Clinical Guidelines for Early Medical Abortion at Home – England

Rationale and Scope

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

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

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

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

Introduction

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

Outline of Early Medical Abortion

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

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

Recommendations for Best Practice

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

Before Treatment

Information Provision and Informed Consent

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

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

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

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

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

- other services that are available, such as sexually transmitted infection (STI) testing, contraceptive services and support for women experiencing sexual coercion or domestic violence.

Women should have access to objective information and, if required, counselling and decision-making support about their pregnancy options. [RCOG 2011, 4.14]

Women who are certain of their decision to have an abortion should not be subjected to delay or compelled to have counselling. [RCOG 2011, 6.3]

Women should be given information about the different methods of abortion appropriate to gestation, the potential adverse effects and complications, and their clinical implications. [RCOG 2011, 6.5]

Women should be informed that there is a small risk of failure to end the pregnancy (1 or 2 per 100 procedures), necessitating another procedure. [RCOG 2011, 5.7; RCOG 2015]

Women should be informed that there is a small risk (usually much less than 5%) of the need for further intervention, such as surgical evacuation. [RCOG 2011, 5.8]

Independent providers of abortion services should have arrangements in place for referring women into NHS services for emergency assessment/admission. [RCOG 2011, 8.4]

Women should be confident that they have the ability to access help both during and after the abortion. A 24-hour telephone helpline number should be available for women to use if they have any concerns. [RCOG 2011, 8.5]

All women should be given a letter providing sufficient information about the procedure to allow another practitioner elsewhere to manage any complications. [RCOG 2011, 8.2]

Women should be provided with verbal and written information about: [RCOG 2011, 8.3]

- symptoms they may experience, emphasising those which would necessitate urgent review
- what they should expect in terms of pain and bleeding
- symptoms suggesting the need for additional medication:
    - If they do not bleed within 24 hours of receiving misoprostol
    - If they fail to take the misoprostol as instructed
- symptoms suggestive of continuing pregnancy:
    - If they have less than 4 days of bleeding
    - If they still 'feel' pregnant at the end of one week or have symptoms of pregnancy such as sore breasts, sickness, tummy growing etc.
    - Where a pregnancy test is used in follow up programmes, if this is positive or 'invalid'
    - If the next expected menstrual period does not come after treatment
    - If they remain concerned that they may still be pregnant

Identification and Management of Vulnerable Groups

Services should identify issues which make women particularly vulnerable (for example child protection needs, domestic abuse / gender-based violence) and refer / signpost these women on to appropriate support services in a timely manner. [RCOG 2011, 4.19]

Healthcare staff caring for women requesting abortion should identify those who require more support in the decision-making process. [RCOG 2011, 6.2]. Pathways to additional support, including counselling and social services, should be available. [RCOG 2011, 6.4]

Staff should be aware that conveying information in a non-judgemental and supportive way is particularly important for adolescent girls who may be visiting a reproductive health facility for the first time. While all young people should be encouraged to involve a trusted adult in their decision if possible, do not insist on parents' authorisation unless it is a legal requirement (e.g. where a young person lacks capacity for consent). If the law requires an adult to consent to her procedure, this should be clearly explained at the start of the consultation. [RCOG 2015]

Young women and other vulnerable groups should be offered access to the same range of treatment options as any other group.

Services must ensure their procedures for safeguarding and child protection are managed and delivered consistent with their registration with the Care Quality Commission [CQC 2018].

Staff should have systems in place to identify women who may feel coerced or endangered, in order to enable them to raise their concerns in confidence.

Where English is not understood by the woman, a suitable translator or appropriate translation service should be used.

Process of Early Medical Abortion

This guideline applies to gestations up to and including 9 weeks 6 days gestation at the time mifepristone is taken

Effective regimens for medical abortion include: [adapted from RCOG 2015]

- Mifepristone 200 mg orally, followed 24–48 hours later by misoprostol 800 micrograms given by the vaginal, buccal or sublingual route
- If abortion has not occurred, a further dose of misoprostol 400 micrograms after 3 hours can be administered. Providers should consider providing this to women, especially those for whom travel to the clinic is difficult

Mifepristone should be taken in the approved hospital or clinic. If the woman vomits within one hour of taking mifepristone, she should be advised to return to the clinic for a repeat dose. In this situation, consider giving her anti-emetic medication.

Women should be advised that the process is most effective when the interval between mifepristone and misoprostol is 24-48 hours. If the interval is shorter, success rates may be reduced (e.g. from 97.1% for interval to 94.5% when given simultaneously)[8]. If it is longer, the likelihood of bleeding in the interval may be increased.

Women should be advised that if they take misoprostol by a sublingual or buccal route, that there is a higher likelihood of side-effects than if used vaginally. Women should be aware that the active drug within the tablets takes 20 minutes to dissolve, that the remaining tablet can be swallowed after 30 minutes, and that they may leave an unpleasant taste in the mouth.

Providers must comply with safe prescribing practices and be aware of any contraindications or allergies to the medications. Breast feeding is thought to be safe after mifepristone and misoprostol.

Women should be offered a means to exclude continuing pregnancy. Providers should design their follow-up programmes to be effective and woman centred (e.g. by offering telephone or text-based services; using low sensitivity pregnancy tests to enable more rapid diagnosis of resolution).

Analgesia (pain relief) should always be offered and provided if requested. In most cases, non-steroidal anti-inflammatory drugs (NSAIDS) supplemented by verbal reassurance are sufficient, but the woman should be given written advice on how to manage pain and be provided with additional analgesia if necessary. [RCOG 2015]

Before leaving the facility, women should receive written instructions about how to care for themselves, including: [RCOG 2015]

- how much bleeding to expect in the next few days and weeks
- how to recognise potential complications, including signs of ongoing pregnancy
- how and where to seek help if required, including a 24-hour telephone helpline number
- what follow up is recommended

Women should be advised that having a partner or trusted adult companion to give support at home is recommended, although if the woman makes an informed choice not to involve anybody else then this should be respected. It has not been standard practice in England to require an adult to be at home following administration of misoprostol, and there are rare scenarios where it may not be appropriate (e.g. where an adult partner is coercive, or where a partner is away and delay to treatment would increase distress or risk of complications).

Local policies should be used to:

- assess Rhesus group and to administer anti-D if appropriate. Providers should use systems that cause minimum disruption to the woman and do not require additional visits (e.g. consider point of care testing if blood group not already known; use systems that do not require the woman to have to return for anti-D)
- ensure legal requirements are fulfilled (e.g. completion of HSA 1 and timely submission of HSA 4 forms)

Specific Recommendations where misoprostol is administered in hospital or clinic settings

It is safe and acceptable for women who wish to leave the abortion unit following misoprostol administration to complete the abortion at their residence. [RCOG 2011, 7.21]

For women suitable for an early medical abortion, so long as it is lawful it is almost always preferable for her to take the medication at her residence rather than having it administered in hospital or

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

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

Specific Recommendations where misoprostol is administered in the woman's residence

Ensure that the woman understands how to administer the medication.

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

When completing the Abortion Notification (HSA4) form, in section 4d ("name and address of treatment with prostaglandin") it is sufficient to record the address as "home" or "residence" as long as this is the same as that entered in section 3c ("patients details" – "postcode or complete address"), otherwise enter full details here. Section 4dii ("date of treatment with prostaglandin") should be recorded as the date on which you advise the patient self-administers misoprostol.

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