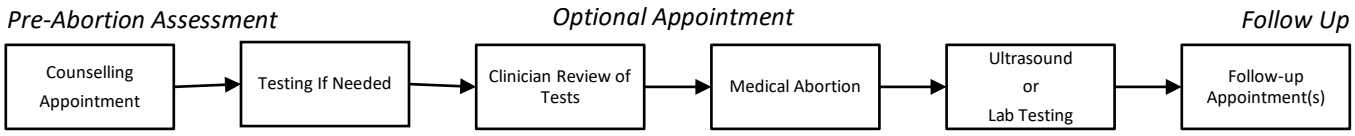
Medical Abortion Prescriber Checklist Resource Guide

Introduction

- This charting sheet is intended for use by health professionals providing first trimester induced medical abortions (MA) to average-risk pregnant patients requesting an abortion.
- This checklist is in accordance with the 2016 SOGC guidelines for medical abortion with mifepristone (MIFE) and misoprostol (MISO) and 2020 pandemic update; other drug regimens are available and are outlined in the SOGC guidelines.

Example Treatment Pathway



1. Counselling

- Pregnancy options counselling could include
  a. A review of pregnancy options: abortion, parenting, adoption, and for abortion options a description of procedures, risks, benefits and range of potential experiences
  b. Discussion of patient supports and confirmation that the decision is voluntary
  c. 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
Bleeding may be heavy	Light bleeding
Typically 2-3 visits* + U/S and lab tests if indicated	Typically 1-2 visits**
Typically no cost if covered by provincial insurance	Typically no cost if covered by provincial insurance
Can be completed alone at home	Requires a support person to drive depending on anaesthesia

**in-person or virtual ** 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 if the patient is agreeable. Discuss resuming intercourse after pregnancy tissue has passed.
  - Oral contraceptive pills (combined or progestin-only), patch, ring, progestin implant can be started without delay after taking mifepristone and should be started as soon as possible after taking misoprostol.
  - 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, use barrier method until inserted).

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, with a second misoprostol dose recommended >63 days.
  3. MA is considered irreversible.
  4. All drugs need to be taken as directed.
  5. In the event of PUL at the time of MA, additional triaging and F/U will be required.
  6. In the event (1%) of an ongoing pregnancy post-MA, a surgical abortion is recommended as misoprostol is teratogenic.
  7. Patients should have access to urgent medical care for the 7-14 days post-MA.
  8. Risks include: bleeding, cramping/pelvic pain, GI symptoms (N/V/diarrhea), headaches, fever/chills, and pelvic/lower genital infection.
  9. 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 Experiences 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 acetaminophen and 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 doxylamine/pyridoxine. 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
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 ingredient hypersensitivity	Allergic reaction.

Relative Contraindications	Rationale and Management
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. Assessment of Pregnancy & Gestational Age

- MA can be provided based on home pregnancy test and LMP dating alone if the patient has no risk factors for, or symptoms of, ectopic pregnancy, is reasonably certain of their LMP, is not using hormonal contraception, has regular menstrual cycles, and has no other contraindications.
    - MA is suitable for patients with intrauterine pregnancies ≤ 70 days gestation.
    - MA is suitable for patients with multiple pregnancies, and may be given if PUL, in the context of appropriate follow up (F/U).
    - Mifepristone is 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.
- The SOGC guidelines recommend that patient should have a pre-treatment ultrasound prior to MA if:
    - LMP is uncertain and pelvic exam is not feasible or uncertain
    - LMP is over 70 days ago
    - Presence of symptoms and signs of, or risk factors for ectopic pregnancy
- Presence of an IUD/IUS at any point in pregnancy

- 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. Initial Labs, Anti-D provision, and Imaging (If indicated)

- 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 F/U. In that case the appropriate βhCG drop is used later in follow-up to confirm the abortion was successful.
    - 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.
- The CBC is used to check for anemia, if indicated.
- The SOGC recommends Rh testing of patients followed by immune globulin administration if gestation is beyond 49 days, this may be withheld prior to 70 days gestation during pandemics and periods of social disruption.
- 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.
- Typical transvaginal ultrasound findings indicating an intrauterine pregnancy ≤ 70 days gestation is characterized by the presence of a gestational sac and ideally 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	--

- Urgent referral to an OB-GYN must be done in cases of suspected or visualization of an ectopic pregnancy.
- If no intrauterine pregnancy or evidence of an ectopic pregnancy is visualized by transvaginal U/S in a patient with a positive pregnancy test, the situation is classified as a PUL and MA is suitable:
    - In the absence of risk factors/clinical symptoms of an ectopic pregnancy and no gestational sac, if the serum βhCG is ≤2,000 IU/L, **OR**
    - In the absence of risk factors/clinical symptoms of an ectopic pregnancy, when a likely gestational sac is present without a yolk sac or fetal pole

5. 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. During pandemics and periods of social disruption, clinicians should prescribe an additional dose of misoprostol 800 mcg (buccal or vaginal) to be used on direction of a healthcare provider in the event of suspected incomplete or failed abortion, and as a planned dose for higher gestational age.
    - 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.
        - Patients with gestational age 63 days or less should take the second dose of misoprostol if no bleeding occurs within the first 24 hours after the first misoprostol dose or as instructed by the clinician.
        - Patients with a gestational age over 63 days should take a second dose of misoprostol 4 hours after the first dose.
- According to the SOGC, routine prophylactic antibiotics are not required; screen-and-treat is preferred.

6. Follow-up Appointment(s)

- 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.
- The follow-up appointment should include screening for complications such as
    - Retained products of conception,
    - Ongoing pregnancy,
    - Post-abortion infection, and
    - Toxic shock syndrome.

- Confirmation of MA completion may be clinical, by ultrasound, serum βhCG measurement or by high sensitivity urine pregnancy test.
  - 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
  - High sensitivity urine pregnancy test → negative test 4 weeks after taking misoprostol
- For PUL, option for rapid F/U on Day 3 → a 50% drop from baseline to follow-up 24-48 hours after MISO is highly indicative of MA completion
- 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.

Planned Parenthood Ottawa / Planning des naissances d'Ottawa

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

UBC THE UNIVERSITY OF BRITISH COLUMBIA

References: 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; Costescu D, Guilbert E, Wagner MS, Dunn S, Norman WV, Black A, Renner R, Bernardin J, Fitzsimmons B, Trouton K. Induced abortion: updated guidance during pandemics and periods of social disruption; Guilbert E, Costescu D, Wagner MS, Renner R, Norman WV, Dunn S, Fitzsimmons B, Trouton K, Bernardin J, Black A, Thorne JG. Canadian protocol for the provision of medical abortion via telemedicine.