2023 British Society of Abortion Care Providers Conference Abstracts

These oral abstracts were presented at the 2023 British Society of Abortion Care Providers (BSACP) Annual Conference on 10 November 2023 titled: 'Excellence in Abortion Care Together: Coming together as a supportive community to improve patient care'. The oral abstract titled "Complications associated with mifepristone use for dilation and evacuation abortion procedures between 22- and 24-weeks' gestation" won the prize for best oral abstract.

Oral Abstracts

1 COMPLICATIONS ASSOCIATED WITH MIFEPRISTONE USE FOR DILATION AND EVACUATION ABORTION PROCEDURES BETWEEN 22- AND 24-WEEKS' GESTATION

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Background One percent of abortions take place after 20 weeks' gestation in England and Wales. Overall rates of complications with second trimester abortion are low, but they increase with gestational age. Dilation and evacuation (D&E) is the most common method of surgical abortion at this stage in pregnancy. The British Pregnancy Advisory Service (BPAS) provides nearly half of all abortions in England and Wales. In 2017, BPAS added mifepristone to their regimen of osmotic dilators for cervical ripening before D&E. This retrospective study analyzed the risk for complications associated with the use of mifepristone for cervical ripening.

Methods BPAS provided data for D&E procedures that occurred between 22 weeks and 23 weeks and 6 days', between February 2012 and February 2017 (osmotic dilators only), and November 2017 to November 2022 (mifepristone and osmotic dilators). Using time as a proxy for mifepristone, the association between mifepristone use and D&E complications was established using multivariate logistic regression.

Results There were 6,516 dilation and evacuation procedures at BPAS during this time. Those who received mifepristone were more likely to experience any complication (OR: 2.40, 95% CI: 1.62, 3.54). They also had higher odds of bleeding (OR: 3.08, 95% CI: 1.12, 8.48). Odds for cervical injury (OR: 2.21, 95% CI: 0.84, 5.80) and infection (OR: 1.89, 95% CI: 0.46, 7.69) were not different.

Conclusion The addition of mifepristone to osmotic dilators was associated with an increase in the odds of complications of D&E, without attenuating the risk of complications related to cervical dilation.

2 GROWING THE TULIP SERVICE – AUDIT OF A NORTHERN IRISH EARLY MEDICAL ABORTION SERVICE

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Introduction Following decriminalisation in Northern Ireland and the worldwide Covid-19 pandemic, interim early medical abortion (EMA) services in the South Eastern Trust (SET) were setup in June 2020, without funding and staffed by one doctor and one nurse.

Objective The first 3-months of service usage were audited and a re-audit was carried out twelve months later to establish any trends within the service and its users and to identify areas where the service could be improved or be built upon.

Methods Retrospective data analysis between June and September 2020 and 2021. Review of each EMA consultation using a standardised proforma to collect information on client demographics.

Results 103 referrals received in 2020 compared with 135 in 2021. Followed by 100 phone consultations in 2020 compared with 132 in 2021. 84 EMA treatments occurred over the same period in 2020 and 110 in 2021.

Average age was 25.75yrs in 2020 and 28.3yrs in 2021. Age range 16–49 in 2020 and 15–48 in 2021.

In 2020, 35% of clients were nulliparous and 65% were parous. In 2021, 30.3% were nulliparous and 69.7% were parous.

In keeping with findings from DH England >90% of abortions in 2020 and 2021 were performed before 10wks and >50% were under 7wks gestation.

42% of clients were using a form of contraception in 2020 compared with 34.5% in 2021. ~48% went on a form of LARC post-EMA in 2020 compared with ~55% in 2021.

Conclusions The main conclusion is the need for full commissioning. A lot of hard work has gone into developing these services yet only EMA is available until 9+6weeks. There is an urgent need for surgical services as well as good access to sexual and reproductive health and contraceptive services. Other issues highlighted included increasing demand over the year and the need for adequate staffing of the service.

3 EXPERIENCES OF PAIN IN EARLY MEDICATION ABORTION: LEARNING FROM A QUALITATIVE UK STUDY

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Introduction Pain in early medication abortion (EMA) is a known issue, as indicated in a growing body of literature. Supported self-management of EMA outside of a clinic setting has necessitated reconsideration of how pain is addressed. Recent increases in UK abortion rates, combined with higher proportions of abortions being self-managed, means that setting realistic expectations, and providing effective pain relief, is more important than ever.

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Objectives The analysis presented in this paper explores accounts of pain during EMA. Developed from a wider study of experiences of abortion during the COVID-19 pandemic, this analysis was designed to support best practice in abortion care.
Methods We recruited 20 people from across the UK who had sought abortion during the COVID-19 pandemic, to take part in a semi-structured telephone interview. Participants were recruited via the My Body My Life website, related social media, and an online classified advertisement. Participants were aged 22–43 and all self-identified as cisgender women.
Results Thematic analysis focused on accounts of pain, which were prominent in many interviews. We constructed the following sub-themes: expected pain can be manageable; the problem with unexpected pain; pain (co)produces fear; and problematising 'period like' pain. . The key issue which our analysis draws out is that, while EMA pain experience might vary, for some it may be much worse than anticipated. Moreover, the common trope of likening it to 'period pain' is potentially misleading and a source of additional uncertainty at an already challenging time.
Conclusion(s) Our findings point to an acute unmet need in the context of supported self-management of EMA. Although our data are grounded in the early uncertainties of the COVID-19 pandemic, pain in EMA is a persistent and ongoing issue. We identify key ways in which expectations and experiences of pain could be improved.

4 IMPROVING ACCESS TO INTRAUTERINE CONTRACEPTION AFTER EARLY MEDICAL ABORTION AT HOME – A QUALITY IMPROVEMENT PROJECT

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Introduction The best method for improving access to post-abortion intrauterine contraception (IUC) has been studied for many years[1 2] and requires reconsideration as our services innovate and modernise.

Objectives Our local health board run abortion service has used multiple methods of arranging IUC following early medical abortion at home (EMAH). Due to concerns of both high DNA ('did not attend') rates in prebooked appointments, and low uptake when the patient is asked to arrange future appointments, each system was compared.
Methods For the first 12 weeks patients who stated that they wanted IUC were asked to call to arrange an appointment when they had a negative pregnancy test (PT) (3.5 weeks post-EMAH). For the following 12 weeks patients were instead given a convenient prebooked appointment, with an SMS reminder around 48 hours prior. A third method was then trialled with patients consenting to a telephone call in the week of their PT to discuss IUC, or being prebooked if preferred.
Results In the first group 16% of patients had IUC fitted, and the DNA rate was 7%. In the second, prebooked, group 45% of patients had IUC fitted but the DNA rate was high at 41%. In the final group in total 37% of patients had IUC fitted, and the DNA rate was 37%. The previous pattern was mirrored with a slightly higher IUC fit rate and DNA rate in the prebooked appointment subset (39% and 45% respectively) compared to the delayed telephone call subset (35% and 27%).
Conclusion Prebooking appointments appeared to give a significantly higher IUC fitting rate and a higher DNA rate compared to patient initiated IUC appointments, although high DNAs present significant costs to the service. Clinicians and patients value individualised choice and therefore a mixed approach of prebooking or arranging future discussion of IUC appears to give a good balance of IUC access and more acceptable DNA rates. Further study would be required to detect whether the cost of high DNA rates may be saved in fewer repeat EMAH procedures, or whether there are additional measures which could reduce DNA rates.

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