NICE National Institute for Health and Care Excellence

2022 exceptional surveillance of abortion care (NICE guideline NG140)

Surveillance report

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Background

The NICE guideline on abortion care aims to improve the organisation of services and make them easier for women to access. The guideline includes recommendations in section 1.8 on the medical management of abortions under 10 weeks, to ensure that women get the safest and most effective care possible. The current recommendations on the medical management of abortions under 10 weeks are based on the updated Abortion Act 1967 that gives women the option for having both pills for abortion at home. NICE has also developed patient decision aids based on the guideline recommendations to help and support women in making their own choices.

An enquirer raised the concern that abortions carried out remotely in women under 10 weeks pregnancy (for example, without ultrasound scan or confirmed gestation) may risk delivery of mid-term or late term foetus due to inaccurate last menstruation date and underestimation of pregnancy age. We explored this concern with the topic experts to look at potential safety implications.

Feedback from topic experts

We sent questionnaires to 11 topic experts and received 4 responses. The experts who responded were all consultant gynecologists with similar interest in sexual and reproductive health, fertility and abortion.

Q1. Do you consider that abortions carried out remotely in women under 10 weeks gestation without a confirmed gestation (for example, without ultrasound scan) carry the risk of delivering a mid-term or late term foetus? If yes, what measurements would you suggest for reducing the risk?

Three out of 4 topic experts responded no to this question and explained:

- The risk is very small and even with the routine ultrasound there is still a risk of inaccurate assessment of gestation because of human error in measurements, observation, and interpretations, although very rare.

- The risk specific to non-scan regimens is mitigated by adhering to best-practice guidance (such as those published by the Royal College of Obstetricians and Gynaecologists [RCOG], the Royal College of Midwives [RCM], British Society of Abortion Care Providers [BSACP] and the Faculty of Sexual and Reproductive Healthcare [FSRH]).

- Evidence from a prospective cohort study of 663 women choosing medical abortion at home via telemedicine (Reynolds-Wright et al. 2021) in Scotland, England and Wales showed that the model of telemedicine abortion without routine ultrasound is safe, and has high efficacy and high acceptability among women. No case of greater than 12 weeks abortion reported.

- Evidence from the UK's largest abortion study, medical abortion without ultrasound via telemedicine n=52,000 (Aiken et al. 2021) reported that while most women were able to provide an accurate last menstrual period (to estimate the gestational age), there was a very small risk of misestimation of gestational age (1:2500=0.04%).

- From a clinical point of view, the clinical risks from this occurrence are low owing to the very high effectiveness of medical abortion with mifepristone and misoprostol.

- The World Health Organization recommends self-management of medical abortion up to 12 weeks of pregnancy.

One topic expert responded that the abortion carried out remotely carries a risk and emphasised on the accurate history taking and giving due consideration to patients with vague dates.

Q2. In your opinion, should we recommend an in-person clinical assessment at some point in the pathway to determine the gestation?

Three out of 4 topic experts responded no to this question and explained:

- Evidence shows that the use of a last menstrual date to estimate gestational age is accurate in most cases. Asking specific questions to aide determination of a reliable menstrual history is essential, considering factors such as regularity of cycles, quality and quantity of menstrual bleeding.

- Patients need to be advised of the potential risk and consequences of misestimation to make an informed decision.

- Where there is uncertainty or a preference for an in-person assessment (for example, an ultrasound), 1 should always be made available.
- The assessment must include consideration of risk for ectopic pregnancy and, similarly, where there are signs, symptoms, or historical factors of concern (such as prior ectopic pregnancy), ultrasound is indicated.
- Requiring an in-person assessment before a medical abortion impedes access largely due to the time delay between the initial assessment and provision of treatment. Removing this routine requirement reduces waiting time to treatment. Increase in waiting times results in higher percentage of later abortions, more abortions in hospital and inefficient use of NHS resources and less patient-centred care.
- Evidence from a current qualitative study in the UK showed that patients value the telemedical model because of convenience, comfort, reduced stigma, privacy and respect for autonomy (Lohr et al. 2022).
- An in-person assessment is costly for patients in terms of time off work, childcare, and travel. It is especially beneficial for vulnerable groups such as those at risk of intimate partner violence, or where transport is difficult (for example deprived, or rural areas).
- Evidence from a risk management study (Boydell et al. 2021) showed that women valued the option of accessing abortion care via telemedicine and described being comfortable with, and in some cases a preference for, not having an ultrasound scan.
- There are multiple statements from royal colleges and organisations in support of telemedicine (joint letter on telemedicine).

One topic expert responded that several aspects of the history cannot be obtained over the phone (for example ambivalence, safeguarding and mobility).

Q3. Are you aware of any safeguarding or women's safety issue associated with the medical abortion at home?

Three out of 4 topic experts responded that:

- All patients seeking an abortion undergo routine assessments to ensure they are protected from harm, with specific safeguarding risk assessments carried out when concerns are noted or in the case of an adolescent, and referrals are made as appropriate.

- The safety of medical abortion at home is well established through systematic review of both randomised and non-randomised trials (Gambir et al. 2020; Schmidt-Hansen et al. 2020).
- Providing both mifepristone and misoprostol for use at home does not impact its effectiveness or safety. Patients can use the regimens correctly and the effectiveness and safety are maintained (Gambir et al. 2020).
- Medical abortion at home facilitates women in some vulnerable situations to access services (as they are not dependent on informing an abuser or parent as to why they need to be away from home or school). This may be positive for women most at risk of gender-based violence, that is, they may be safer when care is delivered by telemedicine.
- Based on our experience people find it easier to disclose distressing and highly personal details over the phone than they would face-to-face where they may feel more intimidated. Accordingly, the rates of detecting safeguarding issues have increased since offering remote consultations. The initial result from the SAPHE study (under publication) confirms such experience.
- There is also evidence that attempts to access illegal abortion have reduced to almost zero (from previously about 5 per day from 1 source alone) since remote access became available. This suggests that women who were previously so vulnerable that they had to risk prosecution to access care can now do so through regulated abortion care, which at least has a chance of detecting and helping those vulnerabilities.
- Medical abortion at home has been the main abortion care treatment over a decade with an excellent safety record (Aiken et al. 2021) and recommended by all national and international guidance.
- A safeguarding assessment can be done via telemedicine (telephone/video/internet) where appropriate women whose initial consultation is done remotely can also be invited to attend an in-person consultation.

One topic expert responded that a partner could coerce a patient to have an abortion.

Q4. In your opinion, what information should be given to women about the risks of accessing pills remotely?

Three out of 4 topic experts responded:

- Patients should receive all of the usual advice on self-management of medical abortion at home including how to take their pills, expected effects and side effects of the medications and how to manage them, signs and symptoms of concern, how and when to obtain healthcare provider support, and how to assess the effectiveness of treatment (usually through the use of a pregnancy test several weeks post-abortion) and how failure of the abortion may be managed.
- Informed consent needs to address benefits, risks, and options which may include surgical abortion or provision of a pre-treatment ultrasound.
- For those considering a medical abortion without an ultrasound, there is a need to discuss the risk of errors in gestational age estimation with the use of last menstrual period and importance of not using the medications beyond 10 weeks of pregnancy.

One topic expert responded that women should be informed of safety issues, risk with wrong gestation estimation, failure of medication, emergency surgery and life-threatening bleeding.

Q5. Do you have any other comments you wish to share on the medical abortion and the use of both pills at home?

Three out of 4 topic experts responded:

- Evidence from a current cohort study (Reynolds-Wright et al. 2021) shows that women can correctly self-administer abortion medications following a telemedicine consultation. The introduction of telemedicine for abortion care was associated with higher percentage of all abortions at earlier gestations and a marker of improved access.
- The benefits outweigh the risks, particularly when provided following careful pre-screening for gestational age using menstrual dating, risk of ectopic pregnancy, and suitability for medical abortion in the home environment.
- The ability to offer telemedicine has been the single biggest quality improvement in abortion care.
- For those who do not prefer it or are ineligible for it, the option of pre-abortion ultrasound or in-clinic care must be accessible.

One topic expert responded that abortion at home should be limited to selected women

and not a routine practice.

Overall decision

We will not update the NICE guideline on abortion care. The current recommendations are based on the updated Abortion Act 1967 and in line with the topic experts' comments that allows women the option for having both pills for safe abortion at home at under 10 weeks gestation.

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