POLICY STATEMENT
This protocol is for management of medical abortion up to 10 weeks gestation. Approximately 30% of all abortions in the United States are medical abortions. With an efficacy and safety profile similar to surgical abortion, medical abortion is an excellent option for women seeking termination of pregnancy below at or below 10 weeks gestation.

CANDIDATE CONSIDERATIONS
1. Prior to the procedure it is the physician’s responsibility to:
   a. Provide the patient with a full explanation of both medical and surgical abortion with risks and benefits of each.
   b. Obtain specific informed consent form for medical abortion and sign the informed consent document.
   c. Counsel the patient about what to expect with medical abortion, including side effects and pain medications. Please see “Medical abortion instructions.”
2. All women will undergo ultrasound evaluation for gestational age assessment.
3. Beyond medical contraindications to medical abortion, the following are considerations for the physician that may require additional counseling and/or result in offering only surgical abortion:
   a. Language or comprehension barriers that may limit communication with providers
   b. Patients who have difficulty returning for follow up (e.g., patients who are homeless, have transportation or substance abuse issues limiting follow up, or live in geographically remote areas without access to emergency gynecological care)
   c. Patients unwilling to have uterine aspiration if medical abortion should fail

METHOD:
Medical abortion regimen will include administration of 200 mg mifepristone orally in clinic by the physician. 800 mcg of misoprostol will then be dispensed to the patient to be taken at home. Other clinical considerations:
1. **Gestational age:** In general, efficacy rates are approximately 95-98% up to 49 days’ gestation, and 92-98% from 57-63 days (1). Success of medical abortion between 8-9 weeks gestation has been shown to be equivalent to 9-10 weeks at approximately 93% (2).
2. **Route of misoprostol administration**: In general, vaginal, buccal and sublingual administration are associated with increased efficiency, decreased ongoing pregnancy rates and allow an increased gestational age range for medical abortion compared oral misoprostol administration (3).
   - Vaginal administration is associated with fewer gastrointestinal side effects compared with buccal or sublingual administration (1).
   - Women may prefer buccal administration to vaginal administration.

3. **Timing of misoprostol administration after mifepristone**: In general, there is equivalent efficacy among regimens with intervals of 24-36 hours for non-oral regimens.
   - Vaginal misoprostol should be encouraged with intervals <24 hours: Studies investigating a shorter interval (15 min to 6-8 hours after mifepristone) with vaginal misoprostol have been shown to have equivalent completion rates compared to intervals ≥24 hours. However, buccal administration is not as effective when given at the same time as mifepristone (1). Therefore, vaginal administration of misoprostol should be encouraged for intervals <24 hours.

4. **Medical abortion without definitive intrauterine pregnancy (IUP)**: A definitive IUP is defined by the presence of at least a yolk sac within the gestational sac. Medication abortion can be performed in patients without a yolk sac or gestational sac *with counseling and close follow up*. See separate policy, “Management of Very Early Medical and Surgical Abortion.”

5. **Antibiotics**: Routine administration of prophylactic antibiotics is not recommended. The risk of infection after first trimester medical abortion is approximately 0.3% (5). One retrospective study using historical controls found that providing antibiotics and changing route of misoprostol administration from vaginal to buccal reduced the risk of serious infection from organisms such as Clostridium species from 0.093% to 0.025% (NNT 1250). More recent evidence suggests that presence of Clostridium species in the genital tract is likely transient and not causative of serious infectious morbidity. The Society of Family Planning does not recommend routine administration of antibiotic prophylaxis to women undergoing medical abortion. Therefore, *routine* administration of prophylactic antibiotics is not recommended.

6. **Follow up**: Standard follow up after medical abortion includes an ultrasound and clinical evaluation 1-2 weeks following the first visit for medical abortion. Many women travel great distances to obtain medical abortion and in-person follow up may not be feasible. The following is an acceptable alternative to in-person follow up:
   - Serum hCG on day of Mifepristone compared to serum hCG one week later: A decline in the serum hCG measurement of 80% from day of mifepristone administration compared to 1 week later is indicative of success (1). Patients may have their follow-up hCG drawn ideally at a Tricore lab. The CRH RN following the hCG results will confirm success with Family Planning attending and will document successful abortion in Powerchart.

Studies utilizing a combination of clinical assessment of success with high-sensitivity urine pregnancy test (UPT) at 2 weeks after mifepristone have not been clinically useful. No data exists evaluating the use of a high-sensitivity UPT between 2-4 weeks after mifepristone; therefore, this method for follow up would only be recommended in a well-counseled patient who cannot otherwise complete follow up, and any positive UPT should prompt in-person evaluation.
If follow up of a patient cannot be confirmed, the CRH RN will discuss with a Family Planning attending and if appropriate, a registered letter will be sent to the patient requesting follow up. A copy of the letter will be kept in PowerChart.

CONSULTATION
Twenty-four-hour consultation is available by calling the Division of Family Planning service at the University of New Mexico Hospital through Reproductive Health PALS.

REFERENCES


The information in this SOP is designed to aid practitioners in making decisions about appropriate obstetric and gynecologic care. These SOP guidelines should not be construed as dictating an exclusive course of treatment or procedure. Variations in practice may be warranted based on the needs of the individual patient, resources, and limitations unique to the UNM setting or type of practice.
### DOCUMENT APPROVAL & TRACKING

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**Approval:**

Chair, Department of Obstetrics and Gynecology

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