I am grateful to Dr Al-Hassan for giving me the opportunity to clarify the safety of oestrogen supplements for the prevention of menstrual migraine.

As mentioned in the review, compared to non-menstrual attacks, menstrual migraines are more severe, have a higher rate of response to symptomatic treatment and more likely to relapse.1 Prophylaxis for menstrual migraine is indicated when acute therapy does not adequately control symptoms.1,2 Short-term perimenstrual prophylaxis is targeted to intervention at the time of need, limiting potential side effects of medication to a few days rather than throughout the cycle. As Dr Al-Hassan emphasises, it is important that such treatments are safe.

Regarding the concern about migraine aura, menstrual migraine is, by definition, without aura so the issue of using oestrogen supplements for prophylaxis is of concern. It is not safe to use oestrogen supplements to bridge the interval between the luteal phase oestrogen decline and the follicular phase. A recommended dose of oestrogen, 100 µg patches provide plasma levels of oestrogen of the order of 382 ± 232 pmol/l (i.e. maintaining luteal phase levels).5 On this basis, the risk of ischaemic stroke associated with perimenstrual supplements should be no greater than the risk associated with the normal menstrual cycle.

In contrast to physiological doses of natural oestrogens, combined hormonal contraceptives (CHCs) contain potent synthetic oestrogens in order to suppress ovulation. Even when taken by healthy women, CHCs are associated with a small but measurable increased risk of ischaemic stroke. This risk has not been shown for natural oestrogens used by perimenopausal women.6 It is unclear why, in their evidence-based response, the Clinical Effectiveness Unit have extrapolated data regarding increased risk of ischaemic stroke in women with migraine associated with use of CHCs to imply that the same risk is associated with use of physiological doses of natural oestrogens.7 In addition, since there is evidence that risk of stroke is associated with frequency of migraine, one could speculate that preventing attacks might be associated with reduced risk.8

On that note, Dr Al-Hassan remarks on delayed migraines following perimenstrual prophylaxis with non-steroidal anti-inflammatory drugs. This has also been shown with perimenstrual prophylaxis with oestrogen and with naronatriptan.9,10 From a clinical perspective, although this can be a problem for individual women, it is not a problem for all. It is usually resolved by extending the duration of perimenstrual prophylaxis and tapering the dose or, as Dr Al-Hassan correctly notes, by continuous prophylaxis.

Finally, prohibiting use of CHCs in women with migraine without aura who have more than one additional risk factor for stroke such as age over 35 years, smoker or obesity.11

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Review of abortion laws
Ann Furedi is the most recent voice to call for a review of the 1967 Abortion Act,6 seeking to set aside some of the checks and balances, which she believes are restrictive. Others, however, feel the laws are too liberal and should be tightened.12 Whatever might have been the case behind the Act, it was well crafted with the interest of the woman uppermost and remains as relevant today despite its 40-year-old age. There are sufficient checks and balances in place to allow women access to terminate unwanted pregnancies, by trained people who want to provide the service in regulated premises to ensure safety and avoid morbidity. The Act does not need amending either one way or the other. Advocates in medicine are occurring all the time and some of these have been incorporated into providing abortions without a need to amend the Abortion Act (e.g. nurse-led medical abortions).12

There is concern, however, that numbers of terminated pregnancies continue to rise, although this is not always the case.13 The National Institute for Health and Clinical Excellence (NICE) has recommended long-acting reversible contraceptives of choice,14 yet these remain poorly promoted and not readily available to women for general practice prescribing. More effort needs to be put into preventing unwanted pregnancies in the first place by effective and reliable contraception. If there were no unwanted pregnancies there would be no requests for termination of pregnancy.15

The National Institute for Health and Clinical Excellence (NICE) has recommended long-acting reversible contraceptives of choice, yet these remain poorly promoted and not readily available to women for general practice prescribing. More effort needs to be put into preventing unwanted pregnancies in the first place by effective and reliable contraception. If there were no unwanted pregnancies there would be no requests for termination of pregnancy.

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3 Brechin S, Stephen G. Members’ Enquiry Response, Reference 1136. Faculty of Family Planning and Reproductive Health Care Clinical Effectiveness Unit, 1 July 2005.
Caesarean section and the competent pregnant woman to have abortions. While the two scenarios may appear similar, they are in fact very different and cannot readily apply. While a competent pregnant woman can always expect to have her refusal of the offer of a Caesarean section respected, a competent pregnant woman cannot at all times expect to have her request for a termination of pregnancy to be honoured. The abortion law as it stands now is robust enough to be needed by all amendments. The delivery of abortion services may be poor in some areas. The solution in such areas is to implement guidelines published by the Royal College of Obstetricians and Gynaecologists (RCOG), which should ensure a high-quality service nationwide, rather than seek to amend the Abortion Act.

Abortion is an emotive issue for all concerned. We should direct our energies towards reducing the number of women aborting by implementing the NICE guidelines on LARC nationwide. This approach will yield better results than an amendment of the Abortion Act.

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References

Reply
Umo Esen is right to argue that the Abortion Act 1967 was “well crafted”, and my earlier article concurred that it has “served women, and their families reasonably well.” It is also true that a liberal interpretation of the law has enabled safe, legal abortion services to develop far more effectively in Britain than in many other countries with legislation that appears less restrictive. However, it is incumbent to conclude that a review of the law is not needed and wrong to assert that it does not require change. There are several areas where the law impedes good clinical practice.

The Royal College of Obstetricians and Gynaecologists guidelines state that women should be able to access a termination as early as possible, because the earlier in pregnancy an abortion is performed, the lower the risk of complications. Ideally, the guidelines state, the abortion should be able to take place within 7 days of the decision being agreed and with a minimum of 24 hours’ notice of the procedure within 2 weeks. The legal requirement that two registered medical practitioners certify that a woman meets the legal criteria for abortion frustrates this by creating the potential for unnecessary delay.

Despite an acknowledged shortage of doctors willing to carry out abortions, nurses and midwives are prevented from carrying out procedures, such as manual vacuum aspiration, which are performed by colleagues in jurisdictions with equivalent qualifications in other countries, because the Abortion Act specifies that abortion is only lawful when carried out by a “registered medical practitioner”, which is interpreted as a General Medical Council registered doctor only. This remains the view of the Department of Health despite challenges that the law could be interpreted differently. Women undergoing early medical abortion with mifepristone and misoprostol are required to make additional, unnecessary clinical visits because both medications are regarded as abortifacient and so must be administered in a hospital or licensed premises. In other countries, such as the USA, it is possible for women to administer the misoprostol herself at home, thus reducing the cost and inconvenience of the procedure.

Doctors’ ability to interpret statutory ground C (section 1(1)(a) of the Act) liberally to allow the abortion of all unwanted pregnancies has allowed the law to meet the needs of modern society. But, this openness to interpretation means that women can never be confident that their abortion request will be viewed sympathetically. Often, women feel they need to exaggerate their distress in order to pretend that they will be psychologically damaged by their pregnancy, while their doctors pretend to believe them. This is a charade that demeans them both.

Women living in Northern Ireland suffer the additional burden of being required to travel to Britain for treatment as this part of the UK is excluded from the provisions of the existing Abortion Act.

It would be far better to have a law that specifically allows a woman to end a pregnancy that is unwanted for any further justification, and permits abortions to be carried out by persons, and in premises, that are able to provide adequate care and support. Access to abortion should be available to women who request it, and regulated by the same principles and standards as other clinical procedures. We can all agree that it would be better if unwanted pregnancies were prevented, and that increased use of long-acting reversible methods of contraception may contribute to this end. However, these methods are not suitable for, or acceptable to, all women. The rising number of abortions demonstrates that abortion is necessary as a backup to other methods of birth control, and this is likely to remain the case in a society that has a liberal attitude to sexual activity and values planned parenthood. Our experience is that the social stigma of abortion is lessening in pragmatic response to this.

My earlier commentary argued that women, and their doctors, deserve “a flexible, fit-for-purpose law accepting that restrictions on abortion should be solely to protect health”. The current review of the medical and scientific aspects of abortion by the House of Commons Science and Technology Select Committee and the forthcoming discussion of the Human Tissue and Embryos (draft) Bill provide an opportunity for Members of Parliament to align our abortion law with modern thinking.

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References

Remember 1967? We do…
I read the comment from the Journal’s Consumer Correspondent in the July issue with great interest. I was 2 years old when the Abortion Act was passed and I have been actively pro-choice since I was 14 years old. It’s very interesting to note that the respondents to Ms Quilliam’s questions have changed their views so much in the intervening 40 years. During that time it seems we have lost the ability to remember women dying from unsafe and illegal abortions in the UK, so the necessity for the law seems less urgent. As Quilliam notes, there still needs to be much better access to sex education and contraceptive services, particularly for young people. The fact the UK leads Europe in unwanted pregnancy suggests that young women are not all turning to abortion as the solution to their unplanned pregnancies. Unfortunately, young people are amongst the most anti-choice because they have unrealistic expectations of parenthood. If frank information about sexual health and family planning could be better presented for young people we could start to genuinely turn this situation around.

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Reference

LETTERS TO THE EDITOR

Letters to the Editor are welcome and generally should not exceed 600 words or cite more than five references. For comments on material published in the most recent issue of the Journal, correspondence should be received within 4 weeks of dispatch of that issue to be in time for inclusion in the next issue. When submitting letters correspondents should include their job title, a maximum of two qualifications and their address(es). A statement on competing interests should also be submitted for all letters. Letters may be submitted to the Editor or the Journal Editorial Office, Faculty of Family Planning and Reproductive Health Care, 27 Sussex Place, Regent’s Park, London NW1 4RG, UK. E-mail: journal@ffprhc.org.uk.

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Review of abortion laws

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