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Original research article

Results of a 4-year study on 15,447 medical abortions provided by privately practicing general practitioners and gynecologists in France

Sophie Gaudu[a,b,*], Monique Crost[c], Laurence Esterle[c]

[a]REVHO, Hôpital Tarnier, 89 rue d'Assas, 75006 Paris, France
[b]Centre d'orthogénie et de planification familiale, Hôpital Bicêtre, APHP, 78 rue du Général Leclerc, 94275 Le Kremlin-Bicêtre Cedex, France
[c]Cermes3, Inserm U988, CNRS UMR 8211, EHESS, 7 rue Guy Môquet, 94801 Villejuif Cedex, France

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Abstract

Background: The main aim of this study was to determine: (1) whether early medical abortion at home is a reliable and safe method when provided by physicians in their private practice outside abortion facilities, and (2) whether early medical abortions at home supervised by general practitioners (GPs) in their private practice have the same efficacy rate and the same safety as those supervised by gynecologists in their private practice.
Study Design: The data are drawn from a prospective survey of 15,447 in-home medical abortions up to 49 days after the last menstrual period (LMP), provided within the Ile-de-France abortion network between privately practicing physicians and hospitals (REVHO: *Réseau entre la ville et l'hôpital pour l'orthogénie*), from 2005 to 2008.
Results: Approximately 150 privately practicing physicians participate in the REVHO network, and over half of them are general practitioners. Three physicians, called the main providers, performed over half the medical abortions. The overall efficacy rate was 97.43% (96.48 % for the gynecologists, 96.44% for the general practitioners, and 98.31 % for the three main providers). The rate was higher when abortion completion was determined by a decline in serum human chorionic gonadotropin rather than ultrasound.
Conclusion: Early medical abortion at home supervised by gynecologists and GPs practicing in their private offices is a reliable and safe method. Promoting networks such as REVHO increases local accessibility to this type of abortion in France.
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Keywords: Early medical abortion; At home; Private practice; General practitioner; Gynecologist

1. Introduction

Using mifepristone for early medical abortion combined with a prostaglandin has been authorized in France and in China since 1988. In 2010, 46 countries had approved the use of mifepristone for medical abortions [1]. The effectiveness, safety and acceptability of this method for early medical abortions have now been fully demonstrated and account for its widespread use [2]. In many countries early medical abortion has been simplified by home self-administration of misoprostol which has been shown to be safe and acceptable [3–6]. In the United States (US) where mifepristone became available in 2000, self-administration of misoprostol at home has rapidly became a standard practice and over one million women have used this form of administration with the supervision of specialized clinics in almost all cases [7,8]. In France, early medical abortion at home was authorized in 2001 but was possible at first only under the medical supervision of doctors working in abortion facilities in hospitals or clinics.

In 2004, legislation made it possible for physicians — both gynecologists and general practitioners (GPs) — to provide at-home medical abortions in their private practices outside abortion facilities of hospitals and clinics [9]. The conditions for private practice are (1) abortions should take place within 49 days since the last menstrual period (LMP); (2) physicians must have the required training and professional experience and a partnership with a hospital abortion center able to treat the patient in case of complications. In France, doctors can easily be supplied mifepristone at local pharmacies and providing early medical abortion does not increase rates for their professional

* Corresponding author. Tel.: +33 145212399.
E-mail address: s.gaudu@revho.fr (S. Gaudu).

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insurance [9,10]. As a result, in France in 2009, 10.22% of the 222,137 surgical and medical abortions and 20.97% of the 108,247 medical abortions were supervised by private physicians outside abortion facilities [11]. The method will spread all the more rapidly if many physicians adopt it in their private practice.

In 2004, physicians practicing abortions in four hospitals of Ile-de-France (a region covering the city of Paris and surrounding areas) came together to create the REVHO (*Réseau entre la ville et l'hôpital pour l'orthogénie*)* network with privately practicing physicians. The aim was to develop the offer of at-home early medical abortion outside the hospital [9]. REVHO has been active since 2005 and is financed by the national health insurance fund. It provides theoretical and practical training to physicians and puts them in contact with a referral hospital for establishing a contract. By 2008, 4 years after its creation, 15,447 home medical abortions had been performed within this network by private physicians. A database on these abortions was created, using standardized medical records filled out by physicians for each patient. This prospective study presents the results from the statistical analysis of this large database. The main aim of this publication is to communicate results on the efficacy and safety of home medical abortions supervised by physicians, including general practitioners, in the context of their private practice. The second objective is to analyze differences in results and practices between private gynecologists and GPs. Finally, the goal is to demonstrate the relevance of a network between private physicians and hospitals for increasing access to abortion for women and encouraging private physicians, and particularly GPs, to provide early medical abortions in France.

2. Materials and methods

2.1. Database

A database was compiled on all abortions carried out in the REVHO network. The data were declarative and were routinely entered into the database from standardized medical records on each patient, transmitted by all private physicians involved in the REVHO network. This file included information on the patient (age, number of weeks of gestation calculated since the LMP, obstetrical history, etc.), the drug regimen used, the outcome of the abortion, any complications observed, and supplementary treatment administered. The patient data were de-identified and the database validated by the CNIL (*Commission nationale de l'informatique et des libertés*), the French national authority set up to protect privacy and personal data. The data were analyzed with Epi-Info™ software (6.04FR version). The statistical tests — chi-square for percentage comparisons and PROC GLM or t test for means comparisons — were carried out on SAS software (version 9.2). The differences were considered significant at $p \leq .05$.

There is no need for an institutional review board approval for this study.

2.2. Physicians and abortion clinics involved in REVHO

GPs and gynecologists in the REVHO network provide abortion in their private offices outside of hospital or clinic abortion facilities. In order to obtain authorization to perform medical abortions, physicians sign a contract with a hospital practicing abortions. The network provides training for GPs. At the end of 2008, 148 physicians and 22 hospital centers (10 of which were situated in Paris and 12 in the suburbs) were members of REVHO.

2.3. Medical abortion process

The patient requests an abortion during a first consultation in the private office of the physician of her choice, who assesses her eligibility for medical abortion treatment at home, gives her information on the procedure and orders additional tests [serum human chorionic gonadotropin (hCG) measurement, pelvic ultrasound to confirm gestational age, determination of blood group and Rhesus factor, etc.]. After a legally mandated 7-day interval, the patient has a second consultation in the physician's office where she signs an informed consent form. The physician gives the patient the mifepristone which she swallows in the presence of the doctor and the misoprostol which she self administers at home 48 h later. In addition, the physician writes a prescription for analgesics. The patient is asked to return for a follow-up visit 14–20 days later. Should secondary surgical aspiration prove necessary, she is referred to the referral hospital center. The total cost for the patient (excluding additional routine tests and treatment for any complications) is about €200, 70% of which is covered by national health insurance.

The maximum gestation period authorized for this procedure is 49 days after LMP, including the 7-day waiting interval.

2.4. Medical abortion regimen

The most frequently adopted regimen (49%) consisted of oral administration of 600 mg mifepristone, followed 48 h later by 800 mcg misoprostol. In 28% of cases, the regimen consisted of administration of 200 mg mifepristone, followed by 400 mcg misoprostol, and in 23% of cases 200 mg mifepristone followed by 800 mcg misoprostol. Regardless of the dose, misoprostol may be taken either per os, sublingually or buccally.

Abortion completion was evaluated either by pelvic ultrasonography, or by sequential hCG blood tests (the first before mifepristone and the second 12–14 days after). In

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