Medication Abortion Protocol

This protocol provides basic requirements for implementing medication abortion services at a family medicine teaching site. An interactive version with citations and practice tips is also available on rhedi.org.

Medication Abortion Protocol

Scheduling:

Patients requesting a medication abortion ideally should be scheduled within 7 days of contacting your office; consider the feasibility of telemedicine/minimal contact care to provide care sooner.

Patient Eligibility:

- Up to 12 weeks (84 days) from first day of last menstrual period (LMP)[1]
- Positive pregnancy test

Contraindications:

- Allergy to mifepristone or misoprostol or other prostaglandins
- Concurrent long term systemic steroid use
- Chronic adrenal failure
- Coagulopathy, hemorrhagic disorders, or on an anticoagulant
- Inherited porphyria
- IUD in place (remove first)
- Ectopic pregnancy[2]

	Current evidence-based protocol (2022)	**FDA label (last updated in 2016)**
Gestational age limit	84 days/12 weeks from LMP	70 days/10 weeks from LMP
Mifepristone	200mg orally Dispensed, mailed, or prescribed	200mg orally Dispensed
Misoprostol	800mcg buccally 24–48 hours after mifepristone[3] OR 800mcg vaginally 6–72 hours after mifepristone[4] A second 800mcg dose of misoprostol may be used 4 hours after the first for patients 64–70d, and is recommended for those 71–84 days.[5] Second dose may be given as backup to all patients.	800mcg buccally, 24–48 hours after mifepristone Dispensed

	Dispensed, mailed, or prescribed	
Follow up (optional)	Per patient preference, can be offered in person or remotely and scheduled for 4–14 days after mifepristone. Also per patient preference, clinicians can offer a follow-up 5–6 weeks after initial dose of mifepristone to discuss UPT result and confirm abortion completion.	7–14 days after mifepristone, in person or remote (not specified)
Who can provide	Provided by or under the supervision of a clinician	Provided by or under the supervision of a clinician

Before the abortion:

- Document patient's preferred contact info and method (i.e., phone, email, portal, etc.)
- Determine eligibility (confirm pregnancy and rule out contraindications)
- Determine gestational age (GA) ≤ 84 days[1] using:
  - LMP[6,7]
  - Bimanual exam only if indicated[8]
  - Ultrasound only if indicated[9,10] or required by law[11] (also see Ultrasound-as-Needed Protocol)
- Rh testing and RhIg administration (for Rh negative patients) not needed for patients <70 days and may be waived before 84 days.[12]
- Complete Mifepristone Patient Agreement and any other consents specific to the practice facility.
- Dispense or prescribe mifepristone 200mg for oral use and discuss day and time patient will take (including that same day in the office if the patient chooses)
- Dispense or prescribe misoprostol 800mcg (x2 doses depending on GA and other circumstances[5]) and discuss day and time patient will take it
  - Patient will take 1st dose (800mcg) at the agreed upon time
  - Patients who are >63 days may be advised to take the 2nd dose of misoprostol 4 hours after the first[5]
  - Patients who are ≤63 days may be instructed to hold onto the 2nd dose and use only after discussion with their provider
- Prescribe pain medications (ibuprofen 800mg 30 minutes before misoprostol, then 400–800mg q6hrs as needed. Also as needed, offer acetaminophen with narcotic (e.g., 5/325mg) and anti-emetic (e.g., ondansetron ODT 4mg SL q4hrs prn or promethazine 25mg po prn q6hrs).
- Review Information for Patients after Medication Abortion
- Confirm that patient knows how to reach the medical team if needed, including after office hours if available
- Discuss a remote or in-person follow-up[13] plan with the patient.
  - If the patient wants a follow-up visit, they can make an appointment for 4–14 days after taking the mifepristone

    - If patient chooses UPT follow-up, provide test or advise patient they can take one on their own 5–6 weeks after using mifepristone. Also offer the patient in-person or telemedicine follow up at this time if desired.
    - If patient chooses serum HCG follow up, draw/order initial serum level and schedule appointment for follow-up blood test
- Ask the patient if they want to discuss contraception the same day or in the future,[14] or not at all
- Complete mandated reporting form as per city or state protocol

At follow up:

- Whether in-person or remote, confirm with patient (at 4–14 days):
    - history of bleeding and cramping consistent with passage of pregnancy
    - they no longer feel pregnant
- If patient chose beta-HCG follow-up, second serum HCG level can be drawn as early as 3 days after taking mifepristone. (Serum HCG should decrease 50% by 3 days, 60% by 4–5 days, and 80% by 7 days)
- Consider a sonogram if patient still feels pregnant, uncertain history, or inconclusive HCG drop
- If patient chose UPT follow-up, test should be done 5-6 weeks after mifepristone is taken. If patient decides to do the test on their own, advise them to contact the office if result is positive.

Notes and References

1. Note that the 2016 FDA protocol specifies a GA limit of 70 days from LMP and several U.S. states require providers to adhere to this limit. (See http://lawatlas.org/datasets/medication-abortion-requirements for more information.) However, current literature and WHO guidelines support medication abortion being safe and effective through 84 days from LMP. See: WHO, Abortion Care guideline. March 9, 2022. https://www.who.int/publications/i/item/9789240039483; Dzuba I, et al. A Non-Inferiority Study of Outpatient Mifepristone-Misoprostol Medical Abortion at 64-70 Days and 71-77 Days of Gestation. Contraception. 2020 101(5):302-308. DOI: 10.1016/j.contraception.2020.01.009; Kapp N, et al. Medical Abortion in the Late First Trimester: A Systematic Review. Contraception. 2019 99(2):77-86.ces: DOI: 10.1016/j.contraception.2018.11.002.

2. Ectopic pregnancy is not a true "contraindication" to medication abortion with mifepristone and misoprostol. Thesemedications are not effective at ending an ectopic pregnancy, but they will not cause a rupture or further complicate an ectopic pregnancy. See Shannon C, et al. Ectopic pregnancy and medical abortion. Obstetrics and Gynecology 2004;104(1):161–7. DOI: 10.1097/01.AOG.0000130839.61098.12. Patients with ectopic pregnancies should be offered an effective treatment.

3. Chen MJ, et al. Mifepristone with buccal Misoprostol for medical abortion: A Systematic Review. Obstetrics and Gynecology 2015;126(1):12–21. DOI: 10.1097/AOG.0000000000000897.

4. A patient may choose to administer misoprostol vaginally to potentially shorten the time to bleeding, cramping, and abortion completion. See: Young D, Fitzgerald K, Laursen L, Whitaker AK. Comparison of vaginal and buccal misoprostol after mifepristone for medication abortion through 70 days of gestation: A retrospective chart review. Contraception. 2022 Nov;115:62-66. DOI: 10.1016/j.contraception.2022.06.012. Epub 2022 Jun 28. PMID: 35772525. Depending on the patient's circumstances you may wish to remind them that fragments of the misoprostol tablets could remain visible in the vagina for some time after insertion. This may be of particular importance for patients presenting in states where abortion is banned.

5. Dzuba IG, et al. A repeat dose of misoprostol 800 mcg following mifepristone for outpatient medical abortion at 64–70 and 71–77 days of gestation: A retrospective chart review. Contraception. 2020 Aug;102(2):104–108. doi: 10.1016/j.contraception.2020.05.012; Also see: National Abortion Federation. Clinical Policy Guidelines, Section 6. Washington DC: National Abortion Federation; 2022. https://prochoice.org/providers/quality-standards/ . A second dose

of misoprostol may also be appropriate for patients who, should a second dose be medically indicated, wish to avoid coming back to the office or going to the pharmacy due to extensive travel, COVID-19 concerns, or other circumstances.

6. Constant D, et al. Accuracy of gestational age estimation from last menstrual period among women seeking abortion in South Africa, with a view to task sharing: a mixed methods study. Reproductive Health 2017; 14(1):100. DOI: 10.1186/s12978-017-0365-7

7. Schonberg D, et al. The accuracy of using last menstrual period to determine gestational age for first trimester medication abortion: a systematic review. Contraception 2014;90(5):480–7. DOI: 10.1016/j.contraception.2014.07.004

8. Raymond EG, et al. Simplified medical abortion screening: a demonstration project. Contraception 2018;97(4):292-6. DOI: 10.1016/j.contraception.2017.11.005

9. Raymond EG, Bracken H. Early medical abortion without prior ultrasound. Contraception 2015;92(3):212–4. DOI: 10.1016/j.contraception.2015.04.008

10. Kaneshiro B, et al. Expanding medical abortion: can medical abortion be effectively provided without the routine use of ultrasound? Contraception 2011;83(3)194–201. DOI: 10.1016/j.contraception.2010.07.023

11. Also note that many U.S. states require ultrasound as part of abortion provision. See: https://www.kff.org/womens-health-policy/state-indicator/ultrasound-requirements/ for more information.

12. For more detailed guidance, see section 4 in: National Abortion Federation, 2022 Clinical Policy Guidelines for Abortion Care (CPGs) Washington DC: National Abortion Federation; 2022.

13. Perriera LK, et al. Feasibility of telephone follow-up after medical abortion. Contraception 2010;81:143–9. DOI: 10.1016/j.contraception.2009.08.008

14. If patient desires a contraception discussion, also consider offering advance provision of 'emergency' contraception including oral levonorgestrel progestin, ulipristal acetate, or CHCs. For more information, see: Emergency Contraception, Kaiser Family Foundation; Rodriguez, Maria I. et al. Advance supply of emergency contraception: a systematic review. Contraception, Volume 87, Issue 5, 590 - 601. DOI: https://doi.org/10.1016/j.contraception.2012.09.011; Polis CB et al. Advance provision of emergency contraception for pregnancy prevention (full review). Cochrane Database Syst Rev. 2007 Apr 18;(2):CD005497. doi: 10.1002/14651858.CD005497.pub2. PMID: 17443596. Patients may also wish to consider same-day insertion of an implant. See: Hognert H, et al. Immediate versus delayed insertion of an etonogestrel releasing implant at medical abortion-a randomized controlled equivalence trial. Human Reproduction 2016;31(11):2484–2490. DOI: 10.1093/humrep/dew238