

WEBVTT

1

00:00:03.800 --> 00:00:06.400

In this video, we will broadly examine

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00:00:06.400 --> 00:00:10.200

abortion after the first trimester in the United States including

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00:00:09.200 --> 00:00:12.700

its prevalence methods of abortion and

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00:00:12.700 --> 00:00:14.400

pre-procedural considerations.

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00:00:15.200 --> 00:00:18.600

About one in four people who can become pregnant will

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00:00:18.600 --> 00:00:20.800

have an abortion before the age of 45.

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00:00:21.800 --> 00:00:24.500

most abortions in the United States occur before

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00:00:24.500 --> 00:00:26.200

13 weeks gestation

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00:00:27.300 --> 00:00:30.500

Based on data from the CDC about 8% of

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00:00:30.500 --> 00:00:33.600

all abortions occur between 14 to 20

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00:00:33.600 --> 00:00:36.400

weeks gestation, and only one percent occur

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00:00:36.400 --> 00:00:38.100

after 21 weeks gestation.

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00:00:39.300 --> 00:00:42.600

While abortion after the first trimester is much less prevalent,

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00:00:42.600 --> 00:00:45.500

the circumstances surrounding people's access

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00:00:45.500 --> 00:00:49.000

to this care can be complex and challenging and

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00:00:48.300 --> 00:00:51.800

these patients deserve are utmost compassion

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00:00:51.800 --> 00:00:52.500

and empathy.

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00:00:53.600 --> 00:00:57.000

Patients seeking abortion after the first trimester sit

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00:00:56.100 --> 00:01:00.000

at the intersection of unjust socio-political

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00:00:59.800 --> 00:01:02.800

constraints that delay or impede access

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00:01:02.800 --> 00:01:04.000

to timely services.

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00:01:05.200 --> 00:01:08.300

They must overcome legislative financial and

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00:01:08.300 --> 00:01:11.800

other barriers to access care. They face stigma

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00:01:11.800 --> 00:01:14.800

both internally within themselves or externally

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00:01:14.800 --> 00:01:17.600

from those that are close to them or the broader community.

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00:01:18.500 --> 00:01:21.800

And many face significant health risks or lethal fetal

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00:01:21.800 --> 00:01:24.500

diagnoses that necessitate terminating a desired

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00:01:24.500 --> 00:01:27.900

pregnancy and because of all of these factors, they

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00:01:27.900 --> 00:01:30.300

can face significant psychosocial stressors.

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00:01:31.400 --> 00:01:34.600

Research has shown that there are many reasons why people seek

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00:01:34.600 --> 00:01:37.500

abortions after the first trimester and many

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00:01:37.500 --> 00:01:40.800

of these reasons relate to barriers to accessing timely

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00:01:40.800 --> 00:01:41.000

care.

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00:01:42.400 --> 00:01:45.400

Patients report having trouble finding a care provider which is

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00:01:45.400 --> 00:01:48.500

aligned with research showing over 90% of us

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00:01:48.500 --> 00:01:50.500

counties are without abortion providers.

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00:01:51.500 --> 00:01:54.300

They report difficulty finding and accessing a

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00:01:54.300 --> 00:01:57.300

provider after being referred from other clinics who couldn't care

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00:01:57.300 --> 00:01:57.700

for them.

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00:01:58.500 --> 00:02:01.200

In securing childcare and transportation as well

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00:02:01.200 --> 00:02:02.800

as other logistical challenges.

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00:02:03.900 --> 00:02:06.700

They also report late recognition of their pregnancy

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00:02:06.700 --> 00:02:09.500

due to not experiencing typical symptoms of

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00:02:09.500 --> 00:02:12.100

early pregnancy or being unsure of

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00:02:12.100 --> 00:02:13.900

the date of their last menstrual period

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00:02:14.700 --> 00:02:17.500

accessing care later in pregnancy can create more

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00:02:17.500 --> 00:02:20.700

barriers for patients including an increased cost

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00:02:20.700 --> 00:02:23.600

of care services and a lower availability of

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00:02:23.600 --> 00:02:26.300

clinicians that provide abortion after the first

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00:02:26.300 --> 00:02:27.700

trimester Nationwide.

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00:02:28.500 --> 00:02:31.300

Structural barriers like targeted regulations on

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00:02:31.300 --> 00:02:34.400

abortion providers or trap laws may require

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00:02:34.400 --> 00:02:37.900

mandatory waiting periods, which further compound delays

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00:02:37.900 --> 00:02:39.400

to accessing abortion care.

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00:02:40.100 --> 00:02:43.100

These structural barriers make it especially challenging for

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00:02:43.100 --> 00:02:46.400

those who must travel far need to raise funds to

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00:02:46.400 --> 00:02:49.700

pay for their care need to take time off of work or

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00:02:49.700 --> 00:02:51.200

make childcare Arrangements.

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00:02:51.900 --> 00:02:54.900

All of this points to the importance of having timely

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00:02:54.900 --> 00:02:57.800

and unrestricted access to abortion as well

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00:02:57.800 --> 00:03:00.800

as increasing the number of clinicians that provide

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00:03:00.800 --> 00:03:03.200

abortion after the first trimester to help

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00:03:03.200 --> 00:03:04.600

prevent further delays.

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00:03:05.200 --> 00:03:08.700

Abortion is a very safe procedure and major complication

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00:03:08.700 --> 00:03:10.600

rates in any trimester are low.

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00:03:11.200 --> 00:03:14.200

While the mortality risk of abortion increases by

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00:03:14.200 --> 00:03:17.700

approximately 38% for each week of gestation above

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00:03:17.700 --> 00:03:20.600

eight weeks abortion remains safer than

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00:03:20.600 --> 00:03:23.700

giving birth in the United States particularly for

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00:03:23.700 --> 00:03:26.500

groups that suffer disproportionate rates of pregnancy

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00:03:26.500 --> 00:03:27.700

related mortality.

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00:03:28.800 --> 00:03:32.000

Abortion after the first trimester can be safely provided

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00:03:31.100 --> 00:03:34.300

with either medications alone or with

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00:03:34.300 --> 00:03:35.000

a procedure.

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00:03:36.300 --> 00:03:39.800

The method of abortion depends on the patient's individual preferences

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00:03:39.800 --> 00:03:42.900

their gestational age availability of

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00:03:42.900 --> 00:03:45.900

services and any potential risk factors

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00:03:45.900 --> 00:03:48.600

that may increase the risk of complications of

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00:03:48.600 --> 00:03:50.100

one method over another.

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00:03:51.100 --> 00:03:54.600

Patients individual preferences for the method of their abortion is

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00:03:54.600 --> 00:03:57.200

a major factor in choosing an appropriate method.

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00:03:58.200 --> 00:04:01.500

Thorough patient-centered counseling should involve discussion of

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00:04:01.500 --> 00:04:04.400

all available options to the patient based on

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00:04:04.400 --> 00:04:05.900

their values and preferences.

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00:04:07.200 --> 00:04:11.000

In the United States most abortions in the second trimester occur

86

00:04:10.200 --> 00:04:13.400

via procedural abortion most commonly through

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00:04:13.400 --> 00:04:16.900

a procedure called dilation and evacuation or DNA.

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00:04:17.500 --> 00:04:20.400

A D&A is a one or two-day procedure that

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00:04:20.400 --> 00:04:23.500

involves preparing the cervix with medications or

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00:04:23.500 --> 00:04:26.500

mechanical methods or both to dilate the

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00:04:26.500 --> 00:04:29.200

cervix sufficiently to then remove fetal parts

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00:04:29.200 --> 00:04:32.900

and pregnancy tissue from within the uterus using specialized

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00:04:32.900 --> 00:04:33.400

forceps.

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00:04:34.300 --> 00:04:37.500

It's a procedure that can be done very safely in various

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00:04:37.500 --> 00:04:40.700

settings including in outpatient clinics ambulatory

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00:04:40.700 --> 00:04:42.500

surgical centers and hospitals.

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00:04:43.400 --> 00:04:46.300

Depending on the clinical setting patients may have access

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00:04:46.300 --> 00:04:49.900

to many forms of pain control including local anesthesia

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00:04:49.900 --> 00:04:52.800

IV sedation deep sedation or

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00:04:52.800 --> 00:04:53.800

general anesthesia.

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00:04:54.800 --> 00:04:57.400

Benefits of a DNA compared with a medication

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00:04:57.400 --> 00:05:00.500

abortion include the shorter duration of the abortion

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00:05:00.500 --> 00:05:03.100

and also more certainty about when it'll be

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00:05:03.100 --> 00:05:06.400

complete and potentially a lower cost as most

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00:05:06.400 --> 00:05:08.700

procedures occur in outpatient clinics.

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00:05:09.900 --> 00:05:12.500

Risks of a DNA include those related to

107

00:05:12.500 --> 00:05:16.200

surgery such as uterine perforation or cervical laceration

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00:05:15.200 --> 00:05:18.800

and anesthetic complications, but

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00:05:18.800 --> 00:05:20.800

major complication rates are low.

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00:05:21.500 --> 00:05:24.600

Additionally overall complication rates of DNA

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00:05:24.600 --> 00:05:27.200

are lower compared to medication abortion in the

112

00:05:27.200 --> 00:05:28.300

second trimester.

113

00:05:29.300 --> 00:05:32.100

DNE requires a skilled provider and training to

114

00:05:32.100 --> 00:05:35.000

reduce or eliminate any complications

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00:05:35.600 --> 00:05:38.700

and while a D&E is the most common procedural abortion

116

00:05:38.700 --> 00:05:42.000

only 34% and 16%

117

00:05:41.300 --> 00:05:44.700

of abortion providing clinics offer

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00:05:44.700 --> 00:05:48.000

abortions after 20 weeks and 24 weeks respectively

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00:05:47.700 --> 00:05:50.300

and there are many areas of the country

120

00:05:50.300 --> 00:05:54.200

where there are no skilled DNA providers limiting access

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00:05:53.200 --> 00:05:55.300

to this procedure.

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00:05:56.600 --> 00:05:59.800

Additionally, there are emergency situations where a

123

00:05:59.800 --> 00:06:02.500

DNA may be the most effective treatment to save

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00:06:02.500 --> 00:06:04.200

the health or life of a patient.

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00:06:05.200 --> 00:06:08.200

And therefore it's imperative that clinical training programs that

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00:06:08.200 --> 00:06:11.700

have abortion provision within their scope continue to

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00:06:11.700 --> 00:06:14.500

integrate this training as a part of routine education.

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00:06:14.500 --> 00:06:17.500

Now, let's move on to medication abortion

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00:06:17.500 --> 00:06:21.000

after the first trimester often called induction termination.

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00:06:21.800 --> 00:06:24.900

Similar to earlier medication abortion this can

131

00:06:24.900 --> 00:06:27.400

include using mesoprostol ideally along

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00:06:27.400 --> 00:06:30.800

with me for pristone to induce labor and delivery and

133

00:06:30.800 --> 00:06:33.700

can also include mechanical dilation with fully

134

00:06:33.700 --> 00:06:37.200

balloons oxytocin and amniotomy patients

135

00:06:36.200 --> 00:06:39.500

may prefer this method over D&A if

136

00:06:39.500 --> 00:06:42.400

they prefer to experience labor to avoid

137

00:06:42.400 --> 00:06:45.300

a procedure or desire an intact fetus after

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00:06:45.300 --> 00:06:47.300

delivery to hold or grieve.

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00:06:47.900 --> 00:06:50.200

Some patients may consider certain aspects of

140

00:06:50.200 --> 00:06:53.200

medication abortion to be disadvantages such as the

141

00:06:53.200 --> 00:06:56.300

need to go through the experience of Labor and birth.

142

00:06:56.900 --> 00:06:59.900

The longer time of procedure and unpredictability of

143

00:06:59.900 --> 00:07:02.500

delivery and risk of retained products

144

00:07:02.500 --> 00:07:05.200

or placenta requiring uterine evacuation.

145

00:07:06.100 --> 00:07:09.800

Additionally many medication abortions in the United States occur

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00:07:09.800 --> 00:07:12.300

in inpatient Hospital settings such as

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00:07:12.300 --> 00:07:15.600

on a labor and delivery unit. And this may be more costly

148

00:07:15.600 --> 00:07:16.200

to patients.

149

00:07:17.100 --> 00:07:20.700

Generally from a provider standpoint medication abortion

150

00:07:20.700 --> 00:07:24.200

after the first trimester does not require significant additional

151

00:07:23.200 --> 00:07:26.400
skills or training compared to

152

00:07:26.400 --> 00:07:29.400
obstetric skills for Labor Management and delivery.

153

00:07:30.300 --> 00:07:33.700
Overall medication abortion and procedural abortion

154

00:07:33.700 --> 00:07:36.800
in the second trimester have similar complication rates.

155

00:07:36.800 --> 00:07:40.000
However, the rates of specific complications

156

00:07:39.700 --> 00:07:43.100
differ slightly between the two methods this

157

00:07:42.100 --> 00:07:45.500
table lists the potential complications with

158

00:07:45.500 --> 00:07:48.300
medication and procedural abortion after the first

159

00:07:48.300 --> 00:07:48.900
trimester.

160

00:07:49.700 --> 00:07:52.500
There are very few studies that compare complication rates

161

00:07:52.500 --> 00:07:53.600
between these two methods.

162

00:07:54.600 --> 00:07:57.600
Here's an example of the comparative complication rates

163

00:07:57.600 --> 00:08:00.600

between medication and procedural abortion from

164

00:08:00.600 --> 00:08:03.000

a retrospective study by Autry at all.

165

00:08:03.500 --> 00:08:06.600

It's important to remember that both medication abortion and

166

00:08:06.600 --> 00:08:09.800

procedural abortion after the first trimester occur

167

00:08:09.800 --> 00:08:12.400

in multiple different settings where patients may

168

00:08:12.400 --> 00:08:15.800

interact with various Healthcare Personnel, including front

169

00:08:15.800 --> 00:08:18.400

desk staff nursing Environmental Services,

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00:08:18.400 --> 00:08:21.300

anesthesiologists and other clinicians.

171

00:08:22.100 --> 00:08:25.400

Because of this adequate training of personnel who may interact

172

00:08:25.400 --> 00:08:28.500

with the patient is incredibly important and should

173

00:08:28.500 --> 00:08:31.600

involve how to provide Compassionate Care to those undergoing

174

00:08:31.600 --> 00:08:34.200

abortion in a way that upholds our

175

00:08:34.200 --> 00:08:37.500

ethical and professional obligations to them and how

176

00:08:37.500 --> 00:08:40.400

to provide a supportive and non-judgmental Care

177

00:08:40.400 --> 00:08:43.600

environment for either Method All patients should

178

00:08:43.600 --> 00:08:46.300

have a pre-procedure evaluation that includes

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00:08:46.300 --> 00:08:49.400

taking a thorough history identifying any risk

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00:08:49.400 --> 00:08:53.200

factors that may increase the risk of complications and

181

00:08:52.200 --> 00:08:56.800

determining gestational age via ultrasound patients

182

00:08:55.800 --> 00:08:58.400

should be sure of their decision to

183

00:08:58.400 --> 00:09:02.900

have an abortion and ideally receive comprehensive non-directive

184

00:09:01.900 --> 00:09:04.500

pregnancy Options Counseling

185

00:09:04.500 --> 00:09:05.600

as part of their visit.

186

00:09:06.300 --> 00:09:09.200

Patients should be counseled about their choice and method of

187

00:09:09.200 --> 00:09:13.200

abortion and provide informed consent legal restrictions

188

00:09:12.200 --> 00:09:15.500

based on whether abortion can be provided

189

00:09:15.500 --> 00:09:18.500

at various gestational ages and how soon

190

00:09:18.500 --> 00:09:21.600

after counseling abortion can occur differ from

191

00:09:21.600 --> 00:09:24.200

state to state and providers should refer to

192

00:09:24.200 --> 00:09:26.400

their own local guidance and protocols.

193

00:09:27.500 --> 00:09:30.500

Pre procedure Labs should be obtained including a

194

00:09:30.500 --> 00:09:33.700

hemoglobin or hematocrit Rh typing and

195

00:09:33.700 --> 00:09:36.500

screening for sexually transmitted infections such

196

00:09:36.500 --> 00:09:39.100

as gonorrhea and chlamydia as desired by

197

00:09:39.100 --> 00:09:42.500

the patient Studies have evaluated the utility of

198

00:09:42.500 --> 00:09:46.200

inducing fetal demise prior to second trimester procedural

199

00:09:45.200 --> 00:09:48.500

abortion, either with inter fetal

200

00:09:48.500 --> 00:09:51.800

digoxin or fetal intracardiac potassium chloride

201

00:09:51.800 --> 00:09:54.900

to evaluate whether this may facilitate ease

202

00:09:54.900 --> 00:09:57.700

of the procedure. However, no definitive

203

00:09:57.700 --> 00:10:00.800

evidence demonstrates benefit of inducing fetal

204

00:10:00.800 --> 00:10:02.300

demise before DNA.

205

00:10:03.300 --> 00:10:07.100

As a result professional societies do not recommend routine

206

00:10:06.100 --> 00:10:10.100

use of feticidal injections before DNA.

207

00:10:09.100 --> 00:10:12.600

There may be instances in which inducing

208

00:10:12.600 --> 00:10:15.200

fetal demise is appropriate for patient or

209

00:10:15.200 --> 00:10:18.900

provider preference or to adhere to institutional guidelines.

210

00:10:19.900 --> 00:10:23.300

Patients who need abortion after the first trimester faced

211

00:10:22.300 --> 00:10:25.000

many barriers as they seek care.

212

00:10:25.700 --> 00:10:28.600

They deserve compassionate de-stigmatized and

213

00:10:28.600 --> 00:10:31.400

easily accessible care that aligns with

214

00:10:31.400 --> 00:10:33.600

their preferences from well-trained clinicians.

215

00:10:34.400 --> 00:10:37.700

Please see other videos in this course for more clinical details

216

00:10:37.700 --> 00:10:40.300

on providing both medication abortion and

217

00:10:40.300 --> 00:10:44.400

procedural abortion after the first trimester preventing and

218

00:10:44.400 --> 00:10:47.500

managing abortion complications in supporting patient

219

00:10:47.500 --> 00:10:50.400

decision-making as they determine what method is right

220

00:10:50.400 --> 00:10:50.700

for them.

221

00:10:51.500 --> 00:10:55.500

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