the women's
the royal women's hospital

Principles of post early medical abortion care

Clinical assessment is key to management

The majority of presentations following an early medical abortion represent minor complications.

Be guided by the presenting clinical signs & symptoms, use this to determine the need for investigation and for ongoing management.

Establish accurate expectations for normal pain and bleeding following administration of MS2Step.

Heavy bleeding with clots in the first 24 hours is expected. Over 7 days bleeding will gradually become lighter. Cramping pain may be experienced for several days.

Distinguish between expected but troublesome bleeding and abnormal or pathological bleeding

Assess bleeding pattern: duration, volume, passage of clots.

Troublesome bleeding may be considered as bleeding that the woman perceives as problematic however is within normal parameters. Normal bleeding can last for up to 4 weeks, but should be becoming lighter without clots or significant cramping.

For a presentation with mild bleeding, normal examination findings, and the patient is clinically well and infection is excluded, offer analgesia, reassurance and schedule routine review as appropriate.

Consider the role of any hormonal contraception used since the abortion procedure or miscarriage and its influence on the bleeding pattern.

Abnormal or Pathological bleeding patterns include:

At 7 days:	• bleeding is heavier than the normal menstrual period or contains clots • persistent cramps • bleeding that waxes and wanes and has been as heavy as a normal period for at least the past 24 hours	**At any time:** • Heavy bleeding is considered to be 2 (or more) saturated sanitary pads per hour for 2 consecutive hours or passing large clots; woman feels faint or perceives the bleeding as heavy
At 14 days:	• bleeding is heavy or persistent bleeding that has not markedly reduced	
At 4-5 weeks:	• bleeding is ongoing after next expected menstrual period.	

Routine use of ultrasound scan (USS) is not recommended

Routine USS is NOT recommended as blood clots, debris, or thickened endometrium are common findings and are not usually clinically relevant. Endometrial thickness is not clinically useful for predicting the need for surgical intervention. ***Follow the symptoms not the scan result.***

USS investigation earlier than 2 weeks post Misoprostol is unlikely to assist management when the patient is clinically well, and ßhCG is dropping.

Ultrasound scan is indicated in the following presentations:

- Suspicion of ectopic
- Abnormal bleeding patterns
  - significant increase in bleeding after initial passage of products of conception (POC)
  - persistent bleeding 2 weeks after procedure
  - exclude an ongoing pregnancy

Diagnosis of incomplete abortion/ retained products of conception (RPOC)

RPOC indicates an incomplete abortion and refers to nonviable placental or fetal tissue retained in the uterine cavity or cervical canal

Management of RPOC is based on symptoms and patient preference. Asymptomatic or incidental findings of RPOC do not routinely require management.

Consider concurrent infection.

Infection

The most common infections are endometritis, urinary tract infection and undefined genital tract infection.

May present with prolonged or return of bleeding and/or crampy pain.

Examine patient to:

- take endocervical and high vaginal swabs,
- check any tenderness or pain over uterus or cervix

Commence empirical treatment while waiting for results.

Risk of STI: if possible check pre procedure screen, any treatment prescribed & administered. Consider risk of new STI infection associated with new or untreated partner.

Use ßhCG measurement to assess resolution of pregnancy

A fall of 80 percent or more from a baseline level (taken within 72 hours of mifepristone administration) to Day 14 is indicative of a completed medical abortion.

For management of RPOC consider:

Expectant management: allows for spontaneous passage of products of conception (POC). Allow up to 2 weeks for spontaneous resolution and expect and manage ongoing pain and bleeding over this time,

Or

Medical management:
Prescribe: misoprostol 800mcg (4 x 200mcg tablets) buccal followed by a repeat dose of 400mcg (2 x 200mcg tablets) 4 hours later if POC not yet passed. Prescribe analgesia and anti-emetics. Arrange follow up. Ensure patient is aware of side effects associated with misoprostol.

Surgical management recommended if:

- hemodynamically unstable
- evidence of infection
- unacceptably heavy bleeding
- moderate to severe anaemia

Further resources:

See: Early medical abortion webpage:
https://thewomens.org.au/health-professionals/clinical-resources/early-medical-abortion-ema

Clinical guidelines
https://www.thewomens.org.au/health-professionals/clinical-resources/clinical-guidelines-gps
Abortion: Medical management to 9 weeks of pregnancy
Abortion or Miscarriage Management of presentation following medical or surgical abortion or miscarriage