FFYP Short Snappers: Medication abortion

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Palais des congrès de Montréal

FMF
Family Medicine Forum
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THE COLLEGE OF FAMILY PHYSICIANS OF CANADA
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Presenter Disclosure

Presenter: Megan Clark, MD, CCFP

Relationships with financial sponsors:

- Any direct financial relationships, including receipt of honoraria: research funding through Saskatchewan Centre for Patient-Oriented Research, Canadian Institute for Health Research, Saskatchewan Health Research Foundation
- Membership on advisory boards or speakers' bureaus: National Abortion Federation Canada medication abortion panel, Wellness Wheel Board of Directors, Saskatchewan College of Family Physicians board of directors
- Patents for drugs or devices: none
- Other: Clinical and academic contract-based work with Saskatchewan Health Authority, University of Saskatchewan, Touchwood Agency Tribal Council

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Megan Clark has received honoraria from the National Abortion Federation Canada.

Dr. Clark has not received any pharmaceutical industry funding.

Learning Objectives

- Appropriately select patients for medication abortion with mifepristone-misoprostol
- Take an appropriate history
- Order appropriate investigations as baseline & F/U
- Prescribe mifepristone-misoprostol for medication abortion – while choosing your investigations wisely
- Appropriately direct ineligible patients

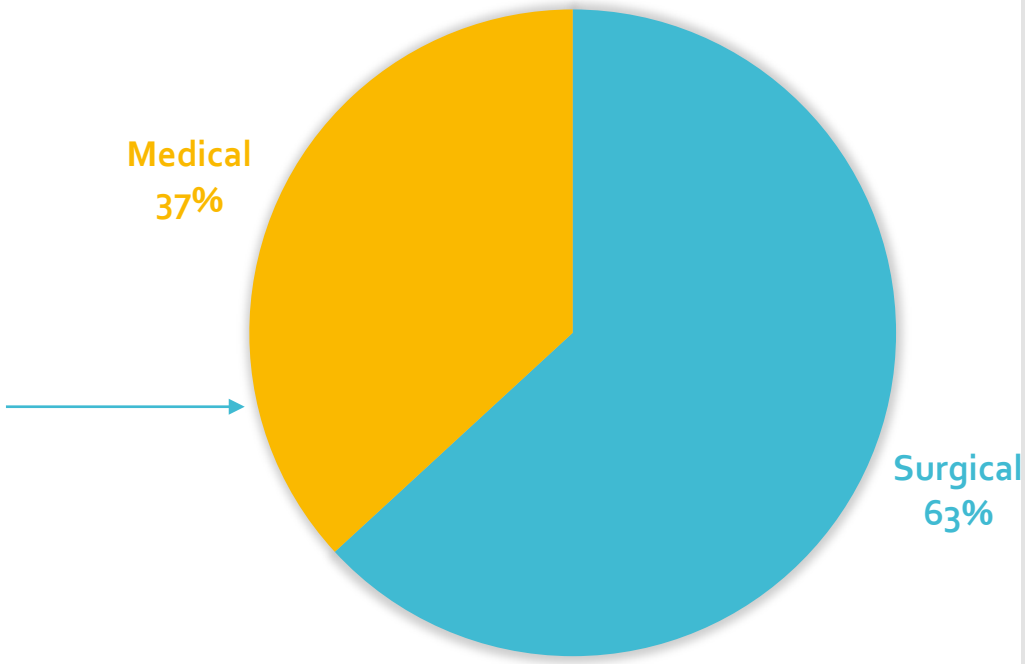
Audience poll

- Who has received training in medication abortion (MAB)?
- Who has prescribed MAB?

Canadian Context

- 1 in 3 Canadian women will have an abortion in her lifetime[1]
- CIHI 2021 induced abortion data:[2]

Method of abortion	Number of induced abortions
Surgical	55,214
Medical	32,210
Total	**87,424**



History of mifepristone-misoprostol in Canada

- Mifegymiso™ (mifepristone 200 mg PO + misoprostol 800 mcg buccally) approved by Health Canada in 2016
  - Used in other countries for decades + to higher gestations
  - Initially, regulations required special registrations to prescribe by MDs/NPs & dispense, ultrasound, even watching patients take mifepristone → no longer required
- 1st-line medication abortion method by Society of Obstetricians and Gynecologists of Canada 2016 guidelines[3]
- Regina General Hospital Women's Health Centre started using in July 2017
  - Shift to over half of all abortions now medical (vs surgical, previously <10%)

Guidelines – all publicly accessible

- National Abortion Federation 2022 Clinical Practice Guidelines
- SOGC pandemic medication abortion guidelines
- SOGC 2016 medication abortion guidelines

Universal coverage = covered for anyone with valid local provincial/ territorial health card

Covered by many provincial plans, NIHB and many private plans as well

MIFEGYMISO: ACCESS AND COVERAGE IN CANADA

ACCESS

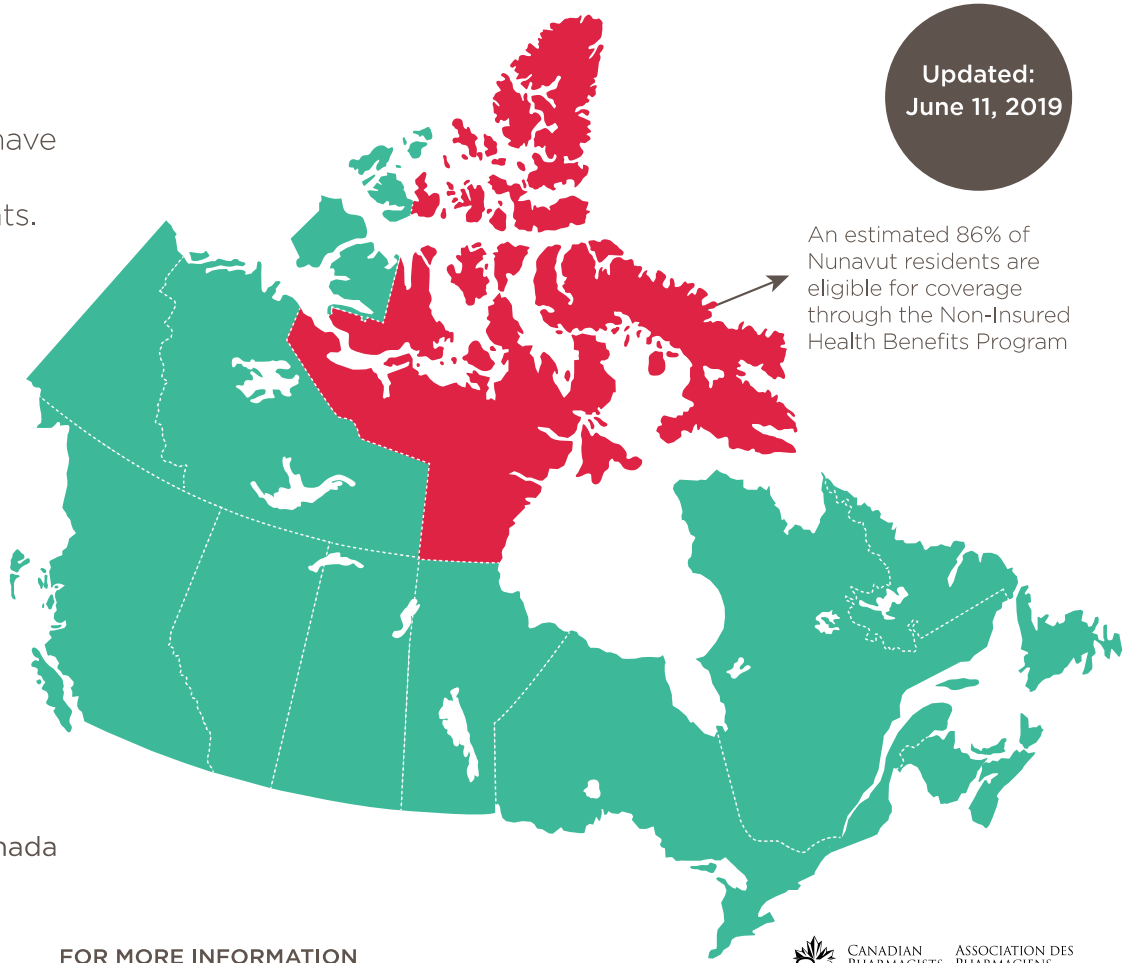
Since November 7, 2017 all pharmacists across Canada have been authorized to dispense Mifegymiso directly to patients.

PROVINCIAL/TERRITORIAL COVERAGE

- Universal Coverage
- No coverage

NATIONAL COVERAGE IS LIMITED TO:

- Non-insured Health Benefits Program
- Interim Federal Health Program
- Canadian Forces Health Services
- Programs for Correctional Services of Canada

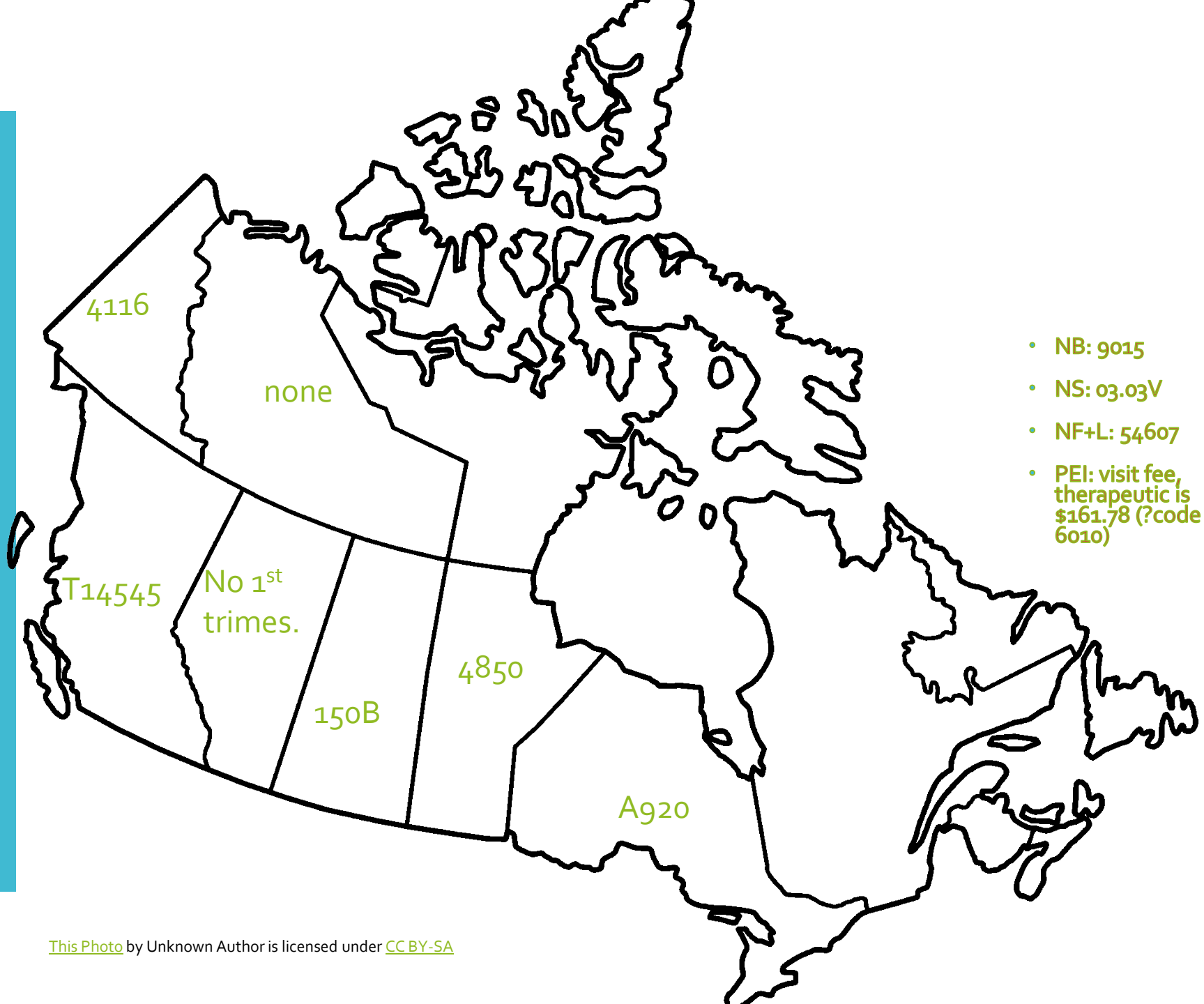


Adapted with permission from the Canadian Abortion Providers Support

FOR MORE INFORMATION
www.pharmacists.ca

Canadian Pharmacists Association / Association des Pharmaciens du Canada

Billing codes for MAB across Canada



- NB: 9015
- NS: 03.03V
- NF+L: 54607
- PEI: visit fee, therapeutic is $161.78 (?code 6010)

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General mifepristone/ misoprostol background

Table 1: Efficacy of mifepristone 200 mg orally and misoprostol regimens by weeks (18, 22, 23, 43)

	Overall efficacy	Ongoing pregnancy
57-63 days gestation		
○ Misoprostol 800 mcg buccal x 1 dose	93.5%	3.1%
64-70 days gestation		
○ Misoprostol 800 mcg buccal x 1 dose	92.3%	3.6%
○ Misoprostol 800 mcg buccal q 4 hours x 2 doses	99.6%	0.4%
71-77 days gestation		
○ Misoprostol 800 mcg buccal x 1 dose	86.7%	8.7%
○ Misoprostol 800 mcg buccal q 4 hours x 2 doses	97.6%	1.6%

- 97% effective to 9 weeks
- 93% effective 9-10 weeks – 99.6% with 2nd dose misoprostol
- Methotrexate-misoprostol (previously used) only 90% effective to 8 weeks
- Low complication rates[5-7]
  - Excessive bleeding: 0.14-1.95%
  - Infection: 0.22-2.6%
  - Blood transfusions: 0.09-0.71%
  - Emergency department visits: 0.87%

^ NAF clinical policy guidelines, 2022

When to select MAB vs surgical abortion

Medication abortion advantages • Private • Avoids surgery • Some people perceive as more "natural", like a miscarriage • >95% successful (with mifepristone-misoprostol)	Surgical abortion advantages • Complete in 1 day • Avoids follow up bloodwork and appointments/phone calls • >99% successful
Medication abortion disadvantages • Takes longer • More follow-ups: visits/phone calls, labwork • Patients are alone at home, with no healthcare provider directly monitoring symptoms	Surgical abortion disadvantages • Risks of conscious sedation and uterine perforation • Less private

See list of abortion centres: Abortion Rights Coalition of Canada @ http://www.arcc-cdac.ca/list-abortion-clinics-canada.pdf

Assess gestational age & need for U/S

Mife/miso does NOT terminate ectopic pregnancies!

- LMP!
  - Unsure → U/S
  - Sure → may consider medication abortion without U/S
  - Needs U/S if:
    - Ectopic symptoms
    - Ectopic risk factors
      - Past ectopic
      - Pregnancy conceived w/ IUD in situ
      - Hx pelvic inflammatory disease/salpingitis
      - Hx tubal ligation or other tubal surgery
    - Using hormonal contraception @ conception
    - Breastfeeding @ conception
    - Pregnancy conceived w/ assisted reproductive technology

PUL on U/S

- **Pregnancy of unknown location** (PUL): ultrasound does not meet criteria for intrauterine pregnancy (no yolk sac or fetal pole), with no clear signs of ectopic pregnancy.
  - Differential diagnosis
    - Ectopic pregnancy (overall <1% of pregnancies in patients presenting for induced abortion)
    - Early intrauterine pregnancy (too soon for visualization on transvaginal U/S)
    - Failing intrauterine pregnancy
- Abortion care should be offered without delay (per SOGC and National Abortion Federation Guidelines) even if pregnancy location is uncertain
  - Asymptomatic/stable patient → advise re: RTC signs, consider a sooner serum beta, and proceed

Rule out contraindications to mifepristone/ misoprostol

Absolute contraindications	Relative contraindications
• Patient ambivalence □ Severe asthma □ Allergy to mifepristone or misoprostol □ Porphyria □ Chronic adrenal failure	□ Long-term steroid use: should be titrated up for 3-4 days post mifepristone □ Baseline Hgb <95 □ IUD in situ: must remove IUD prior to mifepristone administration □ Patient unavailable for follow-up labs or follow-up phone call/in-person visit □ Patient unable to access emergency care for 14 days after mifepristone administration

MAB baseline labs – if doing labs

- CBC
- ~~Blood group and screen (through local lab for timely result)~~
  - Most (NAF, WHO, SOGC pandemic protocol) guidelines recommend no Rh testing or WinRho administration in 1st trimester medication abortion
    - Evidence of minimal fetal alloimmunization
- Baseline serum BhCG (to be done 72 h or less before patient takes mifepristone)
- HIV screen, Hep B surface Ab and Ag, Hep C screen, syphilis, chlamydia, gonorrhea
  - Also consider rubella screen and ensuring Pap smear is up to date

How to Rx

Mifegymiso x 1 pkg:
mifepristone 200 mg PO x 1,
then misoprostol 800 mcg buccally 24-48 h later

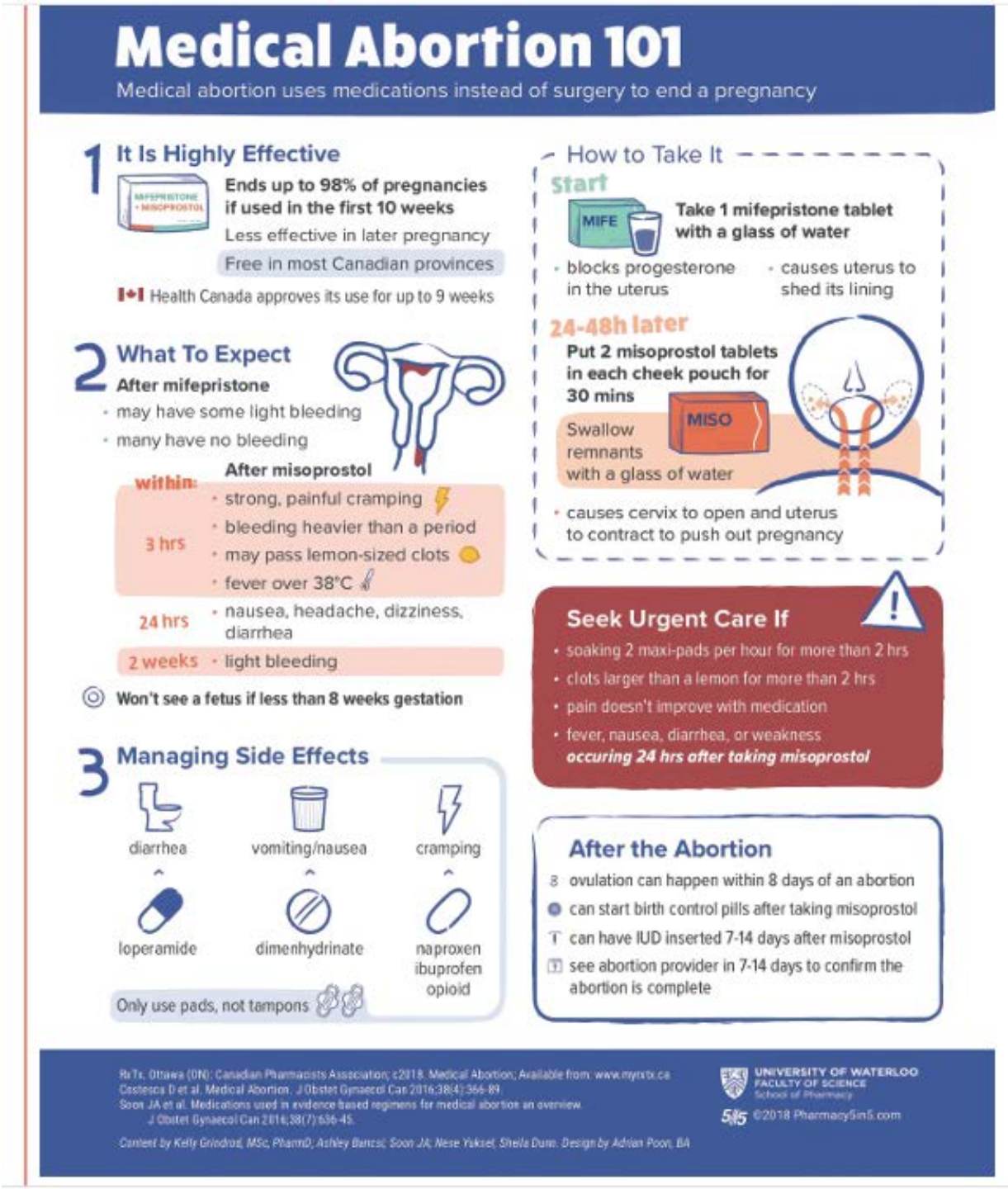
2nd dose of misoprostol 800 mcg buccally 4 h after 1st dose of misoprostol in >9 wks GA

Counsel on what to expect

- Bleeding
  - Patients should expect to bleed within 4-6 h of taking misoprostol, like a heavy period for up to 1-2 days
  - Bleeding should gradually diminish after. Bleeding is variable and can continue for up to several weeks
  - If patient soaks (front to back, side to side) more than 2 large pads per hour for >2 hours in a row, this is too much bleeding and should present to ER
    - Patients should also present to ER if they have 2-3 fist-sized clots or are feeling faint or very dizzy
- Cramping
  - Patient should expect cramping like severe period cramps
  - May be managed at home with acetaminophen, NSAIDs, heat pads

CFP 2020 infographic

Bancsi A, Grindrod K. Update on medical abortion. *Canadian Family Physician, 66:* 42-44. https://www.cfp.ca/content/cfp/66/1/42.full.pdf



Follow-up BhcG for abortion completion

7-day serum option	3-day serum option	Urine beta option

• >80% drop from baseline (taken <72 h before mifepristone administration) → abortion complete
• <80% drop → see <50% drop @ 3 days
	• >50% drop from baseline (baseline being taken 72 h or less before mifepristone) → abortion complete
	• <50% drop → reassess for signs of retained products of conception (heavy bleeding, cramping)
	  • Signs or symptoms of retained products → assess patient for medical vs elective surgical vs urgent surgical management
	  • No signs or symptoms of retained products → refer for surgical abortion or repeat MAB
		• Negative home OTC (qualitative) urine pregnancy test @ 4 weeks

F/U call/visit (2-14 days):

- Passed products of conception?
- Fever?
- Pain?
- Bleeding?
- Discharge?
- Symptoms of pregnancy resolved?
- Contraception

Contraception

- Average time to ovulate = 20 days after mifepristone
- Depo-Provera may decrease efficacy to ~95%, but adherence/satisfaction higher if give Depo day of MAB[12]
- IUDs after MAB deemed complete, ideally within 1 week
- Implant can be inserted day of mifepristone
- Generally start other methods within 1 week

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Thank you!

Any questions?

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Essential Snappers for Early Career Physicians

Medical Assistance in Dying

FMF 2023

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Faculty/Presenter Disclosure

- Faculty: Dr. Brady Bouchard
- Any direct financial relationships, including receipt of honoraria: None
- Membership on advisory boards or speakers' bureaus: None
- Patents for drugs or devices: None
- Other: None

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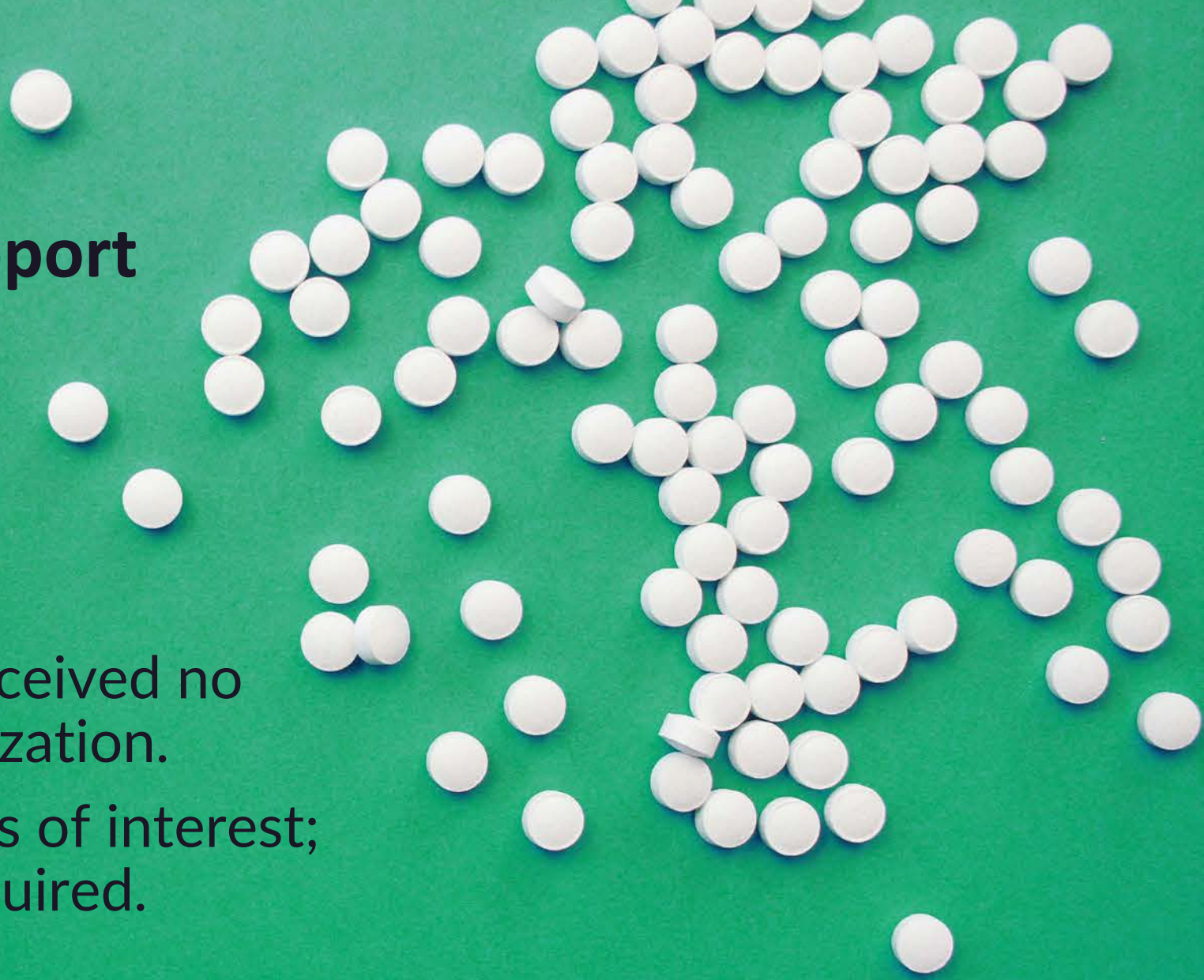

- This presentation has received no support from any organization.
- No potential for conflicts of interest; no mitigation of bias required.

Timeline

June 2016	December 2018	September 2019	October 2020	March 2021
Former Bill C-14 decriminalized medical assistance in dying (MAID) for adults with decision-making capacity who are intolerably suffering and whose natural deaths are reasonably foreseeable, following the Supreme Court of Canada's decision in *Carter v Canada*.	Reports of the Council of Canadian Academies on MAID for mature minors, advance requests and requests where mental disorder is the sole underlying condition are tabled.	Superior Court of Québec declares unconstitutional the eligibility criterion of "reasonable foreseeability of natural death." The ruling, which applies only in Quebec, was not appealed. The Court suspends the declaration of invalidity for six months (until March 11, 2020, followed by four extensions to a final date of March 26, 2021).	Re-introduction of Bill C-7, in response to Superior Court of Québec *Truchon* decision. C-7 was first introduced in February 2020 but progress on the bill's passage was delayed due to the pandemic and re-introduction was needed following prorogation of Parliament in August 2020.	Bill C-7 comes into force (March 17, 2021)

Canada's Framework for MAiD

- The legislation on medical assistance in dying (Bill C-7 and former Bill C-14) sets out the framework for the legal provision of MAID in Canada through a series of criminal exemptions that include **eligibility criteria**, **procedural safeguards** and through **reporting obligations**.
- Criminal exemptions apply to:
  - medical practitioners
  - nurse practitioners
  - pharmacists and pharmacy technicians or assistants
  - person who aids medical practitioner or nurse practitioner
  - other person who aids patient to self-administer substance
- The law allows for two types of MAID:
  - the administration of substance by medical practitioner or authorized nurse practitioner that causes the person's death (**clinician-administered** MAID)
  - the prescription or provision of substance by medical practitioner or authorized nurse practitioner that the person self-administers to cause their death (**self-administered** MAID)

Eligibility

1. Be eligible for government-funded health insurance in Canada.
2. Be 18 years old and have capacity.
3. Have a grievous and irremediable condition*.
4. Make a voluntary request.
5. Give informed consent.

Grievous and irremediable condition

1. Have a serious illness, disease, or disability (excluding a mental illness until March 17, 2024)
2. Be in an advanced state of decline that cannot be reversed
3. Experience unbearable physical or mental suffering from an illness, disease, disability, or state of decline that cannot be relieved under conditions that the person considers acceptable.

Bill C-7

Main elements of the legislation:

Eligibility criteria

- Removal of RFND
- Exclusion of Mental illness (time–limited)

Procedural Safeguards — RFND

- Waiver of final consent

Procedural Safeguards — non-RFND

Monitoring of MAID

Two Tracks

- **RFND:** Requirements eased (no 10 day waiting period), one witness, WFC.
- **Non-RFND:** Ensures reasonable time and expertise to access these cases.

Safeguards
Both Tracks

- Request must be in writing and witnessed (x1).
- Two independent assessors.
- Pt. must be informed they can withdrawal consent at any time, in any manner.
- Must be given the opportunity to withdraw consent **AND** must expressly confirm their consent immediately prior to administering MAiD.

Safeguards
Non-RFD (Track 2)

- Two independent assessors (one must be an **expert** in the condition).
- **Alternatives:** Pt. must be informed of available and appropriate means to relieve their suffering.
- **Consideration:** All (assessors and pt.) need to agree that you've seriously considered alternatives.
- **Wait 90 days** (unless at risk of losing capacity).
- **No WFC**.

Waiver of Final Consent

Or, Advanced Consent Arrangement

- Must be RFD.
- Must be scheduled.
- Must be informed they're at risk of losing capacity.
- Gives consent in writing in advance.
- *Even then only applies if capacity is lost.*

https://www.justice.gc.ca/eng/csj-sjc/pl/ad-am/c7/toc-tdm.html

Caveats

- WFC is **not an advanced directive**.
- There is no legal means to describe a future state in which you would want MAiD.
- *In Quebec, Bill 11 (June 2023) allows 24 months' notice (but is illegal under the Criminal Code; court challenge to inevitably come).*

Resources

- Canadian Association of MAiD Assessors and Providers (CAMAP) – Clinician Resources
- CAMAP MAiD Curriculum (81 Mainpro+ Credits)

Thanks!

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Short Snappers: Choosing a Practice

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Dr Kiran Dhillon, MD, MEd, CCFP

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Presenter Disclosure

Presenter: Dr Anna Schwartz

Relationships with financial sponsors:

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- Patents for drugs or devices: None
- Other: None

Presenter Disclosure

Presenter: Dr Kiran Dhillon

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- Patents for drugs or devices: None
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Potential for conflict(s) of interest:
None.

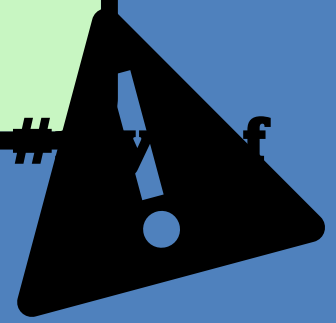
Choosing a Practice… So Many Options!

1. Urban vs Rural vs Remote
2. Solo vs Group
3. General vs Focused
4. Clinic vs Alternative vs Combination
5. Fixed Overhead vs Percentage
6. Payment Models: Fee For Service vs Salaried vs Combination

“Try before you buy”

Thank you!

Please fill out your session evaluation now!



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