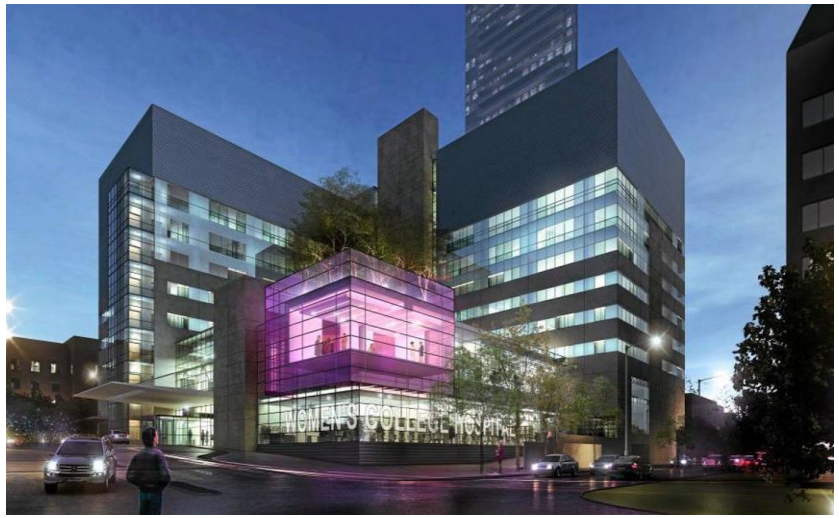
WOMEN'S COLLEGE HOSPITAL
Health care for women | REVOLUTIONIZED

Iffy about Mife?: Improving Access to Medical Abortion in Family Practice



UNIVERSITY OF TORONTO

Samantha Cogan, MD, CCFP, FCFP
Sarah Warden, Msc, MD, CCFP
Sheila Dunn, MD, Msc, CCFP(EM), FCFP
Bay Centre for Birth Control
Women's College, University of Toronto

Disclosure / Conflict of Interest

- Relationship with Commercial Interests: none

"Try this—I just bought a hundred shares."

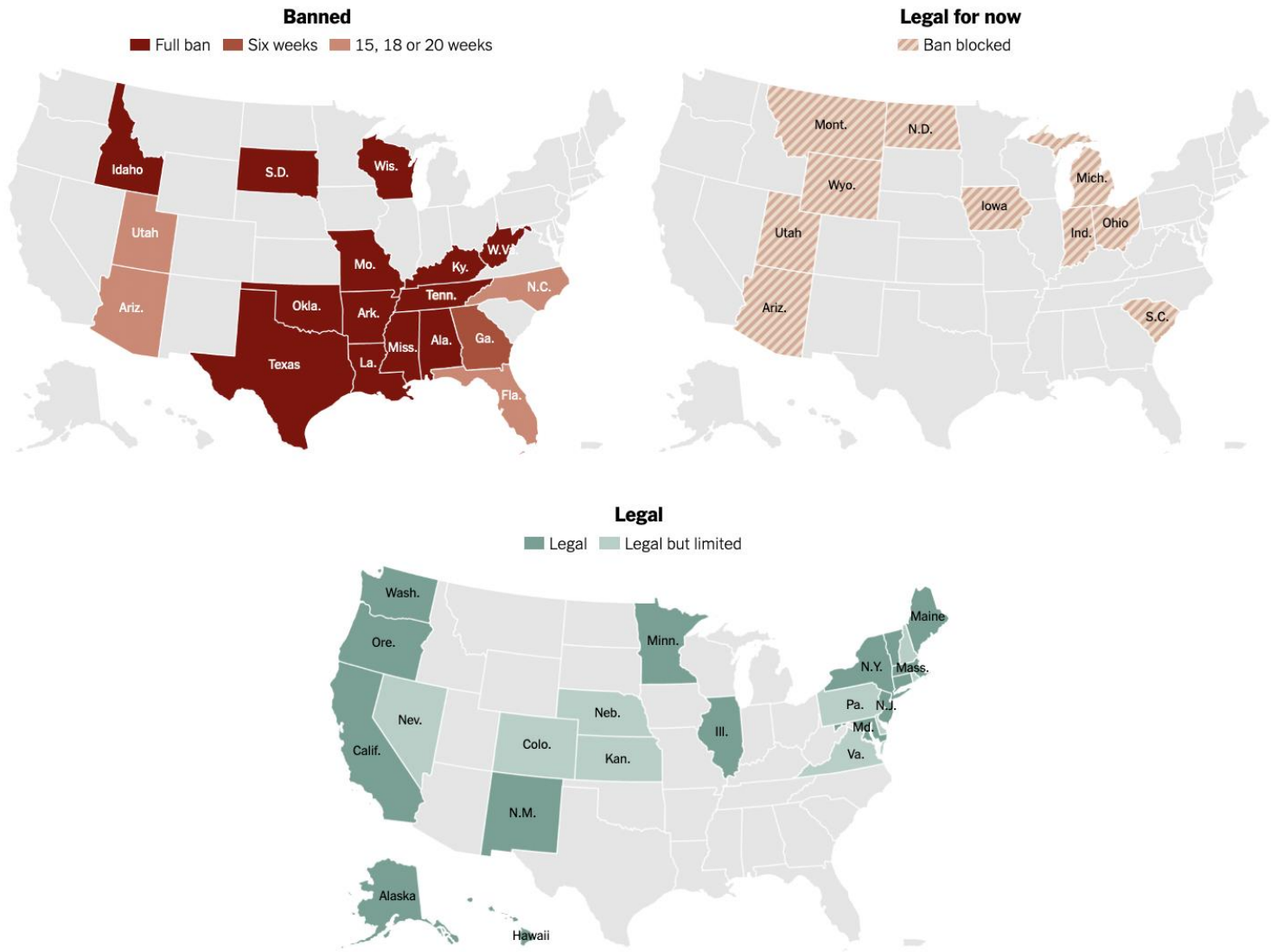
Goals & Objectives:

- 1) Discuss ways to implement mifepristone abortion care in family practice
- 2) Assess and counsel patients regarding risks, side effects, and advantages of mifepristone in patients who are interested in medical abortions
- 3) Assess and manage common questions/concerns and complications of mifepristone

Agenda

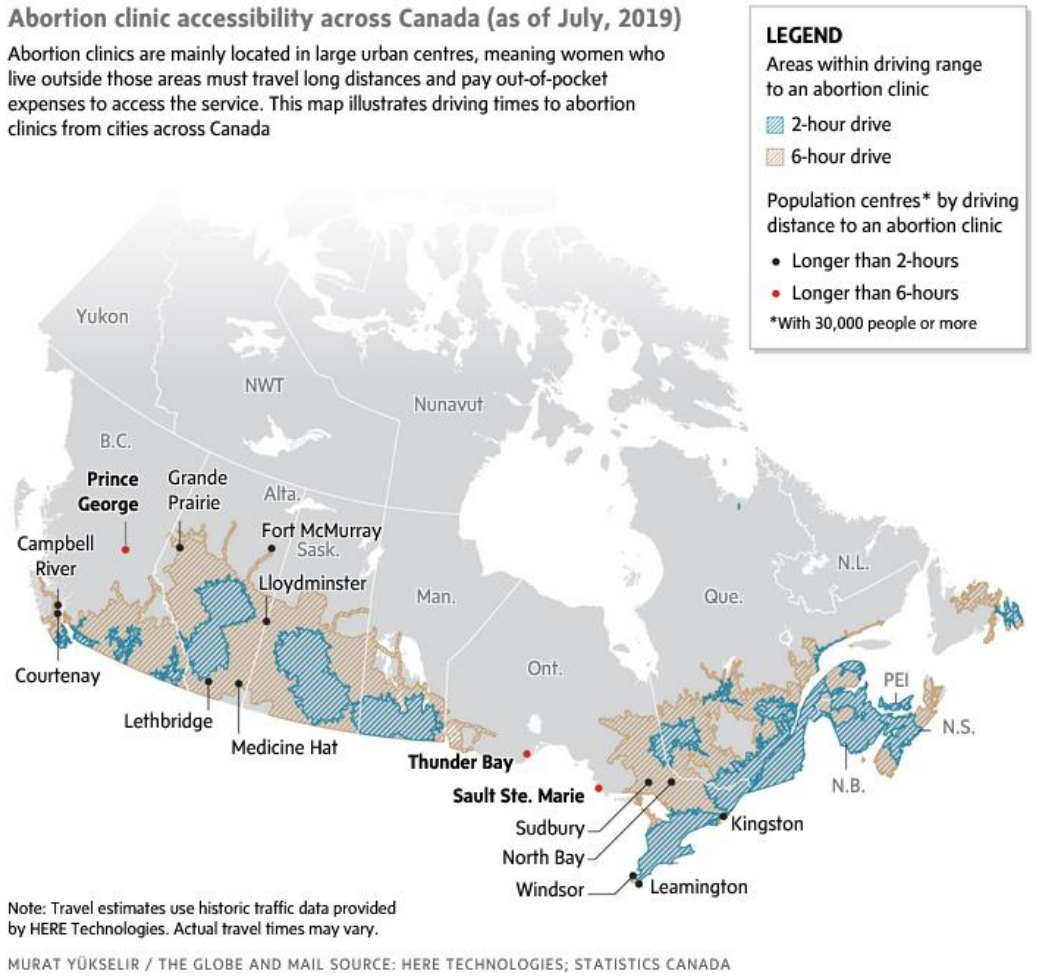
1) Introduction
2) Overview of mifepristone/misoprostol regimen
3) Cases
4) Tools and Resources
5) Questions and Wrap-up

Tracking the States Where Abortion Is Now Banned



Abortion in Canada

- ~ 100, 000 abortions/year
- 1 in 3 women has an abortion in her lifetime
- Limited access outside of large urban centers (except Quebec & BC)
- Prior to mifepristone ~5% of abortions in Canada were medical (mostly in BC)

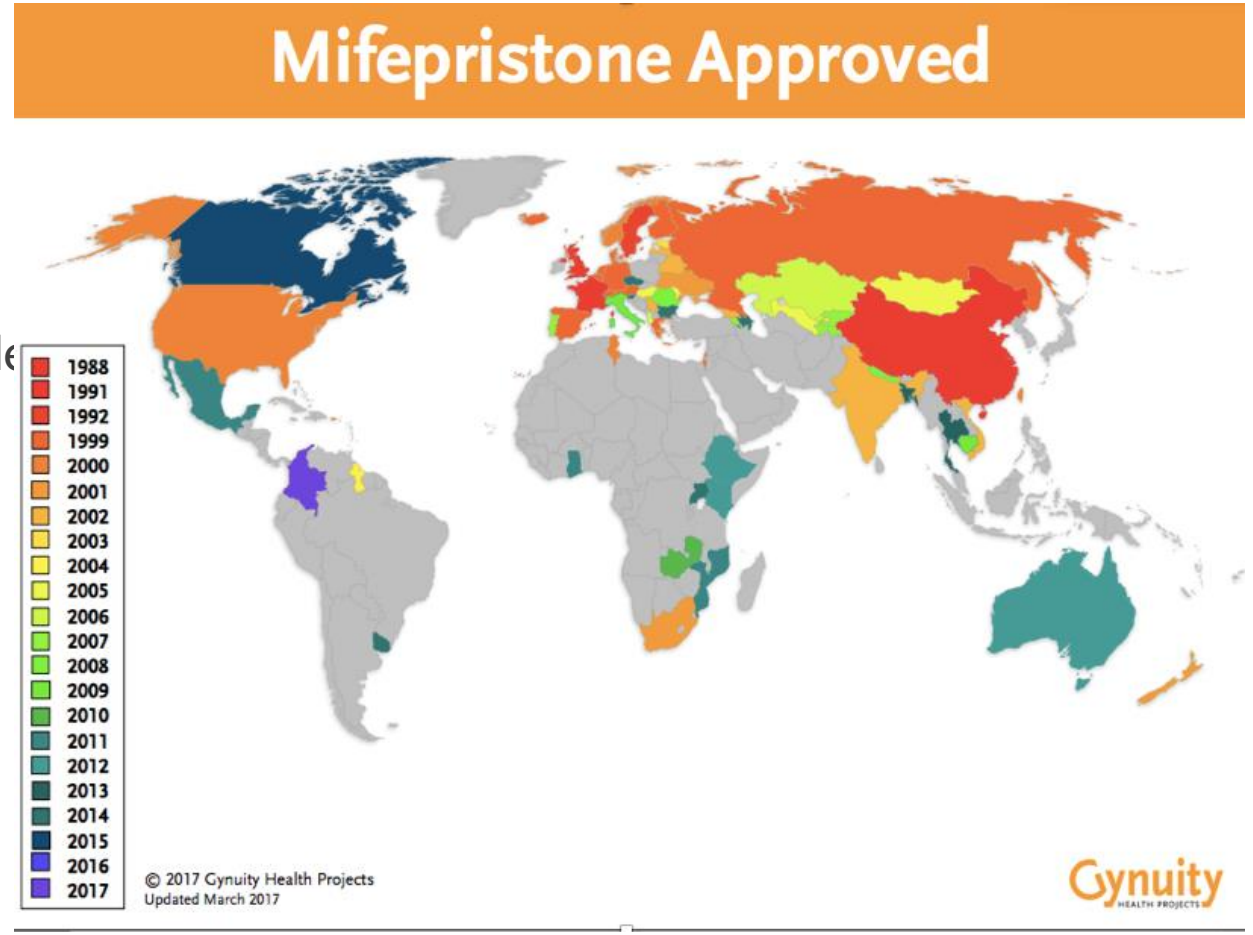


Norman WV, Contraception 2012;85:185-91.
Norman WV, Guilbert E, et al. Canadian Family Physician 2016
Sethna C, Doull M. Women's Studies International Forum 2013

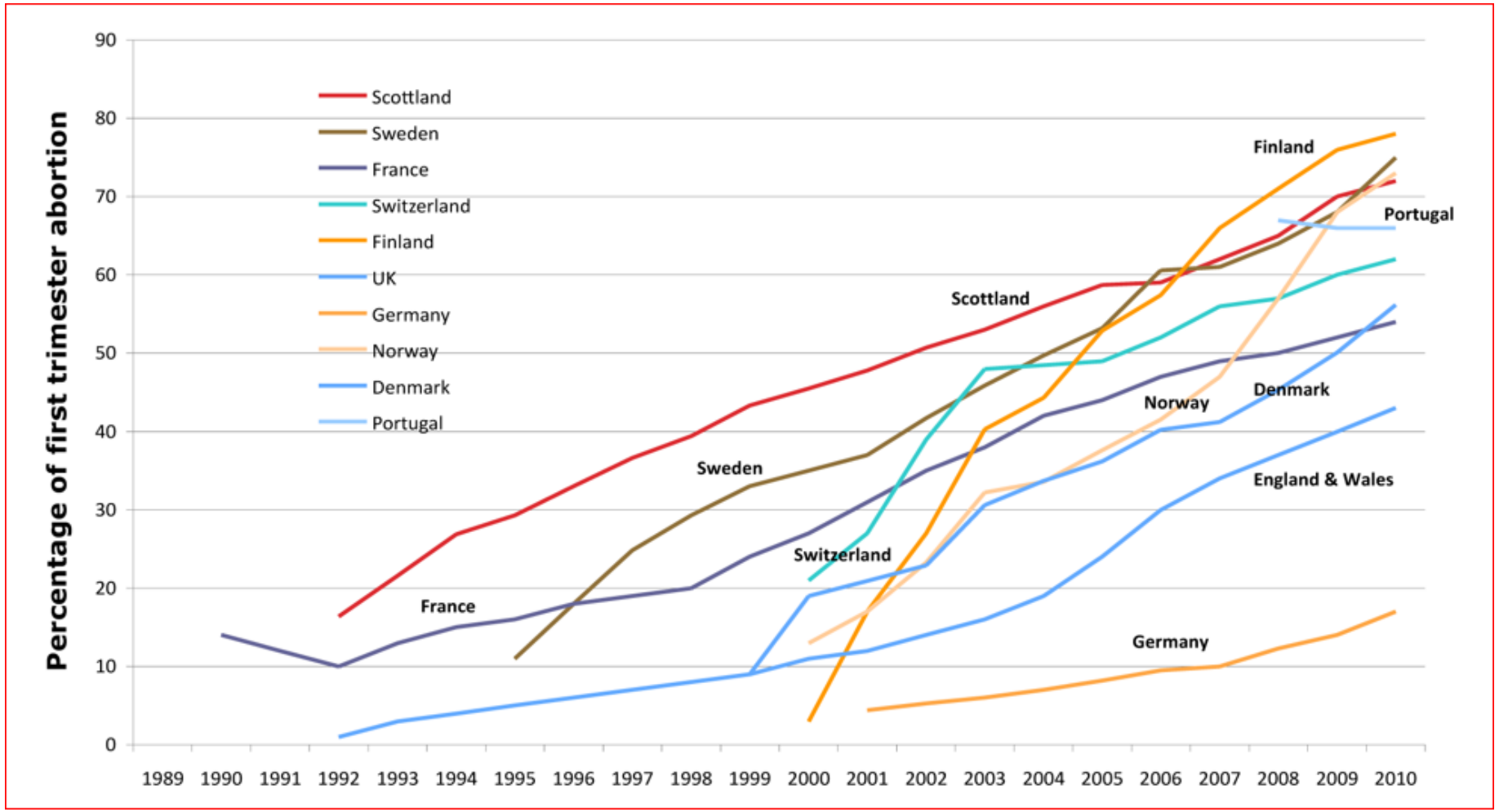
Pro-Choice Rally in NB 2014

History of Mifepristone for MA

- 1st approved in France in 1988 “RU-486”
- Now gold standard for medical abortion worldwide
- WHO List of Essential Medicines
- 62 countries approved between 1988 and 2015
- Approved by Health Canada mid-2015
  “Mifegymiso” mifepristone + misoprostol
- 4 countries since 2015 (mostly in Africa)



Use of mifepristone for abortion



Berard V, Fiala C, et al. PloS ONE DOI: 10.1371/journal.pone.0112401

Options for Patients in Countries Without Legalized Abortion

Why Medical Abortion?

Many patients prefer it

- Less invasive/avoids anesthesia
- Rapid/immediate availability
- Patient ‘takes charge’ of the abortion process

Satisfaction rates comparable to surgical methods

- 80-95% would choose the method again or recommend the method to a friend

Improved access in areas where there are no surgical abortion services

- Increases number of potential providers
- Requires less infrastructure (no OR/procedure room)

Swica Y et al, (2011) Expert Rev Obstet Gynecol 6.4

July 2015 Health Canada Approval

- Mifegymiso®: mifepristone 200 mg (1 tab) and misoprostol 800 mcg (4 x 200 mcg tabs)
- Indication: Termination of pregnancy up to 49 days gestation
- Available by “limited” prescription only
  - Mandatory on-line training & registration for prescribing physicians & dispensing pharmacists
  - Registered physicians could order and dispense
  - Observed ingestion of mifepristone required.
- Signed informed consent and information sheet required.

KEY POLICY CHANGES SINCE APPROVAL

Health care professionals are **not required to witness** a patient when they take medical abortion pills.

Pharmacists may dispense Mifepristone directly to patients like any other drug.

Training is not required to prescribe or dispense mifepristone.

Physicians' **personal information** cannot be shared with the manufacturer.

Nurse practitioners may prescribe Mifepristone in Alberta, BC, Ontario, Nova Scotia, Yukon, and Saskatchewan.

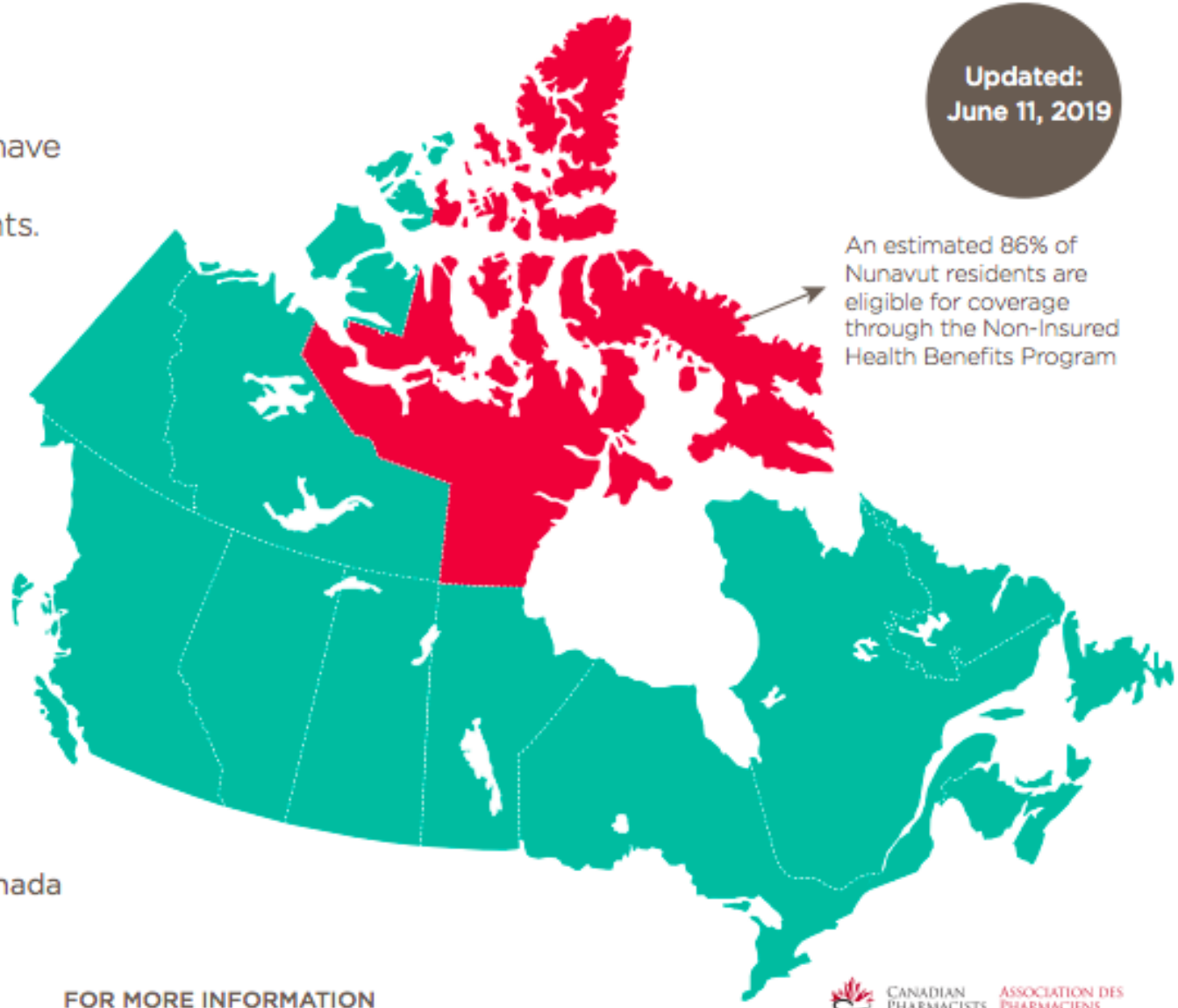
Universal coverage of mifepristone has occurred in all provinces and most of the territories.

MIFEGYMISO: ACCESS AND COVERAGE IN CANADA

ACCESS

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

Updated: June 11, 2019



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

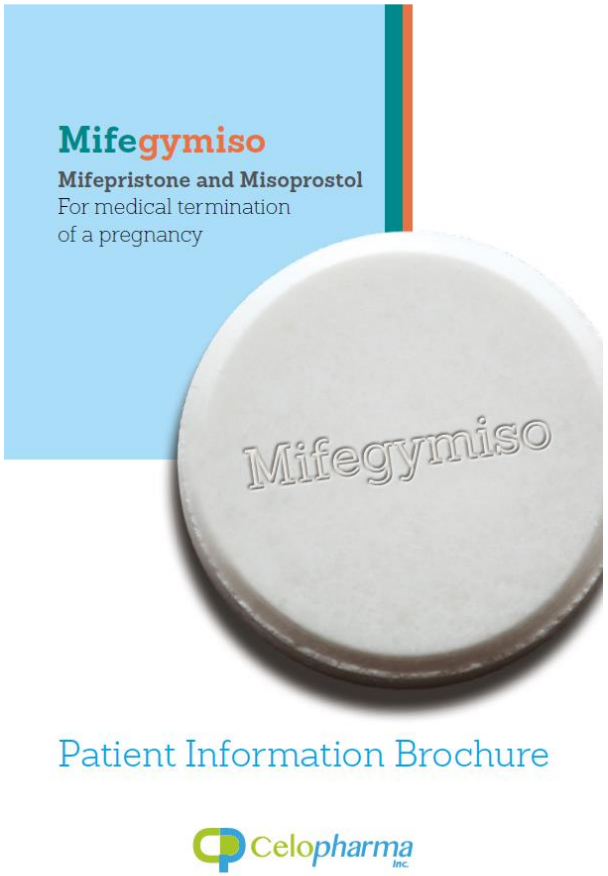
FOR MORE INFORMATION
www.pharmacists.ca

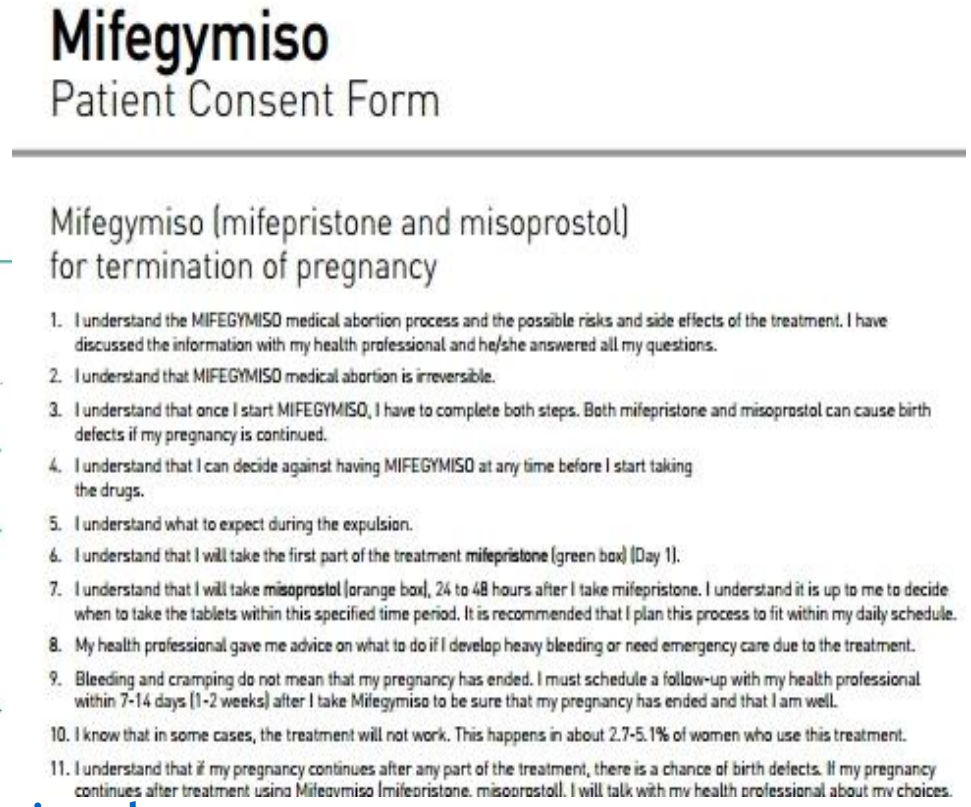
Canadian Pharmacists Association | Association des Pharmaciens du Canada

Current Health Canada Approval
November 7, 2017

- Indication: Termination of pregnancy up to **9 weeks (63 days)** gestation
- **Health professionals** are required to :
- Provide the patient with the current Patient Medication Information and a completed Patient Information Card
- Exclusion of ectopic pregnancy and confirmation of gestational age **by ultrasound** is no longer required (required if ?ectopic or GA uncertain)
- Counsel on the effects and risks
- Ensure patients have access to emergency medical care in the 14 days following administration of mifepristone; and,
- Schedule a follow-up 7 to 14 days after patients take mifepristone to confirm complete pregnancy termination and monitor for side effects.

Approved information and consent





10/17

http://celopharma.com/en/health-professionals

Overview of Regimen

Mifepristone/misoprostol regimen:

1. Mifepristone 200 mg PO
2. Misoprostol 800 mcg buccal* 24-48 hours later

*OFF LABEL: vaginal miso has similar pharmacokinetics, may have less side effects, can use 6-72 hours after mifepristone

- Misoprostol Impairs Female Reproductive Tract Innate Immunity against *Clostridium sordellii*[1]
- David M. Aronoff,[*,2] Yibai Hao,[*] Jooho Chung,[†] Nicole Coleman,[*] Casey Lewis,[†] Camila M. Peres,[†] Carlos H. Serezani,[†] Gwo-Hsiao Chen,[†] Nicolas Flamand,[†] Thomas G. Brock,[†] and Marc Peters-Golden[†]

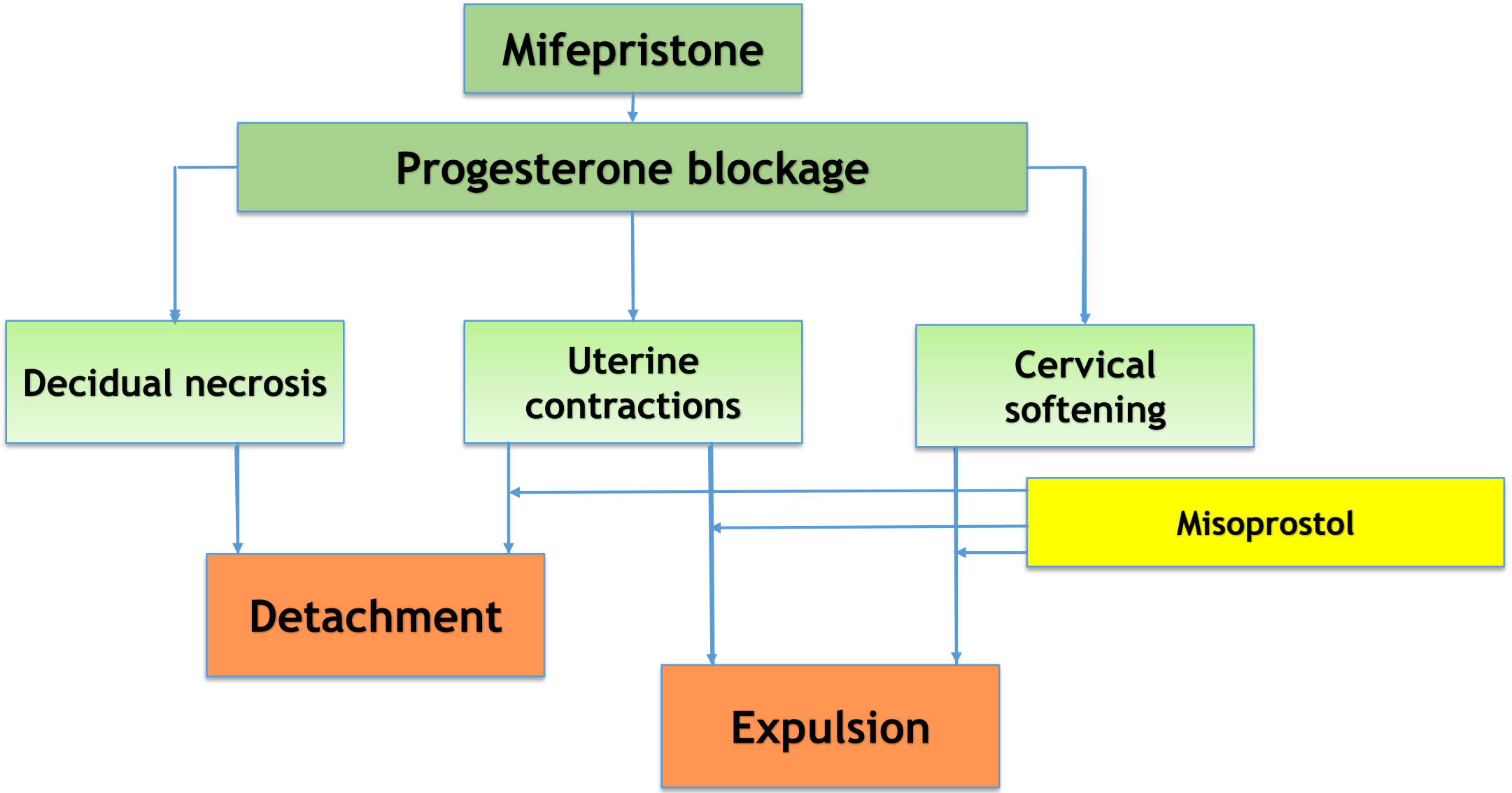
Mechanism of action

Mifepristone – antiprogestin

- Blocks the action of progesterone
- Breakdown of endometrium, cervical ripening
- Increased sensitivity of uterus to prostaglandins

Misoprostol – synthetic prostaglandin

- binds to myometrial cells, causes cervical ripening and uterine contractions


Mifepristone
Progesterone blockage
Decidual necrosis
Uterine contractions
Cervical softening
Misoprostol
Detachment
Expulsion

Expected Side Effects

- **Mifepristone:**
  - no side effects or nausea only, occasionally cramping/spotting (5%)

- **Misoprostol:**

  Common: cramping – may be severe (7-10/10)

  bleeding – may be heavy, including large clots

  diarrhea (2-61%)

  nausea/vomiting (16-47%)

  fever/chills (4-48%)

  headache (2-43%) and dizziness (12-41%)

Chen MJ, Creinin M. Obstet Gynecol 2015

Other drug effects

- **Teratogenicity**
  - Mifepristone – no evidence of teratogenic effect to date (ACOG, 2020)
  - Misoprostol - associated with Mobius syndrome (facial paralysis and limb and chest wall abnormalities)

- **Use in breastfeeding**
  - Mifepristone – excreted in breast milk in very low concentrations (RID = 1.5%)
  - Misoprostol – excreted in breast milk - theoretical potential to cause diarrhea
  - Breastfeeding may continue uninterrupted

National Abortion Federation 2016

Outcomes

- **Efficacy:** 95 - 98% successful abortion without the need for surgical aspiration
- **Ongoing viable pregnancy:** 0.4 – 2.9% from < 49 to 70 days
- **Complications:**
  - Hemorrhage requiring transfusion: 0.08% (0.04-0.9%)
  - Infection: 0.01-0.5%
  - ER visits: 2.9-3.7%
  - Hospitalization: 0.4% (0.04-0.9%)

Chen MJ, Creinin M. Obstet Gynecol 2015

Patient MG

- 26 yo G1P0
- LMP approximately 5-6 weeks ago
- Home urine pregnancy test +
- Wants to terminate

Visit 1 – Unintended pregnancy

- Review options for unintended pregnancy
- Pros/cons of medical vs surgical abortion
- Inclusion & exclusion criteria
- Investigations
- Contraception

Medical vs surgical abortion: decision making

Medical abortion	Surgical abortion
Pros • Avoids uterine instrumentation and anesthesia • Private/happens at home • Support person can be present • Patient ‘takes charge’ of the abortion • May be accessible through primary care/shorter wait	**Pros** • Quick and predictable • Higher success rate • Usually does not require follow up • Allows use of sedation • Less bleeding and cramping
Cons • May take days/weeks to complete • Pain may be severe and bleeding heavy • Multiple visits/follow up needed • Higher failure rate than aspiration • Requires access to emergency care	**Cons** • Instrumentation and anesthesia • Need to travel to surgical abortion facility (involves time, travel and expense for many)

Visit 1
Inclusion Criteria

- Clear decision to have a medical abortion
- Intrauterine pregnancy less than 9 (10) weeks
- Access to telephone and emergency medical care within the next 7-14 days
- Willing to have surgical abortion/D&C in the event that medical abortion is unsuccessful (2%-5% of pregnancies)

Initial visit
Exclusions/Contraindications

- **Absolute contraindication:**
  - Confirmed or probable ectopic pregnancy
  - Chronic adrenal failure
  - Uncontrolled asthma
  - Porphyria
  - Hemorrhagic disorder or concurrent anticoagulant therapy (aspirin excluded)
  - Allergy/Hypersensitivity to mifepristone or misoprostol

Relative contraindications:

- IUD (remove)
- Concurrent long-term systemic corticosteroid therapy
- Anemia - hemoglobin less than 95

Initial Visit Investigations

- Pelvic US
  - Gestational age and location of the pregnancy
- Chlamydia & gonorrhea testing
- Blood type for Rh factor if GA >= 8 weeks
- beta-HCG (on day of mifepristone) and follow up 7-14 days later
- Consider CBC

Initial visit
Contraception post-abortion

- **Rapid return to fertility:** ovulation as early as one week after mifepristone
- Hormonal methods can be started on the day of or the day after misoprostol administration (Return for Depo-Provera)
- Barrier methods can be used as soon as sexual activity is resumed
- Intrauterine devices can be inserted at the follow up visit if abortion complete

Visit 2
Mifegymiso Rx and handouts

- Review investigations, inclusion and exclusion criteria
- Counselling
  - How to take medication
  - Expected bleeding, cramping & side effects
  - Reasons to seek emergency or on-call care
- Informed consent & Patient Take Home Instructions (Linepharma or other) provided
- Prescribe Mifegymiso, pain medication +/- anti-emetic, contraception

Mifegymiso
Patient Consent Form

Mifegymiso (mifepristone and misoprostol) for termination of pregnancy

1. I understand the MIFEGYMISO medical abortion process and the possible risks and side effects of the treatment. I have discussed the information with my health professional and he/she answered all my questions.
2. I understand that MIFEGYMISO medical abortion is irreversible.
3. I understand that once I start MIFEGYMISO, I have to complete both steps. Both mifepristone and misoprostol can cause birth defects if my pregnancy is continued.
4. I understand that I can decide against having MIFEGYMISO at any time before I start taking the drugs.
5. I understand what to expect during the expulsion.
6. I understand that I will take the first part of the treatment **mifepristone** (green box) (Day 1).
7. I understand that I will take **misoprostol** (orange box), 24 to 48 hours after I take mifepristone. I understand it is up to me to decide when to take the tablets within this specified time period. It is recommended that I plan this process to fit within my daily schedule.
8. My health professional gave me advice on what to do if I develop heavy bleeding or need emergency care due to the treatment.
9. Bleeding and cramping do not mean that my pregnancy has ended. I must schedule a follow-up with my health professional within 7-14 days (1-2 weeks) after I take Mifegymiso to be sure that my pregnancy has ended and that I am well.
10. I know that in some cases, the treatment will not work. This happens in about 2.7-5.1% of women who use this treatment.
11. I understand that if my pregnancy continues after any part of the treatment, there is a chance of birth defects. If my pregnancy continues after treatment using Mifegymiso (mifepristone, misoprostol), I will talk with my health professional about my choices, which may include a surgical procedure to end my pregnancy.
12. I understand that if the medicines I take do not end my pregnancy and I decide to have a surgical procedure to end my pregnancy, or if I need a surgical procedure to stop bleeding, my health professional will do the procedure or refer me to another health professional who will.
13. I have my health professional's name, address and phone number and know that I can call if I have any questions or concerns.
14. I have decided to take Mifegymiso (mifepristone, misoprostol) to end my pregnancy and will follow my health professional's advice about when to take each drug and what to do in an emergency.
15. I must ensure that I have access to emergency medical care within a reasonable time-limit in case of emergency.
16. I will do the following:
    - Contact my health professional as soon as possible if in the days after treatment I have a fever of 100.4°F (38°C) or higher, that lasts for more than 4 hours or I experience severe abdominal pain.
    - Contact my health professional as soon as possible if I have heavy bleeding, soaking through two thick full-size sanitary pads per hour for 2 consecutive hours.
    - Contact my health professional as soon as possible if I have abdominal pain or discomfort, or I am "feeling sick", including weakness, nausea, vomiting or diarrhea, with or without fever, for more than 24 hours after taking misoprostol.
    - Take the **Patient Information Card** with me when I visit an emergency room or a health professional who did not give me Mifegymiso, so that they understand that I am having a medical abortion with Mifegymiso.
    - Have a follow-up 7-14 days after taking Mifegymiso to check if my pregnancy has ended. My health professional will talk with me about my options if I am still pregnant.

☐ I have made the decision to end my pregnancy (abortion) after consultation with my health professional. I have made this decision without coercion and on my own free will and being of sound mind.

Patient name (print): _____

Patient signature: _____ Date: _____

The patient has signed the Patient Consent form in my presence after I counselled her and answered all her questions.

Health professional name (print): _____

Health professional signature: _____ Date: _____

After the patient and the health professional sign this Patient Consent form, the health professional shall give a copy to the patient before she leaves the office and keep a copy within the patient's medical record.

Visit 2
Counselling – how to take the medication

Mifepristone orally, 24-48 hr later misoprostol buccal for 30 min

- **Always take misoprostol whether or not they bleed**

UK sponsor

Mifegymiso
Patient Information Card

To be completed by your health professional.
Please keep it with you.

Date and time of treatment:

Step 1 (Green Box): .....

Step 2 (Orange Box): .....

If you have a serious symptom or side effect, get immediate medical help.
If you have an emergency, go to:

.....

.....

.....

[Add the emergency contact information above]
Show this Card to the emergency health professional.

Mifegymiso
Patient Information Card

To be completed by your health professional.
Please keep it with you.

If you have a troublesome symptom or side effect that becomes bad enough to interfere with your daily activities, talk to your health professional.

Phone number and address of your health professional, clinic or treatment center:

.....

.....

.....

You must have a follow-up appointment 7 to 14 days after taking Mifegymiso.

Follow-up appointment date (MM/DD/YYYY) and time:

.....

.....

.....

Distributor in Canada Celopharma

PC3000A10C

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:

Visit 2
Counselling – expected bleeding and pain

- Bleeding – moderate to heavy
- Cramping – mild to severe
- Clots (up to lemon size) and possible tissue
- Most will pass pregnancy within 6 hours after taking misoprostol, 90% within 24h
- Average 9-16 days of bleeding
- 8% of patients bleed for >30d, including delayed heavy bleeds
- Recommend patients take off work/dependent care the day of misoprostol, possibly next day

Visit 2
Typical timeline after misoprostol

- **Hour 0:** take misoprostol
- **Hour 2:** strong cramps, bleeding heavier than period
- **Hour 4-6:** strongest cramps and bleeding, pass pregnancy
- **Hour 8-72:** heavy period-style bleeding
- **For 1-3 weeks after:** light bleeding or spotting

Visit 2

Reasons to seek emergency or on-call service

- Soaking more than 2 large sanitary pads/hour for more than 2 hours
- Severe abdo/pelvic pain not controlled by analgesics
- Fever >38° C for more than 6 hours or that starts >24h after misoprostol
- Continued vomiting, inability to tolerate fluids for >6 hours
- Lightheadedness, fainting, tachycardia
- Feeling ‘sick’ with flu-like symptoms (weakness/malaise, nausea, vomiting, diarrhea) in the days after the abortion, *often without fever*

Visit 2
Counseling - analgesia

- 1st Line: NSAID (ibuprofen or naproxen)
  - Naproxen Rx = 500 mg x 10 tabs (most use less)
- 2nd line: Mild opioid (acetaminophen with codeine)
  - Rx = T3 x 6 tabs (most use less)
- Patients usually use pain medication for first 1-2 days only but some use for longer
- Recommend NSAID one hour prior to taking misoprostol

MG - Review Investigations (Visit 2)

- Meets eligibility and has no contraindications
- TVUS: 5.7 week sac with yolk sac
- Hb: 130
- b-HCG 5932
- Blood group O negative

- Does MG need RhIG?

Alloimmunization- What we know

- Red blood cells express Rh antigen starting at **52 days** from LMP
- There is sufficient maternal-fetal hemorrhage at **63 days** from LMP after surgical abortion to cause alloimmunization
- There is limited evidence for use of RhIG **below 56 days**
- SOGC: Rh immunoglobulin is recommended to Rh negative women undergoing MA beyond 56 days from LMP
- Patients should be advised that the data on RhIG administration is limited.

Jabara S, Barnhart KT. Am J Obstet Gynecol 2003
SOGC Medical Abortion Guidelines, 2016

Visit 2
Written follow-up instructions

- Linepharma Patient Information Card or other
- Requisition for f/u investigation (quantitative beta-HCG or pelvic US)
- Arrange follow up (virtual or in-person appointment) and discuss no show plan

Visit 3
Follow up visit – in person or by phone

7-14 days later

- Assessment of cramping/bleeding, resolution of symptoms of pregnancy, emotional/coping.
- Confirmation of abortion completion
- Repeat serum b-HCG*
  - Abortion complete if level has dropped ≥80% from baseline (day 8-15)
  - Alternative: ≥50% drop 24h after misoprostol (day 3-4)
- Pelvic exam/ultrasound if concern or if b-HCG has dropped <80%
- IUD insertion/Depo injection if chosen method/Contraception check-in
- Info re: prolonged/delayed bleeding

*required for PUL

MG – Day 7

- Took mifepristone day 1, no side effects
- Took misoprostol day 2 (24 hours later), 2 hours later developed severe cramps and heavy bleeding, passed white tissue 1 hour later
- Fever and chills, diarrhea and nausea x 4 hours
- Bleeding decreased to lighter than a period, slight cramps for 2 days
- Today just spotting, 2 liners/day
- Pregnancy symptoms resolved
- Emotionally feeling well

MG – Day 7

bHCG: 949 (Initial 5932)

% Drop = 84% (need 80% drop on day 8)

- = ABORTION SUCCESSFUL

- Started taking OCP on day after misoprostol

RS

- 33 yo G3P2
- LMP 5 weeks ago, positive home urine pregnancy test
- Requesting a medical abortion
- US: no gestational or yolk sac
- Physical exam: small uterus, no uterine or cervical motion tenderness, no adnexal tenderness or masses

Do you go ahead and provide a medical abortion?

RS

Differential Dx?

- early intrauterine pregnancy
- pregnancy failure
- ectopic pregnancy

Is it an intrauterine pregnancy?

- Ultrasound: yolk sac needed to confirm intrauterine pregnancy
- Yolk sac: 5.5 wks transvaginal, 7 wks transabdominal
- Most patients presenting for MA without yolk sac on U/S will be *early* or *failed*, ectopic is much less likely
- Failure to identify a definite intrauterine pregnancy should not delay abortion care at early gestation

Risk of ectopic with PUL

- Goldstone 2013
- 68 patients with no GS, or GS but no YS or double decidual ring
  - 1 ectopic (1.5%) – discovered because initial beta-HCG was >10,000

- Schaff 2001
- 30 patients with positive pregnancy test and no GS.
  - 2 ectopics (6.7%) – 1 discovered because b-HCG > 2000 and the second because follow-up beta-HCG did not drop appropriately

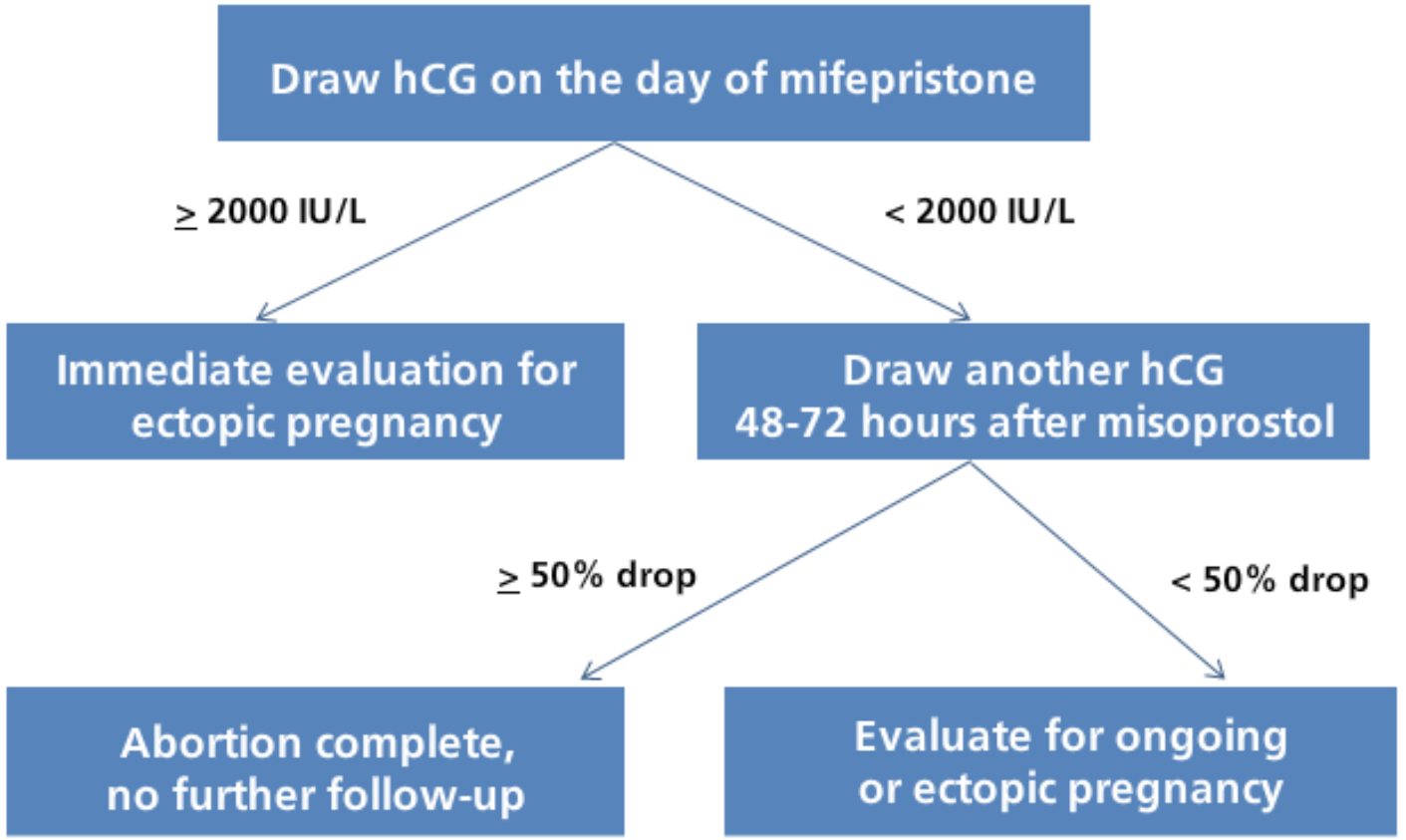
Medical abortion and pregnancy of unknown location (PUL)

- Medical abortion can be safely provided in a PUL if:
  - No risks, symptoms or findings of ectopic pregnancy
  - Follow up is ensured
  - Serial beta-HCG is used for follow-up

Ectopic Pregnancy

- Risk Factors
  - Previous ectopic pregnancy
  - Previous tubal surgery including tubal ligation
  - IUD in place
  - History of PID, salpingitis
  - Pregnancy conceived with assisted reproductive techniques
- Clinical symptoms
  - Abdominal/pelvic pain
  - Vaginal bleeding
- Ultrasound findings
  - Empty uterus with b-HCG of >2000

PUL Management



Courtesy National Abortion Federation

RS

- No ectopic risk factors, symptoms, or signs
- Ultrasound consistent with LMP
- Day 1 b-HCG: 1370

- You proceed with mifepristone abortion
  - **Ectopic warning and early follow-up**
- RS used misoprostol 1 day later with moderate bleeding and cramping within 4 hours
- Day 4 b-HCG: 380
- Day 7 b-HCG: 96

PL

- 25 yo G1P0
- LMP 7 wks ago
- wants a medical abortion
- Ultrasound is not available

- Can you go ahead and provide a medical abortion?

- **Yes** but with certain conditions and with the understanding it is off-label.

Pelvic Ultrasound

- Accurately confirms gestational age and excludes ectopic pregnancy
- Confirmation of GA
- LMP alone is fairly accurate if certain and if not on OCP or breastfeeding
  - 2.4% of 3041 women with certain LMP of < 63 days were over 63 days by US
- History and clinical exam by experienced provider correlates to GA within 2 weeks in the first trimester
  - Study of 4008 MA patients – 1.6% assessed as eligible by Hx and clinical exam were beyond the 63 day eligibility window

Bracken et al 2011

Mandatory Pelvic US

- Uncertain dates
- Conflicting bimanual exam
- History of pain or bleeding
- Risk factors for ectopic
- CMT or adnexal tenderness

Medical abortion without ultrasound

- Patient has certain LMP and consistent pelvic examination
- No risk factors for ectopic pregnancy
- Informed consent for off-label provision
- Manage as per PUL guidelines
  - Provide ectopic warning
  - B-HCG on day of mifepristone
  - Follow up with b-HCG (early)
- Ultrasound needed if concerning symptoms or insufficient fall in b-HCG

Mifegymiso® without ultrasound

OFF LABEL:

- **Product Monograph/HC:** ultrasound dating required
- **SOGC:** ultrasound required if:
  - risks for/symptoms of ectopic pregnancy
  - Irregular periods

  Otherwise LMP, clinical history and focused exam can be used to date a pregnancy
- **NAF:** "ultrasound is not a requirement for the provision of first trimester abortion care"

TO

- 34F G1P0
- LMP 7 wks ago, wants a medical abortion
- U/S confirms IUP 7w4d
- No contraindications
- Rh positive, Hb 132
- B-HCG 99,770

TO

- Mifepristone/misoprostol taken
- Heavy bleed x 1 day, then lighter x 2-3 days
- Still bleeding like a light period at follow-up visit, but no cramping now
- Pregnancy symptoms resolved
- Day 7 b-HCG – 6984 (93% drop)

TO – Day 18

- Pt calls on day 18: still bleeding like a period.
- Is this normal?
- How do you proceed?

TO

- Ultrasound: "Endometrium measures 15 mm, heterogeneous mass with flow consistent with retained products of conception" (RPOC)
- Hgb = 109 (baseline 129) – iron supplements
- What do you do?

Options for management

Incomplete abortion/Persistent Bleeding/RPOC

- Expectant management with follow-up (can take 2 wks), reassess at 1 wk
- Repeat misoprostol 800 mcg buccal or vaginal, reassess at 1 wk
- Surgical management

Ongoing pregnancy (~1%)

- Repeat misoprostol 800 mcg buccal or vaginal, reassess at 1 wk, if unsuccessful – surgical management
- Surgical management

TO

- Decides to take misoprostol – given 2 doses (800 mcg)
- Follow up 1 week later (Day 24):
  - Passed large clot after second dose of misoprostol
  - No further bleeding or cramping
  - Hb 116
  - Pt advised to follow up if further heavy bleeding/clots

Common questions on call:

- **Bleeding:**
- I took the misoprostol 6 hours ago and am still having heavy bleeding and passing large blood clots, is this normal?
- I used the misoprostol pills 24 hours ago and I still haven't had any bleeding. What should I do?
- I took the mifepristone yesterday and started to bleed before using the second pills (misoprostol). Do I still need to use the misoprostol?
- I had my medical abortion 3-5 weeks ago and I'm still bleeding. What should I do?

Common questions on call:

Pain/other symptoms

- I used the misoprostol 3 hours ago. I have really bad pain and am passing clots. I took one of the pain pills but it only helped a bit.
- I used misoprostol 4 hours ago. I'm vomiting and am shaking. What should I do?

Medication issues

- I vomited after I took the pill and am not sure if I threw it up. What should I do?
- I accidently swallowed the misoprostol pills before the 30 minutes was up. Is this OK?

Other

- I took a pregnancy test (after f/u visit) and I'm still pregnant!

Family practice protocol – 3 visits

VISIT 1 (any provider) – review pregnancy options

- Counselling about MA (the process, risks/benefits)
- Review eligibility
- (CBC), Rh, Pelvic US, (b-HCG), urine for GC and Chlamydia

VISIT 2 (MA provider) – review test results and eligibility and prescribe mifepristone

- Informed consent
- Prescribe Mifegymiso® and analgesic, b-HCG, (RhIG)
- Detailed written review of MA process, emergencies, follow-up (Info sheet)
- Contraception plan

VISIT 3 (any provider) – day 7-14 in person or by phone

- Follow up with b-HCG and symptoms, review contraception

Bay Centre (WCH) Protocol: 2 visits

1. Screening, options, decision-making by RN/NP
2. Pelvic ultrasound
   - gestational age/location of pregnancy
3. Bloodwork (baseline BHCG, G&S, CBC); Vitals, urine GC/CHL
4. Clinical Assessment by MD/NP
   - Exclude medical contraindications
   - focused PE prn
   - Ensure patient knows what to expect
   - Consent form reviewed and signed
5. Prescriptions given +/- RhIG
6. Follow up in clinic 1-2 wks or remotely with labwork and phone call
7. IUD at two weeks post mife with b-HCG level >48hrs prior

Provincial Billing Codes

Province	Codes
AB (no specific code)	04A (Initial); 03A (Follow-up)
BC	T14545 ($159.27) – Includes US if done by provider
MB	8428 ($167.65)
NS	03.03V ($120); 03.03 (follow-up)
ON	A921 ($161.15); A921 ($33.70)
PQ	15313 ($133.35); US billed extra
Sask	50P ($387.30)
YT	4116 ($207.70)

Preparing for mifepristone abortion

- Infrastructure
  - Timely appointment for suitable patients
  - Timely US access, Quantitative b-HCG available
  - Access to Rh testing and pathway for RhIG
  - Pharmacy that stocks Mifegymiso®
  - Mechanism for managing emergencies
    - 24 hr - Phone on call
    - ER access
  - Referral pathway for failed abortion/complications (D&C)

Resources

Online Medical Abortion Training

1. Accredited program created through collaboration between:
   - Society of Obstetricians and Gynecologists of Canada
   - College of Family Physicians of Canada
   - Canadian Pharmacists Association
   - 6 modules, 1.5 - 3 hours to complete, $50 https://sogc.org/online-courses/courses.html
2. Linepharma Training Program: https://www.linepharma.ca/the-use-of-mifegymiso-in-canada/

Further Resources:

Medical Abortion Guidelines:

Society of Obstetricians and Gynecologists of Canada:

JOGC April 2016 38(4): 366-389

National Abortion Federation:

https://prochoice.org/resources/clinical-policy-guidelines/

Reproductive Health Access Project (US)

https://www.reproductiveaccess.org

Join Canada's
online community
for health professionals certified to provide Mifepristone.

- Exchange tips, resources, and best practices
- Gain feedback from experts
- Locate pharmacies in your region

LEARN MORE

CAPS CPCA
Canadian Abortion Providers Support
Communauté de pratique canadienne sur l'avortement
www.caps-cpca.ubc.ca

THE SOCIETY OF OBSTETRICIANS AND GYNAECOLOGISTS OF CANADA
CANADIAN PHARMACISTS ASSOCIATION / ASSOCIATION DES PHARMACIENS DU CANADA
THE COLLEGE OF FAMILY PHYSICIANS OF CANADA / LE COLLÈGE DES MÉDECINS DE FAMILLE DU CANADA
CART-GRAC

Version 2 | August 29, 2016
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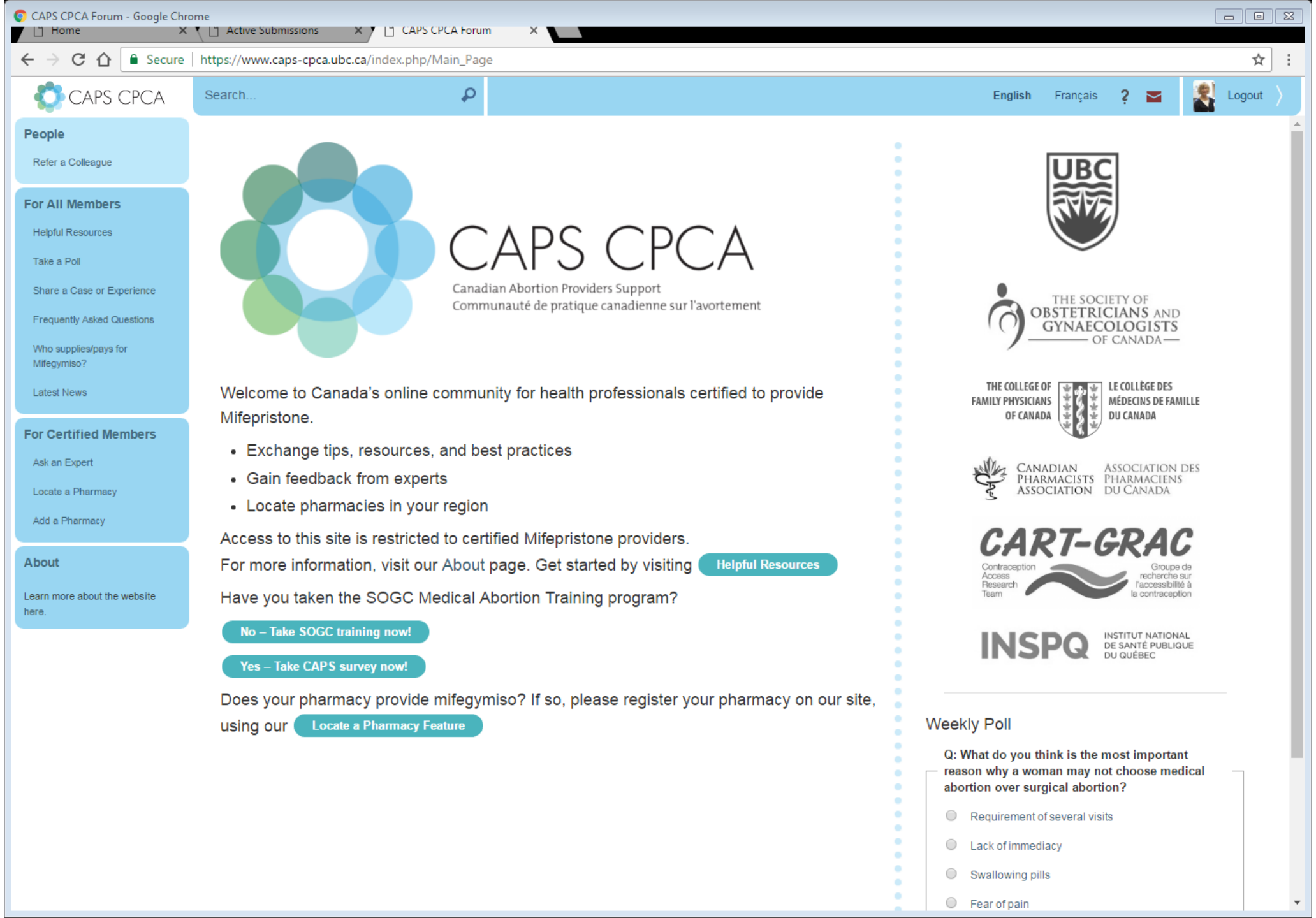
https://www.caps-cpca.ubc.ca/index.php/Main_Page


CAPS CPCA Forum - Google Chrome
Home
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https://www.caps-cpca.ubc.ca/index.php/Main_Page
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People
Refer a Colleague
For All Members
Helpful Resources
Take a Poll
Share a Case or Experience
Frequently Asked Questions
Who supplies/pays for Mifegymiso?
Latest News
For Certified Members
Ask an Expert
Locate a Pharmacy
Add a Pharmacy
About
Learn more about the website here.
CAPS CPCA
Canadian Abortion Providers Support
Communauté de pratique canadienne sur l'avortement
Welcome to Canada's online community for health professionals certified to provide Mifepristone.
Exchange tips, resources, and best practices
Gain feedback from experts
Locate pharmacies in your region
Access to this site is restricted to certified Mifepristone providers.
For more information, visit our About page. Get started by visiting
Helpful Resources
Have you taken the SOGC Medical Abortion Training program?
No – Take SOGC training now!
Yes – Take CAPS survey now!
Does your pharmacy provide mifegymiso? If so, please register your pharmacy on our site, using our
Locate a Pharmacy Feature
UBC
THE SOCIETY OF OBSTETRICIANS AND GYNAECOLOGISTS OF CANADA
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CANADIAN PHARMACISTS ASSOCIATION
ASSOCIATION DES PHARMACIENS DU CANADA
CART-GRAC
Contraception Access Research Team
Groupe de recherche sur l'accessibilité à la contraception
INSPQ
INSTITUT NATIONAL DE SANTÉ PUBLIQUE DU QUÉBEC
Weekly Poll
Q: What do you think is the most important reason why a woman may not choose medical abortion over surgical abortion?
Requirement of several visits
Lack of immediacy
Swallowing pills
Fear of pain