Abortion Beyond the First Trimester

Session Chairs: Dr. Patricia Lohr, Dr. Matthew Reeves

Speakers (in order of appearance):

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Ibis Reproductive Health

Increasing Access to Later Abortion

A project of the Later Abortion Initiative

Monica Dragoman MD, MPH, Susan Yanow MSW

FIAPAC

September 2024

Who Needs Later Abortion – and Why?

Those having abortions at/after 20 weeks of gestation or later are more likely to be younger (20–24 years old) and more likely to be unemployed than those who had their abortions in the first trimester.

Many individuals seeking abortion at 20 + weeks reported at least one difficult life event such as raising children alone (47%), having a history of substance use and/or depression (30%), or having recent conflict or violence with their partner (24%).*

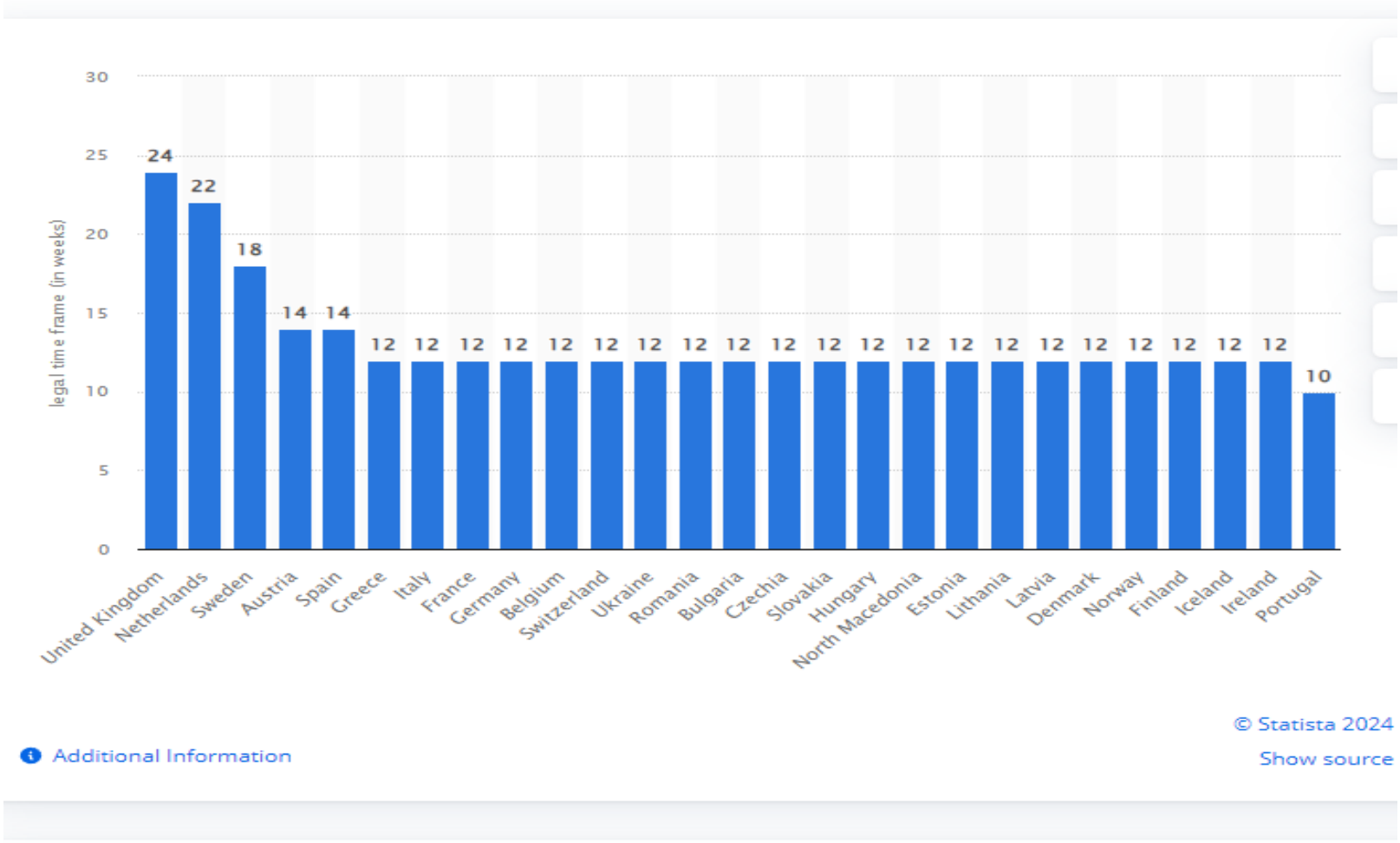
* Foster DG and Kimport K. Who seeks abortions at or after 20 weeks? Perspectives on Sexual and Reproductive Health. 2013:45(4):210-8..

There is a Need for Abortion Care after 12 weeks

People are delayed in seeking abortions because:

- They did not identify the pregnancy until the second trimester
- They needed time to consider their options and make a decision
- As many countries do not provide abortions after 12-14 weeks, they needed to find ways to cover the costs and arrange the logistics of traveling to another country
- There is a maternal health crisis or a diagnosis of fetal anomaly. (small % of later cases)

Access to Later Abortion Care is Limited



Legal abortion time frames in Europe 2020

Published by Jenny Yang, Nov 30, 2023

What is Needed for Change?

- **Advocacy for Removal of Gestational Limits in Law**
- **Expanded Care to the Legal Limit in Every Country**
- **Transparency About Services to Facilitate Referrals**
- **Expanded Clinical Training**

Didactic Learning Module for Expanding from 13.6 - 17 weeks

(available in English and Spanish at https://laterabortion.org/incremental-expansion-abortion-care)

A collaboration between Patient Forward, SFP and LAI

Author: Julia McDonald, DO, MPH

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Didactic Learning Module for Expanding from 23.6 to 26 weeks –

A guide for incrementally broadening D & E skills, available from **lai@ibisreproductivehealth.org**

A collaboration between Patient Forward, SFP and LAI

Authors:

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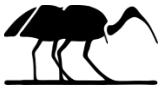
Why Become a Provider of Later Abortion Care?



Clinical Pearls for Increasing from 24 to 26 weeks

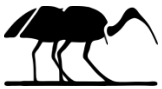
- Advance incrementally; recognize that staff who are skilled to 24 weeks already have the necessary fundamental skills
- Garner support of key stakeholders
- Special resources needed, e.g. mental health/bereavement support, fetal testing, logistical support
- Equipment and supplies
- Staff buy-in and training
- Update protocols and procedures

Other Considerations for Expanding Services

- Engagement with key stakeholders, including organizational leadership, administrative and clinical staff, as well as community medical and social support resources, is important to advance practice
- Physicians focused on advancing their practice may benefit from connecting with mentors and colleagues experienced with this care

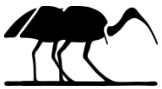
24 to 26 Weeks: Key Differences

- Cervical Preparation
  - Balancing access and safety
  - Addressing patients' expectations
  - Methods similar but optimal protocols not established
  - Mechanical agents
    - Osmotic dilators
    - Cervical balloon catheter
  - Pharmacologic agents as adjuncts to osmotic dilators
    - Mifepristone: reduced procedure time, increased ease of procedure
    - Misoprostol: does not reduce procedure time, side effects



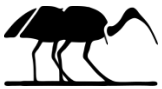
24 to 26 Weeks: Key Differences

- Induction of Fetal Demise
  - Digoxin
    - Efficacy 90-95%
    - Intrafetal injections more effective than intraamniotic
    - Takes time to effect demise
  - Potassium chloride
    - Intracardiac injections more effective than intrafunic
    - High efficacy and rapid asystole
    - Considerations: safety, training
  - Lidocaine
    - Intracardiac injection preferred
    - High efficacy, rapid asystole



24 to 26 Weeks: Clinical Pearls

- D&E Procedure
  - Both intact and standard D&E can be performed
  - Specialized equipment exists for procedures as pregnancy advances which some providers may find useful
  - Recommended procedural techniques include:
    - Ultrasound and digital examination to identify fetal and placental tissue
    - Operating in the midline/LUS to extent possible
    - Adequate decompression of fetal tissue
    - Digital exam of the endocervix to routinely evaluate for injury



Safety Considerations

- Emergency Preparedness
  - Policies and procedures
    - Referrals, triage, hospital transfers
    - Anticipatory guidance for patients returning to restrictive states
  - Equipment and supplies
  - Team training
  - Hemorrhage: SFP Guideline*
    - Uterine atony most common cause
    - Prophylaxis: oxytocin, vasopressin, TXA?
    - Treatment: multiple uterotonics, vasopressin, TXA, balloon tamponade

*Kerns J, Steinauer J. SFP guideline 20131. *Contraception* 2013.

Thank you!

The Later Abortion Initiative at Ibis Reproductive Health

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