ABORTION AND THE ‘BIG QUESTIONS’

By Jennie Bristow, Editor, Abortion Review

The 2010 BPAS annual lecture, titled ‘Why do people get pregnant (when they don’t want to be)?’ was given by Kristin Luker, the foremost American sociologist researching contraceptive use and risk taking around unplanned pregnancy in the USA. Professor Luker tackled key questions about reproductive decision-making and the way that people view and exercise choice and control over their fertility. Her analysis rested on decades of research revealing that individuals do not necessarily make rational, calculated decisions regarding pregnancy; broader factors, from their intimate relationships and social circumstances to cultural ideas about marriage and motherhood, affect the extent to which people ‘take chances’.

A full report on Luker’s lecture is available on Abortion Review Online (http://www.abortionreview.org) (1). Also available to download, in a special edition of Abortion Review, is a speech given by Ann Furedi at the 2008 BPAS conference The Future of Abortion, examining why Britain’s abortion rate remains high when contraception has been actively promoted (2). Furedi addresses the gap between ‘official’ understandings of contraceptive use, which tend to assume that women will avoid the risk of pregnancy if they can, and the more muddled reality of people’s lives, in which sexual risk-taking is bound up with emotional factors such as the desire for spontaneity and intimacy.

Many people may make a conscious decision not to become pregnant, and therefore use the most reliable contraception they can; or to become pregnant, and therefore not use contraception at all. But many other people do not make decisions or choices in such rigorously-planned ways, and an effective sexual health service is one that recognises and provides for this reality.

The gap between official and real-life approaches to contraception and abortion indicates that practical issues of contraception and abortion provision cannot be separated from wider academic, sociological or philosophical discussions about sexual behaviour; the meaning of parenthood, the value of life, the question of autonomy, and many of the other big questions that still preoccupy our society.

Such big questions inform both our abortion laws and the practice of abortion provision. Without understanding the pressures that individuals face, the social circumstances in which they make reproductive decisions, or the way that ideas about pregnancy and parenthood shift with other political and cultural developments, it is difficult to provide a service that properly defends clients’ interests and meets their needs.

BPAS takes a lead in the discussion about abortion, as well as in clinical practice and service delivery. Kristen Luker’s lecture raised a host of challenging issues for abortion providers in the UK, and was followed by a two-day seminar on ‘Pregnancy and pregnancy planning in the new parenting culture’, supported by BPAS, and including a thought-provoking paper by Rachel Jones at the US Guttmacher Institute examining abortion decision-making in a culture of ‘intensive motherhood’ (3). On 31 October 2010, BPAS is sponsoring a number of sessions at the London Battle of Ideas festival, examining the value of life, the rise of conscience and refusal clauses in healthcare, and the ethics of selective reproduction: see overleaf for details.

Engaging with the wider abortion debate is also the role of Abortion Review, and as our recent readers’ survey indicated, many of those working at the frontline of service provision value Abortion Review’s coverage of abortion news and medical developments. Many thanks to those who took part in the survey, for giving invaluable feedback and interesting new ideas. As we develop Abortion Review and the online edition over the coming year, we will push ahead with suggestions about providing in-depth reports on conferences and events, and bringing our wealth of content together into briefing notes on key issues, from early medical abortion to the ‘overpopulation’ debate. Please keep your suggestions coming: email me at editor@abortionreview.org.

(1) Why do people get pregnant (when they don’t want to be)? Abortion Review, 28 June 2010
http://www.abortionreview.org/index.php/site/article/772/
(3) Motherhood, abortion and parenting culture. Abortion Review, 19 July 2010
http://www.abortionreview.org/index.php/site/article/793/
Q) What are the other considerations that need to be taken into account when determining whether to treat obese clients?

Prior to performing an abortion, assessment of gestational age and determination of medical fitness for the procedure are important. Identifying a very early pregnancy using abdominal ultrasound scanning may be more difficult in obese women, necessitating the use of vaginal scanning.

Surgical procedures under local anaesthetic may also be preferable in obese women as obesity is associated with greater difficulty in airway management, the need for larger doses of medications due to distribution in fatty tissues, and prolonged recovery (10).

Q) What medical risks are associated with obesity?

Surgical abortion in obese women can present technical challenges, largely due to difficulties visualising the cervix and gaining access to the uterine cavity (5). Longer operating times and greater blood loss have been documented in obese women undergoing dilatation and evacuation in the second trimester (6, 7). There is some evidence that obese women are at increased risk of death from thromboembolism following surgical abortion, although this adverse outcome remains rare (8).

Obese women undergoing early medical abortion with mifepristone and misoprostol have not been associated with an increased risk of complications and may be preferable. Although this adverse outcome remains rare (8).

There are a number of medical conditions associated with obesity including diabetes, gallbladder disease, cardiovascular disease, obstructive sleep apnoea and some malignancies, for example endometrial cancer (2). A recent population based study in France identified important associations between obesity and sexual health (3). Of 5,535 women surveyed, those who were obese were 30 percent less likely to have had a sexual partner in the last 12 months than normal weight women. However, the odds of reporting an unintended pregnancy or an abortion were four times higher among obese women less than 30 years of age than in normal weight women in the same age group. In addition, obese women were also 70% less likely to report using the oral contraceptive pill and eight times more likely to use less effective methods, such as withdrawal, compared with women with normal BMI.

Having a BMI in the obese range has also been associated with longer time to recognise and test for pregnancy and, therefore, a delay in obtaining abortion care (4). Although the reasons are unclear, it may be because obese women are a higher risk of conditions like polycystic ovarian syndrome which causes menstrual disturbances.

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techniques (10, 11). In addition, if blood pressure measurements are needed, use of a larger cuff is often required to obtain an accurate reading.

Longer instruments, additional lighting, steep Trendelenberg positioning and lateral vaginal retraction by assistants may be needed for surgical procedures (10). For morbidly obese women (BMI >40 kg/m2 or > 35 kg/m2 in the presence of co-morbidities), special equipment may also be required, as standard equipment (beds, operating tables and transfer trolleys) is often rated to a lower maximum safe weight (12). Electronically operated beds are also recommended to reduce the potential risk of injury to staff.

Q) In what instances is BPAS unable to treat obese women?

It is BPAS policy to offer clients a choice of procedure and anaesthesia. There are no set restrictions based on BMI for local anaesthetic procedures or medical abortion. However, the appropriateness of undertaking either of these treatments in a BPAS unit must weigh against the ability to manage complications which require general anaesthesia or the ability to refer efficiently to the NHS for management. Co-morbidities must also be considered. For a surgical abortion under general anaesthetic, in general clients with a BMI of less than or equal to 35 kg/m2 can be treated at any BPAS unit. Clients with a BMI of greater than 35 kg/m2 may be assessed for their fitness to undergo general anaesthetic at selected BPAS units by an anaesthetist. The upper BMI limit for a general anaesthetic at any BPAS unit is 44.9 kg/m2.

BPAS employs a Special Services Manager, Jackie Lydon, for managing complex clients including women who are obese that we cannot treat. She can be reached on 0845 365 0534 and can answer questions about whether a woman can be treated by BPAS, and can assist in finding another provider if necessary.

References


ABORTION NEWS

JUNE / JULY 2010

UK: GPs to gain commissioning powers

GP practices are set to be handed responsibility for most health services under ministerial plans for a radical shake-up of the National Health Service in England. Primary Care Trusts and Strategic Health Authorities will be abolished to make way for their new role. The plans are set out in the Government White Paper titled Equity and excellence: Liberating the NHS.

http://www.abortionreview.org/index.php/site/article/795/

UK: Advertising watchdog rejects abortion ad complaints

Complaints about the first UK television advertisement by an abortion advisory organisation have been rejected by the Advertising Standards Authority. Marie Stopes’ ‘Are you late?’ advert, which ran on Channel 4 in May and June, drew 1,034 complaints from the public, GPs, counsellors and MPs. But the Advertising Standards Authority said it did not mention or advocate abortion. 4/6/10 and 9/8/10


Enhancing the lives of children: How far should we go?

A conference at the Royal Society of Medicine raised some interesting and important questions about how today’s society should view the role of genetic, chemical and behavioural techniques in shaping children’s health and behaviour. Jennie Bristow reports. 6/7/10

http://www.abortionreview.org/index.php/site/article/774/

UK: Important new review on fetal awareness published

There is no new evidence to show fetuses feel pain in the womb before 24 weeks, two new reports by the Royal College of Obstetricians and Gynaecologists have concluded.

The main findings from each of the RCOG’s new documents are:

Fetal Awareness

- The fetus cannot feel pain before 24 weeks because the connections in the fetal brain are not fully formed
- The fetus, while in the chemical environment of the womb, is in a state of induced sleep and is unconscious
- Because the 24 week-old fetus has no awareness nor can it feel pain, the use of analgesia is of no benefit
- More research is needed into the short and long-term effects of the use of fetal analgesia post-24 weeks.

Termination of Pregnancy for Fetal Abnormality

- It is unrealistic to produce a definitive list of conditions that constitute ‘serious’ handicap since accurate diagnostic techniques are as yet unavailable. Likewise, the consequences of abnormality are difficult to predict
- The NHS Fetal Anomaly Screening Programme should be centrally linked so that the outcome of pregnancies with specific congenital abnormalities are monitored over time
- Appropriate information and support should be offered to all women undergoing antenatal screening
- In the case of a possible termination of pregnancy, all staff caring for the mother must adopt a non-directive, non-judgemental and supportive approach.

A commentary by Stuart Derbyshire, a member of the Working Party that produced the report, examines the science of ‘fetal pain’, and the ethics of abortion. 25/6/10 and 7/7/10

UK: About eighty IVF pregnancies per year end in abortion

Figures collected by the Human Fertilisation and Embryology Authority show that one percent of assisted conceptions account for a tiny proportion of all abortions. In a commentary for BioNews Ann Furedi, Chief Executive of BPAS, wrote:

‘We tend to categorise pregnancy neatly as “wanted” or “unwanted”, “planned” or “accidental”. In real life, things are rarely so clear: Some accidental pregnancies are welcomed. For some women, the fact that a pregnancy is intended and wanted at conception, does not mean that it will remain wanted as the weeks progress. Just as unintended pregnancies can, and do, become wanted, so planned, carefully-conceived pregnancies can become unwanted. The use of a technology to assist the conception does not protect it from this.’ 7/6/10 and 14/6/10

http://www.abortionreview.org/index.php/site/article/763/
http://www.abortionreview.org/index.php/site/article/767/

UK: Controversy over teenage ‘repeat abortions’

Media discussion was prompted by government data showing that 89 girls aged 17 or under who terminated a pregnancy last year had at least two abortions previously. In a commentary for Abortion Review, Lisa Hallgarten, Director of Education for Choice, argued:

‘A statistic rarely tells the whole story. For example, if an increase in repeat abortions indicates more women are able to access an abortion when they need it, why don’t we celebrate that we might simply be meeting a previously unmet need rather than assume that women have become too carefree about abortion?...I would suggest that the improvements abortion services have made in caring for women rather than stigmatising them might have led to more honest self-reporting of previous abortions.’ 18/6/10

http://www.abortionreview.org/index.php/site/article/769/
http://www.abortionreview.org/index.php/site/article/770/

Commentary: Should women’s healthcare needs take priority over doctors’ beliefs?

Health Care Refusals: Undermining Quality Care for Women, a report published by the US National Health Law Program’s Standards of Care Project, examines the apparent proliferation of health care refusals based on ‘ideological and political justifications’, and their impact upon the health care received by women in the United States. Jennie Bristow examines the issues. 8/6/10

http://www.abortionreview.org/index.php/site/article/765/

USA: Sarah Palin calls for conservative, anti-abortion feminism

The former governor for Alaska has provoked a barrage of commentary with her claims that women who oppose abortion rights are responsible for an ‘emerging, conservative, feminist identity’ and have the power to shape politics and elections around the issue. 4/6/10

http://www.abortionreview.org/index.php/site/article/766/

UK: Christmas advert revealed

Protestant Churches are joining forces in an advertising campaign that shows a scan of ‘baby Jesus in the Virgin Mary’s womb’, complete with halo. 9/6/10

http://www.abortionreview.org/index.php/site/article/768/

MAY 2010

UK: Abortion statistics show small decline

The abortion rate has dropped for the second year running in England and Wales, official statistics show. The total number of abortions was 189,100 in 2009 - a rate of 17.5 per 1,000 women aged 15 to 44. This compares to 18.2 in 2008, and comes after a general upward trend for the past 40 years which peaked in 2007. The abortion rate in Scotland also fell last year to 12.4 per 1,000.

Ann Furedi, chief executive of BPAS, said: ‘There has been a 2% rise in the number of abortions at under of 10 weeks, which now make up three quarters of all abortions. In fact, 91% of all abortions were carried out at under 13 weeks of pregnancy. This indicates that better NHS funding has helped to build in more of the capacity needed to care for women when they need it.’ 25/5/10

http://www.abortionreview.org/index.php/site/article/757/

Northeast Ireland: Anti-abortion campaigners challenge government guidelines

The Society for the Protection of Unborn Children (SPUC) has won permission to seek a judicial review of the Department of Health’s controversial interim Guidance on termination of pregnancy: the law and clinical practice in Northern Ireland.

A survey of Northern Ireland gynaecologists, conducted by Colin Francome and released the day before the ruling, found that 57 percent of respondents said they would support liberalising the current abortion law, with more than two thirds agreeing that abortion should be legal on grounds of fetal abnormality. 27/5/10 and 26/5/10

http://www.abortionreview.org/index.php/site/article/762/
http://www.abortionreview.org/index.php/site/article/761/

UK: New guidance published on advance provision of emergency contraception

The National Institute for Health and Clinical Excellence (NICE) recommends that pharmacies should offer the morning-after pill in advance, particularly for those under 25. Ann Furedi, chief executive of BPAS, said: ‘The aims of this draft guidance are excellent and ambitious, but there’s a long way to go to make many of these recommendations a reality: Women often tell us that in the pharmacy, there can be reluctance, or even refusal on the part of pharmacists to dispense the “morning after pill” when they ask for an advance supply. This is a serious training issue, as there are no rules to prevent EC being made available in advance by pharmacists.’ 25/5/10

http://www.abortionreview.org/index.php/site/article/758/

USA: Reactions to 50th anniversary of the Pill

The Hollywood actress Raquel Welch blamed the widespread use of oral contraceptives for a breakdown in sexual morality, while others celebrated the liberating effects of safe and effective contraception. 11/5/10

http://www.abortionreview.org/index.php/site/article/739/

Poland: ‘When conscience clauses mean women die’

An article by Anna Wilkowska-Landowska on RH Reality Check discusses a disturbing case. 3/5/10

http://www.abortionreview.org/index.php/site/article/745/

APRIL 2010

UK: Claims about survival of low birth weight babies provokes debate

The Daily Mail reported that the number of babies born weighing only 2lbs has more than doubled in just two years, ‘re-igniting the emotive debate over the abortion time limit’. Consultant Patrick O’Brien, spokesman for the Royal College of Obstetricians and Gynaecologists, noted that ‘there have been major leaps in neo-natal care’, but he cautioned that many such babies would be far from healthy. A study published in the Archives of Disease in Childhood in April found that babies born before 24 weeks are spending longer periods in intensive care but their overall survival rates have not improved. Guidelines have been drawn up which recommend no resuscitation be carried out at 22 weeks, and only at the parents’ request at 23 weeks following a full discussion about the possible outcomes.

Ann Furedi, chief executive of BPAS, said: ‘A greater number of prematurely-born babies is not the same thing as an increased likelihood of fetal survival. Fetal survival is closely linked with gestation, which these figures give no
information on. The 24 week time limit for abortion was examined and endorsed just recently. Politicians and policy makers looked at the reasons why women need access to later terminations and accepted that these are in circumstances where it would be nothing short of brutal to deny them treatment. Very few women need abortions after 20 weeks, but those that do need support and understanding.”

Writing in the Mirror, Miriam Stoppard argued: ‘To say life is viable at this stage is misleading and would give false hope to parents of extremely premature babies. But, that aside, surely the main point should be a woman’s right to choose and not whether a baby might survive with medical intervention?’ 20/4/10, 21/4/10 and 22/4/10

http://www.abortionreview.org/index.php/site/article/726/  
http://www.abortionreview.org/index.php/site/article/728/  

USA: Oklahoma passes restrictive new law

The state requires women to undergo an ultrasound scan just an hour before having an abortion. Even women who are victims of rape or incest will be required to view the image prior to the procedure and listen to a detailed description of what can be seen. The laws, which were immediately challenged by pro-choice groups, also allow doctors to withhold test results showing fetal defects. The Center for Reproductive Rights has filed a lawsuit claiming the ultrasound law breaks the state’s constitution on multiple grounds. On 21 July, Oklahoma County District Judge Noma Gurich approved a temporary injunction blocking enforcement of the law until litigation is completed. 28/4/10

http://www.abortionreview.org/index.php/site/article/741/  

Commentary: It’s time to move beyond Roe v Wade

Stuart Derbyshire argues that for the past 30 years, it has been the Supreme Court, and not broader US society, that has made the necessary decisions about abortion. 25/4/10

http://www.abortionreview.org/index.php/site/article/738/  

UK: More General Practice surgeries intending to provide EMA

Data shows that four health trusts in England have requested licences to carry out early medical abortions in GP surgeries. Another 11 are considering applying for a licence and two clinics are already up and running, according to figures obtained under the Freedom of Information Act by GP newspaper.

BPAS has services in GP practices in Wolverhampton and Newcastle under contracts with primary care trusts (PCTs), and has applied to run a service in Basingstoke. BPAS also provides pregnancy advisory bureaux (PAB) services from GP premises in Coventry, Telford, Shrewsbury and Bath. Ann Furedi, chief executive of BPAS, said:

‘It makes perfect sense for the abortion pill to be available from GP, health centres and family planning clinics where doctors have the time and knowledge to counsel women properly and provide 24/7 advice and support for their patients. It must be borne in mind though, that the abortion pill is not “abortion lite”. It is not a cheaper or easier option that could be slotted into an eight-minute GP appointment - it requires no more, but no less care than other abortion methods.’ 15/4/10

http://www.abortionreview.org/index.php/site/article/727/  

UK: Tory party leader calls for review of abortion time limit

In an interview with the Catholic Herald, David Cameron discussed conscience issues such as abortion and euthanasia. Asked by a reader whether he would press for a reduction in the abortion limit, Cameron said there should be a review. ‘I think that the way medical science and technology have developed in the past few decades does mean that an upper limit of 20 or 22 weeks would be sensible,’ he said.

Talking to her local newspaper, Nadine Dorries, Conservative MP for Mid-Bedfordshire, cited her own ‘20 reasons for 20 weeks’ campaign as a “defining issue” in politics. 9/4/10 and 29/4/10

http://www.abortionreview.org/index.php/site/article/725/  
http://www.abortionreview.org/index.php/site/article/742/  

Mexico: Child’s pregnancy fuels abortion row

A pregnant 10-year-old, allegedly raped by her stepfather, has become a lightning rod in the country’s heated abortion debate, CNN reports. 22/4/10

http://www.abortionreview.org/index.php/site/article/732/  

Italy: Failed abortion story causes ‘outrage’

A 22-week old infant in Rossano, in southern Italy, was found alive following an unsuccessful abortion. He was discovered alive the following day by the hospital chaplain. The infant was taken to a specialist neo-natal unit at a neighbouring hospital, where he died the following morning. Italian police are investigating the case for homicide, and the Italian government has reportedly promised an inquiry. 29/4/10

http://www.abortionreview.org/index.php/site/article/746/  

UK: Foreign Office apologises for ‘brainstorm’ memo

The Pope’s visit to Britain will not be affected by a leaked memo which appeared to mock the Catholic Church, the Vatican has said. The Foreign Office memo suggested that said the Pope could bless a gay marriage or open an abortion clinic. Also in April, leading atheist Richard Dawkins backed a campaign to have the Pope arrested for ‘crimes against humanity’. 26/4/10 and 13/4/10

http://www.abortionreview.org/index.php/site/article/737/  
http://www.abortionreview.org/index.php/site/article/735/  

UK: Study points to limitations of chlamydia screening programme

Women should be tested for chlamydia every time they have a new sexual partner, UK researchers say. The study of 2,500 students, published in the British Medical Journal, found that annual screening is not enough to prevent cases of pelvic inflammatory disease, which can cause infertility. 8/4/10

http://www.abortionreview.org/index.php/site/article/729/  

bpas publication

ABORTION IN PRACTICE: A GUIDE FOR GPs

With around 200,000 abortions taking place each year in England and Wales, the vast majority of GPs will find themselves consulted by women with unplanned pregnancies, referring women for abortion, and caring for women who have had an abortion.

Abortion In Practice: A Guide for GPs makes use of bpas’ experience to provide clear information about:

• Facts and myths about abortion
• Abortion methods at different gestational ages
• Normal and abnormal signs and symptoms post-abortion
• Helping women prevent unplanned pregnancies in the future

For a free copy of Abortion In Practice, contact: development@bpas.org

Or download the publication for free, here:
USA: Immediate postabortal insertion of intrauterine devices

The authors note that insertion of an intrauterine device (IUD) immediately after an abortion has several advantages. The woman is known not to be pregnant, and after induced abortion, a woman’s motivation to use contraception may be high. But insertion of an IUD immediately after a pregnancy ends carries risks, such as spontaneous expulsion due to recent cervical dilation.

The study’s objectives were to assess the safety and efficacy of IUD insertion immediately after spontaneous or induced abortion. The authors concluded that insertion of an IUD immediately after abortion is safe and practical. IUD expulsion rates appear higher than after interval insertions. However, IUD use is higher at six months with immediate than with interval insertion.

http://www.abortionreview.org/index.php/site/article/803/

Australia: Attitudes to early and late abortion

A study of public opinion has found a high level of support for access to early abortion, and little support for professional sanctions against doctors for providing terminations after 24 weeks’ gestation.

http://www.abortionreview.org/index.php/site/article/775/

France: Sexuality and obesity, a gender perspective: results from French national random probability survey of sexual behaviours

The study set out to evaluate medical abortion as a treatment alternative for late first-trimester abortions and to evaluate the decrease in beta-hCG after abortion at 63-90 days of gestation.

http://www.abortionreview.org/index.php/site/article/776/

MAY 2010

Norway: Medical abortion at 63 to 90 days of gestation

The study set out to evaluate medical abortion as a treatment alternative for late first-trimester abortions and to evaluate the decrease in beta-hCG after abortion at 63-90 days of gestation.

http://www.abortionreview.org/index.php/site/article/780/

Sweden: Medical abortion in lactating women – low levels of mifepristone in breast milk

The authors concluded that the levels of mifepristone in milk are low, and that breastfeeding can be safely continued in an uninterrupted manner during medical abortion of this kind.

http://www.abortionreview.org/index.php/site/article/784/


The study set out to determine the prevalence of termination of pregnancy for fetal anomaly (TOPFA) after 23 weeks of gestation in European countries, and describe the spectrum of anomalies for which late TOPFA is recorded.

http://www.abortionreview.org/index.php/site/article/783/

WHO publishes new Emergency Contraception safety factsheet
The World Health Organisation’s factsheet comes in response to in response to media coverage in 2009. The statement concludes that: ‘A careful review of the evidence shows that levonorgestrel-alone emergency contraceptive pills are very safe. They do not cause abortion or harm future fertility. Side-effects are uncommon and generally mild.’ Anna Glasier and Elizabeth Westley have written a commentary to accompany the statement.

http://www.abortionreview.org/index.php/site/article/731/

UK: Survival in infants live born at less than 24 weeks’ gestation: the hidden morbidity of non-survivors

The authors note that although survival rates for infants of less than 26 weeks’ gestation have increased, rates for those born at less than 24 weeks do not appear to have changed. The study objectives were to describe the numbers receiving active treatment and the length of survival in infants live born at 22 or 23 weeks’ gestation but who did not survive, and any changes over the last 15 years. The authors concluded that increasing numbers of babies born at less than 24 weeks received active resuscitation. Overall survival has not changed, but non-survivors endured significantly longer durations of intensive care.

http://www.abortionreview.org/index.php/site/article/726/

Misoprostol for induction of labour to terminate pregnancy in the second or third trimester for women with a fetal anomaly or after intrauterine fetal death
Dodd JM, Crowther CA. Cochrane Database of Systematic Reviews. 2010 Apr;14;4:CD004901.

The study’s objectives were to compare the benefits and harms of misoprostol to induce labour to terminate pregnancy in the second and third trimester for women with a fetal anomaly or after intrauterine fetal death when compared with other methods of induction of labour.

http://www.abortionreview.org/index.php/site/article/782/

UK: Flexible mifepristone and misoprostol administration interval for first-trimester medical termination

This was a systematic review of randomised controlled trials published from 1999 to 2008 to assess the evidence for a shorter mifepristone and misoprostol administration interval at first trimester medical termination.

http://www.abortionreview.org/index.php/site/article/787/

Tunisia: Two medical abortion regimens for late first-trimester termination of pregnancy: a prospective randomised trial

The authors concluded that for late first-trimester termination, a single 800-mcg vaginal dose of misoprostol seems to be as effective as the mifepristone+misoprostol regimen, with acceptable side effects.

http://www.abortionreview.org/index.php/site/article/786/

USA: Effect of prior caesarean delivery on risk of second trimester surgical abortion complications

The authors concluded that second-trimester surgical abortions were associated with a major complication rate of approximately 1%. A history of
two or more caesarean deliveries was associated with a sevenfold increase in odds of major complication and was the strongest independent risk factor for a major complication.

http://www.abortionreview.org/index.php/site/article/747/

MARCH 2010

UK: A comparison of transabdominal and transvaginal ultrasonography for determination of gestational age and clinical outcomes in women undergoing early medical abortion

Lohr PA, Reeves MF, Creinin MD. Contraception. 2010 Mar;81(3):240-4

The authors sought to establish the accuracy of abdominal ultrasonography in determining gestational age and identifying the presence of a gestational sac and embryonic pole before and after medical abortion. They concluded that abdominal ultrasonography is sensitive for diagnosing the presence or absence of a gestational sac, but less sensitive at detecting an embryonic pole. This may lead to a small underestimation of gestational age and missing a continuing pregnancy at follow-up when one exists.

http://www.abortionreview.org/index.php/site/article/752/

USA: Risk of miscarriage with bivalent vaccine against human papillomavirus (HPV) types 16 and 18: pooled analysis of two randomised controlled trials


This was a pooled analysis of two multicentre, phase three masked randomised controlled trials. Participants were randomly assigned to receive three doses of bivalent HPV 16/18 VLP vaccine with AS04 adjuvant (n=13 075) or hepatitis A vaccine as control (n=13 055) over six months. The main outcome measures were miscarriage and other pregnancy outcomes. The authors concluded that there is no evidence overall for an association between HPV vaccination and risk of miscarriage.

http://www.abortionreview.org/index.php/site/article/750/

Taiwan: Sonographic quantification of endometrial changes after abortion with computer-assisted image analysis


The study set out to examine the diagnostic feasibility of sonographic gray scale histograms to assess changes in the endometrium following abortion induced by mifepristone and misoprostol. The authors concluded that partial least square analysis of gray scale histograms of the endometrium in ultrasonicographic images is useful in assessing endometrial changes.

http://www.abortionreview.org/index.php/site/article/749/

FEBRUARY 2010

WHO: Cervical preparation for first trimester surgical abortion


The authors concluded that modern methods of cervical ripening are generally safe, although efficacy and side-effects differ between methods. Reports of adverse events such as cervical laceration or uterine perforation are uncommon overall and no published study has investigated whether cervical preparation impacts these rare outcomes. Cervical preparation decreases the length of the abortion procedure; this may become increasingly important with increasing gestational age, as mechanical dilation at later gestational ages takes longer and becomes more difficult. These data do not suggest a gestational age where the benefits of cervical dilation outweigh the side-effects, including pain, that women experience with cervical ripening procedures or the prolongation of the time interval before procedure completion. Mifepristone 200 mg, osmotic dilators and misoprostol, 400 microg administered either vaginally or sublingually, are the most effective methods of cervical preparation.

http://www.abortionreview.org/index.php/site/article/751/

Spain: Mifepristone-misoprostol midtrimester abortion: impact of gestational age on the induction-to-abortion interval


The authors concluded that the mean induction-to-abortion interval increases by 4 h after 20 weeks GA. This information may be relevant for counselling and planning of the procedure.

http://www.abortionreview.org/index.php/site/article/791/

USA: Buccal misoprostol for cervical ripening prior to first trimester abortion


The study’s objective was to assess the necessity of manual dilation of the cervix when buccal misoprostol is used for cervical priming prior to first trimester uterine aspiration procedures. The authors concluded that buccal misoprostol appeared to decrease the need for manual dilation prior to first trimester aspiration abortion. Earlier gestations and parous patients showed less need for manual dilatation than later gestations or nulliparous women. A larger study with a control group is needed to confirm the benefit of the use of buccal misoprostol in first trimester abortion aspiration.

http://www.abortionreview.org/index.php/site/article/789/

USA: Feasibility of telephone follow-up after medical abortion

Perriera LK, Reeves MF, Chen BA, Hohmann HL, Hayes J, Creinin MD. Contraception. 2010 Feb;81(2):143-9

This study was conducted to assess the feasibility of using telephone calls combined with high-sensitivity urine pregnancy testing as a primary method of follow-up after medical abortion. The authors concluded that telephone follow-up combined with urine pregnancy testing after medical abortion is a feasible alternative to routine ultrasonography or serial serum hCG measurements.

http://www.abortionreview.org/index.php/site/article/788/

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