AUCKLAND DISTRICT HEALTH BOARD
Te Toka Tumai

Information for referrers to Epsom Day Unit (EDU)

Information for referring doctors and nurses/midwives on early medical termination

Medical termination (MTOP): introduction

Medical or medication termination is a safe and effective alternative to surgical termination of pregnancy. The method uses the antiprogestin Mifepristone or Mifegyne® formerly known as RU486, in combination with misoprostol or Cytotec®. The dosage of Mifegyne® given in the protocol used at Epsom Day Unit for early terminations differs from that in the Mifegyne® data sheet because more recent clinical trials have found this regimen to be as effective.

At Epsom Day Unit we offer medical termination up to 63 days (9 weeks) on the day when Mifegyne is given. The combination of oral Mifegyne followed by vaginal (or buccal) Cytotec has a reported efficacy of 96 to 98%.

Some women may have contra-indications to having a medical termination, and others may prefer a surgical termination. However, it is important for women to have an informed choice of both options in the public health care system, and furthermore, it is a legal requirement.

Medical termination offers a number of advantages over surgical termination. One major advantage is that it can be performed as soon as pregnancy is confirmed and the earlier in the pregnancy the more successful it is. Early

diagnosis of pregnancy and efficient referral procedures are therefore important. Medical termination makes the experience more private and proactive for women. It avoids the surgical complications such as perforation. There are no anaesthetic risks and there is less risk of infection. However, surgical facilities must be available for use when the medical method is unsuccessful, in up to 5% of cases. Women must be prepared to accept this outcome.

Some disadvantages of medical termination include that the procedure takes longer (2 visits to EDU 36-48 hours apart), and there is more bleeding than with surgical termination.

The legal situation in New Zealand

All terminations must comply with the NZ law. Medical termination is legal in NZ under the same restrictions as apply to surgical termination. Approval by two certifying consultants is required and all terminations must be performed in licensed premises. This means that both abortifacient drugs must be given on licensed premises. However, after the drugs have been administered the majority of women will go home.

The referring doctor assessment

If medical termination is being considered the following are essential:

- Discuss briefly the advantages and disadvantages of surgical and medical termination and help her to determine whether medical termination is appropriate for her (see below)
- Explain important aspects of the procedure and give her the 'About Our Services' Information leaflet
- Perform the routine referral swabs and bloods (see below)
- Arrange for an ultrasound

To make an informed decision, women need to know the advantages and disadvantages of both methods. The following lists may be helpful:

Advantages of medical termination	**Advantages of surgical termination**
Women feels more in control – the	Time can be scheduled to suit

difference between doing something yourself and having something done to you	
Effective very early in pregnancy – in fact the earlier the better	Suits many women's busy lifestyle with work and/or family commitments
Non invasive – no surgical risks to cervix and no risk of perforating uterus	Over more quickly
Non dependant on surgical skill – although in 5 – 10% surgery will be necessary	Less cramping and bleeding
Non anaesthetic risks	Has been used for many years
Lower risk of infection	Excellent safety record
Good method for women who fear surgery	Usually no doubt about when the termination is complete
Allows more privacy	Must be used if over 63 days (9 weeks) since last normal period
Many women say that it feels less intrusive, more natural and is likened to having a miscarriage	

Requirements for referring to Epsom Day Unit (EDU)

- Early counseling and information giving
- Precise dating of the pregnancy by history, examination and ultrasound - see criteria for USS above.
- Exclusion of ectopic pregnancy - see criteria for USS above
- Routine swabs, smear and blood tests as for surgical termination
- Contraceptive options discussed
- Referral faxed to Epsom Day Unit. Fax: (09) 630 9819

The referral can be made prior to the precise dating of the pregnancy by USS on the proviso that the scan is received by EDU prior to the women's attendance at the Unit.

Contraindications for medical termination in Epsom Day Unit

Social contraindications:

- Indecision about having the termination
- Unwillingness to have a surgical termination if the medical method fails
- Lack of direct telephone access
- Transportation problems (for return visits and in the event of an emergency)

- Any other difficulties in completing all the steps of the medical protocol i.e. getting the initial ultrasound scan, attending EDU for the administration of Mifegyne, returning 36 – 48 hours later to EDU for insertion of vaginal/buccal tablets and returning to referring doctor for the final check about 2 weeks post termination.
- Inadequate support, unable to confide in an adult
- Inability to cope with the cramping and bleeding of the procedure

Absolute medical contraindications:

- No confirmation of the pregnancy
- More than 63 days (9 weeks) from the first day of the last menstrual period when first attending EDU
- Suspected ectopic pregnancy
- Significant cardiac disease e.g. myocardial infarction
- Renal failure, liver failure, chronic adrenal failure, porphyrias
- Allergy to either Mifepristone or Misoprostol
- An intra-uterine device (IUD) must be removed before commencing Mifegyne
- Lives more than 1 hour away from emergency medical services
- Unable to speak English with no available English speaking adult to stay with her during the entire procedure

Relative medical contraindications requiring specialist advice:

- Cardiovascular disease (angina, Raynaud's disease, cardiac arrhythmias, cardiac failure, severe hypertension, high cholesterol)
- Any condition requiring long term steroid therapy. Due to the anti-glucocorticoid activity of Mifepristone, the efficacy of long term steroid therapy may be decreased during the 3 – 4 days following Mifegyne intake and therapy must be adjusted. In patients with asthma using inhaled corticosteroid therapy, it is recommended that the dose be doubled during the 48 hours preceding administration of Mifegyne and continued at that level for about one week.
- Multiple (>2) uterine scars or history of uterine rupture
- Hb < 90 g/L

- Malnutrition

Breast feeding should be stopped for 3 days after taking Mifegyne. Studies have not been done to determine the excretion of Mifepristone in breast milk but the recommendation is made because of its known lipophilic action.

What happens at Epsom Day Unit?

The first visit to Epsom Day Unit includes an offer of counselling, assessment for legal requirement, decision making, the signing of two certificates by the certifying consultants and the signing of the patient consent form. If there are no contraindications and no need for further counselling, the treatment may be started on this day.

Contraception will be discussed and this is a joint responsibility of the referring provider and EDU. Because there is a risk with both drugs that they may cause foetal abnormalities, it is recommended that women do not get pregnant in the first month following the termination. For most women starting on oral contraceptive pills, the advice is to start on the day after the termination is complete. Women requesting either Depo-Provera or Jadelle will have this administered before discharge. For women requesting an IUD, this can be inserted at any time after the pregnancy termination has been confirmed.

The Treatment

The treatment is a two day process. On the first day Mifegyne is administered orally. Mifegyne acts by blocking the action of progesterone at the site of the progesterone receptors thus lower the hormone levels necessary for the continuation of the pregnancy. After taking Mifegyne the expectation is that women will go home. After 12 hours, bleeding may start in some women. It may be quite heavy and women are advised to have maxi/maternity pads available for use at home. A few women, about 3 – 5% will abort within the first 48 hours and will not require any misoprostol. They must still return to EDU for assessment.

Before ending their shift an EDU nurse will telephone the women to check their pain level and give reassurance, information and/or advice. Women will be given the telephone numbers to contact EDU during working hours or contact the on-call nurse after hours.

Women are required to attend EDU for the second medication. There is commonly a 36 – 48 hour interval between medications. The second medication, Misoprostol, is usually inserted into the posterior fornix of the vagina or is given bucally (inside the cheek). Misoprostol is a prostaglandin, which stimulates contractions of the uterus to expel the pregnancy.

Women are encouraged to go home for the completion of their termination with telephone contact with EDU. An after-hours nurse will be on call Wednesday and Thursday nights to ensure women are supported after hours. Women will be given the telephone contact for the on-call nurse. Over the next 6 hours 95% of women will have completed their termination.

Those women who are Rh negative will be given an injection of Anti-D immune globulin on the second visit. Women who want a Jadelle implant will have this inserted at this time too.

Most women cope very well with the process of the medical termination at home. Bleeding starts at a variable time from 30 minutes after the misoprostol to several days. Most women will complete within the first 6 hours. The bleeding may be quite heavy and is likely to include some large clots. Cramping pain is more likely in nulliparous women and in women who suffer from dysmenorrhoea.

Pain relief: Women will be given some pain relief i.e. Nurofen and Paracetamol to take home and will also be given a script for codeine phosphate and Metoclopramide.

Side effects of the medications: Apart from the bleeding and pain women may experience other side effects. After the Mifegyne some women may

experience nausea. After the Misoprostol there may be more side effects which include nausea, vomiting, diarrhea, dizziness, less commonly headaches or warm/hot flushes and in rare instances, oral ulcers or a skin rash. In some cases (about 1 in 300) the bleeding will be so heavy that a blood transfusion and/or curettage may be necessary to stop the bleeding.

Women will be advised to avoid alcohol and smoking during the treatment and for at least 2 days after the insertion of the vaginal/buccal Misoprostol. They are advised to avoid “recreational” drugs.

Complete termination will usually occur in the 6 hours following the administration of misoprostol. The tissue is often passed into the toilet. Beta HCG follow-up is required to confirm the termination.

Information about what to expect at home will be given to women after they have received Misoprostol. This includes advice on managing bleeding, pain relief, what they may see as regards to tissues that are passed, as well as when to contact the after-hours nurse should they be concerned.

To prevent infection, she will be advised to abstain from sexual intercourse or putting anything in her vagina until the bleeding has stopped. That could take as long as 4 weeks so check whether this will create difficulties for her. She will also be advised not to use internal sanitary protection and not to have a bath, use a spa or swim.

Guidelines for the Follow-Up to ensure completion of medical termination

Most women will go home immediately after Misoprostol, when the sac has not been passed, so follow up to exclude ongoing pregnancy is essential. Before she leaves EDU she will be given written and verbal instructions for follow up arrangements. Epsom Day Unit staff will remain in touch with her until tests suggest completion of the termination. She will be requested to make an appointment for follow up with the referring doctor in around 10 days.

The following protocol is used by EDU to assess completion:

- A beta HCG level will be taken at the time of receiving Mifegyne and the women will be given a blood form for this to be repeated 1 week later
- If the second beta HCG is less than 80 i.u or <20% of the base line value, this indicates completion of the termination
- If the levels are higher than this, a repeated measurement in 7 days is needed (sooner if there are any risk factors for ectopic pregnancy). If the level drops at the second measurement, this indicates completion of the termination.

If beta HCG level is static or rising then arrange a transvaginal ultrasound scan.

- If the USS shows a viable intrauterine pregnancy then EDU will arrange a surgical termination
- If USS shows a sac still present (but no cardiac activity) and the patient has no heavy bleeding, a second dose of misoprostol may be given. Alternately, the patient may be given the option of waiting up to 6 weeks post misoprostol to pass the sac on her own. Although this may be discouraging to the women, it is not a complication. Or at any time the woman feels she has had enough waiting we can arrange a surgical termination.
- If the woman is having heavy, prolonged bleeding a surgical termination for pregnancy is appropriate

It is recommended that no USS for assessing retained products of conception should be performed until at least 2 weeks have elapsed from the Misoprostol administration. The sole purpose of USS after prostaglandin post medical termination is to determine that the gestational sac is no longer present. After expulsion, ultrasonographic findings of intrauterine heterogeneous echoic material are normal and to be expected. Rarely does this finding indicate a need for intervention. In the absence of excessive bleeding, care providers can follow such patients conservatively.

After 2 weeks, if there is USS evidence of an ongoing pregnancy or retained products described to be of a size greater than 5cms in diameter and is accompanied by heavy vaginal bleeding, surgical evacuation is required.

Epsom Day Unit doctors and nurses are happy to consult with you at any time if you have questions or concerns about a patient.

Indications for surgical aspiration include one or more of the following:

- Evidence of continuing pregnancy; be alert to the possibility of missed ectopic or twin pregnancy
- Subjective symptoms with a history of persistent heavy bleeding unresponsive to medical measures
- Orthostatic instability
- Low haemoglobin level particularly if the patient continues to bleed
- Patient request

Follow up of women who fail to attend follow up beta HCG appointments

There should be close communication between the referring doctor and EDU to ensure the follow up takes place. If the woman does not attend then EDU will attempt to contact her, if after at least 2 attempts this remains unsuccessful then EDU will notify the referring doctor by fax to follow this up. The minimum effort that should be made is a telephone call followed by a letter. These should be carefully documented.

Follow up by the referring doctor

After completion of the medical termination has been confirmed by the above process a return visit to their referring doctor is recommended around 10 days after misoprostol administration.

The visit should include an assessment of symptomatology and wellbeing and if indicated a full pelvic assessment.

The following guidelines are given for the management of side effects and complications:

Bleeding: Excessive bleeding is rare, although it may be the single cause of greatest concern for the patients and the providers. The amount of bleeding considered normal during a medical termination generally exceeds menstrual blood loss. The quality of bleeding may differ from menstrual bleeding as well. Women often pass clots during the expulsion of the pregnancy. The mean duration of bleeding is 14 – 17 days (range 1 – 69 days); some women bleed until their next menstrual period. While bleeding is an expected side effect, excessive bleeding causing a clinically significant change in haemoglobin is uncommon, as is the need for transfusion or surgical intervention (0.2% and <0.4% respectively). The average drop in haemoglobin is 0.7%. Women who present with excessive bleeding, typically do so after 10 days post misoprostol. Typically the bleeding is heaviest on the day of the misoprostol administration, decreasing steadily. Thirteen days after Misoprostol administration, 77% of women describe bleeding as “spotting” and at day 30, only 9% report bleeding.

The advice given to women is that she can expect heavy bleeding, but if it lasts more than 12 hours (soaking one maxi pad an hour) or if she is soaking more than 2 maxi pads an hour for 2 hours in a row, she is advised to seek medical attention. Should this occur within 24 hours post MTOP, she should be advised to contact Epsom Day Unit during working hours or contact the on-call nurse on after hours (Wednesday and Thursday nights). After 24 hours post MTOP she will be advised to contact either her GP, After Hours Medical Centre or present to the Emergency Department at her nearest hospital.

Acute haemorrhage, prolonged heavy bleeding with reported symptoms of orthostatic instability warrant prompt evaluation and may be indications for immediate surgical evacuation. Contact the gynae registrar on call.

Abdominal pain and cramping: Pain resulting from uterine cramping is an expected part of the termination process. Eighty percent of women have

cramping. For most it is like intense menstrual cramps. Most are relieved with non-narcotic medications. Women that are >49 days gestation are likely to experience more pain than those < 49 days. Pain is rarely a sign of impending complication, however, when accompanied by anxiety, fever or heavy bleeding, this should be evaluated. Persistent pain warrants evaluation of the underlying cause such as infection or for ectopic pregnancy if the pregnancy is very early and this has not yet been able to be excluded. Pain relief such as Paracetamol or NSAIDS should be tried first. Narcotic analgesics may be used, if needed. Hot water bottle and rest can help relieve cramping as well.

GI distress: Many women experience nausea, vomiting and diarrhea. These symptoms are generally mild and self limiting. They are most often managed with reassurance, but may also be treated with anti emetics or antidiarrhoeals.

Infection: Infection is uncommon in medical termination, but should be considered in all women presenting with prolonged fever and pain or systematic unwellness. The medication in medical termination may cause brief thermoregulatory changes, including chills. Fever has been reported in 4% of women undergoing medical termination. Generally this does not warrant further evaluation and can be treated with anti-inflammatories, however, a fever of 38 degrees C or higher that persists for several hours despite the use of antipyretics, or develops days after Misoprostol use, may indicate infection and should be evaluated accordingly.