Guideline

Abortion: medical management, up to 9 weeks of pregnancy

1. Purpose

The Abortion Law Reform Act 2008 allows for the provision of abortion on request for a woman or pregnant person less than 24 weeks of pregnancy. Since 2012, medications for a medical abortion have been available on authority of the Therapeutic Goods Administration (TGA) and listed on the Pharmaceutical Benefits Scheme (PBS) in 2015.
This clinical guideline or procedure outlines the requirement for clinicians to plan, prescribe and manage the care of women or pregnant person undergoing medical abortion.

2. Definitions

MS2Step:

The combined medication regime for medical abortion comprises mifepristone and misoprostol, marketed as MS2Step under licence from MS Health as part of Marie Stopes International. MS2Step is a composite pack and consists of mifepristone 200 mg tablet and misoprostol 4 x 200 microgram tablets. The pack is indicated for use in eligible people (see 4.3) for the purpose of a medical abortion of a developing intrauterine pregnancy, up to 63 days of gestation.
Mifepristone and misoprostol have been used in overseas jurisdictions for medical abortion in the first trimester pregnancy since the 1980s. The combination of these two medicines is a well-established method for medical abortion and is known to be safe, effective and acceptable to women.
MS2 step is prescribed by a certified Medical Practitioner and dispensed by a certified Pharmacist.

Mifepristone:

Mifepristone is a synthetic steroid with an antiprogestational action as a result of competition with progesterone at the progesterone receptors. This action results in disrupting the attachment of a developing pregnancy.

Misoprostol:

Misoprostol is a synthetic analogue of prostaglandin E1. Misoprostol induces contractions of the smooth muscle fibres in the myometrium and relaxation of the uterine cervix. The uterotonic properties of misoprostol should facilitate cervical opening and evacuation of intrauterine contents.
The combination of misoprostol used in a sequential regimen after mifepristone leads to an increase in the success rate and accelerates the expulsion of the conceptus.

3. Responsibilities

Care of the woman or pregnant person undergoing medical abortion may be provided by a team of health care workers.

- Medical Practitioners oversee and supervise clinical management, obtain informed consent and prescribe MS2Step.
- Nurses and Midwives have a recognised role to assess, plan and manage the care of people undergoing medical abortion in a task sharing arrangement with the Medical Practitioner.
- Pharmacists dispense the medication.

Medical Practitioners gain prescribing rights and Pharmacists gain dispensing rights based on successful completion of an online training module, see: https://www.ms2step.com.au/

4. Guideline/Procedure

4.1 **Choice of method:** The request for an abortion and choice of method must be fully considered in a non-judgmental and supportive manner. Obtain psycho-social history including screening for intimate partner, family violence and reproductive coercion.

4.2 **Medical abortion consultation:** The medical abortion consultation should establish that the woman or pregnant person:

- has made an informed voluntary choice for medical abortion,

- has an intrauterine pregnancy no more than 9 weeks of pregnancy calculated from the first day of last menstrual period or ultrasound,
- has no contraindications (see below),
- has a suitable support person available,
- is able to be active in follow-up care,
- is able to access an emergency healthcare facility within approximately one hour of road travel.

4.3 Medial abortion can be safely offered to women and pregnant people up to 63days gestation with an intrauterine pregnancy:

- who have had a caesarean section,
- have a multi-fetal pregnancy,
- are obese,
- have uterine abnormalities, including fibroids,
- who wish to avoid surgical intervention.

4.4 Contraindications: A woman or pregnant person is not a suitable candidate for medical abortion in the following circumstances:

- Lack of access to emergency medical care within 14 days following administration of mifepristone,
- Suspected or confirmed ectopic pregnancy,
- Intrauterine device (IUD) in place. If an intrauterine contraceptive device is present, it should be removed,
- Uncertainty about gestational age,
- Chronic adrenal failure,
- Concurrent long-term corticosteroid therapy,
- Suspected or known haemorrhagic disorders or treatment with anticoagulants, and
- Hypersensitivity to mifepristone, misoprostol (or any prostaglandin), or any of the excipients used in MS-2 Step.

4.5 Precautions for use:

Not recommended in people with cardiovascular disease, hypertensive disease, hepatic disease, respiratory disease, renal disease, diabetes, severe anaemia, malnutrition, heavy smokers.
It is important that the woman or pregnant person is aware of the risk of teratogenicity associated with misoprostol. Consequently, once MS-2 Step is commenced it is important the patient is followed to completion of the procedure and offered surgical abortion in the case of an ongoing pregnancy.

4.6 Informed consent:

The Medical Practitioner must ensure the woman or pregnant person has understood the following:

- MS2Step process and expected outcome,
- risks,
- side effects,
- possible complications,
- need for a support person,
- access to emergency care, and
- need for follow up care.

Documentation of consent is recorded in the patient clinical notes.

4.7 Baseline investigations:

- Pelvic Ultrasound: accurate assessment of gestational age and presence of intrauterine pregnancy, i.e. through visualisation of a yolk sac. Exclude ectopic pregnancy.
- Blood investigations:
  - Quantitative beta hCG
  - Rhesus (Rh) status
  - Full blood count (FBC)

- STI screen: according to risk, minimum requirement bacterial vaginosis, chlamydia, gonorrhoea, mycoplasma genitalium and syphilis. For further information see Melbourne Sexual Health Service, STI Tool pdf.
  https://mshc.org.au/HealthProfessional/MSHCTreatmentGuidelines/STISCREENING

4.8 Dosage and administration of MS2Step:

Administer 2 hours before or 2 hours after a meal.
Mifepristone: 200 mg (1 tablet) mifepristone orally, followed 36 to 48 hours later by the administration of misoprostol.
Misoprostol: 800 microgram (4 tablets) misoprostol buccally, i.e. kept between the cheek and the gum for 30 minutes, any remaining fragments may be swallowed with water
It is recommended the woman or pregnant person have a support person with them during administration of the second phase of treatment (misoprostol administration).

4.9 Rhesus (Rh) isoimmunisation:

Current guidelines require that the women or pregnant person who is Rh negative require Rh D immunoglobulin (250 IU) via intramuscular (IM) injection within 72 hours of mifepristone to prevent Rh factor sensitisation.

4.10 Pain and bleeding expectations:

It is important to provide clear information to create reasonable expectations about the range of normal physical symptoms people experience with a medical abortion and symptoms that require further advice. Discussion about the complications and risks in a way that they can understand is an essential component of consent, with an emphasis on the overall safety of the procedure.
The most common symptoms are pain, bleeding and gastrointestinal side effects.
Bleeding and cramping usually exceeds the expected individual level of menstrual bleeding and cramping. The average bleeding is 10 to 16 days and may last up to 30 days. Bleeding usually occurs within 4 to 6 hours of the misoprostol dose.
The level of pain and the response to the pain is individual and varies greatly. Pain and cramping ranges from mild to severe and usually does not last more than 24 hours and will diminish once the pregnancy is expelled.
Gastrointestinal side effects associated with the misoprostol are common and include nausea, vomiting and diarrhoea.

4.11 Pain management:

Establish accurate expectations. Ensure adequate pain relief is taken with an antiemetic 30 minutes prior to misoprostol dose.
Advise on the use of therapeutic techniques such as rest, heat packs and lower back massage.
Non-steroidal anti-inflammatory drugs are effective especially when taken prior to MS2Step. Combinations of codeine may be effective. Paracetamol alone is not sufficient.
Consider:

- Ibubrofen 400mg 6hourly PRN , with
- Paracetamol 1g 4-6 hourly PRN, or
- Paracetamol-codeine 1g-60mg 6hourly PRN (maximum of 4g paracetamol per 24hours)

4.12 Anti-emetics:

Gastrointestinal disorders are a common side effect of misoprostol.
Consider: metoclopramide 10mg 8 hourly PRN, maximum 30mg/day or ondansetron 4mg 8 to 12 hourly PRN

4.13 Follow up:

Planned follow up is essential even if no adverse events have occurred. Telephone follow up at day 3 to 5, and telephone or direct contact at day 14 to 21 post misoprostol are useful methods to assess progress and to ensure the procedure is complete.
The purpose of follow up is to:

- provide support and reassurance,
- assess wellbeing,

- ensure completeness of the abortion procedure, and
- confirm a plan for ongoing contraception (if desired).

Telephone follow up 3 to 5 days. Assess for:

- Bleeding and cramping the first 24hours after taking misoprostol “Do you believe expulsion has occurred”,
- Persistent heavy bleeding,
- Signs of infection,
- Retained products of conception/incomplete abortion,
- Ongoing pregnancy “If you had pregnancy symptoms before the abortion, are they gone now?”

Telephone or direct contact follow up day 14 to 21. Follow the clinical signs and symptoms and use an objective measure i.e. serum beta or low sensitivity urine hCG to confirm the abortion procedure.

- Serum beta hCG pathology taken between day 14 to 21. An 80 percent decline in serum beta hCG levels from day of misoprostol to 14 days later is considered appropriate.
- Low sensitivity urine hCG self-administered from day 14 detects a hCG level of 1000 mIU/mL and above. A negative result confirms the procedure.

Assess the clinical signs and symptoms to monitor completeness of the procedure. Resolution of symptoms or signs of pregnancy, absence of persistent heavy bleeding and serum beta and urine hCG as an objective measure provide reassurance of completeness. Ultrasound is not a clinically useful predictor of the subsequent need for surgical evacuation. Blood clots or thick endometrium are common findings post medical abortion.

4.14 Complications and risks associated with medical abortion are rare. Complications may include:

- Problem bleeding: Excessive bleeding is considered to be 2 (or more) saturated sanitary pads per hour for 2 consecutive hours or passing fist-size clots. Persistent bleeding beyond the expected next menstrual period requires investigation. Severe haemorrhage requiring medical or surgical intervention occurs in less than 2 percent of cases.
- Infection: Infection occurs in less than 1 percent of cases. Clinical signs and symptoms of mild infection may be managed with oral antibiotics. Severe infection or sepsis requires hospital assessment. Universal STI screening and treatment of positive cases at the time of consult is required.
- Retained products of conception (RPOC) or incomplete abortion: occur in less than 4 per cent of cases and indicates that the procedure has been partially successful. RPOC may be indicated by ongoing heavy bleeding or cramping. Ongoing clinical management is based on symptoms. Ultrasound examination should not be used routinely to screen for incomplete abortion.
- Continuing pregnancy: an ongoing pregnancy is considered a failed medical abortion and occurs in approximately 1 percent of cases. Indicators of continuing pregnancy are ongoing signs and symptoms of pregnancy or clinical signs such as rising serum beta hCG or confirmed on ultrasound scan.

4.15 Contraception:

The medical abortion consultation is an ideal time to discuss ongoing contraception as the woman or pregnant person has proven fertility, is likely to be motivated to explore options and is currently accessing health care. Ovulation occurs within 1 month of first trimester abortions in 90% of cases. People seeking contraception need accurate, evidence-based information about the safety, efficacy, advantages and disadvantages of all methods and be supported to make a choice based on their personal needs, preferences and medical suitability. Long acting reversible contraception (LARC) methods are highly effective and safe across the reproductive life course.

Etonogestrel (Implanon NXT ®) and levonorgestrel (Microlut ®) may be initiated immediately i.e. on the day of mifepristone
Commence combined oral contraceptives the day following misoprostol
Levonorgestrel-Intrauterine Device (IUD) Mirena® - 52mg) or (Kyleena® -19.5mg) and copper IUD may be inserted once it has been determined the abortion is complete i.e. at follow up visit with serum beta hCG assessment.
Depot medroxyprogesterone acetate (DMPA) is an intramuscular or subcutaneous injection administered every 12 weeks and can be initiated at the time of misoprostol administration, 24-48 hours after mifepristone.

5. Evaluation, monitoring and reporting of compliance to this guideline or procedure

Compliance to this guideline or procedure will be monitored, evaluated and reported through VHIMS and consumer feedback.

6. References

Pocius K, Bartz D, Maurer R, Stenquistc A, Fortin J and Goldberg A. (2017). *Serum human chorionic gonadotropin (hCG) trend within the first few days after medical abortion: a prospective study.* Contraception. 95: 263-268.

MS-2 Step - Product Information. MIMS Online Australia. [database on the Internet]. Cited September 2019.

Royal College of Nursing. (2017). *Termination of pregnancy. RCN guidance for nurses, midwives and specialist community public health nurses.* Retrieved from https://www.rcn.org.uk

Royal College of Obstetricians and Gynaecologists. (2011). *The care of women requesting induced abortion. Evidence based clinical guideline number 7*. Retrieved from https://www.rcog.org.uk/globalassets/documents/guidelines/abortion-guideline_web_1.pdf

Royal College of Obstetricians and Gynaecologists. (2015). *Best practice in comprehensive abortion care. Best Practice Paper No. 2.* Retrieved from https://www.rcog.org.uk

Royal College of Obstetricians and Gynaecologists. (2016). *Best practice in comprehensive postabortion care. Best Practice Paper No. 3.* Retrieved from https://www.rcog.org.uk

World Health Organisation. (2012). Safe abortion: technical and policy guidance for health systems. Retrieved from http://www.who.int/reproductivehealth/publications/unsafe_abortion/9789241548434/en/index.html

World Health Organisation (2014). Clinical practice handbook for safe abortion. Retrieved from http://www.who.int/reproductivehealth/publications/unsafe_abortion/clinical-practice-safe-abortion/en/

7. Legislation/Regulations related to this guideline or procedure

Women's Sexual and Reproductive Health: Key Priorities 2017-2020
https://www2.health.vic.gov.au/about/publications/policiesandguidelines/womens-sexual-health-key-priorities

Abortion Law Reform Act 2008
http://www.legislation.vic.gov.au/Domino/Web_Notes/LDMS/PubStatbook.nsf/f932b66241ecf1b7ca256e92000e23be/BB2C8223617EB6A8CA2574EA001C130A/$FILE/08-58a.pdf

8. Appendices

Appendix 1: The Women's Position Statement: Abortion https://www.thewomens.org.au/about/advocacy

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