This Curriculum is dedicated to the family planning and abortion providers and staff members whose steadfast commitment, expertise, and care make such a difference in patient’s lives.

Why the Papaya?
The papaya simulation lab was originally innovated by the TEACH Program's first Director, and is now used globally by new providers learning the skill of uterine aspiration.
TEACH

Early Abortion Training Curriculum

2020 Editor

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1. ORIENTATION: ABORTION IN PERSPECTIVE

Updated June 2020 by Caitlin Weber MD, MS

Welcome to your early pregnancy options and abortion training. We are excited to help assist all providers to deliver comprehensive health care to patients.

Whether or not you choose to participate in all aspects of care, this curriculum can help you be a better primary care provider for patients of reproductive age. There are many skills to gain in pregnancy dating, options counseling, timely referrals, miscarriage management, and family planning.

Primary care providers globally serve an important role in the provision of reproductive health services as they practice in diverse, rural, and underserved areas (Graham 2005), receive procedural training, and care for patients throughout their reproductive years. This text is primarily U.S.- focused, with expanded global reporting for a growing global audience.

It is beneficial to read Chapters 1 and 2 before beginning your training to help explore your personal values about pregnancy options, how they may differ from your patients’ values, and think about professional judgments you may be called upon to make.

CHAPTER LEARNING OBJECTIVES

Following completion of this chapter, you should be able to:

• Explore your personal values and feelings about pregnancy options
• Clarify your individual training goals and strategies to achieve these with faculty
• Describe constraints on reproductive care and access globally
• Be familiar with data on abortion safety and factors that promote/limit safety
• Understand the influence of abortion-related stigma on patients and providers
• Understand professional ethics within a justice-based & public health framework.

VIDEOS

• Overview of abortion in the international context (IERH): https://bit.ly/2YmVorY
• Global Perspectives: interviews of international experts: https://bit.ly/30yDxAV

RESOURCES

• www.prochoice.org/think-youre-pregnant/im-pregnant-what-are-my-options/
• State and Global Policy Updates (Guttmacher Institute):
  o International Laws and Policies https://www.guttmacher.org/international/abortion
• Sistersong Reproductive Justice Resources
  o https://www.sistersong.net/reproductive-justice
**SUMMARY POINTS**

**SKILLS**

- It is valuable to identify and understand the life experiences that have affected your opinions in order to promote a non-judgmental climate for patient care.
- Patient-centered counseling uses a non-directive approach with active listening, open-ended questions, and accurate information about pregnancy options.
- An understanding of abortion prevalence, safety, restrictions, and access is essential to understanding patients’ needs and providing high quality care.

**SAFETY**

- Abortion is safe, and removing legal restrictions is associated with significant reductions in maternal morbidity and mortality globally. In fact, the only factors decreasing abortion safety are those decreasing access (NASEM 2018, Upadhyay 2015, White 2015).
- Nearly half of all abortions worldwide are unsafe, and nearly all unsafe abortions (98%) occur in developing countries (Singh 2018, Sedgh 2016).
- Patients who receive an abortion are not at risk for mental health problems, and are at no higher risk of PTSD than patients denied an abortion (Biggs 2016, Cohen 2013).
- While self-managed abortion is not new, medication abortion has changed how we think about it, by offering methods proven to be safe and effective (Jones 2017).

**ROLE**

- Abortion is among the most common procedures performed among women. One in 4 U.S. women will have an abortion in their lifetime. One in 4 pregnancies end in abortion globally (Jones 2017).
- Given how common unintended pregnancy, abortion, and early pregnancy loss are, most primary health care providers will treat patients experiencing these issues.
- Restrictive laws and regulations create harmful obstacles to care, increase the gestational age at which patients obtain abortions, and increase disparity in access.
- Reproductive health access and training are limited by hospital mergers, religious restrictions at training sites, stigma, and lack of transparency for patients and trainees (Uttley 2013, Stulberg 2010).
- Abortion is provided by physicians and advanced practice clinicians, with similar safety, effectiveness, and patient acceptability in locations where abortion care is not restricted to physicians (NASEM 2018, Sjöström 2017, Barnard 2015).
- If you do not provide abortion services directly, it is important to know how to refer patients and handle follow-up issues within the context of your practice setting.
ABORTION IN PERSPECTIVE

REPRODUCTIVE HEALTH THROUGH A JUSTICE LENS

- There is a long history of coercive reproductive practices, including sterilization abuse, incentivized use of long-acting reversible contraceptives and resistance to remove them, threats to parenthood (including differential referrals to child protective services), and lack of safety in communities (including harmful environmental exposures as well as violence in multiple forms), all of which have been disproportionately imposed upon people of color, low income people, those with disabilities, immigrants, LGBTQ and incarcerated individuals. Sadly, this continues today, and impacts the way individuals and communities perceive family planning services (Thorburn 2005, UCSF Bixby BtP 2020).
- In the 1990s, 12 Black women founded the reproductive justice (RJ) movement (Ross 2017, Chrisler 2012) to improve institutional policies and systems that impact the reproductive lives of marginalized communities.
- The SisterSong Reproductive Justice Collective defines reproductive justice as the “human right to maintain personal bodily autonomy, have children, not have children, and parent the children we have in safe and sustainable communities.”
- Public health guidelines should proactively help patients achieve their reproductive desires, but vary widely between states and countries. Given that coercive practices have historically devalued the childbearing of marginalized populations (Brandi 2018, Brown 2014), we must remain focused on providing care that is respectful of, and responsive to, individual patient preferences and values (Gomez 2014) and ensure that patient preferences and values guide all our clinical decisions (Institute of Medicine 2001). Our curriculum is informed by this history and this lens.

PROFESSIONAL ETHICS IN REPRODUCTIVE HEALTH

Prevention is increasingly recognized as the most effective means of ensuring health within populations and has received heightened focus by recent initiatives such as Healthy People 2020 and the U.S. Affordable Care Act. A comprehensive approach addressing patients’ preferences around pregnancy is an essential component of prevention within a public health framework (Taylor 2011, Levi 2011).

When assisting patients to achieve their reproductive desires, there are important expectations that fall on primary care providers. Contraceptive provision, pregnancy options counseling, and provision or referral to appropriate services for abortion and miscarriage are among the ethical responsibilities of healthcare providers. The availability of modern contraception can reduce but not eliminate the need for abortion.

The concept of pregnancy intention is complex, and not all unintended pregnancies are created equal. New research suggests that our current conceptual framework viewing pregnancy from a strict planned behavior perspective is limited, particularly among low-income populations and younger patients (Gomez 2019, Borrero 2015). Ambivalence, partner influence, and cultural perspective all inform how patients feel about pregnancy intention (Aiken 2016).

The significant political dissonance surrounding reproduction and sexuality is associated with limited funding, research, and guidelines for unintended pregnancy prevention. This in turn places a significant burden on patients and health systems. Additionally, it limits abortion training for interested providers.
COVID-19 AND ABORTION CARE

All aspects of healthcare have been impacted by the COVID-19 global pandemic, and abortion care is no exception. For example, some U.S. states introduced legislation attempting to further restrict abortion access by declaring it “non-essential”, “elective” or “not medically necessary”. The long-standing insistence on using the word “elective” to describe the majority of abortions, frames women’s equality and autonomy as expendable, and represents a moral rather than a medical judgment (Watson 2018). Yet abortion and reproductive health services have been more essential than ever during this public health emergency. COVID-19 responses and quarantines led to concerns of increased unintended pregnancies due to challenges accessing contraceptive supplies, rising income insecurity, and increased incidence of intimate partner violence including reproductive coercion (Bayefsky 2020, Todd-Gerr 2020).

Numerous national and international organizations strongly opposed responses that cancel or delay abortion procedures, and explicitly classified reproductive health care as an essential health service that must be accorded high priority in the COVID-19 response (Bayefsky 2020). In addition to being disproportionately affected by the virus, low-income communities and people of color have also been disproportionately affected by such measures to restrict abortion and reproductive access. Central goals during COVID-19 have been facilitating reproductive autonomy, maintaining access to essential health services, and respecting social distancing as a public health mandate. These goals are not at odds with one another and can be simultaneously met (Karlin 2020). Telehealth has become a critical tool to achieve these goals in many settings.

In response to the pandemic, many providers pivoted rapidly towards innovative practice models streamlining diagnostic tests and minimizing contact between the patient and the healthcare system, using telemedicine and remote follow-up (Raymond 2020; “Chapter 4 page 65”). It has been said in the U.S. that no-test medication abortion protocols have done for medication abortion in a couple months what years of research and discussion could not. It is likely that many of these changes will be long lasting.
GLOBAL ABORTION FACTS AT A GLANCE
Abstracted from Guttmacher Institute’s Induced Abortion Worldwide 2018 Fact Sheet

GLOBAL ABORTION DATA
• Approximately 1 in 4 pregnancies globally end in abortion (Sedgh 2016).
• Estimated global abortion rates are higher among married than unmarried women (35 vs. 26 per 1000, respectively).
• Legal restrictions do not decrease abortion rates (rates are similar in countries where it is legal vs. highly restricted), but make them much less safe.
• Many patients globally are denied abortion even where legal. Many later seek care outside the formal health system, which can increase risks of complications and mistreatment (ANSIRH Global Turnaway Study).

CONTRACEPTIVE USE
• Globally, about half of all women want to avoid a pregnancy; of these, about 75% are using modern contraceptives (defined as sterilization, hormonal methods, IUDs, condoms, fertility awareness, lactational amenorrhea, and emergency contraception).
• Compared to those in industrialized countries, a greater proportion of people in developing countries have an unmet need for contraception, and these account for 84% of unintended pregnancies in developing regions.
• Reducing unmet need for modern contraception globally can decrease rates of maternal and infant mortality (Guttmacher 2017).

SAFETY OF ABORTION
• Abortions are safer where laws are less restrictive and also in countries with higher gross national incomes (Singh 2018).
• An estimated 45% of the abortions performed globally are unsafe (Singh 2018).
• In many regions of the world, stigma is a recognized contributor to maternal morbidity and mortality from unsafe abortion, even where abortion is legal.
• At least 8% of pregnancy related deaths worldwide are from unsafe abortion (although this is likely an underestimate).

WORLD’S ABORTION LAWS
• In 1994, 179 countries signaled their commitment to prevent unsafe abortions and reduce pregnancy-related mortality by signing the first international consensus document recognizing reproductive rights as human rights (CRR ICPD).
• The 25 years since ICPD have seen an overwhelming global trend toward the liberalization of abortion laws, with nearly 50 countries worldwide enacting laws expanding the grounds under which abortion is legal.
• Abortion laws vary widely from country to country. Laws by country are in map below and available from the Center for Reproductive Rights: https://reproductiverights.org/worldabortionlaws
• Many global efforts focus on providing accessible, affordable, and high-quality reproductive health care in ways that recognize autonomy.
• Of the world’s women of reproductive age, 6% live where abortion is banned outright, and 37% live where it is allowed without restriction as to reason. Most people capable of pregnancy live in countries with laws that fall between these two extremes.
EMERGING TERMINOLOGY

- Abortion Modifiers:
  - We use the terms “medication abortion” or “abortion pill” instead of the previously common term “medical abortion” as it more accurately represents the use of effective medication-based methods to terminate unwanted pregnancies. The term “medical abortion” can be associated with medical necessity (Weitz 2004).
  - We have adopted the terms “in clinic” or “aspiration abortion” instead of “surgical abortion” or “dilation and curettage”, as this avoids the connotation of abortion as a surgical procedure that requires an operating room, incisions and/or sharp curettage. However, access to specific procedures including aspiration abortion may vary by practice location.

- Abortion Indications:
  - We avoid the terms “elective” or “therapeutic” abortion. In abortion care, the term “elective” is often used as a moral judgment that determines which patients are entitled to care (Watson 2018). Unless required by an insurer, these terms should be avoided. Regardless of reason, the proper term for abortion is health care.

- Pregnancy loss:
  - We have chosen to use “early pregnancy loss” and “miscarriage” interchangeably, and have purposefully avoided terms like “pregnancy failure” that can leave patients with a sense of responsibility for the pregnancy loss.

- Gender-neutral language:
  - In recognition of a non-binary gender spectrum, we have incorporated gender-neutral language where appropriate including using the term “patient” and the singular “they” instead of “he” or “she” (Moseson 2020).
  - We continue to use gender-specific language to report some research, legal decisions, and some exercises. Also see Chapter 2 Gender Identity, page 31 and Contraceptive Care across the Gender Spectrum, page 125.
**UNITED STATES ABORTION FACTS AT A GLANCE**

Abstracted from Guttmacher Institute’s *Induced Abortion in the United States 2019 Fact Sheet* and other sources

**ABORTION BY THE NUMBERS**

- Abortion is common and safer than carrying a pregnancy to term. All forms of abortion are safe, and the only limits to safety are limits to access (NASEM 2018).
- There is a shortage of providers in the United States.
- 18% of U.S. pregnancies (excluding miscarriages) end in abortion (Jones 2017).
- Most abortions occur early in pregnancy; nearly 90% in first 12 weeks (Jones 2017).
- Medication abortions account for 39% of U.S. abortions (Jones 2017).
- Most U.S. counties (89%) lack an abortion provider; these counties are home to 38% of reproductive age women (Jones 2017).
- While decreasing, U.S. unintended pregnancy rates are higher (45%) than other developed nations (Finer 2016).

Data are limited, however, a significant number of people attempt to self-manage their abortions (Fuentes 2020, Moseson 2020).

**WHO HAS ABORTIONS**

One of every four U.S. women has abortions and they come from all backgrounds.

- Approximately 60% of abortions are among patients who have had at least one child.
- Of patients obtaining abortions, 30% identify as Protestant and 24% as Catholic.
- More than half are in their 20s, and 12% are in their teens (Jerman 2016).
- White patients account for 39% of abortion procedures, black patients 28%, Hispanic patients 25%, and patients of other races and ethnicities 9% (Jerman 2016).
- On average, patients report ≥ 3 reasons for choosing abortion: ¾ say a baby would interfere with work, school, or responsibilities; ¾ say they cannot afford a child; and ½ do not want to be a single parent or report relationship problems (Jerman 2016).
- Nearly 60% of patients who experience a delay in obtaining an abortion cite the time it took to make arrangements and to raise money.
- Transgender and non-binary people may experience undesired pregnancy after transitioning socially, medically, or both, and may seek prenatal or abortion care (Light 2014).

**LONGTERM TURNAWAY OUTCOMES (ANSIRH Turnaway Study)**

- Patients are confident in their decision and the large majority do not regret their decision to have an abortion.
- Long-term research shows that abortion does not harm patients; there is no increased risk of depression, PTSD, low life satisfaction, or other mood symptoms when comparing patients who had abortion vs. those turned away.
- Patients denied an abortion have decreased financial security and four times the odds of living below the federal poverty level (FPL) compared to those who had an abortion.
- Patients denied an abortion are more likely to remain tethered to abusive partners, and more likely to experience pregnancy complications including eclampsia and death.
WHO PROVIDES ABORTIONS

- The number of providers and clinics providing abortion has declined in recent years.
- The number of providers decreases with increasing gestational age: 95% offer abortion to 8 weeks, 34% to 20 weeks, and 16% to 24 weeks.
- At least 30% of providers offer medication abortion services only (Jones 2017).
- While most states allow healthcare professionals to refuse involvement in abortion on the basis of conscientious objection, many abortion providers characterize their provision as conscience-based.

CONTRACEPTIVE USE

- Over 50% of patients having abortions used a contraceptive method during the month they became pregnant (Jones 2018).
- Of those not using a method the month they got pregnant, 33% perceived themselves to be at low risk for pregnancy, 32% had method concerns, 26% had unexpected sex, and 1% were forced to have sex.
- 76% of pill users and 49% of condom users reported inconsistent use.

SAFETY OF ABORTION

- The 2018 report from NASEM (the National Academies of Sciences, Engineering and Medicine) concluded that all forms of abortion (medication, aspiration, dilation and evacuation, and induction) are safe and that the only factors decreasing safety are those decreasing access (NASEM 2018, Upadhyay 2015, White 2015).
- First trimester abortions pose no long-term risk of infertility, ectopic pregnancy, spontaneous abortion, or breast cancer (Guttmacher 2019).
- Abortion does not pose a hazard to patient’s mental health (Biggs 2016, Horvath 2017). The most common emotional response following an abortion is a sense of relief.
- Mortality associated with childbirth is 14 times that of legal abortion (White 2015).
- The risk of abortion complications is minimal in the U.S., with less than 0.5% of patients experiencing a complication that requires hospitalization (NASEM 2018, White 2015).

THE IMPACT OF ABORTION-RELATED STIGMA

- Because abortion is highly stigmatized, patients who seek or undergo abortion may keep their decision a secret.
- A patient may choose not to disclose their decision to family or friends, exclude abortion in their medical history, or delay care or management of emergencies.
- A systematic review showed that patients who have had abortions experience fear of social judgment, self-judgment and a need for secrecy. Secrecy was associated with psychological distress and social isolation (Guttmacher 2016).
- “Stigma and silence produce a vicious cycle: when [patients do not disclose their experience or] providers do not disclose their work, their silence can perpetuate a stereotype that abortion remains rare, or that legitimate, mainstream providers do not perform abortions. This can in turn contribute to marginalization of patients and abortion providers.” (Harris 2013)
- Stigma can lead to the social, medical, and legal marginalization of abortion care around the world and is a barrier to access to high quality, safe abortion care.
AN OVERVIEW OF U.S. ABORTION LAW

Key U.S. Supreme Court decisions serve as the foundation for state abortion laws. In the 1973 *Roe v. Wade* decision, the Court established that:

- In first trimester (up to 14 weeks), state laws cannot interfere with a woman’s right to end a pregnancy; decisions are left to a woman and her medical provider.
- During second trimester (14 to 24 weeks), state laws may regulate abortion procedures only in order to protect the woman’s health.
- During third trimester (after 24 weeks), state laws may prohibit abortion except when it is necessary to preserve the life or health of the woman.

In the 1992 *Planned Parenthood of SE Pennsylvania v. Casey* case, the Court established:

- States can restrict abortions, even in the first trimester, as long as restrictions do not place “undue burden” on women.
- In 2016, *Whole Women’s Health v. Hellerstedt* confirmed that compounding effects of multiple restrictions unfairly singled out abortion providers. In 2020, a similar challenge was brought to a more conservative Supreme Court in June Medical Services v. Russo, and may undermine the ability of abortion providers to bring cases on behalf of patients.

WHAT IF ROE FELL?

- If Roe v. Wade were weakened or overturned, it is estimated that abortion rights would be protected in less than half of U.S. states and no U.S. territories.
- Here is a map of which states and territories would be expected to have expanded access, protected, not protected, and hostile laws. (For interactive maps, see Center for Reproductive Rights).

U.S. LAW AND POLICY HIGHLIGHTS


(Note: Numbers accurate as of publication date and may change with pending cases and legislation.)

Record numbers of restrictive state laws were passed in the last decade.

- **Gestational Age Limits**: 43 states prohibit abortions, except to protect the patient’s life or health, after a specified point in pregnancy (most often fetal viability).
- **Public Funding**: The Hyde Amendment bars the use of federal funds to pay for abortion unless the pregnancy arises from incest or rape, or to save the life of the patient, which disproportionately impacts communities of color who are disproportionately covered by public funding. 33 states and D.C. prohibit the use of state funds except in cases of danger to life, rape, or incest. 16 states use their own funds to pay for all or most medically necessary abortions for Medicaid enrollees in the state.
- **Coverage by Private Insurance**: 12 states restrict coverage of abortion in private insurance plans, most often limiting coverage only to when the woman’s life would be endangered if the pregnancy were carried to term. Most states allow the purchase of abortion coverage at an additional cost. Most Title X clinics carry malpractice insurance that specifically excludes abortion procedures.
• **State-Mandated Counseling:** 28 states mandated counselling intended to deter a person from choosing an abortion that does not follow established principles of informed consent. In 20 states, this counselling includes false medical information on at least one of the following: a purported link to breast cancer (4 states), infertility (4 states), long-term mental health consequences (8 states), early fetal pain (13 states), reversibility of medication abortion (6 states), fetal personhood (5 states).

• **Waiting Periods:** 27 states require a specified waiting period, after state mandated counselling, usually 24 hours, though 6 states require 72 hours; 14 of these require two separate clinic trips because the counseling must take place in person.

• **Medically Unnecessary Ultrasound:** 14 states require an ultrasound prior to an abortion regardless of medical necessity. In several states, patients are forced to view and listen to descriptions of ultrasound images despite their wishes.

• **Parental Involvement:** 37 states require parental involvement in a minor’s decision to have an abortion; 26 require parental consent, and the remainder require notification of one or both parents.

• **Targeted Regulation of Abortion Providers:** 24 states regulate abortion providers beyond what is necessary to ensure patients’ safety; 17 of these even apply to sites where only medication abortion is provided. 14 states require providers have hospital affiliation.

• **Telemedicine MAB Banned:** 18 states ban use of telemedicine for medication abortion.

• **Physician Requirements:** 33 states require all abortions be performed by a licensed physician, & one (MS) restricts abortion provision to obstetrician gynecologists only. 17 states allow APCs to provide medication abortion, and 7 of these also allow APCs to provide aspiration abortion.

• **Hospital Requirements:** 19 states require an abortion to be performed in a hospital after a specified point in the pregnancy, and 17 states require the involvement of a second physician after a specified point.

• **Refusal clauses:** 45 states allow individual health care providers to refuse to participate in an abortion. 42 states allow institutions to refuse to perform abortions, 16 of which limit refusal to private or religious institutions. 12 states allow institutions or providers including pharmacists to refuse to provide services related to contraception alone.

• **Gag Rule:** Prohibits clinics that receive federal funding from providing referrals for abortions or providing options counseling.

• **Protection Against Clinic Violence:** The Freedom of Access to Clinic Entrances (FACE) Act is a federal law that was enacted in 1994 to protect clinics, medical personnel, and patients seeking reproductive health care against blockades and violence. Sixteen states and the District of Columbia have passed similar laws to prohibit specific actions or provide protected “bubble zones” outside of clinics.

• **Federal Abortion Ban:** In 2007 the “so-called PBA Ban” Act was upheld. This decision retreats from an unbroken line of precedent that a woman’s health must remain the paramount concern in any abortion regulation, as it includes no health exception.
ADPTION FACTS AT A GLANCE

THE ADOPTION PROCESS

- In adoption, a birth parent places the child in the care of another person or family in a permanent, legal agreement.
- The birth parent selects the type of adoption (open vs. closed) and may influence who will facilitate the process (agency, attorney, facilitator).
- Social workers are a helpful resource for patients navigating adoption.
- Prospective adoptive parents undergo an evaluative home study, which includes interviews, home visits, health evaluation, income, and references (NAICH 2004).
- The birth parent may be given a limited period of time during which they may change their mind. After that, the courts reverse few adoptions.

<table>
<thead>
<tr>
<th>TYPES OF ADOPTION</th>
<th>Open</th>
<th>Closed</th>
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<tbody>
<tr>
<td>In open adoption, the birth parent may select and have contact with the adopting family (through ongoing visits, phone calls, pictures, or through an intermediary). Birth parents may choose open adoption to be reassured and maintain contact as the child grows.</td>
<td>In closed or confidential adoption, the birth parent and adopting parents have no contact, but do share relevant medical history. All court records are sealed. Patients may choose closed adoption for more privacy.</td>
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INCIDENCE OF ADOPTION

- There is no updated central database on adoption and available data are limited.
- Of U.S. infant adoptions, 59% occur through the child welfare system, 26% involve children born internationally, and 15% involve U.S.-born infants placed (Arons 2010).
- The proportion of infants placed for U.S. adoption declined from nearly 10% before 1973 (the year Roe v. Wade was decided) to 1% by 2002 (Jones 2009).
- Patients choosing to place a child for adoption are more likely to be never married, young, higher income and more educated than those choosing parenting (Arons 2010).
- Of U.S. reproductive aged women, < 1% (0.7%) has ever adopted a child (Ugwu 2015)
- Adoptive parents are more likely to be > 35, ever married, to have previously used infertility services, or to be men, than people who have not adopted (Jones 2009).
- Patients who have ever used infertility services are 10 times more likely to have adopted than those who have never used infertility services (Jones 2009).
- The Hague Convention on Protection of Children was introduced in 1993 as an international treaty providing safeguards to protect the best interests of children, birth parents, and adoptive parents involved in intercountry adoptions.
- The rates of intercountry adoptions have decreased in the last 2 decades, and countries participating continue to change.
PROGRAM OVERVIEW

PROGRAM OBJECTIVES
At the conclusion of the program, you should be able to:

1. List key elements of pregnancy options and informed consent counseling
2. Consider benefits of providing these services in a primary care vs. specialty setting.
3. Describe management options for early pregnancy loss
4. Describe the steps involved or provide early medication abortion care
5. Perform uterine aspiration for abortion or early pregnancy loss
6. Describe the management of complications related to early pregnancy loss, medication abortion, and uterine aspiration
7. Provide patient-centered contraceptive counseling and management

TRAINING SUMMARY
This program will vary depending on the training setting. We encourage use in professional training programs, clinics, or individual practice in the U.S. or abroad.

When this curriculum is reviewed as part of hands-on clinical training, each trainee should:

• Meet with faculty for orientation and values exploration around pregnancy options
• Follow patient(s) through visits from counseling to recovery
• Review best practices and participate in patient-centered reproductive counseling
• Review routine aftercare and follow-up including for those referred out
• Discuss cases involving routine care and rare complications
• Learn the contraceptive options, contraindications, side effects, initiation and removal
• Participate in counseling, evaluation, and management of early pregnancy loss

Those participating in abortion training will also:

• Review steps to evaluate and counsel patients before and after medication abortion
• Handle procedural instruments using the “no touch” technique
• Observe and perform first-trimester uterine aspiration procedures
• Perform tissue examinations to identify pregnancy elements accurately.

LENGTH OF TRAINING
• We encourage evaluation focused on core competencies for individual learners rather than a specific number of procedures or sessions. Depending on patient volume, 4-8 day-long sessions may be adequate for a full participant and 1-4 sessions may provide adequate exposure for a partial participant not learning uterine aspiration.

ADVANCED TRAINING OPPORTUNITIES
• Those interested in gaining more in-depth skills and knowledge may also:
  o Complete elective clinical sessions and procedural exposure
  o Complete further training on complex cases and complication simulations
  o Read Chapter 9 on Becoming a Provider
  o Complete supplemental videos and readings (such as Paul Textbook, 2009)
  o Get involved in networking, advocacy, & leadership activities, such as TEACH’s CREATE (Advanced Training and Leadership) Program, or RHAP Cluster
  o Plan for additional training, mentorship, and / or fellowship opportunities
# TRAINING PLAN

Name: _______________________________________________________________________________________________

Training Initiation Date: ______________________  Training Completion Date: ____________________________

<table>
<thead>
<tr>
<th>Date</th>
<th>Activity</th>
<th>Basic</th>
<th>Advanced</th>
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<tbody>
<tr>
<td></td>
<td><strong>1. ORIENTATION: ABORTION IN PERSPECTIVE</strong></td>
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<td></td>
<td>Discuss Chapter 1 and suggested videos</td>
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<td></td>
<td>• Review Training Plan and clarify training goals</td>
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<td></td>
<td>Discuss reproductive justice lens, professional ethics, and abortion in both global and U.S. perspective</td>
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<td>Discuss policies, safety issues, and emergency cart contents</td>
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<td>Follow patient(s) through an abortion or early pregnancy loss visit</td>
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<td>Review instruments and simulate aspiration procedure</td>
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<td></td>
<td>Discuss Chapter 1 Exercises including Values Clarification</td>
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<td><strong>2. COUNSELING &amp; INFORMED CONSENT</strong></td>
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<td></td>
<td>Discuss Chapter 2 and suggested videos</td>
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<td></td>
<td>Observe or role play pregnancy options counseling</td>
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<td></td>
<td>Observe or role play abortion counseling</td>
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<td></td>
<td>Discuss Chapter 2 Counseling and Consent Exercises</td>
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<td></td>
<td>Paul Textbook Chapter 5 &amp; 16: Informed Consent and Counseling and Answering Questions about Long-term Outcomes</td>
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<td><strong>3. PRE-ABORTION EVALUATION</strong></td>
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<td></td>
<td>Discuss Chapter 3 and suggested videos</td>
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<td></td>
<td>Review pregnancy testing and dating methods</td>
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<td>Review medical history pertinent to uterine aspiration</td>
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<td>Observe and perform early pregnancy ultrasound examinations</td>
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<td>Perform pelvic examinations for uterine sizing and position</td>
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<td>Discuss diagnosis of viable, non-viable and ectopic pregnancy</td>
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<td></td>
<td>Discuss Chapter 3 Pre-Abortion Evaluation Exercises</td>
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<td></td>
<td>Paul Textbook Chapter 6 &amp; 7 – Clinical Assessment and Ultrasound in Early Pregnancy and Medical Evaluation</td>
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<td><strong>4. MEDICATION ABORTION</strong></td>
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<td></td>
<td>Discuss Chapter 4 and suggested videos</td>
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<td></td>
<td>Discuss various medication abortion regimens and access issues</td>
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<td>Review counseling, patient information, and patient selection</td>
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<td>Provide regimen and patient information</td>
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<td>Review follow-up to assess completion of abortion</td>
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<td>Discuss Chapter 4 Medication Abortion Exercises</td>
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<td><strong>5. PAIN MANAGEMENT &amp; MEDICATIONS</strong></td>
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<td>Discuss Chapter 5 and suggested videos</td>
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<td></td>
<td>Review medications including antibiotics, &amp; pain medications used for oral and IV sedation, patient selection, and monitoring</td>
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<td>Review agents and methods used for cervical anesthesia</td>
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<td>Administer effective cervical anesthesia</td>
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<td>Review appropriate selection criteria, monitoring and administration of IV sedation</td>
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<td>Discuss Chapter 5 Pain Management &amp; Medications Exercises</td>
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<td></td>
<td>Paul Textbook Chapter 8 – Pain Management</td>
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Note: Shading indicates optional activities depending on training goals.
<table>
<thead>
<tr>
<th>DATE</th>
<th>Activity</th>
<th>Basic</th>
<th>Advanced</th>
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</thead>
<tbody>
<tr>
<td>6. UTERINE ASPIRATION PROCEDURE</td>
<td>Discuss Chapter 6 and suggested videos</td>
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<td></td>
<td>Observe procedure, review use of equipment and instruments with faculty, and practice “no touch” technique</td>
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<td>Perform accurate tissue examinations</td>
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<td></td>
<td>Review strategies for minimizing and managing complications</td>
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<td></td>
<td>Discuss Chapter 6 Uterine Aspiration Exercises</td>
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<td>Perform MVA to competency</td>
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<td></td>
<td>Perform EVA to competency</td>
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<td></td>
<td>Paul Textbook Chapters 10, 13, &amp; 15 – First Trimester Aspiration, The Challenging Abortion, &amp; Surgical Complications</td>
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<tr>
<td>7. CONTRACEPTION &amp; ABORTION AFTERCARE</td>
<td>Discuss Chapter 7 and suggested videos</td>
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<td></td>
<td>Review and practice patient-centered contraceptive counseling</td>
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<td>Review tools for providing evidence-based contraception and determining medical eligibility</td>
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<td></td>
<td>Perform IUD and contraceptive implant placement</td>
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<td>Review aftercare instructions, and precautions</td>
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<td>Observe recovery room procedures</td>
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<td></td>
<td>Discuss Chapter 7 Contraception and Abortion Aftercare Exercises</td>
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<tr>
<td>8. MANAGEMENT OF EARLY PREGNANCY LOSS</td>
<td>Discuss Chapter 8 and suggested videos</td>
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<td></td>
<td>Review counseling for Early Pregnancy Loss</td>
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<td>Discuss management options for Early Pregnancy Loss</td>
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<td>Discuss Chapter 8 Early Pregnancy Loss Exercises</td>
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<tr>
<td>9. BECOMING A PROVIDER</td>
<td>Discuss Chapter 9 and suggested videos</td>
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<td></td>
<td>Complete Paul Textbook suggested supplemental readings to deepen knowledge base</td>
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<td></td>
<td>Discuss trainee aspirations and pertinent advanced opportunities</td>
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<td></td>
<td>Discuss Chapter 9 Exercises on Becoming a Provider</td>
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<tr>
<td>10. TEACHING POINTS</td>
<td>Review Content while working through each chapter</td>
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<tr>
<td>11. BECOMING A TRAINER (AVAILABLE ONLINE)</td>
<td>Review Content, exercises and suggested videos</td>
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<tr>
<td>12. OFFICE PRACTICE INTEGRATION (AVAILABLE ONLINE)</td>
<td>Review Content, exercises and suggested videos</td>
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<tr>
<td>13. EVALUATION (OPTIONS AVAILABLE ONLINE)</td>
<td>Review Skills Assessment with faculty</td>
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<td></td>
<td>Complete Training Program Evaluation</td>
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Note: Shading indicates optional activities depending on training goals.
PARTIAL PARTICIPATION OR OPT-OUT CURRICULUM

This curriculum is designed to help trainees achieve their individualized learning objectives in reproductive health care. Not everyone will go on to provide abortion care, although it is important that all primary care providers become familiar with services their patients seek to help manage their follow-up care. Benefits commonly reported by partial participants who opt out of abortion training include improved counseling skills, gynecologic procedural exposure, and reflection on individual values (Steinauer 2014).

Professional organizations such as the AAFP, ACOG, ACNM, and NONPF recommend trainees receive exposure to many core skills covered in this curriculum, including:

- Evaluation of pregnancy dating and pregnancy risk
- Pregnancy options and contraceptive counseling
- Management of uncomplicated spontaneous abortion
- IUD and contraceptive implant counseling, placement, and removal
- First trimester uterine aspiration (considered advanced training by professional organizations of Family Physicians, Ob/Gyns, Nurse Midwives, Women’s Health Nurse Practitioners).

After initial orientation and values clarification, trainees benefit from discussing options with their faculty to arrive at a balanced appraisal of appropriate training content.

The alternative or opt out curriculum recommendation below is for partial participants to cover the foundation of values clarification, options counseling, contraception, follow-up care, complication management, and early pregnancy loss, with additional material as desired.

SUGGESTED EXERCISES FOR PARTIAL PARTICIPATION or OPT OUT

<table>
<thead>
<tr>
<th>Date</th>
<th>Chapter / Activity</th>
<th>Reading / Exercises</th>
<th>Initials</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Orientation: Abortion in Perspective</td>
<td>All / All</td>
<td></td>
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<tr>
<td>2.</td>
<td>Counseling and Informed Consent</td>
<td>All / All</td>
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<tr>
<td>3.</td>
<td>Pre-Abortion Evaluation</td>
<td>All / All</td>
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<tr>
<td>4.</td>
<td>Medication Abortion</td>
<td>All / 4.2 (1), 4.3 (1-3)</td>
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<tr>
<td>5.</td>
<td>Pain Control and Medications</td>
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<tr>
<td>6.</td>
<td>Uterine Aspiration Procedure (for EPL and / or Abortion)</td>
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<tr>
<td>7.</td>
<td>Contraception and Aftercare</td>
<td>All / All</td>
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<tr>
<td>8.</td>
<td>Management of Early Pregnancy Loss</td>
<td>All / All</td>
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<tr>
<td>9.</td>
<td>Becoming a Provider</td>
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Note: Shading indicates optional activities depending on training goals.
CHAPTER 1 EXERCISES:
ORIENTATION: ABORTION IN PERSPECTIVE

EXERCISE 1: Feelings about providing abortions

1. As you embark on this experience, consider how you might disclose this training to others. Do you think there is any parallel between the stigma that patients and providers experience?

2. Consider this quotation on the role of conscience in abortion provision, and not just the historical focus on the refusal to participate. What are your thoughts on how this view might decrease stigma?
   “[Providers] continue to offer abortion care because deeply held, core ethical beliefs compel them to do so. They see women’s reproductive autonomy as the linchpin of full personhood and self-determination, or they believe that women themselves best understand the life contexts in which childbearing decisions are made… among other reasons” (Harris 2012, “Recognizing Conscience in Abortion Provision,” NEJM).

EXERCISE 2: Practice environment

1. Reflect on some pros/cons patients might experience receiving abortion services in a primary care setting compared to a specialty setting.

2. How would a one-week delay impact a patient’s care in your setting? Consider impacts of public health crises (i.e. COVID-19), waiting periods, or changes to legislation in your area.

EXERCISE 3: General feelings about pregnancy options

Adapted from The Abortion Option: A Values Clarification Guide for Health Care Professionals. (NAF 2005)

Despite our efforts to be objective, we all hold personal values and belief systems that can influence how we respond to patients. These exercises can help you explore your values about pregnancy options in the context of professional judgments you may be called to make. In multiple global settings, participants in abortion values clarification workshops demonstrate improved knowledge, attitudes, and behavioral intentions with regards to abortion care (Turner 2018). Some of these exercises may evoke strong emotions which may require time for individual reflection prior to discussion.
1. In general, how do you feel about your patients choosing abortion, adoption, or parenting in each of these situations? Are you challenged to accept a patient’s decision in the following circumstances?
   • If the pregnancy threatens their physical health or life
     If the pregnancy involves a fetal abnormality (consider a minor developmental disability like Downs vs. an abnormality incompatible with life like anencephaly)
   • If the patient has an active substance use disorder
   • If the patient is in a surrogacy contract
   • If you, as the provider, are pregnant

2. Were you surprised by any of your reactions? How have your life experiences contributed to these feelings?

EXERCISE 3.2: Your feelings about gestational age and abortion
1. At what gestational age do you start feeling uncomfortable about your patient choosing to have an abortion?

2. Does it matter if you are making a referral vs. performing an abortion? Or the reason for the abortion? If so, why?

EXERCISE 3.3: Your feelings about patients’ reasons or situation
1. How would you feel about referring or providing an abortion for a patient who:
   • is ambivalent about the pregnancy but whose partner wants them to terminate
   • wishes to obtain an abortion because they are carrying a female fetus
   • has had a number of previous abortions
   • indicates that they do not want any birth control method to use in the future
   • conceived using assisted reproductive technology, but changed their mind
   • is in a surrogacy contract and decided to end it

2. How might you handle your discomfort when caring for patients under these circumstances?
CHAPTER 1 TEACHING POINTS:
ORIENTATION: ABORTION IN PERSPECTIVE

EXERCISE 1: Feelings about Providing Abortions

Purpose: This exercise will help clarify your feelings about abortion provision.

1. As you embark on this experience, consider how you might disclose this training to others. Do you think there is any parallel between the stigma that patients and providers experience?
   - As you explore your level of involvement with options counseling and abortion care, consider the implications this may have on disclosure to family, friends, or acquaintances.
   - A “prevalence paradox” is a phenomenon that can affect patients and providers alike (Kumar 2009, Harris 2013). The less something is talked about, the more stigmatized and rare it seems, when in fact it is very common. In other words, silence creates a vicious cycle that often distorts the true nature of things. Research supports that having a safe space to discuss the stigma around abortion may alleviate the burdens on staff and providers (Debbink 2016).
   - Utilize faculty support during this rotation to discuss whether you experience a sense of burden or stigma.

2. Consider the following quotation on the role of conscience in abortion provision, and not just the historical focus on the refusal to participate. What are your thoughts on how this view might decrease stigma?
   “Providers] continue to offer abortion care because deeply held, core ethical beliefs compel them to do so. They see women's reproductive autonomy as the linchpin of full personhood and self-determination, or they believe that women themselves best understand the life contexts in which childbearing decisions are made, among other reasons.” (Harris 2012)
   - It is important to recognize the conscience in abortion provision and not just in the refusal to participate. The goal of this exercise is to assess how provision can address stigma and impact clinical practice, law, religion, and bioethics.
   - Some learners find it helpful to hear about other providers’ path to abortion care. For examples, see Physicians for Reproductive Health or Clinicians in Abortion Care.
   - Consider how your role as a healthcare provider places you in the position of not just having an opinion on reproductive health care, but in a position to provide it.

EXERCISE 2: Practice environment

1. Reflect on the pros/cons of patients receiving abortion care in a primary care setting compared to a specialty setting.
   - Studies evaluating abortion setting preferences have varied, but many patients prefer primary care environment for abortion care (Godfrey 2010, Logsdon 2012).
   - Some potential advantages of receiving abortion care in a primary care setting:
     - Personalized care with a provider they know and trust
     - Continuity of care
     - Decreased stigma and normalized abortion in health care context
     - Not having to travel or face protesters
     - Attention to preventive care integrated into abortion care (i.e. pap test)
     - Demonstrated safety in primary care environments
• Potential disadvantages of receiving abortion care in a primary care setting:
  o There may be less privacy in a smaller community
  o There may be more consequence of judgment
  o There may be more memory of an abortion during ongoing care
  o The staff or provider may be less specifically trained for every situation
  o Possibly more need to refer out for complex issues
• Data shows that many primary care providers do not routinely discuss pregnancy options. For example, while most primary care providers (PCPs) believe that PCPs have an obligation to provide abortion referrals even in the presence of a personal objection, only one in four in a national sample reported routine options counseling when caring for patients with unintended pregnancy compared to 60% who routinely discuss prenatal care (Holt 2017). This highlights a need for professional guidelines and training.

2. How would a one-week delay impact a patient’s abortion care? Consider impacts of public health crises (i.e. COVID-19), waiting periods, or changes to legislation in your area.

• A one-week delay in abortion care might:
  o Put a patient over the gestational limit for a provider or type of abortion
  o Change the cost or travel needs for an abortion
  o Change the safety of abortion. The risk of complications increases with each additional week of gestation (Bartlett 2004).

EXERCISE 3.1: General feelings about pregnancy options

Values exploration exercises can be challenging, satisfying, and thought provoking. Consider the origin of your beliefs. How do your feelings affect the interactions you have with a patient? How could recognizing these feelings have a positive impact upon patient care? How do you anticipate your feelings could change with this training experience?

1. In general, how do you feel about your patients choosing abortion, adoption, or parenthood in each of these situations? Are you challenged to accept a patient’s decision in the following circumstances?

Consider the following key points:

• There are no right or wrong answers to this exercise.
• Patients have the right to make decisions for themselves, follow their own moral authority, and to receive legally available medical services supporting these decisions.
• You serve patients best by providing active listening and accurate information. Even subtle negative reactions to patient behavior may harm the provider-patient relationship.
• Each of us is shaped by our life experiences, families, communities, class, ethnicity, religious beliefs, and other factors that may affect our judgments.
• Self-exploration helps us promote a non-judgmental climate for patient care.
• We cannot know the best decision for each patient.
• Family planning recommendations by providers are found to vary by patient ethnicity and socioeconomic status, contributing to healthcare disparities (Dehlendorf 2010).
• Family planning decisions are well served by a shared decision-making approach, that integrates the patient’s priorities with the best scientific evidence.
• If you feel uncertainty about one of these scenarios, consider what patient situation would change your view.
2. Were you surprised by any of your reactions? How have your life experiences contributed to your feelings?

EXERCISE 3.2: Your feelings about gestational age and abortion

1. At what gestational age do you start feeling uncomfortable about your patient choosing to have an abortion? Check all that apply.
   - Consider what happens between the gestational age that feels acceptable and the one that doesn’t.
   - Does your response have to do with your understanding of fetal development, concerns about fetal pain, physical risk to the patient, what it feels like doing the procedure as a provider, or other perceived ethical concerns?
   - When (if ever) you first saw a gestational sac or fetal parts, how did you feel about it? Were there any factors that influenced how you felt?

2. Does it matter if you are making a referral vs. performing an abortion? Or the reason for the abortion? If so, why?
   - If you are struggling with the idea of making referrals, consider if the situation differs from other medical circumstances where we value accurate, evidence-based information and patient autonomy.
   - Are there ways to respect the moral autonomy of the patient, without undermining your own?
   - What if no other alternative abortion services were accessible? What kind of patient hardship would motivate you to offer services?
   - Each provider is different and needs to find their own comfort level.

EXERCISE 3.3: Your feelings about patient’s reasons or situation

1. How would you feel about referring or providing an abortion for a patient who:
   a. is ambivalent about having an abortion but whose partner wants them to terminate the pregnancy
      - While this decision is important for both partners, the pregnant person not only has the legal right to the decision but will bear the ultimate responsibility for whatever decision they make; including the risks of pregnancy and childbearing, should they choose to continue.
   b. wishes to obtain an abortion because they are carrying a female fetus
      - Sex selection brings up complicated ethical and cultural issues. It might be helpful to ask if there are medical or cultural reasons that support their preference (i.e. sex-linked genetic conditions or family pressure to have a male child). Discussing these with the patient may help you better understand their position.
   c. has had a number of previous abortions
      - Over half (54%) of patients obtaining abortions used a contraceptive method during the month they became pregnant (Jones 2018). Patients have multiple abortions for many reasons. Discussion may help you better understand their personal barriers to avoiding undesired pregnancy. However, it is important to remember that patients are not responsible for making you comfortable with their decision.
• Patient-centered counseling may help them find a method that meets their needs and preferences. However, many patients prefer not to engage in contraceptive counseling while navigating an unexpected pregnancy.

d. indicates that they do not want any birth control method to use in the future
• Remember that many patients will not desire contraceptive counseling at the time of an abortion (Matulich 2014). And patients often wish to avoid sex after abortion. Remind the patient that their choice to be sexually active and their choice to become pregnant are two separates considerations. Considering contraception doesn’t mean they intend to or will have sex sometime soon. Alternatively recommend they return if their situation changes.

e. conceived using assisted reproductive technology, but changed their mind
• Think about why your feelings about abortion might differ in a pregnancy conceived by assisted reproductive technologies (ARTs). Are there ways to respect the moral autonomy of the patient, without undermining your own?
• Patients facing infertility may pursue ART but may still face pregnancy indecision in the face of changing relationships, stressors, or pregnancy abnormalities (Daar 2015).

f. is in a surrogacy contract and decided to end it
• Surrogacy is a method mainly used for treating women with infertility caused by uterine factors, and also by some LGBTQ individuals. Although reviews report methodologic issues, they show that most surrogacy arrangements are successfully implemented and most surrogate mothers are well-motivated, psychologically balanced, and have little difficulty separating from children born as a result of the arrangement (Söderström-Anttila 2016).
• The criteria which influence surrogacy relationships are: the expectations of both parties; the type of exchange involved in surrogacy arrangements; the frequency and character of contact pre- and post-birth; and cultural, legal, and economic contexts (Payne 2020)
• Think about why your feelings about abortion might differ in a pregnancy conceived for the purposes of surrogacy, and which party in the surrogacy relationship you might identify with.

2. How might you handle your discomfort when caring for patients under these circumstances?
• Many providers avoid asking patients the reasons for an abortion, which allows for patient autonomy. Are there ways to respect the moral autonomy of the patient, without undermining your own?
• Recognizing personal discomfort with a situation is also an important step towards providing unbiased care. Remember there may be more to the situation than the patient communicates directly.
• Sometimes referral will be the best option for your patient. Sometimes talking with colleagues may be helpful. Consider how best to provide appropriate support for the patient.
2. COUNSELING AND INFORMED CONSENT

Updated June 2020 by Razel Remen, MD and Nina Pine, MSc

This chapter will provide guidance for patient-centered counseling and care, using a reproductive justice framework. It will include issues related to identifying and addressing bias, and the use of patient-centered counseling to uphold patients’ autonomy in choosing abortion, parenting, or adoption when faced with a pregnancy. The chapter will also touch upon care of patients across the gender spectrum and provide exam, counseling, and procedure techniques that respect and support patients who have experienced reproductive coercion, or sexual trauma.

CHAPTER LEARNING OBJECTIVES

Following completion of this chapter, you should be able to:

• Give patients pregnancy test results in a non-judgmental manner
• Describe the full range of pregnancy options
• Support patients to choose options consistent with their needs, values, and preferences
• Address issues related to indecision, as needed, and help ensure that patients’ decisions are informed, voluntary, and free of coercion
• Provide information to compare medication and aspiration abortion
• Use language that is mindful, sensitive and unassuming - which supports patients through the reaffirmation of their choices during counseling and/or procedures

VIDEOS

• Informed Consent, Decision Assessment, and Counseling in Abortion Care (IERH)  

RESOURCES:

• Perrucci, A. “Your Patient Has the Answer” (https://providers.bedsider.org/articles/your-patient-has-the-answer)
• The Doula Project. DIY Doula: Self-Care for Before, During, and After your Abortion.
• Reproductive Health Access Project. Sam’s Medication Abortion
• Options Counseling Resources:
  - Ferre Institute Pregnancy Options Workbook
  - All-Options’ Pregnancy Options Workshop
  - RHAP Pregnancy Options Counseling Model
  - Chapter 5: Informed Consent, Counseling, and Patient Preparation
  - Chapter 16: Answering Questions About Long-Term Outcomes
SUMMARY POINTS

SKILLS

• Support each patient's decision-making process by eliciting and being responsive to their unique needs and preferences.
• Be aware of assumptions you make about a patient's personal situation, communities, and feelings.
• Explore how bias may show up in our work, and review strategies for self-reflection.
• Be mindful of tone, terminology, and body language (for example, sit at a patient's eye level to communicate an equal power dynamic when culturally appropriate).
• Ask each patient for their name and pronouns, and if appropriate, their preferred anatomical terminology; ensure staff is aware of preferences and that they are reflected in patient records.
• Use open-ended questions and nonjudgmental listening. Allow time for a patient to think, talk further, and ask additional questions.
• Know when to seek help from more experienced providers or staff in a challenging counseling situation.

SAFETY

• Attend to each patient's need for adequate anesthesia, avoiding assumptions about patients' pain tolerance.
• Screen for coercion, intimate partner violence, and human trafficking. Provide patients with local resources.

ROLE

• Support patients to choose pregnancy options consistent with their needs, values, and preferences. Like other medical decision-making, this is within the scope of primary care providers. Know when and how to refer for services beyond what you can provide.
• Determine that the patient's decision about the pregnancy was made freely and without coercion.
• Provide an opportunity to see the patient alone, as well as to involve a support person when feasible and requested by the patient.
• Maintain patient privacy and confidentiality.
• Direct your attention to the patient and include them in any conversations while in the procedure room.
Bias refers to attitudes or stereotypes that affect our understanding, actions, and decisions. These biases can be unconscious or conscious (Marcelin 2019, Zestcott 2016, Kinwan Institute 2015, Blair 2011). These biases are pervasive and may not necessarily align with our declared beliefs. It is easier to see biases in others than ourselves.

Both unconscious and conscious biases can result in discrimination and health disparities, and can be especially harmful to people from at-risk and marginalized communities when working in reproductive health care. Some important historical examples include the widespread stereotype that “poor people are unable to care for children and so should limit their family size.” This bias has fueled forced sterilization, incentivized LARC use, coverage of LARC placement but not removal, and lack of insurance coverage of infertility services among poor and/or marginalized patients (Guttmacher 2014). In studies using standardized videos, providers have demonstrated biases about who should use intrauterine contraception based only on patient race/ethnicity and socioeconomic status (Dehlendorf 2010).

It is important to understand that most societies have systems of oppression in which there are those who benefit. We all have life experience which is a combination of unearned disadvantage and unearned advantage. To see it, one needs to look through a systemic lens, and not only at individuals (McIntosh 1989).

**Self-reflection on implicit biases**

In order to manage the impact that biases can have on the care we provide, the first step is to become aware of them and their influence on our care. To begin to incorporate self-reflection, you may consider some of the following questions:

- To what privileged groups (i.e. educated, heterosexual, citizen) and what marginalized groups (i.e. lower-economic status, undocumented) do you belong?
- Do you find yourself wanting people in specific groups to make certain contraceptive or pregnancy decisions?

Some best practices that help providers:

- Avoid making assumptions, as they often reflect cultural stereotypes and bias.
- Listen more than you speak; assume patients are the experts in their own lives.
- Practice cultural humility - do not impose your values and beliefs on your patients.
- Cultivate partnerships with local reproductive justice and social advocacy groups.
- Commit to lifelong self-evaluation and self-critique (Waters 2013).

**Additional Resources:**

- Inclusive Teaching Curriculum (University of Michigan)
- Diversity Toolkit A Guide to Discussing Identity, Power and Privilege (USC)
When providing pregnancy test results, some patients will be surprised while others will have taken a test at home and only seek confirmation. In either case, the patient may or may not require support in their decision-making process. Our role is to listen and provide them with the appropriate level of support to come to a decision about this pregnancy, if they have not already (Singer 2004). When providing positive results:

- Be explicit: “Your pregnancy test came back positive, which means you are pregnant.”
- Allow some time for the patient to process the information.
- Use open-ended questions to start, such as “How do you feel about this result?”
- Avoid assuming how a patient will react to the result.

For many patients the decision to have an abortion is clear. They won’t need options counseling; we can help them with planning the next steps. Gauging this is important to respecting their decision. Similarly, avoid making assumptions about what emotions the patient may be experiencing or the reasons behind them. For example, avoid assuming abortion itself will be a sad experience, even if the patient shows sadness. Some people may actually be sad about their life circumstances leading to the choice to have an abortion and ultimately feel relief after completing the process (Rocca 2015).

For patients who are less sure, provide basic information in a non-directive manner.

- I want to look at this situation with you so you can come to a decision you are sure of.
- No matter whether you choose to continue or end this pregnancy, a decision eventually has to be made. Some patients feel conflicting emotions, and that is completely normal.
- Is there any part of this situation that is challenging for you?
- Is there anyone in your life who can help you in a supportive way, without judging you or pushing their opinions on you?

The following framework and examples may assist your counseling conversation.
Helpful considerations for patients who are undecided

For patients who are unsure about what decision to make regarding their pregnancy, invite them to imagine their life, now and in a few years, and how it might be different depending on the choice they make. “What is your picture of the next year or five years of your life? How would a different decision change, affect, or support your goals?”

<table>
<thead>
<tr>
<th></th>
<th>Continuing Pregnancy</th>
<th>Ending Pregnancy</th>
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<tr>
<td><strong>Pros:</strong></td>
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<tr>
<td>Short term</td>
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<tr>
<td>Long term</td>
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<tr>
<td><strong>Cons:</strong></td>
<td></td>
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<tr>
<td>Short term</td>
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<tr>
<td>Long term</td>
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</table>

Additional resource:

Video: Counseling for Pregnancy Ambivalence (Innovating Education).

Working through religious, spiritual, or moral conflict

People of all religious and spiritual backgrounds have abortion and you do not need any background in these matters to talk to patients about abortion. You do not have to—and truly cannot—know the answer to the patient’s dilemma; instead, explore what this conflict means for them. It may be beneficial to suggest readings including online faith-based resources below, texts, discussions with their own clergy and/or a supportive religious group, or other counseling referrals.

Patients may experience moral conflict around abortion for multiple reasons. Some may feel that life begins at conception and that abortion is an act of murder. Others may feel that a higher power (God or gods), elders, or others important in their community may not forgive them for their abortion. The counseling framework discussed above can be helpful to explore the patient’s beliefs and options for spiritual reconciliation and healing.

Additional resources:

- Catholics for Choice
- Católicas por el Derecho a Decidir
- Religious Coalition for Reproductive Choice
- Faith Aloud
- Maguire, DC. “Sacred Choices: A Right to Contraception & Abortion in 10 World Religions”
# COUNSELING QUICK GUIDE

<table>
<thead>
<tr>
<th>TRY TO</th>
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| Ask open-ended questions                                              | “What questions do you have for me?”  
“What can I do that is most helpful for you?”                           |
| Clarify the facts                                                     | “Knowing how far along you are will let you know how much time you have to decide.” |
| Reflect/Normalize                                                     | “You seem…”  
“It is okay to cry here.”  
“Many people feel confused/scared/ambivalent…”                         |
| Seek to understand                                                   | “Can you say more about that?”                                                    |
| Validate, don’t fix                                                   | “That sounds really challenging. I’m sorry you’re going through that.”             |
| Frame the situation                                                  | “It sounds like you are being thoughtful and making the best possible decision for your current life circumstances…”  
“Deciding what’s best for you can be hard - but that doesn’t make it wrong.” |
| Reassure the patient                                                 | Encourage them to trust and respect their feelings and their decisions.            |
| Check in about support people                                        | “It may be helpful to tell someone you trust and who will support your decision, no matter what it is. Do you have someone like that to talk to?”  
“If not, “What might happen if your partner/family/friend found out about the abortion?” |
| Communicate acceptance with tone and body language                   | Be mindful of your tone and facial expression. Use eye contact (if culturally appropriate). Sit at their level. |
| Use silence                                                          | Give them time to finish their sentences and thoughts.                             |
| Give the patient control                                             | “Which would you prefer?”  
Keep your patient informed about the next steps.                         |
| Address common fears                                                 | “Can you tell me more about your beliefs? Your fears or worries?”  
Review options for pain control and relaxation.  
Review safety and lack of impact on fertility, mental health and overall health. |
| Pain                                                                 |                                                                                   |
| Spiritual Conflict                                                  |                                                                                   |
| Impact on Health                                                     |                                                                                   |
| Consider language and literacy level                                 | Approach counseling using culturally appropriate language and exercises based on literacy level. Always use a trained medical interpreter when available. |

<table>
<thead>
<tr>
<th>AVOID</th>
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</table>
| False reassurances                                                   | “This won’t hurt.”  
Instead, prepare them for some discomfort and reassure them that the procedure is fast and anesthesia will be individualized to their comfort. |
| Over-identification                                                  | “I know exactly how you feel.”                                                    |
| Medical or stigmatizing jargon                                       | “Elective abortion” implies a chosen vs. indicated procedure.  
Instead, use “abortion” or “induced abortion.”  
Try to mirror a patient’s terminology regarding an abortion. |
| Loaded statements                                                    | “Your family supports your decision, right?”                                      |
When helping a patient decide on medication versus aspiration abortion, get a sense of what factors are important to them (e.g., timing of completion, amount of bleeding, instrumentation, need for privacy/discretion). Include external factors (e.g., childcare, work/school schedule, housing situation) that might make one option a better fit.

<table>
<thead>
<tr>
<th>Medication Abortion with Mife/Miso</th>
<th>Aspiration Abortion</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Quick Summary for Patient</strong></td>
<td></td>
</tr>
<tr>
<td>“Both work very well, both are safe, and neither changes your chances to get pregnant in the future (if that’s what you want).”</td>
<td>“This is done (with me), on an exam table in the office, with instruments inside you. You will be given medicine for pain, and it usually takes 5-10 minutes to complete.”</td>
</tr>
<tr>
<td>“You take one pill first, then take a different medicine later which will cause cramping and bleeding. The pregnancy will usually pass within a few hours.”</td>
<td></td>
</tr>
<tr>
<td><strong>Gestational Age</strong></td>
<td></td>
</tr>
<tr>
<td>Currently up to 11 weeks in the U.S. Beyond 11 weeks in some countries</td>
<td>Aspiration to 14-16 weeks D&amp;E beyond 14-16 weeks</td>
</tr>
<tr>
<td><strong>Advantages</strong></td>
<td></td>
</tr>
<tr>
<td>Patient has more control over where the abortion takes place</td>
<td>Procedure over in 5-10 minutes Usually less post-procedure bleeding</td>
</tr>
<tr>
<td>Avoids procedure</td>
<td>Options for moderate or deep sedation</td>
</tr>
<tr>
<td>More support options possible</td>
<td>Leaves the office visit not pregnant</td>
</tr>
<tr>
<td>May be perceived as more natural, like a miscarriage. Options for personalizing the experience.</td>
<td>Medical staff members with patient</td>
</tr>
<tr>
<td><strong>Disadvantages</strong></td>
<td></td>
</tr>
<tr>
<td>Completed in multiple days</td>
<td>Requires clinical setting</td>
</tr>
<tr>
<td>May experience heavier and longer bleeding and cramps.</td>
<td>Risks of instrumentation</td>
</tr>
<tr>
<td>There is less control over the time during which bleeding and cramping occurs.</td>
<td>Risks of anesthesia, if used</td>
</tr>
<tr>
<td>No clinical monitoring.</td>
<td>May be fewer options for support person(s) during procedure</td>
</tr>
<tr>
<td>May inadvertently see the fetus.</td>
<td>Suction machine may be audible</td>
</tr>
<tr>
<td><strong>Protocol</strong></td>
<td></td>
</tr>
<tr>
<td>Take medication at home or in a clinic</td>
<td>Procedure in office or hospital</td>
</tr>
<tr>
<td><strong>Effectiveness</strong></td>
<td></td>
</tr>
<tr>
<td>&lt; 63 days, 95-99% (See Chap 4 Table, page 65)</td>
<td>Over 99% of the time May need repeat aspiration</td>
</tr>
<tr>
<td>64-77 days, with 2nd miso dose 99.6%</td>
<td></td>
</tr>
<tr>
<td>71-77 days, with 2nd miso dose 97.6%</td>
<td></td>
</tr>
<tr>
<td>If fails, will need aspiration</td>
<td></td>
</tr>
<tr>
<td><strong>Duration</strong></td>
<td></td>
</tr>
<tr>
<td>One to several days to complete</td>
<td>One visit; 5 to 10-minute procedure</td>
</tr>
<tr>
<td><strong>Pain</strong></td>
<td></td>
</tr>
<tr>
<td>Mild to strong cramps after taking misoprostol, lasting a few hours</td>
<td>Mild to strong cramps during and just after the procedure</td>
</tr>
<tr>
<td><strong>Bleeding</strong></td>
<td></td>
</tr>
<tr>
<td>Possible heavier bleeding with clots during the abortion</td>
<td>Heaviest bleeding during procedure Light bleeding can persist on and off for 1-2 weeks or more</td>
</tr>
<tr>
<td>Light bleeding can persist on and off for 1-2 weeks or more</td>
<td></td>
</tr>
<tr>
<td><strong>Pain management</strong></td>
<td></td>
</tr>
<tr>
<td>Oral pain medication</td>
<td>Options of: Oral pain medication Local anesthesia Moderate or deep sedation</td>
</tr>
<tr>
<td><strong>Safety</strong></td>
<td></td>
</tr>
<tr>
<td>Used safely for &gt; 25 years At least 10-fold safer than continuing a pregnancy to term</td>
<td>Used safely for &gt; 45 years At least 10-fold safer than continuing a pregnancy to term</td>
</tr>
</tbody>
</table>
CONFIDENTIALITY AND INFORMED CONSENT


Patient information should be confidential and only shared with people directly involved in the patient’s care, if the patient gives permission to do so, or by exception, such as to comply with:

- Health department laws about required infectious disease reporting
- Required reporting of suspected child abuse
- Required reporting of domestic violence
- A formal subpoena
- Insurance company (if patient consents to submitting claim)

Disclosure of information under any other circumstance is a breach of confidentiality.

Voluntary and informed consent must be obtained from the patient. Use appropriate translation services for comprehension, privacy, and true informed consent. If State-Mandated Counseling is legally required, and includes scientifically inaccurate information, the patient should be informed of the factual discrepancies.

MAKING REFERRALS

Referral begins by providing information to your patient if they need services beyond what you can provide in clinic. It is important to regularly vet referral resources for quality control (consider making “mystery shopper” calls to referral sites). While referral practices and motivations varied, one national study showed few clinicians facilitate referral for abortion beyond verbally naming a clinic if an abortion referral was made at all (Homaifar 2017).

In areas where access is limited, patients may face multiple obstacles to obtaining an abortion, and good care coordination is critical to ensure that patients receive the services they need. Taking a more active role in referrals can help clear up misperceptions or misinformation about the legality and safety of abortion, and can assist with complex social or medical circumstances (Zurek 2015). Important steps to fully assist the patient may include:

- Scheduling an appointment
- Helping access supportive services such as funding, transportation, childcare, insurance coverage, or interpreter services
- Following up on the patient’s satisfaction and outcomes with the care received
- Following up with patients that were referred out

In addition to referrals for services you don’t offer, referral making may also involve:

- A pregnancy options talk line for undecided patients or for support after an abortion
- Prenatal care or adoption facilitators (open and closed adoption)
- Intimate partner violence specialists
- Human trafficking specialists
- Referral for a judicial bypass for a minor
- Sexual abuse care
- Mental health services
- Substance use services
- Post-abortion counseling referrals
- Social support services
CONSIDERATIONS FOR PATIENT-CENTERED CARE

Challenging assumptions about sexual identity in family planning

Sexual identity does not always match sexual behavior and practice. In one study, one in three women attending family planning centers for contraception identified as a sexual minority (not strictly heterosexual) (Everett 2018). Compared with their heterosexual peers, women who are not strictly heterosexual have an elevated risk for unintended pregnancy (Higgins 2019). Providers should avoid assumptions about care based upon sexual identity, learn to take a thorough sexual history, and offer contraceptive and pregnancy options counseling to all patients regardless of sexual orientation.

Gender identity and pregnancy

Everyone has a gender identity—an internal understanding of our gender—and thus, patients across the gender spectrum may require sexual, reproductive, and pregnancy-related care. The term “cisgender” is used to describe someone whose gender identity aligns with the sex assigned to them at birth. “Transgender” or “trans” is an umbrella term for people whose gender identity does not correspond to the sex assigned to them at birth or with the gender expectations associated with that sex (Transgender Law Center 2011). Trans and gender diverse (TGD) people are clinically underserved, and face barriers to both routine health care and transition-related care such as a lack of insurance coverage and mistreatment by health care providers (James 2016).

TGD patients with ovaries and a uterus may want or need contraception, and can experience desired and undesired pregnancy and abortion if they engage in sex with a partner who produces sperm, even after social and/or hormonal transition and regardless of whether they are menstruating. Testosterone does not act as a contraceptive (Light 2018, 2014).

In order to support gender-affirming patient-centered care, providers should create a space that is welcoming, use inclusive language, and perform physical exams that consider the potential physical and emotional discomforts specific to these patients (Bonnington 2020). Implementing a gender-affirming approach to pregnancy options and abortion care is critical to creating a such an environment for TGD clients (Richards 2014). Note that patients’ names and gender identity may not be accurately reflected on their identification, medical record, or insurance documents. Avoid making assumptions around clients’ anatomy and identity, and consider patients’ potentially negative prior experiences with gynecological care.

In addition to the resources below, we also encourage you to reach out to your local resources.

- Transgender Law Center. “10 Tips for Working with Transgender Patients.”
- UCSF Center of Excellence for Transgender Health. Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People.
- See Chapter 7, Contraceptive Care across the Gender Spectrum, page 125
Counseling for People with Disabilities

Approximately 15% of people worldwide and 25% in the U.S. are living with some kind of disability, of whom <5% experience significant difficulties in functioning (WHO 2020, CDC 2020; note differences likely represent reporting issues). A disability can be defined as a long-term physical, mental, intellectual, or sensory condition which substantially impairs a person's full participation in society on an equal basis with others (United Nations 2014).

People with disabilities have the same sexual and reproductive health needs as the general population however are less likely to receive contraception counseling, STI testing, pap tests, mammograms and prenatal care (Taouk 2018). Disabled people are at higher risk of sexual assault and of contracting HIV. They face significant barriers to accessing comprehensive reproductive health care, which include lack of provider training, provider bias, incorrect stereotypes that they are not sexually active or unable to get pregnant, and inaccessible health care facilities and equipment (Taouk 2018).

Disabled people are often mistakenly viewed as passive health care participants who are incapable of independent decision making. When working with people with disabilities assume intellectual competence unless the patient has a severe cognitive impairment. In some circumstances it may be appropriate to facilitate supportive decision making, which is an alternative to guardianship allowing people to choose someone they trust to assist them with making decisions regarding specific topics (NDRN 2019).

Many guardians will request contraception or even permanent sterilization for patients with cognitive impairment, either for hygiene purposes or to avoid pregnancy. Providers should always assume intellectual capacity and decision making regarding these requests. In cases of mild to moderate cognitive impairment providers should request patients be seen without their guardian to best assess the patient's personal wishes. Permanent sterilization of patients with severe cognitive impairment is always an ethical dilemma and providers should seek guidance from an experienced ethics committee when faced with such requests (ACOG 2016).

Special Considerations

- Assume intellectual competence. Do not mistake speech impairment for intellectual incapacity; patients may have motor disorders which can hinder articulation.
- Conduct sexual health screening questions without the parent/guardian present if possible, in adolescents/young adults with mild to moderate cognitive impairment.
- Advocate for inclusive facilities and equipment – ensuring there is appropriate space in the waiting room and a larger exam room available for patients who use a wheelchair. If space is limited, plan ahead and move chairs to accommodate any patient in a wheelchair who are scheduled that day.
- Consider purchasing at least one mechanical exam table with adjustable height and padded leg rests (not stirrups).
- Always ask the patient how they would like to be assisted in transferring from a wheelchair to the exam table.
- Allocate extra time for visits so that the patient’s needs are appropriately addressed.
Early pregnancy loss

If a pregnancy loss is diagnosed, be sure that the patient understands the diagnosis, implications, and various management options. Reassure the patient that most pregnancy loss is caused because the pregnancy was not developing correctly, not because of something they might have done, thought, or wished for. Do not assume how a patient will feel. Some patients feel relief, others sadness or guilt, and others may have concerns about their health or fertility. Clients may also feel a number of emotions simultaneously. “See Chapter 8, Counseling Tips for Early Pregnancy Loss, page 142”

Multiple pregnancies

Multiple pregnancies currently makeup approximately 2-3% of all pregnancies but occur at higher rates with assisted reproductive technologies and increasing maternal age. Miscarriage and complication rates are higher among multiple pregnancies. It is common to discover previously unrecognized multiple gestation during the ultrasound evaluation. Some patients may want to know if they have a multiple pregnancy, others may not. Anecdotally, this information may occasionally change a patient’s decision in either direction. Unless local law requires viewing or describing ultrasound findings, routinely ask each patient if they would want to know about multiple gestations prior to the ultrasound, so you can honor their wishes. Selective reduction is also an option in some settings.

Contraception counseling in the setting of abortion care

It can be helpful to offer contraceptive counseling while remaining aware that some patients prefer not to discuss contraception at the time of abortion (Matulich 2014, Kavanaugh 2011). Patients from historically marginalized communities may feel coerced to use contraception in abortion settings (Brandi 2018), making it particularly important to give patients enough time to think about choices. Advanced notice of method availability has been shown to acceptable, and provides abortion patients more time and knowledge for decision-making (Roe 2018). Those who do desire contraceptive counseling report wanting to hear about methods that are easier to use and more effective than previous methods and want to leave the clinic with a method (Matulich 2014). See Chapter 7, Evidence-Based Contraceptive Guidance, page 123.

Reproductive coercion

Reproductive coercion (RC) is common. Internationally, nearly 20% of respondents in family planning clinics reported previous pregnancy coercion and 15% reported birth control sabotage by a partner (Grace 2016, Silverman 2014). RC may include explicit attempts to pressure a partner to have sex without a contraceptive method, either explicit or covert interference with contraceptive methods, or attempts to control outcomes of a pregnancy. RC can come from intimate partners, family members, clinicians, or community members. These actions limit patients’ reproductive autonomy and compromise their ability to make decisions around contraception, pregnancy, and abortion. While many clinical settings have integrated intimate partner violence screening tools, it may be challenging to identify subtler acts of power and control in relationships.

In addition to asking generally about your patient’s support people, you might ask them if anyone has tampered with or prevented their contraceptive use or is pressuring them to make a decision about this pregnancy. Offer support and resources if they are being coerced.
Sexual trauma

It is common to encounter patients who have experienced sexual trauma such as sexual abuse, rape, incest, or human trafficking. These individuals may have had little control over the abusive situation and are likely to feel especially vulnerable and powerless.

Some groups are particularly at risk of sexual trauma. Transgender individuals as well as those with disabilities are two-three times more likely to be raped (Office of Justice Programs 2014, Basile 2016). In addition, victims of human trafficking are often forced or tricked into working in dangerous conditions or having sexual contact with others against their will. Trafficking occurs in every country. It is estimated that 80% of trafficking victims are female, over 50% are children, and 40% are within the person’s country of origin (NCADV 2014). Many victims of sex trafficking do not recognize that they are the victims of trafficking and may simply believe they are in a bad situation, relationship, or job, and are often at high risk of unplanned pregnancy (Lederer 2014). It is important to screen for sex trafficking and have a planned response to assist. See Adult Human Trafficking Screening Tool and Guide.

If a patient discloses they have been raped, consider supporting them by suggesting:

• "This isn't your fault. No one ever deserves for this to happen to them.”
• "I'm so sorry that happened to you.”
• “Thank you for telling me; you’re brave to do that.”
• “I want you to know that you are safe here. We will take good care of you.”

If any patient is interested in reporting a sexual assault, access the sexual assault service providers most familiar with your local reporting laws and counseling. Consider developing and instituting forensic policies and procedures.

Self-managed abortion

Self-managed abortion is when a person chooses to end their pregnancy entirely outside of a medical setting. It is known to occur in every country worldwide irrespective of the legal climate surrounding abortion (Moseson 2019). Reported reasons include perceived greater bodily autonomy, distrust of medical providers and/or institutions, social stigma, cost, distance, and legal restrictions. For some it is preferred while for others, it is their only option. Methods have included safer methods such as misoprostol alone or with mifepristone, as well as herbs and objects or substances inserted into the vagina or cervix, and deep abdomen massage. While self-managed abortion is not new, medication abortion has changed how we think about it, by offering methods proven to be simple, safe, and effective (Jones 2019).

Additional resources:

• Miscarriage and Abortion Hotline
• Aid Access
• Women on the Web
• Ipas
• Decido Yo
RESPONDING TO CHALLENGING PATIENT QUESTIONS

It can be challenging to respond to complex patient questions. Here we will review some of the most common questions that arise. General guidelines are that you:

- Remain sensitive to both verbal and non-verbal expressions of emotion
- Validate the patient’s feelings
- Mirror the patient’s language (for example, if the client uses the term “procedure” for abortion, use the term “procedure.”)
- Avoid assumptions and ask clarifying questions to assess patient’s specific question
- Provide accurate information

“What do you do with the baby after the abortion?”

Providers might say, “A lot of patients ask about that. Can you tell me a little more about what is concerning you?” Consider responding, “I examine the pregnancy tissue to make sure that you are no longer pregnant.” If there are follow up questions you can say the pregnancy tissue is handled like tissue from any medical procedure. Sites have different policies for handling tissue based on local and hospital policies. You could say, “We send the tissue to the pathology lab if there is any concern, and otherwise it is handled similar to cremation.”

“Can I see it?”

In first-trimester abortion, many providers explain the process of fetal development and show the patient the pregnancy tissue if asked. Consider describing what the pregnancy tissue looks like at that stage, so they can make an informed choice about seeing it.

“Will this hurt the baby?”

Evidence regarding the capacity for fetal pain indicates that fetal perception of pain is unlikely before the third trimester (Lee 2005). For patients having a first-trimester abortion procedure, explaining the facts may alleviate this concern. For example, “At this point in the pregnancy, the fetal nervous system is still not developed enough to feel pain.”

Post-procedure support

After the procedure, you can reassure the patient that everything went well and that they are no longer pregnant. Let them know that the cramps they are feeling are a sign that the uterus is healthy and returning to its non-pregnant size. Reassure them that emotions arising with abortion are normal, and that you are there with them.

Reassure them that your staff will be available to them. They can be offered a follow-up visit if desired or you think it would be helpful, especially if there is relationship continuity. However, it is not usually indicated (Grossman 2004). Additional ideas:

- Many patients respond well to encouragements of artistic expression, through writing (http://projectvoice.org/), visual art, or music.
- Consider providing a journal in clinic where patients can share their thoughts or art. Keep in mind patients may share content that could be difficult or disturbing to others.
- All patients can be offered post-abortion support through:
  - All Options (1-888-493-0092; https://www.all-options.org/)
  - Exhale (1-866-4 EXHALE, www.exhaleprovoice.org/)
  - Faith Aloud (1-888-717-5010; http://www.faithaloud.org/)
  - Connect and Breathe (1-866-647-1764; http://www.connectandbreathe.org)
CHAPTER 2 EXERCISES:
COUNSELING AND INFORMED CONSENT

EXERCISE 2.1: Pregnancy options counseling and screening

Purpose: The following exercise is designed to review pregnancy options counseling. Consider role-playing the following scenarios.

1. One of your patients presents with an unexpected positive pregnancy test during clinic or in the ED. How would you approach this?

2. When you ask a patient what questions they have, they want to know if an abortion will affect their ability to have children in the future. How would you respond?

3. A patient is leaning toward adoption but is trying to decide, and wants to know more about the process and options. How would you respond?

4. While you are explaining the protocol for a medication abortion to a patient, they mention that their boyfriend “absolutely cannot find out about this pregnancy.” What concerns does this raise and how can you explore the situation further? What assurances can you give them, what support may you want to offer them?

5. You receive a phone call from a man who would like to schedule a medication abortion for himself. What questions should you ask during intake and counseling?

6. You have a 19-year old patient who has been to the clinic for several abortions in the past. Her first abortion was when she was 14. She is always accompanied by an older male relative. You are concerned she may be the victim of sex trafficking. What questions might you ask? What should you do if you find out she is the victim of trafficking?
EXERCISE 2.2: Counseling around clinical care

**Purpose:** Discuss what you might do or what you might say to the patient in each of the following situations in the context of a uterine aspiration for abortion or early pregnancy loss.

1. As you enter the exam room you hear the patient’s partner criticizing them for “acting stupid” and telling them angrily to “just shut up.” The partner is looking at the wall and ignores your efforts to introduce yourself.

2. When you come into the room and ask the patient how they are feeling, the patient starts crying uncontrollably. They have their head turned away from you and do not make eye contact.

3. The patient is a 14-year-old rape survivor who is 7 weeks pregnant. Every time you attempt to insert the specular, they raise their hips off the table.

4. You are about to see a 22-year-old G0 patient with a mild motor and cognitive disability. She arrives in clinic in a wheelchair with her mother. During the intake, the mother states that she would like to discuss birth control that will assist her daughter with periods.

5. You have just completed an aspiration for a patient at 8 weeks gestation. The patient asks, “Can I see what it looks like?” How would you respond? How would your response differ at 12 weeks gestation?
CHAPTER 2 TEACHING POINTS:
COUNSELING & CONSENT

EXERCISE 2.1: Pregnancy options counseling and screening

Purpose: The following exercise is designed to review pregnancy options counseling. Consider using role-play in the following scenarios.

1. One of your patients presents with an unexpected positive pregnancy test during clinic or in the ED. How would you approach this?
   - If a pregnancy test is being discussed or requested in advance, some providers will ask patients what result they hope for. Once you have given the result, wait for the patient to respond. If it’s not clear how they’re feeling, or what they want to do, you can ask open-ended questions:
     - “How do you feel about this result?”
     - “What do you know about your options?”
     - “What would it be like for you to continue a pregnancy/have an abortion at this time?”
   - If the test itself was a surprise to the patient, explain that a pregnancy test is often done as a routine part of the visit, and that the result suggests that they are pregnant. Ask if they had at all suspected that they might be pregnant.
   - Your role is to listen, support, and ask questions that will help a patient come to a decision about this pregnancy, although not necessarily at this visit.
   - A patient may have feelings and intentions one way or the other, and may not need (or appreciate) full options counseling.
   - If they need more time, consider giving them space to imagine their life now and a few years from now, and to reflect on how each of the available options might change those circumstances. For a more comprehensive exploration of thoughts, feelings, dreams and goals, offer them the Pregnancy Options Workbook (online, Johnson 2013).
   - A helpful video: Decision Counseling for the Positive Pregnancy Test (IERH).

2. When you ask a patient what questions they have, they want to know if an abortion will affect their ability to have children in the future. How would you respond?
   - Uncomplicated uterine aspiration and medication abortion has been shown to have no effect on a patient's future reproductive health.
   - There is no increased risk of infertility, spontaneous abortion, or pre-term delivery.
   - Available data suggest that multiple abortions pose little or no increased risk compared to a single procedure.
   - You might say “There is a lot of misinformation out there about this issue, but abortion is extremely safe and will not affect your ability to get pregnant in the future if and when you want to.”
3. A patient is leaning toward adoption, but is trying to decide, and wants to know more about the process and options. How would you respond?

- Giving birth and raising a child are two different things. You might be ready for one but not for the other.
- A birth parent can think of adoption as a way to select parents for the baby, as opposed to giving the baby to adoptive parents.
- Birth parents commonly feel sadness about relinquishing a child, even if they feel it is the best decision for them.
- Introduce differences between open and closed adoptions, and give resources and local/national referrals as appropriate. See Chapter 1, Adoption Facts at a Glance, page 11

4. While you are explaining the protocol for a medication abortion to a patient, they mention that their boyfriend “absolutely cannot find out about this.” What concerns does this raise and how can you explore this further?

- Use open-ended questions to explore the relationship dynamics, as there may be reproductive coercion occurring.
- “Tell me a little more about your relationship, and how your partner might feel about the pregnancy.”
- “Is your partner pressuring you to make a decision about this pregnancy, or about the birth control you used?”
- Validate and normalize the patient’s feelings about the situation and remind the patient that you will support their decision no matter what.
- You can explore options for birth control that their partner would not know about or be able to control.
- If not done already, screen for intimate partner violence and make a safety plan.
- Offer to refer the patient for further counseling around these issues if needed.

5. You receive a phone call from a man who would like to schedule a medical abortion for himself. What questions should you ask during counseling and intake?

- TGD patients can experience desired and undesired pregnancy, even if amenorrheic from hormone use, and may need abortion services.
- Hormone therapy is not a contraindication to medication abortion. If client decides to continue their pregnancy, they should connect with their provider about potentially altering hormone therapy.
- Work to create a safe gender-affirming environment by asking about pronouns and any preferred terms for specific parts of their body or their menstrual cycle. Make sure all staff and providers are aware of preferences.
- Ask standard questions to accurately date the pregnancy and ensure that their decision is free of coercion.
- Ask about plans for contraception. TGD patients are free to use any form of birth control they might like, however some may want to avoid estrogens, due to the potential for undesired feminizing side effects.
6. You have a 19-year old patient who has been to the clinic for several abortions in the past her first abortion was when she was 14. She is always accompanied by an older male relative. You are concerned she may be the victim of sex trafficking. What questions might you ask? What should you do if you find out she is the victim of trafficking?

• Make sure to see all your patients privately for a few minutes at the beginning of each visit to assess for intimate partner violence and reproductive coercion.
• Ask about her relationship to the older man; look for cues that she might be deferring decision making to him.
• If she indicates (either through verbal or non-verbal cues) that she feels trapped in the relationship, ask about what might be keeping her—assess for fear of violence or other negative consequences of leaving.
• Ask about work: is she being forced to work, is payment ever withheld based on performance? Is she being coerced into sleeping with other men (either to make her partner happy or because she is afraid)?
• If the answers to any of the above questions lead you to think she is a victim of human trafficking, explain what human trafficking is and tell her that you think she may be in a situation where she is being trafficked. Offer support and access to confidential resources. If the victim is a minor, immediately call child protective services.

EXERCISE 2.2: Counseling around clinical care

Purpose: Discuss what you might do or what you might say to the patient in each of the following situations when you come into the procedure room.

1. As you enter the exam room you hear the patient’s partner criticizing them for “acting stupid” and telling them angrily to “just shut up.” The partner is looking at the wall and ignores your efforts to introduce yourself.

• It is essential to talk to the patient without the partner present.
• Explain that you routinely do an exam with the patient alone and have the partner go out to the waiting room.
• Ask the patient about the tension you observed and how they are feeling about the decision.
• A domestic violence screen is appropriate, and you should know the reporting laws for your state or country.

2. When you come into the exam room and ask the patient how they are feeling, they start crying uncontrollably. The patient has their head turned away from you and does not make eye contact.

• Crying is normal, but check in with the patient about how they are feeling. “Many patients cry at the time of abortion. Is there any way I can help you now?” Consider asking, “Can you tell me a bit about what you’re experiencing?”
• The patient may be afraid, or experiencing sadness or loneliness, but still sure of their decision. Alternatively, they may be unsure, or feeling pressured and trapped. You may add something like, “In order to take care of you, I need to understand how you are feeling about this decision today. Do you need some more time?”
3. The patient is a 14-year-old rape survivor who is 7 weeks pregnant. Every time you attempt to insert the speculum, they raise their hips off the table.

- Consider using a pediatric speculum (which can be used for up to at least 13-weeks gestation).
- Offer, “I’m sorry this is uncomfortable. Would any of these options help? Would it help to insert the speculum yourself or to raise the head of the bed?
- Offer to practice a Kegel during the exam to relax perineal muscles or push their hips downward into the table.
- Reinforce that they are in control of their own body, and give suggestions about what they can focus on to help keep the procedure safe.
- If still unable to tolerate the speculum and keep their hips low, consider more pain medication or conscious sedation.
- Consider the possibility that they may want or need a referral for deep sedation.
- Familiarize yourself with the mandated reporting laws in your state. Most states require reporting for any minor (<18 years old) who reports sexual abuse or if the partner is significantly older than the minor. For state laws: http://aspe.hhs.gov/hsp/08/sr/statelaws/statelaws.shtml.

4. You are about to see a 22-year-old G0 patient with a mild motor and cognitive disability. She arrives in clinic in a wheelchair with her mother. During the intake, the mother states that she would like to discuss birth control that will assist her daughter with periods.

- Counseling on reproductive topics for adolescents and young adults with disabilities can be complex given possible medical comorbidities in these patients, intellectual disabilities that may raise concerns regarding consent, and the involvement of families or caregivers who may seek to support such decision-making (Ernst 2020).
- Assume but assess intellectual competence. Do not mistake problems with speech for intellectual incapacity; this patient’s motor disorder may hinder articulation.
- If possible, conduct part of the interview alone to discuss sexual health screening questions, the patient’s own priorities, and comfort with a supportive decision-making role of the parent.
- Allocate extra time and consider special issues for the visit so that the patient’s needs can be appropriately addressed.
- If an exam in needed, consider using a mechanical exam table with leg rests, and always ask the patient how they would like to be assisted in transferring, and discuss alternative positions for doing a gynecologic exam or procedure.
- For more in depth information on contraceptive counseling in patients’ with disabilities, see Ernst 2020, ACOG 2016, this helpful video (University of Michigan 2017), and Chapter 7: Contraceptive Counseling, page 121.
- You have just completed an aspiration (for abortion or early pregnancy loss) for a patient at 8-weeks gestation. The patient asks, “Can I see what it looks like?” How would your response differ at 12-weeks gestation?
• Normalize the request and ask for clarification. “That’s a common question. Tell me more about what you’re thinking.” Sometimes a patient is really asking just if it’s possible to see it, or what you do with the tissue.

• Before 9 weeks it is difficult to visualize fetal parts, and it can be therapeutic for a patient to see the pregnancy tissue, particularly if they perceive the pregnancy as “a formed baby” (often the impression from the protestors’ signs outside the clinic). You can say, “The pregnancy may look like a blood clot or a cotton ball.”

• For later gestations, consider asking tactfully what the patient expects to see. Alert the patient that the fetus may not be intact and that some recognizable parts will be visible, and confirm they still want to see.

• If you are asked about fetal tissue donation, you can let them know in the rare case that a tissue donation program exists at your facility, that it is entirely voluntary and in accordance with the highest ethical and legal standards. Federal law requires a separate consent, that there be no patient payment or control over what the tissue is used for, and no changes to how or when the abortion is done in order to obtain the tissue.
3. PRE-ABORTION EVALUATION

Updated June 2020 by Montida Fleming MD and Caitlin Weber MD, MS

This chapter will address history, physical exam, and testing prior to abortion to ensure that a patient is eligible for a procedure and the chosen method is safe. The pre-abortion evaluation is focused on pregnancy dating and pertinent medical history. Pregnancy dating is usually done by asking a manual exam, and if needed, with diagnostic ultrasound (US). Although persons of childbearing age are typically healthy and eligible for outpatient abortion, this chapter will address when referral is necessary for safety.

CHAPTER LEARNING OBJECTIVES

Following completion of this chapter, you should be better able to:

• Use clinical findings to confirm intrauterine pregnancy and accurately date pregnancy
• Gather appropriate historical, physical exam, and lab information as needed to safely perform uterine aspiration or medication abortion in an outpatient setting, and know when to consult/refer
• Use sonographic findings to diagnose intrauterine pregnancy or early pregnancy loss
• List clinical, lab, and sonographic findings that constitute red flags for ectopic pregnancy

VIDEOS

• Speculum Care without Stirrups (This is How I Teach Series: IERH) https://bit.ly/2UysNyY

READINGS / RESOURCES

• Ultrasound Lecture Series: Obstetrics and Gynecology (AUIM)
  o https://www.aium.org/uls/lectures.htm
  o Chapter 6: Clinical Assessment and Ultrasound in Early Pregnancy
  o Chapter 7: Medical Evaluation and Management
SUMMARY POINTS

SKILLS

• Accurate pregnancy dating is a key component of the pre-abortion evaluation.
• Using a patient’s last menstrual period is accurate, with low rates of both under- and over-estimation to mid-first trimester (Raymond 2015, Schonberg 2014, Bracken 2011). When pregnancy dating cannot be determined by last menstrual period, ultrasound can be used.
• Ultrasound aids in pregnancy dating and the detection of abnormal pregnancy including ectopic pregnancy and early pregnancy loss.

SAFETY

• Patients with chronic medical conditions planning an abortion should be encouraged to continue their regular medications, with rare modifications, as needed.
• The pre-abortion evaluation may reveal conditions that determine a patient’s eligibility for outpatient medication or aspiration abortion or indicate need for a higher level of care.
• If ectopic pregnancy is clinically suspected, diagnostic testing may include pelvic exam, serial serum hCG levels, transvaginal ultrasound, and diagnostic aspiration. A “normal” rise or fall in hCG levels alone is not sufficient to exclude an ectopic pregnancy.

ROLE

• Removing unnecessary labs and visits can improve access and patient experience, without jeopardizing safety.
• Trusting that patients are the experts in their bodies and their pregnancies can improve provider confidence in eliminating unnecessary diagnostics prior to an abortion.
PREGNANCY CONFIRMATION AND DATING

PREGNANCY TESTS

- High sensitivity urine pregnancy test (HSPT):
  - Widely available, inexpensive urine test available over the counter or in clinics.
  - Simple, accurate qualitative test detecting hCG at concentrations of 20-25 mIU/mL.
  - Usually positive by cycle day 32-35 (95% of pregnancies).
  - May remain positive for up to 4 or more weeks following an uncomplicated abortion.
  - May be used after 4 weeks to monitor for completion of a medication abortion.

- Serum quantitative hCG test:
  - Available in clinics only with an order from a healthcare provider
  - Detects serum levels of hCG as low as 2-10 mIU/mL.
  - Not used to confirm pregnancy nor to determine EGA as level range is wide & variable for any GA.
  - Serial measurements often used to evaluate suspected ectopic, abortion completion (i.e. when products of conception not visualized following aspiration), or in management of molar pregnancy.

- Other hCG assays in limited availability and use in United States:
  - Low sensitivity urine test (detects hCG of at least 1000-2000 mIU/mL)
  - Multi-level pregnancy test (MLPT; a graduated urine test).

LAST MENSTRUAL PERIOD (LMP)

- Providers can safely use clinical dating (LMP +/- exam) for most patients with known LMP to determine eligibility for abortion type and setting, compared to the need to determine EDC for a patient continuing their pregnancy.
- First day of LMP alone (+/- 1 week of certainty) is an accurate means of estimating gestational age, with low rates of under- or over- estimation through mid-first trimester (Raymond 2015, Macaulay 2019, Schonberg 2014, Bracken 2011).
**BIMANUAL EXAM**

<table>
<thead>
<tr>
<th>Bimanual exam may improve estimation of gestational age over LMP alone</th>
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<tbody>
<tr>
<td><strong>Dating by uterine size in centimeters</strong></td>
</tr>
<tr>
<td>• After 4 weeks, uterus increases by approximately 1 cm per week</td>
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<tr>
<td>• After 12 weeks, uterus rises out of pelvis</td>
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<tr>
<td>• At 15-16 weeks, uterus reaches midpoint between symphysis and umbilicus</td>
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<tr>
<td>• At 20 weeks, uterus reaches umbilicus</td>
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<tr>
<td>• After 20 weeks, fundal height from symphysis in cm approximately = weeks</td>
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<table>
<thead>
<tr>
<th>Dating by uterine size in fruit comparisons</th>
<th>5-6 weeks</th>
<th>7-8 weeks</th>
<th>9-10 weeks</th>
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<tbody>
<tr>
<td>lemon</td>
<td>medium orange</td>
<td>grapefruit</td>
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<tr>
<th>Limitations of bimanual sizing:</th>
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<tbody>
<tr>
<td>• Abdominal scarring (multiple cesareans); less uterine mobility</td>
</tr>
<tr>
<td>• Fibroids</td>
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<tr>
<td>• Multiple gestations</td>
</tr>
<tr>
<td>• Molar pregnancy</td>
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<tr>
<td>• Uterine retroversion</td>
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<tr>
<td>• Obesity</td>
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<tr>
<td>Consider ultrasound guidance or additional management</td>
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</tbody>
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**Uterus Size By Week (Marguiles 2001)**

- 5-6 weeks
- 7-8 weeks
- 9-10 weeks

**Uterine Position and Flexion**

- Anteflexed / verted / mid
- Retroverted / flexed

**Note change in cervical position**
MEDICAL EVALUATION PRIOR TO ASPIRATION

History and Physical

- Review medical history, obstetrical and gynecologic history, medications, substance use and allergies. A screening tool can ensure a thorough history is obtained (sample here).
- Review information for the following medical conditions (Guiahi 2012):
  - Cardiovascular (hypertension, valvular disease, arrhythmias)
  - Pulmonary (asthma, active respiratory infection)
  - Hematologic (bleeding and clotting disorders, anticoagulants, severe anemia)
  - Hemorrhage risk factors: See Chapter 5: Managing Complications Table, page 73
  - Endocrine (diabetes, hyperthyroidism)
  - Renal and hepatic disease (affecting drug metabolism & clearance)
  - Neurologic (seizure disorder) or psychiatric (severe depression or anxiety)
- Abortion is an essential and urgent service. Delays should be minimized, especially in people with significant medical problems, as risk increases with advancing gestational age. Medical conditions occasionally warrant management or referral prior to abortion (see table below, page 48).
- Complete physical exam as indicated by history and patient symptoms.
- Patients choosing medication abortion with sure LMP do not need a pelvic exam.
- Pelvic and bimanual exam may be performed immediately prior to the procedure.
  - Bimanual for uterine size and position (may be affected by fibroids or anomalies)
  - Speculum exam can assess cervicitis warranting testing / treatment

Lab Tests if Indicated

Patients without underlying medical conditions do not need routine pre-abortion lab testing. Lack of testing is not a barrier to abortion access. Some labs indicated by history, exam or dating.

- Tests pertinent to underlying conditions
  - Glucose for patients with IDDM
  - INR for patients on certain anti-coagulants (Warfarin) > 12 weeks
- Rh (D) testing:
  - Patients > 56 days from LMP with unknown Rh status. (NAF CPGs 2020)
  - Medication abortion patients may forego Rh testing <70 days LMP
  - Document Rh status or informed waiver declining Rh testing >56 days.
  - Can use donor card if Rh negative, chart, patient report, or lab.
  - If patient wants no future children or declines testing, may forego Rh testing.
- Hemoglobin / Hematocrit
  - Only if history or symptoms of anemia, (fingerstick; not complete CBC),
- Chlamydia (CT) / Gonorrhea (GC):
  - For asymptomatic patients ≤ 25 or at increased risk (i.e. new or multiple sexual partners in last year). If not offered at facility, may refer for testing.
  - If cervicitis on exam, test for GC/CT, and initiate empiric prior to aspiration.
  - Universal antibiotic prophylaxis is supported by available evidence for aspiration abortion (Low 2012; Achilles 2011), and less clear for aspiration for EPL (Lissauer 2019). See Ch. 5 for regimens, page 85.
<table>
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<tr>
<th>Health Condition</th>
<th>Considerations</th>
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| Hypertension (HTN)                       | • Mild - moderate is not contraindicated; referral for treatment as needed.  
• Symptomatic and/or severe HTN (>160/110) should be treated prior to procedure or referred for additional management.  
• Methylergonavine (Methergine) should be avoided for patients with HTN.                                                                                       |
| Seizure Disorder                         | • Anti-seizure medications should be taken as prescribed on day of uterine aspiration, and resumed as usual following procedure.  
• No contraindication to receiving procedural benzodiazepines or opiates.  
• Uncontrolled seizure disorder or seizure in last 2 weeks is a contraindication to in-clinic abortion.  
• Some anti-seizure medications interact with hormonal contraception; options should be reviewed for medical eligibility.                                                      |
| Anemia                                   | • If recent sx / hx, check pre-procedure Hgb. If very low (<10 for first trimester, <12 for second trimester), refer or be prepared to manage bleeding appropriately.                                           |
| Blood-clotting disorders                 | • For active clotting disorders, aspiration can be performed in outpatient setting with appropriate preparation (i.e. IV access, available uterotonic).  
• Anticoagulation medications can be continued with relatively low risk of additional blood loss up to 12 weeks (Kaneshiro 2011)                                              |
| Insulin-Dependent Diabetes               | • No changes in diet or medications are recommended for vacuum aspiration, but consider scheduling early in the day.  
• Low glucose levels (<70) require dextrose or food prior to procedure.  
• High glucose levels (200-400) are not a contraindication, but levels >400 warrant evaluation for DKA; require treatment or referral prior to procedure.        |
| Heart Disease                            | • If symptomatic of underlying heart disease, or severe disease, aspiration may be performed in operating room with monitoring by anesthesiologist or anesthetist.                                     |
| Asthma                                   | • Patients with mild asthma may have routine vacuum aspiration. Advise taking routine asthma meds before procedure bringing meds along to the clinic.  
• Patients with an acute or poorly controlled asthma may need to delay abortion care until better controlled.  
• Misoprostol is safe for use in patients with asthma.                                                                                                           |
| Active respiratory infection             | • Consider delaying procedure. If unable, consider PPE for patient & staff.  
• In context of COVID-19 community transmission, recommend PPE that assumes infection if status is unknown.                                                                       |
| Cervical Stenosis                        | • Consider use of os finder, or performing aspiration under ultrasound guidance.  
• A cervical preparation agent such as misoprostol or laminaria may be helpful.  
• Medication abortion may be offered.                                                                                                                                 |
| Uterine Fibroids                         | • Fibroids may inhibit ability to complete aspiration abortion depending on size and location in relation to pregnancy. US guidance may be a helpful adjunct.  
• Consider referral to a higher level of care with an experienced provider.  
• Medication abortion may be considered as an alternative.                                                                                                           |
| Previous Cesarean Delivery               | • Patient may be at increased risk of hemorrhage. Ensure uterotonic medications are readily accessible. Consider performing ultrasound guidance.  
• Additional rare risk of uterine scar pregnancy if multiple previous cesarean deliveries; consider ultrasound and/or referral to higher-level facility.                                      |
| Alcohol or substance use disorders       | • Alcohol use disorder: may need larger benzodiazepine doses due to tolerance.  
• Opiate use disorder: may need larger opiate doses due to tolerance.                                                                                               |
|                                          | • See Chapter 5 for more information, page 88                                                                                                                              |
ULTRASOUND OVERVIEW, METHODS, TIPS & IMAGES

Ultrasound can be used for pregnancy dating when clinical dating is uncertain. Ultrasound can also be used to determine pregnancy location, viability, and/or provide procedural support. Ultrasound is not a requirement for medication abortion or uterine aspiration.

Whether to use transabdominal or transvaginal ultrasound depends on patient preference, pregnancy dating, and the skill of the sonographer. Transabdominal ultrasound may be used to confirm intrauterine pregnancy (IUP) and date a pregnancy, although if landmarks are unclear or pregnancy is early, transvaginal ultrasound may be helpful. Generally, transvaginal ultrasound gives a good view of the pregnancy landmarks and can be helpful to rule out ectopic pregnancy or early pregnancy failure.

<table>
<thead>
<tr>
<th>Transabdominal Probe</th>
<th>Transvaginal Probe</th>
</tr>
</thead>
<tbody>
<tr>
<td>• External probe</td>
<td>• Internal probe</td>
</tr>
<tr>
<td>• Easy to prepare and clean probe</td>
<td>• Need to prepare and clean probe properly</td>
</tr>
<tr>
<td>• Better view with full bladder</td>
<td>• Better view with empty bladder</td>
</tr>
<tr>
<td>• Difficult to detect pregnancy &lt;6 weeks LMP</td>
<td>• Can detect pregnancy as early as 4.5-5 weeks LMP</td>
</tr>
<tr>
<td>• Good for later pregnancy scanning</td>
<td>• Can see early pregnancy landmarks</td>
</tr>
<tr>
<td>• Body habitus and bladder may affect image quality</td>
<td>• With probe close to pregnancy, body habitus does not affect images</td>
</tr>
<tr>
<td></td>
<td>• Improved ability to perform systematic scan</td>
</tr>
</tbody>
</table>

• A limited first trimester ultrasound exam must include: (NAF CPGs 2020)
  o Uterine scan in both longitudinal and transverse planes to confirm IUP
  o Evaluation of pregnancy number (singleton or multiple gestation)
  o Measurements to document pregnancy dating
  o Evaluation of pregnancy landmarks, such as yolk sac, embryonic pole, or the presence or absence of fetal/embryonic cardiac activity

When Performing US

• Ask if the patient wants to view image, be informed of multiple gestations or other pregnancy findings.
• Inform the patient that ultrasound is being used only to confirm the location and dating of the pregnancy and is not a diagnostic ultrasound.
• Consider starting your scan with transabdominal US, and switching to vaginal US only if you are unable to effectively visualize the pregnancy.
• For vaginal ultrasound, use a non-latex probe cover or condom, with ultrasound gel inside and lubricating jelly outside, where in contact with patient.
• Ask if the patient would prefer to self-insert the ultrasound probe.
• Use clear and simple language to discuss ultrasound findings with the patient.
• Systematically scan in the longitudinal and transverse planes.
Longitudinal view is used to confirm pregnancy is intrauterine. For longitudinal view, notch is up (at 12 o’clock) and uterus is scanned side to side, from ovary to ovary. This view should show uterine fundus connected to cervix with pregnancy inside the uterus.

Transverse view is used for dating and pregnancy landmarks, to evaluate for multiple gestations, and get full 3D image of the uterus. For transverse view, the probe is turned 90 degrees to the patient’s right (counterclockwise or notch turned to 9 o’clock) and uterus is scanned anterior to posterior, from fundus to cervix.

Clinicians should understand the sonographic pregnancy features that should be visible based on the patient’s last menstrual period.

<table>
<thead>
<tr>
<th>Pregnancy Landmarks by Weeks LMP</th>
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<tbody>
<tr>
<td>Gestational Sac</td>
<td>4.5 – 5 weeks LMP</td>
</tr>
<tr>
<td>Yolk Sac</td>
<td>5.5 weeks LMP</td>
</tr>
<tr>
<td>Embryonic Pole</td>
<td>6 – 6.5 weeks LMP</td>
</tr>
<tr>
<td>Cardiac Activity</td>
<td>6 – 6.5 weeks LMP</td>
</tr>
</tbody>
</table>

*Above landmarks are better characterized using transvaginal ultrasound
ULTRASOUND LANDMARKS IN EARLY PREGNANCY

The Gestational Sac

- Gestational Sac (GS) is first single US evidence of pregnancy, can appear as early as 4.5 weeks LMP; should always be seen by 5 weeks 5 days LMP (Barnhart 2012).
- Although location of a pregnancy cannot definitely be diagnosed as intrauterine until a yolk sac or embryo is seen (Richardson 2015), a gestational sac still has a high likelihood of being an IUP even in the absence of certain sonographic features if there is no adnexal mass (Benson 2013, Phillips 2020).
- A true gestational sac should be located in the mid to upper portion of the uterus, be eccentric (not midline) to the endometrial canal, be round or oval in shape, and have the double decidual (or double ring) sign, as demonstrated by the FEEDS mnemonic below.
  - Meeting these criteria does not completely exclude the possibility of ectopic pregnancy (Fjerstad 2004).
  - F – Fundal (in mid to upper uterus)
  - E – Elliptical or round shape in 2 views
  - E – Eccentric to the endometrial stripe
  - D – Decidual reaction (surrounded by a thickened choriodedecidual reaction; appears like fluffy white cloud or ring surrounding sac)
  - S – Size > 4 mm (soft criteria)

Gestational Sac vs. Pseudosac

Gestational Sac

Compared to the GS, the pseudosac is more irregular, central, smaller, and without a decidual reaction, and can be seen with an ectopic pregnancy. Note the “beak-shaped” appearance of the sac. This can look similar to an early GS, although only may meet the F (fundal) criteria of FEEDS. Pseudosac may also appear as a mid-uterine small fluid collection.

Pseudosac (May be associated with ectopic) pregnancy

Image: 2020
The Yolk Sac
The Yolk Sac (YS) is first single US finding that confirms an IUP. The YS is a round echoic ring with anechoic (dark) center seen within GS. It appears typically at 5 ½ weeks when the MSD is 5-10 mm. The YS should not be included when taking a measurement of the embryo. The size of the YS is not diagnostic.

The Embryo and Cardiac Activity
The embryo follows a predictable path of development and therefore can be used to date a pregnancy based on its size. The embryo appears at approximately 6 weeks and grows 1 mm per day thereafter until 12-14 weeks. See below for pregnancy dating using embryonic and fetal measurement. Cardiac activity appears around 6 ½ weeks.

Determining Pregnancy Viability
The following data on viability evaluated patients with desired pregnancies (Doubilet 2013). If a pregnancy is undesired, there is no reason to delay an abortion to wait for confirmation of viability. If a pregnancy is desired, and findings are suggestive of early pregnancy loss (see table below), recheck ultrasound in 7-10 days.

<table>
<thead>
<tr>
<th>US findings</th>
<th>DIAGNOSTIC of EPL</th>
<th>US findings</th>
<th>HIGHLY SUGGESTIVE of EPL †</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>CRL 5-7mm and no cardiac activity</td>
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<tr>
<td></td>
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<td></td>
<td>MSD 13 mm or more and no YS</td>
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EARLY PREGNANCY DATING USING ULTRASOUND

Gestational Sac Measurement and Calculation of Gestational Age:

Used for pregnancy dating before embryo is visible.

Measure 3 dimensions in 2 planes (from inside double ring to inside double ring):

• Longitudinal Plane: Length (L) & Height (H)
• Transverse Plane: Width (W)

Calculate the Mean Sac Diameter (MSD):

• MSD = (L + W + H)/3

Calculate the Gestational Age (GA):

• GA (in days) = MSD (in mm) + 30

Length and height measured in longitudinal view.

Width measured in transverse view.

Crown Rump Length (CRL) Measurement and Calculation of Gestational Age:

• CRL = fetal pole (in mm)
• Long axis not including limbs or YS

Calculate: GA (days) = CRL (mm) + 42

Biparietal Diameter (BPD) Measurement

• > 14 weeks, using the fetal biparietal diameter (BPD) is preferred to CRL.
• Inside to outside of skull circumference
• At the level of the thalamus
• No nuchal or eye structures
**ULTRASOUND FINDINGS WITH ABNORMAL PREGNANCIES**

**Anembryonic pregnancy**
Empty gestational sac without fetal pole.
Need three views (length, width and height) to calculate MSD. An empty gestational sac with a MSD of ≥25 mm is diagnostic for an anembryonic pregnancy. Early pregnancy loss occurs in approximately 10-20% of clinically recognized pregnancies.

**Ectopic pregnancy**
Note that this gestational sac with fetal pole is not intrauterine (no cervix is seen in the same plane). Ectopic pregnancy occurs in approximately 1-2% of pregnancies.

**Free Fluid in Cul-de-Sac**
Longitudinal view of the uterus. Note the presence of anechoic (dark) fluid in the posterior cul-de-sac. This may be a finding consistent with blood from an ectopic pregnancy or uterine perforation.

**Gestational trophoblastic disease (molar pregnancy)**
Image of complete mole (no embryo). A complete mole has a cystic intrauterine mass with no distinct gestational sac with yolk sac or fetal pole. Often has a swiss cheese, snowstorm, or moth-eaten appearance on ultrasound. Refer for inpatient management > 12-week size due to increased bleeding risk. Gestational trophoblastic disease occurs in approximately 0.1% of pregnancies.

**Fibroid uterus**
Uterine fibroids are a common pelvic tumor that may enlarge or distort the cervix or uterine cavity, presenting technical difficulty. Ultrasound can help identify the size, location, and orientation to the pregnancy. Images AUIM Ultrasound Lecture Series 2013, 2018,
EVALUATION FOR ECTOPIC PREGNANCY AND EARLY PREGNANCY LOSS (EPL)

Patients presenting in early pregnancy with symptoms of bleeding and / or pain require evaluation for ectopic pregnancy according to local protocol—for example with US and / or serial hCGs, as well as exam. Referral for formal diagnostic ultrasound and/or emergency attention may be indicated.

Ultrasound

• A patient with a positive pregnancy test and no visible pregnancy on ultrasound is said to have a Pregnancy of Unknown Location (PUL).

Serial Serum hCG Levels

• The minimum rate of decline expected for EPL depends on the initial hCG at presentation, but it ranges from 35-50% at 2 days (Butts 2013).
• Rate of hCG rise with ectopic pregnancy is usually slower than expected for a viable IUP.
• Among patients diagnosed with ectopic pregnancies:
  o The majority had serial hCG rise below the normal range for a viable IUP (i.e. level rose < 35-53% in 2 days).
  o For those with declining hCG, the rate of decline is usually slower than that expected for EPL.
  o However, 21% of ectopics have a hCG rise similar to viable IUP and 8% have a decrease that is normal for EPL (Silva 2006).
• Therefore, use caution when following patients in early pregnancy with possible symptoms of ectopic pregnancy, i.e. intermittent bleeding/spotting, pain.
  o A “normal” rise or fall in levels is not sufficient to exclude ectopic – but should be used in conjunction with other clinical data including exam, ultrasound or diagnostic aspiration.

Change in the hCG Level in Intrauterine Pregnancy, Ectopic Pregnancy, and Spontaneous Abortion
(Note: Studies from ED not abortion care setting; therefore ectopic rate is higher)

An increase or decrease in the serial hCG level in a patient with an ectopic pregnancy is outside the range expected for that of a woman with a growing IUP or a EPL 71% of the time. However, the increase in the hCG level in a patient with an ectopic pregnancy can mimic that of a growing IUP, and the decrease in the hCG level can mimic that of an EPL.

Barnhart NEJM 2009
CHAPTER 3 EXERCISES:
PRE-ABORTION EVALUATION

EXERCISE 3.1

Purpose: To review key steps in early pregnancy evaluation and pregnancy dating.

- A 25-year-old G1P0 patient calls your office for a telehealth visit about options for an undesired pregnancy, following a positive home pregnancy test.
  a. What history should you obtain to appropriately triage the patient?
  b. How will you determine the patient's pregnancy dating?
  c. What additional diagnostic data would you consider obtaining?

EXERCISE 3.2

Purpose: To review appropriate uses for different types of pregnancy tests, indicate whether you would use clinical assessment alone, a high sensitivity urine pregnancy test (HSPT), or a serum quantitative hCG test and why; or answer related questions.

1. A 20-year-old G2P1 patient at 4 weeks 2 days by LMP comes to your office requesting pregnancy confirmation and to discuss options.

2. A 27-year-old G3 P2 patient is 6 weeks by LMP with a pregnancy of unknown location (transvaginal ultrasound examination shows no intrauterine gestational sac and no ectopic pregnancy). The patient has been spotting intermittently but is otherwise asymptomatic. A quantitative hCG is 1000, 48 hours later it is 1400.
   a. What is the differential diagnosis?
   b. Would your approach to care differ with a desired vs. undesired pregnancy?

3. A 32-year-old G2P0 patient returns for a follow-up visit 5 weeks after a first-trimester aspiration because of intermittent bleeding since their procedure, and has been sexually active since the aspiration.

EXERCISE 3.3

Purpose: To review key information about ultrasound in early pregnancy.

1. What is the differential diagnosis of the following ultrasound findings? What steps would you take to clarify the diagnosis?
   a. A 36-year-old G4P2 patient at 5 weeks by LMP. In the longitudinal view of the uterus, a gestational sac is elliptical, fundal and eccentric to the midline. Mean sac diameter is 18 mm with no yolk sac or embryo visible.
   b. Embryonic pole length 8 mm with no visible cardiac activity.
   c. A 24-year-old G2P1 patient at 5 weeks and 3 days by LMP reports having intermittent right-sided pelvic pain and cramping. On ultrasound, you visualize a small 3 mm x 3 mm intrauterine fluid collection in the endometrial canal. The shape of the collection is triangular and there is no double decidual sign.
   d. A 30-year-old G3P0 patient reports they are 10 weeks by LMP and having intermittent spotting. On ultrasound, there is a flattened gestational sac without embryo or yolk sac, with cystic changes in the decidua present resembling “swiss cheese.”
EXERCISE 3.4

**Purpose:** To consider management of case scenarios prior to an abortion. Not all material is covered in the Chapter.

1. A 41-year-old G4P4 patient presents for uterine aspiration at 5 weeks by LMP. Pelvic examination reveals an irregular uterus that is 17 weeks in size. Ultrasound examination shows a 5-week intrauterine gestation and multiple uterine fibroids.

2. A 17-year-old G1P0 patient who is 5 weeks pregnant presents for uterine aspiration. As you insert the speculum, the cervix looks inflamed and friable and has pus at the os.

3. A 40-year-old G4P3 patient at 7w4d presents for an abortion procedure. They have a BMI of 35 and a history of 3 previous cesareans.

4. A 29-year-old G5P2 patient presents for uterine aspiration at 7 weeks gestation, with history of venous thromboembolism, now anticoagulated on warfarin; INR is in therapeutic range.

5. A 38-year-old G3P2 patient presents for a uterine aspiration at 6 weeks gestation, with a blood pressure of 170/110 and a headache.

6. A 26-year-old G2P1 patient with a history of insulin-dependent diabetes presents for a uterine aspiration at 8 weeks gestation. A pre-operative glucose level is 520 mg/dL.
CHAPTER 3 TEACHING POINTS:
PRE-ABORTION EVALUATION

EXERCISE 3.1
Purpose: To review key steps in early pregnancy evaluation and pregnancy dating.

1. A 25-year old G1 P0 patient calls your office for a telehealth visit about options for an undesired pregnancy, following a positive home pregnancy test.

a. What history do you need to appropriately triage the patient?
   • Start with current history including LMP, last unprotected sex, recent contraceptive use, pregnancy symptoms, results of recent pregnancy tests, and review of ectopic symptoms and risks (vaginal spotting, unilateral abdominal pain, history of ectopic or PID, IUD in place at time of conception).
   • If not already established, review how the patient feels about this pregnancy.
   • Review medications, allergies, past medical, surgical, gynecological, and obstetric history. Note any chronic medical conditions, history of anemia, hemorrhagic disorders, Rh type if known, history of STIs, prior pregnancy history and outcomes, and history of abdominal surgeries.
   • See abortion medical history form (sample here).

b. How will you determine the patient's estimated gestational age?
   • In early first trimester (<70 days) pregnancy, LMP alone has been shown to be an accurate means of estimating gestational age with low rates of under- or over-estimation in abortion evaluation to mid first trimester or 63 days (Bracken 2011, Schonberg 2014, MacCaulay 2019).
   • Pairing bimanual exam with LMP dating may increase the accuracy of gestational age estimation but is not required to proceed with a medication or aspiration abortion (Bracken 2011).
   • If pregnancy dating by LMP >70 days, LMP is uncertain beyond +/- 1 week, or if there are any signs or symptoms of ectopic pregnancy, an ultrasound may be warranted (Bracken 2011, Raymond 2020).

c. What additional diagnostic data would you consider obtaining?
   • No labs are required unless:
     • Rh if pregnancy dating >56 days and unknown Rh (Mark 2019, Horvath 2020, Hollenbach 2019)
     • Hgb or Hct only if recent history and / or symptoms of anemia
     • CT / GC if symptoms or risk factors (See Chapter 5, page 85)
     • Tests pertinent to underlying conditions
       a. Glucose for patients with insulin-dependent diabetes mellitus
       b. INR for patients on certain anti-coagulants (Warfarin) > 12 weeks
EXERCISE 3.2

**Purpose:** To review appropriate uses for different types of pregnancy tests. For each scenario, indicate whether you would use clinical assessment alone, a high sensitivity urine pregnancy test (HSPT), or a serum quantitative hCG test and why; and / or answer related questions.

1. **A 20-year-old G2 P1 patient at 4 weeks 2 days by LMP comes to your office requesting pregnancy confirmation and to discuss options.**
   - A HSPT is the most useful test to confirm an early pregnancy, both for home and office-based confirmation of pregnancy.
   - A HSPT can detect levels as low as 20 mIU/ml. These levels may be seen in urine as early as a week after conception or before a missed period (although 95% sensitivity may not be reached until cycle day 32-35). Up to 10% of pregnancies have a negative HSPT at the time of missed menses, due often to delayed ovulation & implantation and to variable hCG concentrations in urine (Paul 2009; p.67). Furthermore, not all HSPT tests are the same; some detect hCG levels at 20 mIU/ml, while others at 50 mIU/ml.
   - If **positive**, assess if pregnancy is desired, and proceed with clinical dating.
   - If **negative**, patient should retest in a week if menses does not start.

2. **A 27-year-old G3 P2 patient is 6 weeks by LMP with a pregnancy of unknown location (transvaginal ultrasound examination shows no intrauterine gestational sac and no ectopic pregnancy). The patient has been spotting intermittently but is otherwise asymptomatic. The quantitative hCG you draw comes back at 1000, and another 48 hours later comes back at 1400.**
   a. **What is the differential diagnosis?**
      - Research indicates that the minimum expected hCG rise for a viable IUP is 35-53% at 48 hours. This patient’s hCG rise is 40% in 48 hours. The differential still includes early pregnancy loss, ectopic, and early viable pregnancy. The hCG patterns need to be combined with EGA and clinical symptoms when clinically managing patients.
   b. **Would your approach to care differ with a desired vs. undesired pregnancy?**
      - According to prediction models (Morse 2012), 99.9% of viable IUPs will have a rise in hCG of at least 35% in 48 hours. However, because some viable IUPs will have a slower rise, it is important to obtain a third hCG measurement and repeat the ultrasound if the pregnancy is desired (Zee 2014).
      - If the pregnancy is undesired, offer a diagnostic uterine aspiration, because that will expedite the evaluation for possible ectopic pregnancy. If pregnancy tissue is found in the aspirate, an ectopic pregnancy can be ruled out. In the more likely case that pregnancy tissue is not found, a repeat hCG level 24-48 hours after the aspiration will be helpful. If the gestational sac was aspirated, the hCG level will drop by more than 50%. If the patient is symptomatic or the hCG does not drop by 50%, an ectopic pregnancy becomes more likely, and a referral is warranted.

3. **A 32-year-old G2 P1 patient returns for a follow-up visit 5 weeks after a first trimester aspiration because of intermittent bleeding since their procedure, and has been sexually active since the uterine aspiration.**
   - The HSPT is helpful if negative, but can stay positive 4+ weeks post-abortion.
   - If there are ongoing symptoms or signs of pregnancy or retained tissue, consider serial hCGs to assess trend. Repeat US may also be helpful.
EXERCISE 3.3

Purpose: To review key information about ultrasound in early pregnancy.

1. What is the differential diagnosis of the following ultrasound findings? What steps would you take to clarify the diagnosis?

   a. A 36-year-old G4 P2 patient at 5 weeks by LMP. In the longitudinal view of the uterus, a gestational sac is elliptical, fundal and eccentric to the midline. Mean sac diameter is 18 mm with no yolk sac or embryo visible.

      • This is an intrauterine gestational sac. The mean sac diameter of 16-24 mm with no yolk sac or embryo is highly suggestive of a non-viable pregnancy in this case, although early viable pregnancy and ectopic are still in the differential. If the mean sac diameter was ≥25 mm without an embryo, it would be diagnostic of early pregnancy loss (anembryonic pregnancy).

      • If a pregnancy is undesired, there would be no reason to delay uterine aspiration to wait for diagnosis; and diagnostic aspiration will assist in the evaluation of a possible ectopic pregnancy.

      • If a pregnancy is desired, diagnosis will be clarified by repeating US in 7-10 days.

   b. Embryonic pole length 8 mm with no visible cardiac activity

      • Embryonic pole length > 7 mm with no cardiac activity is diagnostic for early pregnancy loss (Doubilet 2013). Management options including aspiration, medication, or expectant management. See Chapter 8 for more on EPL counseling and management, page 142.

   c. A 24-year-old G2 P1 patient at 5 weeks and 3 days by LMP reports having intermittent right-sided pelvic pain and cramping. On ultrasound, you visualize a small 3 mm x 3 mm intrauterine fluid collection in the endometrial canal. The shape of the collection is triangular and there is no double decidual sign.

      • This case is concerning for ectopic pregnancy. By 5 3/7 weeks, or 38 days, the mean sac diameter should be 8 mm. A normal sac should also be eccentrically placed and not centrally located in the uterine cavity. Combined with the unilateral cramping pain, findings consistent with a pseudosac should prompt ectopic pregnancy workup.

   d. A 30-year-old G3 P0 patient reports they are 10 weeks by LMP and having intermittent spotting. On ultrasound, there is a flattened gestational sac without embryo or yolk sac, with cystic changes in the decidua present resembling “swiss cheese”.

      • This suggests molar pregnancy, which may appear with heterogeneous or mixed-density echoes on ultrasound. The classic moth-eaten, “swiss cheese” or “snowstorm” appearance on ultrasound may not be visible until 9-10 weeks EGA.

      • For suspected molar pregnancy, tissue diagnosis is needed, so uterine aspiration is recommended over medication abortion. If uterine size is over 12 weeks, refer for inpatient management due to increased bleeding risk.

      • When aspiration is performed, tissue should be sent for pathologic examination, and baseline serum hCG obtained. If molar pregnancy is confirmed, hCGs should be monitored according to established protocols (ACOG 2004).
EXERCISE 3.4

Purpose: To consider management of case scenarios prior to uterine aspiration. Not all material is covered in the Chapter.

1. A 41-year-old G4 P3 patient presents for aspiration at 5 weeks LMP. Pelvic examination reveals an irregular uterus that is 17 weeks in size. Ultrasound examination shows a 5-week intrauterine gestation and multiple uterine fibroids.
   • Because aspiration procedures may be incomplete in patients with fibroids, a discussion is warranted about the patient’s preference between a medication abortion vs. procedural abortion.
   • Rarely, a small gestational sac can be high in the fundus “behind” the curve of large or multiple fibroids, and it may be very difficult to reach. Refer to a higher-level setting with an experienced provider if necessary.
   • Consider checking hemoglobin, as patients with significant fibroids can be anemic, and also may bleed more than others during abortion.
   • Ultrasound guidance may be a helpful adjunct to any procedure with fibroids.

2. A 17-year-old G1 P0 patient who is 5 weeks pregnant presents for uterine aspiration. As you insert the speculum, the cervix looks inflamed and friable and has pus at the os.
   • CT / GC testing and initiation of empiric pre-procedural treatment is indicated, as cervical infection with these pathogens increases risk of post-abortal endometritis (Achilles 2011). Uterine aspiration should not be postponed. An appropriate treatment regimen (CDC 2015 Guidelines) includes:
     o Chlamydia: Azithromycin 1 gm single oral dose OR Doxycycline 100 mg orally twice daily for 7 days are the recommended regimens.
     o Gonorrhea: Ceftriaxone 250 mg intramuscular PLUS treatment for Chlamydia.
     o Symptomatic BV at the time of aspiration should be treated with metronidazole 500 mg orally twice daily for 7 days, without need to delay the abortion.

3. A 40-year-old G4P3 patient at 7w4d presents for an abortion procedure. They have a BMI of 35 and a history of three previous cesareans.
   • The patient’s BMI and previous cesarean sections put this patient in the moderate risk category for hemorrhage (Kerns 2013) and a possibly challenging uterine aspiration. Consider medication abortion for this patient.
   • If considering aspiration abortion, the following should be considered:
     o Have uterotonic medications and supplies accessible to manage bleeding.
     o Add vasopressin to paracervical block.
     o Consider intraoperative ultrasound guidance.
     o With additional risk factors, consider referring to center with transfusion capability, anesthesia, and / or interventional radiology.

4. A 29-year-old G5 P2 patient presents for aspiration at 7 weeks gestation, with history of venous thromboembolism, currently anti-coagulated on warfarin; INR is in the therapeutic range.
   • Additional blood loss in anti-coagulated patients was not clinically significant in a small study of anti-coagulated patients seeking aspiration < 12-weeks gestation compared with matched controls (Kaneshiro 2011). A likely explanation is that myometrial contraction is the primary mechanism of hemostasis after uterine aspiration.
• Cases such as this can be done in the outpatient setting with appropriate preparation for unlikely bleeding. A risk/benefit discussion should guide management of anticoagulation. The benefit of holding the morning dose of warfarin or low-molecular-weight heparin prior to an aspiration abortion is unclear.

5. A 38-year-old G3 P2 patient presents for an aspiration at 6 weeks gestation, with a blood pressure is 170/110 and a headache.

  • **Mild to moderate hypertension** is not a contraindication for an outpatient procedure, but requires subsequent referral for treatment of hypertension.
  • Confirm the blood pressure with appropriate cuff size; check if patient has a history of hypertension and if so, any anti-hypertensive medication and if taken today. Consider encouraging patient to take their anti-hypertensive medication if they have it, or relax for a while and recheck. Sedation will also reduce the pressure.
  • For **severe hypertension** (i.e. >160/110) in a patient who is symptomatic – with new onset headache or neurologic changes and pressures concerning for malignant hypertension. The patient should be treated prior to the procedure or referred for additional management.

6. A 26-year-old G2 P1 patient with a history of insulin-dependent diabetes presents for an aspiration at 8 weeks gestation. A pre-operative glucose level is 520 mg/dL.

  • For patients with insulin dependent diabetes, check blood sugar, and if > 400, take history for diabetic control medications and whether taken today, trends, A1c, and history of recent care.
  • **Mild hyperglycemia** (200-400 mg/dL) is not a contraindication for uterine aspiration.
  • Above 400, assess for ketoacidosis (including urine dip for ketones and assess volume status); if + ketones or poor volume status, stabilize or refer prior to the procedure.
  • **Hypoglycemia** (<70 mg/dL) warrants a patient to be given dextrose or food prior to a procedure.
4. MEDICATION ABORTION

Updated June 2020, by Montida Fleming MD and Stephanie Long MD

Medication abortion (medical abortion, or MAB) provides a safe, effective method of pregnancy termination whose use is increasing in the U.S. and globally. It can be offered in diverse settings without special equipment. This process allows for significant patient autonomy with appropriate education and follow-up as needed.

CHAPTER LEARNING OBJECTIVES

At the end of this chapter you should be better able to:

• Evaluate patients prior to medication abortion
• Effectively counsel patients regarding medication abortion
• Discuss criteria for needing additional follow-up

VIDEOS

NEW VIDEO-BASED MEDICATION ABORTION IN PRIMARY CARE CME

Here you can learn evidence-based ways to:

1. “See, do and teach” model for learning to counsel patients on medication abortion
2. Evaluate patients in your everyday practice for medication abortion
3. Discuss the need for additional clinical services after medication abortion

• Telemedicine for Medication Abortion: https://bit.ly/3exCBB2

READING / RESOURCES

• NAF Clinical Practice Guidelines – Early Medication Abortion (NAF CPG 2020)
• Medical Management of First-Trimester Abortion. (SFP Clinical Guidelines 2014)
• WHO Medical Management of Abortion. (WHO 2018)
• Ipas Clinical Updates in Reproductive Health: Medication Abortion. (Ipas 2020)
• Mifepristone manufacturers (with on-call networks)
• Danco (https://www.earlyabortionpill.com) and GenBioPro (https://genbiopro.com)
• Additional helpful resources for providers and patients:
  o RHAP Provider Abortion Resources
  o RHAP Patient Resource: Sam's Medication Abortion Zine
  o Euki App – a private, unbiased Sexual and Reproductive Health App
SUMMARY POINTS

SKILLS

- Medication abortion (MAB) is technically simple. Skills for medication abortion include assessment of eligibility, counseling, evaluation of success, and evaluation and management of rare complications.
- Medication abortion is increasing globally. In 2017, nearly 40% of eligible patients chose medication abortion. Medication abortion increases access, and one in 4 abortion providers in the U.S. offer only medication abortion (Jones 2019).
- Combined mifepristone/misoprostol regimens are more effective than misoprostol alone or methotrexate/misoprostol (Kulier 2011, NAF 2020).
- Mifepristone 200 mg followed by misoprostol 800 mcg (buccal or vaginal) or 400 to 800 mcg (sublingual) is an effective regimen (FDA label 2016). Evidence-based protocols extend efficacy through 71-77 days LMP with a second dose of misoprostol 800mcg (Dzuba 2020; NAF 2020).
- Regimens beyond 77 days are used in various global settings.

SAFETY

- Medication abortion is safe and effective, with over 95% success rate without need for further intervention (Reeves 2016). Rarely, incomplete abortion or heavy bleeding may require outpatient treatment or aspiration up to several weeks after the abortion.
- Mifepristone can safely be taken at home (NAF 2020; WHO 2018; Chong 2015), though U.S. regulation still requires it be dispensed in a clinical setting by a clinician.
- The medication abortion occurs at home, similar to a miscarriage. You can:
  - Provide patients with a contact number for questions or concerns
  - Give your patients a list of “warning signs” that warrant a call or visit
  - Provide or refer for aspiration procedure in rare event it is needed.
- Self-managed abortion (SMA) is the use of pills for abortion without the oversight by a licensed clinician. With appropriate instructions and timely access to care, evidence has demonstrated the safety and efficacy of SMA (WHO 2018; Aiken 2017; Murtagh 2017). Abortion care sites in the U.S. are increasingly reporting seeing one or more patients who had attempted SMA (18%) (Jones 2019). However, some states have laws against SMA and cases have been reported to the authorities.
- Mifepristone is not effective for ectopic pregnancy. If mifepristone-miso or misoprostol alone-based regimen is given for pregnancy of unknown location (PUL), serial serum hCG evaluation is needed to rule out ectopic pregnancy. If early unruptured ectopic pregnancy is diagnosed, methotrexate regimens are indicated.

ROLE

- Medication abortion is relatively easy to integrate into clinical practice, expands access to abortion care, and can be provided in settings without ultrasound or ability to provide uterine aspiration with appropriate referral option if needed.
- Your confidence in providing medication abortion will grow quickly as you:
  - Gain experience monitoring side effects and assessing success
  - Listen to your patients’ questions and success stories
  - Discuss your questions with experienced colleagues.
COMPARISON OF MEDICATION ABORTION REGIMENS

MIFEPRISTONE WITH MISOPROSTOL REGIMENS

- Mifepristone, in a regimen with misoprostol, was approved by the FDA for abortion in 2000; The label was updated in 2016 to reflect best practices at the time and facilitate improved efficacy, safety, convenience, and side effects.
- Recent data has demonstrated high rates of success of mifepristone 200mg and misoprostol 800 mcg followed by a 2nd dose of misoprostol 4 hours later, at 63-70 days, as well as 70-77 days gestational age (NAF CPG 2020, Dzuba 2020).
- In light of COVID-19, many organizations moved rapidly to no test and minimum contact implementation. Sample protocols below can be adapted for practice setting.
  - No-Test Medication Abortion: Sample protocol during a pandemic and beyond
  - RHEDI Checklist for Minimal Contact Medication Abortion
  - RHAP No Touch Medication Abortion Workflow

<table>
<thead>
<tr>
<th>Based on evidence up to 2020, Partially adapted from NAF Clinical Practice Guidelines 2020</th>
<th>Evidence-Based Mifepristone Regimens</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gestational Age</strong></td>
<td>Mifepristone Dose (Day 1)</td>
</tr>
<tr>
<td>-----------------</td>
<td>----------------</td>
</tr>
<tr>
<td>71 – 77 days4</td>
<td></td>
</tr>
</tbody>
</table>

1. Vaginal route enables wider time frame for use of misoprostol, 0-72 hours after mifepristone, with highest efficacy rates between 24-48 hours.
2. Primary studies demonstrating efficacy from 64-70 days used buccal and sublingual misoprostol regimens; updated evidence confirms similar efficacy with vaginal route in this gestational age range (Hsia 2019).
3. Sublingual misoprostol dose range 400-800mcg. Fewer side effects shown with lower dose though may have lower efficacy rates (Von Hertzen 2010).
4. Medication abortion at 71-77 days LMP is evidence-based, and success rates in the late first trimester are higher with repeat misoprostol doses (Kapp 2019, Dzuba 2020).
6. Ongoing studies are evaluating telehealth protocols that mail mifepristone in the U.S. and abroad.
• Misoprostol-only is a reasonable alternative to mifepristone-containing regimens when mifepristone is not available, though it is less effective (Blum 2012, Kulier 2011). The recommended regimen consists of misoprostol 800 mcg buccally, vaginally, or sublingually with repeated doses as needed for success. (Sheldon 2019, Raymond 2019, Gynuity 2013, Von Hertzen 2007).
• Misoprostol is available by prescription in U.S. or over the counter in some countries.
• In global locations with restrictive laws or poor mifepristone access, misoprostol alone has been used for early abortion in clinical settings as well as in SMA (Stillman 2020). SMA increases in times of threatened access as during the COVID-19 pandemic.
• More information about self-managed abortion safety and access is available in Chapter 2, page 34, and World Health Organization, Aid Access and Women on Web.

<table>
<thead>
<tr>
<th>Gestational Age</th>
<th>Misoprostol Dose &amp; Route</th>
<th>Efficacy</th>
<th>Core References</th>
</tr>
</thead>
<tbody>
<tr>
<td>≤ 63 days</td>
<td>Misoprostol 800 mcg vaginal, sublingual*, or buccal every 3 hours x 3 doses until expulsion</td>
<td>84-96%</td>
<td>Moreno-Ruiz 2007, Von Hertzen 2007, Gynuity 2013, Ipas 2020, WHO 2018</td>
</tr>
<tr>
<td>64 – 70 days</td>
<td>As above. Additional doses may be used if bleeding does not start.</td>
<td>84-87% 93% with 4th dose</td>
<td>Sheldon 2019, Ipas 2020, WHO 2018</td>
</tr>
<tr>
<td>Up to 91 days</td>
<td></td>
<td>75-81%</td>
<td>Raymond 2019, Kapp 2019, Ipas 2020, WHO 2018</td>
</tr>
</tbody>
</table>

1. Increased efficacy demonstrated with sublingual compared to buccal misoprostol in misoprostol-only regimens through 70 days gestation, though with increased incidence of side effects (Sheldon 2019).

**METHOTREXATE REGIMEN**

Methotrexate 50 mg/m2 is used for ectopic pregnancy or can be combined with misoprostol when diagnosis is indeterminate and patient has chosen not to be managed by diagnostic aspiration. Unlike mifepristone, methotrexate is an effective treatment for early unruptured ectopic pregnancy. Success is determined with serial hCG testing, clinical exam and improvement of signs and symptoms (Seeber 2006).
MIFEPRISTONE/MISOPROSTOL ABORTION:  
STEP BY STEP

FIRST TELEHEALTH OR OFFICE VISIT - DAY 1

Initial Counseling

1. Introduce and build rapport with the patient
2. Address pregnancy, abortion options (medication vs. aspiration), and patient concerns
3. Reassure patient that abortion is safe, and does not interfere with ability to get pregnant and stay pregnant in the future if so desired.

Patient Eligibility

4. Determine pregnancy dating and medication abortion eligibility by one of the following:
   - LMP $\leq 77$ days from anticipated date of mifepristone use (within 1 week of certainty)
     - Regular menses with no hormonal contraception use for 2 months prior to LMP
     - First positive pregnancy test less than 6 weeks ago
     - No ectopic risk factors (previous ectopic, history of PID, IUD in place at the time of conception, bleeding since LMP, or unilateral pelvic pain).
   - LMP plus physical examination including bimanual exam as needed.
   - Limited ultrasound not required (except as indicated below).
5. Review medical history for absolute and relative contraindications to medication abortion:
   - IUD in place (must be removed prior to administration of the medications)
   - Allergy to a medication (eg mifepristone or misoprostol)
   - Chronic adrenal failure or long-term use of systemic corticosteroid therapy
   - Known or suspected ectopic pregnancy
   - Hemorrhagic disorders or concurrent anticoagulant therapy or symptomatic anemia
   - Inherited porphyria
   - No severe or unstable chronic condition that increases risk of outpatient procedure

Informed Consent

6. Confirm confidential phone number, email and/or transportation access for follow-up.
7. Discuss safety of medication abortion and review risks ("Managing Complications of Medication Abortion" on page 73):
   - Overall, early medication abortion is at least tenfold safer than continuing a pregnancy to term, although the magnitude of safety varies in global settings.
   - Need for additional misoprostol doses or aspiration with its risks, if needed later.
   - Heavy or prolonged bleeding can occur in up to 3% of cases; Management options include misoprostol, high-dose NSAIDs, and non-urgent uterine aspiration. Rarely emergent uterine aspiration or transfusion indicated.
   - Endometritis (<1%) is very uncommon. Atypical infection with Clostridium is
extremely rare.
• Mifepristone is not associated with teratogenicity.
• There is no evidence-based regimen for mifepristone reversal; Not taking misoprostol after mifepristone may be associated with heavy bleeding (Grossman 2015, Creinin 2020).
• Advise patient about the potential teratogenicity of misoprostol (associated with increased congenital deformities, Möbius syndrome, and limb defects)

8. In the U.S., patients must review and sign required consents and agreements:
• Manufacturer’s Patient Agreement and Medication Guide: Danco (https://earlyabortionpill.com), or GenBioPro (https://genbiopro.com)

Counseling on Abortion Process

9. Provide anticipatory guidance for the abortion process and medication side effects:
• Ask if the patient wants to have a support person available.
• Some patients may experience vaginal bleeding after mifepristone, and should be advised to continue to use misoprostol as directed.
• Cramping/pain occurs in >90% of patients, varies in intensity, peaks after misoprostol dose, and is typically improved by NSAIDs and heat.
• Common side effects of misoprostol include: nausea, vomiting, diarrhea, low-grade fever, chills and myalgias, and usually resolve within 6 hours of use.
• If mifepristone or misoprostol are vomited (or fall out) <15-30 min after use, consider repeat dosing. Antiemetic medications can be used ahead of medications if patient has significant degree of pregnancy-related nausea.
• Vaginal bleeding is usually heaviest within 4-6 hours after misoprostol, often heavier than normal menses and accompanied by the passage of large clots.
• Average bleeding duration is 9 days (range 1-45 days); but clinically significant drop in hemoglobin is rare. Intermittent spotting may last for up to one month.
• A heavy first menses is common following medication abortion.
• Patients bleeding heavier than two pads per hour for over two hours need to be evaluated.

10. Review use of medications:
• Mifepristone:
  o Assists in detaching pregnancy from the uterine lining, preparing the uterus to expel the pregnancy
  o One 200 mg tablet is swallowed
• Misoprostol:
  o Stimulates uterus to contract and expel the pregnancy
  o Describe options for misoprostol so patient can choose their optimal route for home administration:
    • Buccal: place four 200 mcg tablets between gum & cheek for 30 minutes. Swallow remaining fragments. Patients may place 24-48 hours after mifepristone.
    • Vaginal: place four 200 mcg tablets as high as possible in the vagina. Patients may place 6-48 hours after mifepristone.
    • Sublingual: place 2-4 200 mcg tablets under the tongue for 30 minutes. Swallow remaining fragments
If >63 days LMP, a second dose of 800mcg misoprostol 4 hours after the first dose can be considered; and if >70 days LMP, a second dose is recommended.

- If >56 days LMP and Rh negative, give Rho(D)-IG: 50 mcg dose IM within 72 hours of mifepristone.¹ (See Ch 5, page 85).

- Pain control
- NSAIDs are mainstay: Ibuprofen 600-800 mg PO q6-8h or equivalent.
- Data does not support the addition of opiates for medication abortion when compared to NSAIDS alone (Colwill 2019). Some providers may choose to use a limited prescription of opiates in select situations (eg, medication allergy or intolerance to NSAIDs).

- Antiemetics may offer ondansetron, promethazine, or metoclopramide for patient comfort and medication absorption.
- Prophylactic antibiotics are not recommended ²

11. Offer to discuss contraception, while remaining aware that some patients prefer not to discuss at time of abortion (Brandi 2018, Matulich 2014, Kavanaugh 2011). If interested, review options and timing for initiation. Reassure patients that abortion does not affect future fertility and that fertility can resume within a week of an abortion.

- Implant: placement at time of mifepristone enhances patient satisfaction without increasing MAB failure rates (Raymond 2016).
- IUD: place at follow-up visit; may have slightly increased risk of expulsion if done at 1 week (Sääv 2012).
- Sterilization: sign consents, refer and offer an acceptable bridge method
- Injection: may start at any time, may be provided IM in clinic or SQ for home use. Advise that injection at time of mifepristone is associated with slightly increased rate of continuing pregnancy on the order of 1-3% (Raymond 2016).
- Hormonal contraceptives: may start at any time (Tang 2002).
- Barrier methods: Can use as soon as patient resumes intercourse.
- Offer emergency contraception and dispense or prescribe if desired for future use.

12. Home instructions: Discuss how to reach provider on call, especially if the patient has:

- No bleeding within 24 hours of misoprostol (a repeat dose of misoprostol or an ultrasound if not initially performed may be indicated)
- Soaked two or more maxi-pads for two or more consecutive hours
- Unmanageable pain despite taking analgesics prescribed
- Sustained fever >100.4° F or onset of fever >24 hours after misoprostol
- Abdominal pain, weakness, nausea, vomiting or diarrhea > 24 hrs after misoprostol
- Plans to go to a hospital or emergency department. Most patients' concerns can be addressed with reassurance and anticipatory guidance. Many patients can wait to see you in the office rather than be referred to an ER. If ER is needed, facilitation may help improve the patient experience and reduce unnecessary interventions.

---

¹ Data supports that the use of Rho(D)-IG is unnecessary prior to 56 days gestational age, as the degree of fetal-maternal hemorrhage shown to be well below threshold of sensitization in early abortion. Forgoing Rh testing and Rho(D)-IG for medication abortion under 70 days may also be considered. Studies are ongoing to further clarify this recommendation for gestational ages 56-70 days. (Mark 2019, Horvath 2020, Hollenbach 2019)

² Several organizations say the evidence is insufficient to support universal prophylactic antibiotic use during MAB (Ipas 2020, NAF 2020, SFP 2014, WHO 2018). In contrast, there is compelling evidence to support universal antibiotic prophylaxis prior to aspiration abortion.
No Labs or Ultrasound Required, unless:

13. Rh status: if ≥56 days LMP and Rh unknown (this can be ascertained by donor card if Rh negative, chart, patient report, or lab). Additionally, some protocols allow Rh testing to be omitted if a patient expresses a desire to decline Rhogam or states they do not desire future fertility.

14. Hemoglobin or hematocrit: can be considered if history or symptoms of anemia. Rare for clinically significant drop in hemoglobin after medication abortion.

15. Chlamydia/gonorrhoea screen: if patient has symptoms or risk factors. Awaiting GC/CT results should not delay abortion provision.

16. Means of assessing successful abortion:
   - Not needed in the office if using clinical history plus home urine hCG test(s)
   - Baseline serum hCG on day of mifepristone followed by another after misoprostol
   - Baseline and follow-up ultrasound if using serial ultrasounds

---

**FACT SHEET : HOW TO USE ABORTION PILLS**

1. **MAKE SURE YOU ARE READY**
   - Table a menstrual cycle.

2. **CHECK YOUR Dates**
   - Use a calendar or a personal calendar app to ensure.

3. **BE SURE THAT YOU DO NOT PREGNANT**
   - Risks for abortion (please be familiar)

4. **THE PILLS**
   - Premixed mixture of tablets.
   - Follow the instructions on the packaging.

5. **SCHEDULE YOUR MISEPROSTOL**
   - Take the first dose on one cycle.

6. **SECOND DAY**
   - Take the second dose.

7. **EXPECT TO IMPACT**
   - The second pill is often easier to process.

8. **USE MISOPROSTOL**
   - Do not take existing misoprostol pills through one limb, under your tongue, or under your tongue. In the event of any bleeding, if you used any other doses, only take four-hour regimen or sequential pills.

9. **EXPECTED BLEEDING**
   - Can be mild bleeding.

10. **HOW MUCH BLEEDING IS TOO MUCH?**
    - If bleeding through tampon or pad, you should contact your doctor.

11. **WHEN TO START BIRTH CONTROL**
    - You can switch in the pill plan in the day after your abortion.

12. **DO NOT INSERT ANYTHING IN YOUR VAGINA FOR THREE WEEKS**
    - This includes tampons, douches, and other similar items.

(Source: Reproductive Health Access Project)
FOLLOW-UP TELEHEALTH OR OFFICE VISIT – DAY 7 – 14

1. Review patient’s course since taking medications, including timing and extent of bleeding and cramping, and resolution of pregnancy symptoms. Symptoms requiring an in-person evaluation:
   • No bleeding and cramping heavier than a period
   • Continued heavy bleeding without improvement
   • Patient does not feel that the pregnancy has passed
   • Continued symptoms of pregnancy (nausea, breast tenderness)
   • Significant pain unrelieved by usual measures

2. Success of abortion must be assessed by a) clinical history in conjunction with home urine pregnancy tests, b) by serial hCG testing, or c) by ultrasound (NAF CPG 2020).
   a. Clinical history (assessing symptoms by telehealth or phone) is acceptable, when paired with home urine pregnancy test at ≤ one month (Grossman 2011, Oppegaard 2015, Schmidt-Hansen 2019). May give patient an additional pregnancy test so that they do not need to purchase one.
   b. When serial hCG protocol is used, a decrease from baseline hCG of 50% by 72 hours, 60% by 4-5 days (Pocious 2016), and 80% by 7 days from initiating treatment (Fiala 2003) is consistent with a successful MAB.
      • As hCG has physiologic decline in later first trimester, assess symptoms in conjunction with hCG results if clinical suspicion for ongoing pregnancy.

3. When ultrasound is used, success is determined by demonstrating the absence of the previously identified pregnancy (gestational sac or embryo).

4. Review clinical course and results, if any, with patient. Have patient contact clinic for late-onset heavy bleeding or other concerns warranting evaluation and treatment.

5. Review contraceptive plan if desired

6. Because of the safety and efficacy of medication abortion, some providers consider follow-up optional. If planned follow-up is not completed, it is recommended to attempt to contact the patient and to document in accordance with your clinical protocols.

<table>
<thead>
<tr>
<th>Proposed Criteria for Aspiration after Medication Abortion</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Emergent</strong></td>
</tr>
<tr>
<td>• Excessive active bleeding with orthostatic hypotension or significant drop in hemoglobin/hematocrit</td>
</tr>
<tr>
<td>• Signs or symptoms of endometritis with an ultrasound consistent with incomplete medication abortion</td>
</tr>
<tr>
<td><strong>Non-emergent</strong></td>
</tr>
<tr>
<td>• Continuing pregnancy (consider repeat dose of misoprostol, or repeat mifepristone and misoprostol as a patient-centered approach, though data on efficacy minimal)</td>
</tr>
<tr>
<td>• Symptomatic problematic bleeding / cramping unresponsive to medical treatment</td>
</tr>
<tr>
<td>• Patient preference</td>
</tr>
</tbody>
</table>
ULTRASOUND WITH MEDICATION ABORTION

Once pregnancy is confirmed by a urine hCG, pregnancy dating should be established. When pregnancy dating cannot be reasonably determined by other means, ultrasound should be used (NAF CPG 2020). Its use is not a requirement for medication abortion provision (NAF, SFP, ACOG, FDA, Ipas, WHO). Studies demonstrate the safety of eliminating routine ultrasound from medication abortion care (Raymond 2018, Schonberg 2014, Clark 2007, Bracken 2011). This helps streamline care, and avoid cost and delays.

### Limited Ultrasound Indications for Medication Abortion
(Adapted from NAF, RHEDI)

<table>
<thead>
<tr>
<th>Pre-Abortion</th>
<th>Post-Abortion</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Possible pregnancy dating &gt;70 days¹</td>
<td>• History not consistent with successful medication abortion (no or scant bleeding or cramping)</td>
</tr>
<tr>
<td>• Size/date discrepancy on bimanual</td>
<td>• Patient still feels pregnant</td>
</tr>
<tr>
<td>• Provider uncertainty with exam</td>
<td>• If used, serum hCG not declining appropriately</td>
</tr>
<tr>
<td>• Uncertain LMP (irregular menses, or no menses after delivery, abortion, hormonal contraceptive use)</td>
<td>• Provider uncertainty with history</td>
</tr>
<tr>
<td>• Adnexal mass or pain</td>
<td></td>
</tr>
<tr>
<td>• History of, risk factors for, or current symptoms or signs suggestive of ectopic pregnancy</td>
<td></td>
</tr>
</tbody>
</table>

1. Data supports accuracy of pregnancy dating by LMP alone with low rates of over- and under-estimation through mid-first trimester (≤63 days LMP). This can likely be reasonably extended to include pregnancies to 70 days and beyond, depending on your practice setting, though explicit evidence is lacking.

SUCCESSFUL ABORTION

The absence of the pregnancy (gestational sac or embryo depending the US findings prior to MAB) and the presence of thickened endometrial stripe are typical after successful medication abortion. The size of the endometrial stripe has no clinical significance in assessment of success of a medication abortion, and incorrect interpretation can lead to unnecessary intervention (SFP 2014).

PERSISTENT GESTATIONAL SAC AFTER MEDICATION ABORTION

This transvaginal ultrasound shows the presence of an empty gestational sac. Patients can choose their preferred management option: waiting for spontaneous completion, repeat misoprostol (expels GS > 60% of time (Reeves, 2008), or an aspiration procedure. (Or repeat mifepristone and misoprostol but minimal data on efficacy).
## MANAGING COMPLICATIONS OF MEDICATION ABORTION

<table>
<thead>
<tr>
<th>Complication</th>
<th>Clinical Presentation</th>
<th>Management Options</th>
<th>Occurrence Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problematic bleeding and/or cramping</td>
<td>• Prolonged cramping, pain and/or bleeding&lt;br&gt;• Retained gestational sac or tissue may be seen on US; inappropriate decline in hCG</td>
<td>• Expectant management&lt;br&gt;• Repeat misoprostol&lt;br&gt;• Uterine aspiration</td>
<td>2-9% (varies by study &amp; GA)</td>
</tr>
<tr>
<td>Continuing Pregnancy</td>
<td>• May have scant bleeding after medications, persistent pregnancy symptoms&lt;br&gt;• Ongoing viable intrauterine pregnancy (growing gestational sac or cardiac activity on US; rapidly rising hCG)</td>
<td>• Uterine aspiration&lt;br&gt;• Repeat misoprostol (if embryonic pole seen, expulsion occurred in 36% with and 54% without gestational cardiac activity)&lt;sup&gt;1&lt;/sup&gt;&lt;br&gt;• Repeat mifepristone and misoprostol (patient-centered approach but lacking evidence)</td>
<td>≤63 d: &lt;1%&lt;sup&gt;2,3&lt;/sup&gt;&lt;br&gt;64-70 d: 3.6% with 1 dose, 0.4% with 2 doses&lt;sup&gt;2,3&lt;/sup&gt;&lt;br&gt;71-77 d: 1.6% with 2 doses&lt;sup&gt;3&lt;/sup&gt;</td>
</tr>
<tr>
<td>Endometritis</td>
<td>• Typical endometritis: fever (&gt;24 hours after misoprostol), pelvic/abdominal pain, vaginal discharge with odor, uterine/adnexal tenderness&lt;br&gt;• Atypical endometritis: included here for historical importance.&lt;br&gt;• Incidence: extremely rare; 0.58 per 100,000 medication abortions in U.S.&lt;br&gt;• Etiology: Clostridium sordelli- or perfringens-mediated toxic shock syndrome; can be severe or fatal.&lt;br&gt;• Occurs 2-7 days after MAB&lt;br&gt;• Symptoms: nausea, abdominal bloating, diarrhea, pain, malaise&lt;br&gt;• Signs: usually afebrile, tachycardic, hypotensive, elevated WBC &amp; hgb</td>
<td>• Follow CDC guidelines for antibiotic therapy&lt;br&gt;• Uterine aspiration if retained tissue present&lt;br&gt;• Immediate hospitalization and aggressive treatment for atypical infection</td>
<td>0.01-0.5%&lt;sup&gt;2,5&lt;/sup&gt;&lt;br&gt;&lt;10 case reports by CDC&lt;sup&gt;4&lt;/sup&gt;</td>
</tr>
<tr>
<td>Ectopic Pregnancy</td>
<td>• May be asymptomatic or present with minimal bleeding or inappropriate decline in hCG after misoprostol.&lt;br&gt;• May present with pelvic/abdominal pain, history of bleeding or spotting during the pregnancy, shoulder pain, tachycardia/hypotension.</td>
<td>Treat or refer as appropriate</td>
<td>0.6% (in study of GA &lt; 6 weeks in the U.S.)&lt;sup&gt;2&lt;/sup&gt;</td>
</tr>
<tr>
<td>Excessive Bleeding</td>
<td>• Heavy or prolonged vaginal bleeding with associated signs or symptoms (may include Hgb drop &gt;2 points, orthostatic hypotension, tachycardia)&lt;br&gt;• True hemorrhage is life-threatening emergency; rare but can occur&lt;br&gt;• May result from retained pregnancy tissue and may present 2-5 weeks after mifepristone</td>
<td>Medical management (misoprostol, NSAIDs)&lt;br&gt;Uterine aspiration FeSo4&lt;br&gt;Blood transfusion FeSo4</td>
<td>&lt;1%&lt;sup&gt;2&lt;/sup&gt;&lt;br&gt;&lt;0.02-0.6%&lt;sup&gt;2,5&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

CHAPTER 4 EXERCISES: MEDICATION ABORTION

The exercises refer to mifepristone and misoprostol regimens unless otherwise stated.

EXERCISE 4.1

Purpose: To review essential elements of medication abortion.

Let’s review some key lessons from the chapter. (Adapted from Abortion Pill CME)

On the day of initial counseling:

1. What history do you need before administering mifepristone?
2. What physical exam and testing do you need before administering mifepristone?
3. What topics do you discuss with a patient who would like a medication abortion?

At the time of follow-up:

1. How do you assess whether the medication abortion regimen worked?
2. What symptoms or signs require evaluation or treatment?

EXERCISE 4.2

Purpose: To practice responses to questions that may arise during counseling.

What would you tell patients who ask the following questions?

1. I live 4 hours away. Can I still get the abortion pill?
2. What are my chances of needing an aspiration abortion?
3. How will I know if I’m bleeding too much?
4. What will I see when the pregnancy passes?
5. My partner wants me to keep this pregnancy. Will they know that I had an abortion?
6. I got a judicial bypass and my parents don’t know I’m pregnant and having an abortion. Is this the right method for me?

EXERCISE 4.3

Purpose: To practice responding to follow-up questions that may arise by telephone.

How would you respond to the following questions?

1. I took the misoprostol 2 hours ago. Now my temperature is 100.5°F and I feel like I have the flu. Should I be concerned?
2. I took the misoprostol 30 hours ago and passed the pregnancy 24 hours ago, but now my temperature is 101.5°F.
3. I used the medication vaginally, but I think one of those pills just fell into the toilet (or vomited if using buccal or sublingual misoprostol). What should I do?
4. I took the mifepristone in clinic yesterday and started to bleed like a period this morning. I have not taken the misoprostol yet. What should I do?
5. I vomited three hours after using the mifepristone, what should I do?
6. I am having new very heavy vaginal bleeding. It has been 4 weeks since my medication abortion. What should I do?
EXERCISE 4.4

**Purpose:** To practice follow-up and management of complications after medication abortion.

How would you manage the following situations?

1. A 29 year-old G3P1 patient requests medication abortion and is 6 weeks by LMP. Examination reveals a barely enlarged uterus, and serum hCG level is 782 IU/L. They take mifepristone 200 mg, followed 24 hours later by an appropriate dose of buccal, vaginal, or sublingual misoprostol. They have moderate bleeding and cramping during the next several hours. When the patient returns on Day 4, examination is essentially unchanged, and serum hCG level is 5530 IU/L.

2. A 25 year-old G2P1 patient who took mifepristone 200 mg 7 days ago and took misoprostol 800 mcg 6 days ago, returns to clinic today for a follow-up visit. They report moderate bleeding and cramping a few hours after taking misoprostol, and have had no complaints since then. On a follow-up ultrasound, there is a moderate amount of heterogeneous debris in the endometrial cavity.

3. What management would you suggest for uterine debris?

4. How would you manage this patient differently if they were symptomatic with ongoing moderate vaginal bleeding and/or cramping?

5. A 19 year-old G4P0 patient who took mifepristone 4 days ago and took misoprostol 3 days ago returns today because of very heavy vaginal bleeding. They state they have soaked 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 this patient?
   d. What are indications for a uterine aspiration after medication abortion?
CHAPTER 4 TEACHING POINTS: MEDICATION ABORTION

The following exercises refer to mifepristone and misoprostol regimens unless stated otherwise.

EXERCISE 4.1

On the day of mifepristone:

1. What history do you need before administering mifepristone?

   • LMP, history indicating pregnancy is ≤ 77 days (11 weeks)
   • No contraindications to medication abortion
     ○ Allergy to a medication (eg mifepristone or misoprostol)
     ○ Known or suspected ectopic or molar pregnancy
     ○ Hemorrhagic disorders or concurrent anticoagulant therapy or symptomatic anemia
     ○ Chronic adrenal failure or long-term use of systemic corticosteroid therapy – mifepristone blocks steroid effect at receptor and may worsen disease. Too unpredictable to recommend MAB with increasing steroid dose to compensate.
     ○ Inherited porphyria (rare heme metabolism disorder) – mifepristone worsened the condition in animal studies. Data is lacking in humans.
     ○ IUD in the uterus (must be removed prior to administration of the medications)
   • No severe or unstable chronic condition that increases risk of outpatient procedure
   • Certain of desire to have abortion and willing and able to follow up as planned
   • Of note, the following are not contra-indications: asthma on steroid inhalers, obesity, breastfeeding, HIV / AIDS, multiple gestations, or STIs.

2. What physical exam and testing do you need before administering mifepristone?

   • No labs or ultrasound required, unless:
     ○ Rh: if ≥ 56 days LMP and Rh unknown (can be ascertained by donor card, chart, patient report, or lab).
     ○ Hemoglobin or hematocrit: consider if history or symptoms of anemia. Rare for clinically significant drop in hemoglobin after medication abortion.
     ○ Chlamydia/gonorrhea screen: if symptoms or risk factors. Avoid delaying abortion provision while awaiting results.
     ○ Testing based on follow-up plan:
       • None if using clinical history +/- home urine hCG(s)
       • Or serum hCG (day of mifepristone and after misoprostol)
       • Or ultrasound if using serial ultrasounds

3. What topics do you discuss with a patient who would like a medication abortion?

   • When and how to take the mifepristone and misoprostol
     ○ Every patient has different circumstances. Consider discussing the following as applicable: privacy, child care, work / school responsibilities, access to bathroom, support person availability
   • How to manage cramps (with ibuprofen and comfort measures)
   • Number to call if
     ○ Soaking 2 maxi pads/hour for 2 consecutive hours
     ○ Nausea or malaise > 24 hours after misoprostol
At the time of follow-up:

1. How do you assess whether the medication abortion regimen worked?
   - Symptoms of abortion completion assessed by phone or electronic messaging alone (NAF 2020, Perriera 2010), or paired with urine pregnancy testing.
   - Urine pregnancy tests: High sensitivity, low sensitivity or a multi-step approach with both can be utilized depending on your setting.
     - Remember for regimens > 63 days LMP, hCG may be falling naturally in continuing pregnancies. High sensitivity tests may be preferred.
     - High sensitivity urine pregnancy tests should not be used < 1 month after medication abortion, as may remain positive even after a successful medication abortion.
   - Alternatively, either of the following can be used:
     - Serum beta hCG quantitative confirming a drop of:
       - 50% by 72 hours
       - 60% by 4-5 days (Pocious 2016).
       - 80% by 7 days (Fiala 2003)
         - As hCG has physiologic decline in later first trimester, assess patient’s symptoms in conjunction with their hCG results if clinical suspicion for ongoing pregnancy.
   - Ultrasound. Note a thickened endometrial stripe common normal finding after medication abortion, and only requires management if patient is symptomatic with bleeding and / or cramping).

2. What symptoms or signs require evaluation or treatment?
   - Soaking 2 maxi pads/hour for 2 hours in a row. Excessive bleeding with signs of acute hemorrhage or significant drop in hematocrit are very rare; only 0.03-0.6% of patients who take mifepristone need transfusion (Chen 2015).
   - Nausea, malaise, weakness, fevers, or tachycardia >24 hours after taking misoprostol. It is important to evaluate for other infectious etiologies of a patients symptoms and avoid delaying treatment for common medical conditions.
     - Need for IV antibiotics is extremely rare (0.006% to 0.093% of patients). However, toxic shock due to Clostridium Sordelli can be fatal requiring prompt evaluation of tachycardia, hypotension, leukocytosis, or hemo-concentration without fever (Fjerstad 2009).
   - Persistent bleeding/cramps – may need exam, labs +/- ultrasound to r/o:
     - Continuing pregnancy [Rare; 1.2-3.5%] (Chen 2015, Abbas 2015).
     - Retained tissue [can offer another dose of misoprostol, < 4% require a procedure] (Chen 2015).
     - Endometritis [Rare; 0.01-0.5% treated for infection] (Chen 2015).
     - Ectopic or molar pregnancy [Rare; < 0.6%] (Abbas 2015).
   - No significant bleeding – after misoprostol need US to r/o:
     - Continuing pregnancy [Rare; 1.2-3.5%] (Chen 2015, Fjerstad 2009).
     - Ectopic [Rare; < 0.6%] (Abbas 2015).

- Fever > 24 hours after misoprostol
- No bleeding at all 24 hours after misoprostol
- No long-term adverse effects on health or fertility
EXERCISE 4.2

1. I live 4 hours away. Can I still get the abortion pill?
   • Yes. Patients can have a medication abortion if they live reasonably close to emergency medical care, and they have access to a phone and transportation.
   • Studies have demonstrated safety, effectiveness, efficiency, and acceptability of direct-to-patient telehealth provision without any in-person visits (Raymond 2019), though U.S. restrictions still prevent this from being implemented beyond the research setting.
   • Some protocols allow for follow up via phone or telehealth visit (with or without follow up urine hCG or serial blood hCGs drawn at a location in close proximity to the patient), while others require a follow up office visit.

2. What are my chances of needing an aspiration abortion?
   • Medication abortion is >97% effective in most settings. Continuing pregnancy rate is rare (≤1% to 3%, as above) regardless of pregnancy dating when using the recommended mifepristone with misoprostol regimens. Redosing misoprostol alone may be an effective management option for patients who wish to avoid aspiration (or mifepristone and misoprostol although with minimal evidence for efficacy).
   • Uterine aspiration may also be needed for excessive bleeding/cramping, or by patient request.
   • For >63 days LMP, the total incidence of aspiration after medication abortion is 2-9%, with the range decreasing to <1% to 3% when a second dose of misoprostol is used (NAF 2020).
   • For persistent gestational sac without evidence of development, a 2nd dose misoprostol can be offered, or the patient can be followed for several more weeks if stable.
   • For asymptomatic patient (minimal bleeding or cramping) with echogenic material and thickened endometrial stripe on ultrasound, no further treatment is necessary.

3. How will I know if I’m bleeding too much?
   • After misoprostol, bleeding usually starts within 1 to 10 hours (average 4 hours).
   • Bleeding can be heavier than a normal period and accompanied by cramps and/or clots. Bleeding usually slows substantially after passing the pregnancy.
   • If the bleeding soaks more than 2 maxi-pads per hour for greater than 2 hours, that is more than normal; have patient call if they are concerned.
   • Hypovolemia symptoms warrant immediate evaluation (history, orthostatic vital signs, pelvic exam) and urgent uterine aspiration.
   • Hemoglobin or hematocrit can guide the need for iron or blood transfusion.
   • Blood transfusion is rarely needed (<0.2% of cases).
   • There is scant data regarding the optimal treatment for moderate bleeding. The efficacy of commonly used agents (such as a second dose of misoprostol, methylergonovine, or a tapered regimen of high-dose OC’s) is unknown.

4. What will I see when the pregnancy passes?
   • Below 63 days LMP, blood and clots are normally visible, and it is unlikely a patient would identify an embryo.
   • At > 63 days LMP, the fetus may be identifiable and the patient should be counseled accordingly.
• If the patient is anxious about seeing the pregnancy or fetal tissue, consider showing a drawing and counsel with information such as: “At X weeks of pregnancy, this is what the pregnancy / fetus looks like. Would you like more information or do you want to go ahead with the medication abortion?” If they are not comfortable, they may prefer an aspiration abortion.

5. My partner wants me to keep this pregnancy. Will they know that I had an abortion?
• The symptoms of an abortion with pills and a miscarriage (spontaneous abortion) are identical. Miscarriage happens in 15-20% of all pregnancies

6. I got a judicial bypass and my parents don’t know I’m pregnant and having an abortion. Is this the right method for me?
• Discuss the individual circumstance with the patient, to help them decide whether a medication or an aspiration abortion might be preferable.
• Explore options for a safe location where the young person might be able to use the misoprostol; e.g. a supportive relative’s house, a friend’s house.

EXERCISE 4.3
1. a) I took the misoprostol 2 hours ago. Now my temperature is 100.5° F and I feel like I have the flu. Should I be concerned?
• No. Common side effects of misoprostol are temperature elevation, and flu-like symptoms. These are usually self-limited, and the body temperature should return to normal within a few hours. Have the patient recheck temperature again in 2-3 hours.

b) I took the misoprostol 30 hours ago and passed the pregnancy 24 hours ago, but now my temperature is 101.5 ° F.
• Persistent elevated temperature (>100.4 ° F) for several hours or > 24 hours after misoprostol warrants an office visit to evaluate for infection. Work-up should include:
  o Evaluation for other etiologies of symptoms
  o Questions about pelvic pain, bleeding pattern, or odorous discharge
  o Review of systems to rule out other sources of fever
  o Pelvic exam
  o CBC to evaluate for leukocytosis.
• Significant pelvic or cervical motion tenderness with fever suggests post-abortal endometritis, and appropriate antibiotics should be initiated. If US shows significant intrauterine material, uterine aspiration is also indicated.
• If additional concerns arise for atypical infection, further evaluation may be warranted. In very rare cases, patients have presented with low-grade fever and nonspecific complaints (abdominal or pelvic pain, nausea, diarrhea, malaise) along with dramatic leukocytosis and hemoconcentration (Fjerstad 2011, Meites 2010). In patients with this presentation, a high index of suspicion is needed. Clostridium-mediated toxic shock syndrome may progress rapidly to fulminant sepsis and death. If atypical infection is suspected, refer for inpatient sepsis management with infection disease consultation.
2. I used the medication vaginally, but I think one of those pills just fell into the toilet (or vomited if using buccal, sublingual, oral misoprostol). What should I do?
   • If the misoprostol pills are vomited (or fall out if taken vaginally) less than 30 minutes after placed, the patient may need to return for a second misoprostol dose. If >30 minutes has elapsed, there is no need to redose as the active ingredient will have had adequate time to be absorbed, even if the pill appears undissolved. They may choose to wait to see if appropriate bleeding begins, and re-dose if no bleeding occurs within 4 hours.

3. I took mifepristone in clinic yesterday and started to bleed (like a period) this morning. I have not taken the misoprostol yet. What should I do?
   • Mifepristone alone may cause bleeding but is often inadequate for successful abortion; misoprostol significantly increases the efficacy - and therefore the safety of the regimen.
   • Many providers counsel patients to use the dispensed misoprostol regardless of post-mifepristone bleeding to improve chances of success.
   • Advise the patient to take misoprostol now.

4. I vomited three hours after using the mifepristone, what should I do?
   • Nothing. There is no need to redo the mifepristone if ingested for >15 minutes.

5. I am having new very heavy vaginal bleeding. It has been 4 weeks since my medication abortion. What should I do?
   • Assess amount of bleeding, symptoms of hypovolemia to ensure no hemorrhage.
   • Review records for confirmation of MAB completion (symptom check with negative home urine pregnancy test, adequately down-trending serum hCG, or ultrasound).
   • If there has been little to no interim symptoms of prolonged bleeding and cramping, this new onset heavy bleeding may represent onset of menses.
   • If prolonged bleeding and cramping have been ongoing, consider evaluation and management with uterine aspiration as appropriate.

EXERCISE 4.4
1. A 29 year-old G3P1 patient requests medication abortion and is 6 weeks by LMP. Examination reveals a barely enlarged uterus, and serum hCG level is 782 IU/L. They take mifepristone 200 mg, followed 24 hours later by an appropriate dose of buccal, vaginal, or sublingual misoprostol. They have moderate bleeding and cramping during the next several hours. When the patient returns on Day 4, examination is essentially unchanged, and serum hCG level is 5530 IU/L.
   • This patient’s rapidly rising hCG level suggests continuing viable pregnancy, despite history of bleeding after misoprostol. Ectopic pregnancy should also be excluded.
   • Consider ultrasound, if available and the patient is able to follow up in the office.
   • If ectopic can be firmly ruled out, treatment options include aspiration, repeat misoprostol alone (second dose is about 30% effective), or repeat mifepristone with misoprostol (may be a patient-centered option, but no evidence base for efficacy).
• If no intrauterine pregnancy is identified despite rising hCG, the patient must be evaluated and treated for presumed ectopic pregnancy.

2. A 25 year-old G2P1 patient 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. They report moderate bleeding and cramping a few hours after misoprostol, and have had no complaints since then. On a follow-up ultrasound, there is a moderate amount of heterogeneous material in the endometrial cavity.

   a. What management would you suggest for heterogeneous uterine material?
      • If US is performed at the follow-up visit, the sole purpose is to determine if the patient is still pregnant (SFP 2014).
      • Endometrial thickness should not be used to guide management after MAB. 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, avoid unnecessary intervention for US findings (NAF CPG 2020).
      • Providers can monitor such patients based on symptoms (SFP 2014).

   b. How would you manage this patient differently if they were symptomatic with ongoing moderate vaginal bleeding and/or cramping?
      • An aspiration may be warranted for hemodynamic instability or for patient preference (SFP Clinical Guidelines 2014).
      • Clinicians providing MAB may wish to be trained in uterine evacuation procedures; alternatively, they may establish referral relationships with other providers trained in aspiration.

3. A 19 year-old G4P0 patient took mifepristone 4 days ago and took misoprostol 3 days ago returns today because of very heavy vaginal bleeding. They state they have soaked 5 maxi-pads in the last 3 hours.

   a. What should you assess first?
      • Hemodynamic status (orthostasis or orthostatic vital signs)
      • Exam to assess active bleeding and uterine bogginess

   b. What diagnostic work-up may be of assistance?
      • Hemoglobin/hematocrit
      • Ultrasound (if available)

   c. What management options would you offer this patient?
      • Urgent uterine aspiration is indicated
      • Uterotonics may be indicated
      • Initiate iron supplementation as needed
      • Blood transfusion is rarely needed but may be necessary.
d. What are indications for a uterine aspiration after medication abortion?

- Bleeding in hemodynamically unstable patient (emergent)
- Continuing pregnancy: Persistent growth, cardiac activity, or persistent increase in hCG. Can offer:
  - Uterine aspiration
  - A second dose of misoprostol (completes expulsion in 35% patients with ongoing pregnancy <63 days; Reeves 2008), or
  - Repeat misoprostol and mifepristone (patient-centered but not evidence based approach, lacking data on efficacy), or
- Symptomatic problematic bleeding / cramping unresponsive to medical treatment
- Patient preference if declines repeat misoprostol
5. PAIN MANAGEMENT AND MEDICATIONS

Updated June 2016 by Angeline Ti MD, MPH

This chapter describes methods of pain control as well as routine medications used before, during, and after uterine aspiration. Medications indicated for clinical emergencies are also reviewed.

CHAPTER LEARNING OBJECTIVES
Following completion of this chapter, you should be able to:

• Describe the role of antibiotic prophylaxis and cervical ripening in uterine aspiration
• List when to use of Rh-D immunoglobulin in the prevention of isoimmunization
• List pain control options for uterine aspiration, effectiveness, and considerations for patients with a tolerance to opiates
• Perform techniques and describe precautions for paracervical block
• Identify appropriate responses to and medications for a number of clinical emergencies

READINGS / RESOURCES

  o Chapter 8: Pain Management
• National Clinicians’ Post-Exposure Prophylaxis Hotline
  o http://nccc.ucsf.edu/clinician-consultation/pep-post-exposure-prophylaxis/
**SUMMARY POINTS**

**SKILLS**

- Pain perception includes both physical and psychosocial elements, and is best managed with both non-pharmacological and pharmacological techniques.
- Paracervical block helps reduce pain, and there are many variations on technique.
- Oral medications such as NSAIDs, opioids or anxiolytics may be used individually or together during uterine aspiration.
- Intravenous pain management may be chosen if monitoring and staffing are available; patients may require provision of respiratory support.
- Deep sedation (a.k.a. general anesthesia) is used, but is not routinely recommended.

**SAFETY**

- Universal pre-procedure antibiotic prophylaxis for uterine aspiration is well supported by the available evidence.
- Attention to allergies, concurrent medications, conditions that compromise respiratory status, recommended dose limits, and antidotes will improve safety.
- The supplies in your emergency cart should be reviewed, along with procedures and regular simulations for emergency management.

**ROLE**

- In addition to pain medications, utilize gentle procedural technique, deep-breathing techniques, distraction through conversation, the support of a partner, friend, doula, or medical assistant, and the reassuring tone of your voice.
PRE-PROCEDURE MEDICATIONS

PROPHYLACTIC ANTIBIOTICS

There is strong evidence for the use of routine antibiotic prophylaxis in patients undergoing uterine aspiration for abortion. Patients who received antibiotics were 0.59 times as likely to experience post-abortal infection compared to those who received placebo in a Cochrane review of 15 randomized controlled trials (Low 2012). This protective effect was evident in patients with and without risk factors (history of PID, positive CT, or pre-procedural BV). Limited evidence suggests that routine antibiotics are optional for asymptomatic patients undergoing uterine aspiration for EPL (Prieto 1995).

Evidence supports pre-procedure dosing of prophylactic antibiotics for the maximal effect, and the shortest possible course to give the lowest risk of adverse reactions and antibiotic resistance (Achilles 2011). Effective regimens include metronidazole or tetracyclines (e.g. doxycycline) or azithromycin. Despite varying practices in choice of antibiotic and duration of use, there is little data to support post-procedure antibiotics (Achilles 2011) often use to maintain NPO status prior to their abortion.

CERVICAL PREPARATION

There has been much research into the role of misoprostol and other methods of cervical ripening for uterine aspiration. Cervical preparation with misoprostol is generally safe and may decrease procedure time for some patients, but it is not routinely indicated prior to a first trimester uterine aspiration due to increased waiting time, bleeding, cramping, other side effects, and minimal demonstrated benefit in terms of ease of dilation or pain (Kapp 2010, Allen 2007). Its use can be considered on an individual basis when a challenging dilatation is anticipated (such as history of difficult dilation). An early study suggests the priming interval for first trimester may be 1 hour after sublingual administration, but with vaginal and buccal administration, 2 to 3 hours provides a better effect (Saav 2015). The most common regimen prior to first trimester aspiration abortion is 400 mcg.

Rh-D IMMUNOGLOBULIN

While past guidelines recommended all Rh-negative patients be tested and receive anti-D immunoglobulin regardless of gestational age or procedure type, new evidence has called this into question. New flow cytometry studies show fetal red blood cell exposure in the first trimester is below the calculated threshold for maternal Rh sensitization (Horvath 2020, Hollenbach 2019). It is postulated that risk of sensitization is lower in medication abortion and early pregnancy loss, and somewhat higher with aspiration or curettage. The following recommendations have emerged (NAF CPGs 2020, Mark 2019) and may evolve with research:

- Only patients > 56 days from LMP with unknown Rh status should have Rh status documented.
- Patient report is adequate for documentation. If patient does not know Rh status, spot, slide, or Eldon card testing methods may be used.
- Rh status or informed waiver declining Rh testing must be documented >56 days.
- Rh testing may be omitted if patient wants no future children, or declines testing.
- When Anti-D IG indicated, use 50 mcg at < 13 wks, or 300 mcg at > 13 wks.
- Second injection only indicated if last was > than 3 weeks earlier (Bichler 2003).
- Anti D antibodies may be present if a patient had anti-D IG injection within the last 3 months or was sensitized from a prior pregnancy.
- For those sensitized, an additional anti-D IG injection will not prevent isoimmunization.
PAIN MANAGEMENT

Perception of pain during uterine aspiration is a complex phenomenon influenced by both physical and psychosocial elements, and as such, can vary considerably between individuals. The table below summarizes the research to date. In the multivariable analyses, no single factor predicts procedure-associated pain (Singh 2008).

**FACTORS ASSOCIATED WITH PAIN DURING UTERINE ASPIRATION**

<table>
<thead>
<tr>
<th>Increased Pain</th>
<th>Decreased Pain</th>
<th>Conflicting Results</th>
<th>Not Strongly Associated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety/depression</td>
<td>Previous vaginal delivery</td>
<td>Gestational age</td>
<td>Prior pelvic exam</td>
</tr>
<tr>
<td>Ambivalence</td>
<td>Older patient age</td>
<td>Max cervical dilation</td>
<td>Prior uterine aspiration</td>
</tr>
<tr>
<td>Expectation of pain</td>
<td>More pregnancies</td>
<td>Comfort w/ decision</td>
<td>Prior cesarean section</td>
</tr>
<tr>
<td>Younger patient age</td>
<td>Shorter operative time</td>
<td>Provider experience</td>
<td>Manual vs. electric uterine aspiration</td>
</tr>
<tr>
<td>Dysmenorrhea</td>
<td>Participation in the choice of anesthesia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fewer pregnancies</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**NON-PHARMACOLOGIC PAIN MANAGEMENT**

Many patients are anxious about anticipated procedural pain. Supportive verbal communication, including distraction and so-called “vocal local” or “verbicaine”, can play a role in reducing anxiety and pain. Providers can acknowledge the possibility of pain without overly alarming patients. Offering elements of positive suggestion may help to allay concerns. For example:

“Most patients are worried about pain, and are often surprised that the procedure is faster and more tolerable than they expected. Patients have varying amounts of pain, but I will be giving you some numbing medicine and will show you some breathing techniques to help. I will be as gentle as possible.”

Guiding patients to take slow, deep, regular breaths can assist in relaxation, avoid hyperventilation, and also give patients an increased sense of control. Instead of pulling away and tightening, encourage patients to release or push their hips into the table.

Guided imagery can also decrease anxiety and analgesic requirements for surgical patients (Gonzales 2010). Patients may be invited to recall a favorite place, activity, or color, during the procedure. Relaxed images or mobiles above the exam table have also been used to decrease pain and anxiety during gynecologic procedures (Carwile 2014). Playing music in the room may be helpful with anxiety and satisfaction, but does not decrease pain (Wu 2012, Guerrero, 2012, Cepeda 2006). A heating pad or hot water bottle may be helpful during the procedure, in recovery or at home.

**CHOICE OF PAIN CONTROL METHODS**

Relevant information about pain management should be reviewed as part of the informed consent process, including the range of patient experiences, available options for pain control, as well as their risks and benefits. If a patient has a strong preference for an option your facility does not offer, an appropriate referral can be given.

Premedication with NSAIDs has been shown to decrease pain during and after the procedure, and has few contraindications or side effects (Ipas 2016). Some patients choose this less sedating option in order to be more alert, have shorter recovery, or to drive themselves home.

Other patients may choose a more sedating option to be more relaxed, to manage higher levels of anxiety, or to manage a later procedure. Oral opiate analgesics have shown minimal effect on pain compared to placebo and cause more side effects including nausea (Micks 2012). IV sedation may be offered in some settings for patients who request more analgesia, although some medical conditions, monitoring, or facility limitations preclude moderate or deep sedation.
PREFERRED ANESTHESIA METHODS

Preferred method of anesthesia for first-trimester surgical abortion cases performed by responding NAF clinics (n=110). For uterine aspiration, local anesthesia with supplemental oral or IV medication is the most frequently used approach (O’Connell, 2009).

CONTINUUM OF SEDATION LEVEL

Various approaches to pain management may be offered to patients, depending on the clinical situation and resources. Below is a short summary of the levels of sedation, examples of medications used, and the associated risks.

<table>
<thead>
<tr>
<th>Level of Sedation</th>
<th>Example</th>
<th>Responsiveness</th>
<th>Airway</th>
<th>Spontaneous Ventilation</th>
<th>Cardiovascular Function</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal (Anxiolysis)</td>
<td>Oral lorazepam and/or hydrocodone</td>
<td>Normal response to verbal stimulation</td>
<td>Unaffected</td>
<td>Unaffected</td>
<td>Unaffected</td>
</tr>
<tr>
<td>Moderate “Conscious Sedation”</td>
<td>Fentanyl 50-100 mcg + Midazolam 1-3 mg IV</td>
<td>Purposeful response to verbal or tactile stimulation</td>
<td>No intervention required</td>
<td>Adequate</td>
<td>Usually maintained</td>
</tr>
<tr>
<td>Deep</td>
<td>Add propofol or higher doses of meds used for moderate sedation</td>
<td>Purposeful response following repeated or painful stimulation</td>
<td>Intervention may be required</td>
<td>May be inadequate</td>
<td>Usually maintained</td>
</tr>
<tr>
<td>General Anesthesia</td>
<td>Propofol or other medications</td>
<td>Unarousable even with painful stimuli</td>
<td>Intervention often required</td>
<td>Frequently inadequate</td>
<td>May be impaired</td>
</tr>
</tbody>
</table>

Adapted from Continuum of Depth of Sedation: Definition of GA and levels of Sedation / Anesthesia, 2014, ASA.

MONITORING GUIDELINES

• When moderate sedation is used, a person trained to monitor respiratory, cardiovascular and level of consciousness must be present, other than the provider.
• The personnel administering moderate sedation must recognize that conscious sedation may lead to deep sedation with hypoventilation, and be prepared to provide respiratory support.
  o Pulse oximetry should be used to enhance monitoring.
  o IV access should be considered.
  o The patient should be checked frequently for verbal responsiveness.
  o A licensed airway manager should care for patients with severe systemic disease
• When moderate sedation is used, monitoring must be of a degree that can be expected to detect the respiratory effects of the drugs being used.
• The practitioner administering deep sedation or general anesthesia must be certified according to applicable local, hospital, and state requirements.
CONSIDERATIONS FOR OPIOID TOLERANT PATIENTS

Opioid use and dependence is a growing problem in the U.S. (CDC 2013). Some patients may have a tolerance to opioid medications or may be on medically supervised opioid maintenance therapy (OMT), or opioid antagonist therapy with medications that interact with opiate pathways. OMT medications include methadone, a full agonist, and buprenorphine (e.g. Suboxone, buprenorphine-naloxone), a partial agonist (SAMHSA 2015). Antagonist therapies include Vivitrol, a depo naltrexone injection, and oral naltrexone.

For opioid tolerant patients, the goal of pain management continues to be provision of adequate analgesia during the procedure. Here are some general principles (from SAMHSA 2015, Reis 2014, Huxtable 2011, and Alford 2006):

- Recognize that uterine aspiration can be painful but brief. Short acting pain medications are typically used, and higher doses of medication may be required.
- Do not worry about worsening tolerance in the setting of procedural pain.
- Patients with tolerance may worry that pain will not be adequately controlled, which can worsen their acute pain. Empathize and reassure them appropriately.
- Don’t forget to utilize other ways to alleviate pain, such as NSAIDS, local anesthetic breathing, visualization techniques, and a support person in the room.
- Determine dosing by monitoring reported pain, alertness, and respiratory rate.
- Short acting, high affinity opioids like fentanyl or hydromorphone (Dilaudid) are effective and safe for repeated dosing; however, any opioid can be used.
- Those on OMT should continue their medications as prescribed.
- As buprenorphine is a partial agonist with high affinity for opioid receptors, or naltrexone, an opioid antagonist, pain control for patients on it can be difficult. Patients may need a much larger opioid dose or a temporary increase in buprenorphine, during a procedure.
- Patients on OMT can be given a short-term (1-3 days) opiate prescription if indicated, with an OMT clinic follow up within that time frame. The expected duration of their pain from uterine aspiration is the same as patients not on OMT.
- OMT and naltrexone prescribers can provide guidance for acute pain control, and should know that their patient received other opioids. Communicate with the prescribing clinic or physician if possible, or offer a note documenting the opioids received under your care.
PROVIDING EFFECTIVE LOCAL ANESTHESIA

Below are techniques and pitfalls of paracervical block, preparations, and injection approach. A common approach is to inject 1-2 mL at 12 o’clock for the tenaculum, and then inject at 4 and 8 o’clock as depicted above to target paracervical innervation. Other approaches are to inject at 2 and 10 o’clock, or 3 and 9 o’clock.

INJECTION TIPS AND TECHNIQUES

- Paracervical block is effective at reducing pain regardless of gestational age, although it can also be painful at the time of injection (Renner 2012).
- Injection locations and techniques vary by provider.
- Reported pain scores during dilation and aspiration are improved with buffered lidocaine and deep injections (1.5 to 3 cm) in a Cochrane review (Renner 2010).
- Slower injection (60 vs. 30 sec) or injecting ahead of the needle may decrease pain.
- Four-site blocks offer no benefit over two-site injections, and may increase pain.
- Some use a cough technique to distract during injection, but data are limited.
- Local anesthetics block nerve impulses, although physical pressure on nerves due to volume injected also provides analgesic effect. Saline has slightly less effect than lidocaine (Chanrachakul 2001, Glanz 2001).
- Adding ketorolac to block decreased pain of dilation, but not overall pain (Cansino 2009).
- No evidence suggests one anesthetic is superior but options are reviewed below.

<table>
<thead>
<tr>
<th>Generic (Trade)</th>
<th>Potency</th>
<th>Onset</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bupivacaine (Marcaine)</td>
<td>Strong</td>
<td>Moderate (up to 20 min)</td>
<td>Long (3-6 h)</td>
</tr>
<tr>
<td>Lidocaine (Xylocaine)</td>
<td>Medium</td>
<td>Fast (4-7 min)</td>
<td>Moderate (1-2 h) (~3 h with epinephrine)</td>
</tr>
<tr>
<td>Mepivacaine (Carbocaine)</td>
<td>Medium</td>
<td>Fast (4-7 min)</td>
<td>Moderate (3 h)</td>
</tr>
<tr>
<td>Chloroprocaine (Nesacaine)</td>
<td>Weaker</td>
<td>Fastest</td>
<td>Short (30 min) 25 sec half life</td>
</tr>
</tbody>
</table>
TIPS TO MINIMIZE SYSTEMIC ABSORPTION
The maximum lidocaine dose recommended in pregnancy is 200 mg [achieved for example, by giving 20 ml of 1% lidocaine (10 mg/ml)].

When injected (inadvertently) intravenously at moderate concentrations, patients may have peri-oral tingling, dizziness, tinnitus, metallic taste or irregular/slow pulse. At higher concentrations, they may have muscular twitching, seizure, cardiac arrhythmias, unconsciousness, and even death (Paul 2009).

- Minimize direct intravascular injection and excessive anesthetic dosing.
  - Use a combination of superficial (1 cm) and deep injections (3 cm).
  - Move the needle while injecting (superficial to deep) OR aspirate before injecting.
  - Use a dilute concentration (using 0.5% lidocaine or diluting with saline)
  - Use a vasoconstrictor mixed with the anesthetic to slow systemic absorption.

<table>
<thead>
<tr>
<th>One Possible Mixture for Preparation of Anesthetic (Paul et al (eds) 2009)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Take 50 ml vial of 0.5% or 1% lidocaine and draw off 5 cc (save or discard)</td>
</tr>
<tr>
<td>2. Add 2-4 units (0.1-0.2 ml) of vasopressin</td>
</tr>
<tr>
<td>3. Add 5 ml sodium bicarbonate (8.4%) as buffer</td>
</tr>
<tr>
<td>4. About 20 ml of mixture is usually adequate</td>
</tr>
</tbody>
</table>

Some add atropine to above mixture for vasovagal prevention (recommended dose 2 mg / 50 ml).

UNIVERSAL PRECAUTIONS PERTAINING TO UTERINE ASPIRATION
Universal precautions are designed to prevent transmission of blood-borne pathogens when providing health care.

- Wear gloves and protective eye gear when working with body fluids (i.e. injection, procedure, handling of tissue or contaminated instruments).
- Avoid recapping contaminated needles, and place sharps immediately in a puncture-resistant container for disposal.
- If there is a blood exposure, tell your supervisor. Information is available through the National Clinicians’ Post-Exposure Prophylaxis Hotline at [http://www.nccc.ucsf.edu/about_nccc/pepline](http://www.nccc.ucsf.edu/about_nccc/pepline), or OSHA at [http://www.osha.gov/SLTC/bloodbornepathogens/index.html](http://www.osha.gov/SLTC/bloodbornepathogens/index.html).
### BASIC MEDICATION OPTIONS

<table>
<thead>
<tr>
<th>Drug (Class)</th>
<th>Dose Range</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Local Anesthesia and Additives</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lidocaine (Xylocaine) (0.5% – 1%)</td>
<td>Up to 200 mg (20 mL 1% or 40 mL 0.5%)</td>
<td>Most common in U.S. Lower concentration as effective but more expensive</td>
</tr>
<tr>
<td>Bacteriostatic Saline</td>
<td>20 mL</td>
<td>Somewhat less effective than lidocaine</td>
</tr>
<tr>
<td>Bicarbonate Buffer</td>
<td>5 mL / 50 mL anesthetic</td>
<td>Less injection pain</td>
</tr>
<tr>
<td>Vasopressin (Vasostrict)</td>
<td>5-10 u / 50 mL anesthetic</td>
<td>Decreases bleeding and systemic absorption; can be expensive</td>
</tr>
<tr>
<td><strong>Oral and IV Pain Medications</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ibuprofen (Motrin; Advil)</td>
<td>600 – 800 mg PO</td>
<td>More effective at least 30 minutes before procedure</td>
</tr>
<tr>
<td>Naproxen (Naprosyn; Aleve)</td>
<td>250 – 800 mg PO</td>
<td>More effective at least 30 minutes before procedure</td>
</tr>
<tr>
<td>Hydrocodone/Acetaminophen (Norco) or Acetaminophen with Codeine (Tylenol w/ Codeine)</td>
<td>1-2 tablets of 5/325 mg or 300/30 mg PO</td>
<td>Equivalent medications can also be used</td>
</tr>
<tr>
<td>Lorazepam (Ativan)</td>
<td>0.5 – 1 mg SL or 1-2 mg PO</td>
<td>Shorter acting benzodiazepine. Antidote is flumazenil</td>
</tr>
<tr>
<td>Diazepam (Valium)</td>
<td>5-10 mg PO</td>
<td>Longer acting benzodiazepine. Antidote is flumazenil</td>
</tr>
<tr>
<td>Fentanyl (Sublimaze)</td>
<td>50 – 100 μg IV</td>
<td>Give over 30-60 seconds. Antidote is naloxone</td>
</tr>
<tr>
<td>Midazolam (Versed)</td>
<td>1 – 2 mg IV</td>
<td>Give over 2 minutes. Antidote is flumazenil</td>
</tr>
<tr>
<td><strong>Uterotonics for Post-Aspiration Hemorrhage</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Methylergonovine (Methergine)</td>
<td>0.2 mg PO/IM or intracervical</td>
<td>Use with caution in hypertensive patients</td>
</tr>
<tr>
<td>Misoprostol (Cytotec)</td>
<td>800mcg SL or 800-1000mcg PR</td>
<td>Given a rapid time to peak concentration, SL or buccal may be preferable to PR if possible (Kerns 2013)</td>
</tr>
</tbody>
</table>
| Carboprost (Hemabate)*          | 0.25 mg IM, may repeat at 15-90 minute intervals to max of 2mg | Use with caution in asthmatic patients  
* Not available for use outside inpatient medical facilities |
| Oxytocin (Pitocin)              | 10 u IM, or 10-40 u IV in crystalloid, or 10 u IVP | More uterine oxytocin receptors > 20 weeks                               |
| **Emergency Medications**       |                                                |                                                                         |
| Atropine Sulfate (Atopen)       | 0.2 mg (0.5 mL) IV push or 0.4 mg (1 mL) IM, each 3-5 min to max dose of 2 mg | For prolonged symptomatic bradycardia with vasovagal  
Some use in paracervical block to prevent vasovagal |
| Diphenhydramine (Benadryl)      | 25 – 50 mg IM/IV/PO                             | For allergic reaction  
Use PO for mild symptoms and IM/IV for anaphylaxis  |
| Epinephrine 1:1000 (Adrenalin)   | 0.3 – 0.5 mg (1 mg/mL) SQ/IM Repeat doses at 5-15 min intervals as necessary | For anaphylaxis. Preferable to inject in mid-anterolateral thigh |
| Naloxone (Narcan)               | 0.1 mg – 0.2 mg (0.25-0.50 mL) IV / IM each 2-3 min Max dose 0.4 mg | Opiate antidote                                                        |
| Flumazenil (Romazicon)          | 0.2 mg (2 mL) IV each min Max dose of 1 mg     | Benzodiazepine antidote                                                 |
MANAGING EMERGENCIES

<table>
<thead>
<tr>
<th>Maintain Client Safety</th>
<th>Call for Help</th>
<th>Assess Client Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Recent exposure</td>
<td>- High pulse</td>
<td>- Low pulse</td>
</tr>
<tr>
<td>- Hives</td>
<td>- Cool, clammy skin</td>
<td>- Low BP</td>
</tr>
<tr>
<td>- Coughing/sneezing</td>
<td>- Low BP</td>
<td>- Pale, sweaty</td>
</tr>
<tr>
<td>- Low pulse</td>
<td>- Perioral cyanosis</td>
<td>- Cool, clammy skin</td>
</tr>
<tr>
<td>- Flushed/agitated</td>
<td>- Onset over minutes or hours</td>
<td>- Nausea, vomiting</td>
</tr>
<tr>
<td>- More severe: SOB</td>
<td>- Rare syncope</td>
<td>- May lose consciousness</td>
</tr>
<tr>
<td>- Anxious</td>
<td>- Rhythmic limbs, jaw movements</td>
<td>- Absent respirations</td>
</tr>
<tr>
<td>- Rapid, shallow breathing</td>
<td>- Possible incontinence</td>
<td>- Carpal-pedal spasm</td>
</tr>
</tbody>
</table>

### ANAPHYLAXIS
- Epinephrine 1:1000 0.2–0.5 SQ/IV in 10 mL NS, slow push
- Benadryl 50 mg IM
- Oxygen
- Call 911

### HYPOVOLEMIC SHOCK
- Call 911
- Elevate legs
- Place large bore IV, infuse NS rapidly

### VASOVAGAL REACTION (Neurogenic Shock)
- Keep supine
- Elevate legs
- Isometric muscle contractions
- Cool cloth/ice pack
- Ammonia capsule
- Oxygen
- Call 911 & for AED
- Prevent injury
- Lateral position to protect airway
- Let seizure run its course
- Oxygen
- Reassure patient
- Slow-count breathing
- Place paper bag over mouth to re-breathe CO2

### CARDIO-PULMONARY ARREST
- If low BP:
  - Start IV LR or NS
- Evaluate source and manage (6Ts)
- Start 2nd IV line
- If persistent symptomatic bradycardia:
  - Give Atropine 0.2 or 0.4mg IM / IV
- Every 2 minutes check pulse, rhythm, and switch compressors until EMS arrives
- If continues >2min, call 911
- Give Diazepam (Valium) 5 mg IV or Midazolam 5-10 mg IM
- Assure patient is stable before leaving the clinic

- If no recovery, call 911

### SEIZURE
- Call 911 & for AED
- Start CPR (30:2)
- Attach AED; defibrillate if indicated
- If continues >2min, call 911
- Give Diazepam (Valium) 5 mg IV or Midazolam 5-10 mg IM
- Assure patient is stable before leaving the clinic

- Repeat x1 in 5 min. if needed

### HYPERVENTILATION
- If low BP:
  - Start IV LR or NS
- Evaluate source and manage (6Ts)
- Start 2nd IV line
- If persistent symptomatic bradycardia:
  - Give Atropine 0.2 or 0.4mg IM / IV
- Every 2 minutes check pulse, rhythm, and switch compressors until EMS arrives
- If continues >2min, call 911
- Give Diazepam (Valium) 5 mg IV or Midazolam 5-10 mg IM
- Assure patient is stable before leaving the clinic

- If no recovery, call 911

- Repeat x1 in 5 min. if needed

- Clinics should have written protocols for the management of medical emergencies, including bleeding, perforation, respiratory depression/arrest, anaphylaxis, and emergency transfer.
- Clinics should have hospital transfer agreements outlining the means of communication and transport and the protocol for emergent transfer of care. (NAF CPGs 2020)
- Emergency Scenarios are available for medical staff role-plays, debrief, and teaching at teachtraining.org/Resources.html.
CHAPTER 5 EXERCISES:
MEDICATIONS AND PAIN MANAGEMENT

EXERCISE 5.1
Purpose: To review management of side effects and complications from medications used to control pain and anxiety. How would you manage the following case scenarios of patients undergoing uterine aspiration?

1. A patient states that last year they had an allergic reaction to the local anesthetic that the dentist used.

2. A patient chooses to have IV pain management due to extreme anxiety. You administer midazolam 1 mg and fentanyl 100 mcg. As you dilate the cervix, the patient falls asleep and is not easily arousable. The oxygen saturation falls from 99% to 88%.

3. A patient who is 5 weeks by LMP has a history of alcohol and heroin abuse, and states that they “shot up” yesterday. The patient wants all the pain medication possible for the aspiration procedure. Venous access is limited, but you finally succeed in inserting an IV and administer midazolam 1 mg and fentanyl 100 mcg. You insert the speculum, and the patient complains “I can feel everything” and “I need more meds.”

   a. How would you treat this pain? What do you need to take into consideration for patients with opioid tolerance?

   b. How would this change if the patient were on buprenorphine (Suboxone)?
EXERCISE 5.2

Purpose: To become familiar with other medications used with uterine aspiration.

Please answer the following questions.

1. In which of the following situations is administration of Rh-D immunoglobulin (Rhogam) suggested in a patient over 10-weeks gestation?
   a. Patient has positive anti-D antibody titre.
   b. Rh-negative patient received RhoGam 4 weeks ago during evaluation for threatened abortion.
   c. Rh-negative patient 4 days post-abortion who did not receive RhoGam at the uterine aspiration visit.

2. While completing an early uterine aspiration procedure using local cervical anesthesia only, the patient complains of nausea and "feeling faint". The patient is pale and sweating. The blood pressure is 90/50 with a pulse of 48.
   a. What is your differential diagnosis?
   b. How might you prevent this reaction?
   c. How would you manage this patient?
CHAPTER 5 TEACHING POINTS: MEDICATIONS AND PAIN MANAGEMENT

EXERCISE 5.1

Purpose: To review management of side effects and complications from medications used to control pain and anxiety. How would you manage the following case scenarios of patients undergoing uterine aspiration?

1. A patient states that last year they had an allergic reaction to the local anesthetic that the dentist used.
   • It is important to distinguish between allergic reaction, side effect, and toxicity.
   • Allergic reactions to -caines are extremely rare, and mostly occur from the preservative or epinephrine.
   • Allergic reactions include itching, hives, bronchospasm, and progression to anaphylactic shock.
   • In this case, the safest alternative may be to avoid local anesthetic.
   • Instead use saline (plain or bacteriostatic), which is slightly less effective than lidocaine (Chanrachakul 2001, Glanz 2001).

2. A patient chooses to have IV pain management due to extreme anxiety. You administer midazolam 1 mg and fentanyl 100 mcg. As you dilate the cervix, the patient falls asleep and is not easily arousable. The oxygen saturation falls from 99% to 88%.

Both medications cause sedation and respiratory depression. Individuals react differently due to interaction with other agents (e.g. alcohol) or genetic differences in metabolism.

Prevention can be aided by using a stepwise approach to pain management.

   • Smaller doses for low weight patients.
   • Serial doses until adequate pain control is achieved.
   • Reversal using antagonists, in a stepwise and titrated fashion.

<table>
<thead>
<tr>
<th>$O_2$ Saturation</th>
<th>Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>95 – 100%</td>
<td>Continue monitoring</td>
</tr>
</tbody>
</table>
| 90 - 94%         | Check monitor lead placement  
|                  | Advise deep breathing  
|                  | Head tilt – chin lift to protect airway |
| 89% or less      | Provide titrated reversal agents  
|                  | Head tilt – chin lift to protect airway  
|                  | Initiate oxygen  
|                  | PPV if inadequate spontaneous breathing  
|                  | Transfer if persistent |

• Hypoxic patients who have received both an opioid and a benzodiazepine should generally receive naloxone before flumazenil. Naloxone reverses both opioid sedation and respiratory depression. Flumazenil has not been shown to reliably reverse respiratory depression, and also carries seizure risk if the patient has benzodiazepine tolerance or a seizure disorder.

• Monitoring is recommended for two hours after use of reversal agents, because the sedative may last longer than the antagonist (ASA 2002).
3. A patient who is 5 weeks by LMP has a history of alcohol and heroin abuse, and states that they “shot up” yesterday. The patient wants all the pain medication possible for the abortion procedure. Venous access is limited, but you finally succeed in inserting an IV, and administer midazolam 1 mg and fentanyl 100 mcg. You insert the speculum, and the patient complains that “I can feel everything” and “I need more meds.”

a. How would you treat this pain? What do you need to take into consideration for patients with opioid tolerance?
   • Patients with opioid tolerance often require higher doses of medication to achieve pain control. A reasonable starting place for someone with significant tolerance would be to double the starting dose of fentanyl.
   • Keep in mind that intoxication can interfere with informed consent, warranting a delay in the procedure or LARC placement.
   • Rapid reversal of opiates or benzodiazepines in chronic users can also provoke withdrawal or seizures respectively.
   • Remember to utilize non-opioid forms of pain control and relaxation.

b. How would this change if the patient were on suboxone?
   • Individuals on OMT or on chronic pain medications will also raise specific management issues such as caution with use of other meds (benzodiazepines), in addition to higher tolerance of opioids.
   • Those who are prescribed OMT or chronic opioids should continue taking their medications as prescribed.
   • If possible, communicate with their prescriber to plan for the procedure and follow-up or provide a note for patient regarding medications used.
   • Increase opioid dose as needed, guided by monitoring, reported pain, alertness, and respiratory rate.
   • Encourage the patient to have close follow-up with their prescribing physician.

EXERCISE 5.2
Purpose: To become familiar with other medications used with uterine aspiration.

Please answer the following questions.

1. In which of the following situations is administration of Rh-D immunoglobulin (Rhogam) suggested in a patient over 10-weeks gestation?
   a. Patient has positive anti-D antibody titre.
      • The patient may already be sensitized (in which case RhoGam will not help).
      • Or the patient recently received RhoGam and still has those anti-D antibodies in their blood (t ½ is 24 days).
      • In either case, don’t give RhoGam unless there is a new indication and 3 weeks have elapsed since the last dose.
   b. Rh-negative patient received RhoGam 4 weeks ago during evaluation for threatened abortion.
      • RhoGam may be present for up to 9-12 weeks after full-dose administration (Bichler 2003), but the manufacturer advises that it be given if three or more weeks have elapsed since the initial injection in term pregnancies.
      • Until further data delineates therapeutic levels after mini-dose RhoGam, re-dosing after 3 elapsed weeks may be prudent.
c. Rh-negative patient is 4 days post-abortion and did not receive RhoGam at the uterine aspiration visit.
   • RhoGam should ideally be administered within 72 hours.
   • Beyond 72 hours, some recommend anti-D still be given as soon as possible, for up to 28 days (Fung Kee Fung 2003).
   • For medication abortion, RhoGam is ideally given at the time of mifepristone, but many give it up to 72 hours afterwards.

2. While completing an early uterine aspiration procedure using local cervical anesthesia only, the patient complains of nausea and “feeling faint”. The patient is pale and sweating. The blood pressure is 90/50 with a pulse of 48.
   a. What is the differential diagnosis?
      • This appears to be a classic vasovagal reaction, with low pulse, hypotension, and sweating. Vasovagal reflex is caused by stimulation of the parasympathetic nervous system, and occurs often with cervical dilation, fear and other emotions. A patient who is overheated, dehydrated, hypoglycemic, or over-medicated may also be predisposed to syncope.
      • Differential Diagnosis: Vasovagal, hemorrhage, low blood sugar, or an inadvertent intravascular -caine injection.

<table>
<thead>
<tr>
<th>Vasovagal Reflex</th>
<th>Hemorrhage</th>
<th>Low Blood Sugar</th>
<th>Intravascular -caine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Slow pulse (&lt; 50) Low BP Pallor Cool clammy skin +/- N/V +/- Abdominal Cramps</td>
<td>Rapid Pulse Late low BP Pallor, Cool clammy skin +/- N/V +/- Uterine cramps</td>
<td>Normal / late rapid Late low BP Pallor, Cool clammy skin +/- N/V +/- Abdominal Cramps</td>
<td>Slow pulse (&lt;50) Tinnitus Perioral tingling Metallic taste Irregular pulse</td>
</tr>
<tr>
<td>Rare: Syncope, Seizure-like activity</td>
<td>Rare: Syncope</td>
<td>Rare: Syncope, Seizures</td>
<td>Rare: seizure, ventricular arrhythmias, cardiac arrest</td>
</tr>
<tr>
<td>Not orthostatic</td>
<td>Becomes orthostatic</td>
<td>Not orthostatic</td>
<td>Not orthostatic</td>
</tr>
</tbody>
</table>

b. How might you prevent this reaction?
   • To help prevent vasovagal reactions, emphasize hydration, keeping cool (i.e. walking to clinic during warm weather), and staying calm. Isometric extremity contractions may also help prevent vasovagal (see below).
c. How would you manage this patient?
   • Vasovagal Management
     o Airway / Positioning: supine or Trendelenburg, head to side if vomiting
     o Cool cloth on head or neck
     o Sniffing ammonia capsule may help
     o Vasovagal reflex may be aborted prior to syncope by isometric contractions of the extremities (gripping the arm, hand, leg and foot muscles) (Cason 2014). These maneuvers activate the skeletal-muscle pump to augment venous return and abort the reflex.
     o Prolonged vasovagal, consider:
       • Atropine
       • IV Fluids, oxygen
       • Evaluation for other potential causes (hemorrhage, etc.)
       • Record events, and transfer as needed.
6. UTERINE ASPIRATION PROCEDURE

Updated June 2016 by Caitlin Weber MD

This section contains information on first trimester uterine aspiration with manual and electric vacuum, used for both abortion and early pregnancy loss (EPL) management. You will have the opportunity to train in the use of vacuum equipment, steps in the uterine aspiration procedure, and tissue evaluation. Although most early uterine aspiration procedures are technically straightforward, some present challenges. Management of complex cases and complications will also be discussed.

CHAPTER LEARNING OBJECTIVES

Following chapter completion and hands-on experience, you should be able to:

• Approach communication, pelvic exams, and care with a trauma-informed lens
• Consistently use the ‘no touch technique’ while providing uterine aspiration, and describe its importance
• List the steps of the uterine aspiration procedure and tips for cervical dilation
• Correctly use equipment for manual and electric uterine aspiration
• Evaluate products of conception for presence of appropriate gestational tissue
• Assess and manage challenges and complications related to uterine aspiration

VIDEOS / SIMULATIONS

• First-Trimester Aspiration Abortion Video (IERH): https://vimeo.com/129467864
• Procedural simulation papaya workshops:
  o TEACH: http://goo.gl/AtuHF5
  o RHAP: http://goo.gl/zvOxyn
• Managing complications
  o IERH Managing Complications Video: https://vimeo.com/129488044
  o TEACH Simulation Practice Scenarios: http://goo.gl/QzGHrF
  o TEACH Managing Hemorrhage Simulation Workshop: https://goo.gl/rErXOm

READINGS / RESOURCES

• Paul et al (eds), Management of Unintended and Abnormal Pregnancy: Comprehensive Abortion Care (Wiley-Blackwell, 2009)
  o Chapter 10: First Trimester Aspiration Abortion
  o Chapter 13: The Challenging Abortion
  o Chapter 15: Surgical Complications: Prevention and Management
SUMMARY POINTS

SKILLS

• Learn the art of a trauma-informed pelvic care, including establishing rapport, using helpful language, and affirming patients control to help put patients at ease.
• Learning hand-eye coordination, internal landmarks, position, and angle of the uterus and cervical canal are critical to the safety of dilation. With experience, you will develop appreciation for the variability of cervical length and curvature, as well as the amount of pressure you need to exert.
• Become skilled at differentiating products of conception (POC; including gestational sac, membranes, villi, and fetal parts) from decidua (mucous membrane lining the uterus, which is modified during pregnancy and shed during menses or aspiration).

SAFETY

• The risk of abortion complications is minimal, with < 0.5% of patients experiencing a major complication requiring hospitalization (Upadhyay 2015, White 2015).
• Abortion-related mortality in the U.S. is more than 14 times lower than continuing a pregnancy to delivery (Zane 2015, Raymond 2012)
• The prevalence of complications is similar across clinic contexts, suggesting that laws requiring facilities to meet ambulatory surgical center standards or hospital admitting privileges are unlikely to improve abortion safety in office settings (White 2015).
• If you are having trouble dilating the cervical canal, there are various strategies to try, but it is important know when to stop. Rescheduling may improve success.
• Routine post-abortion tissue examination by a pathology lab confers no incremental clinical benefit, although is required in some institutions (Paul 2002).
• Both sharp and excessive curettage increase procedure time, bleeding, pain, and scarring risk (Asherman’s), and should be avoided (Gilman 2014, Tunçalp 2010).
• Early abortion safety, efficacy and acceptability are found to be equivalent between physicians and well-trained advanced practice clinicians (Barnard 2015; Weitz 2013).

ROLE

• Considering risk factors for a challenging procedure ahead of time allows providers to customize care and minimize complications.
• It is optimal to work in concert with an assistant to provide support during uterine aspiration. Your leadership and “normalization” of the experience will ensure a respectful, supportive environment for all.
TRAUMA-INFORMED CARE DURING PROCEDURES

Adapted from RHAP Contraceptive Pearl: Trauma Informed Pelvic Exams 2015

- If the patient has never experienced a pelvic exam, take extra care and time to explain what will happen, what a speculum is, what the procedure may feel like, and how to best position and relax their body. Consider using a pediatric speculum if available when a patient has had very limited sexual experience. Explain that future pelvic exams or pap tests will only involve speculum placement so they do not anticipate the additional experiences of the abortion.
- A pelvic exam can often trigger a trauma response related to past sexual trauma (Sharkansky 2014). Many people will not ever report or disclose abuse to their healthcare provider. It is helpful to perform a trauma-informed exam with every patient, and not just those who disclose a history of assault or abuse. Ask the patient if they have had difficulty with pelvic exams in the past or if they have had any sort of sexual experience or exam which was painful or forced. Clinicians should use the following patient-centered techniques to lower patients’ anxiety.

<table>
<thead>
<tr>
<th>TRY TO</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Establish rapport</td>
<td>Introduce yourself and take a seat to demonstrate respect and ease anxiety.</td>
</tr>
<tr>
<td>Invest in patient's experience</td>
<td>Prioritize the patient’s experience rather than the outcome. This may mean doing the exam at a separate visit.</td>
</tr>
<tr>
<td>Allow a support person</td>
<td>Allow a support person to accompany the patient, such as a partner, friend, family member, or trained doula. Those receiving doula support are less likely to require additional clinic support resources, although pain and satisfaction are unchanged (Chor 2015). Where possible, encourage institutional policies allowing presence of a support person and allow the patient to choose a female examiner if they would like/are available.</td>
</tr>
<tr>
<td>Support the patient's comfort</td>
<td>Keep the patient's body covered, exposing only areas being examined, use the smallest possible speculum, use lubricant, offer frog leg position without stirrups, and call stirrups “foot rests.”</td>
</tr>
<tr>
<td>Review relaxation techniques</td>
<td>Discuss distraction and breathing techniques (See Chapter 5, Non-pharmacologic Pain Management, page 86) before focusing on details of the consent, which may be scary.</td>
</tr>
<tr>
<td>Invite the patient to take control</td>
<td>Ask what would make the exam more comfortable. Let them know they have control over the pace and can stop the procedure if uncomfortable. Offer self-insertion of the speculum.</td>
</tr>
<tr>
<td>Keep the patient informed</td>
<td>Tell the patient about each step right before it happens. Alert them to what they might feel to avoid alarming them. It can also be helpful to say, “We’re about two-thirds through” or “This part takes about one minute.”</td>
</tr>
<tr>
<td>Use your intuition</td>
<td>Assess what will be most helpful and follow the patient’s lead: sometimes quiet, sometimes humor, and sometimes talking about work, kids, school or goals will resonate well with a patient.</td>
</tr>
<tr>
<td>Go at the patient’s pace</td>
<td>If the patient asks to stop, do so adding “Do you need a break now? Let’s try taking some deep breaths, and let me know when you are ready to proceed.”</td>
</tr>
<tr>
<td>Check in frequently</td>
<td>Check in about whether they want physical and/or emotional support during the procedure, offering an assistant’s reassurance or hand to squeeze.</td>
</tr>
<tr>
<td>Use supportive statements</td>
<td>Say “Everything is going really well” or “You are doing a good job relaxing your bottom into the table.”</td>
</tr>
</tbody>
</table>
QUICK GUIDE: COMMUNICATION DURING THE PROCEDURE

If the provider does not do the abortion counseling/consenting

Depending on how your services are set up, a counselor may conduct pre-abortion counseling instead of the provider. This can make establishing rapport even more important, and can be assisted by sitting at a patient’s level, using an accepting tone, and starting with open-ended questions. You might check in with patient: “I know you have spoken to the counselor. I wanted to see what questions you may still have for me.” Or consider using teach back: “Tell me what you have already learned about breathing and relaxation.” Look for emotional cues, and try to create a safe space for them to express their emotions, perhaps saying “all your emotions are safe here.”

Approach to Communication

The use of gentle, neutral language and avoidance of words associated with pain has been shown in some but not all studies to decrease pain perception during procedures such as administration of local anesthesia (Dalton 2014, Ott 2012, Varelmann 2010). This has not specifically been studied in uterine aspiration. Many providers prefer to use language describing what they are doing next rather than what the patient may feel. Others describe symptoms the patient may experience but choose their words carefully, with particular attention to avoiding descriptions of pain or sexual references. For example, “You may feel a cramp,” as opposed to “You are going to feel a poke/prick/stick”. Below are some tips for language during the procedure.

<table>
<thead>
<tr>
<th>Approach to Communication</th>
<th>Instead of</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction sitting at patient’s level</td>
<td>Introduction looking down at patient</td>
</tr>
<tr>
<td>Your pregnancy is 8 weeks along.</td>
<td>Your baby is 8 weeks old.</td>
</tr>
<tr>
<td>Place your feet in the foot holders.</td>
<td>Place your feet in the stirrups.</td>
</tr>
<tr>
<td>There is room for you to move down further on the exam table.</td>
<td>Move your bottom down the bed until you feel like you’re going to fall off.</td>
</tr>
<tr>
<td>Allow your knees to fall to the sides.</td>
<td>Open or spread your legs.</td>
</tr>
<tr>
<td>Your cervix looks healthy and normal.</td>
<td>Your cervix / uterus looks/feels good.</td>
</tr>
<tr>
<td>You may feel some cool wet cotton to swab away your natural cervical mucous.</td>
<td>I am cleaning your cervix (implying the cervix is dirty).</td>
</tr>
<tr>
<td>If…then statements such as If you want the procedure to go as quickly as possible, then hold as still as you can.</td>
<td>You have to hold still.</td>
</tr>
<tr>
<td>This is the numbing medicine. You may feel a cramp, or spreading numbness.</td>
<td>You are going to feel a poke/prick/stick with the injection.</td>
</tr>
<tr>
<td>We’re over halfway through; doing great.</td>
<td>It will be a few more minutes.</td>
</tr>
<tr>
<td>I will place / introduce the IUD or implant.</td>
<td>I will insert the IUD or implant.</td>
</tr>
</tbody>
</table>
When is it appropriate to defer an abortion?

Some patients feel a new sense of uncertainty immediately before the procedure begins. This may be another way a patient communicates heightened fear, or it may be that the reality of being in the procedure room is making the patient reconsider their decision.

It is not appropriate to try to facilitate a decision-making process while the patient is sitting, undressed, on the table. They should be offered supportive counseling and more time to think.

In deciding how to proceed, it is appropriate to trust your instincts. Some patients, who may be having difficulty accepting their decision, recant in an effort to make the provider or the agency “responsible.” In such a case, the provider must ask for a clear statement of the patient’s intent before proceeding. For example:

“I’m not sure if you are ready to go on with the procedure today. If you are not sure, we can postpone. Do you need some more time?”

For many patients, this last moment is what they need; when faced with the possibility of not going forward, they see this option is less appealing, and know they want to proceed. For others, it gives them a chance to think more about what they truly want.
NO-TOUCH TECHNIQUE

Preventing infection after uterine aspiration is an important goal. Measures to accomplish this include properly sterilizing instruments, administering prophylactic antibiotics as indicated, minimizing bacterial entry into the sterile uterine cavity, and meticulously using the “no touch” technique to assure that the portions of instruments entering the uterine cavity remain sterile (Paul 2009). The provider:

• Maintains sterility of the surgical tray: non-sterile instruments should be separately available, and contaminated instruments should be placed separately on tray.
• Avoids contamination by gathering needed materials before placing speculum.
• Holds only the center of dilators, not the tips that will enter the uterus.
• Attaches the sterile cannula to the vacuum source without touching the cannula tip.
• Avoids vaginal contamination of uterine instruments.
• Change instruments that will enter the uterus if inadvertently contaminated.

Even with antiseptic cleansing, it is impossible to “sterilize” the vagina. In fact, randomized studies showed that preoperative antiseptic vaginal cleansing had no effect on post-abortal infection rates (Varli 2006, Lundh 1983). Even using sterile gloves, sterility is compromised when touching the client’s perineum and vagina to insert the speculum. Some providers routinely use non-sterile gloves for uterine aspiration, which is acceptable if the no-touch technique is scrupulously maintained.

Manual Vacuum Aspirator Plus

• Cap
• Cap release
• Valve buttons
• Clasp
• Plunger O-ring
• Collar stop Retaining Clip
• Collar stop
• Cylinder base
• Plunger arms
• Plunger handle

Typical tray set-up Instruments shown: Sterile on left, non-sterile on right (except needle)

• Appropriate sizes of dilators
• Cannula (on sterile field vs. in sterile package)
• Ring forceps with cotton
• Tenaculum
• Speculum
• Gauze
• Anesthetic syringe (not sterile)
• MVA Plus (not sterile)
**STEPS FOR UTERINE ASPIRATION**

Review patient history and confirm gestational age and all completed consents before entering exam room

1. Introduce yourself and ask the patient’s name to confirm identity
2. Establish rapport, elicit and answer patient’s questions:
3. “What questions do you have for me?”
4. Provide reassurance and explain process to the extent that the patient desires.
5. Give IV medications if using
6. Assess patient’s pain level throughout procedure
7. Don gloves and protective eyewear; perform bimanual examination to confirm uterine position and size
8. Prepare equipment tray and all items for procedure (cannula, block, etc.); adjust table and light
9. Insert the speculum, evaluate, and collect samples as needed for infection screening / testing
10. Apply antiseptic solution to cervix, as needed
11. Administer paracervical block
12. Place tenaculum with substantial cervical purchase; close slowly. Exert gradual traction to straighten the canal
13. Dilate the cervix to the size of the cannula you will be using [gestational age in weeks (+/- 1-2 mm)]
   a. Gently and gradually explore canal, holding the dilator loosely and allowing it to rotate within the canal; the canal should have a smooth, mucosal feel.
   b. Although it may be snug; you will often feel the internal os “give way” to gentle, steady pressure.
   c. If unable to pass through the internal os, try the following:
      o Gently apply traction on the tenaculum with slightly greater force to straighten the canal.
      o Change angle of dilator.
      o Try flexible plastic sound or os finder.
      o Change the tenaculum location (placing on posterior lip for a retroflexed uterus).
      o If acutely flexed cervix, try widening the speculum blades.
      o Use transabdominal US guidance.
      o Repeat pelvic exam.
      o Consider shorter, wide speculum.
      o Provide misoprostol (sublingual/vaginal) and reattempt dilation in 1.5 - 3 hours.
14. Insert the cannula through the cervix while exerting gentle but firm traction with the tenaculum, and advance the cannula to the fundus. Connect the aspirator to the cannula.
15. Use manual or electric vacuum to empty the uterus until signs that it is empty
   (see detail table below, page 107)
16. After confirming products of conception (POC) are complete, place IUD or implant if requested.
17. Remove tenaculum, assure minimal bleeding, and remove speculum
18. Check for adequacy of POC, if not already done
19. Inform patient of complete procedure and recovery process
Using MVA and EVA Equipment
Adapted from MVA, a presentation by PRH and ARHP, 2000; 2012

Prepare the aspirator
• Begin with valve buttons open and plunger pushed fully into the barrel.
• Close valve by pushing the buttons down and forward until locked in place.

Create the vacuum
• Pull the plunger back until its arms snap outward over the rim at end of the barrel.
• Make sure plunger arms are positioned over wide edges of the barrel rim.

Gently dilate the cervix
• Use dilators of increasing size to accommodate cannula size chosen based on gestational weeks.
• Dilator:
  o Denniston – dilate to cannula size (e.g. size 7 for 7 mm cannula)
  o Pratt – dilate to cannula size x 3 (e.g. 21 French for 7mm cannula)

Choose a cannula
• Flexible: longer with two openings at tip
• Rigid: larger single opening at tip
• No significant difference in safety or efficacy (Kulier 2001)
• Larger: faster aspiration, intact tissue
• Smaller: less dilation and resistance
NAF Provider’s survey (O’Connell 2009):
• 54% used size (in mm) = weeks gestation
• 37% used 1-2 mm < weeks gestation
• 9% used 1-3 mm > weeks gestation
Insert the cannula

- Apply traction to tenaculum to straighten uterus. Then holding cannula with fingertips, gently insert through cervix with rotating motion.
- Attach aspirator to cannula.
- Do not grasp aspirator by plunger arms.

Release the valve buttons

- When the pinch valve is released, the vacuum is transferred through the cannula into the uterus.
- Blood, tissue, and bubbles will flow through the cannula into the aspirator.

Evacuate the uterus

- Rotate the cannula and move it gently from fundus to the internal os, applying a back and forth motion as clinically indicated until:
  - Grittiness is felt through cannula
  - Uterus contracts and grips cannula
  - There is increased cramping, and / or
  - No more blood passes through cannula.

Choice of Vacuum for Aspiration

- Availability / preference determine use
- MVA is FDA approved to 12 weeks
- Some use > 1 MVA to facilitate emptying, or switch to EVA > 9 weeks
- Minimal differences in pain, anxiety, bleeding, or acceptability (Dean 2003)
- EVA sound disturbs some patients; silent, in-wall suction is available.

EVA use:

- Attach cannula and close thumb valve
- Place cannula into uterus
- Turn on and check suction gauge
- To modify: turn dial or adjust valve
- Release suction (open thumb valve)
- when passing through cervical canal.
Inspect the tissue
- Rinse and strain the tissue
- Place tissue in a clear container
- Backlight is recommended to inspect tissue if gross visual inspection is non-diagnostic.

Gestational sac at 6 weeks
- Shredded (on left) vs. intact
- To minimize shredding, consider using MVA (< pressure than EVA); slightly larger cannula.

Membranes and Villi (POC)
Frond-like villi
Clumps held by membrane
Transparent like plastic wrap
Luminescent; light refractory
Turns white if vinegar added
More stretchy
Floats more in liquid media
Size: see coin sizes above

Decidua (not POC)
No fronds
No villi or thin membrane
Opaque like wax paper
Less light refractory
Minimal color change
More breakable
Sinks more in liquid media
Quantity variable

Decidua capsularis
Caution not to confuse
a) gestational sac (8 wk) with
b) decidua capsularis, a portion of the decidua which grows proportionally to gestational sac but is thicker and tougher (Paul 2009).

Fetal part development
Parts may be seen earlier.
≥ 10W look for 4 extremities, spine, calvarium and gestational sac.
≥12W must find all fetal parts + placenta.
# Managing Complications

<table>
<thead>
<tr>
<th>Immediate Complications</th>
<th>Clinical Presentation</th>
<th>Management Options</th>
<th>Occurrence Rate*</th>
</tr>
</thead>
</table>
| **Vasovagal Episode**    | Presentation may include:  
  - Pale, clammy, dizzy, nauseated or with emesis  
  - Pulse < 60  
  - Rare syncope  
  - During or after procedure  
  - Usually resolves quickly and spontaneously  
  Etiology:  
  - Parasympathetic nerve stimulation and painful stimuli | Pause procedure:  
  - Apply cool compresses  
  - Trendelenburg position or elevate the legs above the chest  
  - Sniffing ammonium may help  
  - Isometric extremity contractions  
  For persistent symptomatic bradycardia:  
  - Atropine 0.2 mg IV or 0.4 mg IM,  
    - May repeat in 3-5 minutes  
    - (max dose of 2 mg) | 0.02 – 0.07% |
| **Excessive Bleeding/Hemorrhage** | EBL > 150 cc = excessive to 10 wks  
  EBL ≥ 500 cc = hemorrhage  
  **Remember 4T’s of etiology:**  
  (ALSO 2014)  
  1. **Tissue** (not completely evacuated)  
  2. **Tone** (inadequate uterine tone)  
  3. **Trauma** (perforation or cervical lac)  
  4. **Thrombin** (rare underlying bleeding disorder)  
  **Hemorrhage risk groups:**  
  (Kerns 2013)  
  1. **Low risk:** no prior c/s, <2 prior c/s and no previa/accreta, no bleeding disorder, no history of obstetric hemorrhage  
  2. **Moderate risk:** ≥ 2 c/s, prior c/s and previa, bleeding disorder, history of obstetric hemorrhage not needing transfusion, increasing maternal age, GA>20 weeks, fibroids, obesity  
  3. **High risk:** accreta/concern for accreta, history of obstetric hemorrhage needing transfusion, +/- others from moderate category | **6T’s** (Goodman 2015)  
  **Tissue:** Assure uterus is empty  
  - Estimate EBL  
  - Reaspirate (with US guidance; EVA for rapid evacuation); check POC  
  **Tone:** Uterotonics  
  - Uterine massage  
  - Medications: Methergine 0.2 mg IM/IC, Misoprostol 800 mcg SL/BU/PR, or Vasopressin 4-8 units (diluted in 5-10 cc NS) IC  
  **Trauma:** Assess source  
  - Cannula test**  
  - Clamp bleeding site at cervix with ring forceps  
  **Thrombin**  
  - Review bleeding history  
  - Additional tests as indicated (coags, repeat CBC, clot test***) | 0.07 – 0.4% |
| **Perforation**           | Instruments pass deeper than expected by EGA and pelvic exam  
  Patient may feel sudden sharp pain; may be painless  
  Risk factors:  
  - Inadequate dilation  
  - Increased gestational age  
  - Uterine flexion  
  - Previous cesarean section  
  - Operator inexperience  
  - Uterine anomaly | Stop procedure:  
  - Turn off suction  
  - Assess patient: VS, pain, bleeding, abdominal exam  
  - Check contents of aspirate for omentum or bowel, and for POC  
  If stable:  
  - Evaluate with US  
  - Experienced providers have safely explored uterus and completed procedure under US guidance  
  - Observe for 1.5-2 hours  
  - Consider uterotonics to contract uterus and control bleeding  
  - Consider antibiotics  
  If unstable or perf with suction, transfer | 0.02 – 0.07% |

*Upadhyay 2015  
*Weitz 2013  
*Yonke 2013  
*Jejeebhoy 2011  
*Kerns 2013  
*Goldberg 2004  
*Goldman 2004  
*Westfall 1998  
*Hakim-Elahi 1990
<table>
<thead>
<tr>
<th>Delayed Complications</th>
<th>Clinical Presentation</th>
<th>Management Options</th>
<th>Occurrence Rate*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Incomplete Abortion</strong> (Residual nonviable fetal tissue)</td>
<td>At time of aspiration: • Inadequate POC or Days to weeks after: • Pelvic pain • Abnormal bleeding • Pregnancy symptoms • Enlarged or boggy uterus US shows persistent IUP or debris [latter is non-specific; may be normal [Russo 2012; Paul 2009, pg. 228]]</td>
<td>Follow serial hCGs if any doubt that aspiration was complete Offer misoprostol or reaspiration to empty uterus Reaspiration preferred if: • Signs of infection • Hemorrhage • Severe pain • Significant anemia</td>
<td>0.2 – 4.4%</td>
</tr>
<tr>
<td><strong>Continuing Pregnancy</strong></td>
<td>Presentation: • Ongoing pregnancy symptoms • Enlarging uterus Risk factors: • Early gestational age • Uterine anomalies/fibroids • Missed multiple gestation • Operator inexperience</td>
<td>If inadequate POCs suspected at time of procedure, consider: • US • Serial hCGs • Ectopic precautions as needed Counsel patient; reaspirate as appropriate</td>
<td>0.4 – 2.3%</td>
</tr>
<tr>
<td><strong>Hematometra</strong> (Accumulation of blood in uterus following procedure)</td>
<td>Immediate: • Minutes to hours post-ab • Severe lower abdominal or pelvic pain • Rectal pressure • Minimal to no post-procedural bleeding • +/- hypotension, vasovagal • US: large amount uterine clot • Uterine exam: enlarged, firm Delayed: • Days to weeks post-ab • Pelvic pressure or cramping • +/- low grade fever</td>
<td>Prompt uterine aspiration of blood offers immediate relief Uterotonic medications post aspiration: • Methergine 0.2 mg IM / IC • Misoprostol 800 mcg PR or buccal</td>
<td>– 2.2 %</td>
</tr>
<tr>
<td><strong>Postabortal endometritis</strong> (Pelvic inflammatory disease)</td>
<td>Presentation: • Lower abdominal / pelvic pain • Fever, malaise • Tenderness • Purulent discharge • Elevated WBC</td>
<td>Diagnose: • US for retained POC / clot • May need reaspiration • Wet mount • Test for GC/CT Treat: • Antibiotics (CDC PID regimen)</td>
<td>0.09-2.6%</td>
</tr>
<tr>
<td><strong>Missed Ectopic Pregnancy</strong></td>
<td>Suspect if inadequate POC at time of aspiration Possible late signs/symptoms: • Pelvic pain or shoulder pain • Syncope or shock</td>
<td>Transport immediately to hospital if: • Ectopic is suspected; for dx / tx • Concern for rupture • Clinically unstable Methotrexate vs. surgical management</td>
<td>0.0 – 0.3%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>(Scant data) Bennett 2009</td>
</tr>
</tbody>
</table>

*Summary occurrence rates from Taylor, 2011: Standardizing early aspiration abortion complication definitions and tracking.

** Cannula test: Watch blood return as you slowly withdraw cannula from fundus to cervix, to identify bleeding zone.

***Cost test: fill plain glass tube with whole blood; leave for 10 minutes. Complete clotting at 10 minutes rules out DIC at that time.
CHAPTER 6 EXERCISES:
ASPIRATION ABORTION PROCEDURE

EXERCISE 6.1

Purpose: To practice management of challenging situations that can arise at the time of aspiration abortion procedures.

1. You are performing an abortion for an anxious 20-year-old G1P0 patient at six weeks gestation. You complete the cervical block and have the tenaculum in place. As you attempt to introduce the smallest dilator, you are unable to advance the dilator through the internal os. After readjusting the speculum and the tenaculum, you again find that there is severe resistance as you attempt to advance the dilator into the cervical canal; it feels dry, gritty, and tight, and does not have the “normal” feel of the dilator tip advancing through the cervical canal.
   a. What is the differential diagnosis?
   b. What would you do next?

2. You have just completed an aspiration abortion for a 19-year-old patient at six weeks gestation. They had reported intermittent episodes of vaginal bleeding on three occasions during the past week, but did not have any severe cramping or clotting. Their pre-procedure ultrasound was performed one week ago, with a 5 mm gestational sac identified, but no yolk sac or embryonic pole. Their pregnancy test was positive. Dilation was not difficult and you were able to use a 6 mm flexible cannula. The tissue specimen is very scant and you are not certain whether you see sac or villi.
   a. What is the differential diagnosis?
   b. What would you do next?

3. You are performing an abortion on a nulliparous 16-year-old patient at seven weeks gestation. You notice that their cervix is very small and it is hard to choose a site for the tenaculum. As you put traction on the tenaculum and try to insert the dilator, the tenaculum pulls off, tearing the cervix. There is minimal bleeding, so you reapply the tenaculum at a slightly different site, although it is difficult because the cervix is so small. This time, the cervix tears after inserting the third dilator, and there is substantial bleeding.
   a. What should you do now?
4. You are inserting the cannula for a procedure on a patient at 9 weeks gestation with a retroflexed uterus. Although the dilation was easy, you feel the cannula slide in easily but at a different angle and much further than you sounded with one of the dilators. You don’t feel any “stopping point.” The patient feels something sharp.

   a. What is the differential diagnosis?

   b. What should you do now?

   c. How might you have anticipated and prevented this problem?

5. A G3P2 patient at 8w5d presents for termination, with a history of one previous cesarean and a post-partum hemorrhage not requiring transfusion. The aspirator quickly fills with blood when suction applied. You empty it, recharge, and it again fills with blood. You have seen some tissue come through. You ask your assistant to prepare another MVA but it promptly fills with blood when attached to the cannula.

   Given the patient’s risk factors, what additional preparations would you consider beyond normal precautions? (see Managing Immediate Complications Table, page 109).

   a. What do you suspect?

   b. What can you do now?

EXERCISE 6.2

Purpose: To practice managing challenges that may occur after uterine aspiration.

1. The nurse consults with you about a possible problem phone call regarding a patient who had an abortion at the clinic five days ago. The patient complains of severe cramping and rectal pressure, has had minimal bleeding, and has a mild fever.

   a. What is the differential diagnosis?
b. Which exam and ultrasound findings would support your diagnosis?

a. What are your management recommendations?

b. If these symptoms developed immediately after an abortion, what would you do?

2. A 21-year-old patient comes to your office for follow-up after an 8-week abortion two weeks ago at another facility, and still has some symptoms of pregnancy including breast tenderness and abdominal bloating. Medications include birth control pills. The patient has had intercourse regularly for the past six days. The patient is afebrile, with normal vital signs. Pelvic exam is normal except for an 8-week size uterus. A high sensitivity urine pregnancy test is positive.

a. What is the differential diagnosis?

b. How can you rule in or out any of your diagnoses?

c. How might your approach differ if the ultrasound showed moderate amount of heterogeneous contents?

d. If the patient is not pregnant, how can you explain their positive urine pregnancy test and breast tenderness?
EXERCISE 6.1

**Purpose:** To practice management of challenging situations that can arise at the time of aspiration abortion procedures.

1. You are performing an abortion for an anxious 20-year old G1P0 patient at six weeks gestation. You complete the cervical block and have the tenaculum in place. As you attempt to introduce the smallest dilator, you are unable to advance the dilator through the internal os. After readjusting the speculum and the tenaculum, you again find that there is severe resistance as you attempt to advance the dilator into the cervical canal; it feels dry, gritty, and tight, and does not have the “normal” feel of the dilator tip advancing through the cervical canal.

   a. **What is the differential diagnosis?**
      - Acute flexion or tortuosity of the cervix
      - Congenital or acquired uterine abnormalities:
        a. Abdominal scarring due to prior (especially multiple) cesarean sections, which often limit adequate traction.
        b. Cervical stenosis from prior cone biopsy
        c. Fibroid in the lower uterine segment
        a. Müllerian anomaly
      - Error in assessment of uterine position (for example: the possibility of a sharply anteverted uterus with high cervix that may appear retroverted by visual exam without a thorough bi-manual exam).
      - False passage of the cannula due to any of the above.

   b. **What would you do next?**
      - See dilation tips from *The Steps for Uterine Aspiration, page 105* of this chapter.
      - Consider having trainer or more experienced provider finish the procedure.

2. You have just completed an aspiration abortion for a 19-year old patient at six weeks gestation. They had reported intermittent episodes of vaginal bleeding on three occasions during the past week, but did not have any severe cramping or clotting. Their pre-procedure ultrasound was performed one week ago, with a 5 mm gestational sac identified, but no yolk sac or embryonic pole. Their pregnancy test was positive. Dilation was not difficult and you were able to use a 6 mm flexible cannula. The tissue specimen is very scant and you are not certain whether you see sac or villi.

   a. **What is the differential diagnosis?**
      - Spontaneous abortion since last ultrasound
      - Failed aspiration abortion
      - Completed aspiration abortion with POC too small to visualize
      - Ectopic pregnancy

   b. **What do you do next?**
      - An US prior to aspiration might have ruled out an early pregnancy loss since prior US, in which case aspiration could have been avoided.
      - Recheck POC, MVA, EVA bottles, tubing, cannula, and strainer, (if used).
      - Use a magnifier and backlighting if available.
• Repeat US and reaspirate if tissue is still visible, with US guidance as indicated.
• Consider using a different cannula, such as rigid curved cannula to follow flexion.
• Consider an ectopic pregnancy in any case without definitive POC:
  c. Draw serial hCGs and give ectopic precautions.
  d. An hCG decrease of 50% within 48 hours suggests successful abortion (and is
     more reliable than US or pathology).
• If free-floating villi are seen without any membranes present, consider the possibility
  of retained gestational sac, and repeat US.
• If you see no villi, you can send the specimen to pathology. “Villi” on a pathology
  report confirms a pregnancy but not size estimation to confirm completion. Provider
  examination of POC reduces the risk of failed abortion, but routine histologic exam
  by a pathologist confers no incremental clinical benefit, and adds cost (Paul 2002).

3. You are performing an abortion on a nulliparous 16-year old patient at seven weeks
   gestation. You notice that their cervix is very small and it is hard to choose a site for
   the tenaculum. As you put traction on the tenaculum and try to insert the dilator, the
   tenaculum pulls off, tearing the cervix. There is minimal bleeding, so you reapply
   the tenaculum at a slightly different site, although it is difficult because the cervix
   is so small. This time, the cervix tears after inserting the third dilator, and there is
   substantial bleeding.
   a. What should you do now?

   These tears are fairly common, especially in small cervices. Try the following:
   • Before applying tenaculum to a small or flat cervix, inject several mLs of anesthetic to add
     bulk and facilitate placement (deeper in cervix, not in bleb).
   • Try a second tenaculum elsewhere on the cervix to provide a broader base of support, or
     an atraumatic tenaculum (pictured in Chapter 5 Paracervical Block image, page 89);
     then re-attempt dilation.
   • If bleeding, apply pressure to the cervix (clamp cervix with ring forceps or apply direct
     pressure). Dilute vasopressin (4-6 units in 5-10 cc sterile saline injected intra-cervically),
     Monsel’s solution, or silver nitrate may also be used; sutures are rarely required.
   • If unsuccessful, consider additional analgesia, misoprostol for 2–4 hours, delaying the
     procedure for a week to allow for more cervical ripening, or offering the patient medication
     abortion if eligible.
   • Consider pre-treatment with misoprostol in adolescents (WHO 2012) or those with a prior
     difficult dilation.

4. You are inserting the cannula for a procedure on a patient at 9 weeks gestation with a
   retroflexed uterus. Although the dilation was easy, you feel the cannula slide in easily
   but at a different angle and much further than you sounded with one of the dilators.
   You don’t feel any “stopping point.” The patient feels something sharp.
   a. What is the differential diagnosis?
      • A probable uterine perforation vs. a false tract.
   b. What should you do now?
      • Remove cannula. Evaluate for sharp or localized pain, vital signs, and bleeding.
      • US may assess fluid collection in the cul-de-sac, but in first trimester it is rare to be
        able to identify abdominal contents in the uterus, or uterine contents in the abdomen.
• If the uterine cavity can be re-identified, an experienced provider may choose to finish the procedure under ultrasound guidance.
• If vacuum has been applied, look for evidence of intra-abdominal contents (i.e. omental fat) in the aspirate. If seen, send to pathology and consider patient transfer.
• If patient remains asymptomatic for pain or bleeding, consider observation for two hours, antibiotic coverage if appropriate (Paul 2009; p. 241), and precautions before discharge.
• Consider uterotonics if bleeding is significant.

Hospitalization is indicated if:
  o The patient is hemodynamically unstable. Place IVs and initiate IV fluid.
  o The patient has significant pain.
  o There is evidence of large perforation, laceration, expanding hematoma, fetal parts in abdomen, or viscera / omentum in uterus or aspirate.

c. How might you have anticipated and prevented this problem?
  • Use gentle steady pressure during dilation until beyond the internal os.
  • Traction on the tenaculum helps straighten uterine flexion. Consider posterior placement for a retroflexed uterus to help straighten the angle.
  • Passage of a flexible uterine sound, os finder, or lacrimal duct probe may help to find the correct path, although use caution as a smaller instrument may increase perforation risk.
  • If your dilator passes easily but the cannula does not, consider using a smaller cannula or dilating one size higher.
  • Do not hesitate to re-check your pelvic exam.
  • Use US guidance, if available.
  • Consider a rigid curved cannula to maneuver the angle better.
  • Cervical ripening with misoprostol can be helpful.

5. A G3P2 patient at 8w5d presents for termination, with a history of a previous cesarean and a post-partum hemorrhage not requiring transfusion. The aspirator quickly fills with blood when suction applied. You empty it, recharge, and it again fills with blood. You have seen some tissue come through. You ask your assistant to prepare another MVA but it promptly fills with blood when attached to the cannula. Given the patient’s risk factors, what additional preparations would you consider beyond normal precautions?

This patient is in the moderate risk category for hemorrhage (Kerns 2013). In addition to what you would do for a low risk patient (see Managing Immediate Complications Table, page 109), the following should also be considered:
  • Consider obtaining consent for transfusion.
  • Have uterotonic medications readily accessible.
  • Consider intraoperative ultrasound guidance.
  • With additional risk factors, you might also consider referring out to center with transfusion capability, anesthesia, and interventional radiology.

a. What do you suspect?
  • The patient has already bled about 200 cc, and is at risk for hemorrhage (defined as 500 cc EBL).
• Consider some causes of hemorrhage with 4 T’s mnemonic: tissue (incomplete aspiration), tone (atony), trauma (cervical laceration or perforation), or thrombin (a rare underlying bleeding disorder). Also consider ectopic pregnancy.

b. What can you do now?
As a memory tool, practice 2 primary steps for each of for 6Ts:

• Tissue: Assure uterus is empty
  a. Estimate EBL
  b. Reaspiration (with US guidance) EVA for rapid evacuation; check POC is adequate. US may assist and identify the rare cervical or cesarean ectopic.

• Tone:
  a. Uterine massage
  b. Medications (methergine, misoprostol, and / or dilute vasopressin)

• Trauma: Assess source
  a. “Cannula test” (watching return as you slowly withdraw cannula from fundus to external os, to identify bleeding zone)
  b. Walk or clamp cervix with ring forceps

• Thrombin:
  a. Review bleeding history
  b. Consider additional tests as indicated (clot test, coagulation tests, CBC)

• Treatment
  a. IV fluid bolus
  b. Uterine tamponade with Foley catheter (inflate bulb)

• Transfer
  a. Vitals every 5 minutes
  b. Initiate transfer

**EXERCISE 6.2**

**Purpose:** To practice managing challenges that may occur after uterine aspiration.

1. **The nurse consults with you about a possible problem phone call regarding a patient who had an abortion at the clinic five days ago. The patient complains of severe cramping and rectal pressure, has had minimal bleeding, and has a mild fever.**
   
   a. **What is the differential diagnosis?**
      • This patient may well have developed a hematometra, or accumulation of blood in the uterus following the procedure.

   b. **Which exam and ultrasound findings would support your diagnosis?**
      • Physical examination reveals a large, tense, and tender uterus.
      • US shows an expanded uterine cavity with heterogeneous echo complex, consistent with clots in the uterus.

   c. **What are your management recommendations?**
      • While small collections of clot may pass spontaneously or with uterotonics if patient’s pain is tolerable, aspiration is usually required for larger clots, with or without intraoperative uterotonics.

   d. **If these symptoms developed immediately after abortion, what would you do?**
      • Aspiration is usually required with or without uterotonics, and may save an ED visit.
2. A 21-year-old patient comes to your office for follow-up after an 8-week abortion two weeks ago at another facility, and still has some symptoms of pregnancy including breast tenderness and abdominal bloating. Medications include birth control pills. The patient has had intercourse regularly for the past six days. The patient is afebrile, with normal vital signs. Pelvic exam is normal except for an 8-week size uterus. A high sensitivity urine pregnancy test is positive.

a. What is the differential diagnosis?
   • A completed abortion in a patient with hormonal contraceptive side effects
   • A failed attempted abortion with an ongoing pregnancy
   • Retained POC / asymptomatic hematometra
   • Ectopic pregnancy or heterotopic pregnancy with continuing ectopic
   • Hydatidiform mole

b. How can you rule in or out any of your diagnoses?
   • Home pregnancy tests are high sensitivity pregnancy tests (HSPT; positive at 20-25 mIU/mL) and can remain positive 4 – 6 weeks after abortion so a positive HSPT two weeks later may be positive for any of the differential diagnoses in this example.
   • Assess whether POC, post-abortion US, or an hCG were checked after the abortion, but a quantitative hCG is an important baseline for further testing.
   • Is serial serum hCG rising or falling, and at what rate? See Chapters 3, page 55 and 8, page 144.
   • US can help identify an ongoing pregnancy, remaining clots, or an ectopic pregnancy. However, a negative US is inconclusive and cannot definitively rule out an ectopic.
   • Exam may be helpful to evaluate uterine size, bogginess, or adnexal masses.
   • Re-aspiration determines uterine contents: presence of POC or pathologic changes.
   • Breast tenderness could be from hormonal contraceptives.
   • 8-week size could be due to fibroids, retained clots, or inter-examiner variability.

c. How might your approach differ if the ultrasound showed a moderate amount of heterogeneous contents?
   • This suggests retained tissue, decidua and/or clotted blood. Uterine re-aspiration may show evidence of chorionic villi, membranes, or fetal parts.

d. If the patient is not pregnant, how can you explain their positive urine pregnancy test and breast tenderness?
   • A high sensitivity pregnancy test may still be positive for up to 4 – 6 weeks following an abortion.
   • Breast tenderness may be secondary to the initiation of hormonal contraceptives.
This chapter will help you to learn the art of patient-centered contraceptive care by establishing rapport with each patient, eliciting their preferences, utilizing the latest evidence to determine eligibility, and providing access to the range of methods as well as removals. It will also help you provide routine aftercare with clear instruction for home care following uterine aspiration.

CHAPTER LEARNING OBJECTIVES

Following completion of this chapter, you should be able to:

• Facilitate informed, patient-centered choice in contraceptive care
• Describe options, indications, contraindications, side effects and common myths to specific contraceptive methods
• Provide post-procedure counseling, including instructions about home care, warning signs for complications, and emergency contact information
• Appropriately prescribe post-procedure medications

VIDEOS

• Global Contraception: A summary of the global unmet need for contraception and a review of modern methods (IERH): https://vimeo.com/129470448
• Contraception 101 (IERH): www.innovating-education.org/2019/05/contraception-101/

RESOURCES

• Medical Eligibility Criteria for Contraceptive Use (MEC; apps available):
  o US MEC
  o WHO MEC
• Selected Practice Recommendations for Contraceptive Use (SPR; apps available):
  o US SPR
  o WHO SPR
• Bedsider Providers Page: providers.bedsider.org
• UCSF Bixby Beyond the Pill: beyondthepill.ucsf.edu
• Contraceptive counseling best practices article (Dehlendorf 2014)
• Reproductive Health Access Project: www.reproductiveaccess.org
• Family Planning National Training Center: http://www.fpntc.org

The CDC & WHO MEC are evidence-based guidelines on safety of contraceptive use - both online and as mobile apps.
SUMMARY POINTS

SKILLS

• Establish rapport with each patient, use open-ended questions, ask patients what matters most to them about a method, and provide access to the range of methods.
• Invest in the patient’s experience, rather than in a particular contraceptive method or outcome. You will learn from both patients and colleagues as you proceed through training.
• Consider the quality of your counseling from the patient’s point of view. For example, new data shows that patients are more likely to be satisfied with counseling and to continue using their selected method if they felt their provider:
  o Respected them as a person
  o Let them say what matters about their method
  o Took their preferences seriously
  o And gave them enough information to make a decision (Dehlendorf 2018).
• Improve access by minimizing unnecessary visits to obtain contraception.
• Ensure that patients have the right to prompt LARC removal for any reason, without judgement or resistance from their provider.

SAFETY

• Determine contraceptive safety for patients with obstetric or medical conditions utilizing the frequently updated evidence in the Medical Eligibility Criteria for Contraceptive Use.
• Understand the risks and side effects associated with both contraception and pregnancy to accurately inform patients.

ROLE

• Ensure that you offer all methods as part of routine contraceptive counseling for all interested patients, including nulliparous patients and adolescents.
• Keep in mind that many patients seeking abortion services will not desire contraceptive counseling or feel pressured by it on the day of abortion. Respect if they prefer to wait.
• Offer all patients condoms to reduce STI risk and emergency contraception, regardless of contraceptive method chosen.
• Provide patients with instructions for home care, medications, contraception, warning signs, and emergency contact information to help minimize patient stress, phone calls, and need for a follow-up appointment following routine aspiration.
CONTRACEPTIVE COUNSELING

The world health community has affirmed the “basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children” ([UN,1994]). The gap in unmet need for modern contraception varies, but exists in all countries ([Guttmacher 2016]).

Contraception is primary health care. All patients with reproductive potential should be counseled regarding their reproductive preferences and offered contraception as needed as a part of routine abortion and primary care ([CDC QFP 2014, Bellanca 2013]).

Optimal contraceptive counseling supports patients in making fully-informed decisions by providing unbiased information about the full range of options. Given the social and historical context in which some communities’ reproduction has been devalued, counseling should not direct patients towards the selection of any specific method or method type, but rather be responsive to each patient’s priorities and concerns ([Dehlendorf 2014]) and include information on the risks, benefits, and side effects of the various methods.

The quality and effectiveness of contraceptive counseling has been validated by a patient-centered measure of interpersonal quality in family planning (IQFP) ([Dehlendorf 2018, 2016]). Patients are more likely to be satisfied with their counseling and continue to use and like their selected method after 6 months if they responded that they felt as if their provider:

- Respected them as a person
- Let them say what matters about their method
- Took their preferences seriously
- Gave them enough information to make a decision.

The following core principles of quality family planning that can guide best practices in contraceptive counseling have been set forth by the CDC: (CDC QFP 2014).

1. **Establish and maintain rapport with the patient**

2. **Assess the patient’s needs and personalize discussions accordingly**
   - If the patient has a strong interest in one method, ask permission before providing information on others.
   - Consider methods that align with patient priorities, such as
     - Changes to menstrual bleeding
     - Route, ease of use, or remembering
     - Privacy from a partner or parents
     - Highly effective
     - No hormones
     - Impact on sex or pleasure
     - Cost

3. **Work with the patient interactively to establish a plan**
   - Anticipate and address barriers to accurate/consistent use for chosen method.

4. **Provide information that can be understood and retained by the patient**
   - Simplify the choice process using visual aids.

5. **Confirm patient understanding**
   - Use active learning strategies such as teach back.
Addressing bias in family planning

Guided by ethical principles of patient-centered care, and informed by the history of reproductive oppression affecting marginalized communities, we encourage patient-centered decision-making that is grounded in patient preferences (Dehlendorf 2018, 2014). Studies have documented provider bias encouraging long-acting methods for low income and patients of color, while discouraging their removal (Amico 2018, Dehlendorf 2016). Low-income and patients of color are more likely to rate their family planning visits less positively, and perceive (or experience) race-based discrimination and pressure to use contraception and limit family size when compared to white, higher-income women (Brandi 2018; Becker 2008).

Improving access

- Avoid delays by sending prescriptions to pharmacy, mailing, or pre-packing for pick up.
- Dispensing 12 months is safe, effective, and improves continuation (Foster 2006).
- Provide virtual or telehealth visits for counseling and initiation for some methods.
- Initiate bridging method as needed, pending a follow-up visit for IUD, implant, sterilization, or DMPA (consider SQ home administration):
  - Video: SubQ DMPA: https://bit.ly/2CEha3b
- Use evidence-based extended use for all methods (Ti 2020, Ali 2017), if desired by patient.
- Both contraceptive initiation and LARC removal upon request are essential services.

Counseling for side effects and common concerns

Many patients have used various contraceptive methods and may have strong opinions about a method based on their preferences and personal experience. Investing in a patient’s experience requires listening to, and identifying, a patient’s preferences.

- Empathize with the patient: for example, “That must have been difficult to bleed every day for 2 months.”
- Normalize their experience: “I hear that from a lot from patients.”
- Reassure the patient: “I can remove your IUD for you today.”
- Offer options that honor the patients’ preferences: “We could discuss options for managing the bleeding if you would like to keep your implant or we could go ahead with removal today – which would you prefer?”

| Evidence-Based Extended Use |
|-----------------------------|---------------------|---------------------|
| Method                      | FDA-approved duration | Evidence-based duration |
| Paragard®                   | 10 years             | 12 years             |
| Liletta®                    | 6 years              | 7 years              |
| Mirena®                     | 5 years              | 7 years              |
| Kyleena®                    | 5 years              |                     |
| Skyla®                      | 3 years              |                     |
| Nexplanon                   | 3 years              | 5 years              |

Tip: First, **empathize**. Then validate and **normalize** the patient’s concern. Then you can ask follow-up questions to understand more about the concern so that you can provide **reassurance** and **offer information and options** in a patient-centered manner.
The rapidly growing body of evidence surrounding contraception is tremendously helpful to our patients. This chapter provides a brief update, with links to more in-depth resources. Keep in mind that many patients seeking abortion services will not desire contraceptive information or feel pressured to choose a method on the day of their abortion (Matulich 2015, Brandi 2018). The goal is not to have every patient leave with a contraceptive method; rather to remove barriers to access for those patients desiring contraception.

Visual Aids for Counseling

It helps to use visual aids so patients can explore their options. It is important to acknowledge the priorities inherent in the chart being used, and focus on methods that match the patient’s priorities. Some examples of visual aids:

- https://www.reproductiveaccess.org/resource/bc-fact-sheet/
- https://www.bedsider.org/methods (web-based method explorer)

Simplified Screening (Class A Evidence; CDC SPR 2016)

Most methods can be safely initiated with few additional requirements, including:

- Medical history for contraindications
- Consult MEC; note MEC category 3: use shared-decision making to discuss risks
- Required exam components for specific methods:
  - BP (self-report adequate): combined hormonal methods
  - Pelvic exam: IUD and some diaphragms
  - STI screening: IUD (same visit; only if risks & not yet screened; Sufrin 2015)
- Not required to initiate contraception:
  - Heart, lung, breast or well-person exam, pap test, hemoglobin or “routine” labs

Quick Start – Initiation of Contraception (CDC QFP 2014)

- Method initiation on same day of patient’s visit in any part of the patient’s cycle
- If unable, provide bridge method until the patient returns to start their desired method
- Quick Start Algorithms: www.reproductiveaccess.org/resource/quick-start-algorithm/

Post Abortion Initiation of Contraception

- Post aspiration, all methods can be started on day of procedure, if desired
- Post medication abortion or miscarriage:
  - Implant and DMPA can be placed or given on day of mifepristone (Raymond 2016, Raymond 2016). Counsel same day DMPA associated with increased ongoing pregnancy rate (<5%), but patient satisfaction higher with same day administration.
  - Pills, patch, and ring can be started after misoprostol administration
  - IUD at follow-up visit; offer bridging method if unable within 7 days (US SPR 2016)

Primer on IUDs and Implants

- IUD and implant are safe, effective, & have high satisfaction and continuation rates
- 3-year LARC continuation ~ 70% vs. among short-acting methods ~ 30% (Diedrich 2015), regardless of age (Rosenstock 2012)
  - Adopt same-visit protocols for improved access (ACOG 2015)
  - Over 20-fold more effective than short-acting methods, regardless of age (Winner 2012)
- Assure removal upon request, for whatever reason, as part of informed consent process
Evidence-based IUD eligibility

- No association of IUD with increased infertility risk (Hubacher 2001)
- PID risk with IUD no greater than any other non-barrier contraceptive method
- No restriction for multiple partners
- Contraindications: Pregnancy, active cervicitis or PID, uterine cavity distortion
- LNG-IUD 52 mg minimizes blood loss with menorrhagia, endometriosis, fibroids

IUD Selection for Individual Patients

<table>
<thead>
<tr>
<th>Cu-T IUD</th>
<th>LNG 52 mcg IUD</th>
<th>LNG 13.5 – 19.5 mcg IUD</th>
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<tr>
<td>Paragard Ô</td>
<td>Mirena Ô / Liletta Ô</td>
<td>Skyla Ô/ Kyleena Ô</td>
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<tr>
<td>Doesn’t want hormones</td>
<td>Doesn’t mind hormones</td>
<td>Doesn’t mind hormones; wants low dose</td>
</tr>
<tr>
<td>Wants regular menses</td>
<td>Wants light menstrual flow Amenorrhea 30% Wants non-contraceptive benefits (for heavy menses or uterine protection)</td>
<td>Wants less menstrual flow Amenorrhea 10%</td>
</tr>
<tr>
<td>Wants EC</td>
<td>Wants EC (Use with LNG ECP)</td>
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</tr>
</tbody>
</table>

LARC insertion and removal videos:

- Implant: www.innovating-education.org/2018/05/larc-insertion-implant-insertion/
  - Pop out removal technique: https://vimeo.com/274167054
- IUDs: https://www.innovating-education.org/course/iud-insertion-videos/
  - CuT using no touch technique: www.innovating-education.org/2018/10/this-is-how-i-teach-no-touch-technique-for-cooper-iud/

IUD insertion tips

- Insert at any time in cycle, once reasonably sure patient is not pregnant (US SPR 2016)
- Routine antibiotic prophylaxis unnecessary (US SPR 2016)
- Routine miso is not evidence based (Pergialiotis, 2014); except after failed insertion: miso 400mcg vaginally 2 hrs prior improves subsequent insertion (Bahamondes 2015)
- Routine IUD string checks not supported by evidence (Davies 2014)
  - Most patients tolerate with PO Ibuprofen
  - Offer paracervical block if available, painful insertion or nulliparous (Mody 2018)

Ensuring IUD / implant removal

- Patients have a right to prompt LARC removal, without provider judgement or resistance
- Clinicians often prefer to await symptom resolution (Amico 2018)
- Resisting removal may jeopardize satisfaction & the clinical relationship (Raifman 2018)
- Some patients more likely to consider IUD if aware of self-removal option (Foster 2018)
- Self-removal is safe; among those who tried, one in five was successful (Foster 2014)

Progesterone only methods (Implant, LNG-IUDs, DMPA, POP):

- Safe for patients with estrogen contraindications (e.g. migraines with aura)
- Generally decrease bleeding & pain; possible amenorrhea (DMPA, LNG-IUD, Implant)
- Decreased risk of endometrial and ovarian cancer (DMPA, 52mg LNG-IUD)
- If LARC insertion delayed > 5 days after abortion, bridge or backup method for 7 days
- For patients with metrorrhagia / menorrhagia, can add back estrogen for first few months
Combined hormonal contraceptives (COC, Patch, Ring):

- Decreased dysmenorrhea, PMS & menstrual migraines, improved acne
- Decreased gyn cancers, ovarian cysts, PID, benign breast tumors, osteoporosis
- Rare adverse health outcomes: VTE, heart attack, stroke, for some risk categories

Extended / continuous contraception to reduce/eliminate withdrawal bleeding

- Safe, acceptable, and as efficacious as monthly cyclic regimens
- Fewer scheduled bleeds; less estrogen-withdrawal symptoms (Edelman 2014)
- Various monophasic OCP and vaginal ring can be used
- Unscheduled bleeding decreases over time with these regimens

Contraceptive Care across the Gender Spectrum

- Transgender and gender diverse (TGD) patients (those whose gender identity or expression is different from that assigned at birth) can be offered the full range of contraceptive options.
- Testosterone therapy is not contraindication to estrogen or progesterone, though some may prefer to avoid exogenous estrogen (Krempasky 2020, Bonnington 2020).
- TGD patients may want non-contraceptive benefits, like menstrual suppression (Boudreau 2019)

Emergency contraception (EC):

- EC will not disrupt an implanted pregnancy, thus will NOT cause an abortion.
- After Ulipristal (UPA) EC pills, delay OCP, Implant, and DMPA for 5 days (ASEC 2016)
- LNG EC pills (ECP) via US pharmacies / online without Rx for all ages / genders
- EC effectiveness:
  - LNG ECP less effective with BMI > 25. UPA less effective with BMI > 30, However, UPA more effective than LNG ECP at any BMI.
  - CuT IUD ~ 100% effective at any BMI or repeat unprotected intercourse; provides ongoing contraception (Wu 2013, Cleland 2012)
  - Offer CuT if increased risk of ECP failure (Glasier 2011, Shen 2017)
  - LNG IUD + LNG ECP are as effective as copper IUD; preferred by many patients (Turok 2016). RCT pending of LNG IUD as EC (no LNG ECP).
## MEDICAL ELIGIBILITY FOR INITIATING CONTRACEPTION

These contraceptive methods do not protect against sexually transmitted infections (STIs). Condoms should be used to protect against STIs. For more information, see [who.int/reproductivehealth/publications/family_planning/9789241563888/en/index.html](http://who.int/reproductivehealth/publications/family_planning/9789241563888/en/index.html), [cdc.gov/mmwr/preview/mmwrhtml/rr59e0528a1.htm?s_cid=rr59e0528a1_e](http://cdc.gov/mmwr/preview/mmwrhtml/rr59e0528a1.htm?s_cid=rr59e0528a1_e), [cdc.gov/mmwr/preview/mmwrhtml/mm6026a3.htm?s_cid=mm6026a3_w](http://cdc.gov/mmwr/preview/mmwrhtml/mm6026a3.htm?s_cid=mm6026a3_w), [http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Adolescent-Health-Care/Adolescents-and-Long-Acting-Reversible-Contraception](http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Adolescent-Health-Care/Adolescents-and-Long-Acting-Reversible-Contraception), [http://pediatrics.aappublications.org/content/early/2014/09/24/peds.2014-2299.full.pdf+html](http://pediatrics.aappublications.org/content/early/2014/09/24/peds.2014-2299.full.pdf+html).

### Condition Qualifier for condition

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<th>Qualifier for condition</th>
<th>Estrogen/ progestin: pill, patch, ring</th>
<th>Progestin-only: pill</th>
<th>Progestin-only: injection</th>
<th>Progestin-only: implant</th>
<th>Progestin IUD</th>
<th>Copper IUD</th>
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<tr>
<td>Cervical cancer and pre-cancerous changes</td>
<td>Cervical intraepithelial neoplasia</td>
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<tr>
<td></td>
<td>Cancer, awaiting treatment</td>
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<td>1</td>
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<tr>
<td>Depression</td>
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<tr>
<td>Diabetes mellitus (DM)</td>
<td>Gestational DM in past</td>
<td>1</td>
<td>1</td>
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<tr>
<td></td>
<td>DM without vascular disease</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
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<tr>
<td></td>
<td>DM with end-organ damage or &gt; 20 years duration</td>
<td>3</td>
<td>2</td>
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<tr>
<td>Drug interactions</td>
<td>Antiretrovirals</td>
<td>All antiretroviral medications (except fosamprenavir) are either 1 or 2 for every contraceptive method.</td>
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<td></td>
<td>Anticonvulsants: phenytoin, carbamazepine, barbiturates, primidone, topiramate, vecarbazepine</td>
<td>3</td>
<td>1</td>
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<tr>
<td></td>
<td>Lamotrigine alone (Lamotrigine/valproate combo does not interact with hormones)</td>
<td>3</td>
<td>1</td>
<td>1</td>
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<tr>
<td></td>
<td>Rifaximin/ rifabutin</td>
<td>3</td>
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<td></td>
<td>ALL OTHER antibiotics, antiparasitics, &amp; antifungals</td>
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<td>1</td>
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<td>Endometrial cancer</td>
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<td>Endometriosis</td>
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<td>Gallbladder disease</td>
<td>Asymptomatic gallstones or s/p cholecystectomy</td>
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<tr>
<td></td>
<td>Symptomatic gallstones, without cholecystectomy</td>
<td>3</td>
<td>2</td>
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<tr>
<td></td>
<td>Pregnancy-related cholestasis in past</td>
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<td></td>
<td>Hormone-related cholestasis in past</td>
<td>3</td>
<td>2</td>
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<tr>
<td>Headaches</td>
<td>Non-migrainous</td>
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<td>1</td>
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<td>With aura</td>
<td>2</td>
<td>1</td>
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<tr>
<td>HIV Infection</td>
<td>High risk for HIV infection</td>
<td>1</td>
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<td>1</td>
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<td></td>
<td>HIV infection (without drug interactions)</td>
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<td>1</td>
<td>1</td>
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<tr>
<td>Hypertension</td>
<td>During prior pregnancy only – now resolved</td>
<td>2</td>
<td>1</td>
<td>1</td>
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<td>Systolic &lt; 120 &amp; diastolic &lt; 90</td>
<td>3</td>
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<tr>
<td></td>
<td>Systolic &gt; 120, diastolic &gt; 90, and/or with vascular disease</td>
<td>4</td>
<td>2</td>
<td>3</td>
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<tr>
<td>Condition</td>
<td>Qualifier for condition</td>
<td>Estrogen/ progestin: pill, patch, ring</td>
<td>Progestin-only: pill</td>
<td>Progestin-only: injection</td>
<td>Progestin-only: implant</td>
<td>Progestin IUD</td>
<td>Copper IUD</td>
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<td>Inflammatory bowel disease</td>
<td>Ulcerative colitis, Crohn’s disease</td>
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<td>Ischemic heart disease</td>
<td>Past or current</td>
<td>4 2</td>
<td>2 3</td>
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<td>Liver Disease</td>
<td>Viral hepatitis carrier</td>
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<td></td>
<td>Viral hepatitis-active</td>
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<td>Cirrhosis-mild</td>
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<td>Cirrhosis-severe</td>
<td>4 3 3 3</td>
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<td></td>
<td>Tumors-focal nodular hyperplasia</td>
<td>2 3 2 2</td>
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<td></td>
<td>Hepatocellular adenoma</td>
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<td></td>
<td>Tumors-malignant</td>
<td>4 3 3 3</td>
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<td>Obesity</td>
<td>BMI &gt; 30 kg/meter squared</td>
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<td>Ovarian cancer &amp; benign tumors</td>
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<td>Pelvic inflammatory disease</td>
<td>Past, with subsequent pregnancy</td>
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<tr>
<td></td>
<td>Past, without subsequent pregnancy</td>
<td>1 1 1 1</td>
<td></td>
<td>1 1</td>
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<tr>
<td></td>
<td>Current</td>
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<tr>
<td>Postpartum, not breastfeeding</td>
<td>&lt; 3 weeks postpartum</td>
<td>4 1</td>
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<td>3-6 weeks, increased risk DVT</td>
<td>3</td>
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<td></td>
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<td></td>
<td>See Postpartum IUDs</td>
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<tr>
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<td>3-6 weeks, normal risk DVT</td>
<td>4</td>
<td>1</td>
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<tr>
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<td>&gt; 6 weeks postpartum</td>
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<td>1 1 1</td>
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<td>Postpartum, breastfeeding</td>
<td>&lt; 3 weeks postpartum</td>
<td>4</td>
<td>2</td>
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<td></td>
<td>See Postpartum IUDs</td>
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<td>3-4 weeks postpartum</td>
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<td>4-6 weeks, increased risk DVT</td>
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<td>1 1</td>
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<tr>
<td></td>
<td>4-6 weeks, normal risk DVT</td>
<td>2</td>
<td>1</td>
<td>1 1</td>
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<tr>
<td></td>
<td>&gt; 6 weeks postpartum</td>
<td>2</td>
<td>1 1 1</td>
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<tr>
<td>Postpartum IUDs</td>
<td>&lt; 30 minutes post-placenta delivery- breastfeeding</td>
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<td></td>
<td>&lt; 30 minutes post-placenta delivery-not breastfeeding</td>
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<td>30 minutes post-placenta delivery to 4 weeks</td>
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<td></td>
<td>&gt; 4 weeks</td>
<td>1</td>
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<tr>
<td>Post-abortion</td>
<td>First trimester</td>
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<td></td>
<td>Second trimester</td>
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<td>Immediately after abortion</td>
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<td>4 4</td>
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<td>Rheumatoid arthritis</td>
<td>On immunosuppressive therapy</td>
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<td>1 2</td>
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<td></td>
<td>Not on immunosuppressive therapy</td>
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<td>Sexually Transmitted Infections (STI)</td>
<td>Vaginitis / Increased risk of STI</td>
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<td>High-risk of STI</td>
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<td>Current GC/Chlamydia/ Purulent cervicitis</td>
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<tr>
<td>Smoking</td>
<td>Age &lt; 35</td>
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<td></td>
<td>Age &gt; 35, &lt; 15 cigarettes/day</td>
<td>3</td>
<td>1</td>
<td>1 1</td>
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<tr>
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<td>Age &gt; 35, &gt; 15 cigarettes/day</td>
<td>4</td>
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<tr>
<td>Seizure disorder</td>
<td>Without drug interactions</td>
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<td>Stroke</td>
<td>Past or current</td>
<td>6</td>
<td>2 3 2</td>
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<td>Surgery</td>
<td>Miser</td>
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<td></td>
<td>Major, without prolonged immobilization</td>
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<td>1 1</td>
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<td>Systemic lupus erythematosus</td>
<td>Antiphospholipid Ab +</td>
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<td>3 3 3</td>
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<td>Severe thrombocytopenia</td>
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<td>Immunosuppressive treatment</td>
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<td>None of the above</td>
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<td>Thyroid disorders</td>
<td>Simple goiter, hyperthyroidism, hypothyroidism</td>
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<tr>
<td>Uterine fibroids</td>
<td>IUDs ok unless fibroids block insertion</td>
<td>1 1 1 1</td>
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<td>Valvular heart disease</td>
<td>Uncomplicated</td>
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<td>1 1 1</td>
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<tr>
<td></td>
<td>Complicated</td>
<td>4</td>
<td>1 1 1</td>
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<tr>
<td>Varicose veins</td>
<td>Family history (first-degree relatives)</td>
<td>2</td>
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<tr>
<td>Venous thrombosis</td>
<td>Superficial thrombophlebitis</td>
<td>3</td>
<td>1 1 1</td>
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<tr>
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<td>Past DVT, high risk of DVT, or known thrombophilia</td>
<td>4</td>
<td>2 2 2</td>
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<td>Current DVT</td>
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ABORTION AFTERCARE

Care of patients following uterine aspiration is usually straightforward, and can occur in a recovery area or procedure room. Care may vary slightly with gestational age of the pregnancy, type of anesthesia, and any complicating factors. Post-aspiration care includes discharge education, observation and support related to analgesia administered, and surveillance for immediate and delayed complications. Post-procedure care includes reviewing any instructions or referrals for the contraceptive method chosen by the patient.

RECOVERY AND MONITORING:

Provider or staff should assess the following parameters prior to discharge:

• Adequate pain control
• Stable, controlled vaginal bleeding
• Normal, stable vital signs
• Normal oxygen saturation
• Ability to ambulate independently
• If IV sedation used, consider using validated score (i.e. Aldrete) to assess alertness

The following discharge medications are given or reviewed for home use:

• NSAID use and any additional pain medications
• If applicable, preferred contraceptive method, including offering condoms and EC

Most patients require only 15-30 minutes of recovery time, including those receiving local anesthesia, NSAIDs, oral opioids or anxiolytics, or short-acting IV sedation. With any sedating medications, a patient should not drive, and should be discharged to the care of a person who will escort them home.

Discharge education should include anticipatory guidance for telling the difference between normal symptoms from warning signs for complications, and instructions should they occur (see below). As patients receiving IV sedation may not recall instructions given after sedation, review instructions prior to sedation and have written materials for the patient to take with them.

While some patients may have specific indications for a follow-up visit, data do not support routine visits after uterine aspiration (Grossman 2004). Most patients can be given aftercare instructions and a phone number to call with concerns, in lieu of either a routine follow-up visit, but specific indications for one include:

• Suspected incomplete abortion, ongoing pregnancy or ectopic pregnancy
• Need for follow-up contraceptive visit (i.e. BP check for elevated blood pressure, unable to place IUD on day of procedure)

A patient may have medical, social, or emotional needs identified during their abortion care. Offer to be available, but also give reliable referral information to respectful providers and facilitate care, including to:

• Support hotlines
• Primary and specialty medical care, including prenatal or fertility services.
• Mental health, behavioral health, intimate partner violence, or substance use counseling
• Social needs such as food, housing, etc.
Today you had an abortion procedure. You will most likely feel fine when you go home. You can return to your normal activities as soon as you want. You can take a shower and wash your hair as soon as you want. You can eat normally, but you may still feel nauseated for a couple days.

**Are there things you should not do?** Yes. For one week, do not use tampons and do not douche. You may or may not feel like being intimate or having vaginal intercourse during this time. It is good to trust your body and resume intercourse when you feel ready.

**WHAT TO EXPECT**

**Vaginal Bleeding:** You can expect to have bleeding for up to 2 weeks. It is common for the bleeding to stop and start for a few weeks after the abortion. Some people have no bleeding for 2 or 3 days and then begin to have bleeding like a period. Other people have only spotting for a few days and then no bleeding at all. You may notice that the bleeding increases when you exercise; this is not dangerous.

**Cramping:** You may have cramps off and on during the week following an abortion. You can use pain medication like Tylenol, Ibuprofen (Motrin or Advil), or Naproxen (Aleve or Naprosyn). You can also use a heating pad or drink some warm tea.

Sadness or mood changes: You may feel relieved when the abortion is over. You may also feel sad or moody. These feelings are may be due to hormonal changes, now that you are no longer pregnant. Feeling moody at this time is normal. If you think your emotions are not what they should be, please talk to us.

**When will your period come back?** You can expect a period in 4 to 8 weeks. This varies.

You should call us if:

- Your bleeding soaks through more than 2 pads per hour for more than 2 hours.
- Your cramps that are getting stronger and are not helped by pain medication.
- Your temperature is higher than 100.4 degrees Fahrenheit (38 degrees Celsius).

To reach us - Call our 24-hour contact number:

______________________________.

If you have any questions or think something is going wrong, please call this number and someone will call you back. It may take 10-15 minutes to return your call. No question is too small. Please feel free to call us.

**Follow-up visit:** You have an appointment on___________ at ____________am/pm.

**Birth Control**

If you want to use birth control pills, the patch, or the ring, I have given you a prescription. You should start these on______________, even if you are still bleeding.

**Additional Support**

Most patients feel better in the month following an abortion or miscarriage. If you are in need of additional support, call us, or consider contacting one of the following hotlines, which help answer questions and provide you with additional support: www.exhaleprovoice.org or 866-4EXHALE, www.alloptions.org or 888-493-0092, or www.connectandbreathe.org or 866.647.1764.
EXERCISE 7.1

**Purpose:** To role-play different aspects of contraceptive counseling and understand recent evidence-based contraceptive developments and medical criteria for use.

1. How would you respond to these common patient concerns about contraception?
   a. I don’t like the idea of having something inside of my body.
   b. I don’t want any hormones.
   c. Won’t IUDs cause an abortion?
   d. I want to have this (IUD / implant) removed (a few months after placement).

2. A 17-year-old G0 old patient comes to the clinic who is sexually active and currently using withdrawal and condoms. Role play how you might initiate a conversation about their contraceptive priorities, and options based on a preference of privacy of contraceptive use (from parents) and avoiding STIs.

3. A 28-year-old G3P3 patient presents to the clinic seeking to switch to a new method of contraception. They are currently on DMPA, which has been causing weight gain, and want something non-hormonal. A friend mentioned having pain with an IUD, so your patient is hesitant to consider that option. Role-play being both the healthcare provider and patient whose priority is avoiding weight gain and other “hormonal side effects”.
   - Using the IQFP measure, what did you do as a provider to ensure that the patient felt respected, listened to, had their preferences identified and received information?
   - As the patient, is there more the provider could have done to establish rapport, identify priorities and share information?
4. What would you discuss with the following patients regarding their desire for contraception? (Consult MEC as a reference)
   a. A 36-year-old smoker with moderate obesity who wants the patch.
   
b. A 29-year-old with migraine headaches with aura who wants the pill.
   
c. A 20-year-old nulliparous patient with a history of Chlamydia at age 15 and who wants an IUD.
   
d. A 28-year-old patient who has BMI > 30, has vaginitis, and wants emergency contraception as well as ongoing contraception. Pt had unprotected intercourse 3 and 5 days ago.
   
e. A 25-year-old with a history of deep vein thrombosis (DVT) 2 years ago, which occurred 6 weeks after a vaginal delivery. They are interested in the vaginal ring.
   
f. A 31-year-old who takes anti-seizure medications and wants the pill.
   
g. A 27-year-old who wants a combined hormonal method but doesn’t want a monthly period.

EXERCISE 7.2

Purpose: To review routine follow-up after uterine aspiration, please answer the following questions.

1. A patient has had nausea and vomiting throughout pregnancy. How long will it take for them to feel better after the abortion?

2. Providers typically advise patients to call the office if they have certain “warning signs” following uterine aspiration. What “warning signs” would you include and why?

3. After an aspiration, how long would you advise your patient to wait before resuming exercise, heavy lifting, and vaginal intercourse? What is the rationale for your recommendations?
CHAPTER 7 TEACHING POINTS:  
CONTRACEPTION AND ABORTION AFTERCARE

EXERCISE 7.1

Purpose: To role-play different aspects of contraceptive counseling and to understand recent evidence based contraceptive developments and medical criteria for use.

1. How would you respond to these common patient concerns about contraception?

• When talking about side effects or common patient concerns, try to empathize, reassure and normalize the patient’s feelings. Saying things that would invalidate a person’s concerns is likely to make them feel unheard.
• Avoid confrontational language. You are not trying to change the patients mind, but instead, elicit the patient’s priorities, and understand their goals.
• Uses phrases like:
  o “Tell me more about that.”
  o “I hear that concern from a lot of patients.”
  o “What worries you the most about that?”
• Ask for permission to share information: For example, “Can I share some information with you about contraception and abortion?” If the patients give permission, then go on to share facts to help their understanding.

a. I don’t like the idea of having something inside of my body.

• It’s normal to be anxious about having something placed inside you; what concerns you most?
• I know it can seem strange to have something inside you. Are you concerned that you will be able to feel it there? Or maybe that your partner(s) will feel it?
• Many patients have shared that they don’t feel the method.

b. I don’t want any hormones.

• A lot of people feel that way. What is it about a hormonal method that concerns you?
• Ok, there are definitely non-hormonal options we can discuss. What is it about hormones that is concerning to you?
• <If interested in a highly effective method> The copper IUD doesn’t have any hormones and works by having copper naturally repel sperm. It’s the most effective non-hormonal option.

c. Won’t IUDs cause an abortion?

• For an abortion to happen, someone has to first be pregnant, and these methods prevent pregnancy in the first place. IUDs work by preventing fertilization of an egg, either by blocking the sperm from reaching the egg or, in the case of Mirena/Skyla/Kyleena/Liletta, by sometimes also preventing the release of an egg.

d. I want to have this (IUD / implant) removed (a few months after placement).

• You can absolutely have your method removed today, and I’m happy to do that for you. I would also love to know more about what is making you want to have the method removed - there are often things we can do to help so that you could keep the method, if you like.
2. A 17-year-old G0 old patient comes to the clinic who is sexually active and currently using withdrawal and condoms. Role play how you might initiate a conversation about their contraceptive priorities, and options based on a preference of privacy of contraceptive use (from parents) and avoiding STIs?

- Ask if satisfied with method or want to discuss others that address these preferences.
- Discuss effectiveness of withdrawal, and times in cycle most important to use condoms.
- Discuss how and where storage will work to keep condoms, patches, pills and/or rings.
- Discuss common changes in menstruation with methods, which can be a signal of a change: DMPA, IUDs, & implants can change heaviness and frequency of periods.
- Screen for safety at home and in intimate relationship(s) and discuss what they might do for contraceptive failures (i.e. emergency contraception, abortion access, etc.)
- Make patient aware that insurance explanation of benefits (EOBs) can be sent to policy holder. [https://www.guttmacher.org/state-policy/explore/overview-minors-consent-law](https://www.guttmacher.org/state-policy/explore/overview-minors-consent-law)
- Know privacy laws in your state or country regarding reproductive health services, STI testing, and parental notification.

3. A 28-year-old G3P3 patient presents to the clinic seeking to switch to a new method of contraception. They are currently on DMPA, which has been causing weight gain, and want something non-hormonal. A friend mentioned having pain with an IUD, so your patient is hesitant to consider that option. Role-play being both the healthcare provider and patient whose priority is avoiding weight gain and other “hormonal side effects”.

- Using the IQFP measure, what did you do as a provider to ensure the patient felt respected, listened to, had their preferences identified and received information?
- As the patient, is there more the provider could have done to establish rapport, identify priorities and share information?

Consider the following principles and steps:

- Establish and maintain rapport with the patient
- Assess the patient’s needs and personalize discussions accordingly
  - If the patient has a strong interest in one method, ask permission before providing information on others
  - Consider methods that align with patient priorities (e.g. bleeding changes, frequency of use, privacy, effectiveness, or modality of administration)
- Work with the patient interactively to establish a plan
  - Anticipate and address barriers to accurate and consistent use of chosen method
- Provide information that can be understood and retained by the patient
  - Simplify the choice process using visual aids
- Confirm understanding
  - Use active learning strategies such as teach back
There are many online tools, curriculum and videos to assist learners with contraceptive counseling. Bedsider has excellent videos discussing contraception from the patients' perspective: [https://www.bedsider.org/methods](https://www.bedsider.org/methods). Watching a few of the videos can help learners appreciate the impact of counseling on patients.

4. **What would you discuss with the following patients regarding their desire for contraception? (Consult MEC as a reference)**

<table>
<thead>
<tr>
<th>Classification of Categories for Medical Eligibility Criteria (MEC)</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. A condition for which there is no restriction for the use of the contraceptive method.</td>
</tr>
<tr>
<td>6. The advantages of using generally outweigh the theoretical or proven risks.</td>
</tr>
<tr>
<td>7. The theoretical or proven risks outweigh the advantages of using the method.</td>
</tr>
<tr>
<td>8. The condition represents an unacceptable health risk if the contraceptive is used.</td>
</tr>
</tbody>
</table>

- It is important to review each of the MEC categories and explore the differences between MEC Categories 1 & 2 vs 3 & 4.
- MEC Category 1 and 2 are both considered safe and OK to proceed with use.
- MEC Category 3: Discuss risks and use shared decision-making with patient. Consult as needed. Document risk-benefit discussions.
- MEC Category 4 is considered an absolute contraindication with no acceptable use of the method with the specific health condition.

a. **A 36-year-old smoker with moderate obesity who wants the patch.**

   There are two issues to consider:
   - Tobacco users who smoke >15 cigarettes/day and are >35 years old should not use estrogen-containing contraceptives due to increased stroke and M.I. risk (MEC 4).
   - Obesity is not considered a contraindication for any birth control ([Lopez 2016](https://www.bedsider.org/methods)).

   This patient could safely use any progestin-only or barrier method.

b. **A 29-year-old with migraine headaches with aura who wants the pill.**

   Avoid estrogen-containing contraceptives in patients with migraines with aura because of an increased stroke risk. Use caution with patients with migraines without aura, and consider additional prothrombotic risks (e.g. smoking). These patients are best served with a progestin-only or barrier method. Additional MEC categories include:
   - Migraine with aura or focal neurological symptoms any age (MEC 4).
   - ≥35 years old and migraine without aura (MEC 3).
   - <35 years old and migraine without aura (MEC 2).
   - Non-migraine headaches at any (MEC 1).

   Migraine with focal neurological symptoms is equivalent to migraine syndrome with aura (or classic migraine), and consists of one or more of the following that usually precedes and sometimes accompanies the headache:
   - Visual disturbances, scintillating scotoma, aura
   - Paresthesias (numbness and tingling)
   - Hemiparesis (weakness or partial paralysis in an extremity)
   - Dysphasia (slurred speech or inability to speak)
c. A 20-year-old nulliparous patient with a history of Chlamydia at age 15 and who wants an IUD.
   • IUDs are safe and well accepted among nulliparous patients (MEC 2).
   • Prior concerns about infertility with IUD no longer pertain with modern IUD designs (using monofilament IUD strings). Tubal infertility is linked to presence of Chlamydia antibodies, not to history of IUD use (Hubacher 2001).
   • Return to baseline fertility is almost immediate upon IUD removal.
   • Although past studies suggested nulliparous patients have a slightly increased risk of IUD expulsion, a prospective study found no difference in rates of expulsions by parity among CuT users, and lower expulsion rates in nulliparous users of the LNG 52mcg IUD compared with parous users (Birgisson 2015).

d. A 28-year-old patient who has BMI > 30, has vaginitis, and wants emergency contraception as well as ongoing contraception. Pt had unprotected intercourse 3 and 5 days ago.
   • CuT IUD EC is nearly 100% effective, including with BMI > 30; provides ongoing contraception, if desired (Wu 2013, Cleland 2012).
   • Vaginitis (MEC 2), vs. purulent cervicitis or PID (both MEC 4).
   • Vaginitis should not preclude placement; simply initiate treatment today.
   • Patients receiving IUDs of EC were half as likely to become pregnant in the following year compared to oral EC (Turok 2014).

e. A 25-year-old with a history of deep vein thrombosis (DVT) 2 years ago, which occurred 6 weeks after a vaginal delivery. They are interested in the vaginal ring. Any patient with a history of a DVT is no longer considered a candidate for estrogen containing birth control, including the vaginal ring. It is important to find out more about the patient’s disease.
   • A postpartum DVT would be considered a pregnancy-associated DVT which is an absolute contraindication (MEC 4).
   • Family history (1st degree relative) is not a contraindication (MEC 2), but someone you should consider testing for thrombophilic conditions.

f. A 31-year-old who takes anti-seizure medications and wants the pill.
   Select anti-seizure medications, antibiotics, and anti-fungals activate the p450 enzyme system in the liver, resulting in faster metabolism of hormones, and decreased efficacy of combination and progestin-only pills and implants (all MEC category 3 while taking these select medications; use shared decision-making; see table below). Keep in mind that some of these medications may also be used to treat certain psychiatric illnesses, headaches, chronic pain and other conditions. Note that CHCs may reduce bioavailability of lamotrigine (Lamictal).
   IUDs or DMPA are the safest options (MEC 1 and 2 respectively).
Drugs known to increase liver enzyme metabolism / reduce contraceptive effectiveness

- Carbamazepine (Tegretol, Equetro, Carbatrol)
- Oxcarbazepine (Trileptal)
- Phenobarbital
- Phenytoin (Dilantin)
- Primidone (Mysoline)
- Topiramate (Topamax) mild ↓
- Rifampin
- Rifampicin
- Rifamate
- Griseofulvin
- St John’s Wort

Drugs with questionable effects

- Troglitazone (Rezulin)
- Felbamate (Felbatol)

Drugs known not to effect liver enzyme metabolism or contraceptive effectiveness

- Lamotrigine (Lamictal)
- Gabapentin (Neurontin)
- Tiagabine (Gabitril)
- Levetiracetam (Keppra)
- Valproic Acid (Depakote)
- Zonisamide (Zonegran)
- Ethosuximide (Zarontin)
- Benzodiazepines
- INH (not in combination with Rifampin)
- Ketaconazole (anti-fungal)
- Fluconazole (anti-fungal)

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g. A 27-year-old who wants a combined hormonal method but doesn’t want a monthly period.

- Extended contraception is safe, acceptable, and as efficacious as monthly cyclic regimens (Edelman 2014).
- Increased ovarian suppression is noted in regimens that shorten or eliminate the hormone free interval, with the potential for increased effectiveness (London 2016).
- Regimens result in fewer scheduled bleeding episodes and fewer menstrual symptoms, particularly headache (Edelman 2014).
- Break through bleeding is common in the first six months of continual use; however this side effect usually resolves within 4-6 months.
- Extended and continuous use formulations of mono-phasic COCs, and vaginal ring may be used.
- Patch is not recommended due to concern over increased levels of estrogen.

EXERCISE 7.2

Purpose: To review routine follow-up after uterine aspiration, please answer the following questions.

1. A patient has had nausea and vomiting throughout pregnancy. How long will it take for them to feel better after the abortion?

- Nausea is one of the first pregnancy symptoms to subside after an abortion, generally within 24 hours. Nausea may be induced by CHC use.
- If it persists beyond a week, rule out ongoing pregnancy or retained products.
- Breast tenderness subsides in 1-2 weeks, but may be influenced by CHCs.
2. Providers typically advise patients to call if they have certain “warning signs” following uterine aspiration. What “warning signs” would you include and why?

- Persistent severe pain or cramping:
  - May indicate hematometra, infection, uterine trauma, or ectopic.
- Pelvic / rectal pain with little or no bleeding:
- Suggests hematometra.
- Heavy bleeding (saturating >2 pads per hour for >2 hours) or orthostatic symptoms:
  - Suggests the need for intervention.
- Peritoneal signs (pain with cough, palpation, or sudden movement):
  - May suggest perforation or infection and warrant reevaluation.
- Sustained fever (greater than 100.4°F / 38°C):
  - Raises concern about pelvic infection.

3. After an aspiration, how long would you advise your patient to wait before resuming exercise, heavy lifting, and vaginal intercourse? What is the rationale for your recommendations?

- **Resuming exercise or heavy lifting**
  Many providers empirically discourage strenuous exercise and intercourse for 1-2 weeks after abortion, to prevent exacerbation of bleeding or cramping, or avoid infection, although there is no evidence that this makes any difference.

  The patient may resume normal activity when they feel ready, this can be as soon as a few hours after their abortion, or more typically within 24 hours. Probably the best advice is to “listen to your body,” enjoy the activities that make them feel better, and avoid activities that make them worse.

- **Resuming vaginal intercourse**
  The patient may not feel like being intimate or having vaginal intercourse during this time. No data suggest increased infection with intercourse after an abortion, so advice may be liberalized. Encourage them to trust their body and resume intercourse when they feel ready. As ovulation can occur within 7-10 days, encourage the patient to initiate their chosen method of contraception promptly after abortion.
8. MANAGEMENT OF EARLY PREGNANCY LOSS

Updated June 2016 by Jennifer Amico MD, MPH

This chapter will assist you in learning skills to support your patients through a common and often emotionally and physically difficult experience - the spontaneous loss of a pregnancy (miscarriage). Management of early pregnancy loss now commonly occurs in the primary care setting, with expectant, medication, or aspiration management. These options are recognized as being both safe and effective, while also providing more choices for patients.

CHAPTER LEARNING OBJECTIVES

Following completion of this chapter, you should be able to:

- Evaluate, diagnose, and counsel patients presenting with signs or symptoms of early pregnancy loss
- Evaluate for ectopic pregnancy vs. early pregnancy loss, including changes in hCG levels
- Answer questions about short and long term implications of early pregnancy loss including emotional effects and implications for fertility
- Present expectant, medication and aspiration management options
- Provide appropriate follow-up, including contraceptive counseling

VIDEOS


READINGS / RESOURCES

- Websites:
  o www.earlypregnancylossresources.org
  o http://provideaccess.org/resources-and-initiatives/pregnancy-loss/
  o https://depts.washington.edu/obgyn/education/miscarriagemanagement/welcome.html
SUMMARY POINTS

SKILLS

• Open-ended questions and active listening are useful for counseling a patient with suspected pregnancy loss, to help them cope with inherent uncertainties, and to elicit their priorities and preferences for management.

SAFETY

• EPL can be managed safely and effectively with expectant care, medications, or uterine aspiration.
• Expectant management has an unpredictable time course, with more bleeding and need for further interventions than aspiration, but no increased risk for infection.
• Medication management with misoprostol is safe, effective, and avoids some risks associated with uterine aspiration, but may take longer and have more side effects.
• Office based uterine aspiration is safe, efficient, cost-effective and more convenient than hospital-based procedures in most situations.
• In areas where abortion access is limited, patients may present with bleeding who have attempted self-induction, although data on this are lacking (Grossman 2010).

ROLE

• Strong patient preferences for management are common, making a shared decision-making approach useful and patient-centered.
• Our role as primary care providers is to give patients as many treatment options as possible, EPL management can be a great first step to bringing other reproductive health services to the primary care setting, such as medication and aspiration abortion.
**EARLY PREGNANCY LOSS (EPL)**

Early pregnancy loss, often referred to as miscarriage or spontaneous abortion, includes all intrauterine non-viable pregnancies in the first trimester. EPL is common, occurring among 10-20% of clinically recognized pregnancies (ACOG 2015, Prine 2011, Blohm 2008). Nearly half of all EPLs are the result of random genetic errors (and the most common risk factors are advanced maternal age and prior early pregnancy loss) while other factors such as environment, exposures, and immunologic factors are also implicated (ACOG 2015, Prine 2011). Most of the time with individual patients, it’s not possible to determine the cause of the pregnancy loss.

Patients with EPL often present with vaginal bleeding and/or abdominal cramping. Alternatively, a non-viable pregnancy can be an incidental finding detected by ultrasound or absence of fetal heart tones at a follow up appointment. EPL can be classified based on ultrasound findings or clinical exam, as outlined in the table below.

<table>
<thead>
<tr>
<th>Terminology</th>
<th>Clinical definition</th>
<th>Ultrasound findings</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Missed Abortion</strong></td>
<td>A non-viable intrauterine pregnancy, either anembryonic or an embryonic demise, often discovered by ultrasound. The patient may be asymptomatic or have a history of bleeding. The cervix is closed.</td>
<td>Anembryonic gestation or embryonic demise (see below)</td>
</tr>
<tr>
<td><strong>Anembryonic Gestation</strong></td>
<td>Growth of a gestational sac without an associated embryo or yolk sac. Formerly called “blighted ovum”</td>
<td>Enlarged gestational sac without embryo (See criteria in Chapter 3, page 52)</td>
</tr>
<tr>
<td><strong>Embryonic or Fetal Demise</strong></td>
<td>Loss of viability of a developing embryo or fetus</td>
<td>Embryonic or fetal pole with no cardiac activity ≥7mm (See criteria in Chapter 3, page 52)</td>
</tr>
<tr>
<td><strong>Threatened Abortion</strong></td>
<td>The cervix is closed with uterine bleeding but without passage of gestational tissue. Pregnancy viable at time of presentation and patient may or may not miscarry.</td>
<td>Findings appropriate for stage of pregnancy, may or may not show subchorionic hemorrhage</td>
</tr>
<tr>
<td><strong>Inevitable Abortion</strong></td>
<td>The cervix is dilated with bleeding and uterine cramping, and passage of tissue is expected.</td>
<td>Findings may be appropriate for stage of pregnancy, with or without fetal cardiac activity.</td>
</tr>
<tr>
<td><strong>Incomplete Abortion</strong></td>
<td>The cervix is dilated and some, but not all, of the pregnancy tissue is expelled.</td>
<td>Heterogeneous or echogenic material, usually in the lower uterine cavity or in cervical canal</td>
</tr>
<tr>
<td><strong>Complete Abortion</strong></td>
<td>The pregnancy tissue has expelled completely</td>
<td>No pregnancy (sac/embryo or fetus) in intrauterine cavity, with possible endometrial thickening</td>
</tr>
</tbody>
</table>

Adapted from Prine, 2011.
In the past, EPL was primarily managed in the operating room with dilation and curettage. Now management of EPL commonly occurs in the outpatient setting, which is recognized as being safe, efficient, and cost-effective, while also providing more choices for patients. While some Emergency Departments (EDs) have worked to build capability to manage EPL, the goal of most has been to evaluate for possible ectopic pregnancy, manage patients with hemodynamic instability, and defer management of stable definitive or potential EPL to the outpatient setting (ACEP 2012). Patients and providers in Catholic institutions may face additional barriers to managing EPL, particularly for inevitable abortion where there is still an embryonic or fetal heartbeat (Freedman 2008).

**COUNSELING TIPS FOR EARLY PREGNANCY LOSS**

Primary care and Emergency Department providers may be the first to evaluate patients with vaginal bleeding and abdominal cramping in early pregnancy. As the diagnosis often cannot be made definitively during the first visit, counseling presents a unique challenge, requiring heightened sensitivity to a patient’s emotional needs.

- If definitive results are not available, reassure that not all vaginal bleeding signifies a pregnancy loss, while avoiding guarantees that “everything will be all right.”
- Keep the patient informed throughout the diagnostic process about your suspicions and next steps, and provide results once EPL is diagnosed, giving the patient time to process.
- Discuss if the pregnancy is desired to help guide EPL management. Many but not all patients with an undesired pregnancy may feel better knowing the pregnancy is non-viable.
- Explicitly address feelings of guilt, reassuring that there is no evidence that a patient caused this pregnancy loss (e.g., from coitus, heavy lifting, stress, etc.).
- Describe that pregnancy loss is common, occurring among 10-20% of clinically recognized pregnancies, and help to normalize the patient’s emotions.
- Advise patients that no interventions are proven to prevent first trimester loss.
- Research shows patients have strong preferences for choosing treatment for EPL, and have greater satisfaction when treated according to their preference (Wallace 2010, Dalton 2006). Since each option is safe and relatively effective in most clinical situations, the choice of management should be in line with a patient’s preferences for treatment.
- Underestimating the discomfort associated with any management option has been negatively associated with satisfaction (Dalton 2006).
- Assure that you or a colleague will be available through the process, answer questions as they arise, and encourage a support person to be at the visit.
- Counsel patients who are particularly bereaved regarding anniversary phenomena, as well as preparing themselves to discuss the loss with family and friends.
- Provide additional counseling resources as needed. Studies show some patients experience depressive symptoms following EPL, while others do not. Evidence is insufficient to demonstrate that counseling is effective post-miscarriage (Murphy 2012).
- Inquire and counsel about future fertility, providing immediate contraception or preconception care as needed. Inform and counsel about recurrent miscarriage risks (approximately baseline risk after one; 30% risk after two and increasing thereafter). Address any treatable risk factors, as appropriate, in a non-judgmental way; this is possibly best saved for follow-up.
EPL DIAGNOSTIC AND CLINICAL CONSIDERATIONS

There is no one classical presentation of EPL; it commonly occurs without symptoms or with one or more of the following:

- Vaginal bleeding (the most common sign)
- Abdominal cramping, pelvic or back pain
- Passing of tissue from the vagina
- Loss of pregnancy related symptoms (breast tenderness, nausea)
- Constitutional symptoms such as fever or malaise

Though vaginal bleeding is the most common sign, it does not always signify EPL:

- 30% of normal pregnancies have vaginal bleeding.
- 50% ongoing pregnancy rate with isolated bleeding and closed cervix.
- 85% ongoing pregnancy rate with confirmation of fetal cardiac activity.

Evaluation should include a physical examination, ultrasound (US), and/or quantitative hCGs. Serial hCGs are most helpful when US is inconclusive (i.e. pregnancy of unknown location), and are unnecessary if US confirms an intrauterine EPL.

Physical exam helps assess the patient’s status and offer diagnostic clues, and should include:

- Vital signs (including orthostatics if symptomatic or with heavy bleeding)
- Abdominal examination (to rule out peritonitis or other causes for symptoms)
- Pelvic examination (for bleeding, cervical dilatation, tenderness)
- Tissue examination (for clot vs. pregnancy tissue)

Diagnosis of EPL is confirmed by one of the following:

1. US confirmation of anembryonic gestation or embryonic/fetal demise in the intrauterine cavity (See Chapter 3, page 54)
2. Absence of previously seen IUP on US
3. Tissue exam confirming membranes and villi expelled or removed from uterus.
4. Diagnosis of EPL is also suggested by clinical history consistent with EPL with rapidly declining hCGs in absence of IUP on US.

In all patients presenting with first trimester bleeding, ectopic pregnancy should be considered. Ectopic pregnancies often present with vaginal spotting, frequently occurring at 6-8 weeks gestation. Due to the implantation of an ectopic pregnancy at sites ill-equipped to support the nourishment of a growing pregnancy, levels of hCG can be insufficient to support the corpus luteum, eventually causing sloughing of the endometrial lining. In the interim, levels of hCG can rise or fall. In addition to vaginal bleeding, other signs and symptoms of ectopic pregnancy include abdominal pain and/or rebound tenderness, referred shoulder pain, and syncope.

Remember two critical aspects of the evaluation in a patient with signs or symptoms of EPL:

- Ensure hemodynamic stability, and manage or refer as appropriate
- Evaluate for ectopic pregnancy, and treat or refer as appropriate
The commonly used algorithm below uses a minimum expected hCG increase of 53% over 2 days to characterize a viable IUP, and a decline of 35-50% over 2 days to characterize a completed EPL (Butts 2013, Prine 2011, Barnhart 2009). Studies have shown that the change in hCG level for patients experiencing an IUP, ectopic pregnancy, or EPL is quite nuanced. For patients with a viable IUP, while the traditional expected increase in hCG is to double every 48 hours, the change in hCG level over 2 days can increase as little as 35% (99.9% sensitive) (Butts 2013). While using a threshold of a 53% increase is 99% sensitive for detecting viable IUPs, consider using a lower threshold in patients with desired pregnancies to avoid misclassification of an early IUP as an ectopic or EPL.

For patients with an initial pregnancy of unknown location (PUL), the ability to predict an ectopic pregnancy is increased if a third hCG level is obtained on day 4 or 7 if the first two levels (day 0 and day 2) are suggestive of an IUP or EPL (Zee 2014). Due to overlap in levels between these diagnoses (as seen in the Chapter 3 Figure, hCG levels must always be correlated with the full clinical picture.

*The hCG level at which a singleton IUP should be seen on TVUS is the discriminatory zone, and varies between 1500 – 2000 mIU depending on the machine and the sonographer.

**The hCG needs to be followed to <5mIU/mL only if ectopic has not been reliably excluded.

***In a viable intrauterine pregnancy there is a 99% chance that the hCG will rise by at least 53% in 48 hours. In ectopic pregnancy, there is a 21% chance that it will rise by 53% in 48 hours. Use 35% instead of 53% minimum increase for desired pregnancies.
A small proportion of patients who present with EPL will need urgent intervention – including those with hemorrhage, hemodynamic instability or evidence of infection. But clinically stable patients can choose among the following management options to achieve completion of their EPL, or switch from one to another during the process:

- Expectant management (wait and watch)
- Medical management with misoprostol +/- mifepristone
  Aspiration in an outpatient or operating room setting.

Choosing from among these options is a preference-sensitive decision, as each of these options are safe and relatively effective, and patients report greater satisfaction when they are treated according to their own preference. As providers, we can provide patient-centered EPL care by supporting our patients in choosing the treatment method that is most in line with their own values and priorities for management.

It is helpful to understand that studies show a wide range of success rates for expectant and medical management, partly due to variability in defining endpoints (based on ultrasound versus clinical scenario) and inconsistencies in when aspiration is offered to participants enrolled in expectant care. And success rates may depend on the type of EPL. Studies suggest that expectant management has higher success rates with incomplete abortion, perhaps because the process of expulsion has already begun, compared to other types of EPL. Providers should counsel patients about their chance of success with each method of management depending upon the type of pregnancy loss (see Comparison Table on next page) and the amount of time the patient is willing to wait until completion.

**EXPECTANT MANAGEMENT**

Clinically stable patients may choose to wait for the natural completion of EPL. “Watchful waiting” may avoid medical and surgical intervention and attendant side effects or complications, although subsequent aspirations are higher ([See Comparison of Management Options for EPL, page 148;](#) Nanda 2012).

Allowed to proceed on its own, an EPL can take days to weeks to complete, but a patient can be managed expectantly for 6 weeks if they remain stable and amenable. Many clinicians provide phone access between visits and reassess their patients every 1-2 weeks, both to monitor progression of the EPL as well as to check in with the patient to see if they would like to continue current management or prefer to switch to another management option for faster resolution.

There is a trend toward increased bleeding with expectant vs. aspiration management, so patients with severe anemia or risk factors for bleeding may be best managed with aspiration (Nanda 2012).

**MANAGEMENT WITH MEDICATIONS**

Medication management offers patients a more predictable time to completion, avoidance of uterine aspiration, and an outpatient option available through their primary care provider.

**Mifepristone and Misoprostol**

Pretreatment with mifepristone followed by treatment with misoprostol results in a higher likelihood of successful management of first-trimester pregnancy loss than treatment with misoprostol alone (relative risk 1.25), with significantly less likelihood of uterine aspiration (relative risk 0.37), and a trend toward less bleeding ([Schreiber 2018, Dzuba 2015](#)). Although the regimen may cost more, fewer follow-up visits are needed. Dosing and timing is similar to medication abortion ([See Chapter 4: Medication Abortion](#)).
Misoprostol Alone
Misoprostol is effective and safe in treating EPL. Some studies show higher levels of bleeding and more follow-up with misoprostol compared to aspiration (Davis 2007, Zhang 2005), so patients with severe anemia or risk factors for bleeding may be best managed with aspiration. Overall though, there are cost savings from medication management over the other two options due to less follow-up than expectant care, and fewer overall costs than aspiration. See Steps Table below for additional contraindications, page 149.

<table>
<thead>
<tr>
<th>Misoprostol Dosing for Miscarriage Management (ACOG 2015, Gynuity)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incomplete miscarriage</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>All other types of EPL</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

Methotrexate
Methotrexate 50 mg/m2 has the advantage of being effective in treating early ectopic in situations wherein the diagnosis of EPL vs. ectopic is indeterminate. Efficacy is determined with serial hCG testing, clinical exams and progression of signs and symptoms. (Seeber 2006)

UTERINE ASPIRATION FOR MISCARRIAGE MANAGEMENT
Uterine aspiration offers the most definitive management of EPL and highest success rates. Patients may choose aspiration for rapid resolution, support through the entire process, or to avoid side effects of medication management. As with aspiration abortion, MVA for EPL can be performed safely for patients in most outpatient primary care settings and the ED. Costs and bleeding-related complications are greater in the operating room vs. office settings (Dalton 2006). Following pregnancy loss, antibiotics are indicated only if infection is suspected (Prieto 2012). See Chapter 6, page 105 for MVA Steps.
EPL OPTIONS COUNSELING

Options counseling for EPL can begin by reviewing all management options, including advantages, disadvantages, and outcomes, as discussed in the Comparison Table above. Consider a shared decision-making approach to counseling – after providing the relevant medical information, elicit the patient’s priorities for treatment through discussion, or use of the checklist below. Then together you can agree on a management decision that honors the patient’s preferences and values for care.

Once the patient has chosen a management method, formulate a treatment and follow-up plan. For expectant or medication management, providers can follow a protocol such as outlined in the Step-by-Step Approach below, and for aspiration management, please see Chapter 7, page 128 Abortion Procedure Aftercare for additional guidance.

(Wallace 2010)
## COMPARISON OF MANAGEMENT OPTIONS FOR EPL

<table>
<thead>
<tr>
<th></th>
<th>Advantages</th>
<th>Disadvantages</th>
<th>Estimated Rates of Success</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Expectant Management</strong></td>
<td>• Non-invasive; body expels non-viable pregnancy</td>
<td>• Process is unpredictable; can last days to weeks</td>
<td>Incomplete EPL:</td>
</tr>
<tr>
<td></td>
<td>• Perceived as natural by patients</td>
<td>• Can have prolonged or heavy bleeding and cramping</td>
<td>• Day 7: 50%</td>
</tr>
<tr>
<td></td>
<td>• Avoids anesthesia and surgery risks if successful</td>
<td>• Despite waiting, may still require uterine aspiration or other intervention</td>
<td>• Day 14: 70-85%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Day 46: 90%</td>
</tr>
<tr>
<td><strong>Medical Management</strong></td>
<td>• Non-invasive</td>
<td>• May cause heavier or stronger cramping than aspiration</td>
<td>Other types of EPL:</td>
</tr>
<tr>
<td>(With Mifepristone and</td>
<td>• Safe</td>
<td>• May cause short-term gastrointestinal &amp; other side effects</td>
<td>• Day 7: 23-30%</td>
</tr>
<tr>
<td>Misoprostol)</td>
<td>• Highly effective</td>
<td>• May still need uterine aspiration</td>
<td>• Day 14: 35-60%</td>
</tr>
<tr>
<td></td>
<td>• Avoids medication, anesthesia and surgery risks if</td>
<td></td>
<td>• Day 46: 65-75%</td>
</tr>
<tr>
<td></td>
<td>successful</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Incomplete EPL:</strong></td>
<td></td>
<td></td>
<td>(Nanda 2012, Casikar 2010, Luise 2002)</td>
</tr>
<tr>
<td><strong>Medical Management</strong></td>
<td>• As above but less effective</td>
<td>• As above</td>
<td>Complete expulsion:</td>
</tr>
<tr>
<td>(With misoprostol)</td>
<td>• Highly cost-effective</td>
<td></td>
<td>• Mife plus single dose misoprostol 84% vs. misoprostol alone 67%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>(Schreiber 2018, Dzuba 2015)</td>
</tr>
<tr>
<td><strong>Office-based Aspiration</strong></td>
<td>• Predictable</td>
<td>• Rare risks of invasive procedure</td>
<td>Incomplete EPL:</td>
</tr>
<tr>
<td></td>
<td>• Offers fastest resolution</td>
<td>• Less pain control options in some settings compared to an in-hospital procedure</td>
<td>• Single Dose 96%</td>
</tr>
<tr>
<td></td>
<td>• Less bleeding than expectant or medication</td>
<td></td>
<td>• Other types of EPL:</td>
</tr>
<tr>
<td></td>
<td>• Low probability of further treatment need (&lt;5%)</td>
<td></td>
<td>• Single Dose 71%</td>
</tr>
<tr>
<td></td>
<td>• Pain control with local plus oral or IV meds</td>
<td></td>
<td>• Second Dose 84%</td>
</tr>
<tr>
<td></td>
<td>• Compared to OR:</td>
<td></td>
<td>• Higher efficacy when no embryo/fetus or cardiac motion detected on US</td>
</tr>
<tr>
<td></td>
<td>o Cost &amp; resource savings</td>
<td></td>
<td>(Ngoc 2013, Neilson 2013, Zhang 2005)</td>
</tr>
<tr>
<td></td>
<td>o Improved patient access</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>o Continuity and privacy</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>o Less patient &amp; staff time</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Operating Room Aspiration</strong></td>
<td>• Can be asleep</td>
<td>• More cost, time, exams than office-based procedures</td>
<td>98-100%</td>
</tr>
<tr>
<td></td>
<td>• Predictable</td>
<td>• Risks associated with invasive procedure; general anesthesia</td>
<td>(Nanda 2012)</td>
</tr>
<tr>
<td></td>
<td>• Less time / bleeding than expectant or medication</td>
<td>• May be more bleeding complications with general anesthesia vs. office</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Low probably of further treatment need (&lt;5%)</td>
<td>procedure</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*(Nanda 2012, Casikar 2010, Luise 2002)*

*(Schreiber 2018, Dzuba 2015)*

*(Ngoc 2013, Neilson 2013, Zhang 2005)*
**STEP BY STEP APPROACH TO EXPECTANT MANAGEMENT OR MANAGEMENT WITH MISOPROSTOL**

### First Visit

1. **Rule out contraindications**
   - Suspected ectopic pregnancy
   - Hemodynamic instability, pelvic infection
   - Caution: anemia, bleeding disorder or taking anticoagulants
   - If medication management:
     1. Allergy to medications used
     2. An IUD in place (remove)

2. **Ultrasound if indications:**
   - No definitive intrauterine EPL confirmed by previous US
   - Bleeding since last US
   - See Chapter 3 for US findings suspicious vs. diagnostic of EPL

3. **Other diagnostic testing**
   - Pregnancy test /serum hCG if needed (See algorithm)
   - Rh
   - Hgb / Hct (if home mgmt, heavy/persistent bleeding or if anemia suspected)
   - STD risk assessment / testing per CDC SPR Guidelines

4. **Counseling and informed consent**
   - Consider patient access to emergency services & follow-up
   - Evaluate patient’s treatment priorities and discuss the risks, benefits, and alternatives
   - Discuss expected symptoms and reasons to call for expectant and misoprostol management
   - Assess the patient’s social support, coping strategies, and emotional state, and offer support as appropriate
   - If >9 week embryo, discuss possible recognizable fetal tissue

5. **Management / Medications**
   - Offer NSAID and a mild opioid
   - Administer Rh IG if Rh negative
     - (50mcg for EPL <13 weeks)
   - If patient elects medication mgmt:
     - Misoprostol (see Table above)
     - Incomplete AB 600 mcg PO
     - or 400 mcg SL
     - Other types of EPL
     - 8000 mcg PV
     - Dispense 1-2 doses with instructions to take 2nd dose if no bleeding by follow up.
   - If patient elects aspiration:
     - See Chap 6 for additional guidance & follow-up.

6. **Establish follow-up and instructions**
   - Answer all questions, and provide 24-hour contact information for patient
   - Review plans for the follow-up visit at 7-14 days
   - Make a contraceptive plan if appropriate

### Follow up visit(s) as needed

<table>
<thead>
<tr>
<th>Assess for completion of miscarriage</th>
<th>Findings consistent with completed miscarriage</th>
<th>Serial hCG Decline &gt;50% in 2 days suggests completed EPL</th>
<th>Ultrasound</th>
</tr>
</thead>
<tbody>
<tr>
<td>History +/- physical</td>
<td>History</td>
<td>Serial hCG Decline &gt;50% in 2 days suggests completed EPL</td>
<td></td>
</tr>
<tr>
<td>Serial hCG or US (in cases where Hx and physical are not consistent with a completed EPL)</td>
<td>Cramping, bleeding with or without clots or tissue (POC) with:</td>
<td></td>
<td>Absence of previously identified gestational sac</td>
</tr>
<tr>
<td></td>
<td>Diminishing bleeding</td>
<td></td>
<td>Note: A thickened endometrial stripe and heterogeneous intrauterine material are typical after successful management, does not indicate failure, and without ongoing bleeding should not indicate the need for aspiration</td>
</tr>
<tr>
<td></td>
<td>No ongoing pregnancy symptoms</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Physical exam</strong> if diagnosis remains unclear</td>
<td>Uterus firm and smaller size consistent with aborted pregnancy</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>VS +/- orthostatics as clinically appropriate</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### If miscarriage not completed

- Clinically stable patients may continue expectant management, consider 2nd dose of misoprostol and a 2nd follow-up, or opt for aspiration. Many providers dispense a 2nd misoprostol dose, to be taken after phone follow-up if no bleeding has occurred
- Uterine aspiration is recommended if there are signs of clinical instability or infection

### If miscarriage is completed

- Confirm contraceptive plans and offer emergency contraception if pregnancy is not desired
- Patient can try to get pregnant when emotionally ready. Discuss future fertility plans and address concerns, as appropriate
- Offer support and referral for additional counseling if needed
CHAPTER 8 EXERCISES:
MANAGEMENT OF EARLY PREGNANCY LOSS

EXERCISE 8.1

Purpose: To practice management of challenging situations in early pregnancy loss, and consider care continuity with one patient. Note: gender specific language is used for this case.

1. A 25-year old woman you have been seeing for 5 years presents for an urgent visit. Past history includes irregular periods, which you have managed with OCPs. She reports not having had a period for 7 weeks, and now is having abdominal cramping and moderately heavy bleeding, up to a pad every hour. Her urine hCG is positive.

   a. How would you proceed with her evaluation?

   b. How would you counsel her while waiting for results?

   c. If an ultrasound reveals an intrauterine pregnancy with the presence of fetal cardiac activity, how would you discuss the result?

2. The same woman comes in one year later. She had a normal delivery following the previous threatened abortion, and never restarted her OCPs. She recently began a new relationship, and has been using condoms intermittently. She began having vaginal bleeding about 5 days ago, and it is now decreasing. Her last menstrual period was 8 weeks ago. Her urine pregnancy test is positive. She brings in tissue and you see gestational sac and chorionic villi.

   a. How would you proceed with evaluation?

   b. How would you approach her initially with these results? How would you answer her if she asks, “Was this miscarriage my fault?”
c. What information would you provide about how this event will affect her ability to carry subsequent pregnancies to term?

d. What other evaluation or management would you initiate? When can she attempt to conceive again?

3. The same patient presents to you three years later, at age 29. She is now in a long-term relationship, and has been attempting to become pregnant. It has been 5 weeks since her LMP, urine hCG is positive, and she has been spotting for 6 days, without passage of tissue or pain. She is tearful and distraught, as this pregnancy is desired.
   a. Does she need an ultrasound in this case? How would you assess her without the use of ultrasound?

   b. On examination, you find a closed cervical os, no gestational tissue, and a nontender uterus consistent with 5-week gestation in size without adnexal tenderness or enlargement. You are able to obtain a transvaginal ultrasound, which shows an intrauterine fluid collection measuring <4mm with no yolk sac present. How do you interpret these results? What are the next steps in her evaluation?

   c. An hCG level drawn at her initial evaluation is 1000. The repeat hCG level drawn two days later is 1300. How do you interpret these results? What are your next steps?

   d. If the EPL is confirmed and completed, what kind of support may be of use to her?
CHAPTER 8 TEACHING POINTS:
MANAGEMENT OF EARLY PREGNANCY LOSS

**Purpose:** To practice management of challenging situations in early pregnancy loss, and consider care continuity with one patient. Note: gender specific language is used for this case.

1. A 25-year-old woman you have been seeing for 5 years presents for an urgent visit. Her past history includes irregular periods, which you have managed with OCPs. She reports not having had a period for 7 weeks, and now is having abdominal cramping and moderately heavy bleeding, up to a pad every hour. Her urine hCG is positive.

   a. **How would you proceed with evaluation?**
      - Differential diagnosis: Threatened abortion with viable IUP, incomplete or inevitable abortion, resolving early pregnancy loss, and ectopic pregnancy.
      - First consider and ensure hemodynamic stability.
      - Then assess how the patient feels about the pregnancy.
      - Proceed with speculum exam, bimanual exam, hCG and/or ultrasound, and Rh type.
      - If the hCG is above the discriminatory zone, an ultrasound is important to determine the location of the pregnancy unless the patient has a previously diagnosed IUP or EPL. Alternatively, serial hCGs can be obtained.
      - If initial value is below the discriminatory zone, serial hCGs can be obtained.
      - If ultrasound is non-diagnostic, proceed with first hCG now. Or if initial value is above the discriminatory zone, proceed with a second hCG in 48 to 72 hours.
      - If the pregnancy is undesired, the patient can choose to proceed directly to uterine aspiration (without waiting for hCG results). This enables the patient to receive treatment without delay, and may enable immediate confirmation of IUP vs. ectopic (if membranes and villi are confirmed).

   b. **How would you counsel her while waiting for results?**
      - The uncertainty of waiting for results can be stressful. Keep her fully informed.
      - Inform that in > 50% of bleeding cases in the first trimester, the pregnancy continues.
      - Ask if she has someone who can support her in this potentially difficult time.

   c. **If an ultrasound reveals an intrauterine pregnancy with the presence of fetal cardiac activity, how would you discuss the result with her?**
      - Over 85% of women with fetal cardiac activity on ultrasound go on to have full term pregnancies. You can initiate or refer for routine prenatal care if desired.
      - Mention a lack of evidence to support limiting activities, being sensitive to anxieties.
If bleeding or cramping continues or begins again, repeat the evaluation.
Determine Rh status, and administer Rhogam as appropriate.
If a termination is desired, you can offer abortion services or a referral.

2. The same woman comes in one year later. She had a normal delivery following the previous threatened abortion, and never restarted her OCPs. She recently began a new relationship, and has been using condoms intermittently. She began having vaginal bleeding about 5 days ago, and it is now decreasing. Her last menstrual period was 8 weeks ago. Her urine pregnancy test is positive. She brings in tissue and you see gestational sac and chorionic villi.

a. How would you proceed with evaluation?
   - The foremost question of ectopic pregnancy is answered by the finding of gestational sac and chorionic villi, except in the rare case of heterotopic pregnancy.
   - The history is consistent with a spontaneous abortion, likely complete given her decreasing bleeding.
   - As with all cases, it is essential to assess for hemodynamic stability, or need for evaluation for anemia or infection. These concerns would prompt a physical exam and labs, including Rh status.
   - If her bleeding and cramping are ongoing, an ultrasound is optional to evaluate the contents of the uterus.
   - If the overall picture is consistent with an incomplete abortion, the patient should be offered expectant, medication, or aspiration management.

b. How would you approach her initially with these results? How would you answer her if she asks, “Was this miscarriage my fault?”
   - Avoid preconceived notions about her feelings about this pregnancy. For example, even though she has a small infant at home, do not assume that this pregnancy was undesired.
   - Tell her an early pregnancy loss is common, unlikely to occur in subsequent pregnancies, and not a woman’s fault, even though many women feel guilty.
   - After discussing the results, await her response and consider open-ended questions about her expectations, such as “How are you feeling about what is happening?” or “How do you feel about what I have told you?”
c. What information would you provide about how this event will affect her ability to carry subsequent pregnancies to term?
   • Early pregnancy loss is common, and in the majority of cases one or two previous EPLs does not predict subsequent pregnancy loss. Studies of women with 3 EPLs found that over half were later able to carry a pregnancy to term.
   • Encourage a follow-up visit to discuss ways to minimize problems with subsequent pregnancies, such as minimizing smoking and alcohol intake and to gain control of chronic medical conditions.
   • Following three consecutive EPLs (or two for patients with advanced age), it is appropriate to initiate evaluation for conditions such as chromosomal abnormalities, anatomic problems, luteal phase defects, or immunologic disorders such as anti-phospholipid syndrome, that may contribute to recurrent pregnancy loss.

d. What other evaluation or management would you initiate? When can she attempt to conceive again?
   • Administer Rh immune globulin as appropriate.
   • Address contraceptive goals, methods and use. In most cases the woman can attempt to conceive when she feels emotionally and physically ready.
   • Offer a follow-up visit for continuity and support.

3. The same patient presents to you three years later, at 29 years of age. She is now in a long-term relationship with one partner, and has been attempting to become pregnant. It has been 5 weeks since last menstrual period, urine hCG is positive, and she has been spotting for 6 days, without passage of tissue or pain. She is tearful and distraught, as this pregnancy is desired.

   a. Does she need an ultrasound in this case? How would you assess her without the use of ultrasound?
      • It is unclear if this is an IUP or if the pregnancy is viable.
      • With a stable patient, you can either obtain an US or serial hCG levels.
      • Given her distress, an US (if available) may provide answers more quickly.
      • If unavailable, begin evaluation with a physical examination and hCG level.
      • Examination should assess for hemodynamic stability, an open os and/or tissue, uterine size, and assessment for adnexal masses or tenderness.
      • Inform her of the possibility of ectopic pregnancy, and give ectopic precautions.
      • She should return in 2 days for a second hCG level.
b. On examination, you find a closed cervical os, no gestational tissue, and a non-tender uterus consistent with 5-week gestation size without adnexal tenderness or enlargement. You are able to obtain a transvaginal US, which shows an intrauterine fluid collection measuring < 4mm with no yolk sac present. How do you interpret these results? What are the next steps in her evaluation?

• The location of your patient’s pregnancy is still undetermined at this point.
• Differential diagnosis includes:
  - IUP too early to be definitively diagnosed on US.
  - Ectopic with an intrauterine pseudosac.
  - EPL.
• When unable to clearly visualize a pregnancy on US in a stable patient, draw serial hCG levels.
• In patients with desired pregnancies, diagnosis based on a more conservative, or slower, rate of increase is preferred, as it can help avoid misclassification of a desired IUP as an ectopic or EPL.
• With a viable IUP, the change in hCG level over 2 days can range from an increase of just 35% to the traditionally expected doubling. Using an increase of > 53% in 2 days you will detect 99% of viable IUPs (Barnhart 2009).
• For patients experiencing EPL, a decline in hCG level is expected. A decline of >50% in 2 days from last hCG supports a diagnosis of resolving PUL.

c. A hCG level drawn at her initial evaluation is 1000. Repeat hCG level drawn two days later is 1300. How do you interpret these results? What are your next steps?

Based on her examination and initial hCG level, this patient could be experiencing EPL, ectopic pregnancy, or have an early IUP. Repeat her bimanual exam, to assess evolution in the clinical picture. Although her second hCG level increased, it did so by only 30%, which is less than expected for a viable IUP. A rise in hCG of less than 53% in 2 days suggests an abnormal pregnancy and should prompt intervention to distinguish an ectopic pregnancy from an EPL. For patients with a desired pregnancy, you may use a cut off of 35% in order to avoid misclassification of an IUP as an EPL or ectopic.

For example considering that this is a desired pregnancy:

Initial hCG = 1000
Repeat hCG done on day 2
Initial hCG x minimal expected % rise on day 2 = minimal expected rise (for a desired pregnancy)
1000 x 0.35 = 350
Initial hCG + expected rise = minimum expected 2nd hCG
1000 + 350 = 1350 (by day 2 should be > 1350)
If this was a non-desired pregnancy, the following calculations could be used if diagnostic aspiration is negative for POC and you are considering ectopic management.

Initial hCG x expected % rise on day 2 = expected rise
1000 x 0.53 = 530

Initial hCG + expected rise = minimum expected 2nd hCG
1000 + 530 = 1530 (by day 2 should be > 1530)

If ectopic is not definitively excluded, continue to follow hCG levels. Due to overlap in levels, hCG levels must be correlated with the full clinical picture.

- When the hCG level does not increase as expected for an IUP or decrease as expected for EPL, adding a third hCG level on day 4 or 7 increases the sensitivity for detecting ectopic pregnancy.

**d. If EPL is confirmed and completed, what kind of support may be of use to her?**

- Reminding her that EPL is not her fault may address her unspoken fears.
- She has now had 2 spontaneous abortions, so she has a > 70% chance of successful future pregnancy. Further work-up is recommended at this time, as described in Teaching Points for Exercise 8.2.c.
- Useful resources for support include her family and community, or counseling resources such as a miscarriage support group.
- With desired pregnancies, giving space to grieve is crucial. You can encourage her to acknowledge her to take special time or find a grieving practice. Set up additional follow-up appointments as needed.
9. BECOMING A PROVIDER

Updated June 2016 by Lin Wang MD

This chapter is designed to aid clinicians who desire to gain advanced training and become an abortion provider in their post-training practice. It offers an overview of advanced training and practice opportunities, interviewing strategies, next steps, and mechanisms for ongoing support.

CHAPTER LEARNING OBJECTIVES

Following completion of this chapter, you should be better able to:

- Discuss advanced training opportunities to build and maintain your skills
- Learn about relevant post-training practice and fellowship opportunities
- Consider opportunities for networking and finding support
- Consider ways to gain experience in reproductive health advocacy
- Reflect on personal considerations relevant to becoming an abortion provider

VIDEOS


READINGS / RESOURCES

- Snapshots: Success stories from providers who have incorporated abortion services in ways that have worked for them (IERH): https://bit.ly/3cPtRo9
- Appendix: Resources for Abortion Providers
- Related Chapter Content:
  - Supplemental Chapter: Becoming a Trainer
  - Supplemental Chapter: Office Practice Integration
SUMMARY POINTS

SKILLS

- Continue building your knowledge about all aspects of reproductive health care—including clinical care, new evidence, and patient advocacy.
- Attain clinical experience during professional training, when your credentialing and malpractice are generally covered by interagency agreements.
- Take advantage of additional abortion training and mentorship opportunities to increase your success with future provision.

SAFETY

- Build relationships and consult often with other reproductive health providers.
- Know when to refer for medical conditions that preclude outpatient care.
- Make arrangements for hospital back up that you may occasionally need.

ROLE

- Value your impact as a provider of pregnancy options counseling, evidence-based contraceptive information, services or timely referrals, and handling of follow-up issues to the patients you serve.
- Use established local and national networks to build a collaborative community, find answers to medical and administrative questions, and learn best practices.
- Overcome commonly reported barriers, including lack of authority to implement services, liability coverage, and staff resistance, by building relationships with key stakeholders and involving staff early in the process.
- Be patient and persistent as the process of integrating care may take time.
BUILDING AND MAINTAINING YOUR SKILLS

For those who intend to go beyond your initial training, there are many options to consider in becoming a reproductive health provider. Consider opportunities to develop and maintain your skills, knowledge, and leadership, both during and after training. Contacts can be identified through the help of your mentors or existing national networks.

BUILDING A STRONG KNOWLEDGE BASE

To develop expertise and keep up with current evidence, consider:

- Signing up with a national listserv (such as Access Listserv, page 166) to participate in ongoing discussions -- membership requires referral by a current participant for security reasons.
- Completing supplementary readings suggested in each Workbook Chapter
- Staying abreast of medical journals such as Contraception, Green Journal, Journal Watch Women’s Health or International Journal of Gynecology and Obstetrics.
- Attending one of these annual reproductive health conferences:
  - Society of Family Planning
  - National Abortion Federation
  - Society of Teachers in Family Medicine (Group on Abortion events)
  - Abortion Care Network

GAINING AND MAINTAINING CLINICAL COMPETENCY

Studies show that both training availability and procedural volume are positively correlated with future abortion provision, regardless of previous intention to provide (Turk 2014, Goodman 2013, Steinauer 2008).

The easiest time to gain procedural experience and advanced training is during professional pre-service training (i.e. residency or nursing program), when both credentialing and malpractice can be covered under interagency agreements between your training program and a high-volume clinical site. The procedure number to achieve confidence will vary between individuals, by comfort level, and exposure to more complex cases. Each skill can be delineated into clear steps with observable competencies for learners and for trainers-in-training. (Cappiello, 2016) Your reproductive health faculty can help you estimate what it will take to achieve competency in the services you hope to provide.

It is also of importance to consider where you will have a receptive environment before investing heavily in training, as the skill is lost if not immediately applied in an ongoing way.

Important aspects of clinical competence include patient comfort and rapport, procedural completeness, speed, and the ability to identify problems as they arise (Levi 2012). Advanced skills include complication management, diagnostic and intra-operative ultrasound, and procedures with advancing gestational age.

Due to the limited training opportunities, skill maintenance and re-training have been significant challenges in most regions of the country. The competition may be greater in urban coastal areas where there are more providers. Clinics in provider shortage areas may be more willing to help with credentialing and malpractice, but back-up and security issues may be more challenging. In either case, persistence is usually essential. For more information on training outside of your program’s standard curriculum or after graduation, see Organizational Resources: Training and Employment, page 165).
MENTORING AND BECOMING A MENTOR

Tap every opportunity for receiving mentorship and serving as a mentor during and after your training. As you near completion of your professional training, connect with the larger community of reproductive health providers.

- Ask faculty to put you in contact with providers where you are going, and to serve as a reference.
- Use the chapter questions to stimulate ideas for practice opportunities and interview strategies.
- Mentor a student or trainee by helping fill in gaps in training at their school or program, or develop a project related to reproductive health.

LEADERSHIP, ADVOCACY AND POLICY

Using opportunities for early leadership and advocacy during training can allow you to develop these skills with guidance from faculty mentors. Educational and advocacy organizations have created advanced curricula and structured electives to help programs integrate these opportunities into training (see TEACH Advanced Training Curriculum and Organizational Resources Table).

LEADERSHIP

Consider collaborating with faculty or reproductive health organizations to tap into other teaching, research, or advocacy projects during training. For example:

- Work with faculty to help lead didactic, experiential or hands-on sessions for incoming trainees, such as values clarification or papaya workshops.
- Speak at a meeting of Medical or Nursing Students for Choice.
- Work with faculty to expand reproductive health services in your clinics. Successful projects have included protocols for EC access, management of EPL in outpatient settings, and clinic integration of medication abortion.
- Help document successes and obstacles encountered integrating these services.
- Collaborate on a research project, conference presentation, or article publication via the network of educators in reproductive health.
- Consider completing Physicians for Reproductive Health’s Leadership Training Academy

ADVOCACY AND POLICY

Access to evidence-based reproductive health care has been under increasing threat due to state and federal legislative restrictions, and religious mergers. Laws that increase disparities in abortion access have included public and private insurance prohibitions, required waiting periods, mandated counseling, and targeted regulation of abortion provider (TRAP) laws, to name a few. At the time of this writing, only five states allow advanced practice clinicians to perform aspiration abortions (Vermont, New Hampshire, Montana, Oregon, and most recently California); one state (Mississippi) restricts abortion provision to obstetricians and gynecologists (Guttmacher 2020). These regulations are not applied to provision of comparable medical services, such as uterine aspiration for miscarriage management.

As a clinician, your opinions and expertise are highly respected by both the public and legislators. You have the potential to influence policy and legislation on a local and national level. Clinicians innately have the skills for being effective and powerful advocates, including a wealth of patient
stories, technical and scientific knowledge, access to and understanding of research, and experience advocating on behalf of patients (Earnest 2010). An easy introduction to legislative advocacy can be undertaking by joining a lobby day coordinated by a reproductive rights organization, since the scheduling and talking points are usually provided by the organization. To make an impact on institutional policies, consider joining a clinic or hospital committee on practice, training or quality.

Working within your state or national chapter of your professional organization, such as the American Academy of Family Physicians and American Academy of Nursing, is another way to improve education and influence policy and legislation. For example, you can join the curriculum advisory for your specialty or the ACGME Residency Review Committee to ensure adequate inclusion of sexual and reproductive health in the curricula. Or you can advocate within your organization to develop to protect the scope of practice for clinicians to include abortion provision (Weitz 2009) or for transparency in medical education in faith-based restrictions that may interfere with training (an AMA resolution adopted in 2014). Many organizations have chapters for trainees or early career clinicians, encourage involvement by younger clinicians, and provide funding for meeting attendance.

For organizations that provide materials, support, and training for clinician advocates, see Organizational Resources Table: Advocacy Section, page 166. A concise overview of advocacy opportunities can be found through Physicians for Reproductive Health.

**FINDING PRACTICE OPPORTUNITIES**

In what setting do you visualize your future participation in reproductive health services? There are many job opportunities available to you that can include reproductive health care provision.

You may join a setting where reproductive health services are already integrated or are the main focus of the practice. If services are not yet integrated, you can have the excitement and challenge of pioneering them at a site. It may be possible to offer some services initially, and expand with time. Below are a few ways to begin thinking about the integration of reproductive health into your future work.

**STRATEGIES FOR INTERVIEWING**

When considering post-graduate employment opportunities, these questions may help you interview and evaluate whether reproductive health service provision will be possible in different practice settings.

- What is the scope of practice specifically regarding reproductive health care? For example, does the site already provide prenatal and obstetric services? What are the patient demographics? What is the mix of reproductive-aged patients?
- What is the range of contraceptive services accessible to patients, and are there patient challenges gaining access to long-acting reversible contraceptives? What are the barriers, e.g. insurance limitations or outdated restrictions?
- What is the political climate in the area? Consider talking to other regional reproductive health providers before approaching a new job site directly.
- How are prenatal care, early pregnancy loss, and/or genetically indicated abortion referrals managed? These questions can help better understand their feelings about reproductive health and their referral systems. Ask how they respond to patients who ask for abortion services.
• If appropriate, consider letting them know that you have special training in abortion care, advocacy, and administrative set-up; and that you would be willing to spearhead the effort to bring a broader array of these services to the practice or training program. If they seem interested, follow up with these questions:
  o Do they encourage staff training? Or training for nurses or clinicians?
  o What arrangements do they have for hospital or OB / GYN back up?
  o Do they already provide 24-hour call?
  o Is there a way you can build in abortion provision from the start? Ideally this can be figured out before you go to your home institution so that the new skill can be applied without a gap, as gaps often mean a retraining will be needed.

• Talk about the importance of continuity of care to your patients, or the importance of including these topics for trainees. Share a success story from your training—a patient who was able to be seen by her own continuity provider and how comfortable felt receiving her reproductive health services in a familiar setting.

We know that the decision to provide reproductive health services may be one of many issues you discuss in the interview. You can use these strategies to identify how the practice responds to patients’ reproductive health needs generally and to undesired pregnancies specifically.

ADDRESSING BARRIERS TO PRACTICE INTEGRATION

Following training, graduates in a variety of fields have experienced barriers to practice. While trained family medicine graduates considered comprehensive reproductive services as important to include in their ideal practice, many faced barriers such as lack of authority or time to implement services, practice restrictions, malpractice coverage, staff resistance, and strength of competing practice interests (Goodman 2013). Post-training practice restrictions, both formally and informally imposed by employers, were associated with decreased odds of provision among obstetrician-gynecologists (Freedman 2010). Advanced practice clinicians have the potential to expand abortion access but have also faced barriers in obtaining training and legal barriers in providing services (Samora 2007).

Consider gradually building on the types of reproductive health care you offer in your setting. For example, begin expanding contraceptive services and abortion referrals, followed by integrating miscarriage management. Cultivate relationships with key stakeholders, involve staff early in the process, and find support from mentors and reproductive health organizations. Be patient and persistent, as the process will take some time. Keep returning to your core beliefs about the importance of expanding care for your patients.

JOINING EXISTING CLINICAL SERVICES

Consider becoming a contract clinician for a high-volume abortion provider. This can be done as your primary work or to supplement another position. It is a great way to maintain your skills, add variety to your job responsibilities, and become more involved in the reproductive health community. Perhaps you can work as a contract clinician in your own community or fly into other parts of the country that lack providers. Speak with your mentors and contacts about the regional needs where you are going, and level of experience suggested to apply. National programs, including Creating a Clinician Corps (C3) at https://cliniciancorps.org/wp/, can match trained clinicians with clinics currently in need of abortion providers. Your willingness to travel to areas of need may assist to get your foot in the door. Your mentors may be willing to provide you phone backup to allow you to feel more comfortable as a new provider.
JOINING FACULTY
One way to build on your skills is to work at a professional training program that needs or already offers reproductive health services. Working alongside more experienced clinicians is a great way for early learners to solidify their experience and confidence. Gaining insight into the steps that your training program took to integrate reproductive health care services can help you be prepared to consider replicating the model in a different setting in the future. RHEDI (Reproductive Health Education in Family Medicine) can connect you with many family medicine residencies around the country. Interested advanced practice clinicians should contact the Primary Care Initiative at UCSF’s ANSIRH Program.

BECOMING A TRAINER
Consider becoming a trainer in your own training program or at another site. This is a great way to advance your own skills while becoming a resource person to others. It will also ensure that you are keeping abreast of the latest research and advances. More detailed information on becoming a trainer is available in Chapter 11.

EXPANDING CONTRACEPTIVE METHODS IN YOUR PRACTICE
Consider whether your practice environment ensures that patients have easy access to the full range of contraceptive options, including the most effective ones (IUDs and implants). Insertions and removals are core skills to acquire during training. For privileges to insert and remove the contraceptive implant, it is necessary to take a training class offered directly by the pharmaceutical company. Integrating long acting methods into your practice can usually be done with minimal effort, equipment, and a bit of research on product ordering and reimbursement. Working to minimize barriers to access, by improving logistics or implementing same-day services, are other areas for productive improvement. For more tools, see http://beyondthepill.ucsf.edu.

IMPROVING REFERRALS IN YOUR PRACTICE SETTING
Taking an active role in improving referral making at your practice may be an excellent first step in expanding access to abortion care (Zurek 2015), and especially important as targeted legislation restricting abortion access has resulted in facility closures and greater complexity in obtaining services. Competent referrals (see Chapter 2, page 30 can help counter misperceptions or deliberate misinformation about legality and safety of abortion, and can assist with complex social or medical circumstances faced when accessing care. Improving care coordination is especially important in settings with limited access where patients face greater stigma.

INTEGRATING MANAGEMENT OF EARLY PREGNANCY LOSS (EPL)
Expanded options for managing EPL - including expectant, medication, and aspiration management - can be integrated into one’s outpatient clinic setting or into Emergency Department services. The counseling, consent, and follow-up for different management options are addressed in Chapter 8, page 142. Mifepristone and / or misoprostol can be pre-ordered and available on-site for patients who desire medication management (Prine 2003). Manual vacuum aspiration requires further training of clinic staff in order to ensure a safe environment (see Office Practice Chapter for step-by-step planning).

Because EPL does not involve a viable pregnancy, its management is not considered an abortion for funding or malpractice purposes, and can be treated like any other minor surgical procedure that you routinely provide. Integrating EPL management might be a stepping-stone towards integrating abortion care in your practice, as the skills and equipment are similar, but the path may be more readily approachable.
PERSONAL SECURITY

As you develop your skills and begin your job search, reflect on how public you want to be as an abortion provider. This decision will be influenced by your local environment and family situation. Your stance may evolve as your career, personal relationships, and political environment change. Regardless of how public you decide to be, it is important to consider personal security precautions. It may be safer to begin with tighter security and become more lax in the future, than the reverse. Taking some basic precautions may also help reduce the stress of living and working in an environment where you could be targeted.

You can start by considering your online security, with privacy settings on social media, avoidance of personal photographs connected to your name, and avoidance of your name on public records (such as home purchases). To avoid having your private information accessible, opt-out information is usually hidden within the “privacy statement” or in website FAQs. Most sites require that you send in a written letter with some proof of your identity and statement that your safety is at risk. There is no cost for doing this. More information and a sample letter are available for you here.

Talk to providers in your area about their own personal security precautions. It is helpful to get mentorship from a provider with security knowledge and personal experience before you get started rather than to remedy problems after they occur. National Abortion Federation members can be provided with personal security assessments, in addition to clinic security support. Physicians for Reproductive Health has launched the Partnership for Physician Safety which aims to supply abortion providers with the information and resources needed to be more secure at home, at work, and in their communities. See Personal Security Tips for more specific advice. And see Chapter 10 Office Practice Integration for detailed information on clinic security.

BEYOND TRAINING

There is a proud, egalitarian, and cooperative history of sexual and reproductive health care that informs the training process around abortion. This movement and the integration of comprehensive reproductive health training into the core curriculum of many professional training programs have vastly changed the delivery of reproductive health care in this country. As we proceed with efforts to improve training and access to abortion services, there are many inspiring examples of collaboration within and across disciplines, not only between specialties, but also between clinicians, staff, scientists and activists. Extensive clinical research and expanding evidence has enhanced effective training and practice in reproductive health. We hope this workbook has given you the knowledge and enthusiasm to join with us as providers and to further expand access to these essential healthcare services.
## ORGANIZATIONAL RESOURCES *

### Medical and Professional Organizations

<table>
<thead>
<tr>
<th>Clinicians in Abortion Care:</th>
<th><a href="https://prochoice.org/health-care-professionals/ciac/">https://prochoice.org/health-care-professionals/ciac/</a></th>
</tr>
</thead>
<tbody>
<tr>
<td>Membership organization for clinicians that is sponsored by NAF. Members are provided with opportunities for networking, mentorship, coalition building, advocacy, and training.</td>
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<table>
<thead>
<tr>
<th>TEACH CREATE Program (Continuing Reproductive Education for Advanced Training Efficacy)</th>
<th><a href="http://goo.gl/3j4Pm2">http://goo.gl/3j4Pm2</a></th>
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<tbody>
<tr>
<td>Partners with residency programs to provide a structured advanced training curriculum for advanced trainees that addresses the barriers between training and future reproductive health provision.</td>
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<thead>
<tr>
<th>Planned Parenthood Federation of America (PPFA):</th>
<th><a href="http://www.plannedparenthood.org">http://www.plannedparenthood.org</a></th>
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</thead>
<tbody>
<tr>
<td>A national umbrella organization for all local Planned Parenthood affiliates. The website has position papers, fact sheets, and FAQs about abortion.</td>
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<thead>
<tr>
<th>Physicians for Reproductive Health (PRH):</th>
<th><a href="http://www.prh.org">http://www.prh.org</a></th>
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</thead>
<tbody>
<tr>
<td>Supports and trains physicians in providing reproductive health advocacy and improving medical education. Their website contains information about their training programs and educational videos.</td>
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<tr>
<th>Provide:</th>
<th><a href="http://www.providecare.org">http://www.providecare.org</a></th>
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</thead>
<tbody>
<tr>
<td>Seeks to ensure access to abortion by increasing services and raising awareness. Their website contains curriculum on making referrals, management of early pregnancy loss, and resources for nurses.</td>
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<thead>
<tr>
<th>Reproductive Health Access Project (RHAP)</th>
<th><a href="http://www.reproductiveaccess.org">http://www.reproductiveaccess.org</a></th>
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</thead>
<tbody>
<tr>
<td>Works directly with primary care providers to integrate abortion, contraception and miscarriage management, and links residents with mentors. See their site for helpful handouts and training tools.</td>
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</tbody>
</table>

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<thead>
<tr>
<th>RHEDI: Center for Reproductive Health Education in Family Medicine:</th>
<th><a href="http://www.rhedi.org">http://www.rhedi.org</a></th>
</tr>
</thead>
<tbody>
<tr>
<td>Provides funding and expertise to integrate comprehensive abortion and family planning training in family medicine residency programs. Their site has clinical resources for integrating services and fact sheets.</td>
<td></td>
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<thead>
<tr>
<th>Ryan Residency Training Program:</th>
<th><a href="http://www.ryanprogram.org/">http://www.ryanprogram.org/</a></th>
</tr>
</thead>
<tbody>
<tr>
<td>Provides resources to institute a dedicated, opt-out family planning rotation for OB/GYN residencies.</td>
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</table>

### Training and Employment

<table>
<thead>
<tr>
<th>Medical Students for Choice (MSFC):</th>
<th><a href="http://www.Msfc.org">http://www.Msfc.org</a></th>
</tr>
</thead>
<tbody>
<tr>
<td>National organization for medical students. Their Training to Competence Externship provides residents with financial and logistical support for receiving abortion training.</td>
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<th></th>
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<tr>
<td>National organization for nursing students. Their site contains education resources and information about their Clinical Externship Program.</td>
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<tr>
<th>Fellowship in Family Planning:</th>
<th><a href="http://www.familyplanningfellowship.org">http://www.familyplanningfellowship.org</a></th>
</tr>
</thead>
<tbody>
<tr>
<td>Fellowship based at UCSF with sites for graduates of family medicine and obstetrics and gynecology residency programs throughout the U.S. Fellows are provided with specialized training in research, teaching, and clinical skills in contraception and abortion over two years.</td>
<td></td>
</tr>
</tbody>
</table>

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<thead>
<tr>
<th>Reproductive Health Care &amp; Advocacy, GAPS, and Miscarriage Management Fellowships:</th>
<th><a href="https://www.reproductiveaccess.org/programs/fellowship/">https://www.reproductiveaccess.org/programs/fellowship/</a></th>
</tr>
</thead>
<tbody>
<tr>
<td>These fellowships provide family physicians with further training in reproductive health care and advocacy. Fellows are provided with clinical, teaching and leadership skills over one year.</td>
<td></td>
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</tbody>
</table>

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<thead>
<tr>
<th>Reproductive Health Fellowship in Women’s Health:</th>
<th><a href="http://goo.gl/N1qbva">http://goo.gl/N1qbva</a></th>
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</thead>
<tbody>
<tr>
<td>A one-year fellowship providing further training for family physicians in contraception and abortion.</td>
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<tr>
<th>TEACH Leadership Fellowship:</th>
<th><a href="http://goo.gl/GBdvID">http://goo.gl/GBdvID</a></th>
</tr>
</thead>
<tbody>
<tr>
<td>This one-year fellowship provides family physicians with further training in reproductive health care, advocacy, and leadership. Fellows are provided with clinical, research, advocacy and leadership skills.</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>The Leadership Training Academy (LTA) of Physicians for Reproductive Health (PRH):</th>
<th><a href="http://goo.gl/mHTSEY">http://goo.gl/mHTSEY</a></th>
</tr>
</thead>
<tbody>
<tr>
<td>This program provides physicians with training in advocacy, leadership and communication skills to become effective advocates. The training consists of webinars and 3 in-person meetings over 8 months.</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Maternal Child Health and Obstetrics Fellowships:</th>
<th><a href="http://goo.gl/jTq71l">http://goo.gl/jTq71l</a></th>
</tr>
</thead>
<tbody>
<tr>
<td>Some of these fellowships provide family physicians with further training in full spectrum reproductive health care. Ask specifically about inclusion of abortion training.</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Creating a Clinician Corps (C3):</th>
<th><a href="http://cliniciancorps.org/wp/">http://cliniciancorps.org/wp/</a></th>
</tr>
</thead>
<tbody>
<tr>
<td>Matches clinicians with clinics and health centers with an immediate need for abortion providers.</td>
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</tbody>
</table>
# Listservs

**STFM Access Listserv**

A private discussion group to discuss clinical, educational and administrative issues in offering comprehensive reproductive health care services. For membership, email techmanager@rhedi.org.

## Advocacy

**Advocates for Youth:** [http://www.advocatesforyouth.org](http://www.advocatesforyouth.org)

Helps young people make informed and responsible decisions about their reproductive and sexual health.

**Catholics For Choice:** [https://www.catholicsforchoice.org](https://www.catholicsforchoice.org)

Information and advocacy for patients, providers, and activists on abortion and reproductive health care issues within a catholic framework.

**Center for Reproductive Rights (CRR):** [http://www.reproductiverights.org](http://www.reproductiverights.org)

Uses the law to advance reproductive freedom as a fundamental human right.

**Feminist Majority Foundation:** [http://www.feminist.org](http://www.feminist.org)

Works to advance women’s equality and empower women and girls in all sectors of society.

**NARAL-ProChoice America:** [http://www.naral.org](http://www.naral.org)

Provides information and political action around issues of abortion and reproductive health care issues.

**The Native American Women’s Health Education Resource Center (NAWHERC):** [http://goo.gl/qQlwv7](http://goo.gl/qQlwv7)

Documents reproductive justice issues and uses activism to promote the voices of Native women.

**National Asian Pacific American Women’s Forum:** [http://www.napawf.org](http://www.napawf.org)

Works on a broad range of issues that affect Asian Pacific American women, including reproductive justice.

**National Latina Institute for Reproductive Health:** [http://www.latinainstitute.org](http://www.latinainstitute.org)

Ensure the fundamental human right to reproductive health for Latinas, their families and their communities through education, advocacy and coalition building.

**National Network of Abortion Funds:** [https://abortionfunds.org](https://abortionfunds.org)

Network of independent organizations that provide financial assistance to women to pay for abortions.

**National Partnership for Women & Families:** [http://www.nationalpartnership.org](http://www.nationalpartnership.org)

Promotes fairness in the workplace, reproductive health and rights, access to quality, affordable health care and policies that help parents meet the dual demands of work and family.

**National Women’s Law Center:** [http://Nwlc.org](http://Nwlc.org)

Champions policies and laws that help women and girls achieve their potential throughout their lives. Assists patients with insurance coverage for contraception (coverher.org)

**Religious Coalition For Reproductive Choice:** [http://www.rcrc.org](http://www.rcrc.org)

National organization of pro-choice clergy and churches. Can provide spiritual counseling.

**Sister Song:** [http://sistersong.net](http://sistersong.net)

Builds networks to improve institutional policies and systems that impact the reproductive lives of marginalized communities, and trains the next generation of activists.

*See Chapter 10 Organizational Resources for a) Hotlines, b) Legal, c) Research, and d) Sexuality Education.*
CHAPTER 9 EXERCISES: BECOMING A PROVIDER

EXERCISE 9.1

1. In which setting(s) do you visualize your future participation in reproductive health or abortion care? Do you imagine joining a team that already offers services? Or do you picture starting services in a new site? Do you see yourself adding reproductive health services in a setting where access is currently limited? Do you see yourself as a trainer or joining a professional training or residency program as faculty?

2. How will you connect with other providers in your region?

3. How do you frame this discussion with potential employers? How would you ascertain if your potential employer is open to offering abortion services?

4. If an employer thought Title X clinics couldn’t provide abortions, what would you say to them?

EXERCISE 9.2 - Employment negotiations

1. Preparation is key to successful interviewing and negotiations with a future employer. Examine your practice priorities and rank them by their relative importance. What strategies can you use to ensure that your priorities are met?

2. Creating a list of questions prior to your interview will help you prepare. What information would you want to obtain? How will you address parts of the interview process that will be more challenging for you?
EXERCISE 9.3 - Managing stigma: the decision to disclose
(Adapted from The Providers Share Workshop, Hassinger 2012)

For most people talking about their work hardly registers as a decision. For abortion providers, doing so always involves assessments (sometimes unconscious) of risks and benefits, for oneself as well as family members. Below is an exercise to help:

- Deepen awareness of ways disclosure is negotiated in your life
- Evaluate the risks and benefits of the decision to disclose or not, and
- Increase control over disclosure decisions.

Exercise Instructions
See table below, and select a relationship in which issues of disclosure arise. Explore the risks and benefits of disclosure (to you or the relationship). If you have time, make a possible disclosure plan, and role-play.

<table>
<thead>
<tr>
<th>Relationship</th>
<th>Time or Age</th>
<th>Contextual Details/Consideration</th>
<th>Disclosure</th>
<th>Non-Disclosure</th>
<th>Decision*</th>
</tr>
</thead>
<tbody>
<tr>
<td>EXAMPLE Adult</td>
<td>Now</td>
<td>My in-laws do not know about my abortion work. They are religiously conservative and anti-choice. I have 2 young children. We are close and rely on their assistance with childcare.</td>
<td>Loss of relationship would be a loss to kids, and loss of family support. Could undermine my work. Risks consequences in their community.</td>
<td>Possibility they accept. Relief from worry about silence, “accidental outing”. Extended family could celebrate my successes.</td>
<td>D ND *</td>
</tr>
<tr>
<td>Extended Family</td>
<td></td>
<td></td>
<td></td>
<td>Uncontrolled accidental outing, Persistent strain on relations. Not sure I can disclose to kids –moves to a family secret.</td>
<td>Preservation of innocent relationships and tenuous peace in family. Continued reliance on them for childcare.</td>
</tr>
</tbody>
</table>

*D = I mostly discuss openly, but sometimes choose not to.  ND = I never discuss; the risks are too great.
CHAPTER 9 TEACHING POINTS: BECOMING A PROVIDER

EXERCISE 9.1

1. In which setting(s) do you visualize your future participation in reproductive health or abortion care? Do you imagine joining a team that already offers services? Or do you picture starting services in a new site? Do you see yourself adding services in a setting where access is currently limited?
   - There are multiple settings in which reproductive health and abortion services may be offered: clinics (community, non-profit, for profit, independent, residency program continuity sites), outpatient surgical centers, private doctor’s offices, and hospitals.
   - You could work on expanding services to include the full range of contraceptive options, outpatient miscarriage management, medication and/or aspiration abortion.
   - There are many ways to get involved: moonlight at a local clinic, join a practice already providing, get involved in teaching other providers, integrate services into your new practice, or providing services through Telemedicine.

2. How would you connect with other providers in your region?
   - Ask faculty mentors to help introduce you to providers in your new area.
   - Look online for providers or ask for contacts on one of the listservs.
   - Contact one of the organizations listed to help make an introduction, or to become a member.
   - Get on mailing lists of state and local pro-choice groups so you know what is happening in your community.
   - Attend a regional or national conference.

3. How do you frame this discussion with potential employers? How would you ascertain if your potential employer is open to offering abortion services?
   - Role-playing a discussion with a potential employer may give you maximal benefit from this exercise, in order to consider your comfort with various approaches and possible responses. Specific questions to ask are discussed in Strategies for Interviewing section of Chapter 9, page 161.

4. If an employer thought that a Title X clinic couldn’t provide abortions, what would you say to them?
   - This is not the case. Agencies who receive Title X funding may still perform and self-refer for abortion services. While federally restricted funds can’t be used for abortion services directly or indirectly, your clinic may have other revenue streams that do not restrict the type of services you can provide.
   - The cost of abortion services and time must be broken out, in most cases, from other services in order to prove that federal funding is not being used to provide abortions. This may require setting up a separate cost center, which is easy to do. More information is available in Chapter 10 (Office Practice Integration: Financial Issues), and guides to assist your administrative/billing department are available.
• Title X clinics may provide “factual, neutral information about any option including abortion, as they consider warranted by the circumstances, but may not steer or direct clients towards selecting any option in providing options counseling.” 65 Federal Register, Section 41270.

EXERCISE 9.2 – Employment negotiations

1. Preparation is key to successful interviewing and negotiations with a future employer. Examine your practice priorities and rank them by their relative importance. What strategies can you use to ensure that your priorities are met?
   • During the interview, highlight your unique contributions to the organization in terms of valuable skills you have as a reproductive health provider.
   • Understand your market worth prior to or as a part of the process of these negotiations. How much are you worth elsewhere (the dollar and reputational value of the skills you are bringing in). Don’t leave it up to the employer to tell you your market worth; you should go into the negotiation knowing (and literally having thought about how you are going to express that).
   • Understand the priorities of the person you are interviewing with and which priorities are aligned or in conflict with yours (Sarfaty 2007, Herbert 2012).
   • After a negotiation, e-mail the other party summarizing the session to be sure you are both on the same page.
   • Do not accept an offer until you review the details in writing.
   • In academic medicine, terms of employment often are conveyed in a formal letter or contract; the contract supersedes all other agreements.
   • Check your contract carefully for clauses that would prevent you from providing abortion services or restrict you from practicing at another site.

2. Creating a list of questions prior to your interview will help you prepare. What information would you want to obtain? How will you address parts of the interview process that will be more challenging for you?
   • Get advice from mentors and faculty to obtain different perspectives.
   • You will want to understand the scope of your duties and responsibilities.
   • Understand the chain of command (Sarfaty 2007, Herbert 2012).
   • Role-playing with a trusted mentor or peer may help you prepare.

EXERCISE 9.3 - Managing stigma: the decision to disclose
(Adapted from The Providers Share Workshop, Hassinger 2012)

• If, when, and how you decide to disclose that you provide abortions is a deeply personal issue that this exercise will help you consider.
• Your ideas on this can and will likely change with time and circumstances.
• Reaching out to others in the field can help provide a supportive environment.
REFERENCES

CHAPTER 1 REFERENCES


CHAPTER 2 REFERENCES


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CHAPTER 3 REFERENCES


CHAPTER 4 REFERENCES


CHAPTER 5 REFERENCES


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CHAPTER 6 REFERENCES

https://www.aafp.org/cme/programs/also.html


CHAPTER 7 REFERENCES


**CHAPTER 8 REFERENCES**


CHAPTER 9 REFERENCES


