

## A Randomized Trial Comparing Oral Misoprostol With Intra-Amniotic Prostaglandin F<sub>2α</sub> for Second Trimester Terminations

### To the Editor:

I read with interest the November 2005 Marquette et al. article on second trimester dilation and extraction (D&E).<sup>1</sup> My thanks to the editors for publishing this, as there are few Canadian articles on second trimester abortion. However, I have some concerns, both from a medico-legal point of view and regarding appropriate treatment recommendations.

First, I would like to challenge the authors on their statement that “the study investigators were not involved in the decision to terminate any pregnancy included in this trial.” Since a 1988 Canadian Supreme Court decision, abortion has no longer been a criminal offence,<sup>2</sup> and it has been a woman’s choice to have an abortion. The therapeutic abortion committees (which were established from 1969 to 1988 in many hospitals in Canada) are no longer needed. Now, if a woman decides that it is in her best interest to terminate a pregnancy, she can seek care directly from a provider. Neither the physician nor any investigator has any role in that decision but should treat her only after adequate training in safely performing this procedure.

Second, I would like to challenge the authors on their statement that “the 12-hour interval between insertion of laminaria and initiation of medication would allow patients time to reflect on and confirm their decision to proceed with termination of the pregnancy.” In second trimester abortions, the insertion of the laminaria, as a safe and effective means of dilatation, is considered the start of the procedure. A woman should be fully informed about the entire process and feel that her decision is clear and not coerced before any intervention is initiated.<sup>3</sup> Fully informed consent to the procedure should indicate that the process starts with the laminaria and ends with the expulsion of the fetus, following induced contractions, suction curettage of the placenta, or by surgical extraction of both fetus and placenta.

Third, I would like to challenge the authors on their recommendation that the process of medical abortion be considered even when an intact fetus is not required for pathological review. For the woman, the dilation and extraction (D&E) procedure is more comfortable, private, and safe. Is there any other situation in medicine for which we would recommend a procedure with a 30% to 40% rate of failure that includes overnight hospitalization and emergency treatment? In this group studied, only 75 of 117 patients succeeded in having the abortion by this method. D&E has a 1% complication rate,<sup>4</sup> requires less time in hospital, and can be planned. The problem not addressed in the Discussion section is that few hospital training programs in the country teach this procedure routinely. In practice, D&E is performed in outpatient facilities by family physicians and gynaecologists for women seeking pregnancy termination.

In conclusion, while we search to find better, safer, and less expensive way to provide second trimester terminations, this must be considered in the context of a woman’s life and in the current legal and medical framework. I am disappointed to see that some of the myths surrounding abortion are perpetuated in this article. I am also startled that there is no concluding recommendation to promote access to trained providers, as well as appropriate and widespread training in techniques that offers a woman a safe effective end to an unplanned and unwanted pregnancy.

**Konia Trouton, MD, CCFP, MPH, FCFP**  
*Medical Director, Vancouver Island Abortion Services*

### REFERENCES

1. Marquette GP, Skoll MA, Dontigny L. A randomized trial comparing oral misoprostol with intra-amniotic prostaglandin F<sub>2α</sub> for second trimester terminations. *J Obstet Gynaecol Can* 2005;27:1013–8.
2. *R. v. Morgentaler*, [1988] 1 S.C.R.30.
3. National Abortion Federation, Clinical Policy Guidelines 2005.
4. Jacot FR, Poulin C, Bilodeau AP, Morin M, Moreau S, Gendron F, et al. A five-year experience with second-trimester induced abortions: no increase in complication rate as compared to the first trimester. *Am J Obstet Gynecol* 1993;168:633–7.

**In Response****To the Editor:**

We thank Dr Trouton for her interest and comments about our published trial.<sup>1</sup> It is unfortunate that even after many revisions of this manuscript some details of this trial remain unclear.

The authors fully agree with a woman's right to choose to terminate a pregnancy. The intent of the Methods section was to state that the authors were not involved in the consent process for termination of pregnancy or the patient's choice of the method of termination. The investigators did not want to be in a position to coerce patients into choosing a medical method of termination and then approach the same women to ask for their participation in this randomized trial of two methods of medical termination.

The investigators also agree with Dr Trouton's second statement that the procedure always starts with insertion of laminaria. In the Introduction section of the manuscript, the text could be misleading. The Methods section states more clearly the intent of the trial: at the end of this 12-hour interval, the patient was asked to sign the consent to this study, not to confirm her intent to continue with the process of termination. All patients were fully informed in order to consent to this trial. At the suggestion of the ethics committee of our institution, the patients signed the consent after this 12-hour period only to re-address the issue of participation in the study. If the patient declined participation in the study, the usual method of medical induction could thus be instituted without delay.

We also agree with Dr Trouton that there was high rate of failure amongst the 117 patients that participated in this

study. On the other hand, only 6 of the 59 patients randomized to the misoprotol group required a dilatation and curettage (D&C) to complete the termination. The present study did not compare dilatation and extraction (D&E) to medical abortion; it was never the intent. All patients had already chosen a medical termination prior to participating in this study. There is a lack of data in our literature on abortion regarding patient preference of method of termination during the second trimester. We cannot assume that D&E would necessarily be the method of choice for all women.

Dr Trouton's conclusion is appropriate in the sense that there are few training programs that address the issue of the lack of providers skilled in the surgical technique of D&E. Although the investigators may agree with this statement, the present trial was not developed to study this issue; therefore, it was never addressed in our Discussion or Conclusion. Finally, as experienced providers of second trimester terminations, we remain committed to offering choice to women and to providing the chosen method without bias.

**Gerald Marquette, MD, FRCSC,<sup>1</sup> Amanda Skoll, MD, FRCSC,<sup>1</sup> Lorraine Dontigny, MD, FRCSC<sup>2</sup>**

<sup>1</sup>*University of British Columbia, British Columbia Women's Hospital and Health Centre, Vancouver BC*

<sup>2</sup>*Université de Montréal, Centre hospitalier de LaSalle, Montréal (Québec)*

**REFERENCES**

1. Marquette GP, Skoll MA, Dontigny L. A randomized trial comparing oral misoprostol with intra-amniotic prostaglandin F<sub>2α</sub> for second trimester terminations. *J Obstet Gynaecol Can* 2005;27:1013–8.

**ERRATUM**

Vol. 28, No. 2, February 2006, Image of the Month entitled: "Vesicovaginal Fistula With Bladder Eversion: A Rare Complication of Third Degree Cervical Descent." On pages 160 and 161, the captions for Figure 1 and Figure 2 were accidentally reversed.

We apologize for the error and any inconvenience it may have caused.