Pain and Abortion

Women's perspective, including cultural aspects

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- If women have the choice, they cope better

Surgical abortion

- Surgical abortion is a very safe procedure

- local anaesthesia is safer than general anaesthesia.
- This has been repeated by:
  - WHO (2003)
  - RCOG (2004)
  - ANAES (2001).

United Kingdom: Sam Rowlands, Patricia Lohr, J Spencer

- 205 000 abortions/y
- National Health Service: 75 000 ab/y: **Gen Anaest**
- Private non-profit organisations: 130 000 ab/y
  - **BPAS**: 53 000 ab **69% surgical abortions**
    - **Local Anaesthesia** (97% MVA, < 12w; if medical risk): **4%**
    - Conscious sedation: one case
    - General Anaesthesia: 96%
  - **Marie Stopes Int**: 68 355 ab **77% surgical abortions**
    - **Cervical block: not used**
    - **Anaesthetic gel in endocervix : 14%**
    - Conscious sedation: 61%
    - General anaesthesia: 25%

The Netherlands: Janna Westerhuis

- Abortion clinics: 94% of abortions (up to 22w)
- 2006: surgical abortions : 85.9%

  – Surgical abortion: **65% local anaesthesia**
  – 14 abortion clinics:
    - 5: general anaesthesia is always possible
    - 5: only local anaesthesia
    - 4: general anaesthesia possible on some days

Spain: Eva Rodriguez

- **80%** of abortions are done in abortion centres authorised => 12w with **local anaesthesia only**

- 20% in abortion centres authorised for 2nd trimester => patients can choose
  - 80% done under sedation (Drs prefer)
  - **Women choose more and more for sedation if they have the choice**
  - After 12w => sedation, general anaesthesia, epidural

Sweden: Kristina Gemzell

- Medical abortion: 53.2% in 2005
- No statistical data on method of anaesthesia
- The woman can choose local, general anaesthesia or conscious sedation ??
- Some centres may not offer all techniques every day
- Karolinska Institute: 1400 ab/y
- 2nd trim: 200 cases: all medical abortions
  - **Up to 9 w: 30% surgical**
  - nearly all under general anaesthesia
  - **Recently moved from all local to general anaesthesia**

Austria: Christian Fiala

- No statistical data on method of anaesthesia
- Most gynaecologists use general anaesthesia
- 2 doctors offer local anaesthesia
- **Vienna**: **44% surgical abortion**
  - **Local Anaesthesia 11.4%**
  - General Anaesthesia 88.4%
- **Salsburg**: **66% surgical abortion**
  - **Local Anaesthesia 9.1%**
  - **General Anaesthesia 90.9%**
- **Anaesthesist** comes on special days for GA

Italy: Mirella Parachini

- **Local Anaesthesia:**

- **2003 13%**
- **2006 12.4%**

Germany 2007 Christian Fiala

Statistisches Bundesamt Scwangerschaftsabbruche 2007

- Surgical abortion: 87.4%
  - **Local anaesthesia: 7%**
  - General anaesthesia: 93%

France Philippe Lefebvre

- Surgical abortion: 60%

- **Local anaesthesia**
  - **2002: 36.5%**
  - **2006: 33%**

  - Private clinics: more general anaesthesia
  - No real choice for women
  - Choice depends of structure and abortion providers

Belgium 2011

(national evaluation commission)

- Abortions performed in Hospital **19 %**
- In outpatient Abortion centres **81 %**

- Medical abortions **19 %**

	Hospital	Centres
Medical abortion	**33%**	**18%**
Surgical abortion:		
– **Local anaesthesia**	**28%**	**97,4%**

- Real choice is not realy available

Belgium

- The outpatient abortion centres who provided abortions when abortion was still illegal, were legalised in 1990 and so was the way they worked.
- In 2002 we finaly obtained reimbursement of abortion in outpatient abortion centres (for women with state medical insurance: RIZIV-INAMI)

Belgium

- **Convention**:
- The abortion centre recieves **445** euro for (pre-ab-post)
- The woman paies 3,5 euro
- It is forbidden to ask the woman more money
- The convention with does not foresee an anaesthesist, and it is forbidden to offer sedation analgesia without anaesthesist in Belgium…
- => **women in outpatient abortion centres have no access to sedation nor general anaesthesia**
- We were advised not to ask for a change of convention because the rightwing government could want to cut costs for abortion (financial crisis)
- **Maybe society thinks it is acceptable for women to feel some pain during the abortion….**

Possible reasons for the huge regional differences?

- **Certainly not women's choice!**
- Routine habits in hospitals
- The hospital earns more money if the procedure is done under general anaesthesia
- Poor management of local anaesthesia, so that the procedure is too painful => general anaesthesia
- No proper accompaniment available in surgery wards of hospitals
- A growing number of women choose "not to be there" at the moment of the abortion
- General anaesthesia is no option in most outpatient abortion centres

Abortion: experiences of women: Belgium

Conseur , Marco Anelli 2002 (5 consumer org Europe)

- **How painful** was the abortion procedure?
  1/3 had more pain than they expected
  - 1-3 24.5%
  - 4-5 17.6%
  - 6-7 20.3%
  - **8-10 37.5%**
- **Evaluation of care** you recieved in ab. Centre
  - 1-3 0.8%
  - 4-5 0.4%
  - 6-7 6.5%
  - **8-10 92.3%**

– **Since then we did improve our technique!**

Emotional Support

Doula support Am J Obstet Gynecol 2014

- **during 1st trim surgical abortion**
- Although doula support did not have a measurable effect on on pain or satisfaction, 96% of women (who had recieved doula support) recommended it for routine care and 60% indicated interest in training as doulas !
- Less additional clinical staff needed (2,9% versus 14,7%; $p < 0,01$)

Emotional Support: Music

- **Music during 1st trim surgical abortion local anaesthesia**
  - **Decreased pain** (Contraception may 2010 Renner: Shapiro 1975)
  - **No effect on pain** (Contraception may 2012) earphones, selected from pre-loaded tracks
    - Trend towards less anxiety postprocedure ($p = .065$)
    - Better coping ($p < .05$)
  - **More pain** (Contraception august 2012) self-selected favorite music; headphones
    - No interaction with the provider => more anxiety & pain ?
    - Listening to music is a good idea: 91%
- **Slow nonlyrical music, 60 decibel, external speakers**

Interaction with staff is important!

Emotional Support and more…
medical self-hypnosis

- Emergency medicine
- Interventional radiology: costeffective Dr Elvira Lang
- Diagnostic procedure: lumbal, bonemarrow punction
- Dental treatment
- Dermatologic treatment: burns
- Thyroid operations: Prof Dr Faymonville (university Liège)
- Breastcancer operations: University hosp St Luc Brussels

medical hypnosis

Congrès Hypnose GGOLFB

1/6/2013

Hypnose et chirurgie carcinologique du sein

Christine Watremez UCL

Effet placebo, effet nocebo

Maurice SOSNOWSKI ULB

Mastectomy under local anaesthesia & hypnosis in the UCL university hospital

- A woman said: I had the feeling to participate actively in my treatment and my healing
- By learning self-hypnosis, the woman has tools to cope with further treatments and other painfull experiences
- Shorter hospital stay (significant)

- The central perception of pain diminishes (- 50%)

Mastectomy under local anaesthesia & hypnosis in the UCL university

- Essential
  - Motivation of the patient
  - Confidence
  - Collaboration
- 90% of people can go in trance
- Some African patients are used to trance

Hypnose in the operation theatre: **how does it work?**

- **Consult surgeon**: proposition of hypnose, explanations by the surgeon
- **consult anaesthesist** (takes **10 min longer**)
- The whole team of anaesthesists had a special training about hypnosis
  - speak about finding a « secure place »: during the surgery, daydream away to a secure place where you feel good
- Explain the surgical procedure in detail so that the patient knows what is going to happen (so there will be no bad surprises)
- **in the operation theatre:** Evt premedication with Alprazolam;
- The patient says what her « secure place » is
- « Signaling » : small sign with a finger if not comfortable :
- infusion: Remifentanil if needed (0,05µg/kg/min); NSAID
- Fixation of the eyes, install the patient in her « secure place » in a deep and stable trance by speaking to her.
- Desinfection, lidocaine 0,5% et levobupivacaine 0,25% +/- adren
- Wait , then start the surgery; **the operation time is not longer**
- During the periods of silence: touching the patient is important (touch the forehead)
- My voice goes with you and keeps you safe (Ma voix vous accompagne en toute sécurité)

Hypnosis: Effect on the brain can be seen on PET scan

- Anterior cyngular cortex is in charge

- No endorphine: Naloxone does not inhibit the effect of hypnosis analgesia (analgesia starts and stops immediately)

Placebo, Nocebo

- **Nocebo effect**: beta-blockers & erectile dysfonction
  - Pts who ignore the side effects 15,6%
  - Pts who were told the risk 31,2%

  Nocebo effect of internet! Dr Google

  Patients can ask **not** to be told the side-effects
- **You give a given painkiller**
  - You don't say anything => a small effect
  - You say you are giving a strong painkiller => effect >>>
  - You say: we need to give you a painfull injection. => the effect of the painkiller is antagonized
  - You say: I will give you a painkiller but I doubt it will have an effect at this dosis! => painkiller is antigonised

Effect on the brain

- **Placebo effect: opioïd system**
  - Not the same zones in the brain that are activated with placebo and hypnosis
  -
- **Nocebo effect: CCK (cholecystokinine)**
- A nocebo suggestion provoques hyperalgesia via hormones of the hypothalamo-hypophyso-corticotropic axix and cortisol

Avoiding negative suggestions

- Negative expectations and anxiety: more pain is felt: hyperalgesia
- **If the woman recieves a painkilling injection**:
- If you use **negative words** like pinch, burn and sting to « warn » patients, the sensation will be more painfull or unpleasant; the words become a **self-fulfilling prophecy**
- Patients are likely to « feel » what they have been told they will feel
- You can say: I will give you the local anaesthetic now; it will put the cervix to sleep.
- In MRI, you can hand the patient the « call button » instead of the « panic button »

Avoiding negative suggestions

- Don't express **doubts**:
  - Lets try this medicine: sometimes it helps
- **The inconscious ignores negation!**
  Vasectomy does (**not**) stimulate prostate cancer
- **Each question is a powerfull suggestion** and should have a positive content
  - Do you feel cold ?
  - Are you warm enough?
- **Painscores => confortscore**
  - When you say the word « pain », the pain zone is activated in the brain

hypnosis in abortion care

(Isabelle Marc AJOG 2008)

- Open randomized trial
- 350 women divided in two groups
- Standard care: Ibuprofen, paracervical block, and on request: IV sedation analgesia (fentanyl and midazolam)
- Hypnotic group: in addition to standard care, an intervention by a hypnotherapist 20 min before and throughout the surgical procedure

hypnosis in abortion care

(Isabelle Marc AJOG 2008)

- Results:
- Women who underwent hypnosis required **less intravenous sedation analgesia**:108/172 (**63%**) than the control group: 149/175 (**85%**) (p<.0001) and self-reported no difference in pain, but not in anxiety.
- Ccl: hypnotic interventions can be effective as an adjunct to pharmacologic management of acute pain during abortion

hypnosis in abortion care

(Isabelle Marc Womens Health 2009)

- High level of women's satisfaction:
  - Resume normal activities right after the abortion
    - Hypnosis: 72% control group: 56%
  - Appreciation of accompaniment during procedure
    - **Hypnotherapist: 97%** nurse: 56%
  - For women in the hypnosis group: **97% would recommend hypnosis** to a friend for a similar procedure
  - 98% would again volunteer in studies evaluating hypnosis for pain management
- **Hypnotic interventions can improve pain management and care**

Emotional Support: Respect for rituals

- Ellen is 35 and has 4 children (youngest 7 mths)
- She stopped breastfeeding, was waiting for menses to start the pill; condom broke, no EC
- Both families live very far away: no practical help
- She feels guilty and unhappy that she cannot accept this baby with enthousiasm and love like the others
- Before the surgery, she asks for 5 minutes of silence: she needs to meditate
- After she tells us: I needed to say goodby, to explain to the baby why I could not keep him
- She is very gratefull we respected her wish
- It diminished the emotional pain of her abortion

Emotional Support: Respect for rituals

- To ease emotional pain, some women want:
- A foto of the ultrasound
- A bit of the gestational sac to burry

Empathic respectfull listening

- Women coming for abortion may have the need to express conflicting feelings !
- Abortion is still a big taboo and many women can't talk to their friends nor family about it, so its important they can talk to someone who listens with empathy!

Empathic respectfull listening

- Listen to **all** expressed feelings:
  - Pride
  - Sadness
  - Shame
  - Anger
  - Hate
  - Guilt
  - Helplessness
  - Ambivalence
  - I was always against abortion, and here I am!
  - I love children, and now I am going to do an abortion!
  - Abortion was ok for others, but I would never have one!

Usefull information to tell women

- Most women are releaved
- You are not alone!
- Unplanned pregnancy can happen to (nearly) all of us
- By the age of 50, depending on the country, 1/2 - 1/7 of women will have needed an abortion
- If you take 10 women of 50 years old, certainly a few will have had an abortion

Early Medical abortion

- No child => risk that it will be more painfull
- Greater gestational age => greater pain
- Painfull menses => painfull medical abortion

- **Most women prefer home-use of misoprostol**

- Proper painkillers available (Ibuprofen or diclofenac and codein or tramadol if needed; paracetamol is not effective)
- Taking NSAID before the misoprostol is not more effective than taking it when there is pain!

Early Medical abortion

- At home she can move as she wishes
- Warm water bottle, coldpacks
- With partner or friend to help
- Personal phone support: It is ok for me to call!
- Support by text messages following mifepristone
- **So women can better manage pain and bleeding by reducing anxiety and stress**

Early Medical abortion

- Women who prefer to stay in the medical structure should be able to do so, with proper emotional support and access to IM NSAID painkillers (in case of vomiting, diarhee) and narcotic analgesia (codein, tramadol)

Second trimester medical abortion

- in hospital, epidural or rachi anaesthesia should be offered (start before administration of misoprostol)
- Of not available : NSAID and narcotic analgesia.

Conclusion: surgical abortion

- In Europe there are huge differences in the way surgical abortion is managed, and it is impossible that this reflects women's choice.
- Local anaesthesia is, medically speaking, safer than general anaesthesia.
- With a proper technique (priming of the cervix, local anaesthesia, oral painkillers) and a good accompaniment, it is acceptable by most women.
- Hypnosis, Doula's and Music can be of further help
- **Do we have to fight to have more local anaesthesia?**
- **Or should we fight for the right of women to choose which anaesthesia they want for their abortion, and make it available ?**

Conclusion

- Besides adequate pain management:
- Each woman needs to feel the empowering support and respect from care providers
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- It will help her to cope and respect herself; help her to take the right decisions needed to get on with her life in a positive way