SCHOOL OF MEDICINE
DEPARTMENT OF OBSTETRICS & GYNECOLOGY

STANDARD OPERATING PROCEDURE- GUIDELINE

MEDICATION ABORTION

SCOPE/APPLICABILITY:

This protocol is for medical management of abortion up to 11 weeks gestation. Approximately 30% of all abortions in the United States are medication abortions. With an efficacy and safety profile similar to procedural abortion, medication abortion is an excellent option for women seeking termination of pregnancy below at or below 11 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 medication and in-clinic aspiration abortion with risks and benefits of each.
    b. Obtain specific informed consent form for medication abortion and sign the informed consent document.
    c. Counsel the patient about what to expect with medication abortion, including side effects and pain medications. Please see "Medication abortion instructions."

2. All women must have ultrasound documentation of gestational age.

3. Beyond medical contraindications to medication abortion, the following are considerations for the physician that may require additional counseling and/or result in offering only in-clinic aspiration abortion:
    a. Language, comprehension, or technology barriers that may limit communication with providers
    b. Patients who have difficulty with follow up (e.g., patients who have complex social considerations that may limit follow up)
    c. Patients unwilling to have uterine aspiration if medication abortion should fail

PROCEDURES:

Medication abortion regimen includes administration of 200 mg mifepristone orally in clinic by the physician. One or two doses of 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). After 63 days, efficacy rates with two 800 mcg doses of misoprostol taken four hours apart are similar to earlier gestations: 99.6% at 64-70 days and 97.6% at 71-77 days (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 medication abortion compared oral misoprostol administration (3).
    - Vaginal administration is associated with fewer gastrointestinal side effects compared with buccal or sublingual administration (1).

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. An interval of 24 hours appears to have the highest efficacy.
    - For intervals <24 hours, vaginal misoprostol should be encouraged: 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 for patients at less than 63 days. However, buccal administration is not as effective when given at the same time as mifepristone (1).

4. **Medication 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 clinical guideline, "Management of Very Early 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 medication abortion.

6. **Follow up**: Standard follow up after medication abortion includes an ultrasound and clinical evaluation 1-2 weeks following the first visit for medication abortion. Many women travel great distances to obtain medication abortion and in-person follow up may not be feasible. The following are acceptable alternatives 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 the Complex Family Planning attending and will document successful abortion in the patient's chart.

    - Telephone follow up: Telephone follow up is only available if there is a confirmed IUP at the start of medication abortion. The patient will have a nurse telephone visit approximately 7 days after taking mifepristone, following the CRH Nurse Initiated Protocol for medication abortion follow up (6,7). If the patient feels that the pregnancy was expelled and clinical history does not require a return visit then she will be instructed to take a home pregnancy test 4 weeks after taking mifepristone. Both the telephone visit and the home pregnancy test will be documented in the patient's chart.

    If follow up of a patient cannot be confirmed, the CRH RN will discuss with a Complex Family Planning attending and if appropriate, a registered letter will be sent to the patient requesting follow up.

CONSULTATION

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

REFERENCES:

1. Creinin MD, Daneilsson K. Medical abortion in early pregnancy. In: Paul M, Lichtenberg S, Borgatta L, Grimes D, Subblefield P, Creinin M, editors. Management of Unintended and Abnormal Pregnancy: Comprehensive Abortion Care. Wiley-Blackwell; 2009.

2. National Abortion Federation. 2020 Clinical Policy Guidelines for Abortion Care.

3. Medical Management of First-Trimester Abortion - ACOG [Internet]. Available from: http://www.acog.org/Resources-And-Publications/Practice-Bulletins/Committee-on-Practice-Bulletins-Gynecology/Medical-Management-of-First-Trimester-Abortion

4. Goldstone P, Michelson J, Williamson E. Effectiveness of early medical abortion using low-dose mifepristone and buccal misoprostol in women with no defined intrauterine gestational sac. Contraception. 2013 Jun;87(6):855–8.

5. Achilles SL, Reeves MF, Society of Family Planning. Prevention of infection after induced abortion: release date October 2010: SFP guideline 20102. Contraception. 2011 Apr;83(4):295–309.

6. Perreira LK et al. Feasibility of telephone follow up after medical abortion. Contraception 2010(81):143-9.

7. Chen MJ et al. Comparing office and telephone follow up after medical abortion. Contraception 2016(94):122-6.

APPROVALS:

SOP Owner:	Lisa Hofler, MD/ Family Planning Division	Date: 8/3/20
Chair Approval:		Date: 8/20/2020
Effective Date:	August 3, 2020	