



Editorial comment

Pain during pharmacologically induced termination of pregnancy

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In this issue of the Scandinavian Journal of Pain, Suhonen et al. [1] publish a study where they analyse pain during induced medical abortion and how pain may affect the perceived ability to stay at home during the treatment. They also studied how well these women remembered the intensity and unpleasantness of the abortion pain 3–6 weeks after the termination of pregnancy. Medical abortion was induced by the combination of the two drugs mifepristone and misoprostol. The uterine contractions following misoprostol will regularly cause pain in the lower abdomen. The reported pain intensity may vary, and in a Canadian study the mean maximum intensity was 6.2 (NRS pain 0–10) and 23% of the women reported NRS 9 or 10 despite analgesic therapy [2]. Medical abortion has replaced surgical abortion as the routine method in some clinics [3]. The easiness of this low tech treatment are welcomed by many but some politicians have even raised critical questions on ethical grounds and have questioned if it is too easy to have abortion.

There are surprisingly few controlled analgesic trials in this population [4] and it seems like the meagre evidence may have led to insufficient treatment and great variation between abortion clinics [5]. The combination of adequate doses of paracetamol and a non-steroid analgesic drug (NSAID) for acute pain is well documented [6,7], but is probably still not implemented in standard analgesic treatment. The British guidelines for medical abortion published by The Royal College of Obstetricians and Gynaecologists even conclude, in a separate paragraph about pain, that “Requirements for analgesia vary and there is no benefit in routine administration of prophylactic analgesics” [8]. Some recent, well designed randomized controlled trials of pain relief during medical abortion have documented the efficacy of paracetamol or ibuprofen, the latter being the most efficacious [9].

Surgical termination of pregnancy will also cause pain, but the duration is shorter, and analgesic treatment will be provided by personnel in the post-anaesthesia care unit. Hopefully, most of these women will have adequate doses of both opioid and non-opioid analgesics during their stay. A recent publication in Pain documented that pain after surgical abortion can be effectively relieved by transcutaneous electrical nerve stimulation (TENS) and

that this treatment was more effective than i.v. fentanyl [10]. There is reason to believe that TENS could produce significant pain relief during medical abortion too.

We should be concerned by the reports of moderate or severe pain during pharmacologically induced abortion. We therefore welcome the study by Suhonen et al. [1] who have studied a population where recruitment into scientific trials is hard. The evidence produced by this study may be questioned, and the extent of generalisation it permits is modest. They have documented that the degree of pain and unpleasantness during medical termination of pregnancy is, as expected, negatively related to parity. The women also assessed their expected ability to staying at home. They were asked to do this assessment both during the treatment in the clinic and 3–6 weeks later as they registered the remembered pain intensity, the degree of unpleasantness, and finally, reassessed their ability to go through the treatment at home. The study documented a fair correlation of pain, and a good correlation of unpleasantness, 3–6 weeks after the procedure. A recall bias of pain is expected and well known, and this is not a major point in the study. The authors refer in the conclusion to a previously published study that documented that peak pain and pain at the end of a painful procedure are expected to be recalled with reasonable accuracy [11]. However, the memory of the unpleasantness during the medical termination of pregnancy were more reproducible. The impact of psychological and social factors was only briefly mentioned in the article and should be kept in mind when studying symptoms in connection with abortion [12].

The study does not answer the question about how the experience of medically induced abortion affects the choice of medical or surgical abortion in the future. They did not register whether the women who had a previous abortion had experience with medical abortion or if all had surgical termination of pregnancy. These limitations may be solved in a future study, which also needs to be larger. The implication for clinical practice is that these patients need better care and that there may be room for improvements in the analgesic treatment. Practice guidelines for medical abortion should include recommendation for adequate doses of both paracetamol and NSAIDs.

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