RANZCOG Abortion Care Guideline in practice

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Disclosures

Member of RANZCOG Guideline Development Group Abortion Care
Board Member of WHEN (Women's Health Education Network), a non-profit
Board Member of International Federation of Abortion and Contraception professionals (FIAPAC), a non-profit
Lead for abortion services in Metro South Health, Brisbane

Inclusive language

RANZCOG currently uses the term ‘woman’ in its documents to include all individuals needing obstetric and gynaecological healthcare, regardless of their gender identity

RANZCOG aims to provide an inclusive and welcoming space to all who access our College and specialist services.

The College gender equity and diversity working group are actively looking at how this can best be achieved

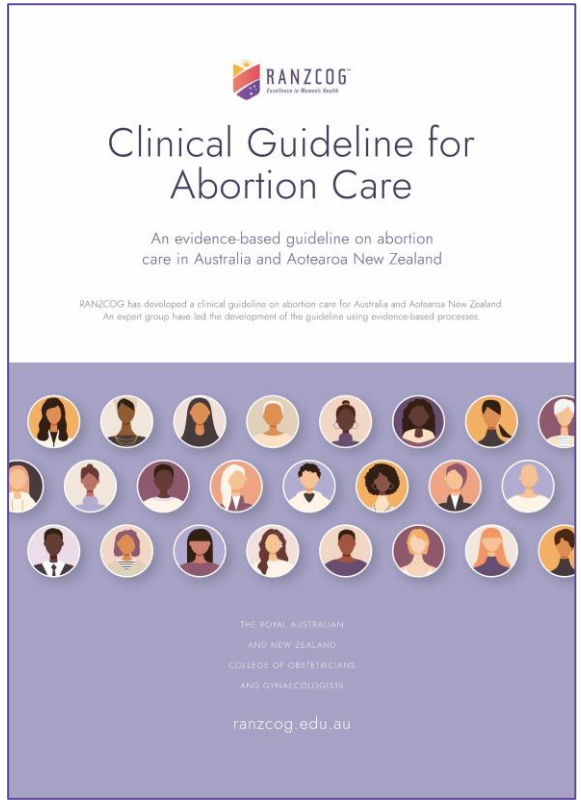
Introduction

- Abortion is common: it is estimated that 1 in 4 Australian women will have an abortion in their lifetime[1]
- RANZCOG supports equitable access to sexual and reproductive health services, including abortion
- The College believes women & pregnant people in Australia and Aotearoa New Zealand should be able to choose the method of abortion that is most acceptable to them, without coercion, informed by their values and preferences

1. Taft, A. J., Powell, R. L., Watson, L. F., Lucke, J. C., Mazza, D., & McNamee, K. (2019). Factors associated with induced abortion over time: secondary data analysis of five waves of the Australian Longitudinal Study on Women's Health. Australian and New Zealand Journal of Public Health, 43(2), 137-142.

Abortion Care Guideline Overview

- Evidence-based clinical practice guideline published 2023
- Binational: Australia and Aotearoa New Zealand
- The guideline includes:
  - 28 Recommendations
    - 20 of these are evidence-based
    - 8 are consensus-based
  - 22 Good Practice Points
- Companion decision aid to support informed decision-making
- Follows RANZCOG's development processes: GRADE



RANZCOG 2023. Handbook for the development of evidence-based guidelines and statements (v2). Professor Cindy Farquhar and Jinty Wilson (Eds). Royal Australian and New Zealand College of Obstetrics and Gynaecology. Melbourne

Purpose, Scope and Key Topics

Purpose: to provide evidence-based recommendations to abortion providers in Australia and Aotearoa New Zealand

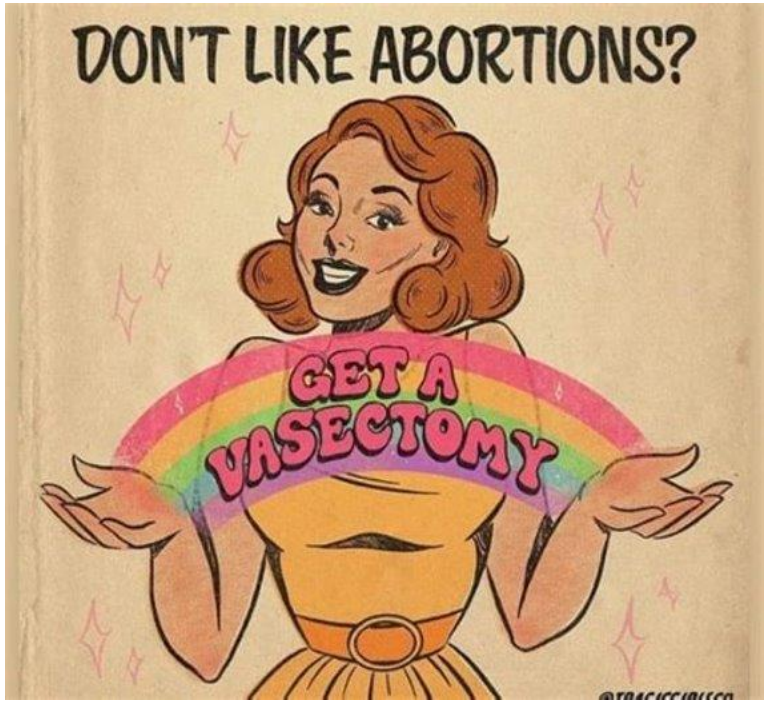
Scope: all abortion care for the first and second trimester

Key topics covered in the guideline include:

- Telehealth for early medical abortion
- Routine testing (Rh D status, Hb)
- Ultrasound
- Pain relief
- Cervical priming prior to surgical abortion
- Antibiotic prophylaxis
- Choice of medical or surgical abortion

Outline

- Telehealth for early medical abortion (EMA)
- Routine testing before abortion
- Ultrasound prior to abortion
- Pain relief for EMA
- Contraception after abortion
- Incomplete abortion



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Early Medical Abortion by telehealth

Early Medical Abortion (EMA) services by telehealth have been reported to be safe, effective and acceptable.

Recommendation 2	Evidence-based recommendation	Conditional

For women seeking early medical abortion, all abortion services or components of abortion services could be accessed by telehealth or in person.

GRADE of evidence: Low

Good Practice Point 2

For medical abortions up to 10^{+0} weeks, offer expulsion of pregnancy at home based on patient preference, clinical need and access to timely urgent care.

Testing prior to abortion: key recommendations and GPPs

- Routine testing for Rh D status, is not recommended for either medical or surgical abortion up to 10 weeks pregnant
- Routine haemoglobin not required: use clinical judgement
- National Blood Authority guideline updated to align with RANZCOG

Recommendation 3	Consensus-based recommendation
Routine testing of haemoglobin is not required prior to abortion.	

Recommendation 4	Consensus-based recommendation
Routine testing of blood group for Rh D status, up to 10 weeks pregnant for either medical or surgical abortion, is not required prior to abortion.	

Good Practice Point 3
Clinical judgement should be used to evaluate selective testing of haemoglobin and blood group prior to abortion in women at increased risk of haemorrhage, including but not limited to anaemia or advanced gestation.

Ultrasound prior to abortion: key recommendation and GPPs

- Mandatory ultrasound can present a significant barrier to abortion care
- Guideline supports options other than ultrasound to determine gestational age of pregnancy up to 14 weeks

Recommendation 5	Evidence-based recommendation	Conditional

The gestational age of the pregnancy should be determined prior to an abortion; this could be by clinical means (history including last menstrual period, with or without examination) or by ultrasound scan.

GRADE of evidence: Very low

Good Practice Point 5

An ultrasound is recommended prior to abortion up to 14 weeks pregnant if there is uncertainty about gestational age by clinical means, or if there are symptoms or signs suspicious for ectopic pregnancy or other clinical concerns.

Where gestational age has been established by clinical means, the decision about ultrasound prior to abortion should be made according to patient preferences and access to services.

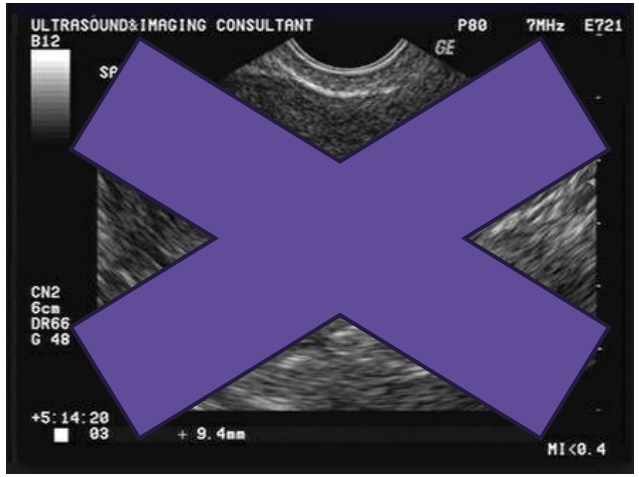
After 14 weeks pregnant, all women seeking an abortion should have an ultrasound scan to confirm gestational age and position of placenta if previous uterine surgery.

What is “no scan” abortion?

Actually “selective scan” abortion….

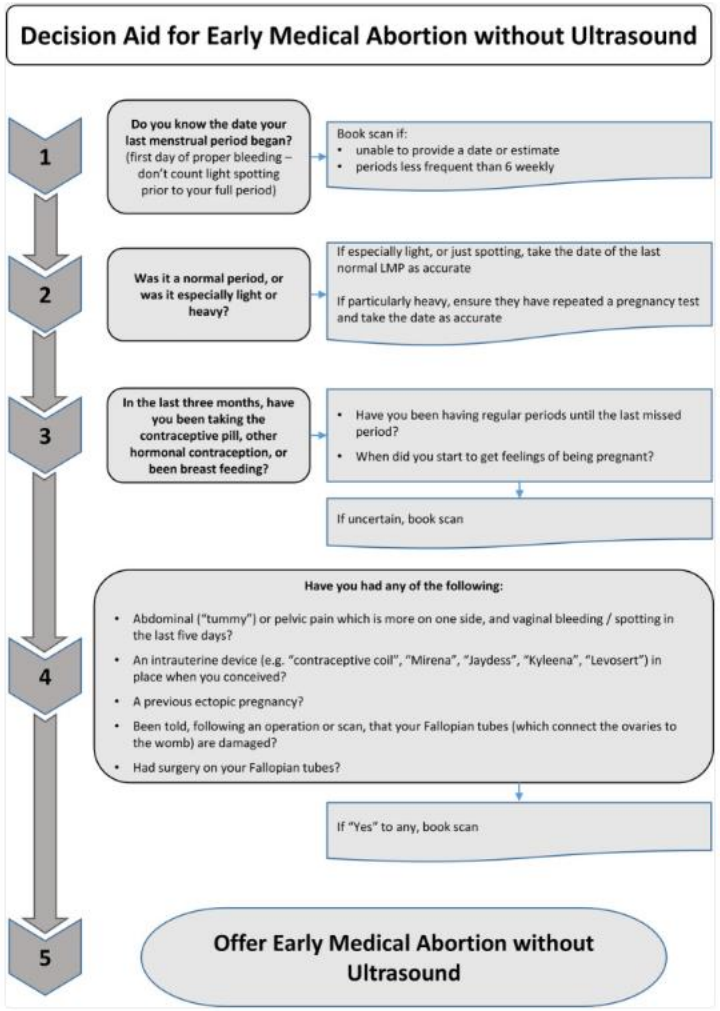
Select people who:

1. Know how pregnant they are and
2. Don’t have risk factors for ectopic pregnancy

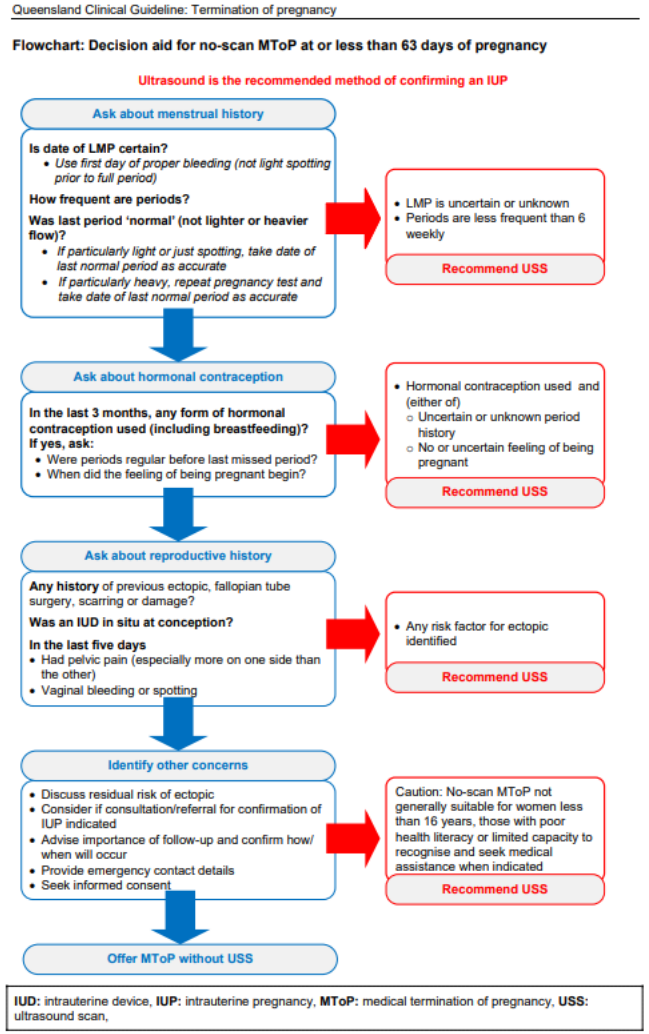


Use a history- based screening tool: best delivered by a clinician

Screening tools



Decision aid for early medical abortion without ultrasound (adapted with permission from RCOG Coronavirus (COVID-19) infection and abortion care – information for healthcare professionals; 2020-06-04-decision-aid-for-early-medical-abortion-without-ultrasound.pdf [rcog.org.uk][17])



Flowchart F24.21-3-V1-R29 .

Adapted from: RCOG (2020). Decision aid for early medical abortion without ultrasound

Evidence supporting no scan EMA

Comprehensive analysis of the use of pre-procedure ultrasound for first- and second-trimester abortion. Contraception 2011;83:30–3.

- Selective pre-procedure ultrasound in the first trimester, only performed in case of discrepancy between last menstrual period and uterine size, bleeding or symptoms indicative of ectopic pregnancy, has been reported as being both safe and effective when women are cared for by experienced clinicians.

Aiken A, Lohr PA, Lord J, Ghosh N, Starling J. Effectiveness, safety and acceptability of no-test medical abortion (termination of pregnancy) provided via telemedicine: a national cohort study. *BJOG*. 2021;128(9):1464-1474. doi:10.1111/1471-0528.16668

- 18 435 EMA with no ultrasonography; 99% complete, serious AE 0.02%, EP incidence 0.2%

Reynolds-Wright JJ, Johnstone A, McCabe K, Evans E, Cameron S. Telemedicine medical abortion at home under 12 weeks' gestation: a prospective observational cohort study during the COVID-19 pandemic. *BMJ Sex Reprod Health*. 2021;47(4):246-251.

- Complete abortion in 650 (98%), 5 ongoing pregnancies, 4 incomplete abortion, 1 EP (had a scan), none over gestational limits

Upadhyay UD, Raymond EG, Koenig LR, et al. Outcomes and Safety of History-Based Screening for Medication Abortion: A Retrospective Multicenter Cohort Study. *JAMA Intern Med.* 2022;182(5):482–491. doi:10.1001/jamainternmed.2022.0217

- EP incidence 0.22%, serious AE's 0.54% (same for both models of care)

Guidelines (supporting selective scan models of care)

New Zealand Aotearoa Abortion Clinical Guideline. Wellington: Ministry of Health. 2021.

- Recommend selective ultrasound prior to first-trimester abortion if there is uncertainty about gestational age by clinical means, or if there are symptoms or signs suspicious for ectopic pregnancy.

World Health Organization, Abortion care guideline. Geneva, 2022

- Recommend against the use of ultrasound scanning as a prerequisite for providing abortion services.

RCOG Best Practice in abortion care 2022

- Routine pre-abortion ultrasound scanning is unnecessary but, if available, should be used if there is clinically relevant uncertainty about the pregnancy duration or if there is a suspected ectopic pregnancy

National Abortion Federation Clinical Policy Guidelines for Abortion Care. 2022

- The use of ultrasound is not a requirement for the provision of first trimester abortion care

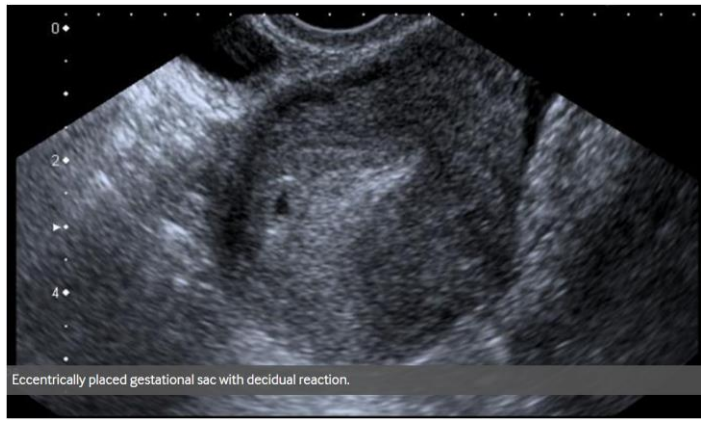
ACOG Practice Bulletin Summary, Number 225. Obstetrics & Gynecology: October 2020. Medication Abortion Up to 70 Days of Gestation

- For patients with regular menstrual cycles, a certain last menstrual period within the prior 56 days, and no signs, symptoms, or risk factors for ectopic pregnancy, a clinical examination or ultrasound examination is not necessary before medication abortion.

VEMA vs No ultrasound abortion

VEMA

Medical abortion
Very early gestation
Ultrasound performed
Screening criteria applied
MTOP with serum HCG tracking



Heller R, Cameron S Termination of pregnancy at very early gestation without visible yolk sac on ultrasound *Journal of Family Planning and Reproductive Health Care* 2015;**41:**90-95

No ultrasound abortion

Medical abortion*
Any gestation (first trimester)
Screening criteria applied
No ultrasound performed if suitable
MTOP with serum HCG tracking (or **LSUP)

- No USS STOP not recommended in wealthy countries unless exceptional circumstances
- **Low sensitivity urine preg test

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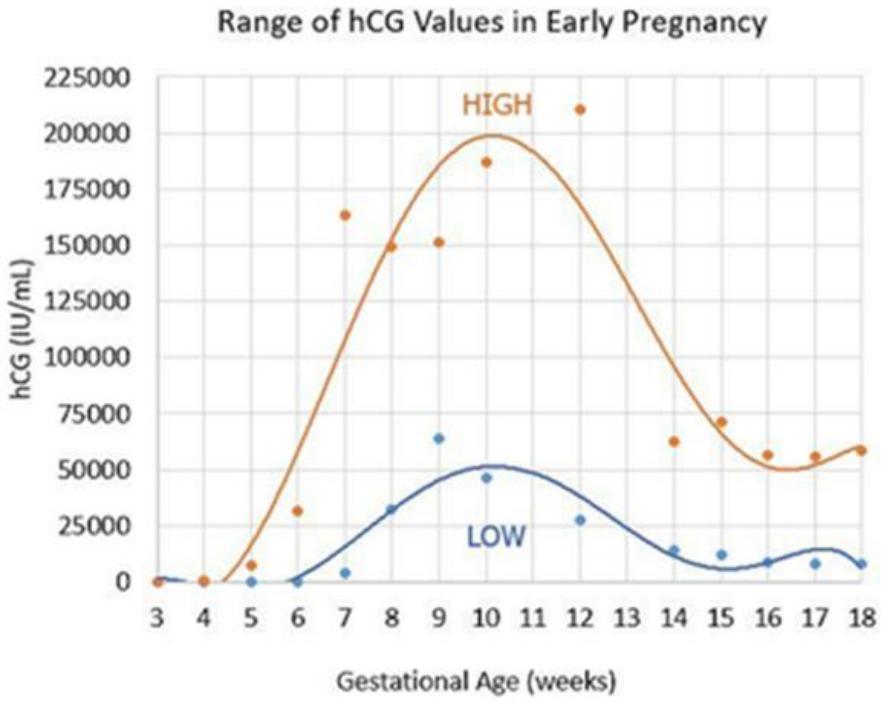
No Ultrasound MTOP practicalities

Ensure:

- Day 1 HCG is consistent with GA calculated from LMP or DoC
- Follow-up process is robust e.g. day 5 or 7 HCG
- Consent reflects no ultrasound procedure
- Patient information with emergency contacts and signposting for concerns



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Selective Ultrasound in Australia

Feasibility of no ultrasound screening tool

Queensland Virtual Early Medical Termination of Pregnancy service (QVEMToPS)

MSI Australia telehealth service

Early medical abortion and pain relief: key recommendation

- Stat dose ibuprofen 1600mg (off label) is supported by moderate evidence
- No studies comparing opiates to other analgesic options for EMA
- Maternity services advise against the use of codeine for medical abortion in women who are breastfeeding
- Further research needed

Recommendation 15	Evidence-based recommendation	Strong
For medical abortion up to 14 weeks pregnant offer a single dose ibuprofen 1600 mg (off-label use), followed by ibuprofen 400 mg to 600 mg eight-hourly. A maximum dose of ibuprofen 2400 mg can be taken in 24 hours while symptoms of pain persist. **GRADE of evidence:** Moderate		

Contraception

Don’t delay!

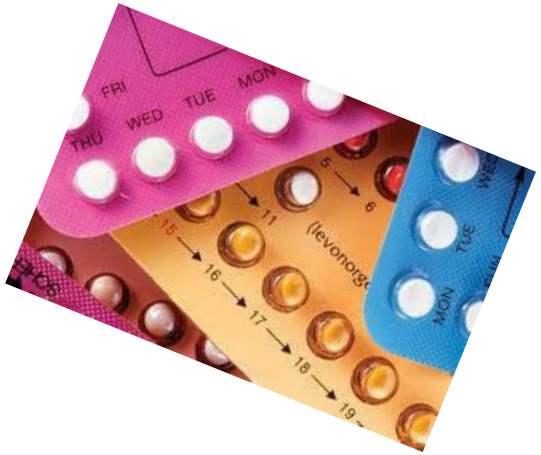
5.12 Contraception following abortion

Recommendation 20	Evidence-based recommendation	Strong

For women choosing an intrauterine contraceptive (IUC), immediate insertion should be offered at the time of surgical abortion, or for medical abortion as soon as possible after the pregnancy has been expelled.

For women choosing contraceptive implants, immediate insertion should be offered after surgical abortion, or for medical abortion at the same time mifepristone is administered.

GRADE of evidence: Low



Good Practice Point 15

For women having a medical abortion and requesting depot medroxyprogesterone acetate, the injection may be administered at the time of medical abortion (including prior to pregnancy expulsion), after discussing the potential small added risk of ongoing pregnancy with the woman.

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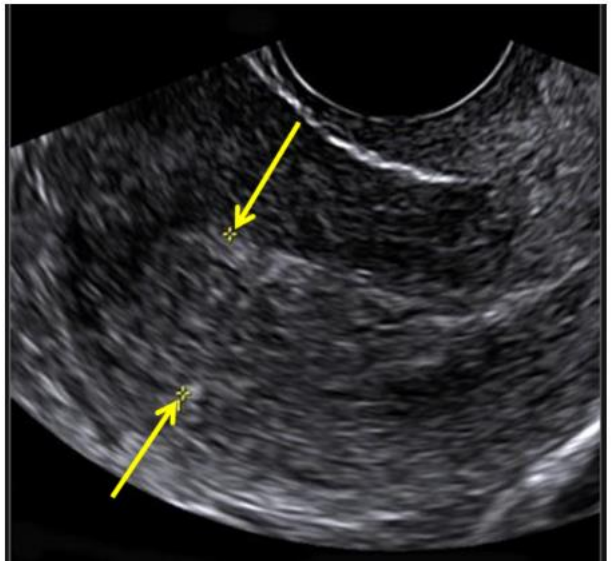
Incomplete abortion

- Expectant management
- Medical management
- Surgical management



Recommendation 24	Evidence-based recommendation	Conditional

Women with incomplete early medical abortion could be offered surgical evacuation, a repeat dose of misoprostol, or expectant management. This decision will depend on the preferences of the woman, signs and symptoms, clinical stability, and access to surgery.
GRADE of evidence: Very low

Recommendation 25	Consensus-based recommendation

Women with incomplete abortion after surgical methods could be offered a repeat surgical evacuation of the uterus, misoprostol, or expectant management. This decision will depend on the preferences of the woman, signs and symptoms, clinical stability, and access to surgery.

Good Practice Point 18

Ultrasound for suspected retained products is not required prior to medical management with misoprostol but is generally recommended prior to surgical evacuation unless heavy bleeding is present. Refer to "Principles of post early medical abortion care" from the Royal Women's Hospital, Melbourne for information on abnormal or pathological bleeding patterns following an abortion.

Good Practice Point 19

Misoprostol dose for management of incomplete abortion (regardless of initial method): misoprostol 800 mcg buccally followed by repeat dose of misoprostol 400 mcg 4 hours later if pregnancy tissue has not passed.

Implementation: EMA tips from the guideline

- Minimise unnecessary pre-abortion tests
  - STI testing recommended ☑
  - No routine antenatal screen ☒
- Select people who do not require an ultrasound scan
- Anti-D not required up to 10 weeks gestation
- Initiate contraception immediately
- NSAIDs for EMA pain relief (1600mg ibuprofen stat)
- Have misoprostol tablets (400mcg) in your clinic in take home packs
- Use an LSUP for person-led follow-up: do not do routine scan

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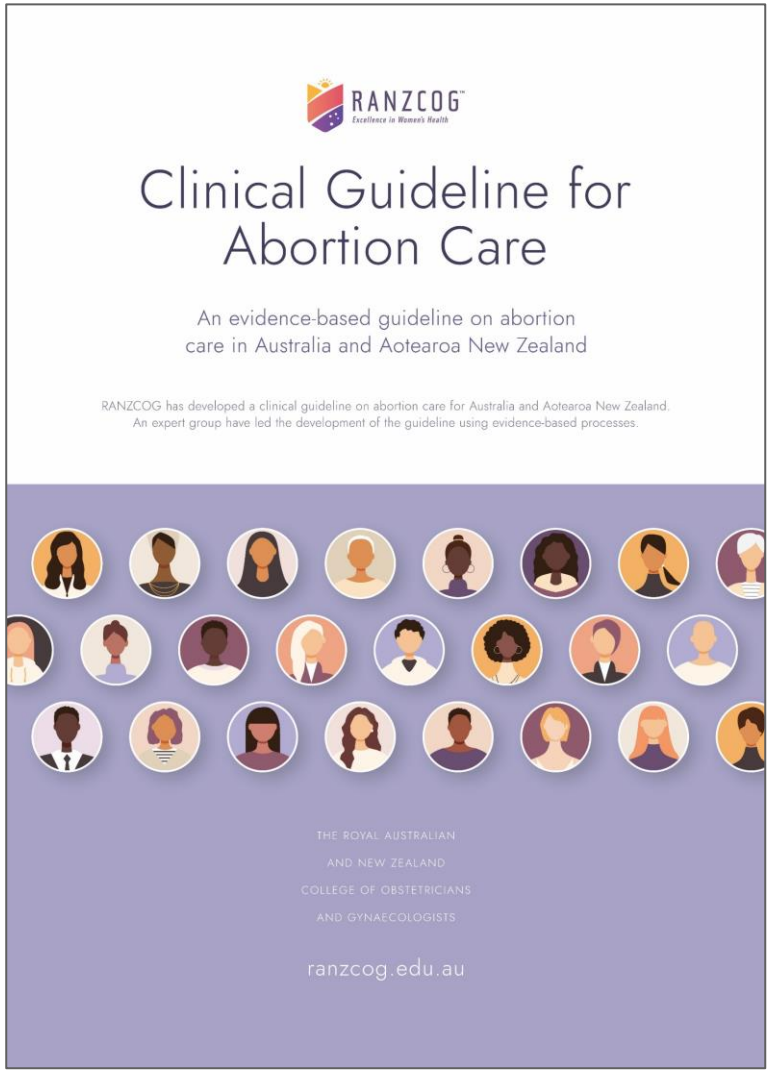
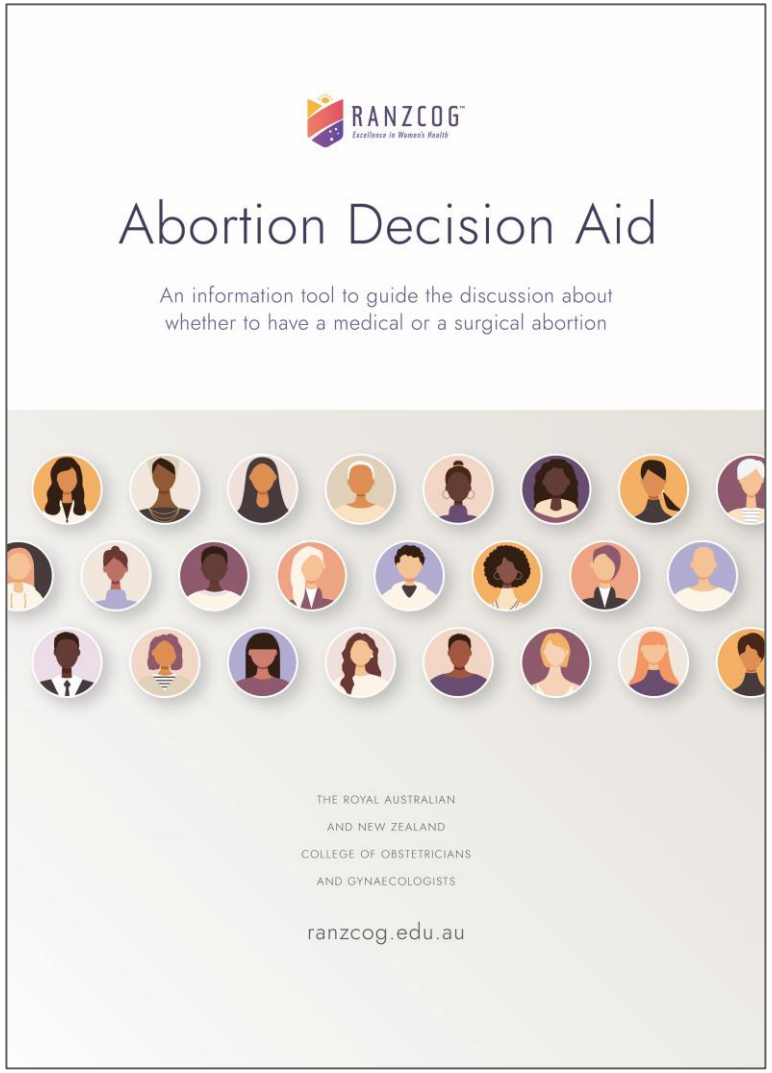
RANZCOG Evidence Based Guideline: Decision Aid

Clinical Guideline for Abortion Care

https://ranzcog.edu.au/womens-health/statements-guidelines/abortion/





Acknowledgments

RANZCOG would like to acknowledge the generous, thoughtful contributions of the members of the Guideline Development Group.

Thank you!

For any queries regarding the RANZCOG Clinical Guideline for Abortion Care, contact: womenshealth@ranzcog.edu.au

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