7. MEDICATION ABORTION

SUPPLEMENTAL EXERCISES

Purpose: To practice follow-up and management of complications after medication abortion. How would you manage the following situations?

Note: Teaching points are available at end of this document.

EXERCISE 7.4

25 y/o G2P1 woman who received mifepristone 200 mg 7 days ago and took misoprostol 800 mcg 6 days ago, returns to clinic today for a follow-up visit. She reports moderate bleeding and cramping a few hours after her misoprostol, and has had no complaints since then. On a follow-up ultrasound, there is a moderate amount of heterogeneous uterine debris that slightly distends the uterine cavity.

a. What management would you suggest for uterine debris?

b. How would you manage her differently if she was symptomatic with ongoing moderate vaginal bleeding and / or cramping?

EXERCISE 7.5

19 y/o G4P0 woman who received mifepristone 4 days ago and took misoprostol 3 days ago returns today because of very heavy vaginal bleeding. She states she has filled 5 maxi-pads in the last 3 hours.

a. What should you assess first?

b. What diagnostic work-up would you initiate?

c. What management options would you offer her?

d. What are indications for a uterine aspiration after medication abortion?

EXERCISE 7.6

36 y/o G3P2 woman who is getting a medication abortion today, and is considering implant or implant vs. IUD, and wants to know what is the soonest time she can get either.

a. What are the pros and cons of implant placement today vs. on day-of-follow up visit?

b. What are the pros and cons of IUD placement on day-of-follow up visit vs. at a later visit?
c. If she had moderate debris on her ultrasound at the follow-up visit, would you be less likely to offer an IUD?

**EXERCISE 7.7**

32 y/o G3P1 women presents to clinic requesting a medication abortion. She has irregular periods with an LMP 5 wks ago and some spotting 2 wk ago. Urine pregnancy test is positive and US shows a slightly thickened endometrium with a 3 mm anechoic sac (no yolk sac or fetal pole).

a. Can a medical abortion be started in a pregnancy of unknown location?

b. You see the patient back in one week after a medication abortion and she reports bleeding, cramping, and passage of tissue the same day after taking misoprostol at home. She feels fine now and is having light bleeding. Ultrasound shows absence of the previously seen 3 mm sac. hCG level is checked and is 360 (was 1800 at first visit). Is any further action required?

**Note:** See below for the Teaching Points to these Exercises
CHAPTER 7: MEDICATION ABORTION
SUPPLEMENTAL EXERCISES TEACHING POINTS

Purpose: To practice follow-up and management of complications after medication abortion. How would you manage the following situations?

EXERCISE 7.4

25 y/o G2P1 woman who received mifepristone 200 mg 7 days ago and took misoprostol 800 mcg 6 days ago, returns to clinic today for a follow-up visit. She reports moderate bleeding and cramping a few hours after her misoprostol, and has had no complaints since then. On a follow-up ultrasound, there is a moderate amount of heterogeneous uterine debris that slightly distends the uterine cavity.

a. What management would you suggest for uterine debris?

• When US is performed at the follow-up visit, the primary purpose is to determine whether a gestational sac is still present (by comparison with previous US).

• Endometrial thickness alone should not be used to guide management after medical abortion. The post-abortion uterus will normally contain sonographically hyperechoic tissue that consists of blood, blood clots, and decidua (Reeves 2009, 2008) In the absence of heavy bleeding or cramping, no further management is needed for uterine debris on US. (NAF Guideline 2014)

• Health care providers can monitor such patients based on symptoms. (SFP Guideline 2014)

b. How would you manage her differently if she was symptomatic with ongoing moderate vaginal bleeding and / or cramping?

• An aspiration may be warranted for hemodynamic instability or for patient preference. (SFP Guideline 2014)

• Clinicians who wish to provide medical abortion may either be trained or be able to refer to a clinician trained in aspiration abortion.
EXERCISE 7.5

19 y/o G4P0 woman who received mifepristone 4 days ago and took misoprostol 3 days ago returns today because of very heavy vaginal bleeding. She states she has filled 5 maxi-pads in the last 3 hours

a. What should you assess first?
   • Hemodynamic status (vital signs and orthostatics).
   • Extent of active bleeding.

b. What diagnostic work-up would you initiate?
   • Hgb / hct
   • Ultrasound (if available)
   • Exam to assess active bleeding and uterine bogginess

c. What management options would you offer her?
   • Uterine aspiration
   • If bleeding has already diminished or patient is now stable, may weigh option of repeat misoprostol.
   • Initiate oral FeS04 as needed

d. What are indications for a uterine aspiration after medication abortion?
   • Bleeding in hemodynamically unstable patient.
   • Persistent cardiac activity at follow-up after a 2nd dose of misoprostol, if still < EGA cutoff. (2nd dose was 29 – 37% successful among those with persistent gestational sac; Reeves 2008)
   • Persistent gestational sac (viable or non-viable) 4 weeks after meds (PP)
   • Patient preference or ongoing symptoms unacceptable to her.

EXERCISE 7.6

36 y/o G3P2 woman who is getting a medication abortion today, and is considering implant or implant vs. IUD, and wants to know what is the soonest time she can get either.

a. What are the pros and cons of implant placement today vs. on day-of follow up visit?
• Pilot study of implant placement on the day of medical abortion shows continuation rates of over 85% at 1 year and higher satisfaction than placement at time of follow-up. (Sonalkar 2013) As more data accumulates supporting the efficacy of concurrent medication abortion and the safety of medication abortion without follow-up visit (e.g. phone follow up), implant placement on the day of medication abortion may become more commonplace.

b. What are the pros and cons of IUD placement on day-of-follow up visit vs. at a later visit?

• Early placement of IUD after medical abortion (at first follow-up or approximately 1 week) is safe and well tolerated with no increased incidence for expulsion, bleeding or complications compared to later placement (at 3-6 weeks). (Shimoni 2011, Saav 2012)

• There is a trend toward higher IUD use at 6 months post-abortion among those with immediate compared to delayed placement (Shimoni 2011).

• A higher proportion of women had unprotected intercourse prior to returning for insertion in the delayed group compared with the early group. (Saav 2012)

• Early placement should be offered as routine for women undergoing first trimester medical abortion. (Shimoni 2011, Saav 2012)

c. If she had moderate debris on her ultrasound at the follow-up visit, would you be less likely to offer an IUD?

• It is not recommended to restrict IUD insertion based on ultrasound data, since expulsion is uncommon even with thicker endometria and no clear cutoffs have emerged from analysis, even though expulsion increases slightly with thicker endometria and lower baseline position (Shimoni 2014).

EXERCISE 7.7

32 y/o G3P1 women presents to clinic requesting a medication abortion. She has irregular periods with an LMP 5 wks ago and some spotting 2 wk ago. Urine pregnancy test is positive and US shows a slightly thickened endometrium with a 3 mm anechoic sac (no yolk sac or fetal pole).

a. Can a medical abortion be started in a pregnancy of unknown location?
• Some protocols allow initiation of medication abortion while concurrently following serial hCGs, as long as there are no exclusion criteria (>35 d by LMP, no adnexal mass on bimanual or US) and cautious hCG follow-up. The concern is to avoid missing an ectopic pregnancy.

• Recall that a normal early gestational sac is characterized by the following findings (FEEDS mnemonic), to distinguish from pseudosac in ectopic pregnancy, which tends to be irregular, central, smaller, and without a decidual reaction). Having all criteria does not guarantee a true gestational sac, nor an intrauterine pregnancy:
  • F - Fundal (in mid to upper uterus)
  • E - Elliptical or round shape in 2 views
  • E - Eccentric to the endometrial stripe
  • D - Decidual reaction (a thickened choriodecidual reaction)
  • S - Size > 4 mm

• Most commercial pregnancy tests are positive at approximately 25 mIU/ml. Because these tests are so sensitive, they are often positive before the client has missed her period, and can remain positive long after a pregnancy ends.

• Discriminatory Zone = hCG 1500–2000 mIU/ml = approx 35 days LMP = gestational sac should be visible on TVUS.

• If hCG ≥ 2000 mIU/ml and gestational sac is not seen on transvaginal ultrasound, ectopic pregnancy must be ruled out.

b. You see the patient back in one week after a medication abortion and she reports bleeding, cramping, and passage of tissue the same day after taking misoprostol at home. She feels fine now and is having light bleeding. Ultrasound shows absence of the previously seen 3 mm sac. hCG level is checked and is 360 (was 1800 at first visit). Is any further action required?

• The hCG level dropped by ≥80% after 7 days. Medication abortion should be deemed successful. Discuss contraception, if it hasn't already been addressed.
REFERENCES


NAF Clinical Guidelines 2014: p. 34, 35

PPFA Standards and Guidelines 2014.


