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Ensuring Safe and Informed Medical Abortion Practices: A Comprehensive Response to Recent Concerns

Response Letter to Published Article: Ir Med J; March 2024; Vol. 117, No. 3

In response to 'Medical Termination of Pregnancy – An Emerging Risk for Maternal Mortality'.

Dear Editor,

I am writing in response to your recent publication of a case report by Janjua et al. concerning the safety of early medical abortion(EMA) without ultrasound.

While the case report raises concerns about the diagnosis and management of ruptured ectopic pregnancy, it is crucial to contextualise these findings within the broader framework of established safety measures and empirical evidence used within a safe, accessible community model of care for the provision of early medical abortion in Ireland.

Firstly, it is essential to recognise the existing safety net within the Irish model of care and clinical guidelines for EMA provision in Ireland. This model incorporates rigorous training for healthcare providers, stringent protocols for risk assessment, and clear guidelines for the management of potential complications, including ectopic pregnancy. While the case report highlights a negative outcome, it is imperative to understand that a single case does not define the overall safety of the service. The Irish healthcare system is equipped with robust mechanisms to mitigate risks and ensure patient safety throughout the EMA process.

The assertion made by the authors that the report "highlights medical abortion is a risk factor for ectopic pregnancy" is inaccurate. EMA itself is not a risk factor for ectopic pregnancy; rather, the patient in this case was unfortunately already carrying an ectopic pregnancy before receiving EMA, and the risk of rupture is not affected by EMA. Therefore, it is misleading to suggest that EMA caused or exacerbated the ectopic pregnancy.

Providers of early medical abortion care in Ireland are trained to screen for ectopic risk, and where such a risk is deemed to be high, it can be mitigated by ultrasound (where gestation is greater than 6 weeks) or by a process of serial tracking of beta hcg level (where gestation is less than 6 weeks). However, the risk of ectopic pregnancy is 10 times lower in the abortion population than in the general population. Thus, insisting on universal ultrasound prior to EMA in the abortion population lacks evidence-based justification.

Additionally, in very early gestations, providing EMA may actually unmask an ectopic pregnancy before it becomes clinically evident.

Moreover, a large study from the UK (N= 52,142) Aiken et al provided additional insights into the safety of EMA without ultrasound. The study compared outcomes before and after the implementation of a telemedicine-hybrid model for EMA. The results demonstrated that treatment success rates, incidence of serious adverse events, and the incidence of ectopic pregnancy were not

significantly different between the traditional model with ultrasound and the telemedicine-hybrid model without ultrasound. Moreover, the telemedicine-hybrid model improved access to care, shortened waiting times, and was highly acceptable to patients. This evidence suggests that EMA without routine ultrasound screening can be both effective and safe when implemented within a well- designed healthcare system.

In conclusion, while the case report by Janjua et al. underscores the importance of vigilance and risk assessment in EMA provision, it should not overshadow the existing safety measures and empirical evidence supporting the safety of EMA without routine ultrasound screening. The Irish model of care, coupled with a large body of international evidence, ensures that EMA can be provided safely and effectively within a well-structured healthcare system.

It is essential to consider these factors when evaluating the safety and efficacy of EMA services and making informed decisions regarding clinical practice and policy.

Declaration of Conflicts of Interests:

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