# Medical abortion after 12 weeks of gestation

Essentials in Abortion Care Fiapac 2024

Ninni Manneberg
PhD-student, RNM

Karolinska Institutet

KAROLINSKA UNIVERSITY HOSPITAL

# Abortion care after the first trimester – How to care for women through medical abortion after 12 weeks of gestation

- WHO-recommendations/best practice statements through the abortion care pathway

- A Swedish example of active management.

# WHO recommendations for medical abortion >12 weeks

- No mandatory waiting period
- That abortion be available on the request of the pregnant person without the authorization of any other individual, body or institution.
- Facility-based care with access to medical specialists/surgical backup
- No routine ultrasound scanning as a prerequisite for providing abortion services.
  - Legal regulations with gestational limits
  - Clinical reasons

# WHO recommendation of medical management >12 weeks


- 200 mg Mifepristone administered orally


- 1–2 days later repeat doses of 400 µg misoprostol administered **vaginally**, sublingually or buccally every 3 hours until success of abortion process.

- Anti-D administraton if patient is Rh-negative

- No prophylactic antibiotics.

# Contraindications to medical abortion >12 weeks

## No absolute contraindication

- Previous allergic reaction to one of the drugs involved
- (Known or suspected ectopic pregnancy)

***Contraindications Mifepristone:***

- Inherited porphyria
- Chronic adrenal failure
- Severe uncontrolled asthma
- Longterm corticosteroid therapy

## Higher-risk patients

- Haemorrhagic disorder
- Severe anaemia
- Pre-existing heart disease or cardiovascular risk factors
- Long-term corticosteroid therapy (including severe uncontrolled asthma)
- Previous large bleed at birth/abortion/miscarriage
- Prior uterine incision

# WHO Pain/discomfort management recommendations for medical abortion >12 weeks:

**Side-effects of medical abortion:**

- Abdominal cramping/contractions
- Bleeding
- Nausea/vomiting
- Diarrhea
- Chills/fever

Routinely offered pain medications (NSAIDs)

Additional methods paracetamol, local anesthesia, epidural anesthesia

Anti-emetics

# Active management in Sweden – Patient example

- Healthy parous woman, 2 vaginal births, Rh-positive. Now in gestational week 19 with an unwanted pregnancy. She wishes to terminate the pregnancy.
- First visit with midwife – Mifepristone and information

- Methods of abortion/pain management
- What will occur before, during and after the abortion
- How long the procedure/process and the recovery are likely to take
- When normal activities can be resumed
- Reasons to return to follow up care
- When, where and how to access follow-up care

# Active management in Sweden: Patient example

- **05:30 am** 800 µg misoprostol vaginally, ibuprofen/paracetamol and an antiemetic.
- **7:30 am** arrives at hospital for in clinic care.
- **8:30 am** second dose of Misoprostol, 400 µg sublingually.
- **9:00 am** Vaginal exam is offered, the midwife breaks the membranes and administers a paracervical block.
- **10:00 am** counsellor visit
- **11:30 am** third dose of Misoprostol, 400 µg sublingually, ibuprofen/paracetamol/anti-emetics. Experiences Misoprostol side effects

# Active management in Sweden: patient example

- **12:45 pm** Fetal expulsion, iv oxytocin injection, NPO, no placenta yet.
- **1:45 pm** after 45 min the midwife offeres to performe a new exam. Still no placenta. Patient is given 400 µg Misoprotol sublingually again.
- **2:05 pm** Placental explusion/examination. Measuring of vaginal bleeding.
- **3:00 pm** The patient wishes to see and hold her fetus.
- **4:00 pm** dinner/information/discharged

# Is it done? Is everything alright?  Can the patient go home?

- Incomplete abortion is only treated if the patient has symtoms.
- Routine ultrasound examination should not be used to screen for incomplete abortion
- Routine uterine curettage following complete expulsion of the fetus and placenta is unwarranted.
- <10% of retained placenta. Uterine evacuation to remove placenta should only be performed in individuals who have heavy bleeding, fever and retained placenta over 3-4 hours after expulsion of fetus.

# Active management in Sweden – patient  example

- No medical need for a routine follow-up visit.

- Alarm criterias to seek follow-up care:

  - **Prolonged or heavy bleeding** (soaking more than two large pads per hour for two consecutive hours)
  - **Fever/chills lasting more than 24 hours** after the last misoprostol dose
  - **Severe pain that persists** (evaluation is needed to rule out uterine rupture, a rare complication, which is more likely with a history of prior uterine incision).

# Complications

- Need for further intervention to complete procedure (13/100)
- Infection (<1/100)
- Severe bleeding requiring transfusion (1-4/1000)
- Uterine rupture is a rare complication (<1/1000)

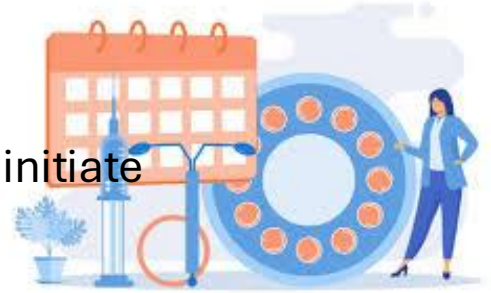
# Management

- **Incomplete abortion**: Suggest the use of repeat doses of 400 µg misoprostol administered sublingually, vaginally or buccally every 3 hours. Hospitalize if necessary
- **Infection:** Provide antibiotics and uterine evacuation, hospitalize if necessary.

# Postabortion contraceptives

All patients who are  seeking abortion has:

- **Right to be offered** contraceptive counselling
- **Right to decide** if they want a contraceptive
- If they want it they have the **right to decide when** to have the counselling – before or after the abortion

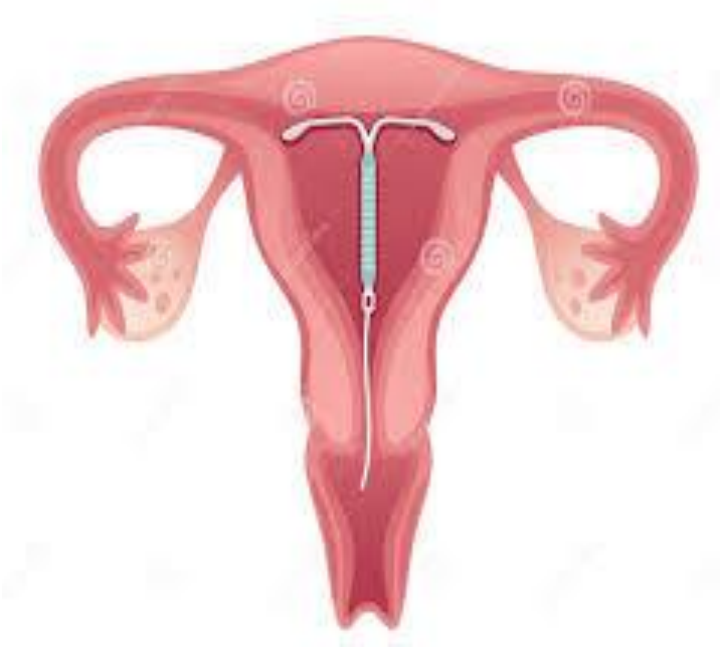


It's important that the abortion provider never implies in any way that agreeing to initiate contraception is a must to obtaining the abortion

Inform all women that ovulation can occur 8 days after abortion

# Timing of post-abortion contraceptives

- Hormonal contraceptives later same day as Mifepristone
- Contraceptive ring when heavy bleeding has stopped.
- IUD can be placed at the time the success of the abortion procedure is determined but with a higher risk of expulsion in later gestational weeks.



# Evidence based advice and guidelines



Royal College of Obstetricians & Gynaecologists

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