**Medication Abortion in Early Pregnancy Workshop**

**Case Studies**

Facilitator’s Guide

These case studies are meant to be completed through group discussion as a way to apply everything participants have learned through the presentation thus far. Participants should each have a Learner’s Guide that will allow them to follow along and work through the cases. Anything in the Facilitator’s Guide that is in *italics* is **not** in the Learner’s Guide – these are the pieces that participants should generate and the facilitator can guide them towards.

Ask one of the participants to read the first paragraph:

**Case 1- Ellen “It went so smoothly”**

Day 1: Ellen is a 34-year-old G2P1 who identifies as female and presents to your office to start birth control. She is sexually active with her boyfriend and they use condoms sometimes. Her last period was 5 weeks ago, but her periods usually occur monthly. A urine pregnancy test is positive.

1. **As the clinician, how do you counsel Ellen on her options?**
2. *Options Counseling:*
3. *Continuing the pregnancy and parenting*
4. *Continuing the pregnancy and adopting*
5. *Terminating the pregnancy*

Ellen is upset but is also clear that it’s not the right time to have another child, and she would like to have an abortion.

1. **As the clinician, how do you counsel Ellen on her options between medication and a procedure abortion?**
2. *Options counseling*
3. *Given dating <11 weeks, options of medication vs procedure ab*

\*\*\*\*REFER TO RHAP “[Early Abortion Options](https://www.reproductiveaccess.org/resource/early-abortion-options/)” Handout\*\*\*\*

1. **You are Ellen, what questions do you have about the abortion?**
2. *Pros and cons of medication vs procedure abortion*
3. *How safe is it?*
   1. *It’s very safe – some risks include infection, heavy bleeding, ongoing pregnancy*
   2. *Abortion is at least 10x safer than continuing a pregnancy!*
   3. *Infection (i.e. endometriosis <1%) and very rare risk of atypical infection*
   4. *Heavy/prolonged bleeding (up to 3%)*
4. *How effective is it?*
   1. *Failure rates (ongoing pregnancy)*
   2. *1-5% in first 63 days gestational age*
   3. *1-9% within 64-77 days gestational age. Failure rates with a regimen that includes a second dose of misoprostol is less than 2% for 9-11 weeks.*
   4. *May need repeat dose of miso or aspiration in 1-3/250*
5. *Will there be a lot of bleeding?*
6. *Will there be a lot of pain?*
7. *Ibuprofen, hydrocodone, heating pads*
8. *Will you have to do an exam?*
9. *Will you have to do bloodwork?*
10. *Will you have to do an Ultrasound?*
    1. *Limited ultrasound protocol*
11. *Will I see anything?*
    1. *<9 weeks = tissue, blood, clots*
    2. *9-11 weeks = fetus may be identified*
12. *How does it work?*
    1. *Mife stops pregnancy (antiprogesterone)*
    2. *Miso works on uterus to expel contents; uterotonic and cervical ripening*
    3. *Advantages of miso = no effect on bronchi/blood vessels, inexpensive, can store at room temperature*
13. *What is the cost?*
14. *Is there any follow up?*

**4. Ellen decides to have a medication abortion. What do you know about the protocol?**

1. *Give mifepristone (200 mg) - will end pregnancy. Can take at home or in the office.*
2. *6-72 hours later, Ellen will place misoprostol (4x 200mg) in cheeks or vagina - this will cause the uterus to cramp and expel the pregnancy.*
3. *Buccal vs vaginal use*
   1. *Buccal = 24-48 hours later*
   2. *Vaginal = 6-72 hours later*
4. *You ask that she follow up in 1-2 weeks for repeat blood test*
5. *If she were between 9-11 weeks, you would instruct her to use a second dosage of misoprostol 4 hours after the first dosage and to use the 24-28 hour window*
6. **You want to know a little more about Ellen’s history to make sure the medication procedure is safe, what are some important questions you ask her?**
7. *IUD in place? Any other birth control use prior to the procedures?*
   1. *IUD should be removed prior to medication abortion*
8. *Is she certain of her LMP?*
9. *History or symptoms of ectopic?*
10. *Allergy to meds? (prostaglandins or mifepristone)*
11. *Chronic adrenal failure*
12. *Long term systemic corticosteroids*
13. *No PID, chlamydia infection, etc.*
14. *Concern for ectopic pregnancy*
15. *Bleeding disorders*
16. *Use of anticoagulant therapy (excludes aspirin)*

Ellen is healthy, not on any other medicines, and you determine she is eligible for medication abortion.  You go over the consent form:

* \*\*\*Refer to RHAP “[Mifepristone/Misoprostol Protocol](https://www.reproductiveaccess.org/resource/medication-abortion-protocol/)” Handout\*\*\*
* \*\*\*Refer to RHAP “[Medication Abortion Consent Form](https://www.reproductiveaccess.org/resource/medication-abortion-consent-form/)” Handout\*\*\*
* \*\*\*Refer to RHAP “[Medication Abortion Aftercare Instructions (vaginal miso)](https://www.reproductiveaccess.org/resource/medication-abortion-aftercare-instructions-vaginal-miso/)” and “[Medication Abortion Aftercare Instructions (buccal miso)](https://www.reproductiveaccess.org/resource/medication-abortion-aftercare-instructions-buccal/)” Handouts\*\*\*

You give Ellen a 24-hour emergency contact number

1. **What are some reasons you would like her to call this number?**
2. *Bleeding – too much or too little*
   1. *Too much = 2 pads/hour times 2 hours*
   2. *Too little = little or no bleeding for 24 hours, will need to confirm that pregnancy is intrauterine and then give another dose of misoprostol*

\*\*\*Refer to “[Algorithm for Phone Triage of Bleeding with Medication Abortion](https://www.reproductiveaccess.org/resource/algorithm-phone-triage-bleeding-medication-abortion/)” Handout\*\*\*

1. *Infection – fevers 24 hours later (after miso)*
   1. *Workup = h/o pelvic pain, bleeding patterns, odorous discharge, ROS for other sources of fever, pelvic exam*
2. *Feeling really ill – abdominal pain, weak, diarrhea > 24 hours after miso*
3. *Unmanageable pain despite taking medications*
4. **What are some other reasons Ellen may contact you in between visits?**
5. *Vomiting or diarrhea after the mife and/or miso*
6. *NO bleeding*
7. *Emotional reasons*

Ellen elects to take the mifepristone in the office. You and her discuss when is best for her to take the misprostol, and she decides to take off work tomorrow morning and place it vaginally then.

1. **Is there anything else you would like to ask Ellen before she leaves?**
2. *Would she like a method of birth control from you?*
3. *COCs - as immediately as the next day after taking misoprostol, even if still bleeding (COCs = pill, patch, ring)*
4. *Implant - day of visit or follow up*
5. *Depo or IUD - place at follow up*

Day 2: Ellen’s blood results return, her B-Hcg quantitative value is 9,000. We did not check her blood type because she is less than 8 weeks pregnant. Her hemoglobin is 11.5. With these results, you determine you don’t need to call her back to the office early. You also don’t get any phone calls from Ellen.

1. **What hemoglobin would be too low to proceed?**

Day 10: Ellen returns to your clinic. She states about 3 hours after placing the miso, she bled a bit heavier than her period for the next two days. It has slowed down since then, but she still needs to wear a pad. She did have significant cramping, but ibuprofen helped. She isn’t having any more nausea, and her breast tenderness has gone down significantly. She wants to use the patch for birth control.

1. **Do you have any other questions for Ellen?**
   1. *Vaginal sex – may begin with barrier methods the day after & contraception after 72 hours (but really there is no evidence on this recommendation).*
2. **What lab(s) do you want to get?**
   1. *hCG*

Day 11: Ellen’s B-Hcg is 600.

1. **Is the medication abortion complete?**
2. *Bhcg should decline by 80% after 1 week.*

**Case 2-  Danielle “Not as smooth”**

**Ask one of the participants to read the first paragraph**

Day 1-2: Danielle is a 24 yo G1P0 who identifies as female and comes to your office for a medication abortion. She is certain her LMP was 7 weeks ago, her periods are regular, and she wasn’t on any contraception. You counsel her well, rule out any contraindications, and give her the medicine in the office and to take home. She calls you a day after placing the misoprostol, telling you she hasn’t felt much cramping and is only having some spotting. Her initial bHCG is back and was 21,000.

1. **What do you do?**
2. *Concern misoprostol did not work*
3. *Need to establish location of pregnancy (ectopic pregnancy is very rare in the population who has unplanned pregnancies, but it is not something we want to miss!)*

You order an external ultrasound, as you don’t have a machine in your office. She returns to you the next day with the report, showing an intrauterine gestational sac with yolk sac and fetus consistent with her LMP.

1. **What do you do?**
2. *Medication vs MVA: discuss options with patient*

She chooses to repeat the misoprostol. Six hours after taking the 2nd dose, she has cramping and bleeding with clots.

1. *Some providers are repeating both the mifepristone and the misoprostol when the first dosage fails, since the study on miscarriage (Schreiber et al., 2018) showed that mifepristone plus misoprostol is more effective.*

Day 7: Danielle returns for follow up. Her bleeding has stopped. You repeat a B-Hcg, which went from 21,000 to 1,000.  She started OCPs the day after her second dose of misoprostol.

**Case #3 Maria “Abortion Aftercare or Self-Managed Abortion”**

Ask one of the participants to read the first paragraph:

You get a call from one of your long term patients. She tells you that she is with a 32-year-old friend who traveled from another state to visit her because she needs medical care and didn’t know where to else go. Her friend lives in a state that has passed many abortion restrictions and so she thought abortions were illegal and thus purchased some pills through a shady pharmacy in her town, used them and now has been bleeding for four weeks. Her friend speaks Spanish only and you speak English only, so the friend is translating.

1. **What else do you want to know?**
2. *LMP? G’s and P’s*
3. *How much has she been bleeding, how many pads per day or per hour?*
4. *Is she feeling light-headed or dizzy?*
5. *Any fever?*
6. *Did she see any tissue pass?*
7. *Does she know the name of the pills and how was she instructed to take them?*
8. *Did she ever get an ultrasound to establish that her pregnancy was intrauterine?*

Your patient speaks to her and then tells you that her last period was 6 weeks before she took the pills, she is G5P4, she went to a crisis pregnancy center where they told her she was too far along to have an abortion. After she took the medicines (4 pills every 3 hours x 3) she had heavy bleeding with clots for 4 hours and saw some gray/yellow stuff in the toilet. The bleeding after that was about four pads a day for a few days. For the past 3 weeks, she has had intermittent light bleeding. She’s worried.

1. **What advice should you give the friend to give her?**
2. *This could be a normal post-abortion course*.

She’s really worried, so you offer to see her in the office.

1. **She comes to the office. What do you need to do?**
2. *Vitals, fingerstick hemoglobin, urine bhCG.*

Her blood pressure is 110/60, her heart rate is 90, she does not appear pale, clammy, or cold. Her urine pregnancy test is negative. Her fingerstick Hgb is 9.0. She reports that the bleeding has slowed down again. Physical exam reveals no blood in the vagina, and a normal-sized, nontender uterus.

1. **What do you think now and what are your next steps?**
2. *Today’s exam confirms that she is no longer pregnant.*
3. *She is mildly anemic, but hemodynamically stable.*
4. *Despite the uncertainty about what the medications actually contained, this is a typical medication abortion course, with several weeks of stop-and-start bleeding.*
5. *She needs oral iron supplementation and a plan for contraception.*
6. **What if she hadn’t been willing or able to come to the office? Would you have been able to handle this by phone?**
7. *You can assess the severity of bleeding and symptoms of anemia/hemodynamic instability (dizziness, fatigue, shortness of breath, etc) by phone. If the patient is asymptomatic, you can advise them to take a home pregnancy test. A negative result makes the office visit unnecessary.*
8. *This history is not unusual for a medication abortion, some women do bleed up until their next period. It is also important to know that the first period after a medication abortion is often quite heavy and patients may call when this happens if they have not been prepared for it.*