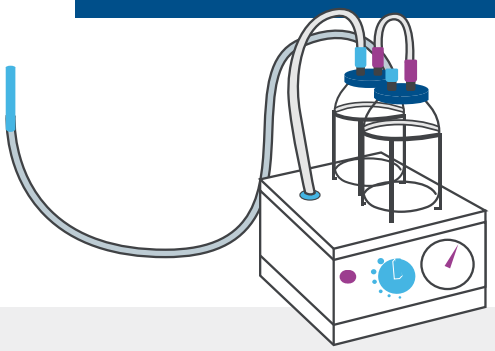
Making Abortion Safe

Royal College of Obstetricians & Gynaecologists

Surgical abortion from 14 weeks of pregnancy: summary sheet

1. METHODS OF SURGICAL ABORTION

VACUUM ASPIRATION WITH LARGE DIAMETER CANNULAE AND SUCTION TUBING (TO 16 WEEKS)



DILATATION & EVACUATION (D&E)

Recommended surgical method from 14 weeks

Where available, far more common than medical induction abortion.

HYSTEROTOMY OR HYSTERECTOMY RARELY USED

METHODS OF DILATATION & EVACUATION (D&E)

STANDARD

- 1.5 - 3cm dilation achieved with osmotic dilators and/or medications
- Serial removal of fetus and placenta with forceps

INTACT

- Dilatation & extraction (D&X)
- 4+ cm achieved with 2+ days osmotic dilators
- Intact removal using assisted breech delivery

2. PAIN MANAGEMENT

General anaesthesia/ deep sedation

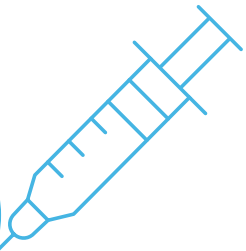
IV proprofol and fentanyl
Typically without intubation

Avoid inhalational agents such as isoflurane, as cause:

- **relaxation of myometrium**
- **increased blood flow**
- **increased blood loss**

Conscious sedation

Intravenous midazolam & fentanyl with local anaesthesia & oral analgesia



Local anaesthesia and oral analgesia

Paracervical block

NSAIDs
600-800 mg oral ibuprofen
1-2 hours pre-procedure

Limited evidence for optimal paracervical block.

3. SURGICAL ABORTION

CONTRAINDICATIONS

- Inability to remove the pregnancy through the cervix
  - large fibroid filling vagina,
  - post trachelectomy/permanent abdominal cerclage
- Placenta percreta

CONSIDERATIONS

- Bleeding disorders
- Caesarean scar implantation
- Anticoagulant meds
- Severe cardiopulmonary disease
- Very high BMI
- Uterine cavity distortion
- Previous cervical surgery
- Type 3 FGM

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4. CERVICAL PREPARATION

ESSENTIAL FOR SAFE D&E

- *Softens cervix: safer passing of dilators/ instruments*
- *Dilates cervix: reduces the risk of cervical/uterine injury*

14-18+6 weeks

Mifepristone 200 mg Orally 24-48 hours before the procedure

AND

Misoprostol 400 mcg Vaginally or bucally 2-3 hours before the procedure

Sublingually 1-2 hours before the procedure

OR

Osmotic dilators Inserted 3-24 hours before the procedure

AND

Either or: **Mifepristone** / **Misoprostol**

OR

Both: **Mifepristone** & **Misoprostol**

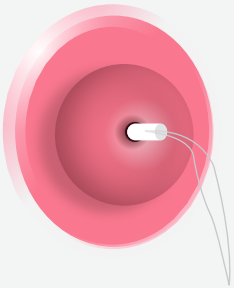
19-24 WEEKS: OSMOTIC DILATORS PLUS EITHER OR BOTH MIFEPRISTONE/MISOPROSTOL

5. SIDE EFFECTS

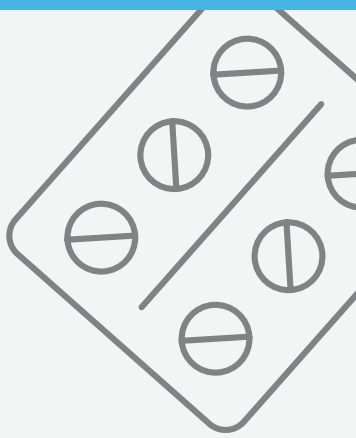
MIFEPRISTONE
- Bleeding
- Vomiting
- Nausea
- Cramping

MISOPROSTOL
- Extramural/expulsion
- Diarrhoea & Vomiting
- Nausea
- Bleeding
- Cramping
- Chills/fever

OSMOTIC DILATORS
- Bleeding
- Extramural expulsion
- Perforation/false passage
- Cramping



- **Swell** after insertion and **dilate** the os
- Stimulate release of endogenous **prostaglandins**
- The number placed are gestation and provider dependent



6. CONSENT FOR SURGICAL ABORTION

WHAT TO EXPECT BEFORE, DURING AND AFTER THE PROCEDURE

BEFORE
- Cervical priming
- Can they eat and drink
- Where and when to come
- Need for further investigations/ medication adjustment

DURING
- How the abortion will be performed
- How long procedure will take
- Level of awareness
- Amount of pain and bleeding

AFTER
- Amount of pain & bleeding
- When they can go home
- Need for someone to accompany them home
- Whether they can drive
- Need for medication

INFORMATION ON METHOD AND ALTERNATIVES

Pre-printed consent forms are useful

EXPLAIN THAT IF CLIENTS CHANGE THEIR MIND ABOUT THE ABORTION THAT THE OSMOTIC DILATORS CAN BE REMOVED BUT THERE MAY BE A RISK OF PREGNANCY LOSS

RISKS

Complications/risks	
Continuing pregnancy	1 in 1,000
Retained products of conception	1 in 1,000
Infection	1-10 in 1,000
Haemorrhage	1-10 in 1,000
Uterine, cervical or vaginal injury	1-4 in 1,000
Hysterectomy	1 in 10,000
Rate of major complications	**<1 in 100**

RISK FACTORS FOR COMPLICATIONS

UTERINE

- Fibroids
- History of transmural myomectomy or endometrial ablation
- 2+ caesarean deliveries

CERVICAL

- Conisation/repeat LLETZ
- Cervix flush with vault
- Trachelectomy
- Cerclage

PLACENTAL/ HAEMATOLOGICAL

- Placenta accreta spectrum
- Severe anaemia
- Coagulation disorder or fully anticoagulated

Currently fully anticoagulated

- Treat in a hospital setting
- Advice from haematologist

High risk of VTE: thromboprophylaxis needed

- Consider starting low molecular weight heparin for at least 7 days after the abortion

7. COMPARING SURGICAL AND MEDICAL METHODS AFTER 12 WEEKS OF PREGNANCY

	Surgical	Medical
Location of abortion	Clinic or hospital	Clinic or hospital
Pre-procedure care	Cervical preparation 3–24 hours pre-evacuation	Mifepristone 24–48 hours pre-induction
Procedure duration	10–20 minutes (day case)	6–8 hours (median duration) (15% > 10 hours)
Pain during procedure	Minimal to none due to anaesthesia (Osmotic dilator placement - 'moderately' painful)	Painful contractions and delivery
See products	Not unless chosen	Possibly
Intact fetus	No May be possible with dilatation and extraction (D&X)	Yes
Bleeding post-procedure	About 1 week, less each day	About 2 weeks, less each day

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8. FETICIDE

NOT ROUTINELY RECOMMENDED
Feticide is hard for some patients and may not be wanted

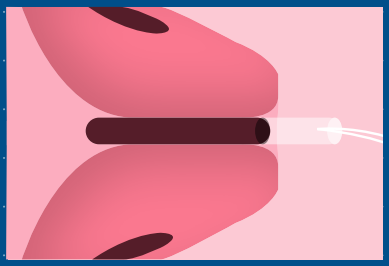
- Offered for fetal anomaly
- Provided in response to patient request

- Softens fetal parts and cervix
- Makes evacuation easier, faster and safer
- Extramural delivery/peri-viable period: avoids consequences of a live birth

COMMON METHODS
- Intra-cardiac potassium chloride (10% or 15%)
- Intra-amniotic or intra-fetal digoxin (1–2 mg)
- Intra-cardiac or intra-umbilical cord lidocaine (1–2%)

9. HOW TO INSERT OSMOTIC DILATORS

1. Assist client into lithotomy position
2. Insert speculum
3. Clean cervix with antiseptic solution
4. Place tenaculum *(Can place paracervical block at this stage)*
5. Apply traction to straighten cervical canal
6. Grasp the first osmotic dilator with ring forcep
7. Insert the osmotic dilator through endocervical canal
8. Repeat these steps to insert enough dilators
9. Record the number of dilators placed



END OF DILATORS SHOULD BE VISIBLE AT EXTERNAL CERVICAL OS

10. HOW TO PERFORM D&E

1. Prepare equipment

Continuous procedural ultrasound recommended to guide instrumentation

Prevention of infection:
Sterilisation of instruments
No-touch technique
Vaginal and cervical cleansing
STI screening
Antibiotic prophylaxis

EFFECTIVE
Nitroimidazoles e.g. metronidazole
Tetracyclines e.g. doxycycline
Penicillins

2. Assist client into lithotomy position
3. Insert a speculum
4. Clean cervix with antiseptic solution
5. Place tenaculum and do a paracervical block
6. Once block is placed, apply gentle traction to straighten cervical canal
7. Drain the amniotic fluid
8. Insert the forceps, grasp the fetal part, withdraw and repeat
9. Final vacuum aspiration with a manual or electric device

- Passively by rupturing membranes and retracting cervix with ring forcep
- Actively with vacuum aspiration

END OF PROCEDURE

- Assess amount of bleeding
- Inspect cervix for lacerations
- Confirm haemostasis
- Fit an IUD if requested
- Remove instruments

PROVIDE ANTI-D IF RHESUS NEGATIVE !

11. POST-PROCEDURE CARE

CLIENT CAN GO HOME WHEN:

- Cramping is tolerable
- Awake, alert and able to walk unassisted
- Bleeding is light to scant
- Observations are normal
- Feels ready to leave

Recovery with local anaesthetic: **30-60 mins**

Recovery with conscious sedation: **30-60 mins**

Recovery with general anaesthetic: **1–3 hours**

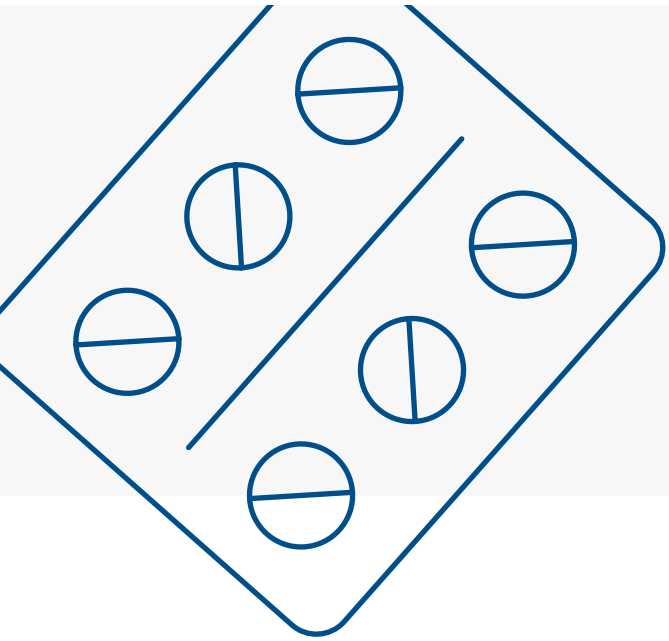
When to seek medical attention:

- **Very heavy bleeding**
- Persistent/worsening abdo pain
- High fever or systemically unwell
- Unusual smelling vaginal discharge
- Any signs of ongoing pregnancy

ROUTINE FOLLOW-UP NOT NEEDED

CRAMPING AND BLEEDING: IMPROVES EACH DAY

NEXT PERIOD: 4-6 WEEKS



12. CONTRACEPTION

- **Injection, pills, ring, patches:** Can be started at the time of the procedure
- **Implant and IUD:** Can be inserted at the time of the procedure