

# Medication Abortion in Early Pregnancy Workshop Case Studies

## Facilitator's Guide

### Case 1- Ellen

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?

- Pregnancy Options Counseling:
  - Continuing the pregnancy and parenting
  - Continuing the pregnancy and adopting
  - Terminating the pregnancy

Ellen decides that it's not the right time to have a child, and she would like to have an abortion.

#### 2. As the clinician, how do you counsel Ellen on her options?

- Abortion Options Counseling
  - Given dating <11 weeks, options of medication vs procedural abortion

#### 3. Imagine you are Ellen, what questions do you have about the abortion?

- How safe is it?
  - It's very safe – some risks include infection, heavy bleeding, ongoing pregnancy
  - Infection (i.e. endometriosis <1%) and very rare risk of atypical infection
  - Heavy/prolonged bleeding (up to 3%)
- How effective is it?
  - Failure rates (ongoing pregnancy): 3.1% in first 63 days gestational age; 3.0% within 64-70 days gestational age; 8.7% within 71-77 days gestational age, 2% within 78-84 gestational age.
  - May need repeat dose of misoprostol or aspiration. With repeat dose of misoprostol, the medication abortion is successful 98-99% of the time.
- Will there be a lot of bleeding?
  - Yes, expect heavy bleeding with clots during the abortion. It should start a few hours after taking misoprostol. After, lighter bleeding may continue off and on for a few weeks
- Will there be a lot of pain?
  - You'll have mild to very strong cramps off and on during the abortion.
  - Pain pills (Ibuprofen, naproxen, acetaminophen) help, and heating pads.
- Will you have to do an exam?
  - If the clinician can confirm gestational age with LMP and there aren't any other medical concerns that would warrant a pelvic exam, you won't need one.
  - You may confirm gestational age with size from bimanual exam if there is uncertainty
- Will you have to do bloodwork?

- Optional: quant hCG may be done prior to the administration of the mifepristone and again at a follow-up visit to monitor the success of the abortion (not for dating purposes, but to measure whether the abortion is complete)
- Rh-testing: Based on current practice guidelines, it is reasonable to forego Rh testing for MAB. Use shared decision-making with your patient -- counseling on probability of risks and allowing the patient to come to an informed conclusion of what works best for them. The risk of fetal Rh alloimmunization is very low in first trimester and likely beyond.
- Will you have to do an Ultrasound?
  - Ultrasound as needed protocol: uncertain LMP, no menses after delivery or abortion, or recently taking or stopping contraception, size/date discrepancy or uncertainty, history of or suspected ectopic/ectopic risk factors
- Will I see anything?
  - <9 weeks = tissue, blood, clots
  - 9-12 weeks = products of conception may be identified
- How does it work?
  - Mifepristone stops pregnancy from growing (antiprogesterone)
  - Misoprostol works on uterus to expel contents; uterotonic and cervical ripening
- What is the cost?
  - Depends on where you go, insurance coverage
- Is there any follow up?
  - Follow-up is not required, but can be offered as an appointment or phone call in 7-14 days. It is not routinely required. The patient can assess completion of abortion on their own. It's most important that the patient has an ability to follow-up with you (phone call, MyChart message, etc) if they have any questions or concerns.

\*\*\*\*REFER TO RHAP "[Early Abortion Options](#)" Handout\*\*\*\*

Ellen decides to have a medication abortion. You discuss the process with her and how it will work:

- Give mifepristone (200mg) - will end pregnancy. Can take at home or in the office.
- 24-48 hours later, Ellen will place misoprostol (4x 200mg) in cheeks, under tongue or vagina - this will cause the uterus to cramp and expel the pregnancy.
- Buccal/sublingual vs vaginal use:
  - Buccal/sublingual = 24-48 hours later
  - Vaginal = 6-72 hours later
- Offer an option of a follow-up phone call or appointment, though routine follow-up is not required.

**4. You want to know a little more about Ellen's history to make sure the medication abortion option is safe, what are some important questions you ask her?**

- IUD in place? Any other birth control use prior to the procedures?
  - IUD should be removed prior to medication abortion
- Is she certain of her LMP?
  - Can ask extended screening questions to better assess gestational age.

- History or symptoms of ectopic?
- Allergy to meds? (prostaglandins or mifepristone)
- Chronic adrenal failure
- Long term systemic corticosteroids:
- No PID, chlamydia infection, etc.
- Bleeding disorders
- Use of anticoagulant therapy (excludes aspirin)

Ellen does not have any contraindications to medication abortion and you determine she is eligible. You go over the consent form:

\*Refer to RHAP "[Mifepristone/Misoprostol Protocol](#)" Handout

\*Refer to RHAP "[Medication Abortion Consent Form](#)" Handout (this is not an FDA patient agreement)

\*Refer to RHAP "[Medication Abortion Aftercare Instructions \(vaginal miso\)](#)" and "[Medication Abortion Aftercare Instructions \(buccal miso\)](#)" Handouts

You give Ellen a 24-hour emergency contact number:

#### 5. What are some reasons you would like her to call this number?

- Bleeding – too much or too little
  - Too much = 2 pads/hour times 2 hours
  - Too little = no bleeding for 24 hours, may need another misoprostol dose

\*\*\*Refer to "[Algorithm for Phone Triage of Bleeding with Medication Abortion](#)" Handout\*\*\*

- Infection – fevers 24 hours later (after miso)
  - Workup = h/o pelvic pain, bleeding patterns, odorous discharge, ROS for other sources of fever, pelvic exam
- Feeling really ill – abdominal pain, weak, diarrhea > 24 hours after miso
- Unmanageable pain despite taking medications
- Any questions or concerns at all?

#### 6. What are some other reasons that Ellen may contact you in between visits?

- Vomiting or diarrhea after the mifepristone and/or misoprostol
- NO bleeding
- Emotional reasons

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

#### 7. Is there anything else you would like to ask Ellen before she leaves?

- Is she interested in contraception? If so, what kind of contraception would she like to start?

- Pills, implant, patch, ring, shot, barrier methods - as immediately as the day they use mifepristone, though Depo Provera may decrease the effectiveness of mifepristone
- IUD – as early as 4 days after misoprostol

Day 2: Ellen's blood results return, her B-Hcg quantitative value is 9,000. Her blood type is A+. 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.

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.

**8. What lab(s) do you want to get?**

- hCG

**9. Do you have any other questions for Ellen?**

- You don't need to get labs to confirm. Can ask 4 cardinal questions to assess complete abortion: Did you take the pills? Did you have bleeding? Did you have cramping? Do you still feel pregnant?

Day 11: Ellen's B-Hcg is 600.

**10. Is the medication abortion complete?**

- Bhcg should decline by 80% after 1 week.
- Checking in on the medication abortion experience and pregnancy symptoms also show that she completed her abortion.

## Case 2- Dani

Day 1-2: Dani is a 24 y/o G1P0 who identifies as female and comes to your office for a medication abortion. She is certain her LMP was 5 weeks ago, her periods are regular, and she wasn't on any contraception. You counsel her, rule out any contraindications, and give her the medicine. She decides to take mifepristone in the office and take misoprostol at home. She calls you a day after placing the misoprostol, telling you she hasn't felt much cramping and is only having some spotting.

### **1. What do you do?**

- Concern misoprostol did not work
- Discuss options of misoprostol repeat vs MVA

Dani decides to try the medication again. You call Dani the next day, and now she states she's had more bleeding and cramping, about the same as her period. You feel reassured that the medicine is working this time.

Day 7: Dani calls you again and says her bleeding has stopped, and she's still feeling a little nauseated. She's also having a little right sided back pain. You ask her to come in for an appointment to see what's going on.

She's able to come in for an appointment. You repeat a B-Hcg, which went from 11,000 to 9,000.

### **2. What could be going on?**

- Ectopic?
- Failed medication abortion?

### **3. What do you do?**

- Send for ultrasound

You decide to send Dani for an ultrasound because you are concerned this could be an ectopic pregnancy. She returns to you with the report, showing an intrauterine gestational sac with yolk sac.

### **4. What do you do?**

- Misoprostol vs MVA