Regulation of fertility can be difficult, and women need highly dependable contraception to achieve their desired fertility. Only 20% of early abortions in England and Wales and 60% in Scotland are undertaken by the medical method. Medical methods for early abortion appear to be promising alternatives to surgical abortion, and widespread dissemination of this method is needed. Instituting fast and efficient referral systems may also enable women to exercise this choice. This opinion document reviews and extends guidelines produced by the Royal College of Obstetricians and Gynaecologists.

Key words: abortion/choice/non-surgical

### Introduction
Regulation of fertility can be difficult, and if the chosen contraceptive method fails, abortion may be the only option available to women. The Government strategy for health in England identified unintended pregnancy as one of the five key areas of concern. Targets have been set up to reduce the unwanted pregnancy rate by 50% from 9.8/1000 in 1986 to 4.8/1000 by the year 2000 (DOH, 1992). However, by 1996, we have only reduced the rate to 8.6/1000, which is a slow pace.

Approximately 160 000 women have abortions each year—a rate of 14.77/1000 in 15–44 year old women (Abortion Statistics, 1995). Surgical abortion accounts for a large proportion of gynaecologists’ operative workload. Only 20% of early abortions in England and Wales and 60% of those in Scotland are undertaken by the medical method (Cameron et al., 1996).

Most European countries (Austria, Belgium, France, Greece, Italy, Norway, Netherlands and Sweden) and most of former Eastern Communist Europe allow early abortion on request. In Finland and Hungary, the woman decides whether her situation is stressful enough to warrant an abortion. In Ireland and Malta, abortion is illegal, except to save the life of the pregnant woman. In Brazil, abortion is legal in cases of rape or incest. In Poland and Portugal, abortion is legal only in exceptional medical circumstances and in Cyprus, Luxembourg and the UK, it is legal only if sanctioned by two doctors, meaning that the right to choose is qualified and uncertain. Although legislation in the USA is similar to UK, access to the abortion service in USA can be problematic and rather difficult.

The overall responsibility of the abortion service should rest with a consultant in community gynaecology and reproductive healthcare and not a hospital gynaecologist, as general gynaecology workloads can result in a fragmented service, leaving women with very little choice. A pre-abortion medical assessment by a doctor is required, and medical abortion can thereafter be supervised by trained nurse practitioners with the consultants taking on a supervisory role (Marwick et al., 1994). Protocols agreed by consultants enable competent nurses to inform women appropriately and give medication. In the UK, the RCOG Working Party identified and recognized the need for skill mix in obstetrics and gynaecology, including reproductive medicine (RCOG, 1996). Recent RCOG reports detail guidelines on the abortion law (RCOG, 1996) and methodology (RCOG 1997) and the Birth Control Trust has also produced a model specification for abortion services (Birth Control Trust, 1991).

Before 7 weeks, medical abortion is recommended (98% success rates) (Henshaw and Templeton, 1993; Aubery et al., 1997) and from 7 to 9 weeks, either method may be offered (success of medical abortion = 93%; Henshaw and Templeton, 1993). From 9 to 13 weeks, the only option is a surgical method. With early gestations, suction termination should be avoided, as it is three times more likely to fail (Kaunitz et al., 1985).

Women requesting an abortion should be seen within 5 days of referral and have the procedure undertaken within 7 days of appointment (Penney and Templeton, 1994). Fast tracking and efficient referral systems should be in place to remove the concepts of waiting lists for abortion services. It should be possible to carry out pre-abortion assessment in a gynaecology, a family planning or a genitourinary medicine clinic (GUM), as the needs of young women requesting an abortion may overlap. Written protocols for sexually transmitted infections (STI) and for contraceptive advice should be agreed and developed between general practitioners (GP), GUM physicians, hospital gynaecologists and reproductive healthcare physicians. Breaking boundaries and integrating primary and secondary care according to interdisciplinary guidelines and protocols appears useful. The HIV seropositivity rate in women attending for abortion was as high as 1:160 in inner city London in an anonymous survey in 1994 (DOH, 1994); this stresses the importance of HIV testing and counselling in a termination clinic. Follow-up in 2 weeks excludes an ongoing
pregnancy or incomplete abortion, ensures that abortion is complete and provides assessment of untoward side-effects.

The RCOG (1997) recommends that women should be offered screening for genital tract organisms. Chlamydial detection rates have improved with the advent of non-invasive DNA amplification techniques (polymerase chain reaction (PCR) and ligase chain reaction (LCR)). In low prevalence areas, these tests offer better sensitivity (90%) (Oostergaard et al., 1996) and in general appear to have a higher patient acceptability. Screening and treatment of positive cases not only reduces the risk of post-abortion infection, but is a step to reduce a reservoir of infection in male partners by allowing contact tracing and treatment. Cases positive for *Chlamydia* may be treated with doxycycline for 7 days (£3.80) or one dose of azithromycin (1 g), the latter being more cost effective (£8.95) as it ensures compliance (Magdid et al., 1996). Prophylactic antibiotics (to cover bacterial vaginosis and chlamydial infection) as opposed to screening and treatment are widely accepted, accessible and effective both in developing and developed countries (Winikoff et al., 1997). It has been extensively studied (Urquhart and Templeton, 1991; Creinin and Darney, 1993; Broome, 1994). Women choose this method to eliminate the requirement for anaesthesia and/or surgery, fear due to past history of sexual abuse, the need to punish themselves or to pay for their mistake, (Henshaw et al., 1996). Vomiting and diarrhoea occur in 25 and 13% of women undergoing medical abortion, and blood transfusion is required in 1:2000 women (Henshaw, 1995), the mean blood loss being <100 ml following the medical method.

The acceptability of antiprogesterone/prostaglandin abortions has been extensively studied (Urquhart and Templeton, 1991; Creinin and Darney, 1993; Broome, 1994). Women choose this method to eliminate the requirement for anaesthesia and/or surgery, fear due to past history of sexual abuse, the need to punish themselves or to pay for their mistake, (Henshaw et al., 1993, 1996; Hausknecht, 1995) is perceived sense of staying in control, and feel that it is perhaps more natural. After the experience, the frequent visits, pain and gastrointestinal side-effects may account for less satisfaction, although women would still choose the same method again. In the developing countries, women have generally felt more satisfied with the medical than with the surgical method (Winikoff et al., 1997).

In the USA and Canada, where mifepristone is not available for routine clinical use, a regime of methotrexate 80 mg i.m. or 50 mg/m², followed 7 days later by 800 µg vaginal misoprostol (Creinin et al., 1993, 1996; Hausknecht, 1995) is employed. Administering 800 µg of misoprostol after 7 days is superior to administering it after 5 days and the vaginal route appears better than the oral route (Grimes, 1997). The methotrexate/misoprostol regime has an efficacy of ~88–97% and the drug costs are £4, but it may take as long as 2 weeks for uterine emptying (Creinin, 1993). Gastrointestinal side-effects are similar to the mifepristone/gemeprost regime. Women find it an acceptable and desirable method, 75% stating that it was a good experience (Creinin and Burke, 1996). There is a question of teratogenicity in the event of a continuing pregnancy, and this requires careful supervision and follow up (Ferris and Basinski, 1996). This regime is not licensed in the UK and large scale multicentre trials are needed on safety before it can be advocated.

**Conclusion**

Non-surgical methods for early abortion appear to be promising alternatives to surgical abortion and have distinct advantages. Their use should be encouraged by the Department of Health, hospital and community trusts in gynaecology units and family planning clinics and outpatient clinics in general practice. Consideration should be given to approving family planning
clinics and general practice clinics for termination of pregnancy to enable the administration of antiprogesternes. Widespread dissemination and easy access to medical abortion services is required, but social, political and religious pressures may prevent this from becoming a reality. Thereafter, fast and efficient referral systems should be developed to enable women to exercise this choice. Research should continue to determine the minimum and optimum but effective dose of mifepristone and prostaglandins associated with the fewest side-effects without compromising efficacy.

References


Received on January 16, 1998; accepted on May 28, 1998

Early non-surgical abortion