Development of a national referral centre for surgical abortion at Homerton University Hospital

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Abortion services in the UK are increasingly commissioned within the independent sector. This has improved accessibility and lowered costs for the care of women who have no significant medical problems, but creates access problems for women requiring hospital-based abortion care, as hospital-based National Health Service (NHS) units lose funding and cease to operate. To indicate the scale of need for hospital-based abortion care, The British Pregnancy Advisory Service (bpas), an independent-sector abortion provider, has reported that in 2016 and 2017 it arranged referrals to NHS providers for 2900 women. Due to the shortage of hospital-based services, particularly those offering care in the second trimester, these patients often have to wait several weeks for a referral to be accepted and may face a further wait until their appointment. They also may need to travel large distances. A significant minority of these women are unable to access abortion at all and are forced to continue pregnancies they would almost certainly be eligible to terminate within the UK legal framework[1]. These ongoing pregnancies will furthermore be complicated by the same condition that complicates their abortion. Given that comorbid medical conditions account for two-thirds of maternal deaths in the UK, this represents a serious ethical and clinical failure.[2]

In response to this situation, Homerton University Hospital in London expanded its abortion service to accept referrals from outside its local area, and increased the departmental gestational limit from 17 to 24 weeks gestational age for terminations provided under section 1 (1)a of The Abortion Act, or Ground C as stated on the HSA1 form (Certificate A). We provide a brief retrospective report of the first year of this service development to demonstrate the success of the service, and to invite other hospitals to implement similar changes. We present here an analysis of patients referred into the service and the outcomes of their care.

Key messages

- In the UK there is inadequate provision of hospital-based abortion services, causing delays, difficulties, and denial of care for women with medical problems seeking to access a termination of pregnancy.
- Surgical abortion by dilatation and evacuation is frequently the optimal method of abortion for women in the second trimester with complex medical problems, but availability of this procedure is especially limited.
- We demonstrate the feasibility of expanding a hospital-based abortion services to accept referrals from across the UK. Other units, with the support of commissioners and the relevant national bodies, should consider doing the same, to ensure women are able to access care and are not forced to continue unwanted pregnancies that endanger their health.

Between October 2016 and September 2017, the service accepted 75 referrals. 55% came from outside London, including Scotland and Wales. Sixteen women did not attend their appointments. Some of these women chose to continue their pregnancy, but a minority reported that the costs of travel and accommodation were an insurmountable barrier that played a role in their decision not to attend.

The mean age of our patient group was 29 years (table 1). The mean gestation at the time of referral was 17 weeks and 6

Table 1 Patient demographics

Demographic	n (%)
Patient age (years) (mean (range))	29 (16–42)
Gravidity (n)	
1	7 (12)
2–3	18 (31)
4–5	20 (34)
≥6	13 (22)
Parity (n)	
0	12 (21)
1–2	25 (43)
≥3	21 (36)
Previous caesarean sections (n)	
0	30 (52)
1	8 (14)
2	11 (19)
≥3	9 (16)
Previous spontaneous vaginal deliveries (n)	
0	37 (64)
1	9 (16)
≥2	12 (21)
Previous terminations (n)	
0	32 (55)
≥1	26 (45)

Table 2 Reasons for referral

Reason for referral	Patients (n)
Previous caesarean section(s)	20
Difficult transcervical access	11
High body mass index	9
Hypertension	3
Uncontrolled asthma	4
Other respiratory pathologies	1
Anaemia	4
Other haematological pathologies	2
Cardiovascular pathologies	2
Psychiatric issues	5
Systemic issues	1
Infection	2
Oncological pathologies	1
Complex fetal abnormalities	4
Epilepsy/seizures	5
Endocrinology pathologies	1

days, with 47% of women referred at a gestation of 20 weeks or more. The median interval between referral and abortion was 16 days. 49% of women had a history of at least one previous caesarean section, 37% had a history of at least one vaginal delivery, and 45% had a history of previous abortion (table 1).

57% of the women were referred due to conditions with implications for anaesthetic safety, such as poorly controlled asthma and epilepsy.43% were referred due to surgical concerns, such as a history of previous caesarean section(s) (with or without a low or anterior placenta) or anticipated difficult transcervical access (e.g. the presence of lesions obstructing access to the cervical canal, for example, fibroids, large ovarian cysts; or previous cervical procedures such as, trachelectomy). 10% were referred for other reasons, including haematological conditions (such assevere anaemia, sickle cell disease, clotting disorders) or rare genetic syndromes (table 2).

Mean gestational age at time of abortion was 20 weeks, with 64% performed at a gestation of 20 weeks or more and 5% at less than 13 weeks. 88% of patients underwent surgical termination by transcervical dilatation and evacuation (D&E). One patient underwent hysterotomy. The remainder had either inpatient medical abortion or manual vacuum aspiration under local anaesthesia (which we provide to 13 weeks gestational age).

All patients at 14–17 weeks and 6 days of gestation underwent cervical preparation with mifepristone 200 mg 24 hours prior to the procedure, and misoprostol 400 μg 1–2 hours pre-operation. All patients at 18 weeks gestation or greater had Dilapan-S osmotic dilators (MEDICEM International, Prague, Czech Republic) inserted into the cervical canal the day prior to the operation. Feticide was performed prior to all D&Es at a gestational age of 20 weeks and 0 days or greater, using ultrasound-guided intracardiac injection of potassium chloride. We have since revised our protocols to insert overnight Dilapan-S in all patients at 14 weeks and 0 days or greater gestational age because of its superior cervical priming effect and the reassuring data regarding subsequent pregnancy outcome.[3]

Complications occurred in five women. There was one case of laceration of the external cervical os, which was repaired transvaginally. Four women suffered postabortion haemorrhage (>500 ml estimated blood loss). Two of these cases were due to uterine atony, which in both cases was managed with uterotonics and an obstetric balloon.Two cases of haemorrhage were due to morbidly adherent placenta (MAP). In both cases of MAP this condition was suspected pre-operatively: both patients had a history of multiple previous caesarean sections and low anterior placentas, with ultrasound features suspicious for MAP. Both patients were counseled regarding the increased risk of complications and hysterectomy. Both cases resulted in uncomplicated emergency hysterectomy immediately after D&E, and subsequent histology confirmed a diagnosis of placenta accreta.

82% of the patients were treated as day cases and were discharged on the day of abortion. In addition to the cases in which surgical complications necessitated a hospital stay, the remainder of the postoperative admissions were for monitoring of the comorbid condition which led to their referral. 66% of women started contraception immediately after their abortion.

DISCUSSION

There is scant medical literature concerning the care of women with complex medical or surgical needs requesting abortion UK guidance does not contain specific recommendations regarding the management of, for example, patients requesting abortion who are suspected of having MAP.[4] In the USA, the Society for Family Planning has produced guidance on women with co-morbid medical problems requiring first-trimester abortion.[5] As our case report indicates, a significant number of women requiring hospital-based abortion care are in the second trimester, when procedures will involve longer operating times and blood loss, and hence comorbidities pose greater risk. The majority of the medical indications for hospital-based care in our series were conditions commonly dealt with by most hospital-based anaesthestists, such as asthma and epilepsy. The benefit of hospital-based care is the prompt availability of specialist equipment and support in case of deterioration of the chronic condition. Surgical problems require experienced surgeons who are comfortable performing trans-cervical uterine evacuation with ultrasound guidance, and with recourse to definitive surgical management of post-abortion bleeding.

Almost all the patients presenting to us in the second trimester underwent surgical termination by D&E, which is safer, cheaper, requires a shorter hospital admission, and appears to have have better emotional outcomes than medical abortion at this gestation range.[6–11] There is limited availability of second-trimester medical abortion in our service as this requires admission to the delivery suite. It is not routinely offered to the patients referred to us with medical complexity, but can be organised if requested or deemed medically preferable. Both of these situations are very rare.

In our service, the skills needed to provide assessment, surgical abortion, and laparotomy/hysterectomy are spread across, and supported by, various members of the multidisciplinary team. In other units there may be individual clinicians possessing all these skills. There are various ways of organising such a service, and it should not be a barrier that one clinician is not able to provide all elements of care. For example, experienced D&E surgeons may not be experienced at performing major gynaecological surgery such as hysterectomy, hence team-work ensures patients are managed optimally.

Training in the provision of second-trimester surgical abortion is not a requirement of core training in Sexual & Reproductive Health or Obstetrics & Gynaecology in the United Kingdom. Motivated trainees wishing to obtain these skills are able to opt in to training modules, but it is difficult to find specialists and trainers who can train within the NHS. Surgeons working in the independent sector are sometimes able to offer training, but barriers include indemnity issues, travel time and costs.

One of the principal challenges to expanding the service was ensuring the support of theatre staff to care for women undergoing termination of pregnancy at higher gestations. The lead for the service at Homerton (TM) arranged several workshops with an external facilitator to explore staff feelings about the service development. We encourage involvement for those who are interested, while supporting conscientious objection, or partial participation,

To help women with chronic disease avoid unplanned pregnancy, there is a role for improving the links between specialist contraception providers and medical specialists caring for women with chronic illness of reproductive age. Some women in our series had planned their pregnancy but deterioration of their medical condition prompted the request for termination. However, women with medical problems may have limited options for safe contraception, and specialist input would ensure that women are not prescribed unsafe contraception, nor denied safe contraception.

Abortion services are currently commissioned by Clinical Commissioning Groups (CCGs) at a local level, and at this level the number of women requiring tertiary level care to manage their comorbidities or later gestation will be small. However, at a national level, a significant number of women require these services.Coupled with the limited number of skilled clinicians and the substantially greater cost of services relative to the tariff to which CCGs are accustomed, it is unlikely that local-level commissioning will address this problem promptly, sustainably, or equitably. We would therefore advocate that hospitals are incentivised to set up these units by a national tariff that recognises the skills and motivation of individual clinicians, and the ongoing infrastructure that is required to provide such a service.

CONCLUSIONS

This report demonstrates the feasibility of establishing a referral service for abortion care in an NHS hospital, including the care of women in the second trimester and the provision of D&E to 24 weeks gestational age. Just as the care of pregnant women in general has become increasingly complex, as the rate of caesarean section has increased and the management of chronic medical conditions has improved health and fertility, so has the care of women requesting abortion. Services

must adapt to meet the needs of more complex patients and ensure that women with medical problems do not face the difficulties, delays, and denial of care that currently characterise the pattern of abortion provision in the UK.

Correction notice Since this article was first published online first, an update in the introduction section has been made. The referral figure of 3000 women has been reduced to 2900 women.

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