Managing Medical Abortions

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Disclosures

Affiliations:

- I have no relationships with for-profit or not-for-profit organizations.

Financial Support:

- This session/program has not received financial or in-kind support.

Objectives

1. Outline the indications, contraindications, and work up for medical abortion

2. Explain the medical abortion procedure

3. Review the after care and complications for a patient who has had a medical abortion

4. Identify providers of medical abortion across Northern Ontario to establish a contact list for referring physicians

Medical abortion vs Surgical abortion

Medical abortion	Surgical abortion
Highly effective (97-99%)	Highly effective (99%)
(Usually) **avoids surgery**, although usually **more pain and bleeding** than with surgery	May be done with sedation/anesthesia
Can take **days to complete**	Completed rapidly
Heavy bleeding, more than a period	Light bleeding
Usually **2-3 visits**	Usually 1-2 visits
Can be done at home	Cannot be done at home

Types of surgical abortion:
Up to 10 weeks GA: Manual vacuum aspiration
Up to 13 weeks GA: Suction and curettage
Up to 24 weeks (location dependent): Dilation and evacuation

Medical abortion regimens

Misoprostol alone (uncommon)

Methotrexate and misoprostol (not approved by Health Canada)

- Up to 7-8 weeks GA

Mifepristone and misoprostol

- Up to 9-10 weeks GA

Mifepristone and misoprostol

November 2017:

- approved for up to 63 days gestation (9 weeks)
- can be dispensed like any other drug
- prescribers no longer have to do the mandatory education modules

Training?

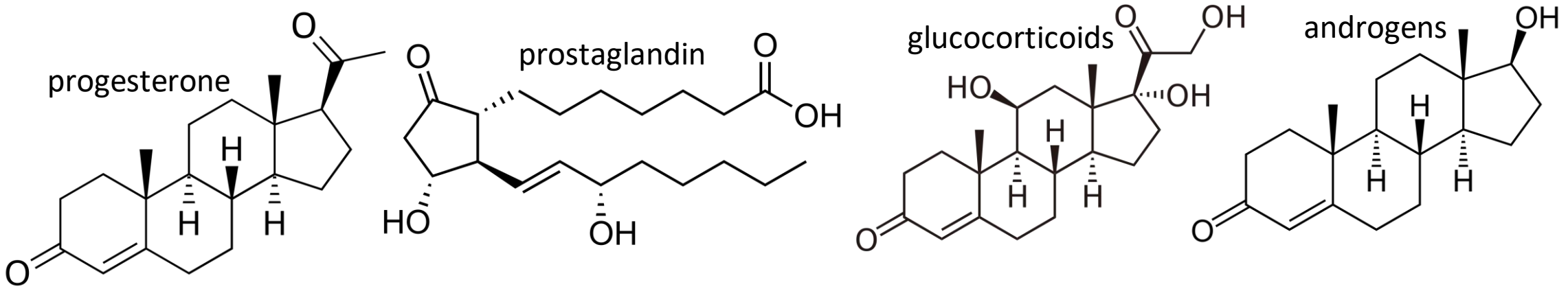
CPSO: It is the professional responsibility of a physician to ensure that they have sufficient knowledge, skills and judgement to competently prescribe any medication and supervise patient care

Module through SOGC eLearning portal – developed by the SOGC, the CFPC, and the Canadian Pharmacists Association ($$)

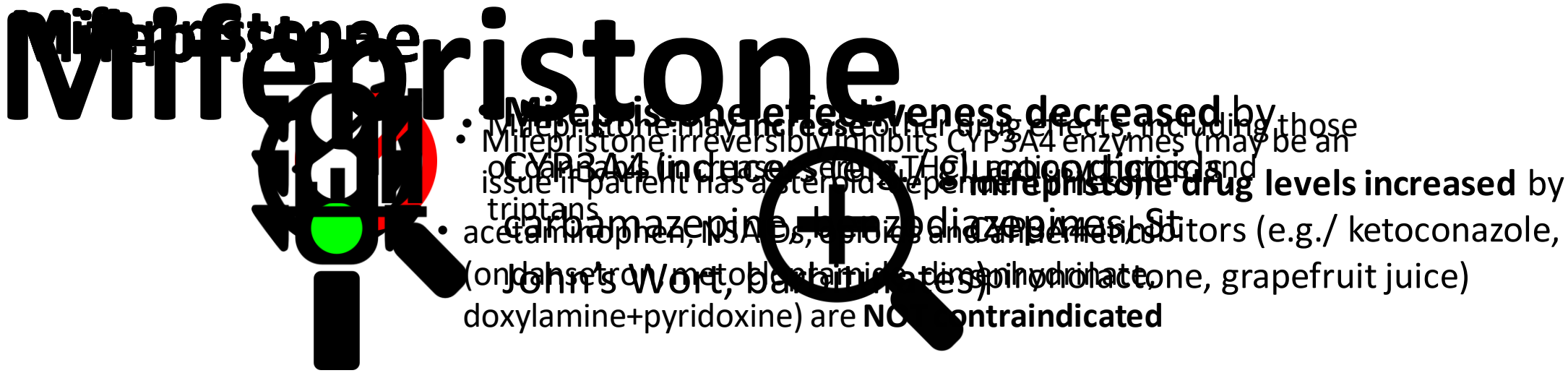
Also an educational program online from celopharma - http://celopharma.com/en/health-professionals/ (free)

Mifepristone

- Works at the decidua (endometrium) by blocking progesterone receptors (endometrial degeneration) and releasing endogenous prostaglandins (uterine contractility)
- Also strongly blocks glucocorticoids and weakly blocks androgens



Drug interactions (Mifepristone)



- Mifepristone may increase other drug effects, including those of cannabis (increase serum THC concentrations and issue if patient has a steroid dependency)
- Mifepristone irreversibly inhibits CYP3A4 enzymes (may be an
- acetaminophen, NSAIDs, opioids and antiemetics (e.g./ ketoconazole, grapefruit juice)

Misoprostol

Synthetic prostaglandin E1 – causes cervical softening and uterine contractions

Also acts on GI tract smooth muscle – nausea, vomiting, diarrhea

Side effects: can make people feel like they have a 24hr 'flu' – headache, fever, fatigue, nausea, vomiting, diarrhea

No known drug interactions

Absolute contraindications to MA

- Known ectopic pregnancy
- Chronic adrenal failure
- Inherited porphyria
- **Uncontrolled asthma**
- Known hypersensitivity to mifepristone or misoprostol
- **Ambivalence in the abortion decision**

Relative contraindications to MA

- Unconfirmed gestational age
  - resolve by ordering an U/S
- Intrauterine device (IUD) in place
  - resolve by removing the IUD and ordering an U/S to rule out ectopic
- Concurrent long term corticosteroid therapy
  - if not life-threatening to have a small period of reduced efficacy, may be able to just increase steroid dose for 3-4 days after mifepristone administration
- Bleeding disorder or anticoagulation
  - women with severe anemia (Hb < 95g/L) and bleeding disorders should not undergo MA

First visit:

1. Ensure certainty of decision, adequate social support, access to a phone, & ability to follow up
   - Offer SW referral (not required)
2. Counsel re: risks, benefits, complications, need for follow up, need for access to emergency care x 14 days
3. Ensure no contraindications
4. Screen for/treat STIs
   - routine urine screening for chlamydia/gonorrhea is recommended by SOGC
5. Check vitals and consider doing a pelvic exam
6. Order serum bHCG and Rh factor (if unknown), Hb if concerned re: anemia
7. Arrange an ultrasound for dating/location if uncertain of dates/risk factors for ectopic

Is an U/S always needed?

No

U/S is needed when there are risk factors for ectopic pregnancy or when dating cannot be reliably determined

Interpreting early dating U/S with bHCG

<7wks gestation may not be able to find intrauterine pregnancy on U/S

If low risk for ectopic, can proceed if:

- bHCG ≤2000 IU/L and no gestational sac

  or

- a likely gestational sac with no yolk sac or fetal pole

- **32-33 days post LMP: bHCG >1500 IU/L, gestational sac visible in uterus (measuring 2-3mm and growing about 1mm/day)**
- **35-42 days post LMP: bHCG 7200-10800 IU/L, yolk sac apparent in gestational sac (confirms IUP)**
- **40-49 days post LMP: fetal pole apparent adjacent to yolk sac (3.4mm at 42 days and grows about 1mm/day – when reaches 10mm interpreted as 7w+0 to 7w+2)**
- **<8 weeks (56 days): CRL <17mm**
- **<9 weeks (63 days): CRL <23mm**
- **<10 weeks (70 days): CRL <30mm**

Second visit:

1. Review again expected side effects/when to seek reassessment
2. Review contraception plan
3. Instruct how to take
   - 200mg mifepristone swallowed with water
   - If Rh-, also give 120-300mcg RhIG on the day of mifepristone or within 72hrs of bleeding
   - 24-48hrs later 800mcg misoprostol buccally or vaginally
   - 24hrs later OCP/depo or 7 days later IUD
4. May want to prescribe an analgesic (e.g./ NSAID) or antiemetic
5. Give req for serum bHCG to be done in 7-14 days
6. Book f/u and ensure pt has clinic number, telehealth/ER number
7. Offer SW referral if not done previously

Signed co

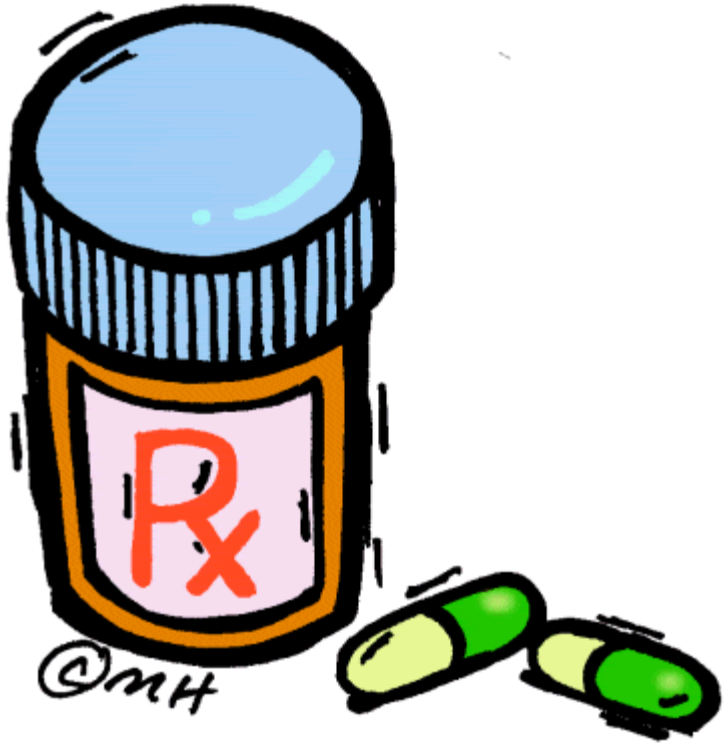
Not required, however

da

https://www.shorecentre.ca/wp-content/uploads/NEW-Mifegymiso-Information-Brochure-min.pdf

Writing the prescription

- Call the pharmacy re: timeline
- Make sure the pharmacist knows how to get the cost covered



Troubleshooting

- Pain
  - Heat, cold
  - NSAIDs have more evidence than acetaminophen
  - Safe to use NSAIDs, acetaminophen, weak opioids (unless otherwise contraindicated)
  - If severe, send to ER
- Nausea
  - Dimenhydrinate, ondansetron, doxylamine+pyridoxine
  - If vomit >1hr after dose of misoprostol or mifepristone, no new prescription needed
- Prolonged but not severe bleeding, or bleeding re-starts
  - Average length of bleeding about 2 weeks (up to 4 weeks)
  - Repeat dose of misoprostol 400-800mcg – consider vaginal administration
- Well, but retained products on U/S
  - Normal
  - Consider U/S again after next normal period

Third visit (follow-up)

1. Confirm completion
   - Serum bHCG should drop >50% 24-48hrs after misoprostol and drop >80% by follow up at 7-14 days
   - Can also assess with U/S
2. Assess for complications
   - ‘retained products’ on U/S in an otherwise well patient is not a complication
3. Reinforce contraceptive plans/provide contraception
   - Urine bHCG may remain positive for a month or longer post-medical abortion

Billing

A920 – initiation of medical abortion (second visit)

- Counselling/consult fee absorbed into this code
- $161.15

A921 – follow-up visit

- Confirm that abortion is complete, review contraception
- $33.70

Support

CAPS CPCA

Canadian Abortion Providers Support
Communauté de pratique canadienne sur l'avortement

UBC

The Society of Obstetricians and Gynaecologists of Canada

The College of Family Physicians of Canada / Le Collège des médecins de famille du Canada

Canadian Pharmacists Association / Association des pharmaciens du Canada

CART-GRAC Contraception Access Research Team / Groupe de recherche sur l'accessibilité à la contraception

INSPQ Institut national de santé publique du Québec

Where else to direct patients?

Action Canada for Sexual Health & Rights – 1-888-642-2725

Choiceconnect.ca

Questions?

References

Accredited Medical Abortion Training Program, Society of Obstetricians and Gynecologists of Canada (currently unavailable due to recent website redesign, original eLearning platform used is inactive)

Health Canada, Government of Canada, http://healthycanadians.gc.ca/

Medical Abortion. Costescu, DustinGuilbert, EdithBernardin, JeanneBlack, AmandaDunn, SheilaFitzsimmons, BrianNorman, Wendy V.Pymar, HelenSoon, JudithTrouton, KoniaWagner, Marie-SoleilWiebe, Ellen et al. Journal of Obstetrics and Gynaecology Canada , Volume 38, Issue 4, 366 - 389

Mifegymiso (mifepristone, misoprostol) Educational program for health care professionals. Celopharma Inc. November 2017. http://celopharma.com/wp-content/files_mf/training-program-EN.pdf

Mifegymiso Mifepristone and Misoprostol for termination of first trimester pregnancy. Celopharma Inc.

Canadian Abortion Providers Support (CAPS-CPCA), www.caps-cpca.ubc.ca

References

Canadian Institute for Health Information, Induced Abortions Reported in Canada in 2017, https://www.cihi.ca/sites/default/files/document/induced-abortion-2017-en-web.xlsx

Bernard N, Elefant E, Carlier P, Tebacher M, Barjhoux C, Bos-Thompson M, Amar E, Descotes J, Vial T. Continuation of pregnancy after first-trimester exposure to mifepristone: an observational prospective study. *BJOG* 2013;120:568–575.

The Additive Value of Pelvic Examinations to History in Predicting Sexually Transmitted Infections for Young Female Patients With Suspected Cervicitis or Pelvic Inflammatory Disease. Ann Emerg Med. 2018 Dec;72(6):703-712.e1. doi: 10.1016/j.annemergmed.2018.05.004. Epub 2018 Jul 2

Vauzelle C1, Beghin D, Cournot MP, Elefant E. Birth defects after exposure to misoprostol in the first trimester of pregnancy: prospective follow-up study. *Reprod Toxicol*. 2013 Apr;36:98-103. doi: 10.1016/j.reprotox.2012.11.009. Epub 2012 Dec 1.

Murray et al, Patients' Motivation for Surgical Versus Medical Abortion, JOGC Sept 2019, volume 41, issue 9, 1325-1329.

Soon, Judith and N. Rebic, Guide for Dispensing Mifegymiso for Medical Abortion, available at: https://www.caps-cpca.ubc.ca/AnnokiUploadAuth.php/8/80/Canadian_Medical_Abortion_Dispensing_Guide_V8_2018-10-18.pdf

References

Ireland LD, Gatter M, Chen AY. Medical Compared With Surgical Abortion for Effective Pregnancy Termination in the First Trimester. Obstet Gynecol. 2015 Jul;126(1):22-8. doi: 10.1097/AOG.0000000000000910. PMID: 26241252.