doxycycline **or**
- 1 g oral azithromycin as a single dose before the procedure, followed by 500 mg once daily for 2 days.

1.4.6 Do not routinely offer metronidazole in combination with another broad-spectrum antibiotic such as doxycycline for women having a surgical termination of pregnancy.

To find out why the committee made the recommendations on antibiotic prophylaxis and how they might affect practice, see rationale and impact.

1.5 Venous thromboembolism prophylaxis

1.5.1 For guidance on risk assessment for women who are having a termination of pregnancy, see recommendations 1.1.9 and 1.1.10 in the NICE guideline on reducing the risk of venous thromboembolism.

1.5.2 For women who need pharmacological thromboprophylaxis, consider low-molecular-weight heparin for at least 7 days after the termination of pregnancy.

1.5.3 For women who are at high risk of thrombosis, consider starting low-molecular-weight heparin before the termination of pregnancy and giving it for longer afterwards.

To find out why the committee made the recommendations on venous thromboembolism prophylaxis and how they might affect practice, see rationale and impact.

1.6 Choice of procedure for termination

1.6.1 Offer a choice between medical or surgical termination of pregnancy before 24^{+0} weeks' gestation (see table 1). If any methods would not be clinically appropriate, explain why.

To find out why the committee made the recommendation on the choice of procedure for termination of pregnancy and how it might affect practice, see rationale and impact.

1.7 Termination before definitive ultrasound evidence of an intrauterine pregnancy

1.7.1 Consider termination of pregnancy before there is definitive ultrasound evidence of an intrauterine pregnancy (a yolk sac) for women who do not have signs or symptoms of an ectopic pregnancy.

1.7.2 For women who are having a termination of pregnancy before there is definitive ultrasound evidence of an intrauterine pregnancy (a yolk sac):

- explain that there is a small chance of an ectopic pregnancy
- explain that they may need to have follow-up appointments to ensure the pregnancy has been terminated and to monitor for ectopic pregnancy
- provide 24-hour emergency contact details, and advise them to get in contact immediately if they develop symptoms that could indicate an ectopic pregnancy (see symptoms and signs of ectopic pregnancy and

initial assessment in the NICE guideline on ectopic pregnancy and miscarriage).

To find out why the committee made the recommendations on termination of pregnancy before definitive ultrasound evidence of an intrauterine pregnancy and how they might affect practice, see rationale and impact.

1.8 Expulsion at home for medical termination before 10^{+1} weeks

1.8.1 Offer the option of expulsion at home to women who are having a medical termination of pregnancy if they will be taking the mifepristone before 10^{+1} weeks' gestation.

To find out why the committee made the recommendation on expulsion at home for medical termination before 10^{+1} weeks and how it might affect practice, see rationale and impact.

1.9 Medical termination before 10^{+1} weeks

1.9.1 Offer interval treatment (usually 24 to 48 hours) with mifepristone and misoprostol to women who are having a medical termination of pregnancy between 9^{+1} and 10^{+0} weeks' gestation.

1.9.2 For women who are having a medical termination of pregnancy before 9^{+1} weeks' gestation, give them the choice of having mifepristone and misoprostol at the same time, but explain that:

- the risk of ongoing pregnancy may be higher, and it may increase with gestation
- it may take longer for the bleeding and pain to start
- it is important for them to complete the same follow-up programme that is recommended for all medical terminations before 10^{+1} weeks (see recommendations 1.14.1 and 1.14.2).

To find out why the committee made the recommendations on the interval between mifepristone and misoprostol for medical termination of pregnancy before 10^{+1} weeks and how they might affect practice, see rationale and impact.

1.10 Medical termination between 10^{+1} and 23^{+6} weeks

1.10.1 For women who are having a medical termination of pregnancy between 10^{+1} and 23^{+6} weeks' gestation and who have taken 200 mg mifepristone, offer an initial dose (36 to 48 hours after the mifepristone) of:

- 800 micrograms misoprostol, given vaginally, **or**
- 600 micrograms of misoprostol, given sublingually, for women who decline vaginal misoprostol.

Follow the initial dose with 400 microgram doses of misoprostol (vaginal, sublingual or buccal), given every 3 hours until expulsion.

1.10.2 Use a shorter interval between mifepristone and misoprostol if the woman prefers this, but explain that it may take a longer time from taking the first misoprostol dose to complete the termination of pregnancy.

To find out why the committee made the recommendations on medical termination of pregnancy between 10^{+1} and 23^{+6} weeks and how they might affect practice, see rationale and impact.

1.11 Medical termination after 23^{+6} weeks

1.11.1 For women who are having a medical termination of pregnancy between 24^{+0} and 25^{+0} weeks' gestation, consider 200 mg oral mifepristone, followed by 400 micrograms misoprostol (vaginal, buccal or sublingual) every 3 hours until delivery.

1.11.2 For women who are having a medical termination of pregnancy between 25^{+1} and 28^{+0} weeks' gestation, consider 200 mg oral mifepristone, followed by 200 micrograms misoprostol (vaginal, buccal or sublingual) every 4 hours until delivery.

1.11.3 For women who are having a medical termination of pregnancy after 28^{+0} weeks' gestation, consider 200 mg oral mifepristone, followed by 100 micrograms misoprostol (vaginal, buccal or sublingual) every 6 hours until delivery.

To find out why the committee made the recommendations on medical termination of pregnancy after 23^{+6} weeks and how they might affect practice, see rationale and impact.

1.12 Cervical priming before surgical termination

Before 14^{+0} weeks

1.12.1 For women who are having a surgical termination of pregnancy before 14^{+0} weeks' gestation, offer cervical priming with:

- 400 micrograms sublingual misoprostol, given 1 hour before the termination **or**
- 400 micrograms vaginal misoprostol, given 3 hours before the termination.

If misoprostol cannot be used, consider cervical priming with 200 mg oral mifepristone, given 24 to 48 hours before the termination.

1.12.2 Explain to women that cervical priming:

- reduces the risk of incomplete termination of pregnancy for women who are parous
- makes dilation easier for women who are parous or nulliparous
- may cause bleeding and pain before the procedure.

Between 14^{+0} and 23^{+6} weeks

1.12.3 For women who are having a surgical termination of pregnancy between 14^{+0} and 23^{+6} weeks' gestation, offer osmotic dilators for cervical priming.

1.12.4 For women who are having a surgical termination of pregnancy between 14^{+0} and 23^{+6} weeks' gestation, consider inserting osmotic dilators the day before the termination.

1.12.5 Do not offer misoprostol for cervical priming if the woman has had an osmotic dilator inserted the day before the termination of pregnancy.

1.12.6 For women who are having a surgical termination of pregnancy between 19^{+0} and 23^{+6} weeks' gestation, consider 200 mg oral mifepristone as well as osmotic dilators inserted the day before for cervical priming. If using mifepristone, give it at the same time as the osmotic dilator.

1.12.7 For women who are having a surgical termination of pregnancy and who cannot have or decline osmotic dilators, consider cervical priming with:

- 200 mg oral mifepristone, given the day before surgical termination, for women who are between 14^{+0} and 16^{+0} weeks' gestation **or**
- buccal, vaginal or sublingual misoprostol for women who are between 14^{+0} and 19^{+0} weeks' gestation.

To find out why the committee made the recommendations on cervical priming before surgical termination of pregnancy and how they might affect practice, see rationale and impact.

1.13 Anaesthesia and sedation for surgical termination

1.13.1 Consider general anaesthesia, deep sedation, conscious sedation with local anaesthesia, or local anaesthesia alone for women who are having surgical termination of pregnancy. To help women make an informed choice, discuss the options with them and explain that:

- having local anaesthesia alone means they will be able to spend less time in hospital
- intravenous sedation plus local anaesthesia will help if they are anxious about the procedure

- with deep sedation or general anaesthesia they will not be conscious during the procedure.

1.13.2 When using conscious sedation for a surgical termination of pregnancy, use intravenous rather than oral sedation.

1.13.3 When using general anaesthesia for a surgical termination of pregnancy, consider intravenous propofol and a short-acting opioid (such as fentanyl) rather than inhalational anaesthesia.

To find out why the committee made the recommendations on anaesthesia and sedation for surgical termination of pregnancy and how they might affect practice, see rationale and impact.

1.14 Follow-up and support after a termination

Follow-up after medical termination before 10+1 weeks

1.14.1 For women who have had a medical termination of pregnancy before 10^{+1} weeks' gestation with expulsion at home, offer the choice of self-assessment, including remote assessment (for example telephone or text messaging), as an alternative to clinic follow-up.

1.14.2 Use a low sensitivity or multi-level urine pregnancy test to exclude an ongoing pregnancy.

Support after a termination

1.14.3 Explain to women:

- what aftercare and follow-up to expect
- what to do if they have any problems after the termination of pregnancy, including how to get help out of hours
- that it is common to feel a range of emotions after the termination.

1.14.4 Advise women to seek emotional support if they need it, and how to access it (if relevant). This could include:

- support from family and friends
- peer support, or support groups for women who have had a termination of pregnancy
- counselling or psychological interventions.

1.14.5 Providers should offer emotional support after termination of pregnancy, and (if needed) provide or refer women to counselling services.

To find out why the committee made the recommendations on follow-up and support after a termination of pregnancy and how they might affect practice, see rationale and impact.

1.15 Improving access to contraception

1.15.1 Commissioners and providers should ensure that the full range of reversible contraceptive options (depot medroxyprogesterone acetate [DMPA], contraceptive implant, intrauterine methods, oral contraceptives, contraceptive patches, vaginal rings or barrier contraception) is available for women on the same day as their surgical or medical termination of pregnancy.

1.15.2 Providers should ensure that healthcare professionals have the knowledge and skills to provide all contraceptive options.

1.15.3 Providers should ensure they can provide the contraceptive implant, and that women who choose this method are offered it on:

- the day of the surgical termination of pregnancy **or**
- the day they take mifepristone (for medical terminations).

1.15.4 Providers should ensure they can provide intrauterine methods of contraception, and that women who choose this method are offered this:

- at the same time as the surgical termination of pregnancy **or**
- as soon as possible after expulsion of the pregnancy (for medical terminations).

1.15.5 For women who are having a medical termination of pregnancy and who choose DMPA intramuscular injection for contraception:

- consider providing it at the same appointment when they take the mifepristone
- explain that having the injection at this stage may increase the risk of ongoing pregnancy, although overall the risk is low.

To find out why the committee made the recommendations on contraception after termination of pregnancy and how they might affect practice, see rationale and impact.

Recommendations for research

The guideline committee has made the following recommendations for research.

Key recommendations for research

1 Antibiotic prophylaxis for surgical termination of pregnancy

Is a single dose of azithromycin or doxycycline before the procedure as effective as a full course of treatment at preventing infection after surgical termination of pregnancy?

To find out why the committee made the research recommendation on antibiotic prophylaxis for surgical termination of pregnancy see rationale and impact.

2 Cervical priming before surgical termination of pregnancy

What are the most effective and acceptable methods of cervical priming before dilatation and evacuation after 16^{+0} weeks' gestation?

To find out why the committee made the research recommendation on cervical priming before surgical termination of pregnancy see rationale and impact.

3 Anti-D prophylaxis for surgical termination of pregnancy

Should women have anti-D prophylaxis if they are having a surgical termination of pregnancy before 10^{+0} weeks' gestation and are RhD (or D) negative?

To find out why the committee made the research recommendation on anti-D prophylaxis for surgical termination of pregnancy see rationale and impact.

4 Expulsion at home for medical termination of pregnancy

For women who are having medical termination of pregnancy between 10^{+1} and 12^{+0} weeks, what is the efficacy and acceptability of expulsion at home compared with expulsion in a clinical setting?

To find out why the committee made the research recommendation on expulsion at home for medical termination of pregnancy between 10^{+1} and 12^{+0} weeks see rationale and impact.

5 Anaesthesia and sedation for surgical termination of pregnancy

What local anaesthetic techniques are most effective for women having surgical termination of pregnancy?

To find out why the committee made the research recommendation on anaesthesia and sedation for surgical termination of pregnancy see rationale and impact.

Other recommendations for research

Medical termination of pregnancy after 23^{+6} weeks

What is the effectiveness and safety of regimens using mifepristone and misoprostol for women who are having medical termination of pregnancy after 23^{+6} weeks' gestation and have had a previous caesarean section or uterine surgery?

Anaesthesia and sedation for surgical termination of pregnancy

What is the optimal regimen for general anaesthesia for women having surgical termination of pregnancy?

Rationale and impact

These sections briefly explain why the committee made the recommendations and how they might affect practice. They link to details of the evidence and a full description of the committee's discussion.

Service organisation

Why the committee made the recommendations

Making it easier to access services

Recommendations 1.1.1 to 1.1.4

Evidence showed that obtaining a termination of pregnancy can be complicated for women and that the information available on how to do this is often inconsistent. There was also evidence that integrating and streamlining services would improve access.

There was evidence that women wanted a choice of termination procedure. The committee agreed that it is not practical for all services to offer all termination of pregnancy options. To ensure women still have a choice if local services do not provide the full range of options, the committee made a recommendation covering referral.

Evidence also showed that:

- it can be difficult to get a prompt GP appointment
- women may face negative attitudes from healthcare professionals, and that this makes it harder to get referrals for termination of pregnancy.

With this in mind, the committee recommended that services enable women to self-refer. This will improve women's experiences and could also help them avoid stigma and negative attitudes when requesting a termination of pregnancy. There was no evidence on the best way to enable self-referral (for example through dedicated booking systems, centralised referral, drop-in services, or online booking), so the committee could not make a more specific recommendation.

There was evidence that travel costs can be a significant barrier to accessing services. This may be a particular problem for women with low incomes and women who need to travel for a service that is not available locally. Women having a termination of pregnancy often have to travel at very short notice and may have difficulty arranging funds before the appointment. The committee recognised that it will not always be possible to provide care locally, but they agreed that interventions

such as upfront funding of women's travel and accommodation costs could improve access.

Waiting times

Recommendations 1.1.5 to 1.1.8

While termination of pregnancy is very safe overall, there was evidence that morbidity and mortality increases for every additional week of gestation, so earlier terminations are safer. There was also evidence of long waiting times and delays for women trying to access termination services. Reducing waiting times can ensure women have more options available, decrease adverse events, and improve women's experience.

In addition, there was strong evidence that substantial cost savings can be achieved if women present earlier for termination of pregnancy. Most of this saving comes from women having a medical rather than a surgical termination. With this in mind, the committee felt that it was important to make recommendations on minimising delays for assessment and termination of pregnancy.

In some countries there are local policies such as compulsory counselling and imposed time for reflection before women are allowed to have a termination of pregnancy. The evidence showed that these can cause delays in accessing termination of pregnancy services. Further, the committee agreed, based on their experience, that these policies can cause distress and many women do not want counselling. Therefore, the committee agreed that these policies should not be used.

The committee recognised that it is not possible for all services to offer terminations every day of the week. This can lead to a choice between travelling further to have a termination of pregnancy sooner, or waiting longer to have a termination closer to home. It is important that women understand the implications of waiting, so the committee made a recommendation to address this.

Location of services

Recommendations 1.1.9 to 1.1.10

Community services and telemedicine appointments are recommended because the evidence showed they improve access to termination of pregnancy services. There was also limited evidence that patient satisfaction is the same with terminations provided by community or by hospital services, and with appointments provided via telemedicine or at the hospital.

Workforce and training

Recommendations 1.1.11 to 1.1.14

There was evidence that women prefer services led by nurses or midwives. Although there are legal restrictions that prevent nurses and midwives from providing certain parts of termination of pregnancy services, the committee agreed that there are ways their role could still be expanded and that this would improve care.

The committee made recommendations on training because evidence showed that a shortage of trained staff with the necessary skills is making it harder to provide some termination of pregnancy procedures. There was evidence that NHS hospital-based providers are losing clinical skills because termination of pregnancy is currently mainly carried out in the independent sector. Ensuring all trainees have the training is important because otherwise healthcare professionals may see this training as optional, rather than as essential training for a common healthcare procedure.

Complex comorbidities

Recommendations 1.1.15 to 1.1.16

There was no evidence on how to improve access for women with comorbid conditions. Based on their knowledge and experience, the committee recommended that services develop pathways for women having a termination of pregnancy. This will reduce delays and improve access, particularly for women who need care at specialist centres.

Avoiding stigma

Recommendations 1.1.17 to 1.1.18

There was evidence that women present later if they have had a negative experience from a previous termination of pregnancy. However, no evidence was

available on specific interventions to reduce stigma or improve privacy, so the committee made a general recommendation highlighting that the way professionals communicate with women can negatively impact on the woman's experience.

In addition, evidence shows that women are also concerned about privacy and confidentiality and are worried about reactions from other people. Further, the committee agreed, based on their experience, that women are often concerned that information about their termination will be shared unnecessarily with other healthcare professionals. Therefore, the committee made a recommendation about being sensitive to those concerns.

How the recommendations might affect current practice

Improving access to termination of pregnancy services is likely to result in substantial cost savings. Most of this saving comes from women having a medical rather than a surgical termination. Earlier terminations also have lower rates of complications. Recommendations on location of services, ease of access and complex comorbidities could reduce inequalities for:

- women living in remote areas
- women with low income
- women with comorbid physical and/or mental health problems
- vulnerable women
- girls and younger women.

Funding for travel is already available for women with low income under the NHS Healthcare Travel Costs Scheme, but this policy requires that women pay upfront and claim back costs after the termination of pregnancy. Setting up processes for upfront funding will involve some initial costs, but otherwise the recommendation for women with a low income will only affect the timing of the payment and not the absolute cost. There will be some costs involved with providing funding for women who do not have a low income but who are travelling for a service that is not available locally. The new costs involved with funding travel and accommodation may be regained through women having earlier terminations.

Even small reductions in waiting times would result in large cost savings. A reduction of 1 day in the average waiting time would save the NHS £1.6 million per year. Because of this, even relatively expensive interventions would be cost saving if they decrease waiting times. To reduce waiting times, services will need to consider ways to enable more rapid referral and develop pathways for self-referral. Some termination of pregnancy services may need to reconfigure so that they are available on a greater number of days per week. More collaboration between NHS services and the independent sector may also be needed. However, recommendations on expulsion at home and remote follow-up will minimise the number of appointments needed, so there will be greater resources available for new referrals.

Establishing dedicated phone and online booking systems, or centralised booking services, will have upfront costs. However, they are likely to lead to substantial savings through reduced waiting times.

Many services already have videoconferencing facilities. Videoconferencing software is not expensive, so services that don't have these facilities in place will not face significant upfront costs.

There has been an increase in community-based services in recent years, so additional costs associated with providing services in the community will be minimal. Women having a termination of pregnancy in the community may need to make fewer arrangements regarding time off work, childcare and travel. This may enable them to present earlier for a termination, which would result in cost savings for the NHS.

Women prefer services led by nurses or midwives. Expanding the role of these professionals should increase the number of appointments available, enable women to present earlier and may also contribute to cost savings from earlier terminations.

Commissioners will need to work with national organisations such as Health Education England to agree changes to training curriculums.

Full details of the evidence and the committee's discussion are in evidence review A: Accessibility and sustainability of termination of pregnancy services and evidence review B: Information needs of women undergoing a termination of pregnancy.

Return to recommendations

Providing information

Recommendations 1.2.1 to 1.2.10

Why the committee made the recommendations

The recommendations are based on evidence showing what women want to know about termination of pregnancy, and what formats they want information in. Some evidence came from women who were having terminations for specific reasons, such as fetal anomaly (under the Abortion Act). However, the committee agreed that improving information provision would benefit all women who are having a termination of pregnancy, so made recommendations that could apply to everyone.

The committee also made some recommendations based on their knowledge and experience covering:

- medical terminations at home
- what to expect when viewing a fetus after termination.

The committee were aware of systematic reviews and guidance from the Academy of Medical Royal Colleges (2011), American College of Obstetricians and Gynecologists (2009) and Royal College of Obstetricians and Gynaecologists (2011; 2015) that indicate there is no evidence that termination of pregnancy increases the risk of long-term health problems such as infertility, cancer or mental health issues. As there was evidence that women looked on the internet for information about termination of pregnancy, and the committee were concerned that some of this information may be inaccurate, they made a recommendation about long-term health risks to inform women.

Information for women who are having a termination because of fetal anomaly

Recommendations 1.2.11 to 1.2.12

For women having a termination of pregnancy because of fetal anomaly, there was evidence that they wanted more information on the nature of the anomaly. The committee agreed that this would be better addressed by the maternity service that

diagnosed the fetal anomaly, so included communication between services in their recommendation on service organisation.

There was evidence that women wanted information about how to tell other people, (for example friends and family members), about the end of their pregnancy, but there was not enough evidence to make a recommendation.

How the recommendations might affect current practice

Services already provide women with information about their termination of pregnancy. These recommendations may mean services need to change what information they are providing, but the cost of giving women more information is minimal and will result in women being better informed about their options and the process for termination of pregnancy.

Full details of the evidence and the committee's discussion are in evidence review B: Information needs of women undergoing a termination of pregnancy.

Return to recommendations

Anti-D prophylaxis

Recommendations 1.3.1 to 1.3.4

Why the committee made the recommendations

There was no evidence on anti-D prophylaxis for women having a termination of pregnancy before 14^{+0} weeks' gestation. There is also no international consensus on this, with significant variation between different international and national guidelines.

Current practice in the NHS is to give anti-D to all women who are having a termination and are rhesus D negative. However, testing for rhesus status and then administering anti-D can result in significant delays for women. They may need to visit the service more than once to receive anti-D, and this can be a particular problem for women who are travelling a long way or who find it difficult to afford travel. The cost of testing for rhesus status and giving anti-D also needs to be considered.

With these points in mind, the committee made recommendations based on their knowledge and experience. They agreed that, for women before 10^{+0} weeks' gestation, the volume of fetal blood cells transmitted to the mother is unlikely to cause maternal sensitisation. The impact of delays to the termination, travel problems, and costs to services are likely to outweigh any benefit prophylaxis provides. The NICE guideline on ectopic pregnancy and miscarriage recommends against anti-D prophylaxis for women having a medical termination for these conditions. The committee agreed that the risks and benefits of anti-D prophylaxis would be similar for women having a medical termination of pregnancy for other reasons. Therefore, the committee made a recommendation in line with the NICE guideline on ectopic pregnancy and miscarriage.

Although there is no evidence to distinguish surgical and medical termination of pregnancy on this topic, the committee agreed there may be risk of more fetal blood cell transmission during a surgical termination. Because of this, anti-D prophylaxis before 10^{+0} weeks may be beneficial for this group.

In the independent sector, point-of-care testing is used and anti-D is provided immediately. In contrast, NHS transfusion laboratories usually follow the same processes for managing anti-D as they do for managing whole transfusion systems. This is unnecessary and introduces delays, and means that women must choose between not having testing and prophylaxis or returning to the service after the termination. To help reduce delays, the committee made a recommendation in line with current practice in the independent sector.

In the absence of evidence, the precise benefits and risks of anti-D prophylaxis are unclear. The uncertainty is highest for women having a surgical termination before 10^{+0} weeks' gestation, so the committee made a research recommendation covering this group.

How the recommendations might affect practice

Restricting anti-D prophylaxis to women who are most likely to benefit from it could potentially produce cost savings of over £1 million annually across the NHS. Staff will be freed up to focus on more important and beneficial areas of the termination service.

NHS Trusts and transfusion laboratories may need to amend their systems and processes to ensure they can provide rhesus status testing and anti-D prophylaxis without introducing delays to the termination process.

Full details of the evidence and the committee's discussion are in evidence review C: Anti-D prophylaxis for women up to 13^{+6} weeks' gestation.

Return to recommendations

Antibiotic prophylaxis

Why the committee made the recommendations

Medical termination

Recommendations 1.4.1 to 1.4.3

The evidence on antibiotic prophylaxis for women who are having medical termination of pregnancy showed lower rates of severe infection with antibiotic prophylaxis compared with no antibiotic prophylaxis. However, the committee had concerns with the quality of the evidence, and the absolute risk of severe infection was very low. Routinely prescribing antibiotics after medical termination would increase the risk of antibiotic resistance, and the risk of non-sexually transmitted infections after medical termination of pregnancy is uncertain. With these points in mind, the committee restricted the recommendation to women who were at the highest risk of sexually transmitted infection.

There was no evidence to show which antibiotic prophylaxis regimen was most effective, so the committee recommended regimens based on treatment doses for chlamydia, which is the most common sexually transmitted infection. The specific doses recommended are taken from the British Association for Sexual Health and HIV guidelines.

Metronidazole in combination with another broad-spectrum antibiotic is not routinely recommended because:

- it is not widely used as it is poorly tolerated due to gastrointestinal side effects

- it was unclear from the review of antibiotic prophylaxis for surgical termination whether there was any difference in outcomes for women who were given doxycycline and metronidazole compared with doxycycline alone.

However, the committee agreed that metronidazole is effective for a broader range of infections than doxycycline and azithromycin, due to its anti-anaerobe properties, so there may be situations where metronidazole is clinically indicated.

Surgical termination

Recommendations 1.4.4 to 1.4.5

Antibiotic prophylaxis is part of current clinical practice for women having a surgical termination of pregnancy. The committee wanted to encourage this, so they made a recommendation in support. The evidence reviewed by this guideline did not identify which specific antibiotic regimen is most effective, so the committee recommended regimens based on treatment doses for chlamydia, which is the most common sexually transmitted infection. The specific doses recommended are taken from the British Association for Sexual Health and HIV guidelines. These regimens would also be effective at treating most of the organisms that are commonly found in the urogenital tract and that could cause problems if they ascend to the upper genital tract or the bacterial load increases.

On the duration of antibiotic prophylaxis, there was some limited evidence for doxycycline. The evidence was unclear on whether or not there were clinically important differences in the rates of pelvic inflammatory disease after termination, patient adherence, vomiting, or diarrhoea between 3-day and 7-day courses. The committee recommended a 7-day course based on their expert knowledge and experience that:

- the longer course will also treat sexually transmitted infections such as chlamydia that may be present
- there is no evidence of increased antibiotic resistance with a 7-day course, compared with a 3-day course.

The 7-day course of doxycycline is consistent with recommendations on treating chlamydia from the British Association for Sexual Health and HIV. These

recommendations also cover azithromycin. There was no evidence for antibiotic prophylaxis with azithromycin, but it has the same spectrum of activity as doxycycline and the full course of treatment has equivalent efficacy for treating chlamydia. However, in current practice women are routinely given a single dose of azithromycin before the procedure instead of the full course. A single dose has better adherence and reduced side effects, but there was no evidence to show it was effective. Because of this, the committee agreed that further research would be beneficial and made a research recommendation. A single dose of doxycycline was also included in the research recommendation for when azithromycin is contraindicated.

Metronidazole in combination with another broad-spectrum antibiotic is not routinely recommended because:

- compared with doxycycline alone, it was unclear if it made a clinically important difference to the rate of pelvic inflammatory disease after termination in women who have elevated vaginal pH and amines in vaginal discharge, or a positive gram stain for bacterial vaginosis
- although there was no evidence on the gastrointestinal side effects when compared with doxycycline alone, the committee agreed that in clinical practice metronidazole may be poorly tolerated with significant side effects.

However, the committee agreed that metronidazole is effective for anaerobic infections, so there may be situations where it is clinically indicated.

How the recommendations might affect practice

Medical termination of pregnancy

Despite the shortage of evidence, it is current clinical practice to offer antibiotic prophylaxis to women who are having medical termination of pregnancy. Because of this, the recommendations will likely reduce the number of women having antibiotic prophylaxis for medical termination of pregnancy. This has the potential to be cost saving and to reduce the risk of antibiotic resistance.

Surgical termination of pregnancy

The recommendations support routine antibiotic prophylaxis, which is current practice. The recommended regimens for doxycycline and azithromycin also match the regimens currently used in practice. Metronidazole is currently used in combination with other broad-spectrum antibiotics, so the recommendation not to use this regimen routinely will likely cause a reduction in use.

Full details of the evidence and the committee's discussion are in evidence review D: Antibiotic prophylaxis for medical and surgical termination of pregnancy.

Return to recommendations

Venous thromboembolism prophylaxis

Recommendations 1.5.1 to 1.5.3

Why the committee made the recommendations

There was no evidence on the optimal timing and duration of venous thromboembolism (VTE) prophylaxis for women having a termination of pregnancy who need pharmacological thromboprophylaxis. In the absence of evidence, the committee made a recommendation based on the recommendations for women who have had a termination in the last 6 weeks in the NICE guideline on reducing the risk of venous thromboembolism.

The recommendation for women at high risk is based on the committee's knowledge and experience. They agreed that it may be safer to start prophylaxis earlier and provide it for longer in this group. However, the lack of evidence meant they were unable to be more specific. The recommendation is in line with antenatal and postnatal risk assessment tools from the Royal College of Obstetricians and Gynaecologists.

How the recommendations might affect practice

These recommendations are in line with the NICE guideline on reducing the risk in venous thromboembolism. Unlike that guideline, the recommendations here cover all women at risk, rather than just those admitted to hospital. This means there will be an increase in the number of women receiving prophylaxis.

There will be increased costs from the increased use of low-molecular-weight heparin and the training needed to administer it. The size of this increase will depend on current local practice and the number of women who are at risk of thrombosis. These costs will be partially offset by a reduction in the incidence of VTE, but the savings associated with this may be small as VTE is rare in this context.

Full details of the evidence and the committee's discussion are in evidence review E: venous thromboembolism prophylaxis for women having termination of pregnancy.

Return to recommendations

Choice of procedure for termination

Recommendation 1.6.1

Why the committee made the recommendation

The evidence showed that women having a termination of pregnancy for fetal anomaly preferred a choice between medical or surgical termination, and in the committee's experience women having a termination for other reasons also valued having a choice of procedure.

Comparing medical and surgical termination of pregnancy in women between 13^{+0} and 23^{+6} weeks' gestation, the evidence showed that it was unclear whether or not there was a clinically important difference in:

- haemorrhage that needed transfusion, or blood loss of 500 ml or more
- termination completed by the chosen method
- uterine injury
- infection within 1 month of the termination.

It was also unclear from the evidence whether or not there was a clinically important difference in cervical injury between medical and surgical termination of pregnancy. However, the committee agreed that the risk of cervical injury with medical termination of pregnancy would be extremely low as no instruments or dilators are inserted into the cervix. There was a higher clinically important rate of incomplete termination needing additional surgical intervention for women who had medical termination. There was also some evidence that women prefer surgical termination.

However, the evidence in this area was limited, and the committee did not feel confident in making a recommendation in favour of 1 method. This guideline did not review evidence comparing medical and surgical termination before 13^{+0} weeks, because it is well established that both methods are highly safe at this gestational age and that they have similar effectiveness. In addition, evidence for terminations after 23^{+6} weeks was not reviewed because all terminations in England and Wales after this gestational age are medical procedures.

Given the evidence that women preferred a choice of procedure, and the lack of evidence that either procedure is superior, the committee recommended offering women up to 23^{+6} weeks a choice (as long as it is clinically appropriate).

How the recommendation might affect current practice

This recommendation will lead to a change in practice because termination of pregnancy services for women vary widely nationally. Many services only offer either surgical or medical termination. There are also relatively few doctors trained to provide surgical termination of pregnancy in the second trimester in the NHS, and most independent sector services are not set up to provide inpatient medical termination.

To address these issues, greater collaboration may be needed between and across sectors to provide women with a choice of methods. Theatre teams in the NHS may also need support if they are going to introduce a new service offering surgical termination by dilatation and evacuation. Modern dilatation and evacuation practice uses ultrasound scanning during surgery, so scan machines need to be in theatre and staff need to be able to undertake intraoperative scanning when needed.

Before services can start offering medical termination, they need to ensure they have beds available and nursing staff who are trained to care for women having medical termination of pregnancy in the second trimester.

Full details of the evidence and the committee's discussion are in evidence review B: Information needs of women undergoing a termination of pregnancy and evidence review K: Medical versus surgical termination of pregnancy between 13^{+0} and 24^{+0} weeks' gestation.

Return to recommendation

Termination before definitive ultrasound evidence of an intrauterine pregnancy

Recommendations 1.7.1 to 1.7.2

Why the committee made the recommendations

Only limited evidence was available for this area. However, it suggested that termination of pregnancy (medical or surgical) works just as well before there is definitive ultrasound evidence of an intrauterine pregnancy (that is, a yolk sac) as it does afterwards. There was no clinically important difference in the rates of complete termination, whereas it was unclear whether or not there was a clinically important difference in the rates of missed ectopic pregnancy and ongoing pregnancy.

These findings matched the clinical experience of the committee for medical termination at this stage for women who do not have signs or symptoms of an ectopic pregnancy. In addition, evidence from other areas of the guideline showed that women prefer to have the termination as soon as possible.

As the evidence was limited, the committee felt that it was important to make women aware of the potential risk of not identifying an ectopic pregnancy, and what they should do if there is a problem.

How the recommendations might affect current practice

Some services do not currently provide termination of pregnancy before there is definitive ultrasound evidence of pregnancy. As a result, the recommendation will make termination available earlier than it is currently provided. This will make it easier for women to access services and reduce waiting times. There may be a larger impact on providers of surgical termination, as this is not always offered as early as medical termination.

Services providing termination before ultrasound evidence will need to have systems to confirm that the pregnancy has been aspirated. For example, they will need to have staff trained to inspect the products of conception for the presence of chorionic villi and a gestational sac, and provide the necessary equipment to do this (typically

a light box and a clear receiver) or immediate access to ultrasound. Services offering surgical or medical termination before ultrasound evidence of pregnancy will also need to be able to assess human chorionic gonadotropin (hCG) serum, and have staff trained in interpreting test results. If an ectopic pregnancy is suspected, services will need to have processes in place to refer the woman promptly to an early pregnancy assessment unit.

Full details of the evidence and the committee's discussion are in evidence review F: termination of pregnancy before ultrasound evidence.

Return to recommendations

Expulsion at home for medical termination before 10^{+1} weeks

Recommendation 1.8.1

Why the committee made the recommendation

Comparing women who take mifepristone before 9^{+1} weeks' gestation with women who take it between 9^{+1} and 10^{+0} weeks, the evidence on home expulsion showed no difference in:

- the risk of serious complications, such as the need for emergency care or hospitalisation, haemorrhage needing transfusion, or 500 ml or more blood loss
- the rate of adverse events such as pain, vomiting and diarrhoea.

It was unclear whether or not there was a difference in completing termination of pregnancy without the need for surgical intervention when home expulsion was performed before 9^{+0} weeks or between 9^{+1} and 10^{+0} weeks. Evidence on patient satisfaction showed it was the same in both groups.

The committee noted that the evidence on women having home expulsion up to 12^{+0} weeks was from a single low-quality study from settings outside the UK. They agreed that further research on home expulsion up to 12^{+0} weeks in the UK would be beneficial to inform future practice and made a research recommendation.

How the recommendation might affect current practice

Currently, medical termination of pregnancy with expulsion at home is offered for women who take mifepristone before 10^{+1} weeks' gestation in some areas, but only before 9^{+1} weeks in others. As well as standardising practice, the recommendations are likely to result in more women being able to have an early medical termination at home. In current practice women need to be admitted to hospital and have to wait for bed availability. Expanding home expulsion would reduce the number of women admitted to hospital, reducing waiting times.

Full details of the evidence and the committee's discussion are in evidence review G: Expulsion at home for early medical termination of pregnancy.

Return to recommendation

Medical termination before 10^{+1} weeks

Recommendations 1.9.1 to 1.9.2

Why the committee made the recommendations

There was limited evidence comparing simultaneous mifepristone and misoprostol with interval treatment (misoprostol given 23 to 48 hours after mifepristone) for termination of pregnancy in women who were before 9^{+1} weeks' gestation. The evidence that was available showed no difference in:

- ongoing pregnancy rate
- rates of haemorrhage that needed transfusion, or blood loss of 500 ml or more
- patient satisfaction
- the need for repeat misoprostol
- incomplete termination needing surgery.

However, for all of these outcomes apart from patient satisfaction, it was unclear whether or not there was a clinically important difference. In addition, the committee were concerned that the findings from this review were inconsistent with their experience. They believe terminations are less likely to be successful with simultaneous treatment, particularly as gestational age increases. This is also shown in a large retrospective study that the committee were aware of (Lohr 2018).

There was evidence that bleeding and pain started later with simultaneous mifepristone and misoprostol. This may be an advantage for women who are taking both of the drugs in hospital or clinic before travelling home to complete the termination of pregnancy. In addition, the total time from start to completion of termination is shorter, and many women are likely to prefer simultaneous mifepristone and misoprostol because of this.

The committee did not recommend simultaneous treatment as an option for women between 9^{+1} and 10^{+0} weeks' gestation because there was no evidence for women with a longer gestation period. Interval treatment was recommended for these women because it is standard clinical practice.

How the recommendations might affect current practice

Simultaneous administration of mifepristone and misoprostol is not routinely offered, so these recommendations could result in changes to practice.

Full details of the evidence and the committee's discussion are in evidence review H: Medical termination of pregnancy up to 10^{+0} weeks' gestation.

Return to recommendations

Medical termination between 10^{+1} and 23^{+6} weeks

Recommendations 1.10.1 to 1.10.2

Why the committee made the recommendations

Most studies included a vaginal loading dose of 800 micrograms misoprostol in their regimen. The dose for vaginal misoprostol is the same dose used for termination of pregnancy before 10^{+1} weeks' gestation, so this will be simpler for services to provide for women between 10^{+1} and 23^{+6} weeks' gestation. The evidence showed no significant difference between an initial dose of vaginal misoprostol compared with sublingual misoprostol on time to expulsion or rate of completed termination. Some women will prefer not to have vaginal misoprostol, so giving the option of sublingual administration takes account of patient preference. The sublingual dose was taken from the study comparing the vaginal and sublingual doses. The evidence showed that oral misoprostol had more side effects than sublingual or vaginal

regimens and also had a longer interval between induction and termination. There was no evidence available regarding effectiveness of oral misoprostol administered as a loading dose. Because of this, no recommendation was made on oral misoprostol.

For follow-up doses, most of the studies reviewed used 400 micrograms misoprostol given vaginally, orally, sublingually or bucally. In addition, there was limited evidence that this dose had a shorter time to expulsion than the 200 microgram dose.

There was evidence that time to expulsion was shorter when there was a longer interval between mifepristone and misoprostol administration. In comparisons of different intervals:

- a 36- to 38-hour interval gave a shorter time to expulsion than simultaneous administration
- a 48-hour interval gave higher rates of completed termination and shorter time to expulsion than a 24-hour interval.

The committee noted that some women would prefer not to wait 36 to 48 hours between taking mifepristone and taking misoprostol, because of factors such as travel difficulties. To take account of patient preference, they recommended giving women the option of a shorter interval.

How the recommendations might affect current practice

These recommendations will reduce variations in practice in the use of misoprostol for termination of pregnancy between 10^{+1} and 23^{+6} weeks. The recommendations will also reduce the use of oral misoprostol, which is used currently.

Full details of the evidence and the committee's discussion are in evidence review J: Medical termination of pregnancy between 10^{+1} and 24^{+0} weeks' gestation.

Return to recommendations

Medical termination of pregnancy after 23^{+6} weeks

Recommendations 1.11.1 to 1.11.3

Why the committee made the recommendations

Termination of pregnancy after 23^{+6} weeks' gestation is rare. In 2017, these terminations accounted for 0.1% of the total. The statutory grounds for termination at this stage are for fetal anomaly or, in an emergency, either to save the life of the pregnant women or to prevent grave permanent injury to her physical or mental health.

There was no evidence on which regimen is optimal for medical termination of pregnancy after 23^{+6} weeks. In the absence of evidence, the committee based the recommendation for women between 24^{+0} and 25^{+0} weeks' gestation on the dose regimens for women having a termination before 24^{+0} weeks. Considering the increased sensitivity of the uterus to misoprostol as gestational age increases, the initial high loading dose of misoprostol was not included in the regimen for this group.

For women between 25^{+1} and 28^{+0} weeks' gestation, the recommendation is based on the committee's knowledge and experience. They noted that the uterus becomes more sensitive as gestational age increases and so the dose of misoprostol should be reduced. The recommendation is also in line with the International Federation of Gynecology and Obstetrics (FIGO) guidance on misoprostol in women at this gestation.

For women after 28^{+0} weeks' gestation, the committee recommended the regimen based on their expertise and on the guidance from FIGO.

Because the uterus becomes more sensitive to misoprostol later in gestation, women who have had a previous caesarean section or uterine surgery may be at higher risk of uterine rupture with increased doses of misoprostol. Given this risk and the lack of evidence in this area, the committee made a research recommendation on drug regimens for medical termination after 23^{+6} weeks in women who have had a previous caesarean section or uterine surgery.

How the recommendations might affect current practice

There is currently no guidance on what regimen to use for medical termination of pregnancy after 23^{+6} weeks. Current practice varies as a result, and some services

use lower doses of misoprostol that may not be as clinically effective as higher doses. These recommendations will help to standardise practice.

Full details of the evidence and the committee's discussion are in evidence review L: Medical termination of pregnancy after 24 weeks' gestation.

Return to recommendations

Cervical priming before surgical termination

Why the committee made the recommendations

Before 14^{+0} weeks

Recommendations 1.12.1 to 1.12.2

There was good evidence that vaginal and sublingual misoprostol reduce the risk of an incomplete termination of pregnancy and reduce the force needed to dilate the cervix, compared with no cervical priming.

The timings given were chosen to minimise the amount of time spent with preoperative pain and bleeding while still ensuring adequate priming. More force was needed to dilate the cervix when vaginal misoprostol was given 1 hour before the procedure, so this regimen needs to be given earlier than sublingual misoprostol. This means women will spend more time with preoperative pain and bleeding if they have vaginal misoprostol. However, based on the committee's experience, sublingual misoprostol causes a larger number of gastrointestinal side effects than vaginal misoprostol. It may therefore be less acceptable to women, and managing the side effects can place additional demands on the service. Because of these advantages and disadvantages, the committee recommended both so that women can choose which is best for them, and so that providers can be flexible (for example on appointment times) based on what works best for each woman.

The dose of 400 micrograms was chosen for both routes of misoprostol administration because there was more evidence for this than for 200 micrograms, and because it was unclear whether or not there were clinically important difference in side effects between the two.

There was very little evidence for mifepristone. However, the evidence that was available suggested that mifepristone may be as effective as misoprostol. Because of this, the committee recommended mifepristone when misoprostol cannot be used, so that women in this situation have another option. The dose is based on the evidence reviewed and on standard clinical practice. The timings are based on the evidence available, but a range is recommended because there was limited evidence comparing mifepristone given 48 hours before the procedure with mifepristone given 24 hours before the procedure.

While cervical priming makes the procedure safer, women may be put off by the possibility of preoperative pain and bleeding associated with its use. Women are more likely to choose cervical priming if the benefits and harms are fully explained to them, so the committee made a recommendation to ensure this happens.

Between 14^{+0} and 23^{+6} weeks

Recommendations 1.12.3 to 1.12.7

There was good evidence that cervical priming regimens using osmotic dilators either increase cervical dilation, make procedures easier to carry out, or both, compared with cervical priming without dilators so the committee agreed they should be offered. Limited evidence showed that inserting osmotic dilators the day before the termination of pregnancy will also make the procedure easier, compared with inserting them on the same day, so this should be considered by clinicians. However, osmotic dilators can be less acceptable to women than the alternatives and would involve an additional visit to the clinic if they were inserted the day before the termination. The committee agreed that further research comparing the timing of osmotic dilator insertion would be beneficial to inform future practice, so decided to make a research recommendation.

Misoprostol does not provide any benefit when used in combination with osmotic dilators, and it may have additional side effects. Further, it was unclear from the evidence whether or not there was an increased risk of preoperative expulsion when the combination was used compared with dilators alone. It is feasible that this risk may increase with additional cervical priming. Therefore, the committee recommended that the combination is not used. There was good evidence that

mifepristone combined with osmotic dilators reduces procedural difficulty compared with osmotic dilators alone. The committee recommended this regimen for women who were between 19^{+0} and 23^{+6} weeks' gestation, because later gestational age is associated with increased procedural difficulty.

Mifepristone or misoprostol alone are also recommended because there was evidence that they are more acceptable to women than osmotic dilators. In addition, the evidence comparing single priming agents against each other was unclear on whether or not there are differences between dilators and mifepristone in a number of important outcomes, such as cervical trauma, uterine perforation and preoperative expulsion. It was also unclear whether misoprostol alone and osmotic dilators alone gave equivalent baseline cervical dilation, or whether there are clinically important differences. These drugs are only recommended between 14^{+0} and 16^{+0} weeks and between 14^{+0} and 19^{+0} weeks respectively because there was no evidence for them beyond this stage. The committee agreed that further research in this area would be useful (particularly on whether pharmacological priming is an acceptable alternative to osmotic dilators), so made a research recommendation. On doses, there was evidence for the 200 mg oral dose of mifepristone, but not enough evidence to recommend a specific dose for misoprostol.

How the recommendations might affect practice

Before 14^{+0} weeks

These recommendations will reduce variations in practice in the use of cervical priming. The recommendations will also reduce the use of oral misoprostol, which is currently used but which has worse side effects than sublingual or vaginal regimens. The option to have misoprostol 1 hour before the procedure may make it easier and more convenient for women to have cervical priming, particularly if they live in remote areas with longer journey times.

The recommendations will likely increase the use of cervical priming, which may increase costs. The cost to individual services will depend on their current practice. However, this increased cost may be offset by savings from fewer additional operations for incomplete terminations.

Between 14+0 and 23+6 weeks

These recommendations will lead to greater use of osmotic dilators, and may increase the number that are inserted the day before, requiring more women to attend an appointment for cervical priming the day before the termination of pregnancy. This additional appointment will result in increased costs and burden on the woman. There may be further costs for services that provide accommodation for women who have travelled for their termination, but this will depend on local policies.

Overall, few women have a surgical termination during the second trimester, so the absolute cost impact is likely to be small, although the impact on the woman and her family may be considerable.

Full details of the evidence and the committee's discussion are in evidence review M: Cervical priming before surgical termination of pregnancy.

Return to recommendations

Anaesthesia and sedation for surgical termination

Recommendations 1.13.1 to 1.13.3

Why the committee made the recommendations

There was only limited evidence comparing different types of sedation or anaesthesia for surgical termination of pregnancy. The evidence that was available did not show that any particular method was more effective. The committee are aware that women have different preferences on anaesthesia. For example:

- some women need to minimise their recovery time (if they are driving home, or if they care for dependents)
- some women are anxious about the procedure and would prefer not to be conscious during it.

With this in mind, the committee recommended discussing all the anaesthesia options and explaining the differences to the woman.

There was not enough evidence to recommend a specific method for administering local anaesthesia. The committee agreed that further research on local anaesthesia

methods (including intrauterine anaesthesia) would be beneficial, so made a research recommendation.

There was good evidence that women who had intravenous conscious sedation experienced less pain and nausea than women who had oral conscious sedation. Women who had intravenous sedation were also more likely to say they would choose it again.

Inhalational anaesthetics cause dose-dependent uterine relaxation. This may cause more bleeding compared with other medications used for general anaesthesia, such as propofol. The evidence comparing propofol and sevoflurane did not show any difference in haemorrhage requiring transfusion or blood loss greater than 500 ml. However, this is a rare event and the evidence was from a single study, so the committee recommended more research.

How the recommendations might affect practice

These recommendations will increase awareness of the options available for sedation or anaesthesia for surgical termination of pregnancy, reduce variations in practice, and increase the choice available to women.

The recommendations will also reduce the use of oral conscious sedation, which is currently used but is not as effective as intravenous conscious sedation. Intravenous conscious sedation takes effect quicker than oral conscious sedation and has a shorter recovery time, so resource use should be reduced and scheduling flexibility may be improved as women spend less time in hospital. The recommendations may lead to a rise in the number of women opting for intravenous conscious sedation, causing an increased need for staff trained in administering it. Although conscious sedation is not currently used in all termination of pregnancy services in the NHS, its use is widespread in other areas (such as endoscopy and assisted conception). As there are staff experienced in administering conscious sedation for other procedures, the resource impact in terms of staff training is not likely to be large.

Full details of the evidence and the committee's discussion are in evidence review N: Anaesthesia or sedation for surgical termination of pregnancy.

Return to recommendations

Follow-up and support after a termination

Why the committee made the recommendations

Follow-up after medical termination before 10+1 weeks

Recommendations 1.14.1 to 1.14.2

Limited evidence was available showing no clinically important difference between remote and clinic follow-up for rates of adherence to follow-up. It was unclear whether or not there was a clinically important difference between remote and clinic follow-up in rates of:

- missed ongoing pregnancy
- unscheduled phone calls or visits
- surgical intervention.

There was only very limited indirect evidence on patient satisfaction, suggesting a preference for remote over clinic follow-up. No randomised controlled trial evidence was available for self-assessment, but the committee included this in the recommendation because it is offered as an option in current practice, and it gives women an additional option.

Evidence on pregnancy tests was also limited, showing that it was unclear whether or not there was a clinically important difference in rates of missed ongoing pregnancy or surgical intervention with multi-level urine pregnancy tests (these have several thresholds of human chorionic gonadotropin [hCG], such as 25, 100, 500, 2,000 and 10,000 international units [IU]), compared with high-sensitivity urine pregnancy tests (with a typical detection threshold of 10 to 25 IU hCG). Rates of patient satisfaction also appeared to be the same with both types of test. However, the committee did not recommend high-sensitivity tests because these can lead to higher clinically important rates of unscheduled clinic visits due to high rates of false-positive results in the month following the termination of pregnancy. Instead, the committee recommended either multi-level or low sensitivity (detection limit 1,000 IU hCG) are reliable 2 weeks after the termination. Low sensitivity tests are already widely used in the UK and the rest of Europe, and are approved for home use.

Although the evidence only included women having termination of pregnancy before 9^{+1} weeks' gestation, the committee agreed that the recommendations were appropriate for women having a termination of pregnancy before 10^{+1} weeks' gestation because this is current standard clinical practice, and because the range of hCG remains above the detection limit (1,000 IU) into the second trimester.

Support after a termination

Recommendations 1.14.3 to 1.14.5

The recommendations are based on evidence showing that some women sought support for a number of reasons after a termination of pregnancy. The evidence showed that they sought support from various different sources and they valued support that was specific to their circumstances. However, it also suggested that women sometimes found it difficult to get the support they need.

While most of the evidence came from women having a termination of pregnancy for fetal anomaly, the committee agreed that all women would benefit from information about what to expect and how to access support following a termination of pregnancy, should they wish this. The committee also made a recommendation covering aftercare, based on their knowledge and experience.

How the recommendations might affect practice

Follow-up after medical termination before 10^{+1} weeks

The use of low sensitivity or multi-level pregnancy tests instead of a routine clinic visit for ultrasound will reduce the number of clinic visits needed for women and be associated with cost savings for services. The recommendations should also reduce variation in practice by reducing the use of high-sensitivity pregnancy tests. These tests are associated with more clinic visits and a longer time period before the outcome of the termination of pregnancy can be confirmed.

Support after a termination

These recommendations should make it easier for women to get support after a termination of pregnancy, and reduce the variation in what support is offered.

The impact for providers will vary according to what support they currently offer but many providers already offer emotional support and have arrangements in place for referring women to counselling services.

Full details of the evidence and the committee's discussion are in evidence review I: Follow-up after medical termination of pregnancy before 10^{+1} weeks and evidence review O: Support after termination of pregnancy.

Return to recommendations

Improving access to contraception

Recommendations 1.15.1 to 1.15.5

Why the committee made the recommendations

Service organisation

There was evidence that providing contraception immediately after a surgical termination of pregnancy improved uptake and continued contraception use, compared with providing contraception later. There was some variation in these outcomes after medical termination, but providing contraception immediately (or as soon as possible) after termination still reduced rates of subsequent terminations. There were also higher rates of patient satisfaction when contraception was provided immediately.

There was limited evidence that:

- more women received long-acting reversible contraception when providers had staff who were skilled in providing all types of contraception
- having the full range of contraceptive methods available increased uptake and continued contraception use, and reduced the rate of subsequent terminations.

Skilled healthcare professionals are needed to administer a number of long-acting methods of contraception and ensure that the full range of contraceptive methods are available. Without them, it may not be possible for women to receive their preferred choice of contraception immediately. Therefore, although the evidence was limited, the committee made a recommendation that providers ensure they have the

full range of contraceptive methods available, and staff with the skills to provide them.

Effectiveness and safety

When compared with delayed insertion, immediate implant insertion provides a clinically important reduction in the rates of subsequent unintended pregnancy, and higher rates of patient acceptability and satisfaction. The evidence also showed that it was uncertain whether or not there were clinically important differences in the rates of:

- continuing pregnancy
- incomplete termination with the need for surgical intervention
- complete termination without the need for surgical intervention
- subsequent unintended pregnancy at 3 months.

The evidence showed that, compared with delayed intrauterine insertion, early or immediate insertion of intrauterine devices provides either higher rates or no clinically important difference in rates of levonorgestrel intrauterine system (LNG-IUS) or copper intrauterine device (IUD) uptake and continued use. There was also evidence covering all gestational periods for LNG-IUS and covering gestation up to 9^{+0} weeks for IUD looking at:

- uterine perforation
- infection within 1 month
- subsequent pregnancy within 1 year.

However, the evidence was unclear on whether or not there were clinically important differences in any of these outcomes. For uterine perforation, the absolute risk was very small. For infection, the evidence did not distinguish between infections caused by intrauterine device insertion and those caused by the termination in the women who received the device early or immediately.

Immediate depot medroxyprogesterone acetate (DMPA) intramuscular injection provides a clinically significant improvement in patient satisfaction, compared with delayed injection. In addition, the evidence showed that it was unclear whether or not

there were clinically significant differences between the 2 interventions in the rates of:

- incomplete termination with the need for surgical intervention
- complete abortion without the need for surgical intervention
- subsequent unintended pregnancy.

There was a potentially higher rate of ongoing pregnancy with immediate DMPA intramuscular injection compared with the delayed injection. However, there was uncertainty around this estimate, the absolute risk was small, and it was only seen in 1 study reviewed. Because of this, the committee agreed that immediate injection can be recommended as long as women are advised of the potential risk.

How the recommendations might affect practice

Currently, some providers do not offer DMPA intramuscular injection immediately, due to concerns that this might affect the efficacy of the termination of pregnancy. Therefore, these recommendations will reduce variations in practice. There may be an initial cost associated with providing training for staff in termination services to administer long-acting reversible contraception. However, this will be offset by not needing an additional appointment to administer contraception, and increased access leading to fewer subsequent unintended pregnancies and terminations.

There is unlikely to be a significant change in practice resulting from these recommendations as intrauterine contraception is currently already offered to women after a medical termination of pregnancy; all that is likely to change is the timing.

These recommendations will reduce variation in practice on contraception provision after termination of pregnancy. They will also increase the choices available to women. The impact on individual services will depend on current practice. In the independent sector, most services are commissioned to provide all forms of contraception whereas, in the NHS, some trusts have difficulty getting funding for certain contraceptive methods.

Overall, these recommendations should not increase costs or resource use, as the range of contraceptive methods covered is already available to women. However, there may be a change in who is funding contraception, with greater funding from

clinical commissioning groups compared with local authorities. This will mean changes in the way services are organised, and commissioners will need to develop services to enable the recommendations.

Full details of the evidence and the committee's discussion are in evidence review P: Contraception after termination of pregnancy.

Return to recommendations

Context

Termination of pregnancy is an integral part of reproductive healthcare for women. Although the total number of terminations performed annually has decreased since 2007, termination remains a common procedure. In 2017, just under 193,000 women in England or Wales had a termination. Almost all of these terminations were funded by the NHS, but 70% were performed by the independent sector.

Most terminations are carried out because the pregnancy was unintended, and the majority of procedures (77% of terminations in England and Wales in 2017) are conducted in the first 10 weeks of pregnancy. Termination is a safe procedure, and can be performed medically (taking mifepristone followed by misoprostol) or surgically.

The trend in England and Wales over the past decade has been towards increasing use of medical termination. In 2017, 66% of all terminations in England and Wales were medical, and this rises to 80% of terminations in the first 10 weeks of pregnancy.

In recent years, there have been changes in how and where termination of pregnancy services are delivered. This has resulted in variation in the type and choice of procedures available across the NHS, for example, in the offer of local anaesthesia and sedation for a surgical procedure. In addition, the procedure used for medical termination has been refined and women in the first 10 weeks (up to 9 weeks and 6 days) may now self-administer misoprostol at home in England and Wales. Furthermore, methods for checking whether a medical termination has been

successful have also been simplified. Some of these developments could significantly reduce costs to the NHS and be more acceptable to women.

Termination of pregnancy services also provide other important sexual and reproductive health services to women, including contraceptive services. However, there is marked variation across the country, involving different types of providers and, increasingly, organisations outside the NHS. In addition, accessing termination of pregnancy services may be difficult for women who live in remote areas, who are in the second trimester of pregnancy, or who have complex pre-existing conditions or difficult social circumstances.

This guideline will help ensure that termination procedures are carried out based on the best available evidence, and that a choice of services is easily accessible to all women who request a termination of pregnancy.

Finding more information and resources

To find out what NICE has said on topics related to this guideline, see our web page on pregnancy.