Mifepristone/misoprostol abortion protocol

The FDA updated its labeling for mifepristone on March 29, 2016. The new label incorporates most recent evidence, allowing us to provide medication abortion in a way that minimizes adverse effects while enhancing safety, privacy, and convenience for patients and providers.

The new FDA label has made the following updates:

- The maximum **gestational age is 70 days** (higher than the prior 49-day gestational age limit).
- The **mifepristone dosage is 200 milligrams** (one pill) rather than 600 milligrams. The new label states that the mifepristone must be **"dispensed" in the office** but does not specify where the pill should be taken – which allows option for home administration.
- **Mucosal misoprostol administration** has increased efficacy and minimizes gastrointestinal side effects and is now specified over the prior oral administration. The FDA label recommends misoprostol 800 mcg buccally from 24-48 hours after mifepristone. An alternate evidence-based route is vaginal misoprostol administration, allowing a window of 6-72 hours after mifepristone. NOTE: For gestational ages under 5 weeks and over 8 weeks, optimal misoprostol timing is 24 hours for either buccal or vaginal routes.
- **Home use of misoprostol** is now recommended rather than office administration. Home use is safe and preferable to patients and decreases the number of required office visits.
- The prior label specified office follow-up 14 days after mifepristone. The new label recommends follow-up in 7-14 days after mifepristone, and **does not explicitly specify a follow-up location**, which allows options for alternative methods (e.g. phone call with a home urine pregnancy test).
- The **prescriber can be any prescribing clinician,** including advanced practice clinicians like nurse practitioners, rather than the prior specification of "physician."

Protocol Comparison Table

	FDA regimen 2000	FDA regimen 2016 Buccal Misoprostol	Alternative: Vaginal misoprostol
Maximum gestational age	49 days from LMP	70 days from LMP	70 days from LMP
Mifepristone dose/location	600 mg. orally administered in office	200 mg. orally Dispensed in office	200 mg. orally
Misoprostol dose/route	400 mcg. Orally (2 tablets)	800 mcg. Buccally (4 tablets)	800 mcg. Vaginally (4 tablets)
Misoprostol timing	48 hours after mifepristone	24-48 hours after mifepristone *	6-72 hours after mifepristone *
Misoprostol	Office	Home	Home

location			
Follow-up/ Location	14 days after mifepristone Office	7-14 days after mifepristone (Not specified)	7-14 days after mifepristone Office or alternative
Minimum number of office visits	3	1-2	1-2
Prescriber	…under the supervision of a qualified physician	…By or under the supervision of a certified prescriber	…By or under the supervision of a certified prescriber
Cost	Higher	Lower	Lower

***** For gestational ages under 5wks and over 8wks, recommend 24 hour administration for any route

Patient Referral

If you accept medication abortion referrals from your partners or colleagues, the following paragraph may be helpful to them: The primary provider should counsel the patient about pregnancy options and contraception. If the patient chooses medication abortion, they should receive an appointment with an appropriate provider as soon as possible. To avoid delays, a medication abortion provider should be contacted directly (by the primary provider or nursing staff) and a prompt appointment should be arranged.

Initial Assessment – Office Visit - Day 1

Counseling

1. Options counseling: Consider aspiration abortion or continuing the pregnancy and parenting or adoption. Advise that medication abortion has a failure rate (i.e. ongoing pregnancy) of about 1 in 250 and an aspiration abortion may be needed in 1 to 3 of 250 cases. Compared with aspiration abortion, medication abortion causes longer bleeding duration and more abdominal cramping. Medication abortion is non-invasive, avoids surgical and anesthetic risk, and can occur very early in pregnancy. It has been perceived by many patients to be more natural, and allows more privacy and control. (See consent form.)

2. Review of expected effects: Bleeding and cramping (usually heavier than with menses). Diarrhea and other gastrointestinal side effects are common. There is a very small risk of prolonged bleeding requiring an aspiration abortion or MVA. The patient should be instructed in how much bleeding would be considered excessive and when to call the clinician.

3. Adherence to protocol: Explain to the patient the process and the importance of finishing the medication abortion protocol. If the abortion is unsuccessful, an aspiration

abortion or a repeat dosing of medications must be performed due to the possible teratogenicity of misoprostol.

Compliance with State Requirements

Many states have specific requirements affecting abortion. Most of these laws apply both to medication and aspiration abortion. Providers must comply with mandatory waiting periods, parental notification, gestational age limits, and department of health reporting as required. To find out more about these regulations, consult www.reproductiverights.org/.

Medical History and Physical Exam

1. Confirm pregnancy with a urine pregnancy test.
2. Rule out contraindications:
    - IUD in place (may be removed prior to medication abortion)
    - Allergy to prostaglandins or mifepristone
    - Chronic adrenal failure
    - Long-term systemic corticosteroid therapy
    - Ectopic pregnancy
    - Hemorrhagic disorders
    - Concurrent anticoagulant therapy (excluding aspirin)

3. Ensure that the patient has access to a telephone and transportation, and that they agree to return for follow-up appointments as needed.

4. Obtain a medical history and perform a focused physical exam. A bimanual exam should assist in gestational dating if ultrasound will not be available or if the patient is not sure about their LMP. Obtain a Pap smear and test for gonorrhea and Chlamydia infection (if indicated).

Dating Pregnancy

Ultrasound examination should be performed if gestational age is uncertain, if there is a size/date discrepancy, if sizing is difficult, if the patient's last menstrual period occurred while they were taking hormonal contraception, or if the clinician suspects ectopic pregnancy or if the LMP places them over 9 weeks. If none of these conditions warrant an ultrasound, a quant hCG should be done prior to the administration of the mifepristone and again at the follow-up visit to monitor the success of the abortion. The quant does not "date" the pregnancy, it allows for a comparison of the hCG levels before and after to assure a drop of > 80% at one week after the cramping and bleeding.

Rh status, quantitative bhCG, hemoglobin measurements obtained
Rh status may be determined from a blood donor card, from the patient's history, or by obtaining a new measurement. A quantitative bhCG level may be needed for comparison with a subsequent level. A baseline hemoglobin or hematocrit level can be ordered as well, especially if there is any history of anemia.

Review the required provider/patient agreement and the consent form.

Give medication and directions for misoprostol administration:
Buccal administration: The patient will administer four 200-microgram misoprostol tablets, holding two in each cheek for 30 minutes and then swallowing them with a drink, at a convenient time 24-48 hours after taking mifepristone.
Vaginal administration: The patient will place four 200-microgram misoprostol tablets in their vagina 6 – 72 hours after taking the mifepristone. The patient will then lie down for 30 minutes. If the tablets fall out after 30 minutes, they can be discarded.
If expulsion (i.e., cramping and bleeding) does not occur within 24 hours of the initial misoprostol dose, the patient should consult their provider. A second dose of misoprostol may be indicated.

Administer Rh-IG if indicated. Micro RhoGam will be used instead of the full dose and should be given prior to using the misoprostol or within 72 hours of bleeding. Patients should be informed that this medication is a human blood derivative. For patients who refuse the injection, a signed statement to that effect should be included in the chart. There is not good evidence that this injection is needed for very early pregnancies, and it is not used routinely in Europe. It is the tradition or "standard of care" in the US, however.

Advise patient on use of pain medications: Prescriptions for acetaminophen with a narcotic and/or Ibuprofen 800 milligrams should be offered to the patient. Patients should be encouraged to fill the prescription/s in advance and to have the pain medications on hand to be taken as needed.

Make sure patient knows how to reach provider on-call. An information sheet with instructions about how to call or page the provider should be given to each patient, and the information should be reviewed to be sure they understand. The patient should be instructed to call their provider if they do not bleed within 24 hours of using the misoprostol, if bleeding exceeds two maxi-pads per hour for two consecutive hours, or if they begin to feel very ill at any time during the medication abortion process.

Administer mifepristone: 200-milligram tablet by mouth.

Note: The 2016 FDA label states to "dispense" the mifepristone in-office, so if needed – the patient could take the mifepristone home for later administration. Office-administration may still be easier to limit the number of steps that need to be done at home.

Review plans for post-abortion contraception: Patients who choose combination hormonal contraceptives (oral, patch, ring) may begin the method as immediately as the next day or on the most convenient day after taking misoprostol – even if they are still bleeding. The implant may be provided at the first visit, same day of mifepristone administration. Depot progestin (Depo Provera) injection or IUD insertion can take place at the follow-up visit. Patients may begin to have vaginal sex with barrier contraception after 72 hours. Patients who choose tubal ligation should be referred as appropriate to avoid delays.

Follow-up Assessment – Office or alternative – Day 7-14

Follow-up to assess completeness of abortion

1. To assess the completeness of the abortion, providers should use the following criteria:
   - history (patient's description of bleeding - which should be at least as much as their menses – with cramping and passage of clots);
   - declining serum bhCG levels (by more than 80% at one week after the bleeding) or by negative urine pregnancy test (i.e. below minimum level) and/or ultrasound.

2. If pregnancy is ongoing, i.e. a rising bhCG or a sonogram with a growing pregnancy, an aspiration completion can be performed. If the abortion is incomplete (i.e. a sonogram showing no interval growth and no fetal heartbeat), the patient can choose a repeat dose of vaginal misoprostol or an aspiration procedure. If the pregnancy was being followed by quant hCGs and they did not fall as expected, an urgent ultrasound should be obtained to assess for failed abortion vs ectopic pregnancy.

3. All test results (Pap, GC, and Chlamydia) should be available, and results should be reviewed with the patient and managed appropriately.

4. The contraception plan should be reviewed and confirmed.

Further follow-up

Patients should be instructed to call or return if bleeding persists beyond 4 weeks or becomes heavy again.

CHART REVIEW FORM: MEDICATION ABORTION

	Yes	No	N/A
Options counseling documented			
Adverse effects education documented			
Protocol explanation documented			
Informed consent form: In chart			
Labeled			
Signed			
Rh status documented			
RhoGam given (if indicated)			
Initial Beta-HCG level documented			
Hemoglobin level documented			
Pain medication prescribed			
Follow-up visit completed			
Assessment of abortion completion documented: History			
Beta-HCG level fell more than 80%			

Sonogram			
Contraception plan documented			
Pap smear result documented (if applicable)			
Gonorrhea and Chlamydia results documented *Appropriate treatment offered (as indicated)			

Patient Name: _____
Chart Number: _____

CHECKLIST FOR MEDICATION ABORTION WITH MIFEPRISTONE

		Yes	No	N/A
Options counseling documented				
Adverse effects explained				
Protocol explained:	Timing of medications			
	Need for follow-up visit			
	On-call system			
Contraindications ruled out:	No IUD in place			
	No allergy to prostaglandins/mifepristone			
	No chronic adrenal failure			
	No long-term systemic corticosteroid tx			
	No concurrent anticoagulant therapy			
	No ectopic pregnancy			
	No hemorrhagic disorder			
Informed, evidence-based consent form signed				

Rh status (circle one): Positive Negative Declined			
RhoGam given (if indicated)			
Initial beta-HCG level: _____			
Hemoglobin level _____			
Ultrasound dating, if done			
Pain medication prescribed			
Mifeprex lot number recorded: _____date administered:			
Follow-up visit completed on: _____			
Abortion completion assessed by: History			
Beta-HCG level			
Sonogram			
Contraception plan reviewed			