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In this issue

Abortion in the spotlight

In this final issue of 2017, the 50th anniversary year of the passage through parliament of the UK Abortion Act, we make no apology for dedicating many of our articles to the topic of abortion, ranging from very early self-induced abortion as fertility control, through early first-trimester abortion, to mid-trimester abortion and then to post-abortion care.

In her Editorial, Mary Pillai refers to the article by Koh *et al.* (page 252) comparing three prostaglandin regimens for medical induction of mid-trimester abortion. While late abortion forms only a small proportion of the total number, its risks and complexity are greater than with early abortion. But the risks are dependent on the method used and there is evidence that the surgical approach to mid-trimester abortion using dilatation and evacuation (D&E) carries significantly fewer risks than the medical approach. She draws attention to the decreasing cohort of skilled D&E practitioners in the UK, such that in many cases women cannot be offered a choice between a rapid, safe and relatively pain-free abortion and a prolonged, riskier and undoubtedly painful and distressing experience. Training of a new cohort of doctors who are prepared to perform D&E is urgently needed. *See page 249*

Randomised controlled trial of second-trimester medical abortion methods

This important study by Koh *et al.* from Singapore compared three mid-trimester medical abortion regimens using misoprostol in two doses, and gemeprost, all without mifepristone. The main outcome measure was abortion within 48 hours of administering the first prostaglandin dose. The authors conclude that despite being licensed for this indication, gemeprost is no longer the best first-line treatment. Unfortunately completeness of abortion with the three methods could not be evaluated as local policy required routine surgical evacuation after abortion. *See page 252*

The legal argument supporting nurse and midwife-performed vacuum aspiration for induced abortion

Sheldon and colleagues present a cogent and persuasive argument that vacuum aspiration for abortion could legally be

performed by nurses and midwives in the UK. A 1981 legal judgment relating to the conduct of second-trimester abortions found that while a doctor “should accept responsibility” for all stages of treatment for the termination of pregnancy, they need not necessarily carry out the specific actions personally. Reviewing the ruling in detail, the authors propose that nurses and midwives, acting as part of a multidisciplinary team including doctors, could perform surgical abortions legally. This interpretation clearly offers the potential for developing more streamlined and cost-effective abortion services. *See page 260*

Womens' preferences regarding abortion terminology

Do we know how best to consult with women seeking to end a pregnancy? Cameron and colleagues investigated 2259 women's preferences or distress when using the terms ‘termination of pregnancy’ and ‘abortion’ in clinics in Britain, using an anonymised questionnaire. More women found ‘abortion’ distressing than ‘termination of pregnancy’, and more expressed a preference for the use of the latter term, but the majority of women did not report distress. People working in abortion services should be aware that some women may find the language they use distressing. Where possible, the best option is to ask women which term they prefer. *See page 265*

Film to support women considering early medical abortion

A high proportion of women wishing to terminate an unwanted pregnancy now opt for early medical abortion (EMA) and need information about the procedure and what to expect. In Edinburgh, UK, a 9-minute animated film was created and uploaded to the abortion service's website. *Lara's Story* is based on one woman's detailed account of her experience of EMA. Sherman and colleagues interviewed women after they had watched the film and then analysed the recordings qualitatively. All felt that the film would be useful for women seeking abortion, with very few feeling that modifications were necessary. *Lara's Story* appears to be a real advance in the provision of accessible information for women considering EMA. *See page 269*

Fertility control in Pakistan: the role of misoprostol

The authors of this study tentatively suggest that misoprostol use in Pakistan has taken on a role equivalent to oral contraceptive use in Western countries. The study used focused fieldwork, with interviews of clinic attenders and health-care providers. Establishing rapport over 4 months enabled sensitive data to be collected. Women sought misoprostol as a result of contraceptive failure, discontinuation of contraceptives due to side effects or because contraception was not used. Misoprostol has emerged to provide women in Pakistan with a practical and accessible means of fertility control. *See page 274*

Relationship between deprivation and LARC prescription in Lothian, Scotland

Scottish teenage pregnancy rates are higher than in many countries in Western Europe and strongly correlate with deprivation. Using electronic prescribing data, Morgan and colleagues examined the relationship between long-acting reversible contraception (LARC) prescribing and geographical areas in Lothian, to see if prescribing inequality contributed to unintended pregnancy rates. Around 21% of the 90000 women included had been prescribed LARC and women in the most deprived areas were significantly more likely to have these methods. The authors propose various reasons for this, but women in more deprived areas who are prescribed contraception do appear to be accessing the most effective methods. *See page 281*

Intrauterine contraception and uterine perforation: the long view

Uterine perforation remains a major concern for providers and users of intrauterine contraception (IUC). In their review of records of known perforations at a large UK community sexual health clinic, collected prospectively over 16 years, O'Brien and Pillai found a low mean annual perforation rate, broadly similar to that of other studies. A peak in the number of perforations around 3 months after delivery was found and there was a strong association with breastfeeding. They highlight a new technique to establish whether the perforation rate in any time period differs significantly from that expected, an

important factor in quality control. Finally, the authors present a brief protocol to help minimise the risk of perforation and encourage early diagnosis. *See page 289*

Primary care endometrial sampling for abnormal uterine bleeding

The first year of a new service for primary care endometrial sampling for premenopausal abnormal uterine bleeding (AUB) was evaluated. Most women had an ultrasound scan, and 37% were found to have fibroids. Almost all (97%) had normal samples and were managed solely in primary care, predominantly with the levonorgestrel intrauterine system (IUS). Compared with a retrospectively reviewed secondary care cohort, IUS use was much more common in primary care. The authors conclude that most premenopausal patients with AUB could be assessed and managed in primary care. There were no cases of endometrial cancer in either cohort, raising the question of whether endometrial sampling is necessary in all cases of AUB. *See page 296*

Regional variation in adolescent pregnancy in Chile

Despite a 25% decline in the adolescent birth rate in Chile over 20 years, it still remains high. Analysis across the country's 15 regions found no correlation between poverty rates and adolescent birth rates. But deeper analysis of one region did show a strong correlation between birth rate and poverty rate. In Chile all abortion is illegal, yet it still occurs, meaning that unwanted pregnancy rates may be under-reported. Chile's birth rate variability needs further study: poverty rates are insufficient explanation. *See page 302*

Access to contraception and to SRH information after abortion

This literature review of sexual and reproductive health (SRH) information and access for women in low- and middle-income countries after medical or surgical abortion asks the question: 'Do adequate Post Abortion Care (PAC) and SRH access increase uptake of contraception and SRH information?'. Nine studies were included from PAC services in geographical areas with varying legal status of abortion. The review found that with access to a wide range of contraceptive methods, combined with comprehensive SRH information and education, contraception uptake in women post-abortion does increase. However, there were many barriers, including lack of contraceptive stocks and poor availability of counselling, as well as abortion stigma.

The review also highlights the inconsistencies in what is termed 'post-abortion counselling'. *See page 309*

Quick starting hormonal contraception after use of oral emergency contraception

This is the only systematic review to date to examine the effectiveness and impact on bleeding patterns and side effects of 'quick starting' hormonal contraception (HC) after oral emergency contraception. Three randomised trials were identified, but were unsuitable for meta-analysis due to their disparate study designs. The main findings were that the contraceptive action of hormonal methods is not reduced when quick started after ulipristal acetate (UPA), but the ability of UPA to delay ovulation was reduced if a desogestrel progestogen-only pill was quick started. However, the confidence intervals were wide. Overall, the findings support the FSRH recommendation that women should wait at least 5 days after using UPA before initiating any HC. *See page 319*

Improving access to cervical screening for previously sexually abused women

Women with previous forced sexual experiences have emotional barriers to accessing medical services, including cervical screening. The My Body Back Clinic in a London sexual health service has been set up to cater specifically for their needs. Women are able to collaborate with the staff at their own pace to keep control. Clinicians and volunteers identified a need for specialist help and solutions to improve uptake, with the benefit of offers of sexually transmitted infection (STI) testing and contraception. Detailed evaluation is awaited, but after a 6-month pilot the model has now been incorporated into the service. Challenges remain regarding training, staffing and funding, of importance to other services wishing to develop similar models. *See page 327*

Ethics of offering incentives to accept contraceptive procedures

In her winning entry for the FSRH's 2017 Margaret Jackson Essay Prize for medical students, Georgeina Jarman examines two schemes, in the USA and the UK, in which women who are drug-addicted or suffering severe social deprivation are offered incentives to accept contraception or even, in the case of one of the schemes,

sterilisation. She uses the well-established 'Four Principles' of biomedical ethics to assess the merits and drawbacks of the schemes and concludes that for many women, being offered a large cash incentive amounts to coercion that is not ethically justifiable. *See page 331*

Two approaches to improving doctor-patient communication in general practice

Patients presenting with sexual problems can be a heartsink to busy clinicians, leaving them floundering as how best to understand and help them. Gareth Hughes describes his journey to acquiring specialist skills, with benefit to all his doctor-patient interactions. Now, far from feeling baffled by patients' problems, he is able to help them understand what lies behind their symptoms and to move forward. He encourages others to consider a short introductory training with the Institute of Psychosexual Medicine. Continuing this theme, in her latest Person in Practice article, Abi Berger contemplates patient-doctor communication, and concludes that when differing objectives and misunderstandings arise during a consultation, it may be necessary for the clinician to refine their listening and negotiating skills. *See pages 335 and 338*

Then & now

In his review of this journal's content a quarter of a century ago and of today's issues, our International Advisory Editor focuses on a remarkably insightful lecture by Dr Elphis Christopher on the problems facing family planning in the early 1990s. In 1992, the journal also reported on proposals for a Faculty of Family Planning, which came to fruition early in the following year. Twenty-five years later, our specialty is well established, but on a global scale its aims are threatened by withdrawal of budgetary support by the current United States administration. The great contributions of the USA to contraception research and to service provision worldwide are threatened by its withdrawal from solidly evidence-based policies. *See page 339*

Venus

In her quarterly mission to identify interesting SRH research findings, amongst other things Venus considers LARCs, STIs (specifically gonorrhoea and HIV), fertility preservation for both men and women and digital decision aids and apps. It appears that app users need to exercise a healthy degree of scepticism about the accuracy of the STI information provided. *See page 346*