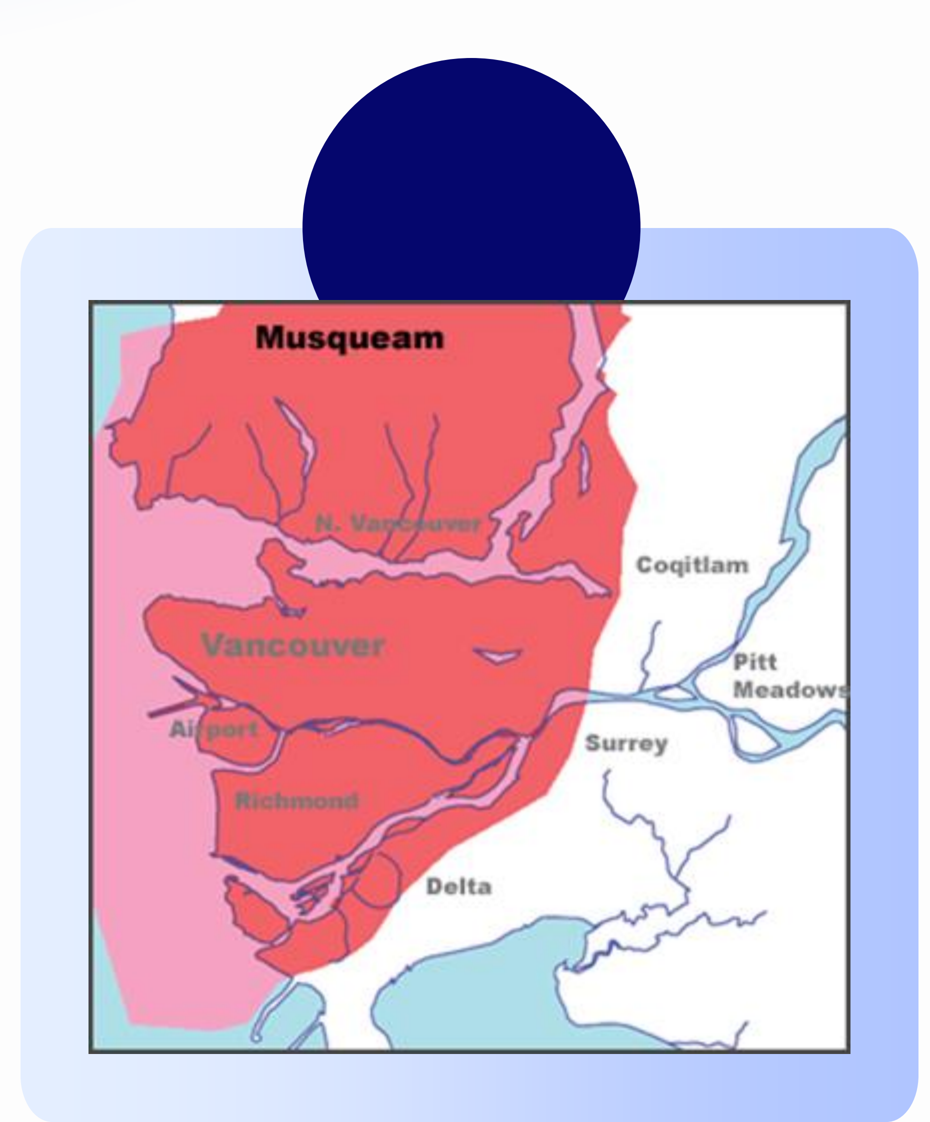
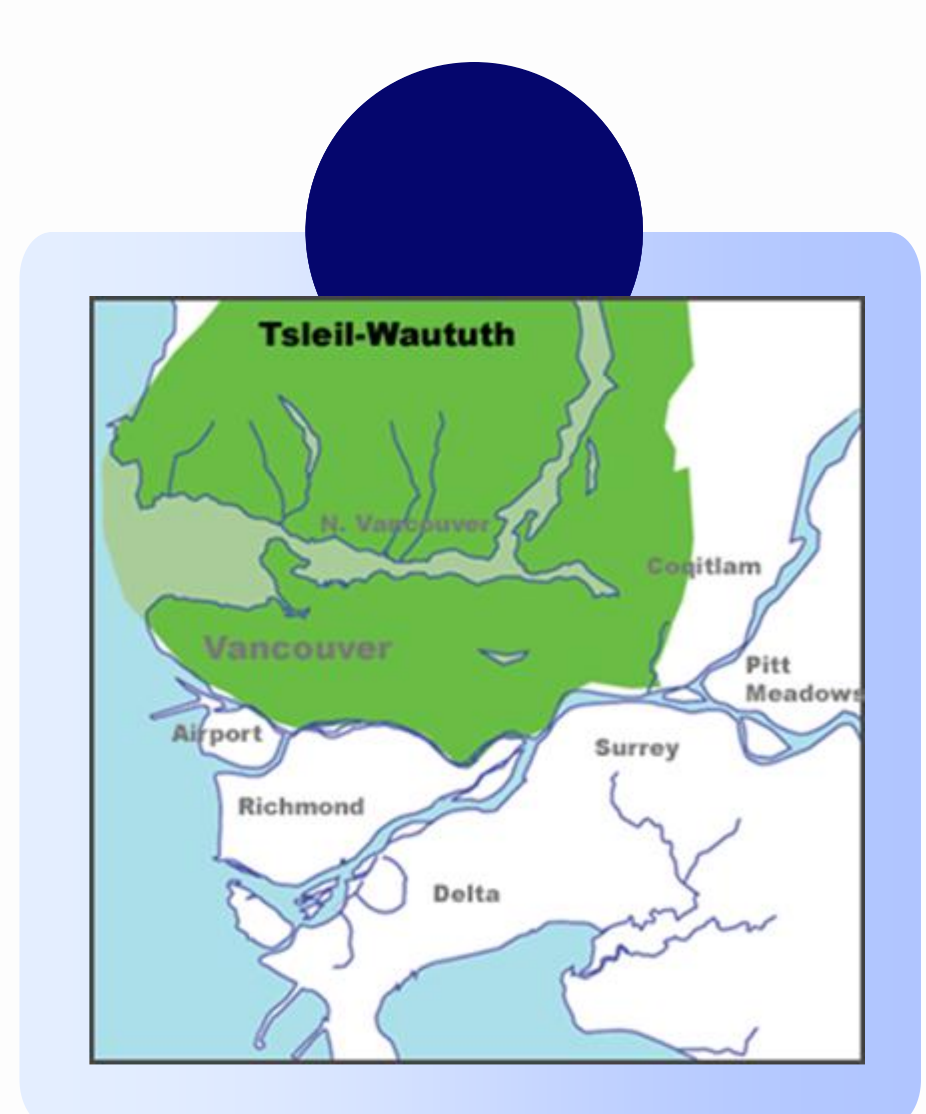
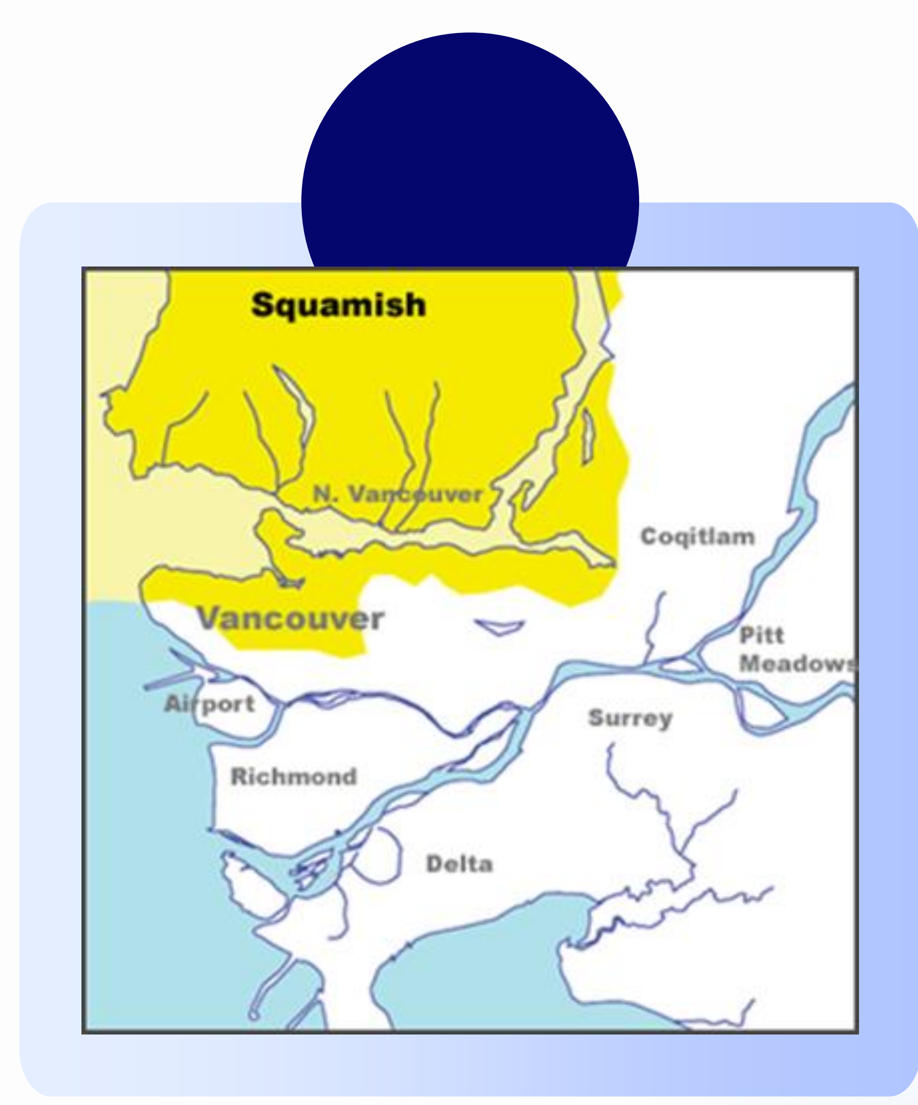
Medication Abortion Updated Guidance and Resources for Practice

Sheila Dunn, MD, CCFP(EM), FCFP
Regina Renner, MD, MPH, FRCPC
Renée Hall, MD, CCFP, FCFP

Land Acknowledgement







We would like to respectfully acknowledge that we are gathered today on the traditional, unceded territories of the Musqueam, Squamish and Tsleil-Waututh peoples. We would like to offer our gratitude to the First Nations for their care for, and teachings about, our earth and our relations. May we honour those teachings.

Conflict of Interest Disclosure

Associate Professor, Dept of Family and Community Medicine, U of T

Dr. Dunn has received research support from U of T and Women's College Research Unit. She has no conflicts to declare.

Clinical Professor, Dept OBGYN UBC

Dr. Renner has no conflicts to declare

Clinical Associate Professor, UBC
Co-Medical Director Willow Reproductive Health Centre

Dr. Hall has been on advisory boards for and/ or received speaking honoraria from Bayer, Organon, Searchlight, Merck & Aspen

Mitigation of Conflicts of Interest

- This topic is not specifically related to the members of industry listed
- No funding, planning or organization of this presentation has been provided by industry

Learning Objectives

1. Integrate new evidence-based recommendations for mifepristone-misoprostol abortion up to 10 weeks gestation into practice

2. Assess pregnant patients for suitability for low - or/ no touch medication abortion

3. Use newly developed clinician and patient-facing information tools, and clinical mentorship to support abortion care.

Outline

01 Introduction

02 Medication Abortion Overview

03 Low and No Touch Protocols

04 Case Discussions

05 Resources and Tools for Your Practice

06 Final Thoughts and Questions

Introduction: Transformation in Abortion Care

1969

- Abortion legalized for life and health of the woman

1988

- Abortion decriminalized, considered a right under the Charter
- Abortions were surgical and relied on access to MD with procedural skill and a providing facility

2017

- Mifepristone available with initial restrictions on use
- By 2017 most restrictions removed and both MDs and NPs can provide

2024

- Medical abortion ≈ 40% of abortions
- Increase in community primary care and rural abortion providers
- Telemedicine and low/no touch self-managed abortion

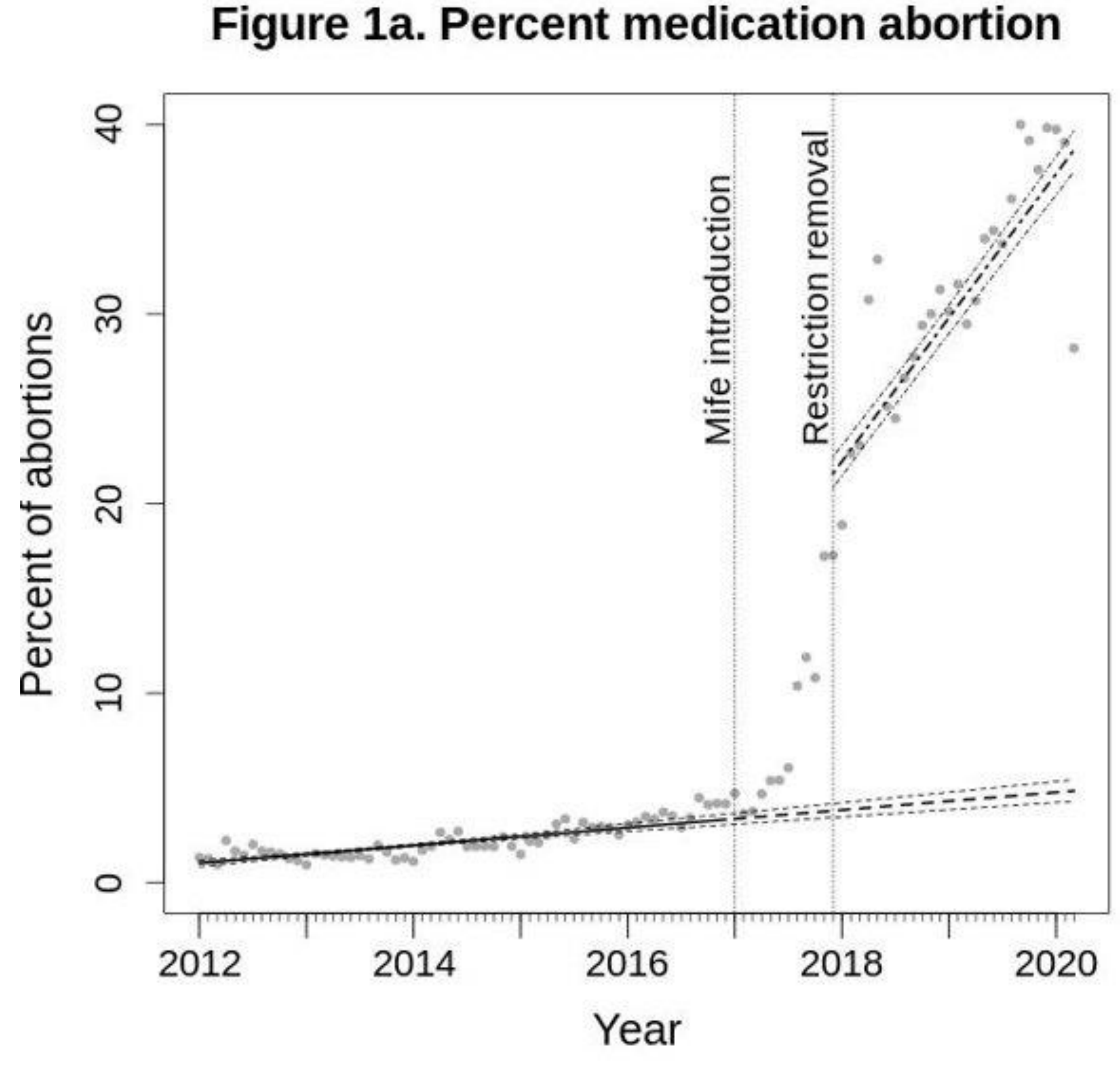
Medication Abortion is Increasing

Interrupted time-series of all abortions in Ontario 2012-2020

- MA increased from 2.2% of all abortions to over 30% and was 40% by the end of the study

- Abortion rate did not change

- CIHI 2022 Canada-wide data MA was 40% of all abortions



Schummers et al. Abortion safety and use with normally prescribed mifepristone in Canada. NEJM 2022

Canadian Institute for Health Information. [Induced abortions in Canada]

Family Physicians are The Largest Providers of Abortion

Canadian Abortion Provider Survey (CAPS) Renner R, et al. CMAJ Open 2022

Survey of 465 abortion providers across Canada about practice in 2019

- Respondents reported providing approximate ½ of estimated abortions in Canada
- 28% were medication abortions (MA)
- 44% of abortions in rural areas were medical vs 26% in urban areas

- Primary care clinicians provided 71% of all abortions and 98% offered MA and 70% exclusively MA
- Most were community based and took up abortion practice in past 5 years
- NPs provided 2.4% of all MAs
- Median # of MAs was 5 for rural and 10 for urban PCPs

Ennis M, et al. Provision of first-trimester medication abortion in 2019: Results from the Canadian abortion provider survey. Contraception 2022

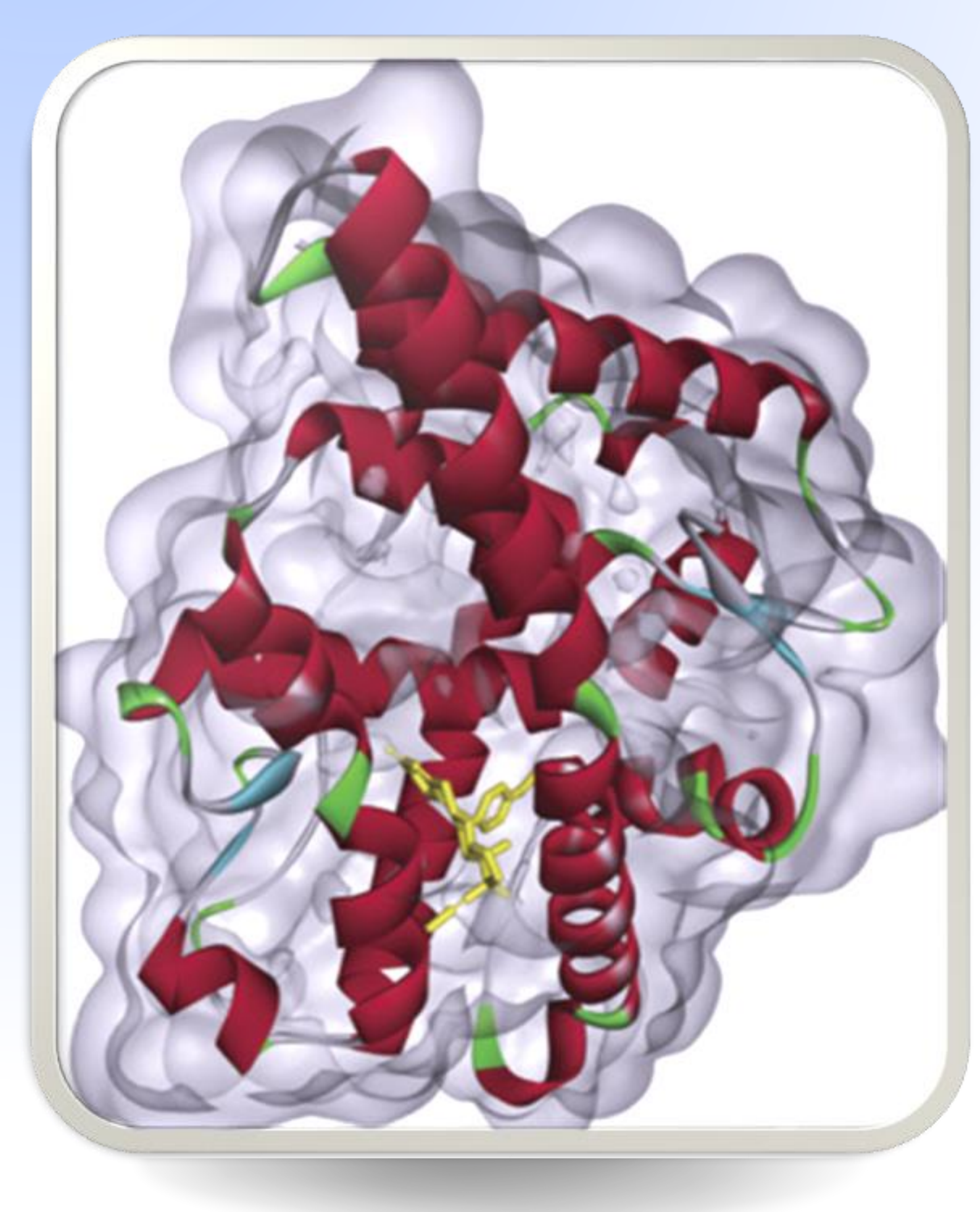
Medication Abortion

OVERVIEW

Medical Abortion Evidence Based Regimens

Regimens	Success Rate (%)	Advantages/ Disadvantages	Gestation Age Limit
Mife/miso Mife 200 mg PO Miso 800 mcg PV, Buccal, or SL 24-48hrs later	95-99%	Less time to completion, fewer side effects, but higher cost	70 days (Health Canada: 63 days)
MTX/miso MTX 50mg/m2 IM Miso 800 mcg PV 1-7 days later x 2	81-96%	Low cost and readily available but longer time to completion	63 days
Miso only Miso 800 mcg PV or SL q3hrs x 3 doses	84-85%	Low cost and readily available but less effective	63 days

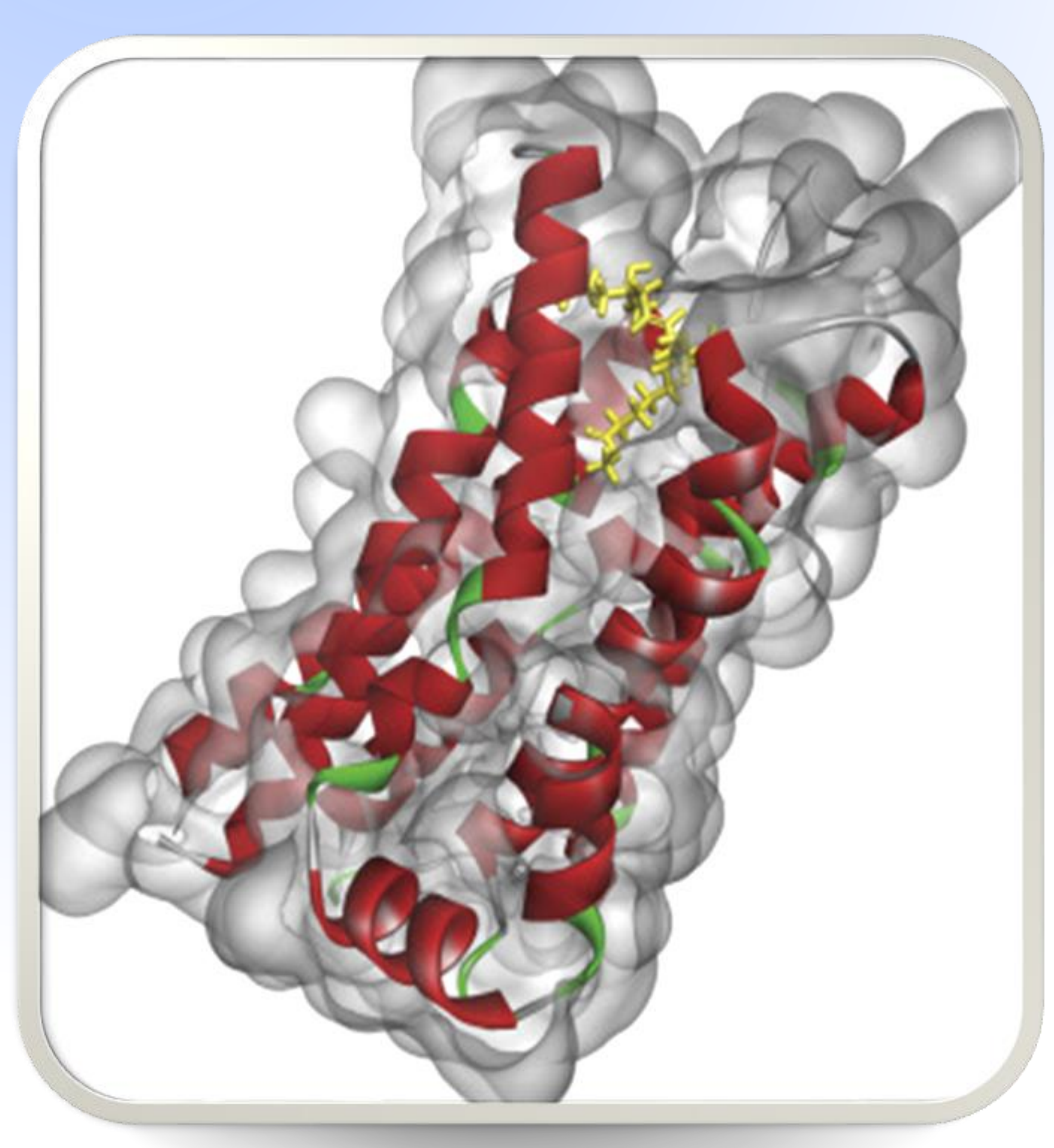
Soon JA, Costescu D, Guilbert E. Medications used in evidence-based regimens for medical abortion: an overview. Journal of Obstetrics and Gynaecology Canada. 2016 Jul 1;38(7):636-45.



Mifepristone

- Antiprogestin with antiglucocortoid properties
- Rapidly absorbed, terminal half life 18 hours
- Mechanisms of action:
  - Blocks the action of progesterone
  - Induces uterine contractility
  - Causes decidual necrosis
  - Cervical ripening
  - Increases the sensitivity of the uterus to prostaglandins
- Does not work directly on the trophoblast (like methotrexate)

Soon JA, Costescu D, Guilbert E. Medications used in evidence-based regimens for medical abortion: an overview. Journal of Obstetrics and Gynaecology Canada. 2016 Jul 1;38(7):636-45.



Misoprostol

- Synthetic prostaglandin analog
- Peak levels in 80 mins, half life 20-40 mins
- Peak uterine activity after 4 hours
- Mechanism of action:
  - Causes uterine contractions
  - Can be used buccally, vaginally, or sublingually
  - Less effective orally (swallowed)
  - Causes expulsion of products of conception

Soon JA, Costescu D, Guilbert E. Medications used in evidence-based regimens for medical abortion: an overview. Journal of Obstetrics and Gynaecology Canada. 2016 Jul 1;38(7):636-45.

Indications

- Product monograph:
  - Mifegymiso is indicated for pregnancy termination up to 63 days
  - No absolute lower gestational age limit
- Robust data supporting its use as an effective regimen up to 70 days
- Used for missed abortion and second trimester cervical prep also

Hsia, Jennifer K., et al. "Medical abortion with mifepristone and vaginal misoprostol between 64 and 70 days' gestation." *Contraception* 100.3 (2019): 178-181
Mifegymiso Product Monograph Dec 2022 revision

Contraindications

- Known or suspected ectopic pregnancy
- Uncontrolled asthma
- Anemia (Hgb <95 - relative contraindication)
- IUD in place – remove first
- Inherited porphyria
- Long term systemic corticosteroid use
- Chronic adrenal failure
- Hemorrhagic disorder and concurrent anticoagulant use
- Hypersensitivity to mifepristone or misoprostol

Mifegymiso Product Monograph Dec 2022 revision

Rates of Ongoing Pregnancy

Gestational age	Ongoing pregnancy
22-28 days	0.72%
29-35 days	0.46%
36-42 days	0.16%
43-49 days	0.27%
50-56 days	0.73%
57-63 days	1.63%
64-70 days	3.0%
Overall	**0.5%**

- Overall rate of major congenital malformations was 4.2%

Gatter, M et al. "Efficacy and safety of medical abortion using mifepristone and buccal misoprostol through 63 days." *Contraception* 91.4 (2015): 269-273.
Winikoff, B et al. "Extending outpatient medical abortion services through 70 days of gestational age." *Obstetrics & Gynecology* 120.5 (2012): 1070-1076.

Administration

For medical abortion <u>less than 9w 0d</u>

Day 1: Mifepristone 200mg PO

Day 2-3:

(24-48 hrs) Misoprostol 800 mg pv or buccally

Day 7-14: Follow-up to verify complete expulsion

Day 3+:

Rx Miso 800 mg prn if little to no bleeding

Administration

For medical abortion <u>greater than 9w 0d</u>

Day 1: Mifepristone 200mg PO

Day 2-3: (24-48 hrs) Misoprostol 800 mg pv or buccally

Day 7-14: Follow-up to verify complete expulsion

Repeat Miso 800 mg after 4h (buccally if bleeding)

Administration

For <u>non-viable</u> pregnancy

Day 1: Mifepristone 200mg PO

Day 1-2:

(7-20hrs)

Misoprostol 800 mg pv or buccally

Day 7-14: Follow-up to verify complete expulsion

Day 3+:

Rx Miso 800 mg prn if little to no bleeding

Waiting 24 hours may not provide additional benefit

Medical vs Surgical

Medical Abortion	Surgical Abortion
Can be done on surgically difficult cases	**Can be done on medically difficult cases**
Usually heavy cramping/heavy bleeding	Usually little bleeding/cramping
Highly effective (>95%)	Highly effective (>99%)
Infection rate 0.18%	Infection rate 0.5%
Up to 63 days (off label up to 70 days)	Into second trimester
No surgery, anesthesia or instrumentation	Can be done with anesthesia
From days to weeks	5-10 min for procedure, 1-3 hours in clinic
Need clinic then can be done at home (unless no-touch)	Need facility –time/travel cost
No requirement for another person	Facility may require someone to drive you home
Two or more contacts with provider, lab..	One to two in person visits
Cost of analgesia only if covered by provincial health plan	No cost if covered by provincial health plan

Addressing Expectations & Myths

- Reasons for choosing MA include
  - Avoidance of surgery and anesthesia
  - Avoidance of pain
  - Perceived safety
  - More private and more effective
  - The ability to accommodate other commitments

Medical Evaluation Prior to MA

Medical History

- Assess gestational age, exclude contraindications, determine whether additional tests are indicated (Hgb, STI)
- Consider appropriateness for MA – ability to follow up, appropriateness to abort at home, review informed consent (to be discussed)

Physical Examination

- Pelvic exam as indicated – Uterine size, STI, IUD removal

Investigations

- UPT
- STIs
- +/- Ultrasound

Laboratory

- Hgb (with history of anemia)
- BHCG

Establishing Pregnancy and Gestational Age

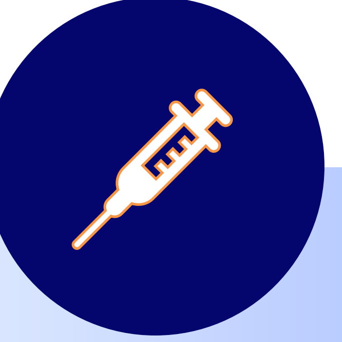
- Positive urine preg test is sufficient to establish pregnancy

Medical History

- Prospective study 4484 women - 2.4% would receive MA meds who were beyond approved GA limits

Physical Examination

- Exam found to be accurate within 2 weeks, prospective study experienced providers exam only – assess <9 week GA in 98.4%



BHCGs

- Less than 23 745 IU/L (sensitivity of 94% and specificity of 91% for < 42 days)
- Combine with history

Ultrasound

- Gold standard but evidence does not show improved safety outcomes

Costescu et al., Clinical Practice Guideline: Medical Abortion. J Obs Gyn Canada, 2016;38(4):366-69

Determining GA by History

- When was LMP?
- How regular are they? Do they track on an app?
- Was the amount of flow in LMP as they expect?
- Any bleeding since?
- Were they on hormonal contraceptive recently? Or did they take emergency contraceptive recently?
- Are they breastfeeding?
- Recent pregnancy?
- Have they had a recent negative UPT?

Pregnancy Dating

LMP dd-MMM-yyyy
GA by LMP weeks
GA by LMP days
Last Period: Normal, Abnormal
Certainty of LMP: Sure of Dates, Not Sure
Menstrual Cycle Regularity: No Periods, Regular every month, Irregular
Contraception Around Time Of Conception: None, Not required, Implant, LNG-IUS, Mirena, Kyleena, Copper IUD, OCP, POP, Patch, Vaginal Ring, Depo Provera, FAM, Withdrawal, EC, Condoms, Vasectomy, Undecided
Date of positive UPT dd-MMM-yyyy
Notes

If no further testing planned still need to check for contraindications like ectopic signs symptoms and risk factors

Range of hCG Values in Early Pregnancy

HIGH

LOW

hCG (IU/mL)

225000
200000
175000
150000
125000
100000
75000
50000
25000
0

3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18

Gestational Age (weeks)

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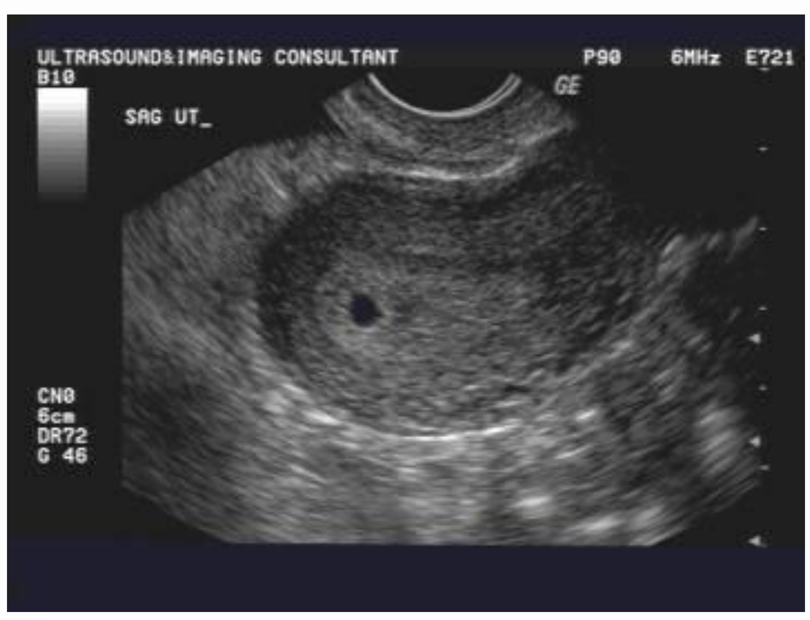
Establishing GA & Completion by BHCG

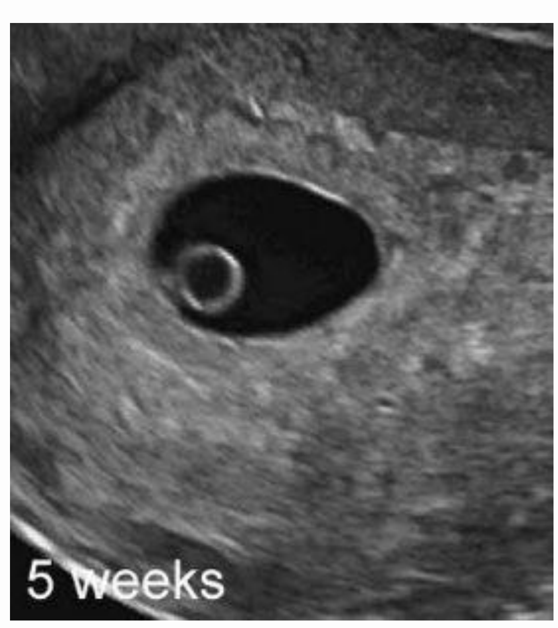
Establishing GA by Ultrasound

Not required as per NAF, SOGC, WHO

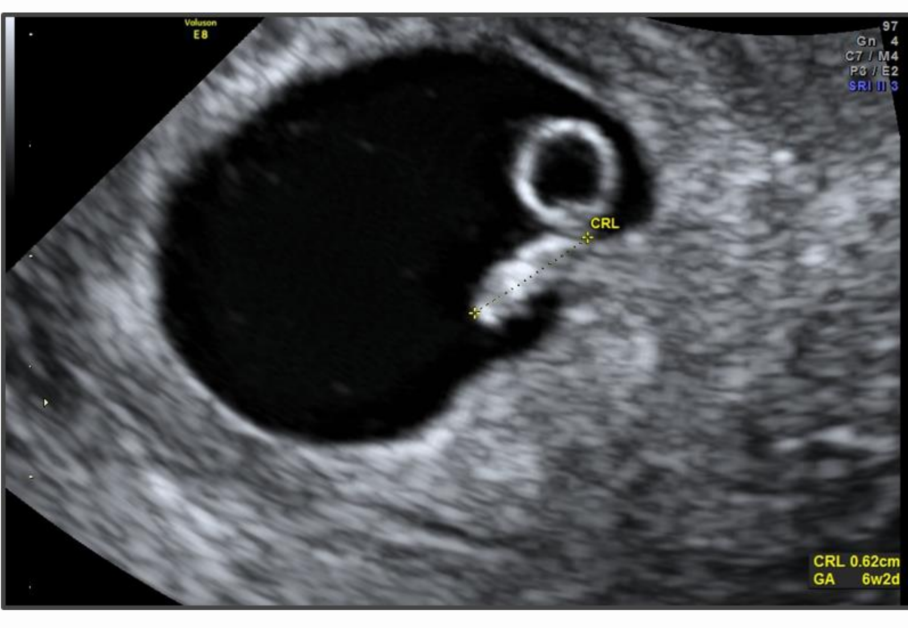
- Double layer rounded eccentric fluid filled sac
- Transvaginal can see sac by 32-33 days from LMP – BHCG >1000



- Yolk sac appears (35-42 days from LMP) – BHCG starting at 7200-10800



- Fetal pole appears at 40-49 days



Special Populations

- Asthma – uncontrolled asthma is a contraindication
  - Uncontrolled asthma: poor symptom control, frequent severe exacerbations, at least one hospitalization, airflow limitation
- Breastfeeding – continue uninterrupted
  - Mifepristone & Misoprostol excreted in breast milk in very low concentrations
  - Misoprostol theoretical potential to cause diarrhea
- Adolescents
  - The incidence of complications is similar or lower in adolescents receiving medication abortion compared to adults
- Obesity – no change in effectiveness
- Multiples – no change in effectiveness
- PUL/ectopic – to be discussed in Cases

Prophylactic Antibiotics

- NAF, ACOG, SFP, nor the WHO recommends routine prophylactic antibiotic use
- Frequency of infection is very low 0.02% in a 2009-2010 PPFA review of 233 805 MAs
- 2550 need to be treated to prevent 1 infection
- When possible, screen-and-treat preferred
- Advise patient to monitor symptoms and signs of infection

Fjerstad, Mary, et al. "Rates of serious infection after changes in regimens for medical abortion." *New England Journal of Medicine* 361.2 (2009): 145-151.

RH Testing

- Maternal fetal hemorrhage in early abortion is negligible and does not clearly correlate with alloimmunization
- NAF Clinical Policy Guidelines 2022
  - Reasonable to forego Rh testing and anti-D immunoglobulin < 12 weeks LMP for any type of abortion
- SFP Guidelines 2022
  - Rh testing and administration not recommended <12 weeks gestation for SA, MA, TA
- World Health Organization Abortion Care Guideline 2022
  - Recommend against Rh immunoglobulin administration <12 wk for MA and TA
- ACOG Dec 2024
  - Recommend forgoing testing & prophylaxis <12 weeks for MA, TA, & SA
- SOGC 2020
  - Rh testing and RhIG may be withheld for MA during the COVID-19 pandemic – < 10 wks

KEY TAKEAWAY

Many centres are forgoing RH testing and treatment up to 12 weeks

SOGC: Induced Abortion: Updated Guidance during Pandemics and Periods of Social Disruption

Counselling and Informed Consent

Key components of abortion counselling

Decision	• Offer optional decision making discussion
Consent	• Review safety, efficacy, side effects, risks and complications
Teaching	• Discuss medication administration, expectations, resources, contact information
Contraception	• Offer optional non-coercive contraceptive counselling

Informed Consent: Risks

- Retained products of conception (RPOC) - 3-5%
- Ongoing pregnancy - 0.5-1%
- Likelihood of aspiration ~ 5%
- Pelvic infection - 1% risk of infection, 0.001% risk of life-threatening infection (ex. toxic shock syndrome)
- Hemorrhage - <1% require IV fluids or a transfusion
- Mortality - 0.4/100 000

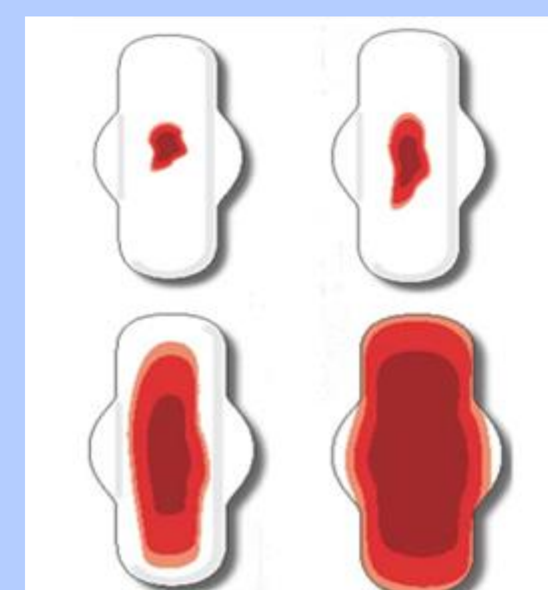
KEY TAKEAWAY

Risk of death from a full term pregnancy & childbirth is 12 x greater than the risk of death from an abortion.

Costescu D, Guilbert E, Bernardin J, Black A, Dunn S, Fitzsimmons B, et al. Medical Abortion - Journal of Obstetrics and Gynaecology Canada. Journal of Obstetrics and Gynaecology Canada. 2016 Apr 1;38(4):366–89.
Fjerstad, Mary, et al. "Rates of serious infection after changes in regimens for medical abortion." New England Journal of Medicine 361.2 (2009): 145-151

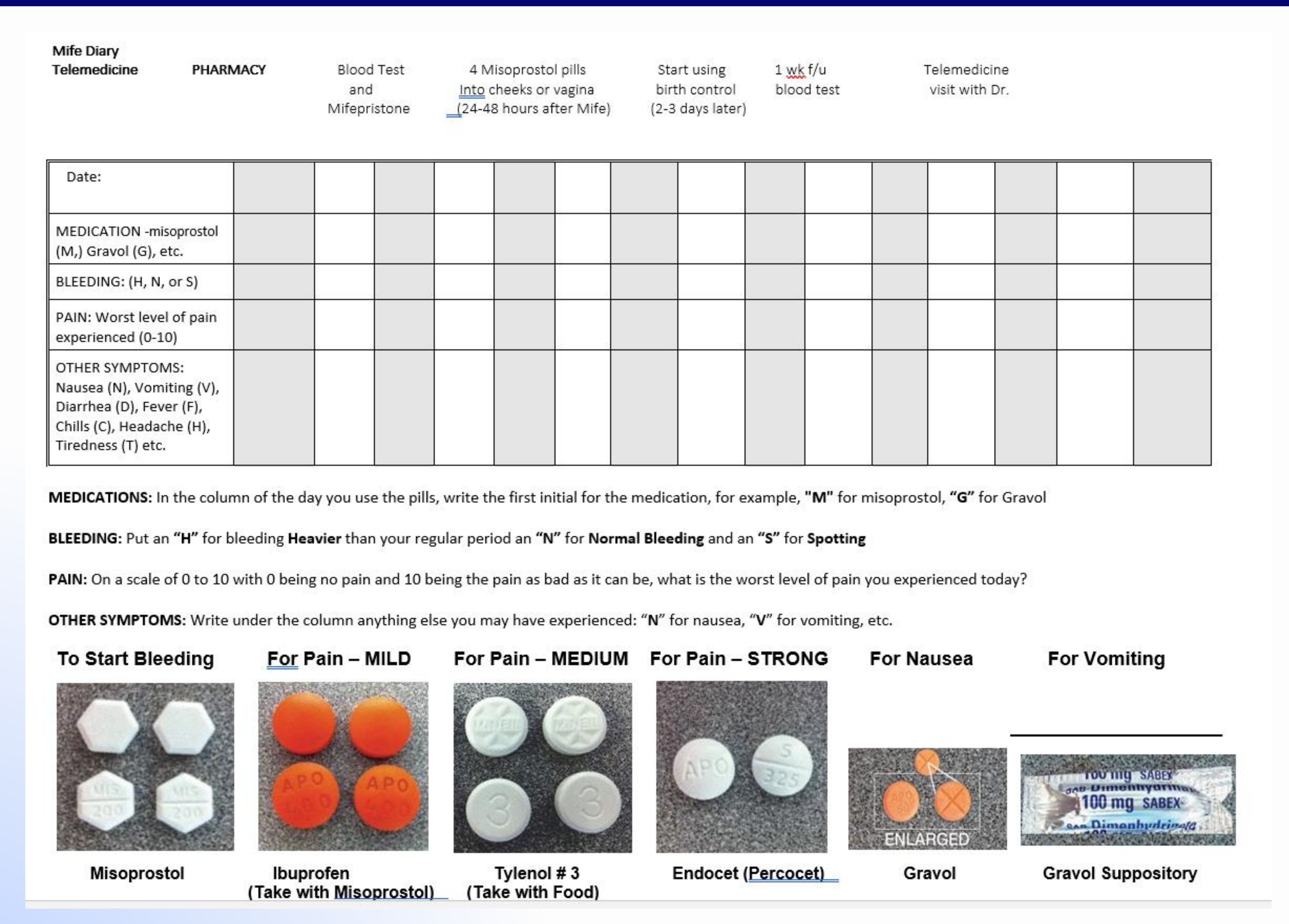
Side Effects

Patient experience can greatly vary



- Bleeding - 10-20% after mife, heaviest 2-4 hours after miso
  - When to worry: More than 2 pads an hour for two consecutive hours or dizzy, racing heart, lightheaded
- Pain
  - Non-pharmacological management - Heat, massage, shower, support
  - Pharmacological - Ibuprofen 200-800 mg every 4 to 6 hours - 30 minutes before miso or with cramping, Naproxen 500mg PO every 12 hours, add acetaminophen prn
  - Opioid analgesics - do not have good evidence to support their use
- Prostaglandin effects
  - Nausea - 30% (may also be pregnancy related) - Diarrhea - 58%, Vomiting - 21%, Mild fever or chills - 45%
  - Non-pharmacological - reassurance - self-limited often disappear day after misoprostol
  - Pharmacological - dimenhydrinate, ondansetron, or diclectin

Patient Education: Handouts and Diaries



Mife Diary
Telemedicine | **PHARMACY** | Blood Test and Mifepristone | 4 Misoprostol pills Into cheeks or vagina (24-48 hours after Mife) | Start using birth control (2-3 days later) | 1 wk f/u blood test | Telemedicine visit with Dr.

Date:															
MEDICATION -misoprostol (M,) Gravol (G), etc.															
BLEEDING: (H, N, or S)															
PAIN: Worst level of pain experienced (0-10)															
OTHER SYMPTOMS: Nausea (N), Vomiting (V), Diarrhea (D), Fever (F), Chills (C), Headache (H), Tiredness (T) etc.															

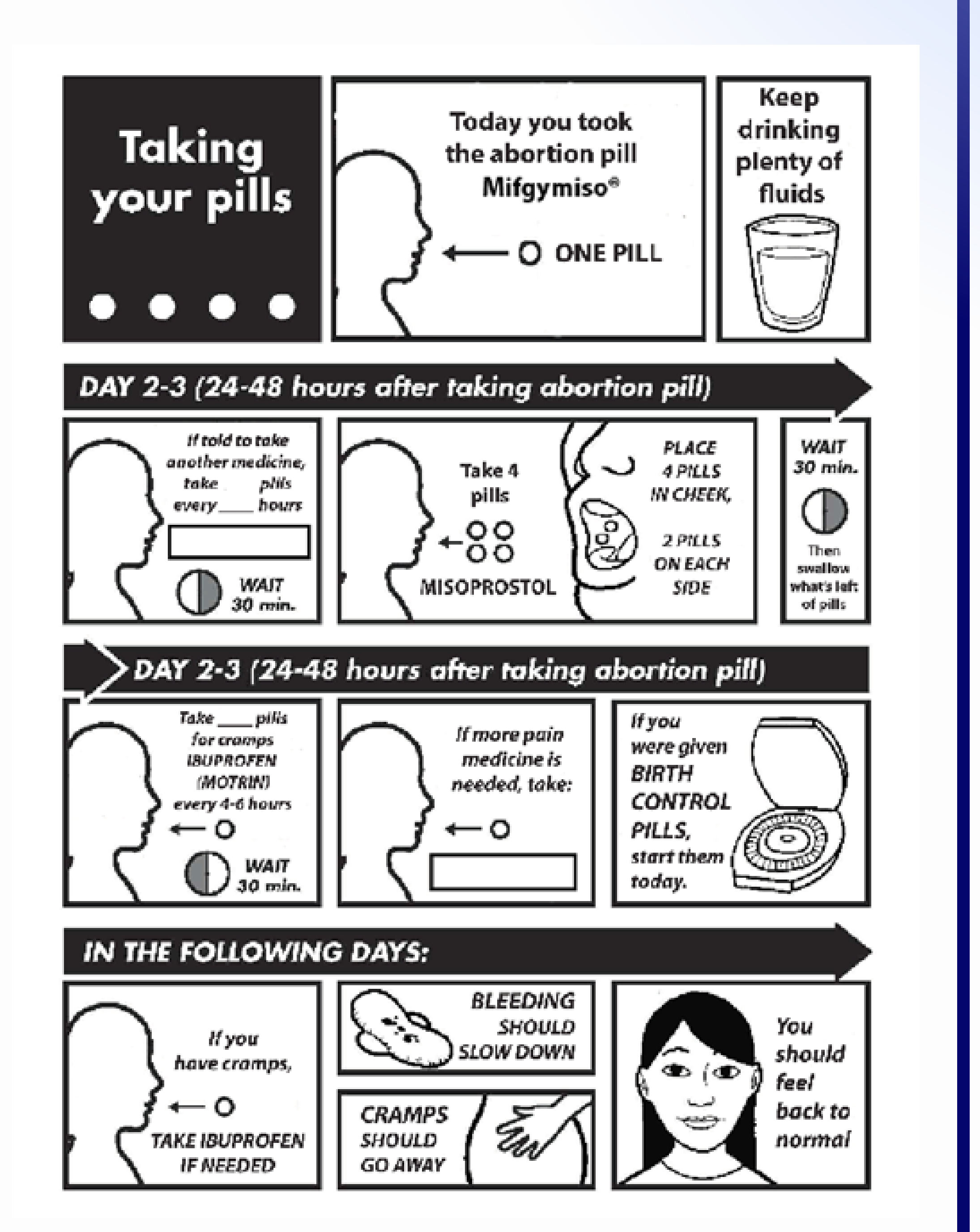
MEDICATIONS: In the column of the day you use the pills, write the first initial for the medication, for example, **"M"** for misoprostol, **"G"** for Gravol

BLEEDING: Put an **"H"** for bleeding **Heavier** than your regular period an **"N"** for **Normal Bleeding** and an **"S"** for **Spotting**

PAIN: On a scale of 0 to 10 with 0 being no pain and 10 being the pain as bad as it can be, what is the worst level of pain you experienced today?

OTHER SYMPTOMS: Write under the column anything else you may have experienced: "**N**" for nausea, "**V**" for vomiting, etc.

To Start Bleeding	For Pain – MILD	For Pain – MEDIUM	For Pain – STRONG	For Nausea	For Vomiting
Misoprostol	Ibuprofen (Take with Misoprostol)	Tylenol # 3 (Take with Food)	Endocet (Percocet)	Gravol	Gravol Suppository



On Call

KEY TAKEAWAY

Good Counseling is key to a successful medical abortion

- 24 hour coverage required
- Counselling is key
  - Helps patients anticipate symptoms decreases after hours need for advice
  - Learning curve – call volume decreases with experience in counselling
- A 3-month study of patient-initiated calls after MA found that, among 100 calls from 671 women who had undergone MA
  - 67% were considered preventable
  - Educate your on call colleagues
- Consider an in-service if others are covering

Wiebe E, Fowler D, Trouton K, Fu N. Comparing patients' telephone calls after medical and surgical abortions. Contraception 2006;73:271e3.

Confirming Completion

- Should happen 7-14 days after mifepristone
- Purpose - Confirm termination, manage complications

History & UPT

- Successful expulsion based on history is highly predictive of completion
- Urine preg test negative 4 weeks after misoprostol

- 19% have +UPT at 4 weeks in a successful MA

BHCG

- Typical follow-up 7-8 days
- Drop >80% = successful abortion
- Low levels of BHCG can be detectable up to 4-6 weeks

- BHCG timing with mife dose can make result difficult to interpret

Ultrasound

- Absence of sac provides definitive evidence of MA completion
- Useful when:
  - Outcome uncertain
  - Symptoms of concern present

- Be cautious of overdiagnosis of RPOC

Confirming Completion by History

- When did they take meds?
- Did they take extra meds?

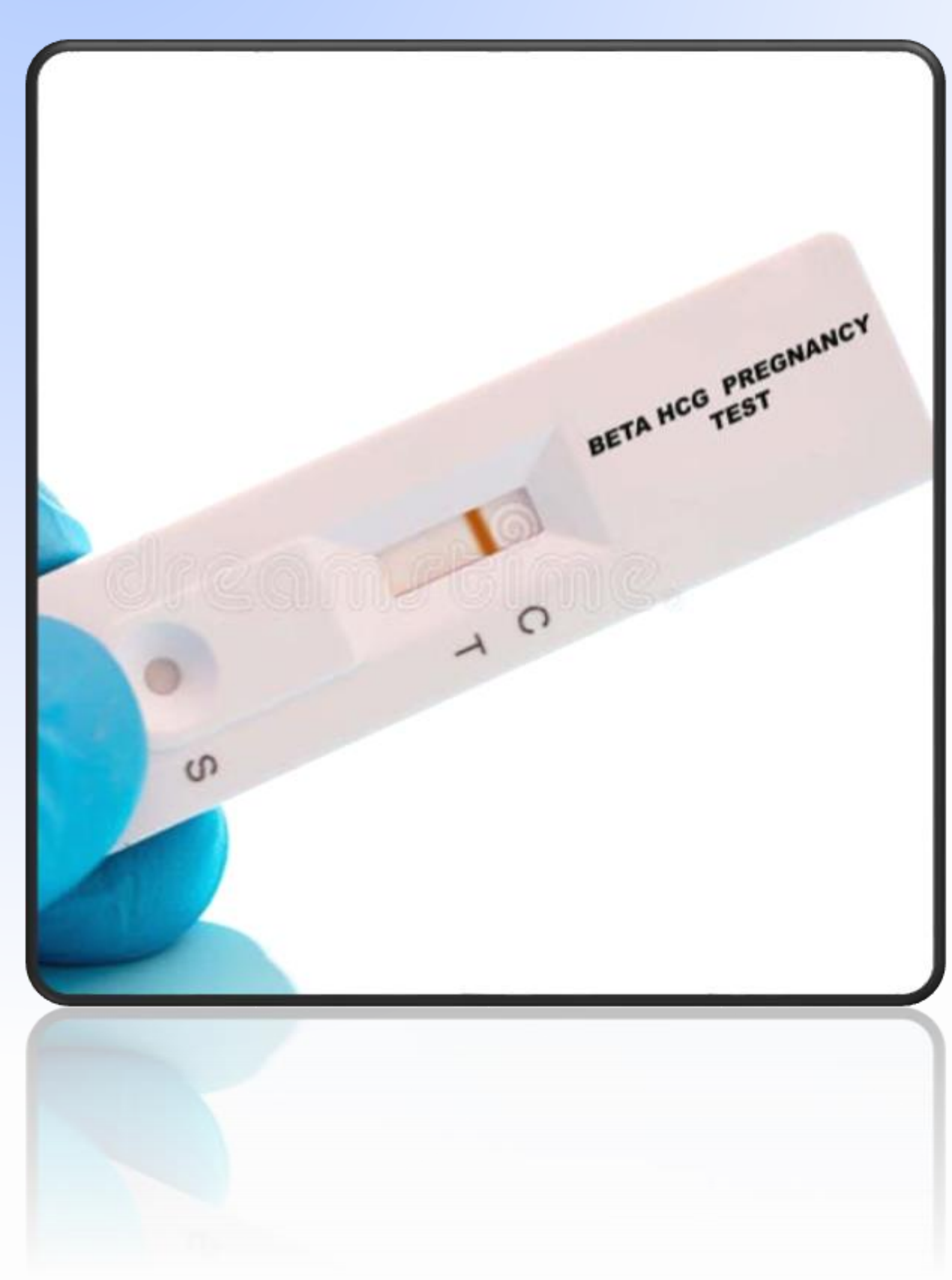
NAF MA Completion Questions

Question	Yes	No	Uncertain
Cramping/bleeding heavier than a period within 24 hrs of miso	☐	☐	☐
Patient reports bleeding lighter now than heaviest bleeding after miso	☐	☐	☐
Patient states clots/tissue passed	☐	☐	☐
Patient feels pregnancy symptoms are resolving	☐	☐	☐
Patient feels she has passed the pregnancy	☐	☐	☐

Complications Following Medical Abortion

- Ongoing pregnancy
  - Persistent cardiac activity is uncommon
  - Could consider 2nd dose miso, repeat mifegymiso entirely
  - Aspiration recommended
- Infection
  - 1.33% risk – fever or chills (more than 24 hours after miso), pelvic tenderness & pain, prolonged bleeding, elevated WBC, foul smelling d/c
  - Infections are usually polymicrobial – treatment consists of broad-spectrum therapy - see Candian STI guidelines PID
- Retained products of conception (RPOC) – To be discussed in cases

Fjerstad, Mary, et al. "Rates of serious infection after changes in regimens for medical abortion." *New England Journal of Medicine* 361.2 (2009): 145-151.



Low and No Touch Protocols

a place of mind
THE UNIVERSITY OF BRITISH COLUMBIA

A telemedicine/in-person medical abortion hybrid protocol

Regina M Renner[1,2], Madeleine Ennis[1,2], Wendy V Norman[2,3,4], Sheila Dunn[2,5], Helen Pymar[2,6], and Edith Guilbert[2,7]

Presented by: Dr. Madeleine Ennis

[1]Department of Obstetrics and Gynaecology, University of British Columbia; [2]Contraception and Abortion Research Team, Women's Health Research Institute; [3]Department of Family Practice, University of British Columbia; [4]London School of Hygiene and Tropical Medicine; [5]Department of Family and Community Medicine, University of Toronto; [6]Department of Obstetrics, Gynecology and Reproductive Sciences, University of Manitoba; [7]Department of Obstetrics, Gynecology, and Reproduction, Laval University.

Introduction

According to a series of Canadian Abortion Provider Surveys[1,2,3]:

1. First trimester medical abortions (MA) increased from 4% in 2012 to 28% in 2019 of all abortions in Canada;
2. Family physicians provided the majority of first trimester MAs (68.1% in 2019); and
3. 44% of first trimester MA practitioner respondents provided some components of care via telemedicine.

COVID-19 has been a catalyst for the development of protocols that use telemedicine to limit in-person assessment or testing for eligible medical abortion patients[4,5,6]. By late 2020, provision of telemedicine by Canadian providers had increased to 89% [7,8].

Objectives

We propose a hybrid protocol for telemedicine and in-person first trimester MA in Canada that provides guidance for clinicians providing first trimester MA.

Methods

- This protocol was developed by clinical and research experts from the Contraception and Abortion Research Team
- It was based on results from a national survey[3,8], as well as reviews of the Society of Obstetricians and Gynaecologists of Canada's low-/no-touch protocol and international literature[4]

Care for a patient who is considering a first trimester abortion[a]

Offer pre-abortion consultation either via telemedicine or in-person depending on patient preference, resource availability and accessibility of services[1,2,3]

Via telemedicine or in-person[b,c]:
Determine eligibility for MA care using mifepristone.[1,2,4]

Contraindications to MA include: suspected ectopic pregnancy, chronic adrenal failure, porphyria, uncontrolled asthma, concurrent long-term use of corticosteroid therapy, haemorrhagic disorder, concurrent anticoagulant therapy, severe anaemia, hypersensitivity to product ingredients, or ambivalence[2]

In case of contraindications, and depending on patient preference, resource availability and accessibility of services. → Explore other options, such as surgical abortion care

Via telemedicine or in-person[b,c]:
Determine eligibility for a no-test based MA approach[2,4]

Contraindications to no-touch MA include: uncertain LMP, LMP is over 70 days ago, irregular menstrual cycles, and risk factors for or symptoms/signs of ectopic pregnancy[d,1,2,4]

In case of contraindications, and depending on patient preference, resource availability and accessibility of services. → Proceed to testing[b] with ultrasound, bloodwork[f] (serum quantitative hCG, CBC[e]), and/or STI testing[1]

If patient has contraindications to MA based on results → Explore other options, such as surgical abortion care

If patient is eligible for MA based on results →

Via telemedicine or in-person[b,c]:
Provide instructions and emergency resources and assess comprehension of the process[g] AND
a) telemedicine: send prescription to local pharmacy where patient lives or mail medication to patient
OR
b) in-person: provide prescription to patient to fill at pharmacy of their choice or in case of stocking the medication dispense directly to patient.

Via telemedicine or in-person[b] follow up 2 weeks post misoprostol AND
a) high sensitivity urine pregnancy test (at home or in office) 4 weeks post misoprostol[g, h]
OR
b) testing with ultrasound or serum quantitative hCG (7-14 days) post misoprostol[g, h]

Footnotes

[a]Use a trauma-informed, culturally safe, non-racist, coercion-free and patient-centered care approach. If applicable, discuss the option of having an interpreter, spiritual guide, cultural support, knowledge keeper or other support person included in the care. Base safeguarding assessment on patient risk factors, assess for possible coercion.
[b]Base medication abortion care on clinician competence, patient preference, resource availability, and accessibility of services.
[c]If patient is interested, offer coercion-free contraceptive counselling
[d]Includes: previous ectopic pregnancy, tubal surgery, assisted reproduction techniques pregnancies, tubal ligation, intrauterine device/system presence, history of salpingitis or pelvic inflammatory disease, abdominal pain, and vaginal bleeding.[9,10,4]
[e]Complete blood count is required if suspected severe anaemia or hemoglobinopathy. If measured, hemoglobin should be over 9.5 g/dl before starting MA[4]
[f]Rhesus (Rh) status can be considered if not documented elsewhere (e.g. donor card, previous results) AND if patient would accept Rh immunoglobulins: according to current evidence, Rh testing is required when gestational age (GA) is over 56 days.[12,13] However, during the COVID-19 pandemic, expert opinion recommends that Rh testing may be withheld up to 70 days GA.[4]
[g]Further follow-up and testing as clinically indicated
[h]Implant or intrauterine device/system insertion if requested by patient
MA: medical abortion; LMP: last menstrual period; hCG: human chorionic gonadotropin; CBC: complete blood count; STI: sexually transmitted infection

Discussion

Our protocol:

- Comprehensively includes an algorithm for safe low-/no-touch/test care and in-person care
- Describes triaging patients to either pathway based on multiple factors (e.g. clinical indications and patient preference)
- Is applicable to a variety of resource settings and includes details on decision-making about testing (e.g. ultrasound) as well as surgical management alternatives
- Promotes trauma-informed, culturally safe and coercion free care
- Has the potential to improve equitable access to high quality first trimester MA, and decrease rural-urban disparities

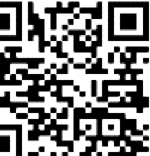
References

(1) Norman et al. 2016. CFP. (2) Guilbert et al. 2016. CFP. (3) Renner et al. 2022. CMAJ Open. (4) Guilbert et al. 2020. SOGC. (5) Upadhyay et al. 2020. Contraception. (6) Aiken et al. 2021. BJOG (7) Ennis et al. 2021. Family Practice. (8) Renner et al. 2022. Telemed J E Health. (9) Costescu et al. 2016. SOGC. (10) Costescu et al. 2020. SOGC. (11) First Nations Health Authority. 2020. FNHA (12) Mark et al. 2019. Contraception. (13) National Abortion Federation. 2020. NAF

Acknowledgement

We thank the Canadian Institutes of Health Research for funding this study. In kind support was provided by the Women's Health Research Institute of British Columbia Women's Hospital, British Columbia Women's Hospital, the Society of Obstetricians and Gynecologists of Canada and the Canadian Nurses Association.

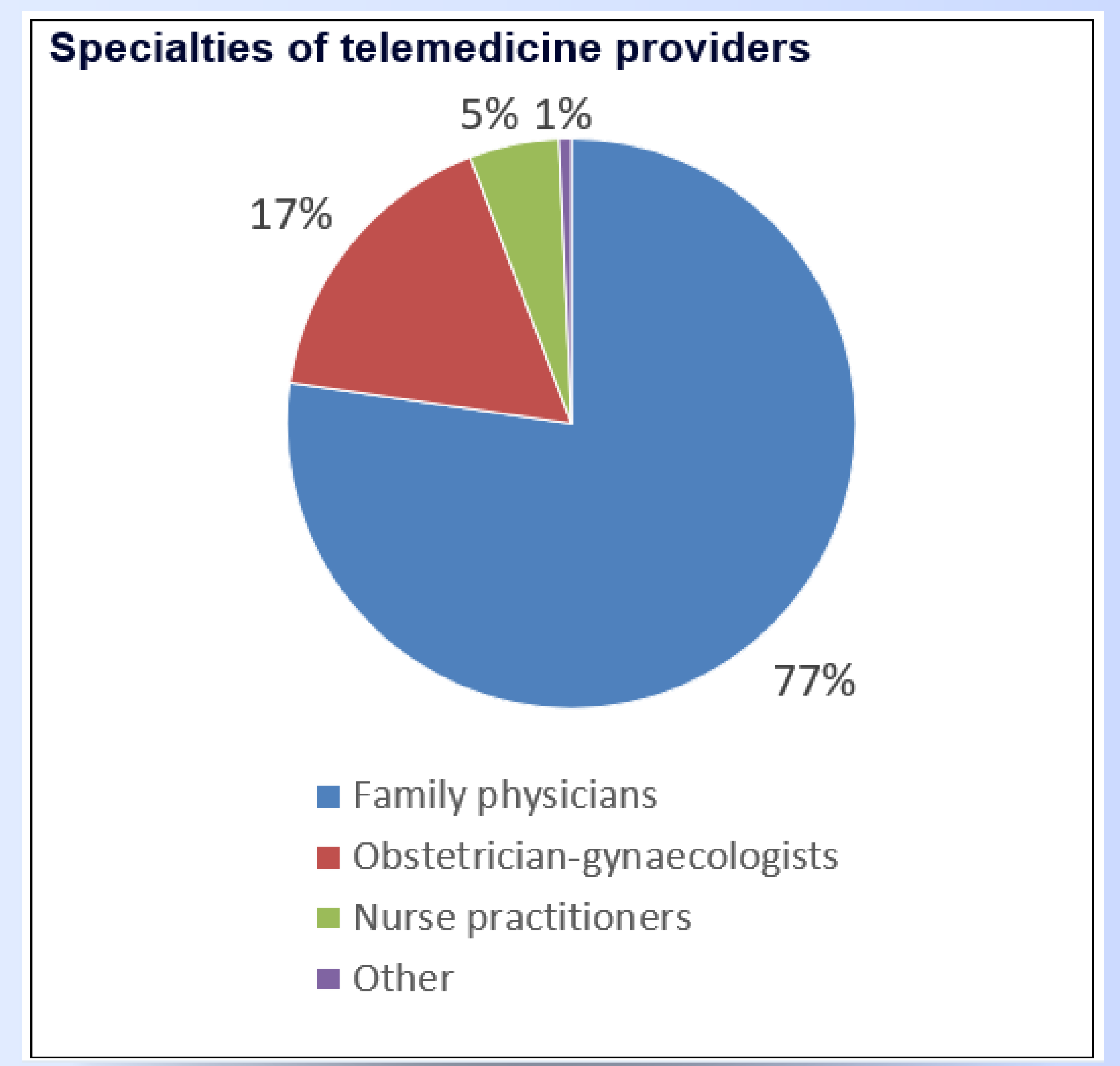
For more information on the abortion provider survey

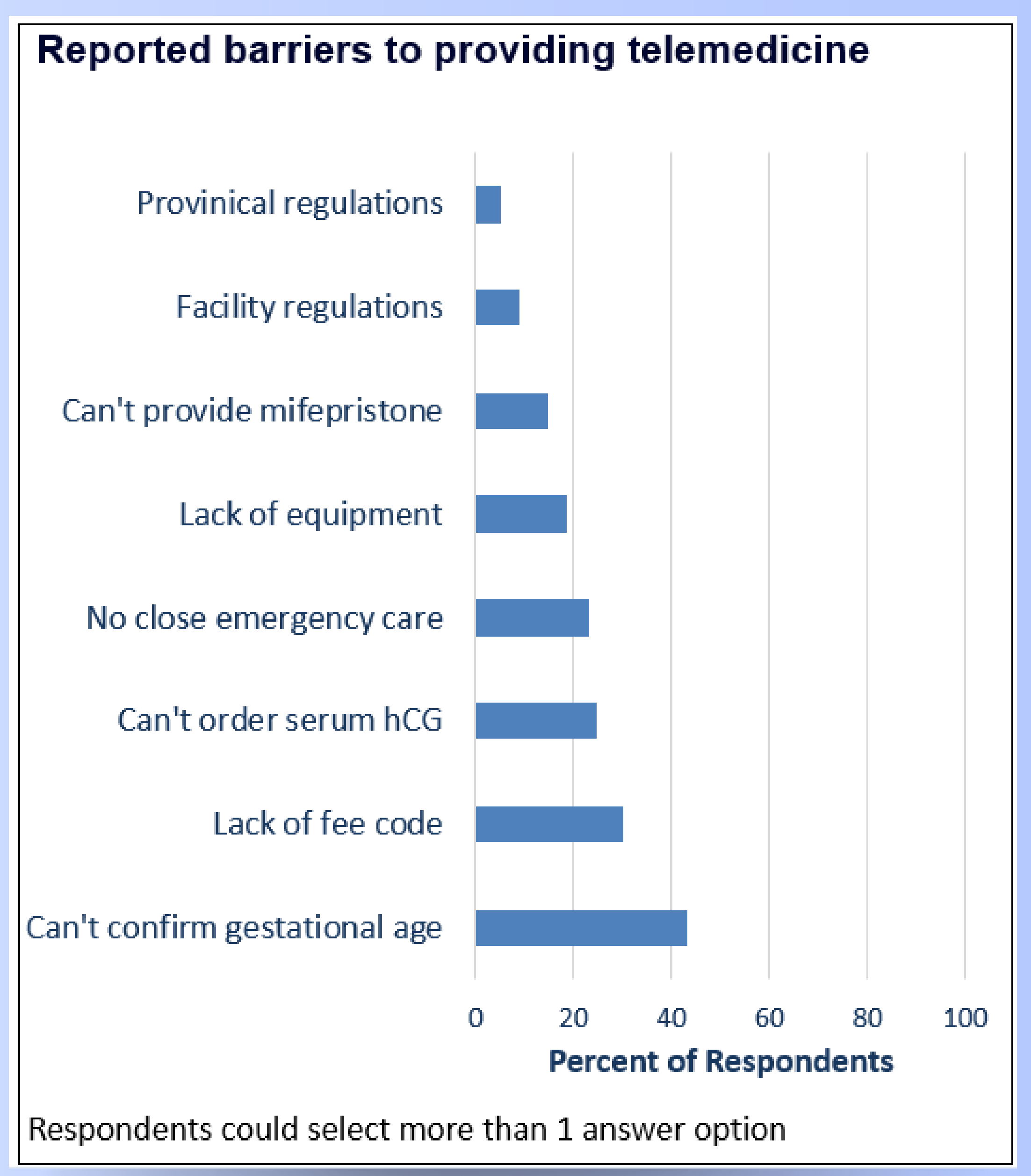


Telemedicine For First trimester Medical Abortion

Results from the 2019 Canadian Abortion Provider Survey

- 44.0% of 388 first trimester medical abortion respondents reported use of telemedicine;
- 49% of primary care clinicians and 28.7% of specialists





Renner RM*, Ennis M*, Kyeremeh A, Norman WV, Dunn S, Pymar H, Guilbert E. Telemedicine for First Trimester Medical Abortion in Canada: Results of a 2019 Survey. Journal of Telemedicine and e-Health. 2022 Sep 20.

Background

- Wiebe et al 2020. Contraception:
  - Retrospective Canadian study compared telemed MA with in-person MA obtained between 2017-2019 at a single clinic.
  - Virtual care and dating ultrasounds only as clinically indicated.
  - Follow-up: serum hCG testing.
  - Efficacy and safety were similar in both groups, but remote patients more often initiated unscheduled communications.
- SOGC April 2020 recommended use of a low-/no-test medical abortion protocol via telemedicine[1]
- Ennis et al 2021. Family Practice:
  - Canadian Abortion Provider Survey during COVID-19 reported some adoption of the SOGC COVID low-/no-test protocol[1]. Majority ordered ultrasound only as indicated (81.2%), but always ordered serum hCG or hemoglobin (59.6 and 55.6% respectively).
  - Late 2020, provision of telemed by Canadian providers increased to 89%[2, 3].

[1]Guilbert et al. 2020. SOGC. [2]Ennis et al. 2021. Family Practice. [3]Renner et al. 2022. Telemed J E Health.

Low-/no-test protocols

- Rely primarily on telemed appointments and patient history for pre-abortion assessment and to triage for the need of testing.
- Mifepristone/misoprostol obtained through mail or at a local pharmacy.
- Follow-up usually includes a telemedicine encounter and a home urine pregnancy test 4 weeks after taking misoprostol with additional follow-up as needed.
- A move from pre-COVID-19 in-person medical abortion to telemedicine medical abortion since the pandemic onset observed in Canada, the United States, England and Scotland.
- With triage for eligibility, low-/no-test medical abortion is as effective (95.0-98.8% required no surgical intervention), safe, and acceptable as traditional in-person care.

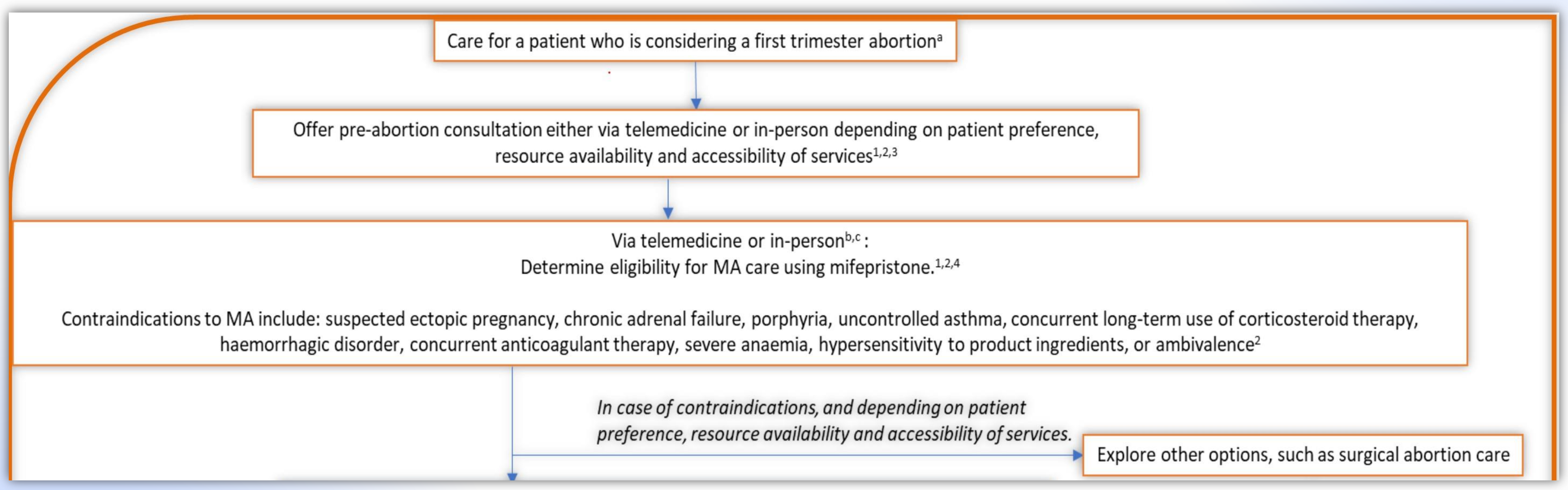
Guilbert et al. 2020. SOGC; Upadhyay et al. 2020. Contraception; Aiken et al. 2021. BJOG; Chong et al. 2021Contraception; Kerestes et al. 2021. Contraception; Reynolds-Wright et al. 2021. BMJ SRH; Raymond et al. 2020 Contraception; Renner et al. 2022. Telemed J E Health;

Low-/no-test protocols – Caveats

- Protocols that do not rely on ultrasound have potential to improve access for rural and remote patients.
- Wide range of ultrasound use, either as indicated by protocol or due to patient or provider preference ranging from 28.3 - 85.0% of patients.
- Ongoing need for access to testing highlighted in multiple studies.
- English study 39% of patients did not meet criteria for a no-test telemedicine medical abortion - had in-person appointments with ultrasound.
- Hawaiian study on telemedicine medical abortion, 1/3 patients elected to receive in-person care, demonstrating that it is still important to offer in-person care for those who have limited technology access, require an ultrasound, or prefer a face-to-face interaction.

Upadhyay et al. 2020. Contraception; Aiken et al. 2021. BJOG; Chong et al. 2021Contraception

Hybrid Protocol



Footnotes:

[a]Use a trauma-informed, culturally safe, non-racist, coercion-free and patient-centered care approach. If applicable, discuss the option of having an interpreter, spiritual guide, cultural support, knowledge keeper or other support person included in the care. Base safeguarding assessment on patient risk factors, assess for possible coercion.

[b]Base medication abortion care on clinician competence, patient preference, resource availability, and accessibility of services.

[c]If patient is interested, offer coercion-free contraceptive counselling

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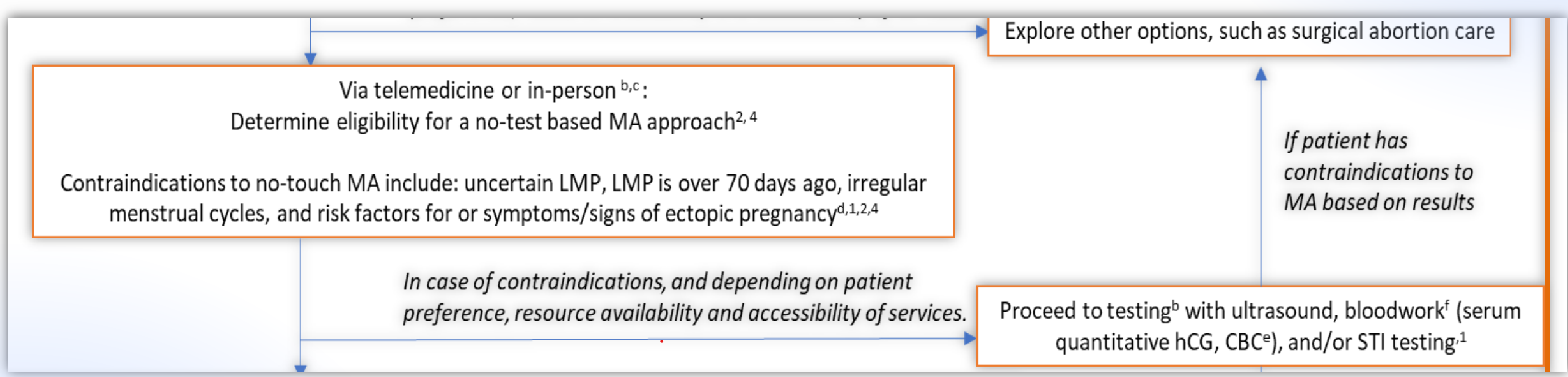
Hybrid Protocol Continued



- [b]Base medication abortion care on clinician competence, patient preference, resource availability, and accessibility of services.
- [c]If patient is interested, offer coercion-free contraceptive counselling
- [d]Includes: previous ectopic pregnancy, tubal surgery, assisted reproduction techniques pregnancies, tubal ligation, intrauterine device/system presence, history of salpingitis or pelvic inflammatory disease, abdominal pain, and vaginal bleeding.[9,10,4]
- [e]Complete blood count is required if suspected severe anaemia or hemoglobinopathy. If measured, hemoglobin should be over 9.5 g/dl before starting MA[4]
- [f]Rhesus (Rh) status can be considered if not documented elsewhere (e.g. donor card, previous results) AND if patient would accept Rh immunoglobulins: according to current evidence, Rh testing is required when gestational age (GA) is over 56 days.[12,13] However, during the COVID-19 pandemic, expert opinion recommends that Rh testing may be withheld up to 70 days GA.[4]

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Hybrid Protocol For Eligible Patients

Via telemedicine or in-person[b,c]:
Provide instructions and emergency resources and assess comprehension of the process[g] AND
a) telemedicine: send prescription to local pharmacy where patient lives or mail medication to patient
OR
b) in-person: provide prescription to patient to fill at pharmacy of their choice or in case of stocking the medication dispense directly to patient.

↓

Via telemedicine or in-person[b] follow up 2 weeks post misoprostol AND
a) high sensitivity urine pregnancy test (at home or in office) 4 weeks post misoprostol[g, h]
OR
b) testing with ultrasound or serum quantitative hCG (7-14 days) post misoprostol[g, h]

- [b]Base medication abortion care on clinician competence, patient preference, resource availability, and accessibility of services.
- [c]If patient is interested, offer coercion-free contraceptive counselling
- [g]Further follow-up and testing as clinically indicated
- [h]Implant or intrauterine device/system insertion if requested by patient

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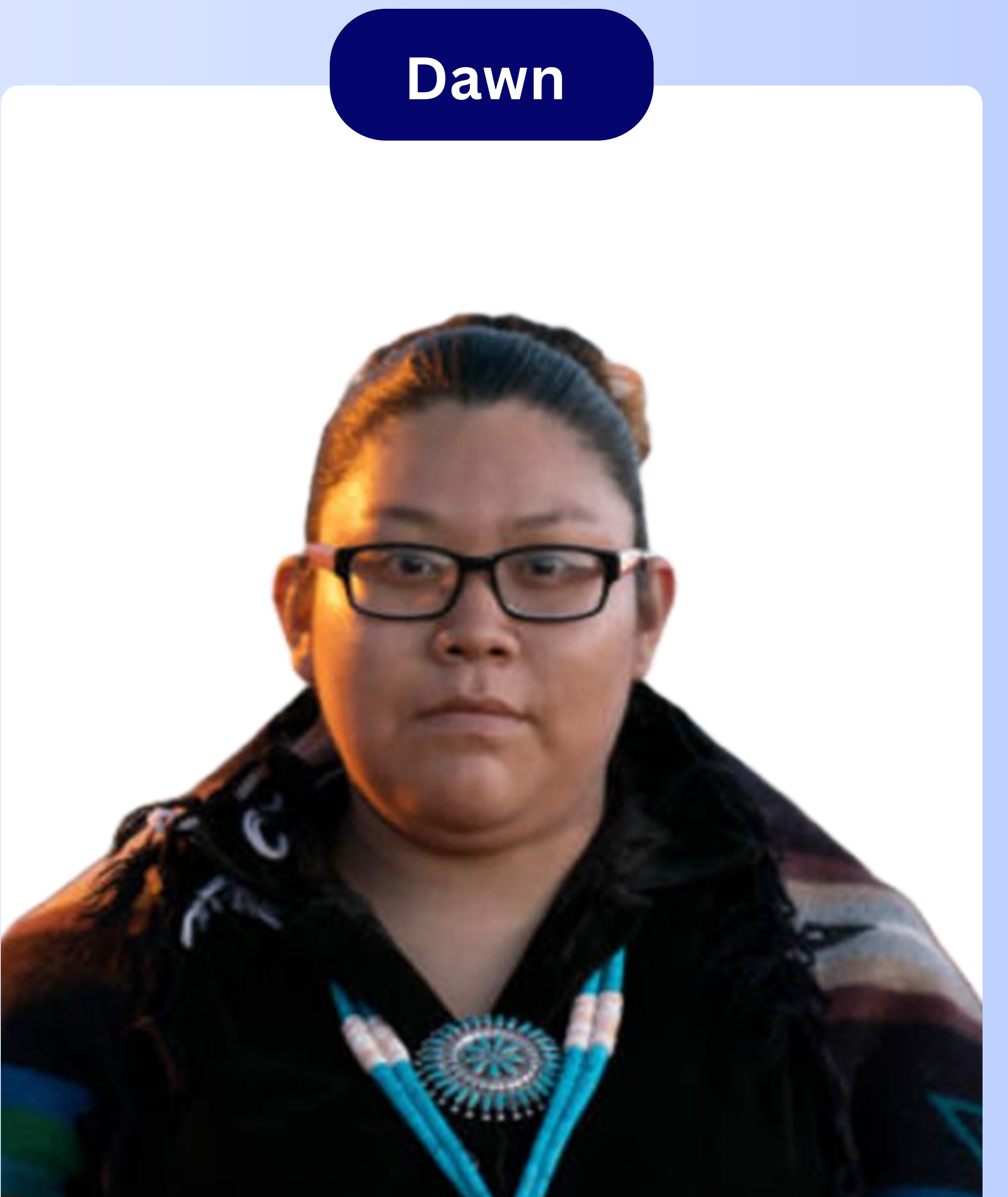
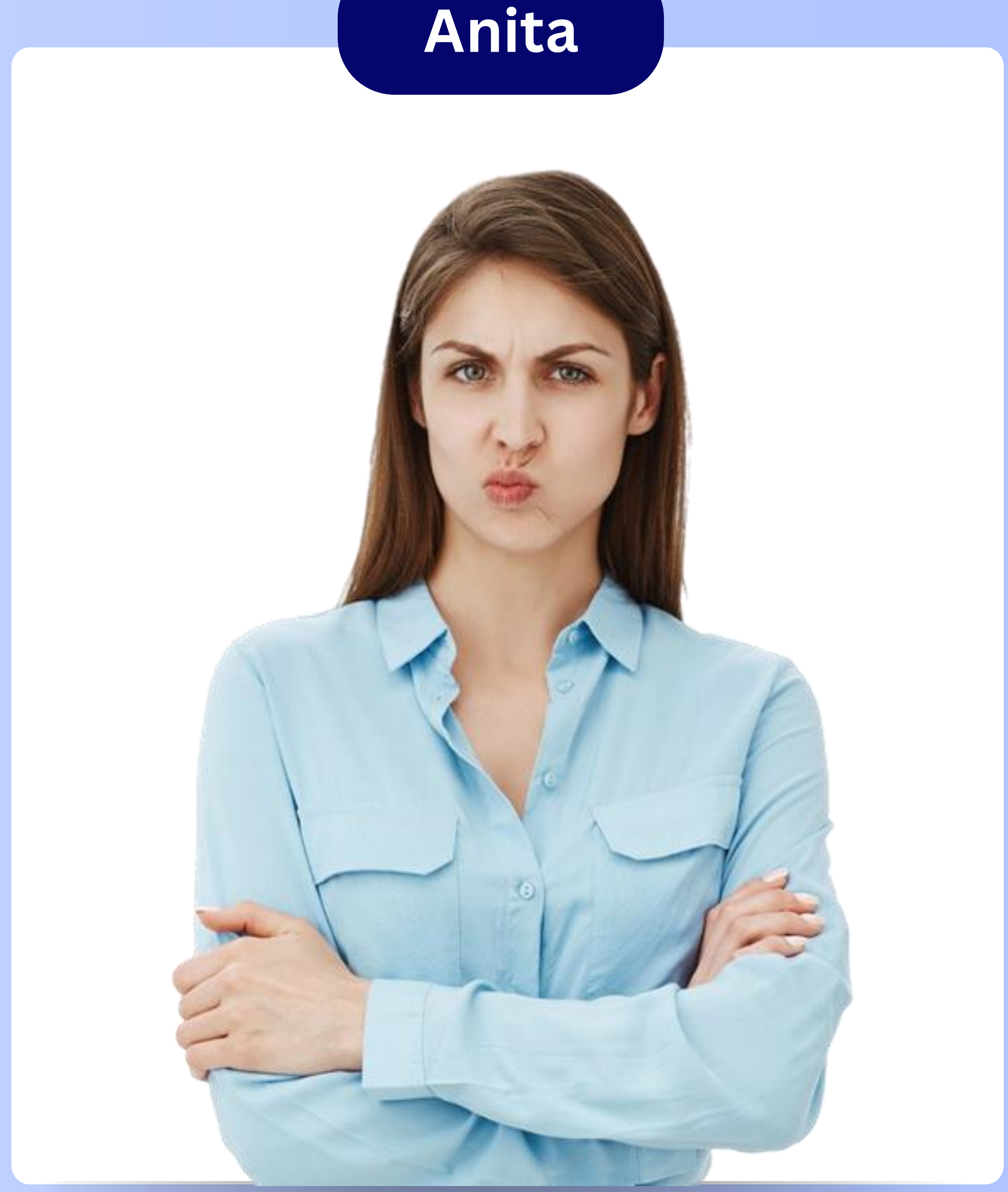
Case Discussions

Sasha

Dawn



Anita



Case 1

- Sasha is a 17 y.o G2TA1 presents for MA at 6 weeks 5 days from LMP
- Positive UPT at home
- Uses an app to track her period and had a negative UPT 3 weeks ago
- What further history and investigations would you like?

Case 1

- Her periods are regular, last one was the amount expected, no bleeding or spotting since, she was not on birth control, no signs symptoms or risks of ectopic, nor any other contraindications

- UPT in office is positive
- STI testing done
- What now? Can we proceed?

Case 1

- You provide counseling including informed consent regarding the risk of misdating and ectopic for a no touch MA and patient information including 24 hour phone number and prescribe the patient MA meds and adjuncts
- She is able and prepared to have her abortion at home and has support from her family.
- She declines any birth control discussion at this time as she is feeling overwhelmed

Case 1

- She calls on call and says she vomited 90 minutes after mifepristone
- Can she proceed?
- She proceeds and calls you to say she vomited 45 minutes after taking misoprostol
- What should she do?

Case 1

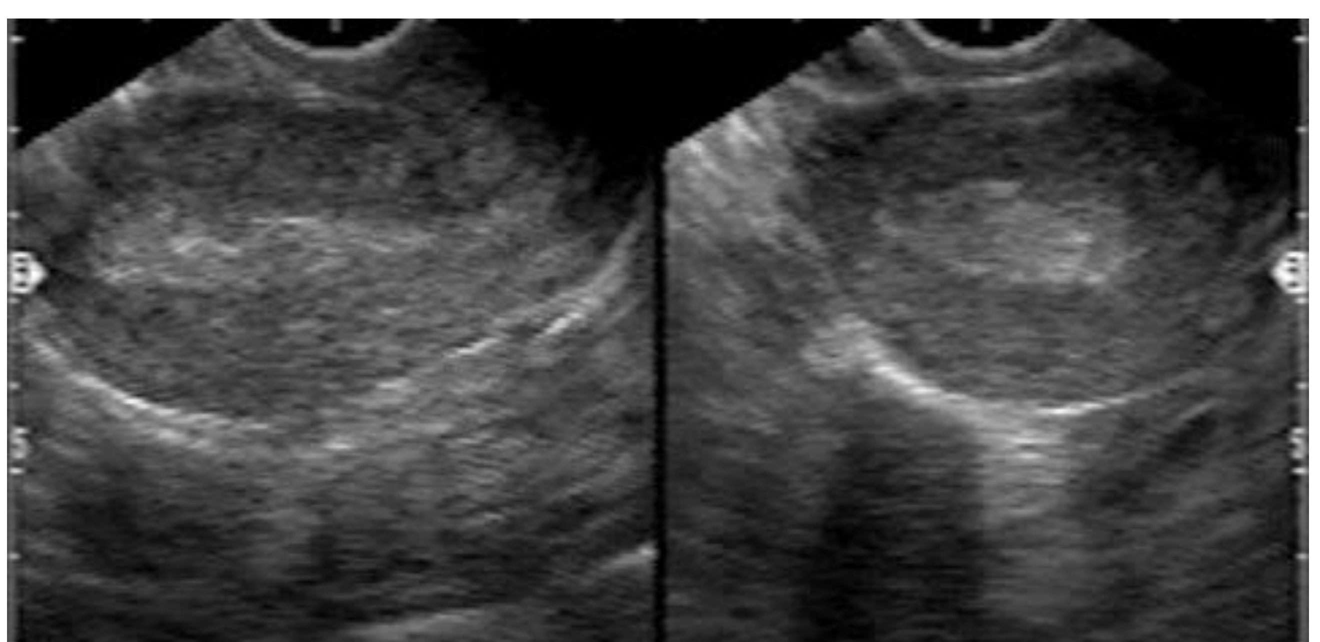
- You don't hear from her again until the 10 day follow up visit
- She tells you she went to the ER 3 days earlier because she was worried about the amount of bleeding and they had ordered an ultrasound for the next day
- You received a copy of the ultrasound report:

"The endometrium is echogenic and thickened at 4.1 mm, with increased doppler flow. No gestational sac was visualized. The findings are consistent with retained products of conception. Gynecology consult recommended."

- The patient asks "Do I need surgery?"

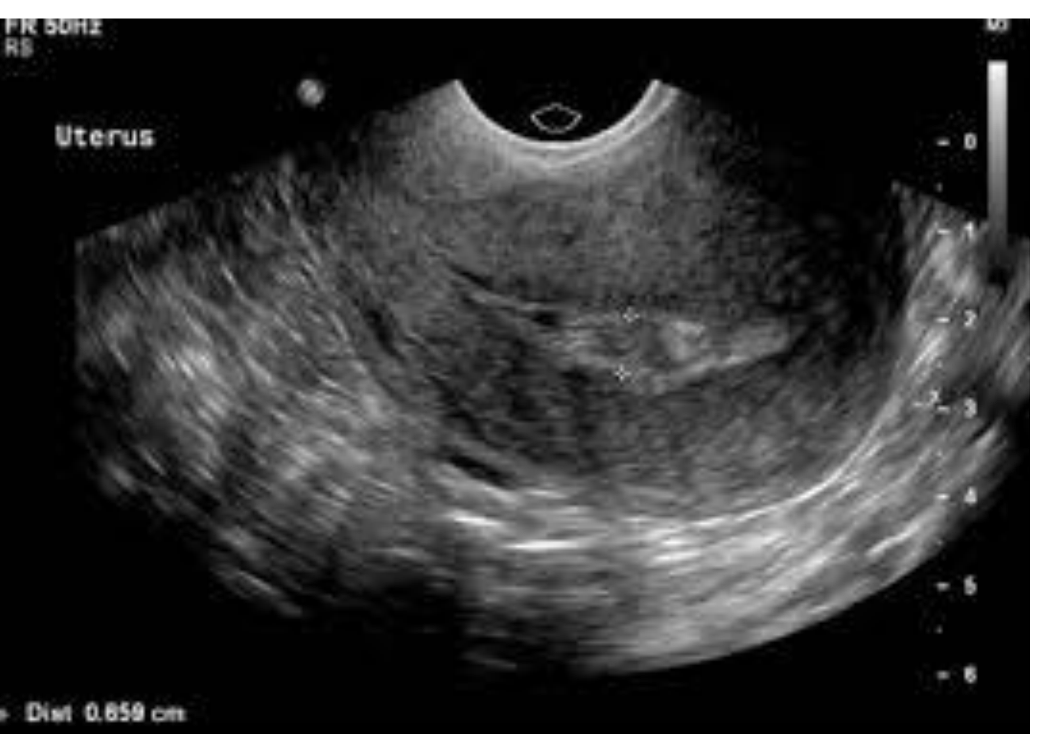
Confirming Completion: Ultrasound

- Absence of sac provides definitive evidence of MA completion
- Routine ultrasound not proven to be superior to other follow-up modalities
- Ultrasound also useful when:
  - Outcome uncertain
  - Symptoms of concern are present - unexpected pain, prolonged, heavy bleeding, or inadequate bleeding
  - Be cautious – do not over diagnose retained products of conception (to be discussed)



Retained Products of Misconception

- Higher aspiration rates are seen when MA is introduced into new countries
- Uncommon - 3-5% require post MA aspiration
- Ultrasound determination of completion involves absence of sac only
- Endometrial thickness, doppler flow and hyperechoic tissue are normal ultrasound finding post MA
- First menses after MA can be diagnosed as RPOC – 4-6 weeks after miso

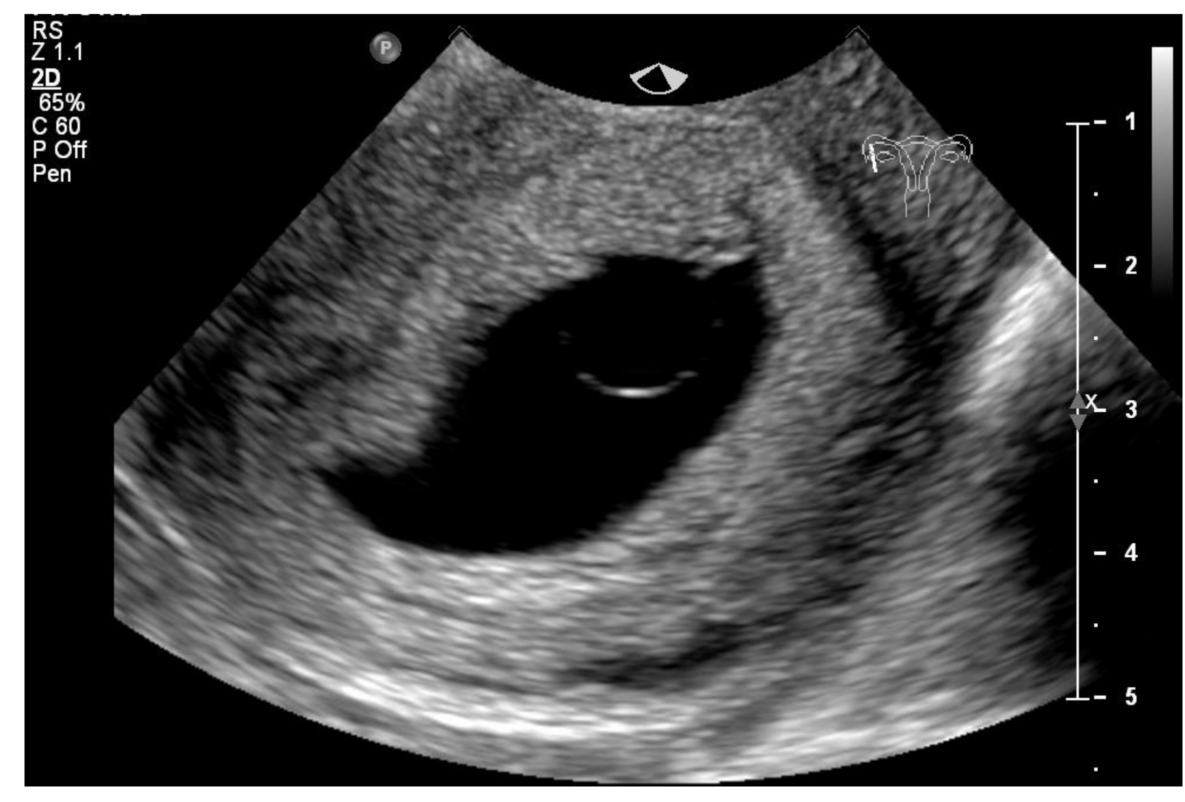


RPOC

- Patient symptoms are important in diagnosis

Heavy Bleeding >2 pads/hr for > 2 hours or symptomatic	Bleeding like a period for >4 weeks	Ongoing spurts of heavy bleeding	No Bleeding

- Ultrasound & BHCG
  - Along with symptoms can be contributory to diagnosis
- Treatment
  - Expectant – if symptoms minimal and patient willing, many will pass on own
  - Medications – miso (or mifegymiso) 69% with sac passed with second dose miso
  - Aspiration – urgent if bleeding heavy and uncontrolled



Case 1

- The patient's bleeding subsided, she has been spotting here and there today
- Her nausea breast tenderness is much better
- You discuss her ultrasound findings and explain that this can be normal however if she has heavy bleeding, cramping, fever or chills to contact you again
- You remind her about the quick return to fertility and order a hemoglobin which comes back normal

- 4 weeks later her UPT is negative, and she would now like to further discuss IUDs with you

Case 2

- Dawn is a 36 y.o G4T2E1L2 presents for MA at 7 weeks 0 days from LMP
- Positive preg test at home
- Busy with kids, lives rurally would really like fully no touch protocol
- No medical issues, no allergies, no pregnancy symptoms yet, no spotting, no pain
- Anything else you need to know?
- Can you proceed?

Ectopic Symptoms & Risk Factors

- SOGC MA Guidelines

Table 4. Risk factors of ectopic pregnancy

History	Clinical symptoms
Previous ectopic pregnancy	Abdominal pain
Tubal surgery	Vaginal bleeding
Pregnancy conceived with assisted reproduction techniques	
Tubal ligation	
IUD in place	
History of salpingitis or pelvic inflammatory disease	

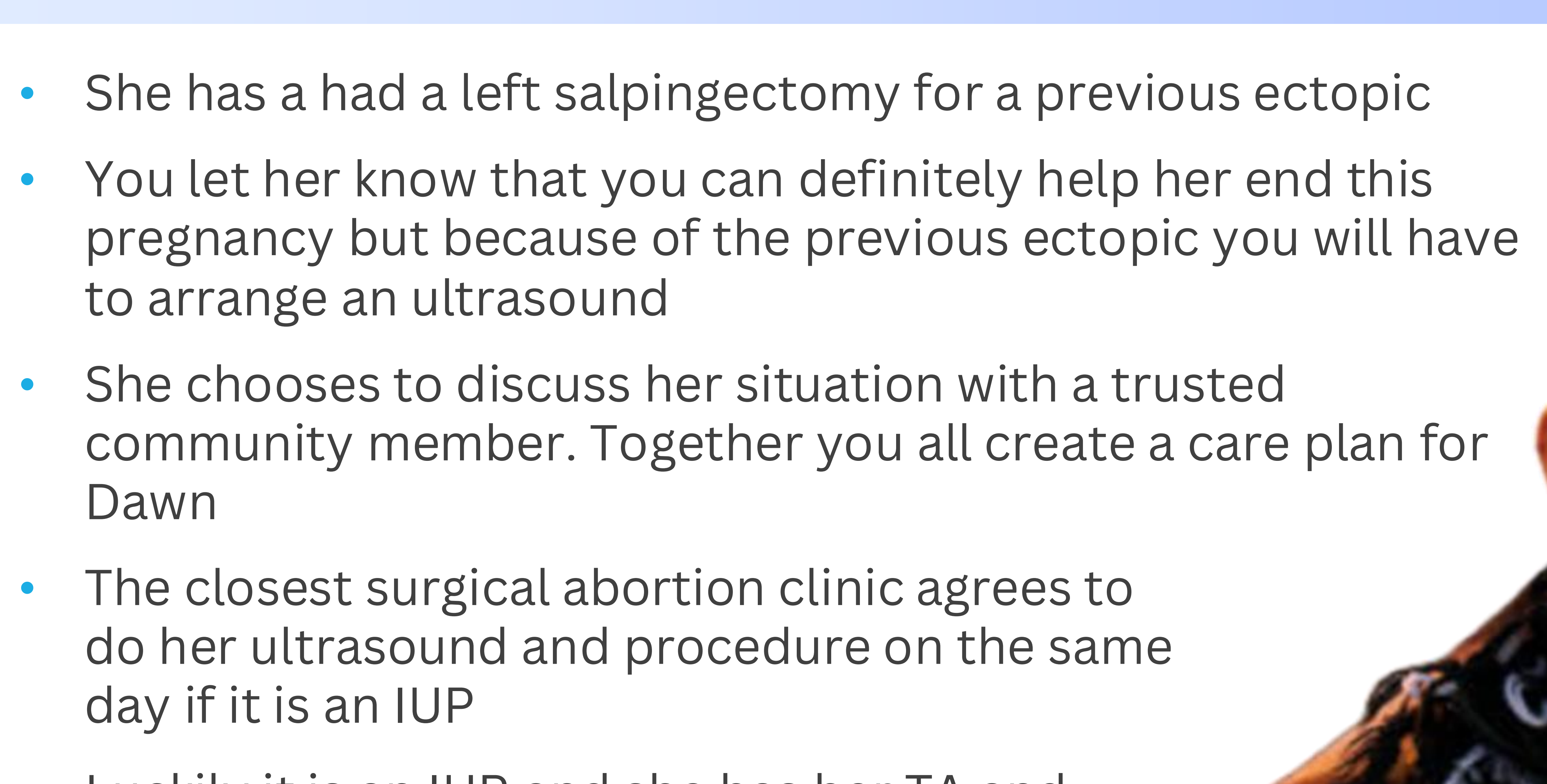
IUD: intrauterine device.

Adapted from Barnhart K, van Mello NM, Bourne T, Kirk E, Van Calster B, Bottomley C, et al. Pregnancy of unknown location: a consensus statement of nomenclature, definitions, and outcome. Fertil Steril 2011;95:857–66.[112]

KEY TAKEAWAY

If any risk factors for ectopic MA is contraindicated without confirmation of IUP on ultrasound

Case 2



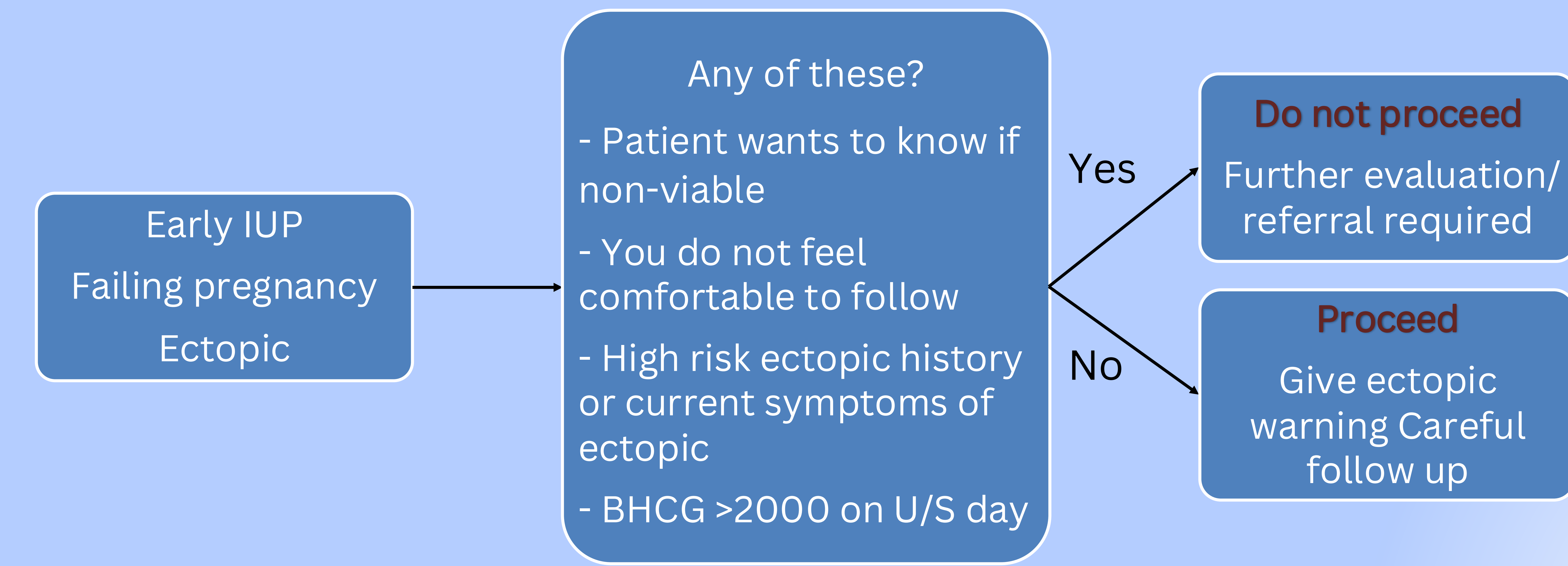
- She has a had a left salpingectomy for a previous ectopic
- You let her know that you can definitely help her end this pregnancy but because of the previous ectopic you will have to arrange an ultrasound
- She chooses to discuss her situation with a trusted community member. Together you all create a care plan for Dawn
- The closest surgical abortion clinic agrees to do her ultrasound and procedure on the same day if it is an IUP
- Luckily it is an IUP and she has her TA and chooses to have an IUD inserted on the same day

Case 3

- Anita is a 28 y.o G1P0 presents in office for MA at 5 weeks 0 days from LMP
- Had a bedside ultrasound last week when she went to urgent care for UTI and found out she was pregnant – no IUP seen, no BHCG done
- Other than being told she had anemia years ago she has no medical issues, no surgeries, no allergies, no pregnancy symptoms yet, no spotting, no pain
- Anything else you want to know? Can you proceed?

Pregnancy of Unknown Location (PUL)

- Positive PT and ultrasound showing no intrauterine pregnancy (IUP) and no ectopic
- Likely one of 3 diagnoses:



Ectopic Symptoms & Risk Factors

KEY TAKEAWAY

If any risk factors for ectopic MA is contraindicated without confirmation of IUP on ultrasound

- SOGC MA Guidelines

Table 4. Risk factors of ectopic pregnancy

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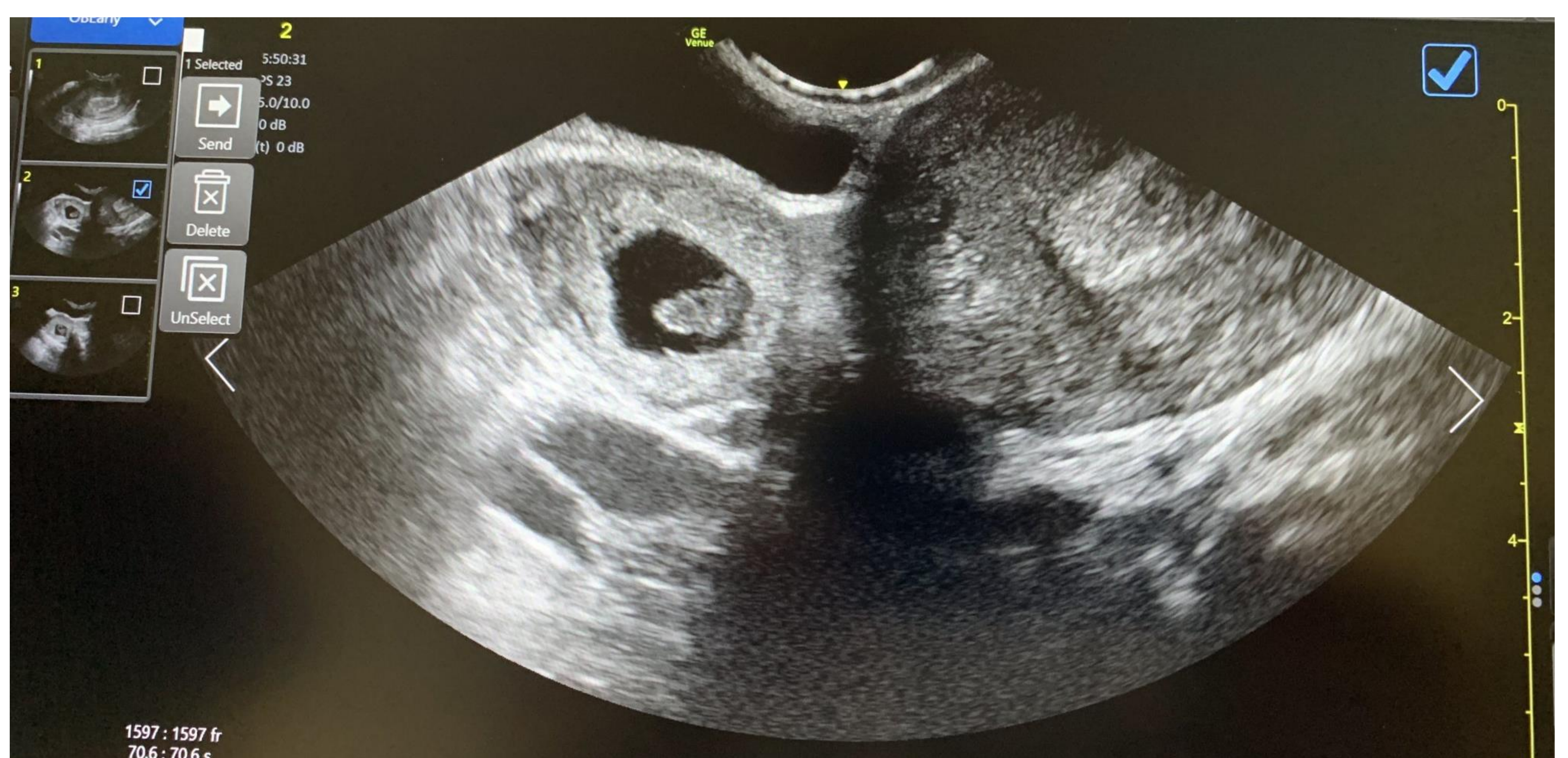
Ectopic Pregnancy

- Consistently lower rates in those presenting for abortion
- 1-2% in general population
- Consistently lower in those seeking abortion (Vancouver ~0.2% - including those who did not receive meds)
- If high risk or symptomatic – MA is contraindicated with out ultrasound confirmation of IUP



Case 3

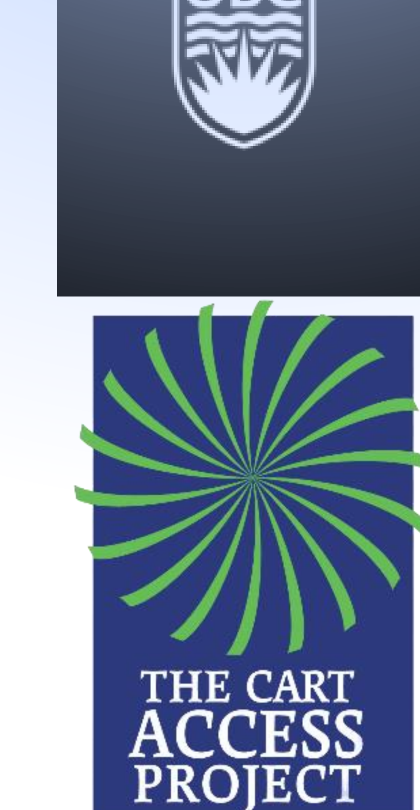
- You do a hgb in your office on a hemocue and it is normal.
- She has no risks for misdating, nor ectopic pregnancy and she has no other contraindications for mifegymiso.
- You provide counseling including informed consent regarding the risk of misdating and ectopic for a no touch MA and patient information including 24 hour phone number and prescribe the patient MA meds and adjuncts
- She also chooses to have an implant inserted and you insert if for her on the same day.

Case 3

- After 8 days you speak with her and she had heavy bleeding with clots that is now subsiding, she feels the pregnancy passed, and is having fewer pregnancy symptoms
- You tell her the concerning signs to watch for and plan for FU at 4 weeks
- At 4 weeks after multiple attempts at follow up using, text, email and phone calls you are unable to get a hold of her and close her file.

Resources and Tools for Your Practice

The Virtual Community of Practice Project: An Online Abortion Platform

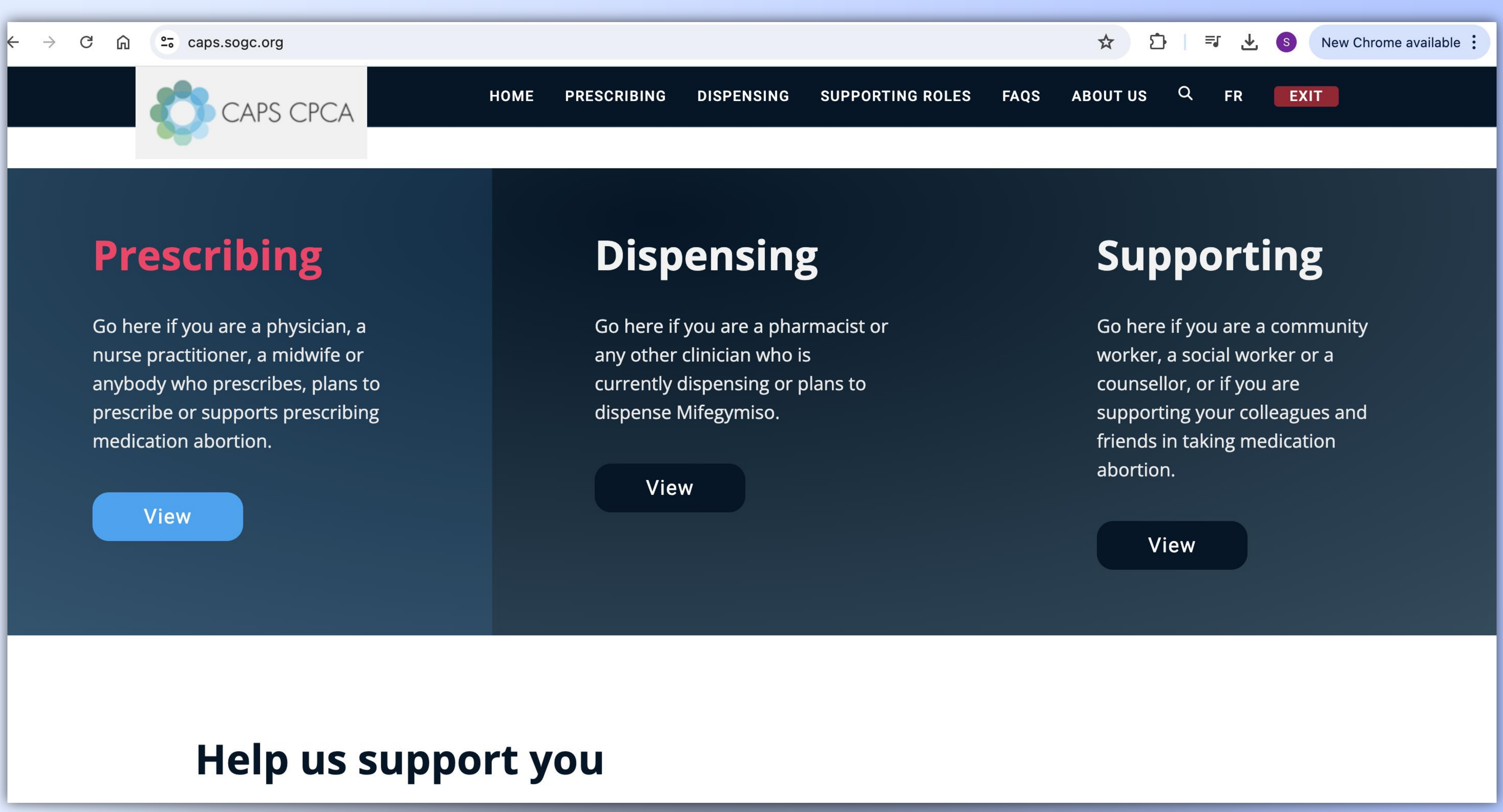


Fatawu Abdulai, PhD UBC School of Nursing
Ken Koike, MPH, SOGC

Financial contribution:
Health Canada Santé Canada

Hosted by SOGC: https://caps.sogc.org/

Resources Grouped for Prescribers and Health Care Teams



About Mifegymiso
Patient Counselling
Pre-abortion Medical Evaluation
Basic screening
Pregnancy & Gestational Age Screening
Ectopic Pregnancy
Pregnancies of Unknown Location
Rhesus Screening
Anemia, STIs & Others
Post-abortion Assessment
Virtual & Hybrid Care
Physician Billing Codes
Regulations, Insurance & Inclusivity Toolkits
Guidelines, Checklists & Toolkits

https://caps.sogc.org/prescribing/#3

Basic screening ↑

Medical history must be taken to assess gestational age, evaluate contraindications and identify additional precautions. The history also provides a baseline for follow- up and helps determine suitable contraception options and whether additional tests are needed[6].

Baseline vital signs and pelvic examination should be performed as directed by history. Practices may vary[6].

Pregnancy & Gestational Age Screening ↑

A positive urine beta human chorionic gonadotropin test (βhCG) is sufficiently sensitive to confirm a pregnancy[6].

Ultrasound: Ultrasound provides the most accurate measurement of gestational age (GA) but is not a routine requirement unless the patient is uncertain of their last menstrual period (or there are symptoms and risk factors for ectopic pregnancy as explained later). It is recommended to choose an ultrasound clinic whose staff are capable of offering non-judgmental sonography[6].

Medical history: If the patient is certain of their last menstrual period and if they were having

About Mifegymiso

Patient Counselling

Pre-abortion Medical Evaluation

Post-abortion Assessment

Virtual & Hybrid Care

- Initial Steps
- Virtual Assessment
- Informed Consent
- Follow-up

Physician Billing Codes

Regulations, Insurance & Inclusivity Toolkits

Guidelines, Checklists & Toolkits

Urine bhCG[7]:

Urine βhCG Testing to Assess Completion of Medication Abortion

Typically used in virtual follow-up using the following protocol.

Ensure that patients take the urine pregnancy test (the first test) **at least 3 weeks after misoprostol** was taken.

If the test is negative: the abortion is complete.

If the test is positive, review signs and symptoms of ongoing pregnancy, retained product of conception and ectopic pregnancy.

If signs and symptoms are present:

Consider ordering ultrasound and / or βhCG, and if ultrasound shows:

- **Retained products**: consider an additional dose of misoprostol or procedural abortion.
- **Ongoing pregnancy**: consider an additional dose of misoprostol or procedural abortion.
- **Ectopic pregnancy**: manage as is clinically indicated and refer as needed (possibly with urgency).
- **Negative ultrasound**: consider a new pregnancy of unknown location, rule out ectopic pregnancy and have the patient repeat urine pregnancy test

If absent:

Ask the patient to repeat the urine pregnancy test (second test) one week after the first pregnancy test.

- **If the test is negative**: the abortion is complete.
- **If the test is positive**: order urgent in-person assessment with ultrasound and βhCG.

https://caps.sogc.org/prescribing/#4

British Columbia

The information below is updated as of March 2024.

Gynaecology

Initial visit: **14545** Medication abortion – $170.95
Follow-up visit: **4012** Limited consultation – $85.49
4007 Follow-up – $53.52
Telehealth: **14545** Same code for consultation – $170.95
4072 Limited consultation – $85.49
4077 Follow-up – $53.52

Primary Care

Initial visit: **14545** Medication abortion – $170.95
Follow-up visit: **00100** Follow-up – $34.04
Telehealth: **14545** Same code for consultation – $165.97
13437 Follow-up – $31.84

Notes: For telehealth, methods of virtual care can include phone, video or provincial telehealth platform, all

Patient Counselling

Pre-abortion Medical Evaluation

Post-abortion Assessment

Virtual & Hybrid Care

Physician Billing Codes

Regulations, Insurance & Inclusivity Toolkits

- Regulatory Landscape
- Facility Setup
- Addressing Abortion Concerns
- Federal Insurance Schemes
- Non-Insured Patients
- 2SLGBTQIA+ Patients
- Indigenous Patients

Guidelines, Checklists & Toolkits

Facility Setup

Below is a general guide of the steps to be taken when initiating medication abortion (MA) services in your facility. Some of these may not apply, depending on your facility[12].

Review protocol:

- Review guidelines for MA.
- Prepare your protocol and invite the clinical team to review and give feedback on the protocol.
- Determine if purpose of offering MA is for occasional support for current primary care caseload or if it will be made available as a service in the community.
- Evaluate related protocols including contraception, STI testing and treatment and other sexual and reproductive healthcare services, and integrate them with the abortion protocols if appropriate.

Review regulations and compensation processes:

- Review provincial and territorial regulations and scope of practice for physicians and nurse practitioners, and assess the potential involvement of registered midwives in providing MA.
- For physicians, get familiar with provincial billing codes for provision of MA, including codes for any testing that you would be doing on-

FAQs – Distilled From "Ask an Expert"

HOME PRESCRIBING DISPENSING SUPPORTING ROLES FAQS ABOUT US FR EXIT

Medication

Patient Counselling

Side effects & Complications

Breastfeeding

Multiple Gestation

Methadone

Methadone

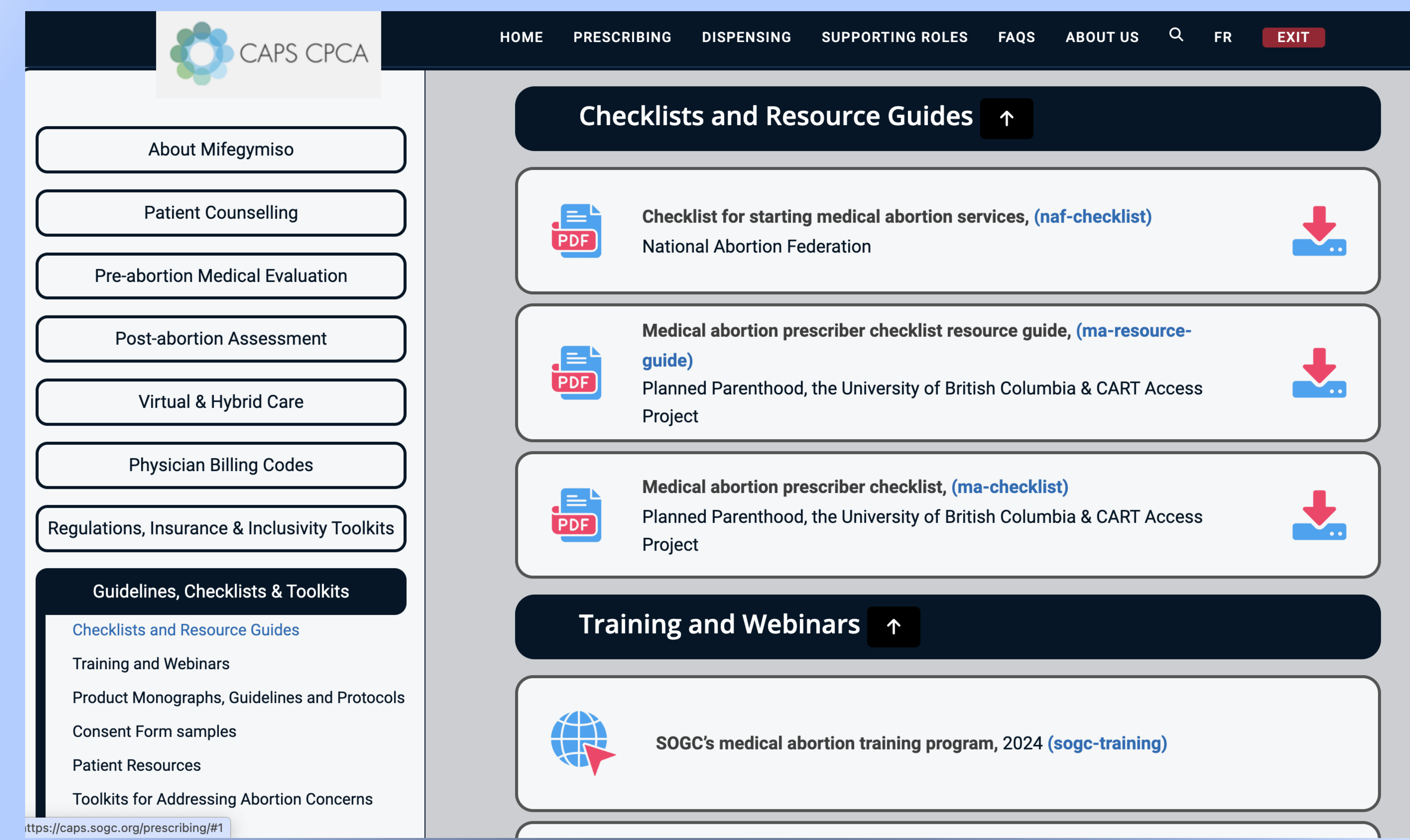
Q: Is there an interaction between methadone and mifepristone?

A: Bottom Line:

Post-marketing surveillance of mifepristone use in numerous countries for the past 25 years has not raised concerns about this interaction. Although there are limited trials and published literature on this drug interaction, the precautionary principle states that women using both drugs simultaneously be adequately informed, accompanied during the abortion process and followed for the occurrence of adverse events and completion of the abortion. Even if arrhythmia were not a potential side effect based on pharmacodynamics, it may emerge as an adverse drug reaction as mifepristone penetrates the population more widely including opioid/opiate dependent women.

We include below an opinion from a Pharmacology professor at UBC. Additionally, three highly experienced leaders in mifepristone provision in the USA have offered their opinion that they have not seen evidence for any adverse effect interaction. The answer from a Drug Metabolism/Pharmacokinetic point of view is: probably not. The (slightly longer) explanation is as follows: Methadone primarily binds the "mu" opioid receptor similar to other opioids, which is why it is a replacement therapy for people with addictive and

Guidelines/Tools to Support Your Practice



MEDICAL ABORTION CHARTING FORM

Patient Name: Tel:
DOB: Age:
Health Card:

1. Counselling

- ☐ Pregnancy options counselling provided
- ☐ Surgical vs. medical abortions discussed
- ☐ Medical abortion protocol explained
  - ☐ Reviewed timing of ultrasound, lab tests, medications, follow-up appointment
  - ☐ Reviewed effectiveness, side effects and potential complications
- ☐ Contraception plan: ______________________ start date: ___ / ___ / ___

2. Determine Eligibility for a Medical Abortion

Confirm All Inclusion Criteria

- ☐ Expresses clear decision to have an abortion
- ☐ No indication of being coerced into abortion
- ☐ Informed consent process completed
- ☐ Understands expected side effects (bleeding, cramping)
- ☐ Agrees to comply with the visit schedule
- ☐ Agrees to a surgical abortion should pregnancy continue
- ☐ Understands when and where to consult in case of emergent complications
- ☐ Has access to a telephone, transportation, and emergency medical care
- ☐ Review of current medications
- ☐ Allergies: ______________________

Absolute Contraindications *(exclude all)*

- ☐ Chronic adrenal failure
- ☐ Inherited porphyria
- ☐ Uncontrolled asthma
- ☐ Allergy to mifepristone or misoprostol
- ☐ Ectopic pregnancy
- ☐ Coagulopathy or current anticoagulant therapy

Consider and Manage Relative Contraindications:

- ☐ Pregnancy of unknown location or gestational age
- ☐ Long term corticosteroid use
- ☐ Anemia with hemoglobin Hb < 95 g/L
- ☐ IUD in situ (no longer a contraindication if removed)

3. Physical Exam, Gestational Age, Pregnancy Location

- ☐ LMP: ___ / ___ / ___ *(date)*
- ☐ G: ___ T: ___ P: ___ A: ___ L: ___
- ☐ Vital signs: BP ___, HR ___
- ☐ Gestational age on ___ / ___ / ___ is: ___wks ___days
  - ☐ confirmed clinically and with urine test *OR*
  - ☐ confirmed by ultrasound
- ☐ βhCG done or planned *[see section 4, Labs]* *OR*
- ☐ βhCG not done
- ☐ Follow-up appointment scheduled ___ / ___ / ___ *(date)*

4. Initial Labs and Imaging

Lab tests completed/results:

- ☐ ABO RH ___ ☐ Antibody Screen ___
  - ☐ 120 or 300 µg Rho(D) IG given
- ☐ Hemoglobin ___
- ☐ Baseline βhCG ___ IU on ___ / ___ / ___
- ☐ Gonorrhea and chlamydia

Imaging

- ☐ Dating ultrasound requisition, appointment on ___ / ___ / ___ *(date)*

5. Provision of Mifegymiso®

- ☐ Review U/S and lab results with the patient and agree to proceed
- ☐ Prescribe Mifegymiso® (indicate on prescription a "dispense before" date appropriate for gestational age)
  - ☐ Planned date for mifepristone: ___ / ___ / ___ *(date)*
  - ☐ Planned date for misoprostol: ___ / ___ / ___ *(date)*
- ☐ Review how and where to take the medication, timing
- ☐ Review pain and bleeding management and side effects with the patient and prescribe pain medication
- ☐ Provide written information on follow-up, when and where to seek emergency care, and who to call for questions
- ☐ **Other discussion** ______________________

Initial Appointment Signatures

Signature of healthcare professional providing counselling:	Date:
Signature of prescribing healthcare professional:	Date:

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6. Follow-up Appointment (7-14 days post mifepristone) | Date: ___ / ___ / ___ = ___ days since mifepristone

- ☐ Review actual dates medication used:
  - ☐ Date mifepristone taken: ___ / ___ / ___
  - ☐ Date misoprostol taken: ___ / ___ / ___
- ☐ Review pre-abortion βhCG on ___ / ___ / ___ result ___ IU
- ☐ Post-abortion βhCG on ___ / ___ / ___ result ___ IU
  - ☐ βhCG > 50% drop from baseline at 3 days post MIFE → successful pregnancy termination
  - ☐ βhCG > 80% drop from baseline at 7 days post MIFE → successful pregnancy termination
  - ☐ βhCG < 80% drop from baseline at 7 days post MIFE → order ultrasound
- ☐ Ultrasound result on ___ / ___ / ___ (date): ______________________ *(if done)*
- ☐ Screen for complications: ______________________
- ☐ Reviewed contraception plan: ______________________

Follow-up Appointment Signatures

Signature of healthcare professional conducting follow-up:	Date:

Notes

Reference: *Costescu D, Guilbert E, Bernardin J, Black A, Dunn S, Fitzsimmons B, et al. Medical abortion. J Obstet Gynaecol Can. 2016;38(4):366–89*

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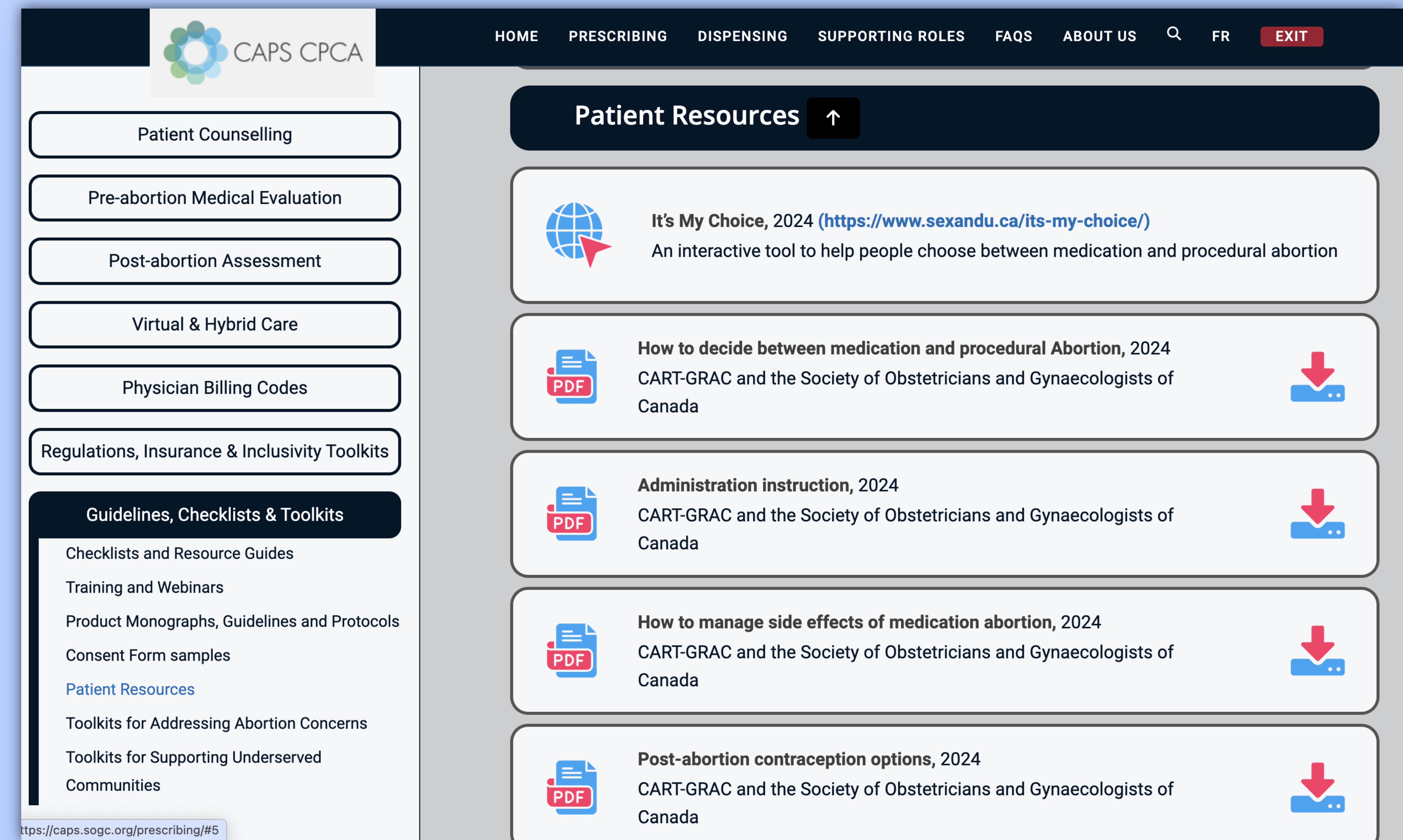
Guidelines/Tools to Support Your Practice



What to expect when ending a pregnancy at home

If you are having a medication abortion, here are some things to keep in mind. Medication for abortion is often called the abortion pill, but it is not just 1 pill. It involves taking 2 medications, mifepristone and misoprostol, early in the pregnancy. Both medications are available for sale in Canada under the brand name Mifegymiso®, which is used only if your last period started 63 days ago or earlier.

How to get the medications

When you present a prescription to a pharmacist, they can dispense both medications and explain when and how to take them.

How do the medications work?

Mifepristone is the first medication you take. It works by blocking progesterone, which is needed to keep pregnancy going. When progesterone is blocked, it triggers the end of the pregnancy. Mifepristone causes little to no symptoms, so you probably will not feel anything after taking it.

Misoprostol is the second medication you take 24–48 hours after mifepristone. Misoprostol causes the uterus to contract and relaxes the opening of the cervix, thereby expelling the pregnancy. Vaginal bleeding and cramping starts a few hours after taking the tablets. You need to be somewhere you can relax for this step.

How to take the medications

Take the **mifepristone** tablet by swallowing with a glass of water.

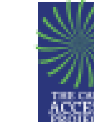
Take the 4 **misoprostol** tablets by placing them between your cheeks and gum; keep them in place for 30 minutes and swallow any pieces that are left with water.

SYMPTOMS	NORMAL TIME FRAME	HOW TO MANAGE
Nausea, vomiting & diarrhea	Nausea may occur right after taking misoprostol and for a couple of days afterwards.	• Take an antinauseant medication (e.g., dimenhydrinate) before taking misoprostol and ensure you have easy access to a bathroom. • If vomiting occurs less than 1 hour after taking mifepristone or while taking misoprostol, contact the prescriber or pharmacist. • No action is needed if vomiting happens after swallowing the small remaining pieces of misoprostol that were held in place for 30 minutes.
Pain & cramping	May start within 4 hours of taking misoprostol. Cramping often starts before the bleeding and often feels stronger than menstrual period cramping.	• Heating pads or hot water bottle provide comfort. • Take over the counter (OTC) ibuprofen and naproxen as directed on the package or fill the prescription of pain medication that was provided.
Vaginal bleeding	Starts from 30 minutes to 24 hours of taking misoprostol; usually within 2-4 hours. May be heavier than a period for 2-3 days. You may see blood clots and tissue the size of a grape.	• Obtain large menstrual pads before taking the medications. Do not use menstrual cups or tampons. • Obtain thin liner pads for light bleeding; bleeding may be present up to 30 days after treatment.
Dizziness & weakness	Short term; typically lasts no more than 24 hours.	• Rest and do not drive or operate machinery.
Headache	Short term; typically lasts no more than 24 hours.	• OTC ibuprofen or naproxen may provide some relief.
Breast tenderness	1-2 weeks.	• Ice packs and a supportive bra may relieve discomfort.

When symptoms become a medical emergency

SYMPTOMS	TIME FRAME
• Abdominal pain or discomfort, feeling sick – including weakness, nausea, vomiting, diarrhea (with or without fever)	• More than 24 hours after taking misoprostol
• Heavy bleeding; enough to soak through 2 thick, full-size menstrual pads OR • Prolonged heavy bleeding	• Soaking through the pads each hour for more than 2 consecutive hours • Passing lemon-sized tissues for more than 2 hours • Heavy bleeding lasting more than 16 days
• Abnormal vaginal discharge	• During and/or after the process
• Prolonged pain and cramping	• Pain not relived by pain medications or cramping lasting more than 16 days
• Fever >38°C and chills	• Lasting 6 hours or more

Association des pharmaciens du Canada



Patient Decision Aid – It’s my Choice

https://www.sexandu.ca/its-my-choice/

https://youtu.be/z0pdOMDoW2U

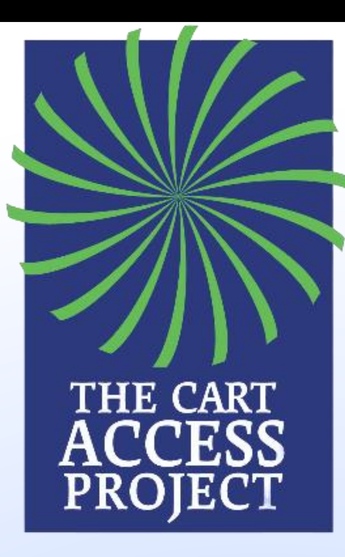
Financial contribution:

Health Canada Santé Canada

National Mentorship Hubs Network

“Real time” support for clinicians

Centre hospitalier
de l’Université de Montréal



Financial contribution:

Health Canada
Santé Canada

Accessing Support in Your Region

- BC
  - RACE (Rapid Access to Consultative Expertise)
  - Medical Termination of Pregnancy Advice within 2 hours
  - Phone 604-696-2131 or 1-877-696-2131
- Manitoba
- Ontario
  - Clinical support through Bay Centre for Birth Control
- Nova Scotia
  - Email to ROSEClinic@nshealth.ca.
  - Clinic physician will respond by email, text or phone

Abortion Care Cost and Support

- Free for anyone with provincial coverage
- ~$400-800 without
- NAF Canada Support
    - Dr. Henry Morgentaler Patient Assistance Fund and Information Service
    - Hotline: 1-800-772-9100
    - For patients with financial barriers to care - Procedure fees, travel cost, medication
- Abortion clinics often provide decision making counselling

Abortion Care is Changing

- GA extended to 10 weeks using adjusted protocol
- US is not mandatory but used if GA uncertain or ectopic risks/symptoms
- Elimination of Rh testing and RhIG administration supported
- Low/low touch protocols are options for care
- Increasing providers – FPs, NPs, Midwives (PQ)

Abortion Care is Changing

2024

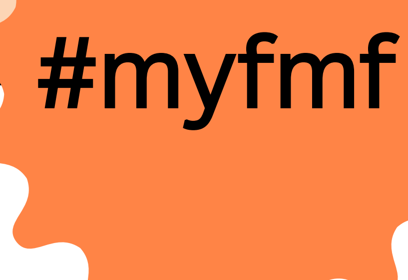
- Medical abortion ≈ 40% of abortions
- Increase in number of community primary care and rural abortion providers
- Telemedicine abortion with access to low touch/no touch self-managed abortion

Looking ahead

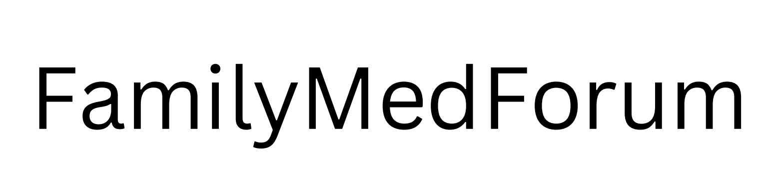
- Continued increase in MA delivered by community-based FPs, NPs, Midwives
- Tailored patient & system supports (information, navigation, counselling, aftercare, etc) to improve access for disadvantaged groups
- ➢ **! Maintain access to procedural abortion despite declining numbers**

Thank you!
Questions?

Please fill out your session evaluation now!



FamilyMedicineForum



FamilyMedForum