

Abortion: choosing between medical or surgical abortion

Decision aid: user guide and data sources

Update February 2023

In February 2023 the decision aid for abortion before 14 weeks was updated to reflect the changes to the Abortion Act 1967 relating to supply and administration of medicines for medical abortion under 10 weeks gestation.

Background

Recommendation 1.2.2 of the [NICE guideline on abortion care](#) states:

1.2.2 Provide information about the differences between medical and surgical abortion (including the benefits and risks), taking account of the woman's needs and preferences. Do this without being directive, so that women can make their own choice.

Decisions about which method of abortion to have are highly preference-sensitive. They involve a trade-off between taking medicines to end the pregnancy or having surgery.

The 2 NICE decision aids for abortion before 14 weeks and abortion from 14 weeks to before 24 weeks can help healthcare professionals explain and discuss these trade-offs. They describe the possible risks associated with medical and surgical abortion, with icon arrays (diagrams) to illustrate the numerical data. The woman can review the information to help her decide which method of abortion is most suited to her circumstances and preferences.

Developing and updating the decision aid

The decision aids were developed by the NICE Medicines and Technologies Programme, and healthcare professionals and lay members of the guideline committee.

NICE decision aids are reviewed as part of the surveillance process for the guideline to which they relate. If the guideline and the relevant recommendations are modified, the decision aid will also be updated.

Sources of data

The NICE guideline did not review the evidence on medical versus surgical abortion before 13⁺⁰ weeks. All quantitative data on the likely effectiveness of medical and surgical abortion before 13⁺⁰ weeks are taken from the Cochrane review medical versus surgical methods for first trimester abortion ([Say et al. 2002](#)), forest plot analysis 5.1. All quantitative data on the risk of complications with medical and surgical abortion before 13⁺⁰ weeks are taken from the [Abortion statistics for England and Wales: 2018](#), data table 8.

The decision aid on abortion after 14 weeks and before 24 weeks is based on the evidence review on [medical versus surgical abortion between 13+0 and 24+0 weeks' gestation \(evidence review K\)](#), carried out for the NICE guideline on abortion care. All quantitative data on the likely effectiveness of medical and surgical abortion and the risk of complications are taken from GRADE table 3 and the associated forest plots.

Other information in the decision aids is based on the project group's expertise.

Medical abortion versus surgical abortion before 14 weeks

Abortion not completed with intended method

These data are taken from 1 randomised control trial (RCT) included in the Cochrane review by Say et al. (2002). The study included 111 women.

There was no statistically significant difference in number of abortions not completed with intended method for medical abortion compared with surgical abortion ([odds ratio](#) 2.12, 95% [confidence interval](#) [CI] 0.37 to 12.06).

Serious complication rates

These data are taken from the Abortion statistics for England and Wales: 2018.

The national abortion statistics report that:

- for abortions carried out between 3 and 9 weeks' gestation, complications (including haemorrhage, uterine perforation and/or sepsis) occurred in 1.2/1,000 women who had a surgical abortion and 0.7/1,000 women who had a medical abortion
- for abortions carried out between 10 and 12 weeks' gestation, complications occurred in 1.1/1,000 women who had a surgical abortion and 6.1/1,000 women who had a medical abortion.

Most (97.5%) medical abortions take place between 3 and 9 weeks, meaning the weighted average complication rate is approximately 1/1,000 women.

Medical abortion versus surgical abortion from 14 weeks and before 24 weeks

Incomplete abortion with the need for surgical intervention

These data are taken from 2 RCTs included in the evidence review on medical versus surgical abortion for the NICE abortion care guideline. The studies included 140 women.

Rates of incomplete abortion were statistically significantly lower with surgical abortion compared with medical abortion (2.8% vs. 13.0%, risk ratio [RR] 4.58, 95% CI 1.07 to 19.64).

Complications

These data are taken from 2 RCTs included in the evidence review on medical versus surgical abortion for the NICE abortion guideline. The studies included 140 women.

Information about the NICE decision aids on abortion: choosing between medical or surgical abortion

Several complications were reported in the studies:

- Bleeding: There was no statistically significant difference in rates of haemorrhage requiring transfusion or 500 ml or more blood loss in women having a surgical abortion compared with medical abortion (RR 0.21, 95% CI 0.02 to 1.72).
- Uterine injury: No women in the studies had a uterine injury (including rupture).
- Cervical injury: There was no statistically significant difference in rates of cervical injury needing repair in women having a surgical abortion compared with medical abortion (RR 0.34, 95% CI 0.01 to 8.29).
- Infection: There was no statistically significant difference in rates of infection reported within 1 month of abortion in women having a surgical abortion compared with medical abortion (RR 7.0, 95% CI 0.41 to 118.69).

References

Department of Health and Social Care (2018) [Abortion Statistics for England and Wales: 2018](#) [Accessed 1/08/2019]

Say L, Brahmī D, Kulier R et al. (2002) [Medical versus surgical methods for first trimester termination of pregnancy](#). Cochrane Database of Systematic Reviews, Issue 4. Art. No.: CD003037. DOI: 10.1002/14651858.CD003037.pub2.

2023 update

Aiken A, Lohr P, Lord J et al (2021) [Effectiveness, safety and acceptability of no-test medical abortion \(termination of pregnancy\) provided via telemedicine: a national cohort study](#) British Journal of Obstetrics and Gynaecology 128: 1464–1474

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