SCHOOL OF MEDICINE
DEPARTMENT OF OBSTETRICS & GYNECOLOGY

STANDARD OPERATING PROCEDURE- POLICY

MANAGEMENT OF VERY EARLY ABORTION

SCOPE/APPLICABILITY:

This protocol is for the management of women desiring abortion at early gestational ages (i.e. prior to ultrasound identification of a gestational sac with yolk sac). Abortion in this subgroup remains safe and effective, with appropriate informed consent.

EARLY GESTATIONAL AGE:

Women may present for pregnancy termination at very early gestational ages. All women desiring abortion should have ultrasound performed for dating and confirmation of intrauterine pregnancy (IUP). This protocol specifically applies to asymptomatic women less than 7.0 weeks from LMP with a positive urine or serum hCG and

- Without a gestational sac and/or without a yolk sac on transvaginal ultrasound AND
- With no concerning adnexal masses on examination or transvaginal ultrasound

This procedure does **NOT** apply to women with clearly identified extra-uterine pregnancies who should be treated for ectopic pregnancy.

PROCEDURES:

Abortion is reasonable and effective in asymptomatic women with very early pregnancy. Providers should counsel patients of a 2-3% risk (for procedural abortion) [1] and 2% risk (for medication abortion) [2] of ongoing pregnancy, risk of undiagnosed ectopic pregnancy and the need for continued follow up. The woman has 2 options:

1. Postpone abortion and follow up in 1-2 weeks to confirm IUP (gestational sac with yolk sac seen on ultrasound).

2. Proceed with very early abortion with close follow up. This option may involve additional cost for the patient, but allows the patient to begin the abortion process sooner.

If the woman elects very early MEDICATION ABORTION:

1. In addition to standard counseling, counseling for very early medication abortion should include the option to postpone abortion until IUP is confirmed, and information about the possibility of ectopic pregnancy and symptoms of ectopic pregnancy.

2. Obtain quantitative serum beta hCG on the day mifepristone is taken and send as a STAT lab. Place patient in the beta book for follow-up and notify the covering beta book team.

a. If the beta hCG level is **above** the discriminatory zone, defined as 3,500 if no gestational sac is seen and 17,000 if a gestational sac is seen but no yolk sac is seen[5]:
    i. Contact the patient and refer her to OB Triage for evaluation, including diagnostic ultrasound
    ii. Counsel the patient about specific concern for ectopic pregnancy; consider uterine aspiration or methotrexate

3. Obtain a follow-up quantitative serum beta hCG in one week. A successful abortion is defined as ≥80% decrease in hCG levels.[3]

4. The medication abortion procedure is described in the UNM Ob/Gyn department SOP, "Medication Abortion."

If the woman elects very early <u>PROCEDURAL ABORTION</u>:

1. In addition to standard counseling, counseling for very early procedural abortion should include the option to postpone abortion until IUP is confirmed, and information about the possibility of ectopic pregnancy and symptoms of ectopic pregnancy.

2. Obtain quantitative serum beta hCG prior to the uterine aspiration procedure.

3. After the uterine aspiration, evaluate the products of conception in the usual manner.

    a. If a gestational sac was seen on ultrasound, and the physician identifies the gestational sac and chorionic villi on gross tissue inspection, no further follow up is needed. Quantitative serum beta hCG does not need to be sent.

    b. If the physician identifies chorionic villi on gross tissue inspection, but no gestational sac is seen:
        i. Send the products of conception to pathology to confirm chorionic villi and quantitative serum beta hCG as STAT lab. Place patient in the beta book for follow-up and notify the covering beta book team.
        ii. Obtain follow-up quantitative serum beta hCG in 24-48 hours; successful abortion is defined as a >50% decrease in the hCG level.[4]

    c. If no chorionic villi are identified:
        i. Send products of conception to pathology; consider "rush pathology" on the tissue slip for rapid turnaround of results.
        ii. Send quantitative serum beta hCG obtained prior to procedure as STAT lab. Place patient in the beta book for follow-up and notify the covering

beta book team. If hCG is above discriminatory zone, as described above, consider referral to OB Triage for further evaluation.

iii. Counsel the patient about signs and symptoms of ectopic or continuing pregnancy.

iv. Obtain follow-up quantitative serum beta hCG in 24-48 hours; successful abortion is defined as a >50% decrease in the hCG level.[4]

REFERENCES:

1. Dean G et al. Manual compared with electric vacuum aspiration for abortion at less than 6 weeks of gestation. Obstet Gynecol 2015;125(5), 1121-9.

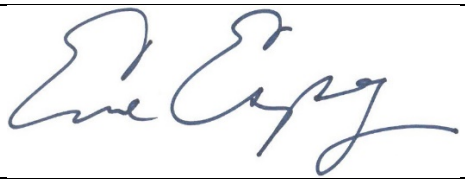
2. Bizjak I et al. Efficacy and safety of very early medical termination of pregnancy: a cohort study. BJOG 2017;124(13):1993-9.

3. Fiala C et al. Verifying the effectiveness of medical abortion; ultrasound versus hCG testing. Eur J Obstet Gynecol Reprod Biol 2003;109(2):190-5.

4. Rivera V, Nguyen PH, Sit A. Change in quantitative human chorionic gonadotropin after manual vacuum aspiration in women with pregnancy of unknown location. Am J Obstet Gynecol 2009;200(5):e56-9.

5. Connolly A, Ryan DH, Steube AM, Wolfe HM. Reevaluation of discriminatory and threshold levels for serum beta hCG in early pregnancy. Obstet Gynecol 2013;121(1):65-70.

APPROVALS:

SOP Owner:	Lindsay Dale, MD Lisa Hofler, MD, MPH, MBA	Date: 03/08/2021
Chair Approval:		Date: 06/07/2021
Effective Date:	June 7, 2021	