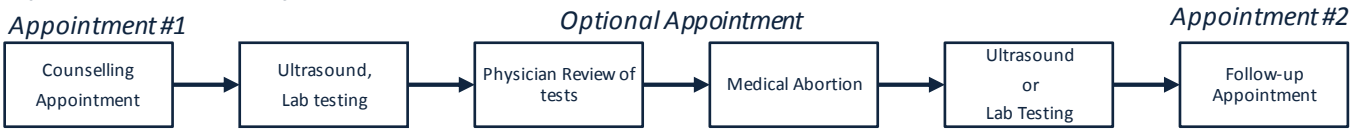
Explanations for the Medical Abortion Charting Form

Introduction

- This charting sheet is intended for use by health professionals providing first trimester induced medical abortions (MA) to average-risk patients with a confirmed intrauterine pregnancy.
- This checklist is in accordance with the SOGC guidelines for medical abortion with mifepristone (MIFE) and misoprostol (MISO); other drug regimens are available and are outlined in the SOGC guidelines.
- This checklist does not provide guidance for managing ectopic pregnancy or pregnancy of unknown location (PUL) when ultrasound is used. If there are any indications of an ectopic pregnancy or PUL, providers should refer to the SOGC guidelines.

Example Treatment Pathway



1. Counselling

- Pregnancy options counselling could include
  a. A review of pregnancy options: abortion, term pregnancy, adoption
  b. Description of different abortion options
  c. Risks and benefits of each type of abortion
  d. Discussion of patient supports and confirmation that the decision is voluntary
  e. Discussion of emotional needs, values and coping abilities

Comparison of Surgical and Medical Abortion

Medical Abortion	Surgical Abortion
Avoids surgery	Surgical procedure
Can take days to complete	Completed in 5-10 min followed by 30 min to 1 hour of observation time
Somewhat and variably painful	Usually less painful, anaesthesia available
≥ 95% success rate within 1-3 weeks	99% success rate
Much heavier bleeding than a period	Light bleeding
Typically 2-3 office visits + U/S and lab tests	Typically 1-2 visits*
Medications may be expensive*	Typically no cost if covered by provincial insurance
Can be completed alone at home	Requires a support person to drive depending on anaesthesia

** depending on province/territory and location of access*

- Contraception counselling: Fertility can return 8 days after a MA; a contraceptive plan should be decided at the first visit. Discuss resuming intercourse after pregnancy tissue has passed.
  - Combined hormonal contraceptives should be initiated the first day after misoprostol administration.
  - Condoms can be used immediately; cervical cap or diaphragm initiation should be delayed until bleeding stops.
  - Intrauterine contraception can be inserted once the abortion is shown to be completed (at the follow-up appointment).
  - Progestin-only contraception (pill, injection) should be initiated once misoprostol has been taken.

2. Determining Eligibility for a Medical Abortion

- To obtain informed consent for MA, patient should be informed of the following and have a chance for questions/discussion:
  1. MA involves using drugs to end a pregnancy
  2. MA with mifepristone 200 mg oral and misoprostol 800 mg buccal are considered as safe as surgical abortion before 49 days following LMP and are highly effective up to 70 days LMP.
  3. MA is considered irreversible
  4. All drugs need to be taken as directed
  5. In the event of an ongoing pregnancy post-MA, a surgical abortion is recommended as the MA drugs are teratogenic.
  6. Patients should have access to urgent medical care for the 7-14 days post-MA.
  7. Risks include: bleeding, cramping/pelvic pain, GI symptoms (N/V/diarrhea), headaches, fever/chills, and pelvic/lower genital infection.
  8. Special risks include a need for urgent surgical intervention if there is heavy bleeding, severe pain, ongoing pregnancy or retained products. The risk of mortality is 0.3 in 100,000, usually from infection or undiagnosed ectopic pregnancy. The mortality risk is similar to surgical abortion and lower than for a term pregnancy.

Common Medical Abortion Side Effects and Recommended Management

Side Effect	Recommendations
Bleeding – typically starts a few hours after taking misoprostol; bleeding heavier than regular menses, with clots, for 2-4 hours.	Patients should be advised to seek help if they soak > 2 maxi pads per hour for > 2 consecutive hours, or feel dizzy, lightheaded, or have a racing heartbeat.
Pain – cramping and pain is expected before and at the time of expulsion.	In most cases NSAIDs can be used to manage pain as needed. Mild opioid analgesics can be prescribed to be taken as needed. Patients should be advised to seek help if severe pain during abortion is not controlled by analgesics.
Prostaglandin effects – nausea, vomiting, flu-like symptoms, diarrhea, dizziness, headache, chills/fever	Nausea can be treated with dimenhydrinate, ondansetron or diclectin. Diarrhea, fever and chills are usually self-limiting and can typically be managed with OTC medications. **Patients should be advised to seek help if they present fever > 38°C lasting more than 6 hours, especially after the day of misoprostol administration and if they feel flu-like symptoms, weakness/faintness, nausea, vomiting, diarrhea in the days after abortion.**

Exclusion Criteria

Absolute Contraindications	Rationale
Ambivalence	MA should only be initiated when a patient is certain of their decision
Ectopic pregnancy	MA does not treat ectopic pregnancy and the consequences of a missed diagnosis could be life threatening
Chronic adrenal failure	MIFE is an anti-glucocorticoid and can impair the action of cortisol replacement therapy
Inherited porphyria	MIFE can induce δ-aminolevulinic synthetase; the rate limiting enzyme in heme biosynthesis
Uncontrolled asthma	MIFE is an anti-glucocorticoid and can impair the action of cortisol replacement therapy
Known hypersensitivity to product ingredients	Allergic reaction

Relative Contraindications	Rationale and Management
Unconfirmed gestational age	If GA is uncertain, ultrasound should be performed
Long term corticosteroid use	Steroid effectiveness may be reduced for 3-4 days post-MIFE and therapy should be adjusted.
Hemorrhagic disorders or current anticoagulant therapy	MA routinely results in blood loss. Precautionary measures may be appropriate.
Anemia with hemoglobin Hb < 95 g/L	In many studies, anemic patients did not obtain MA. Precautionary measures may be appropriate.
IUD in place	Pregnancies with IUDs in situ are more likely to be ectopic. Ectopic pregnancies must be excluded. If the U/S indicates an intrauterine pregnancy, the IUD should be removed before MA if possible.

3. Physical Exam and Assessment of Gestational Age

- Confirmation of pregnancy can be obtained with a positive, office-based urine βhCG test or an ultrasound.
- Following confirmation of pregnancy, gestational age (GA) and pregnancy location may be confirmed by ultrasound. Ultrasound provides confirmation of gestational age and location of the pregnancy. Where ultrasound not available, clinical assessment using LMP, history and bimanual examination can be used to determine eligibility, for patients without risks, signs or symptoms of ectopic pregnancy.
    - MA is suitable for patients with intrauterine pregnancies ≤ 70 days gestation.
    - MA is suitable for patients with multiple pregnancies.
    - MA is absolutely contraindicated in patients with ectopic pregnancy.
    - MA is not suitable for patients with a molar pregnancy; refer to SOGC guidelines for guidance.
    - In patients with pregnancy of unknown location (PUL), MA may be suitable in certain circumstances and providers should follow the PUL medical abortion guidelines outlined by the SOGC.
- Alternatively, in patients who are reasonably certain of their LMP, with no risk factors of ectopic pregnancy, pelvic examination can be used to estimate GA and pregnancy location.

- The SOGC guidelines recommend that any patients with significant risk factors, signs or symptoms of an ectopic pregnancy should have a pre-treatment ultrasound and a baseline quantitative serum βhCG. Risk factors for ectopic pregnancy include:

1. Previous ectopic pregnancy
2. Tubal surgery
3. Pregnancy conceived with assisted reproduction techniques
4. Tubal ligation
5. IUD in place
6. History of salpingitis or pelvic inflammatory disease
7. Abdominal pain
8. Vaginal bleeding

4. Lab Requisitions

- Quantitative serum βhCG may be measured to establish a baseline reading on the day of taking mifepristone, if the plan is to use it for follow up. In that case the appropriate βhCG drop is used later in follow-up to confirm the abortion was successful.
- The CBC is used to check for anemia.
- The SOGC recommends Rh testing of all patients followed by immune globulin administration if indicated.
- Patients planning a MA should be screened for chlamydia and gonorrhea and treated if positive. Chlamydia and gonorrhea are associated with increased rates of pelvic inflammatory disease following surgical abortion.

5. Review of Lab Results and Imaging

- Typical transvaginal ultrasound findings indicating an intrauterine pregnancy ≤ 70 days gestation is characterized by the presence of a gestational sac and at least a yolk sac:

Ultrasound Finding	Indication of Gestational Age	Typical βhCG (IU/L)
Gestational Sac	Appears 32-33 days from LMP	> 1000
Yolk Sac	Appears 35-42 days from LMP	7 200 - 10 800
Fetal Pole	Appears 40-49 days from LMP	--

- If no intrauterine pregnancy is visualized by transvaginal U/S in a patient with a positive pregnancy test, the situation is classified as a pregnancy of unknown location (PUL) and providers should refer to the SOGC guidelines for management. Referral to an OB-GYN must be done in cases of visualization of an ectopic pregnancy.
- βhCG levels rise more or less linearly during the first 6 weeks of pregnancy; this high variability limits the utility of βhCG for dating. Baseline and follow-up serum βhCG levels are useful to assess completion of MA.

6. Provision of Mifegymiso®

- In Canada, the approved mifepristone/misoprostol combination product consists of 200 mg of mifepristone oral and 800 µg of misoprostol buccal, taken 24 to 48 hours after mifepristone administration.
    - Day 1: Mifepristone. The patient takes one MIFE 200 mg tablet orally and swallows it with water
    - Day 2-3: Misoprostol. 24-48 hours after taking MIFE, the patient places 4 MISO tablets between the cheeks and teeth and leaves them in place for 30 minutes, at which point patient swallows any leftover fragments with water.
- According to the SOGC, routine prophylactic antibiotics are not required; screen-and-treat is preferred.

7. Follow-up Appointment

- A follow-up appointment in office or by phone is required to confirm termination of pregnancy. This appointment should be scheduled 7-14 days after administration of mifepristone.
- Confirmation of completion of the MA may be clinical, by ultrasound, or by serum βhCG measurement.
    - Ultrasound → typically only needed if the outcome is uncertain or there are symptoms such as prolonged bleeding
    - βhCG → an 80% drop in serum βhCG 7-14 days from baseline level is highly predictive of MA completion
- The follow-up appointment should also include screening for complications such as
    - Retained products of conception,
    - Ongoing pregnancy,
    - Post-abortion infection, and
    - Toxic shock syndrome.
- Adverse reaction reporting to Health Canada: Complete a report online at https://webprod4.hc-sc.gc.ca/medeffect-medeffet/index-eng.jsp or call Canada Vigilance Regional Office at 1-866-234-2345.

Reference: *Costescu D, Guilbert E, Bernardin J, Black A, Dunn S, Fitzsimmons B, et al. Medical abortion. J Obstet Gynaecol Can. 2016;38(4):366-89.*

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