PEER REVIEW COMMENTS

Guidance notes:
Patient information aims to interpret a source document (RCOG Green-top guideline, Scientific Advisory Committee opinion paper or NICE Guidance) to women and their families/friends. One of the purposes of patient information is to assist women to make informed choices. The points below are intended to assist you, as a peer reviewer, to submit brief and structured comments:

- Please critically appraise the content and structure of the patient information in terms of the document being an accurate reflection the content of the source document, balanced, and unbiased.
- Please make your comments constructive, structured and brief.
- **Detailed copy-editing or layout comments are not necessary**, as this document will be edited and typeset before publication.
- Please disclose any conflicts of interest, although these do not preclude you from reviewing the document.
- The RCOG reserves the right to summarise and edit comments received, or not to publish them at all, where the comments are voluminous, publication would be unlawful or inappropriate.

Please email this form to Jessica Hayford at: jhayford@rcog.org.uk
Closing Date: 7th August 2023

Name of Peer Reviewer	Section / page number	Comments	FOR OFFICE USE ONLY PIC response to comment
CMF	**General**	It might be worth a comment near the beginning recognising that this is/can be a difficult experience and women may have mixed feelings. Relegating the very brief section on emotional support to much later in the leaflet, and using overly medicalised language (eg, 'expelling/removing the pregnancy') may not be adequately sensitive to women's experiences	
	Key Points	We note that the (BNF) standard definition of 'common' adverse events is anything with a frequency between 1% -10%. 'Uncommon' events have a frequency of 0.1% - 1%, and >10% is 'very common.' (https://bnf.nice.org.uk/medicines-guidance/adverse-reactions-to-drugs/). This is at odds with the wording of the draft leaflet. For example, in the Key Points box, it states that 'Complications are uncommon at any stage of pregnancy' but according to standard classification some complications are common (see next point)	
	Line 149	This is not uncommon – even assuming a figure of 1%-2% (see contrasting figures from NICE in next comment) - following a medical abortion; by definition it is 'common.'	
	Line 150-51	NICE states (https://www.nice.org.uk/guidance/ng140/resources/abortion-before-14-weekschoosing-between-medical-or-surgical-abortion-patient-decision-aid-pdf6906582255) that the need for surgery is 7% after medical abortion and 3.5% after surgical abortion. Again, this is 'common' according to the standard definition	
	Line 158-159	As explained above (and later re: infection), significant complications are common. Since what might count as 'serious' is somewhat subjective, and patients might consider something like RPOC/ERPC or infection serious, it could easily mislead patients by using vague terms like 'serious' when the reality is that substantive complications are indeed common. Understating risks misleads women and prevents them from making fully informed decisions.	
	Line 128	We suggest the line be added: 'You may decide not to proceed with the dose(s) of misoprostol – if you do, then the chances that the embryo/fetus will survive may be up to 20%.' This could also be mentioned around line 90 in connection with withdrawal of consent	

	Lines 92-98	In our view, the leaflet should strongly recommend these tests, not simply provide information about them, as there are risks attached to foregoing them. For example, the need for a blood transfusion for excessive bleeding in patients after medical abortion is estimated to be about 1 per 1000 women. A delay in cross-matching blood for transfusion could have serious consequences. Again, accuracy in dating a pregnancy is important, not least in order to know if it is within the timeframe for medical abortion at home, but also for the woman to avoid serious legal risks (eg, from the Carla Foster case) and medical risks (eg, unattended late-gestation abortions/deliveries, Rhesus isoimmunisation in later pregnancies not receiving anti-D). We believe an ultrasound scan should be part of routine care for these reasons and also, to rule out ectopic pregnancies. Failing this, the leaflet should at least recommend blood tests, physical examination or ultrasound – or at least clearly explain the risks of not having these. Along similar lines, the Royal College of Obstetricians and Gynaecologists (RCOG) recommends screening for Chlamydia and other STDs in all women having an abortion. (The care of Women Requesting Induced Abortion London: Royal College of Obstetricians and Gynaecologists; 2011). Clearly, this cannot be done other than by a face-to-face appointment.	

	Line 104	Is surgical abortion definitely available at all stages of pregnancy? Our understanding is that at very late gestations in the third trimester, induction would be the norm. It is unclear what surgical abortion would look like at this stage. Since many women want to know if abortion will hurt the fetus (for example, it is included in MSI's FAQ), it would be worth noting in the leaflet that there is disagreement about when fetal pain is possible, with recent research (Derbyshire SWG, Bockmann JC. J Med Ethics 2020;46:3–6) suggesting that the fetus may feel pain from as early as 12 weeks and certainly by 18 weeks. Some scholars suggest it could be earlier; others suggest later. This is at odds with RCOGs 2022 'Fetal Awareness Evidence Review' that suggested the fetus cannot feel pain until 28 weeks gestation (which has been critiqued here: https://onlinelibrary.wiley.com/doi/10.1002/ejp.2109). Provision of analgesia for late second and third-trimester abortions is not consistent across NHS Trusts (https://cmfblog.org.uk/2023/04/25/you-wouldnt-do-it-to-a-dog-current-fetal-pain-relief-in-nhs-abortions/). We urge RCOG to review its position on the need for fetal analgesia/sedation in late second and third stage abortions, so that it can include in this information leaflet a confident assurance for women in these stages that their fetuses will not experience pain in abortion. Failing this, please include in the leaflet mention of the controversy over when a fetus can feel pain – some say 12 weeks, others earlier.	
	Line 105	Clarify that some women may not have a choice because there are contraindications to medical abortion – rather than giving the false impression that both options should always be available to women to choose.	
	Lines 108-109	Clarify that bleeding typically lasts for 2 weeks and that it can last for some months. The leaflet should also explain clearly when to seek help for pain/bleeding with clear parameters.	
	Lines 174-176	RCOGs Abortion Clinical Guideline No. 7 quotes two UK studies into the incidence of infection following abortion, ranging from 0.92% - 2.54% for medical abortions of all gestations, and also notes that other studies suggest rates up to 10%. A Finnish study, also cited, reported an incidence of 1.7%, with no difference between medical and surgical procedures. As most studies suggest the rate is in excess of 1%, this is by definition a 'common' complication. In the interests of fully informed consent, we also suggest that to the end of the sentence in line 176 be added the phrase: 'that can result in infertility.'	

	Line 173	The latest meta-analysis from the leading researcher in this field (https://pubmed.ncbi.nlm.nih.gov/23553240/) indicates that women who have abortions for an unwanted pregnancy have elevated risks of anxiety, suicidality, drug abuse and alcohol abuse compared to similar women who continue an unwanted pregnancy, after adjusting for confounders. This meta-analysis is more recent and robust than the NCCMH/AMRC study normally relied upon by the RCOG to dispute this link. Rather than, or in addition to, generic comments about mental health, it is important that women know specific mental health outcomes relating to abortion. Studies demonstrate that the risk of abortion-specific PTSD following abortion range from around 1% to 14% (https://jamanetwork.com/journals/jamapsychiatry/fullarticle/481643 1.5% USA and https://pubmed.ncbi.nlm.nih.gov/15448616/). These findings are important to note because the symptoms are abortion-specific and therefore can confidently be causally related to the abortion. Women should also be told the risk factors for poor psychological outcomes after abortion, so they can identify whether they are at risk and therefore in more need of emotional support prior to, or after, the abortion. These risk factors are widely recognised and listed in the American Psychological Association's report on abortion and mental health and the NCCMH/AMRC studies.	

	Suggested additions	A link to the NHS pregnancy week-by-week website explaining the nature of the pregnancy at each stage for those who might wish to know. https://www.nhs.uk/pregnancy/week-by-week/ 2. As per NICE guidance, women should be alerted to the possibility that the fetus may make movements following a medical abortion (p12 https://www.nice.org.uk/guidance/ng140/resources/abortion-care-pdf66141773098693) 3. Alternatives to abortion – support, financial rights, legal/employment rights, adoption – and where they can access information and support, including from independent organisations (not only from abortion providers). 4. Women should be clearly told, in particular, that if the abortion is not their choice or is being pressured on them by someone else, that they cannot be forced to have an abortion and that there are options (ideally listed/named) to find support in situations of coercion. 5. Women should be informed that induced abortion is associated with a small increase in the risk of subsequent preterm birth, which increases with the number of abortions. (p44 https://www.rcog.org.uk/media/nwcjrf0o/abortion-guideline_web_1.pdf) 6. Signs of a ruptured ectopic pregnancy and when to seek emergency assistance. 7. Options for disposal/burial of the remains.	