Abortion for Fetal Abnormality: What Can The Independent Sector Provide?

Richard Lyus
British Pregnancy Advisory Service
What Can The Independent Sector Provide?

- Surgical abortion in the second trimester – D&E (dilatation and evacuation)
- Vacuum aspiration at lower gestations
- Induced fetal demise
- Specialised service with
  - Extremely low complication rates
  - Short wait times
  - Supportive staff

This talk is primarily about
- Why D&E is important in the setting of TOPFA
Abortion Options in the Second Trimester

Both safe and effective, but a very different experience

• **Medical**
  – Medication (mifepristone and misoprostol) causes uterine contractions and passage of intact fetus
  – Woman’s experience is significantly different in early versus later medical abortion (acceptability falls with gestation)

• **Surgical**
  – The uterus is emptied through the cervix using suction
  – In the 2\textsuperscript{nd} trimester fetal parts and placental tissue require greater cervical dilation and use of forceps in addition to suction (D&E); the fetus is not removed intact
Abortion services should aim to provide high-quality, efficient, effective and comprehensive care which respects the dignity, individuality and rights of women to exercise personal choice over their management. An abortion service should be an integral component of a broader service for reproductive and sexual health, encompassing contraception, management of STIs and support.

All services should be able to offer a choice of recommended methods for each gestation band.

Where possible, women should be given the abortion method of their choice.

A full range of services should be commissioned, to include a choice of medical and surgical procedures for all gestations up to the legal limit, as part of a pathway of care. Individual local referral pathways should be used to support this, to include a clear process for managing women presenting at late gestation.60
Medical and surgical termination of pregnancy conducted according to RCOG guidance, appear to have comparable outcomes. Wherever possible, women should be offered the choice of method.
RCOG

• Excellent that this guidance supports patient choice, but is this what is happening?
  – No
TOPFA – Are We Providing a Woman-Centred Service?
Fisher, et al. Poster at BMFMS 2013

- Retrospective survey of 351 women requesting TOPFA,
- Mean GA: 17 weeks
- 94% NHS
- 74% offered only medical induction
- **Only 14% offered choice of method**
  - Only 8% over 14 weeks
- 55% karyotypic abnormality
- 78% underwent medical induction
  - 88% said because it was the only method offered
TOPFA – Are We Providing a Woman-Centred Service?
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- Of those offered a choice, 60% chose surgical
- Women having surgical were more likely to feel the method was right for them
Women’s Preferences NOT in the setting of TOPFA: Kelly et al

- A UK based RCT with 122 women at 13-20 weeks gestation
- Same procedure again?
  - 100% of women in the surgical group
  - 53% in the medical induction group \( (P \leq 0.001) \)
- Worse than expected?
  - None of the women in the surgical group
  - 53% of women in the medical induction group \( (P = 0.001) \)
- Women in the medical induction group
  - experienced more bleeding
  - more pain on the day of the procedure
  - more days of pain
  - had poorer scores on the Impact of Event scale (a measure of distress) two weeks after the procedure.

Kelly T *BJOG* 2010;117:1512-20.
Furthermore

- Of the 107 women who declined to participate in the study, 67% expressed a preference for surgery.

- An RCT in the United States comparing the methods was unable to draw any conclusions regarding medical vs surgical because so few patients were willing to be randomised to medical abortion.

Why Is There Are Difference?

• Hypotheses
  1. Women having TOPFA have different preferences regarding abortion method than women having abortions for other reasons
  2. Access to surgical abortion in the 2\textsuperscript{nd} trimester is limited in the NHS
  3. Need for intact fetus for fetal post-mortem examination
  4. Clinician preference
1. Do Women Choosing Abortion for Fetal Abnormality Have Different Preferences?

• Limited data, but:

• D&E for these patients has been in the literature for a long time

• Interviews with 21 women with maternal or fetal complications
  – A key theme was the value women placed on the ability to choose the method of abortion
  – 13 (62%) chose surgical abortion while 8 (38%) chose medical abortion.

Shulman, Obstet Gyn 1990
2. Is Access to D&E in the NHS is Very Limited?

- No recent data
- In 2001: 79% of NHS hospitals providing abortion care for women over 13 weeks of gestation only offered medical abortion

3. Is There Always a Need For an Intact Fetus for Post Mortem Examination?

• No clear guidance about when it is useful

• Of little or no benefit in cases of karyotypic abnormality confirmed with prenatal testing (1/3 or TOPFA in UK)

• Structural Abnormalities
  – PM provided supplemental information in only 16% of such cases
  – Altered patient counselling regarding future pregnancies in less than 1%

4. What Are Clinicians’ Preferences?

• Some find surgical abortion distasteful or emotionally challenging, and those who do provide it may be stigmatised

• Clinicians have concerns (but nothing published?)
  – D&E safety
  – Effect of D&E on subsequent pregnancies


Harris LH. Reprod Health Matters 2008;16(31 suppl):74-81.
4. What Are Clinicians’ Preferences?

- Some find surgical abortion distasteful or emotionally challenging, and those who do provide it may be stigmatised
- Clinicians have concerns (but nothing published?)
  - D&E safety
  - **Effect of D&E on subsequent pregnancies**

D&E and Subsequent Pregnancy Outcomes

• Three studies have looked specifically at subsequent pregnancy morbidity after dilation and evacuation and found no significant association with adverse pregnancy outcomes

• All in the USA – important caveat of cervical preparation protocols

D&E and Subsequent Pregnancy Outcomes

• **Chasen**
  – 383 D&Es, all 20+ wks
  – 120 SPs
  – Preterm delivery in 4.5%

• **Kalish**
  – 600 D&Es at 14-24 weeks
  – 96 SPs
  – Preterm delivery in 6.5%

• **Jackson** (control group)
  – 317 D&Es at 12-24 weeks
  – 85 SPs
  – Spontaneous preterm delivery rate 6% vs. 2.4%
    • Note the very low rate in control group
  – 1 week difference in GA at delivery; mean BW 150g difference
    • Conclusion: statistically significant, not clinically significant
D&E and Subsequent Pregnancy Outcomes

• Therefore, while further research with bigger numbers is needed, patients can be reassured that D&E does not appear to be associated with increased risk of subsequent
  – Pre-term birth
  – Late miscarriage
For example

**Termination of pregnancy following fetal abnormality**

Medical termination of pregnancy, which involves the use of medicine, is recommended for women who are having a termination in later stages of pregnancy (after 14 weeks). This is because it is more dangerous to stretch the cervix after 14 weeks gestation.
Europe compared to North America

- In the USA 1/3 of fetal medicine specialists provide D&E
- In the UK?

Kerns et al. Am J Perinatology
2012
'The ethical principles of beneficence, autonomy and justice require that D&E be routinely offered by gynaecologists who perform second trimester abortions. The uneven geographical availability of D&E may stem from lack of information, lack of requisite equipment and training, or lack of motivation. According to the principles of evidence-based medicine and bioethics, these barriers to better care for women can and should be overcome.'
Practical Considerations – Providing Care

• Research: What are the needs of women undergoing TOPFA compared to women having abortions for other reasons?
• Collaboration: NHS, BPAS, ARC, patient groups

• Communication to mitigate fragmented care pathway
• Formalised referral pathways to facilitate care
• Commissioning of services
Conclusion

• Both medical and surgical methods of second trimester abortion and are safe and effective for women choosing TOPFA
• National guidance requires that women be offered a choice of method
  – This is not happening
• The independent sector can provide D&E, and possibly training in D&E, as well as other services
• Either
  – NHS units should be referring women to the independent sector
  – Or setting up a service to provide D&E for these patients
‘D&E has two prerequisites: an open cervix and an open mind. The uneven availability of D&E today suggests that the latter prerequisite is the more difficult to achieve.’
