Empowering Care: Best Practices for Prescribing Medication Abortion

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Objectives

- Explain accepted protocols and contraindications of medication abortion
- Discuss safety and efficacy profile, including complications, of medication abortion
- Identify unique aspects of providing medication abortion through telemedicine

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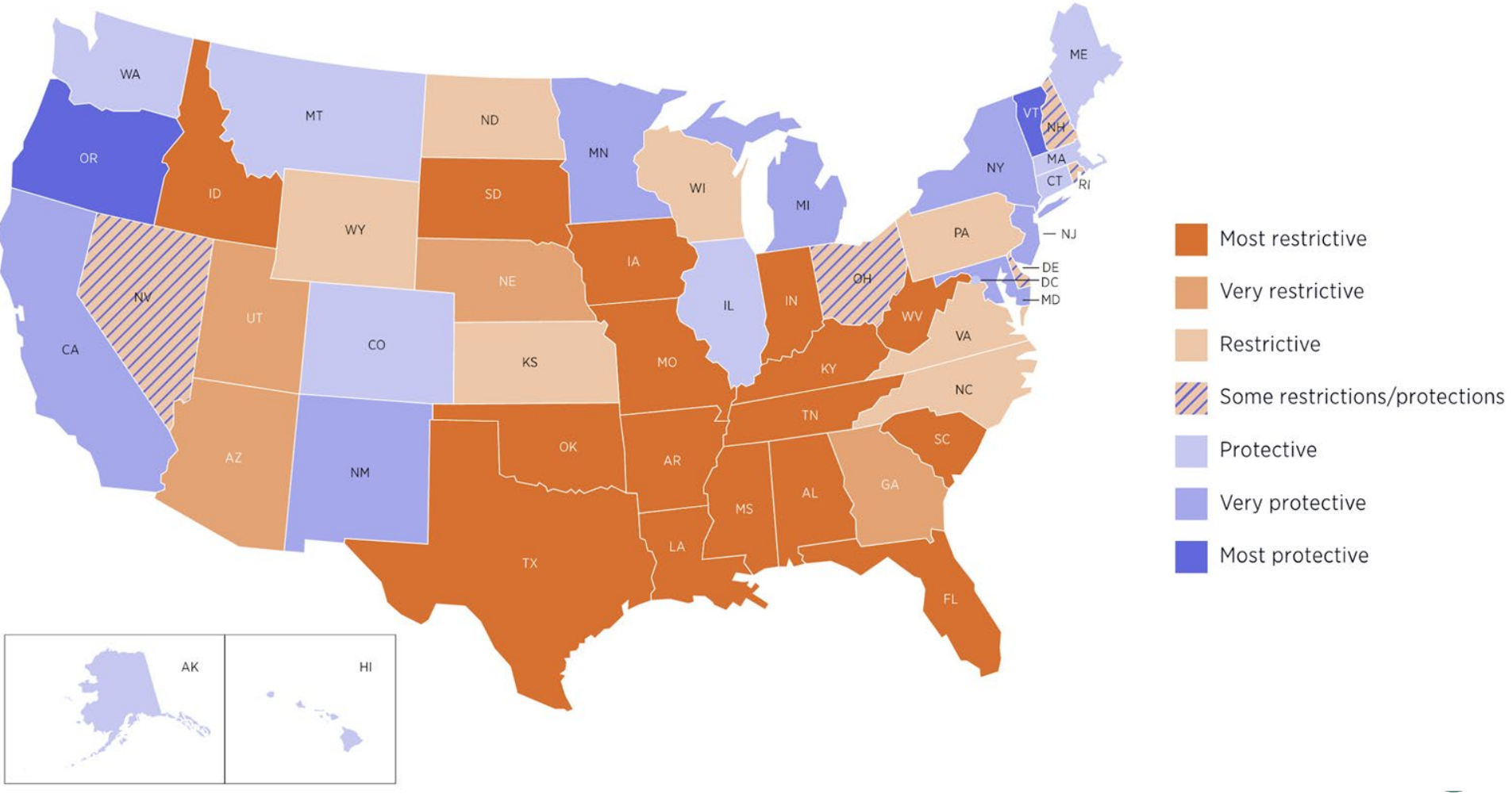
A Historical Perspective

- Abortion isn't modern
- Ancient Egyptian papyrus (1600 BC) first documented ways to use herbs, vaginal douches and suppositories to end pregnancy
- Ancient Greeks and Romans didn't consider a person pregnant and didn't consider a fetus alive until "quickening"
    - Advice on abortion focused on "restoring menstrual irregularities"
- Enslaved Black Americans in pre-Civil War-era USA used self-managed abortion as a form of resistance against plantation owners (and often sexual abusers)
- Questions around personhood and legal challenges are more modern inventions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Most restrictive
Very restrictive
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Some restrictions/protections
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Why should abortion be part of primary care?

- Improves equity in access to reproductive health care
- Many areas have no abortion clinic but have primary care providers (90% of US counties do not have a known abortion provider)
- 1 in 14 people in the U.S. relies on an FQHC for health services
- Referrals are difficult for patients
- Improves continuity of care
- Helps provider morale and retention
- Decreases siloing of abortion, making it harder to protest and defund
- Stand-alone abortion clinics may be impacted with out-of-state patients

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What is a reproductive justice lens?

Reproductive Justice

The right to **have** children	The right to **not have** children

Founded in the 1990s by black women, indigenous women, and other women of color.

Who has abortions in the US?

- 1 in 4 people with uteruses will have an abortion in their lifetime
- 70% are poor (<200% FPL)
- 55% had at least 1 prior birth
- 10% are adolescents (but only 2% ≤17 years old)
- Most (60%) in their 20s
- 15% identify as non-heterosexual

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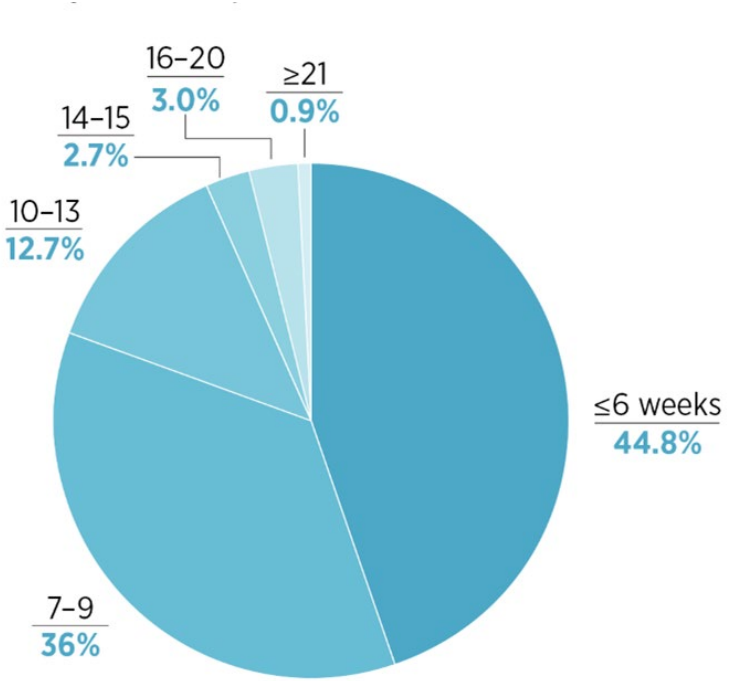
Most abortions are early!

- 80% ≤9 weeks
- Almost 95% ≤ 13 weeks



Source: Centers for Disease Control and Prevention, 2023.

Hyde does NOT prohibit abortion in FQHCs!

- No federal funds can be spent on abortions
- FQHCs can offer an “other line of business” outside of 330 grants
- Alternate ways to cover abortion costs:
  - Use state-only funds
  - Grant funds
  - Donations

Abortion is covered in CA

- Medi-Cal and Presumptive Eligibility cover abortion
- CVS and Walgreens accept prescriptions for mifepristone and misoprostol to be dispensed at the local pharmacy
- HoneyBee pharmacy will ship mifepristone and misoprostol to the patients' home
- You can order mifepristone and misoprostol to stock at your clinic to dispense in person

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MEDICATION ABORTION 101!

Medication abortions are safe

- Mortality associated with childbirth is **~15 times** higher than that of abortion [2]
- Less than 0.4% experience a major complication [1]

Table 2-4: Comparison of mortality rates	
Procedure (Study period)	Mortality Rate (# of deaths per 100,000 procedures)
Abortion (legal) (1988-2010)	0.7
Childbirth (1988-2005)	8.8
Dental procedures (1999-2005)	0.0 to 1.7
Plastic surgery (2000-2012)	0.8 to 1.7
Tonsillectomy (1968-1972)	2.9 to 6.3

[1]Raymond 2013, [2]Upadhyay 2015 [3] National Academy of Sciences, Engineering, and Medicine 2018

1. MIFEPRISTONE
progesterone blockade

Decidual Necrosis

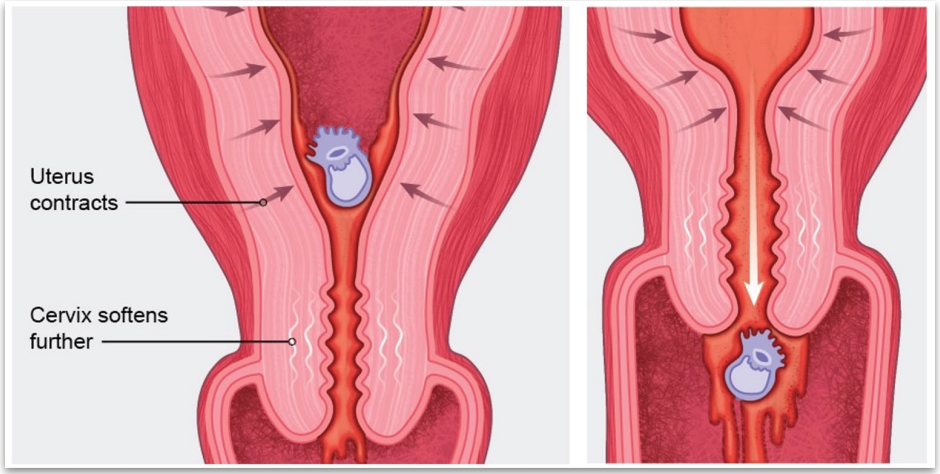
Cervical Ripening

Pregnancy detachment

2. MISOPROSTOL
prostaglandin

Uterine contraction

Pregnancy expulsion



Considering Gestational Age

- Mife is FDA approved through 10w
- More widely used through 11w in USA
- MAB beyond 11 weeks has proven safety and efficacy in international studies, some organizations expanding GA in US to 12-13 weeks
- Self-managed abortion into the second tri has become more common post-Dobbs

Length of pregnancy	% who needed further medical care
0- 49 days (0-7 weeks)	<2 %
40-63 days (7-9 weeks)	2.5%
64-70 days (9-10 weeks)	2.7%
71-77 days (10-11 weeks)	3.3%
77-84 days (11-12 weeks)	5.1%
85-91 days (12-13 weeks)	8%

Women on Web

Contraindications

- Previous allergic reaction to mifepristone* or misoprostol
- Known or suspected ectopic pregnancy
- Inherited porphyria*
- Chronic adrenal failure*

Precautions

- IUD in place (remove before treatment)
- Severe anemia (HGB < 10)
- Other severe or unstable health conditions, including (but not limited to)
  - hemorrhagic disorders or concurrent anticoagulation therapy
  - heart disease
  - uncontrolled asthma*
  - long-term corticosteroid therapy*

Ipas

Rhogam? Labs? Ultrasound?

- If < 12 weeks from LMP, can forego Rh(D) testing & Rhogam
- No H/H needed unless recent history of severe and/or symptomatic anemia
- No US needed if sure LMP <77d (+/- 1wk) and no ectopic risk factors

(NAF May 2022, WHO 2022)

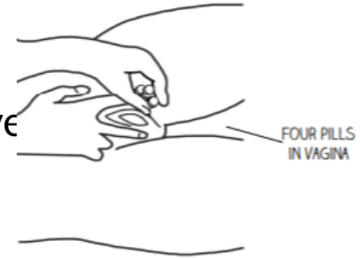
Summary chart of recommendations on medical management of abortion

RECOMMENDATIONS	COMBINATION REGIMEN[a]		MISOPROSTOL-ONLY
	MIFEPRISTONE	1–2 DAYS → MISOPROSTOL	MISOPROSTOL
27a. INDUCED ABORTION <12 WEEKS	200 mg PO once	800 µg PV, SL or B[b]	800 µg PV, SL or B[b]
27b. INDUCED ABORTION ≥12 WEEKS[c]	200 mg PO once	400 µg PV, SL or B every 3 hours[b]	400 µg PV, SL or B every 3 hours[b]
31. MISSED ABORTION < 14 WEEKS	200mg PO once	800µg B,PV or SL[b]	800µg B,PV or SL[b]
32. INTRAUTERINE FETAL DEMISE ≥14–28 WEEKS[c]	200 mg PO once	400 µg PV or SL every 4–6 hours[b]	400 µg SL (preferred) or PV every 4–6 hours[b]
36a. INCOMPLETE ABORTION <14 WEEKS UTERINE SIZE	Use misoprostol-only regimen		600 µg PO or 400 µg SL[b]
36b. INCOMPLETE ABORTION ≥14 WEEKS UTERINE SIZE	Use misoprostol-only regimen		400 µg SL, PV or B every 3 hours[b]
	LETROZOLE	MISOPROSTOL	
27c. INDUCED ABORTION < 12 WEEKS[d]	10mg PO daily for 3 days	800µg SL on day 4	

WHO 2022

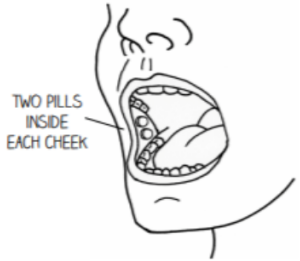
Protocols - choice of administration

Vaginal:
92-98% effective
fewer GI
side effects



- PROS: least GI side effects, avoids flavor/feel of pills in mouth
- CONS: pill fragments may be observable on internal exam, may not absorb properly if already having VB, requires privacy

Buccal:
95% effective



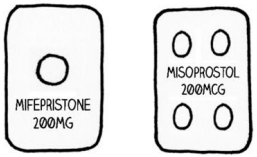
- PROS: absorption is less variable than VA, private & not discoverable
- CONS: requires holding in mouth, more GI side effects than VA

Sublingual:
97-98% effective

- PROS: fastest absorption and onset of action
- CONS: requires holding in mouth, produces more saliva/discomfort than buccal, stronger side effects (GI, fever, chills)

4. THE PILLS

You need two types of pills.
The first is **mifepristone**.
The second is **misoprostol**.



5. TIMELINE FOR TAKING PILLS

Time since last period →	8 weeks or less	9-11 weeks	11+ weeks
Day 1	Take mifepristone	Take mifepristone	Take mifepristone
Day 2 (24-48 hours after taking mifepristone)	Take pain medication ↓ Then take 4 tabs of misoprostol	Take pain medication ↓ Then take 4 tabs of misoprostol ↓ Wait 4 hours, then take 4 more tabs of misoprostol	Take pain medication ↓ Then take 4 tabs of misoprostol ↓ Wait 3 hours, then take 2 tabs of misoprostol ↓ Repeat 2 tabs every 3 hours until pregnancy passes

6. FIRST DAY: TAKE MIFEPRISTONE

Swallow one 200-mg pill.

7. SECOND DAY: TAKE PAIN MEDICATION

Up to four 200-mg ibuprofen pills, up to two 220-mg naproxen pills, or up to two 500-mg acetaminophen pills. You can take any of these pain pills before misoprostol. You can take more if needed – follow the directions on the package.

8. SECOND DAY: USE MISOPROSTOL

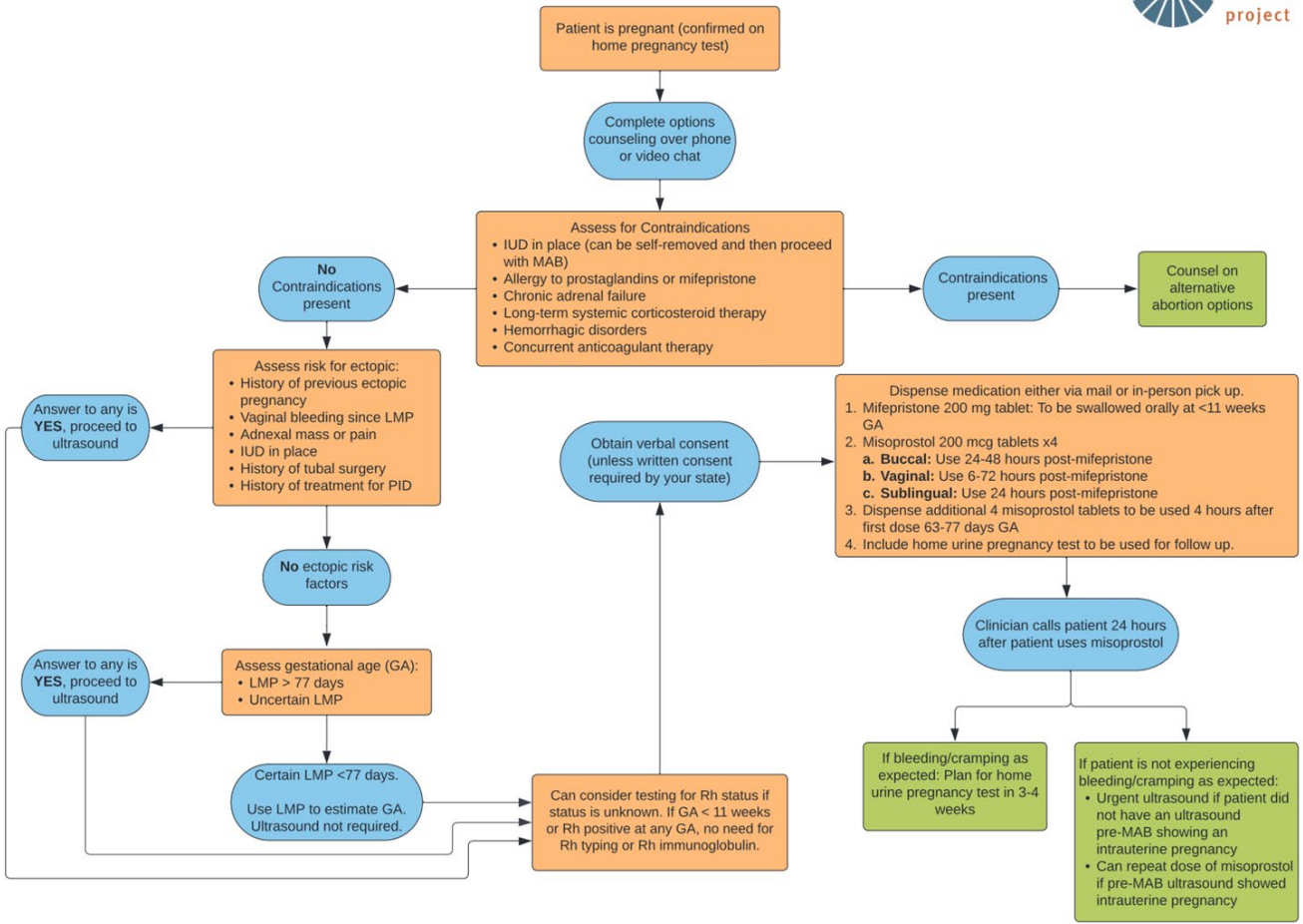
Choose: Put pills inside your cheeks, under your tongue, or in your vagina. Choose the method that feels best to you. Do this about 24 hours after swallowing the mifepristone.
8 weeks or less: If your period was 8 weeks or less ago, just use 4 of the 200mcg misoprostol pills. If your period was over 8 weeks, put a second dose in your mouth 4 hours later.
More than 11 weeks: If your period was more than 11 weeks ago, use 4 pills of the misoprostol at 24 hours and then 2 more pills 3 hours later, and then 2 more pills 3 hours after that and then 2 more pills every 3 hours until the pregnancy passes.
For Mouth: Put two pills inside each cheek or put four pills under your tongue. Hold them there for 30 minutes while your body absorbs the medicine. Then swallow the pills with a drink.
For Vagina: Put pills in your vagina. Lie down for 30 minutes as your body absorbs the medicine. If the pills fall out after 30 minutes, throw them away.

Your body absorbs the medicine from the pills within 30 minutes.

M+A Hotline

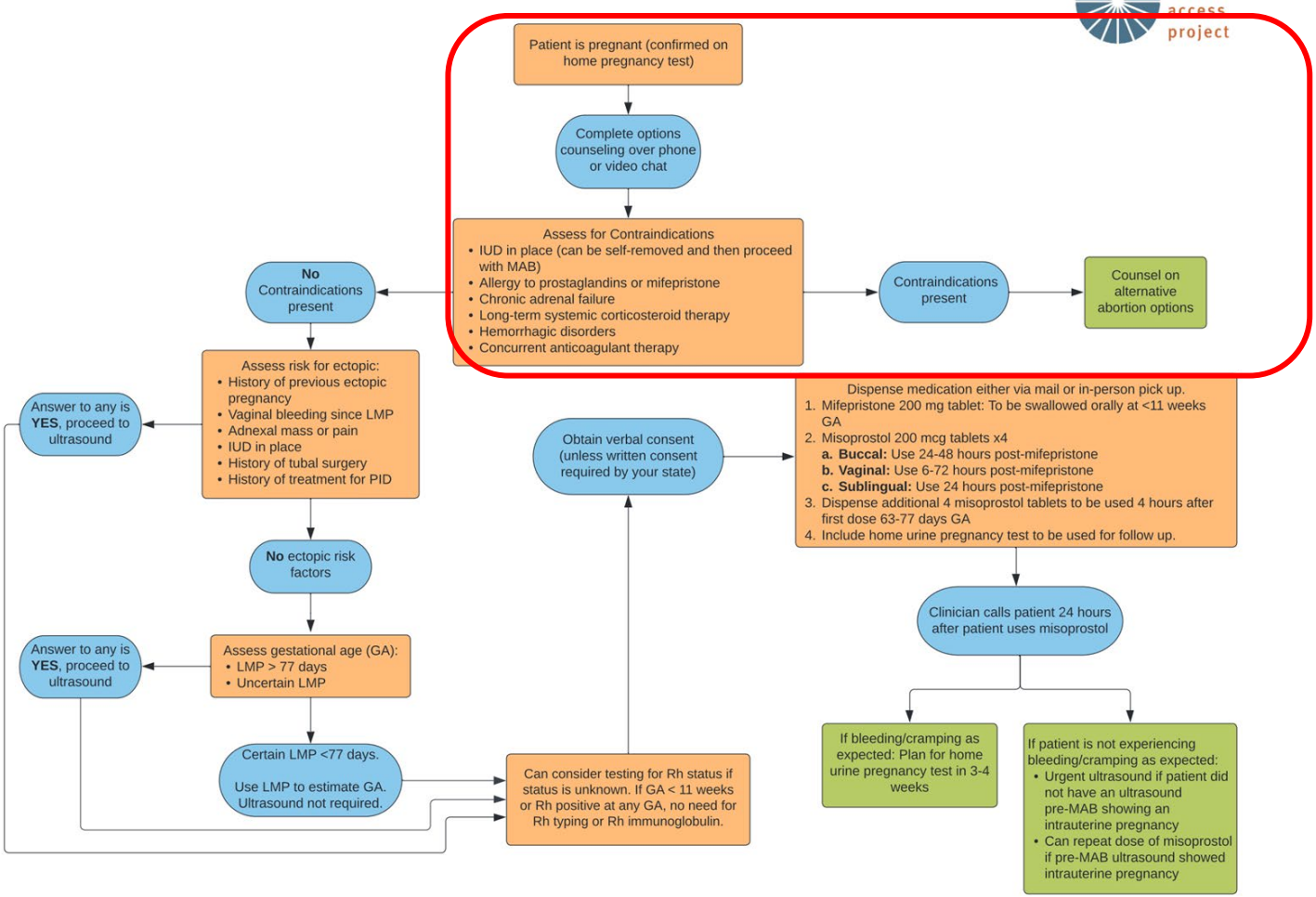
Telehealth Care for Medication Abortion Workflow

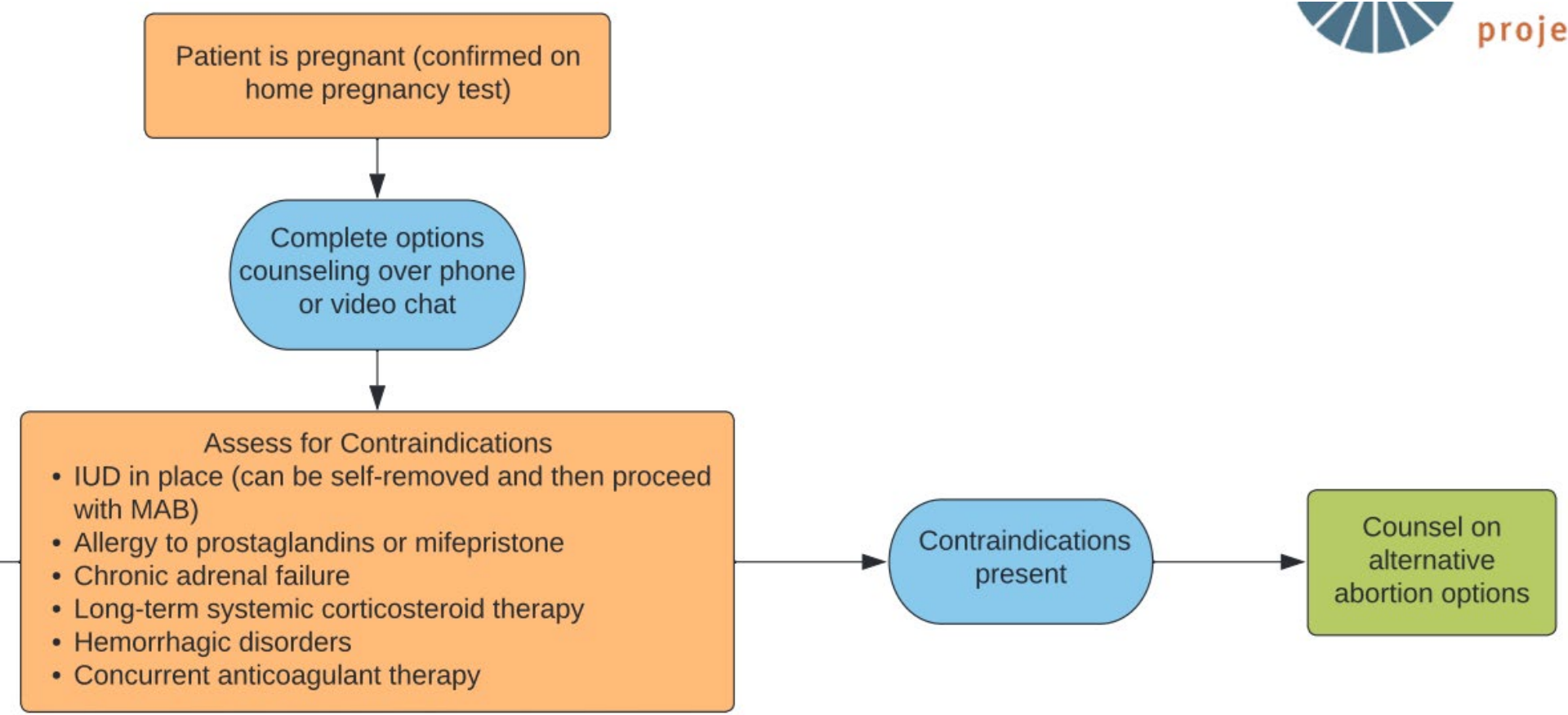
reproductive health access project



Telehealth Care for Medication Abortion Workflow

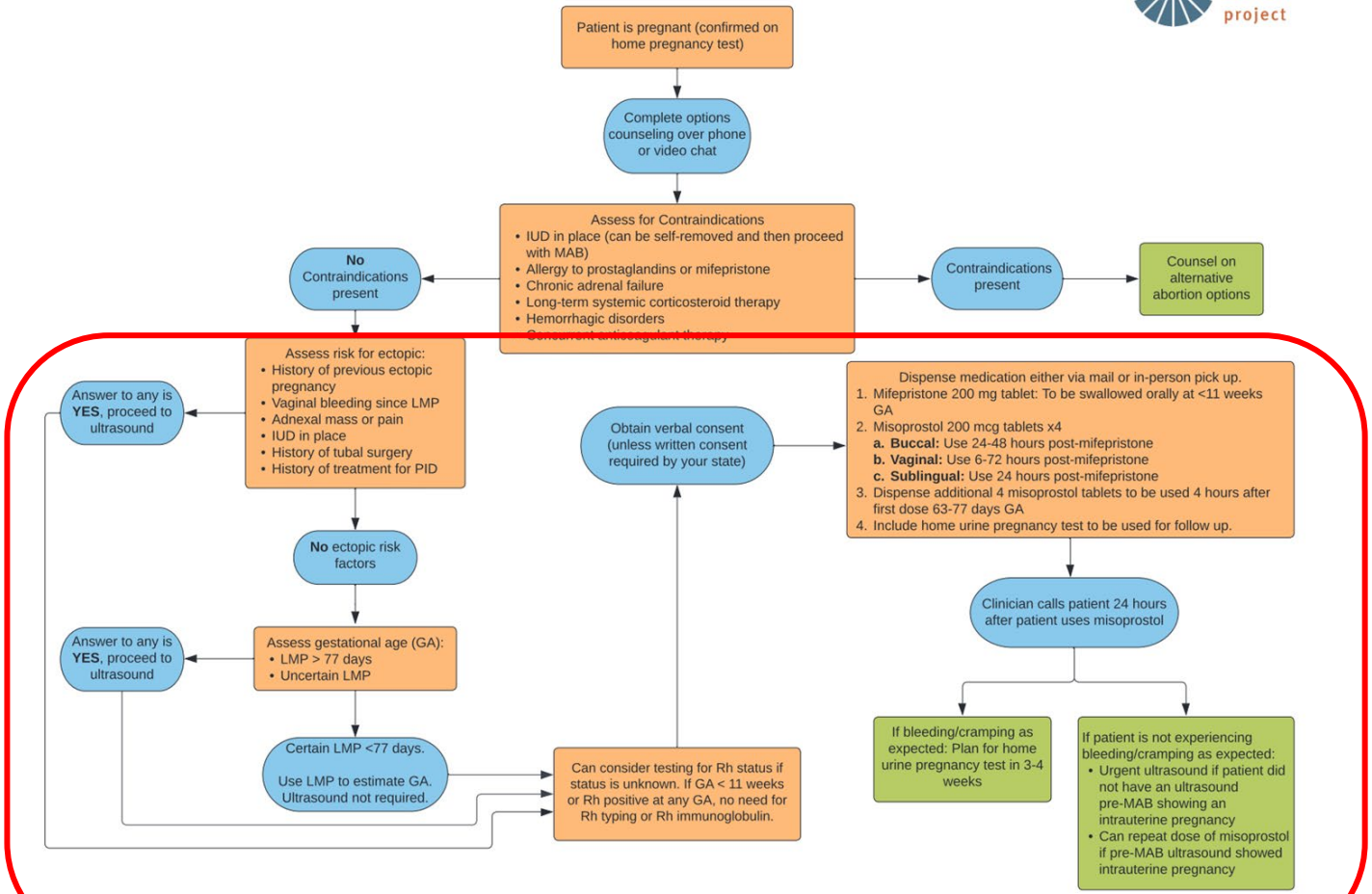
reproductive health access project

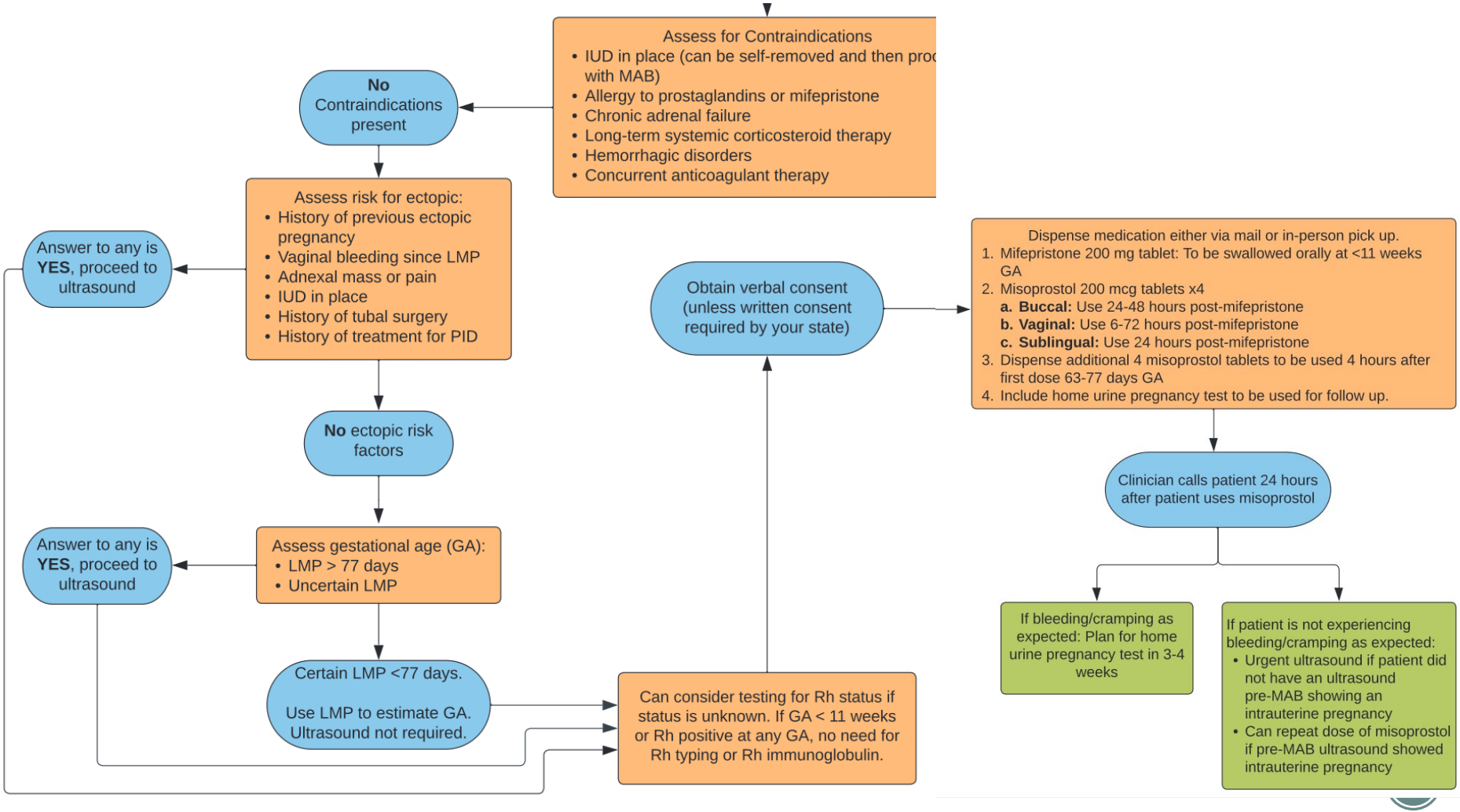



Patient is pregnant (confirmed on home pregnancy test)
Complete options counseling over phone or video chat
Assess for Contraindications
• IUD in place (can be self-removed and then proceed with MAB)
• Allergy to prostaglandins or mifepristone
• Chronic adrenal failure
• Long-term systemic corticosteroid therapy
• Hemorrhagic disorders
• Concurrent anticoagulant therapy
Contraindications present
Counsel on alternative abortion options

Telehealth Care for Medication Abortion Workflow

reproductive health access project




Assess for Contraindications
• IUD in place (can be self-removed and then proc with MAB)
• Allergy to prostaglandins or mifepristone
• Chronic adrenal failure
• Long-term systemic corticosteroid therapy
• Hemorrhagic disorders
• Concurrent anticoagulant therapy
No Contraindications present
Assess risk for ectopic:
• History of previous ectopic pregnancy
• Vaginal bleeding since LMP
• Adnexal mass or pain
• IUD in place
• History of tubal surgery
• History of treatment for PID
Answer to any is YES, proceed to ultrasound
No ectopic risk factors
Assess gestational age (GA):
• LMP > 77 days
• Uncertain LMP
Answer to any is YES, proceed to ultrasound
Certain LMP <77 days.
Use LMP to estimate GA. Ultrasound not required.
Can consider testing for Rh status if status is unknown. If GA < 11 weeks or Rh positive at any GA, no need for Rh typing or Rh immunoglobulin.
Obtain verbal consent (unless written consent required by your state)
Dispense medication either via mail or in-person pick up.
1. Mifepristone 200 mg tablet: To be swallowed orally at <11 weeks GA
2. Misoprostol 200 mcg tablets x4
a. Buccal: Use 24-48 hours post-mifepristone
b. Vaginal: Use 6-72 hours post-mifepristone
c. Sublingual: Use 24 hours post-mifepristone
3. Dispense additional 4 misoprostol tablets to be used 4 hours after first dose 63-77 days GA
4. Include home urine pregnancy test to be used for follow up.
Clinician calls patient 24 hours after patient uses misoprostol
If bleeding/cramping as expected: Plan for home urine pregnancy test in 3-4 weeks
If patient is not experiencing bleeding/cramping as expected:
• Urgent ultrasound if patient did not have an ultrasound pre-MAB showing an intrauterine pregnancy
• Can repeat dose of misoprostol if pre-MAB ultrasound showed intrauterine pregnancy

Ensuring Completion

1. History checklist at one week and negative home pregnancy test at 5 weeks

- Did you have bleeding at least as much as a period* within 24 hours of taking misoprostol?
- Do you feel like you passed the pregnancy (as if you had a spontaneous abortion)?
  - Should report passing clots/tissue
- Are your pregnancy symptoms resolving?
  - Nausea usually resolves in 1-2 days, vomiting, breast tenderness in 1-2 weeks
- Is your bleeding lighter now than the heaviest bleeding after misoprostol?
  - Bleeding should be lighter, may continue until next period

2. Serial beta HCG levels – draw quantitative beta Hcg on day of mifepristone and repeat 1 week later

- Hcg should fall by 80% to ensure completion

3. Ultrasound before and after abortion

- If intrauterine pregnancy seen on pre-MAB US, and not after MAB, the abortion is complete
- No need to measure or treat thickened endometrial stripe or intrauterine material
- "Treat the patient not the ultrasound"

* very early MAB (~4-5 weeks EGA) can have less bleeding than a typical period, there is a wide range of normal

What does Pregnancy Tissue Look like?

(after washing off blood and removing uterine lining)

MYA Network

Warning Signs

More than 24 hours after last misoprostol dose, it is NOT normal to have:

- Fever 100.4 or higher x 4 hours
- Severe abdominal pain or pelvic pain
- Bleeding that soaks through more than 4 large/nocturnal pads in 2 hours and not slowing down

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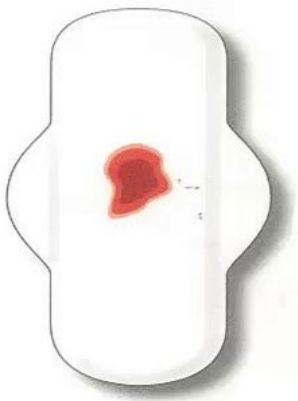
What to expect?

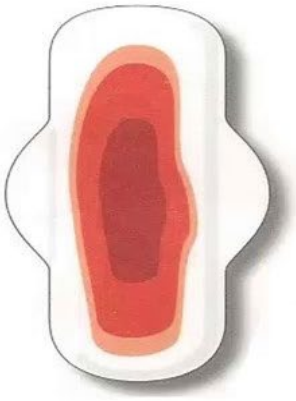
- Usually there are no side effects from mifepristone (OK to drive, work, etc).
  - Some patients will have bleeding or cramping; this is normal, and they should still take misoprostol as planned.
- Misoprostol causes bleeding and cramping which usually starts 2-6 hours after dissolving pills
  - More on this in next slide
- Should plan to take misoprostol:
  - After taking a painkiller like ibuprofen
  - When/where there is access to a bathroom
  - It's nice to have a support person, but at minimum not be responsible for caring for others
- Miso can cause flu-like symptoms (nausea, vomiting, diarrhea, fever, muscle aches, etc) in first 24 hrs after administration
- Bleeding usually slows down after several hours but can wax and wane until next period
- Anecdotally, the first period after MAB is often heavier than normal - a frequent source of patient concern

What to expect: bleeding & cramping

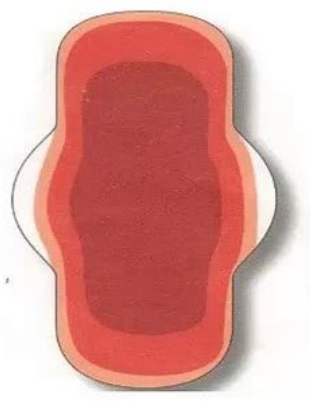


Scant amount
Blood only on tissue when wiped or less than one-inch stain on maxi pad within one hour.

Light amount
Less than four-inch stain on maxi pad within one hour.



Moderate amount
Less than six-inch stain on maxi pad within one hour.



Heavy amount
Saturated maxi pad within one hour.

By 1 week post-MAB follow-up, patients generally:

- Feel normal
- Are back to their usual routine and activities
- Be experiencing minimal pain and cramping
- Have no pregnancy symptoms (N/V resolved)
- Be on contraception if desired
  - pill/patch/ring, POPs, depo, implant can be started on day of mifepristone
  - IUD can start at/after follow up

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Managing Complications

Medication abortion using mifepristone and misoprostol	
Need for unplanned uterine aspiration for reason other than ongoing pregnancy	1.8% to 4.2%
Ongoing pregnancy	0.8%
Hemorrhage requiring transfusion	0.03% to 0.6%
Undiagnosed ectopic pregnancy	0.02%
Pelvic infection	0.01% to 0.5%

Macnaughton et al. 2021

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Mife/miso can also be used for:

- Early pregnancy loss - recommended by ACOG because it is faster and more effective than misoprostol alone
- Advanced provision - can be prescribed and ordered before someone is pregnant
  - Great for someone who might be moving to a restrictive state and definitely would not want to continue a pregnancy
- Missed period pills - can be taken if someone wants to “bring on a period” but doesn’t want to take a pregnancy test first
- https://www.plancpills.org lists places that sell MAB pills and has vetted them to be sure they are legitimate

Looking forward & next steps

- For you:
  - TEACH's free online Abortion Pill CME
  - TEACH's Abortion Training Curriculum, also available for CME and updated version is en route for 2025
- A few additional resources:
  - M+A Hotline
  - MYA Network
  - Aid Access
  - National Network of Abortion Funds
  - Repro Legal Helpline
  - Exhale Pro-Voice
  - Beyond Do No Harm Principles
- Integrating Abortion into Primary Care! (RHAP Toolkit)

Reproductive Health Service Corps Accelerator

- Individual didactics and clinical abortion training opportunities for California providers (MD, DO, NP, PA and CNM)
- Priority: rural, underserved, providing culturally concordant care
- Apply now! https://teachtraining.org/rhscaccelerator

RHSC
REPRODUCTIVE
Health Service Corps

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RHSC REPRODUCTIVE Health Service Corps

INTEGRATE REPRODUCTIVE HEALTH

START-TO-FINISH TECHNICAL SUPPORT

FUNDING AVAILABLE FOR FQHCS, COMMUNITY HEALTH CENTERS & TRAINING PROGRAMS

Support to integrate reproductive health in existing practices

Training for the entire healthcare team in:

- Early pregnancy loss
- Abortion
- Options counseling
- Contraceptive training

Learn more and apply for funding at:

www.teachtraining.org/integrate

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1-844-REPROHH / 1-844-737-7644

The **Reproductive Health Hotline** is launching in Spring 2025!

A free, on-demand, evidence-based hotline for health care providers staffed by clinicians with expertise in sexual and reproductive health (SRH)
Open M-F 6AM – 5 PM Pacific Time

Nationwide | Clinician-to-Clinician | Confidential

Saturday May 10, 2025
In-person in Berkeley & Virtual

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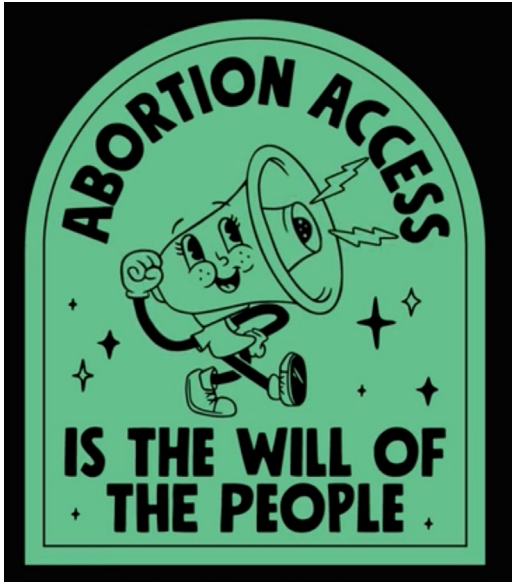
Acknowledgements

Thank you to prior TEACH fellows for adaptation and use of teaching materials



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More Reproductive Health Education

https://education.familydocs.org

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