WEBVTT

1
00:00:04.530 --> 00:00:05.410
- In this video,

2
00:00:05.410 --> 00:00:08.200
we will define complications
of procedural abortion

3
00:00:08.200 --> 00:00:09.700
and review prevention strategies

4
00:00:09.700 --> 00:00:12.690
using a clinical case
to guide us throughout.

5
00:00:12.690 --> 00:00:13.640
We hope you come away

6
00:00:13.640 --> 00:00:15.780
with an understanding
of these complications

7
00:00:15.780 --> 00:00:18.450
and have the evidence
for how to prevent them.

8
00:00:18.450 --> 00:00:21.100
Let's start by defining what
we mean by complications

9
00:00:21.100 --> 00:00:23.560
which can be major or minor.

10
00:00:23.560 --> 00:00:26.340
Major complications include hemorrhage,

11
00:00:26.340 --> 00:00:29.580
unanticipated surgery after

the abortion procedure,

12
00:00:29.580 --> 00:00:30.750
infection,

13
00:00:30.750 --> 00:00:32.270
perforation of the uterus

14
00:00:32.270 --> 00:00:34.810
and incredibly rarely, death.

15
00:00:34.810 --> 00:00:37.560
Minor complications
include cervical laceration

16
00:00:37.560 --> 00:00:39.340
and the need to re-aspirate the uterus

17
00:00:39.340 --> 00:00:40.830
after the abortion procedure.

18
00:00:40.830 --> 00:00:42.440
The overall complication rate

19
00:00:42.440 --> 00:00:46.930
for first trimester abortion
procedures is 0.07%.

20
00:00:46.930 --> 00:00:49.210
The rate for second
trimester abortion procedures

21
00:00:49.210 --> 00:00:51.700
is slightly higher at 0.6%.

22
00:00:51.700 --> 00:00:52.533
I wanna highlight

23

00:00:52.533 --> 00:00:55.040
that first and second
trimester abortion procedures

24
00:00:55.040 --> 00:00:56.220
are very safe,

25
00:00:56.220 --> 00:00:59.460
and that complications for
abortion are significantly less

26
00:00:59.460 --> 00:01:02.280
than those of carrying
a pregnancy to term.

27
00:01:02.280 --> 00:01:03.290
Excessive pain,

28
00:01:03.290 --> 00:01:05.050
although not a true complication,

29
00:01:05.050 --> 00:01:07.440
is a notable side effect
of procedural abortion

30
00:01:07.440 --> 00:01:09.100
that should be prevented.

31
00:01:09.100 --> 00:01:10.830
It's important to have a consistent way

32
00:01:10.830 --> 00:01:13.830
to measure complications
of procedural abortion.

33
00:01:13.830 --> 00:01:16.110
This table is an example
of the ways that we have

34

00:01:16.110 --> 00:01:18.260
to measure different complications.

35
00:01:18.260 --> 00:01:20.650
On the left are some major
and minor complications

36
00:01:20.650 --> 00:01:22.720
with various ways to measure them.

37
00:01:22.720 --> 00:01:25.060
The challenge of reporting
abortion complications

38
00:01:25.060 --> 00:01:27.470
is that there is no
consensus on definitions

39
00:01:27.470 --> 00:01:29.890
or criteria of these conditions.

40
00:01:29.890 --> 00:01:30.723
For example,

41
00:01:30.723 --> 00:01:34.090
some studies define hemorrhage
as requiring transfusion,

42
00:01:34.090 --> 00:01:35.410
while others define hemorrhage

43
00:01:35.410 --> 00:01:37.540
as a certain amount of blood loss,

44
00:01:37.540 --> 00:01:41.490
either greater than 250
milliliters in the first trimester

45
00:01:41.490 --> 00:01:45.270

or greater than 500 milliliters
in the second trimester.

46
00:01:45.270 --> 00:01:46.370
Other studies define it

47
00:01:46.370 --> 00:01:49.470
as needing a uterine
re-aspiration after abortion

48
00:01:49.470 --> 00:01:52.240
or a certain percent drop in hemoglobin.

49
00:01:52.240 --> 00:01:53.740
The Society of Family Planning

50
00:01:53.740 --> 00:01:55.500
recently proposed a definition

51
00:01:55.500 --> 00:01:58.010
that includes a clinical
response to excessive bleeding

52
00:01:58.010 --> 00:02:00.330
such as transfusion or hospital admission

53
00:02:00.330 --> 00:02:03.890
and/or bleeding more than 500 milliliters.

54
00:02:03.890 --> 00:02:05.890
You can see what the other complications

55
00:02:05.890 --> 00:02:08.640
that there are a variety of
ways to measure them as well.

56
00:02:08.640 --> 00:02:09.930
I'd like to pause for a moment

57
00:02:09.930 --> 00:02:11.630
to review estimated blood loss,

58
00:02:11.630 --> 00:02:13.800
as this is a crucial
component to understanding

59
00:02:13.800 --> 00:02:15.750
when we should worry
about excessive bleeding

60
00:02:15.750 --> 00:02:18.090
and attempt to prevent hemorrhage.

61
00:02:18.090 --> 00:02:20.140
Studies have shown that
estimating blood loss

62
00:02:20.140 --> 00:02:22.400
is a difficult skill for providers.

63
00:02:22.400 --> 00:02:23.233
For example,

64
00:02:23.233 --> 00:02:25.300
a 2018 study designed to compare

65
00:02:25.300 --> 00:02:27.160
estimated versus measured blood loss

66
00:02:27.160 --> 00:02:29.290
at the time of dilation and evacuation

67
00:02:29.290 --> 00:02:31.830
for second trimester abortion procedures

68
00:02:31.830 --> 00:02:34.480
found that providers

consistently and significantly

69
00:02:34.480 --> 00:02:36.440
underestimate blood loss.

70
00:02:36.440 --> 00:02:39.300
Using familiar objects as
a proxy for blood volume

71
00:02:39.300 --> 00:02:42.060
can be a helpful way to
visualize blood loss.

72
00:02:42.060 --> 00:02:42.893
For example,

73
00:02:42.893 --> 00:02:45.930
an orange-sized clot around
five centimeters in diameter

74
00:02:45.930 --> 00:02:49.430
is about equal to 250
milliliters of blood.

75
00:02:49.430 --> 00:02:50.540
Double that diameter,

76
00:02:50.540 --> 00:02:54.090
a softball-sized clot is
about 500 milliliters.

77
00:02:54.090 --> 00:02:57.710
A standard soda can has 355 milliliters.

78
00:02:57.710 --> 00:03:00.130
Finally, remember that
the uterine aspirator

79
00:03:00.130 --> 00:03:03.000

can fill with 60 milliliters of fluid.

80
00:03:03.000 --> 00:03:05.140
The ideal method for
determining the blood loss

81
00:03:05.140 --> 00:03:06.870
is quantitatively weighing blood.

82
00:03:06.870 --> 00:03:09.710
However, these can be helpful estimators.

83
00:03:09.710 --> 00:03:11.490
We're now going to walk through one case

84
00:03:11.490 --> 00:03:13.940
to help illustrate some of these points.

85
00:03:13.940 --> 00:03:14.773
Case one is MM,

86
00:03:14.773 --> 00:03:17.170
an 18-year-old gravida 0

87
00:03:17.170 --> 00:03:18.950
who uses she/her pronouns,

88
00:03:18.950 --> 00:03:20.980
presenting for an abortion.

89
00:03:20.980 --> 00:03:23.070
By her reported last menstrual period,

90
00:03:23.070 --> 00:03:24.770
she is seven weeks gestation.

91
00:03:24.770 --> 00:03:25.603
But on exam,

92
00:03:25.603 --> 00:03:28.590
her uterine size feels more like 13 weeks.

93
00:03:28.590 --> 00:03:30.750
She undergoes counseling at your clinic

94
00:03:30.750 --> 00:03:33.530
and consents for procedural abortion.

95
00:03:33.530 --> 00:03:34.830
Some questions to think about

96
00:03:34.830 --> 00:03:36.950
as we go through the rest of this case:

97
00:03:36.950 --> 00:03:39.280
what complications is she at risk for?

98
00:03:39.280 --> 00:03:40.690
And what measures can you take

99
00:03:40.690 --> 00:03:43.240
to decrease her risk of complications?

100
00:03:43.240 --> 00:03:45.370
Let's first review baseline risk factors

101
00:03:45.370 --> 00:03:47.950
for abortion procedure complications.

102
00:03:47.950 --> 00:03:50.560
Things to consider are patient age.

103
00:03:50.560 --> 00:03:52.660
Accurate pregnancy
dating is also important

104
00:03:52.660 --> 00:03:54.050
to prevent complications,

105
00:03:54.050 --> 00:03:57.850
especially as complications
increase with gestational age.

106
00:03:57.850 --> 00:03:59.810
We also consider parity,

107
00:03:59.810 --> 00:04:02.670
any concern for abnormal placentation,

108
00:04:02.670 --> 00:04:05.610
previous uterine or cervical procedures,

109
00:04:05.610 --> 00:04:07.490
presence of uterine fibroids,

110
00:04:07.490 --> 00:04:09.600
history of hemorrhage in the past,

111
00:04:09.600 --> 00:04:11.650
history of a coagulopathy

112
00:04:11.650 --> 00:04:13.740
and history of severe anemia.

113
00:04:13.740 --> 00:04:15.520
First, let's think about MM's risk

114
00:04:15.520 --> 00:04:18.220
for procedural complications generally.

115
00:04:18.220 --> 00:04:19.970
You can see these listed percentages

116

00:04:19.970 --> 00:04:22.710
are the proportion of people
undergoing procedural abortion

117
00:04:22.710 --> 00:04:25.930
by trimester who
experienced complications.

118
00:04:25.930 --> 00:04:28.210
It's important to take these
numbers with a grain of salt,

119
00:04:28.210 --> 00:04:30.950
knowing that studies have
used a variety of definitions

120
00:04:30.950 --> 00:04:33.240
with a variety of ways to measure.

121
00:04:33.240 --> 00:04:35.610
The most important
takeaway from this slide

122
00:04:35.610 --> 00:04:39.180
is that the overall risk of
complications is incredibly low,

123
00:04:39.180 --> 00:04:41.020
regardless of the trimester.

124
00:04:41.020 --> 00:04:43.220
So how about individualized risk factors

125
00:04:43.220 --> 00:04:45.300
for this patient in particular?

126
00:04:45.300 --> 00:04:47.560
What are the pertinent factors
that you can think about

127
00:04:47.560 --> 00:04:50.780
for MM that we discussed
on that first slide?

128
00:04:50.780 --> 00:04:52.370
Some would include the patient's age,

129
00:04:52.370 --> 00:04:54.240
as she's 18 years old,

130
00:04:54.240 --> 00:04:55.870
as a young age and nulliparity

131
00:04:55.870 --> 00:04:58.770
may increase the risk
for cervical laceration.

132
00:04:58.770 --> 00:05:01.050
Certainly the gestational
age is important.

133
00:05:01.050 --> 00:05:03.070
And particularly for this patient,

134
00:05:03.070 --> 00:05:04.290
since there was a discrepancy

135
00:05:04.290 --> 00:05:07.620
between her last menstrual
period and our physical exam,

136
00:05:07.620 --> 00:05:10.250
you want to ensure accurate dating.

137
00:05:10.250 --> 00:05:12.110
It's also really important to consider

138
00:05:12.110 --> 00:05:14.910

the skill and experience level
of the clinicians and staff

139
00:05:14.910 --> 00:05:18.910
when thinking about complications
after procedural abortion.

140
00:05:18.910 --> 00:05:20.210
Before we review the evidence

141
00:05:20.210 --> 00:05:21.910
for various prevention strategies,

142
00:05:21.910 --> 00:05:23.470
we're gonna take a moment to pause

143
00:05:23.470 --> 00:05:25.293
and cover levels of evidence.

144
00:05:26.410 --> 00:05:29.740
This is a tool that clinicians
use to decide how and when

145
00:05:29.740 --> 00:05:32.560
we should put research
findings into practice,

146
00:05:32.560 --> 00:05:35.890
like in the prevention of
abortion procedure complications,

147
00:05:35.890 --> 00:05:37.390
I will reference some of these levels

148
00:05:37.390 --> 00:05:39.700
when we talk about interventions.

149
00:05:39.700 --> 00:05:42.640
Level A evidence is the best

level of evidence that we have

150
00:05:42.640 --> 00:05:45.420
and usually comes from large
randomized control trials

151
00:05:45.420 --> 00:05:47.350
or systematic reviews.

152
00:05:47.350 --> 00:05:50.130
Level B evidence comes out
of observational studies

153
00:05:50.130 --> 00:05:53.220
such as cohort studies
and case-control studies.

154
00:05:53.220 --> 00:05:55.340
The lower level of evidence is level C

155
00:05:55.340 --> 00:05:58.930
which generally comes from
case series expert opinion.

156
00:05:58.930 --> 00:06:02.370
So let's walk MM through
her procedural abortion.

157
00:06:02.370 --> 00:06:04.330
What is the evidence for
preoperative measures

158
00:06:04.330 --> 00:06:07.180
that we can take to prevent complications?

159
00:06:07.180 --> 00:06:09.890
The first step here would
be performing an ultrasound.

160

00:06:09.890 --> 00:06:11.000
And in her case,

161
00:06:11.000 --> 00:06:12.930
this would be to confirm gestational age,

162
00:06:12.930 --> 00:06:14.900
specifically because
there's that discrepancy

163
00:06:14.900 --> 00:06:17.600
between her last period and her exam.

164
00:06:17.600 --> 00:06:20.130
This is considered level B evidence.

165
00:06:20.130 --> 00:06:22.410
Using ultrasound to
confirm gestational age

166
00:06:22.410 --> 00:06:25.410
is particularly important
in training settings.

167
00:06:25.410 --> 00:06:28.140
Evidence has shown that
highly trained clinicians

168
00:06:28.140 --> 00:06:31.100
have quite good agreement upwards of 95%

169
00:06:31.100 --> 00:06:35.000
for basing gestational age
upon physical exam alone.

170
00:06:35.000 --> 00:06:35.860
Conversely,

171
00:06:35.860 --> 00:06:37.200

in training settings,

172
00:06:37.200 --> 00:06:39.220
several studies have
shown that specifically

173
00:06:39.220 --> 00:06:41.530
where there are attendings and residents,

174
00:06:41.530 --> 00:06:43.810
there is only about 75% agreement

175
00:06:43.810 --> 00:06:45.270
between exam and ultrasound

176
00:06:45.270 --> 00:06:47.840
when residents are performing the exam.

177
00:06:47.840 --> 00:06:48.673
However,

178
00:06:48.673 --> 00:06:50.580
regardless of training or practice status,

179
00:06:50.580 --> 00:06:52.770
the standard of care is
to obtain an ultrasound

180
00:06:52.770 --> 00:06:55.970
to confirm dating before
procedural abortion.

181
00:06:55.970 --> 00:06:57.130
The next piece to consider

182
00:06:57.130 --> 00:06:59.280
is whether or not to
use cervical preparation

183
00:06:59.280 --> 00:07:01.940
prior to first trimester
procedural abortion.

184
00:07:01.940 --> 00:07:04.410
This is considered level C evidence.

185
00:07:04.410 --> 00:07:05.760
There is still ongoing debate

186
00:07:05.760 --> 00:07:07.960
about the best method
of surgical preparation

187
00:07:07.960 --> 00:07:10.880
and what it is indicated
in the first trimester.

188
00:07:10.880 --> 00:07:13.200
It should be mentioned
that surgical preparation,

189
00:07:13.200 --> 00:07:15.260
whether pharmacologic or mechanical,

190
00:07:15.260 --> 00:07:18.410
is always standard in
second trimester procedures.

191
00:07:18.410 --> 00:07:19.950
For first trimester procedures,

192
00:07:19.950 --> 00:07:21.980
the Society of Family Planning recommends

193
00:07:21.980 --> 00:07:25.140
considering surgical
preparation for adolescents

194
00:07:25.140 --> 00:07:27.760
in situations where there
is provider inexperienced

195
00:07:27.760 --> 00:07:29.280
like training settings

196
00:07:29.280 --> 00:07:31.570
or in any situation where
the clinician believes

197
00:07:31.570 --> 00:07:33.320
that the patient might have risk factors

198
00:07:33.320 --> 00:07:36.650
for complications from
inadequate dilation.

199
00:07:36.650 --> 00:07:37.900
The last piece to consider

200
00:07:37.900 --> 00:07:40.380
is getting a pre-procedure hemoglobin.

201
00:07:40.380 --> 00:07:42.040
The National Abortion Federation

202
00:07:42.040 --> 00:07:43.750
recommends obtaining a hemoglobin

203
00:07:43.750 --> 00:07:46.570
prior to all second trimester procedures.

204
00:07:46.570 --> 00:07:48.120
For first trimester procedures,

205
00:07:48.120 --> 00:07:50.240
they recommend a pre-procedure hemoglobin

206
00:07:50.240 --> 00:07:53.110
only in patients with a history of anemia.

207
00:07:53.110 --> 00:07:55.450
This is level C evidence.

208
00:07:55.450 --> 00:07:56.860
Now that we've reviewed the evidence

209
00:07:56.860 --> 00:07:59.550
for some preoperative measures
to prevent complications,

210
00:07:59.550 --> 00:08:01.460
let's get back to our case.

211
00:08:01.460 --> 00:08:02.990
The provider does an ultrasound

212
00:08:02.990 --> 00:08:05.800
and finds that she's
10 weeks and two days.

213
00:08:05.800 --> 00:08:08.070
And now the question of
cervical preparation,

214
00:08:08.070 --> 00:08:09.560
should you do it?

215
00:08:09.560 --> 00:08:11.730
The answer, really, is maybe.

216
00:08:11.730 --> 00:08:13.150
The World Health Organization

217
00:08:13.150 --> 00:08:16.020

and the Royal College of
Obstetrics and Gynecology

218
00:08:16.020 --> 00:08:18.630
both recommend that cervical
preparation be considered

219
00:08:18.630 --> 00:08:21.240
for those under 18 years old.

220
00:08:21.240 --> 00:08:24.320
The Royal College recommends
that all people over 10 weeks

221
00:08:24.320 --> 00:08:26.620
receive surgical preparation of some sort.

222
00:08:26.620 --> 00:08:28.910
And the World Health
Organization recommends

223
00:08:28.910 --> 00:08:32.760
that all those over 12 weeks
receive surgical preparation.

224
00:08:32.760 --> 00:08:33.593
In addition,

225
00:08:33.593 --> 00:08:35.720
the World Health
Organization also recommends

226
00:08:35.720 --> 00:08:38.700
that those who are nulliparous
and greater than nine weeks

227
00:08:38.700 --> 00:08:42.430
have cervical preparation
prior to procedural abortion.

228
00:08:42.430 --> 00:08:43.440
Given this evidence,

229
00:08:43.440 --> 00:08:44.700
when we consider MM

230
00:08:44.700 --> 00:08:46.200
who's 18 years old,

231
00:08:46.200 --> 00:08:48.600
nulliparous and over 10 weeks pregnant,

232
00:08:48.600 --> 00:08:50.760
we would recommend cervical preparation,

233
00:08:50.760 --> 00:08:54.460
likely with misoprostol on
the same day as her procedure.

234
00:08:54.460 --> 00:08:56.750
Additional information
on cervical preparation

235
00:08:56.750 --> 00:09:00.500
can be found in the resources
and supplemental materials.

236
00:09:00.500 --> 00:09:03.040
Let's take a moment to
talk about pain control,

237
00:09:03.040 --> 00:09:05.270
as it is important for a safe procedure

238
00:09:05.270 --> 00:09:07.120
and minimal side effects.

239
00:09:07.120 --> 00:09:08.650

The first point to remember

240
00:09:08.650 --> 00:09:10.750
is to select the
appropriate clinical setting

241
00:09:10.750 --> 00:09:12.670
for a patient's procedure.

242
00:09:12.670 --> 00:09:13.840
For example,

243
00:09:13.840 --> 00:09:16.840
considering whether an in-office
ambulatory care setting

244
00:09:16.840 --> 00:09:19.760
with oral or IV sedation is appropriate

245
00:09:19.760 --> 00:09:21.440
versus an in-hospital setting

246
00:09:21.440 --> 00:09:24.730
with higher levels of sedation
offered by anesthesiologists,

247
00:09:24.730 --> 00:09:28.420
like propofol or other
forms of general anesthesia.

248
00:09:28.420 --> 00:09:29.910
This is something that should be reviewed

249
00:09:29.910 --> 00:09:31.740
ahead of time with patients

250
00:09:31.740 --> 00:09:33.670
based on their clinical history,

251
00:09:33.670 --> 00:09:34.680
risk factors

252
00:09:34.680 --> 00:09:37.510
and availability in the
region where you practice

253
00:09:37.510 --> 00:09:40.690
to assess what setting
is most appropriate.

254
00:09:40.690 --> 00:09:43.280
There are a wide variety
of options for pain control

255
00:09:43.280 --> 00:09:45.340
during and after abortion procedures.

256
00:09:45.340 --> 00:09:48.010
And we see significant
variability in practice

257
00:09:48.010 --> 00:09:50.460
depending on a multitude of factors.

258
00:09:50.460 --> 00:09:52.210
It's important to check in with patients

259
00:09:52.210 --> 00:09:53.720
to assess their level of comfort

260
00:09:53.720 --> 00:09:56.490
and what's most important
for the individual.

261
00:09:56.490 --> 00:09:58.780
We recommend the video on
pain control in this course

262
00:09:58.780 --> 00:10:01.810
for a full review of the
evidence-based practices.

263
00:10:01.810 --> 00:10:03.980
The main takeaway is that significant pain

264
00:10:03.980 --> 00:10:06.090
can make abortion
procedures more difficult

265
00:10:06.090 --> 00:10:08.060
and lead to complications.

266
00:10:08.060 --> 00:10:11.880
If a patient is experiencing
severe pain during a procedure,

267
00:10:11.880 --> 00:10:13.560
it is recommended to pause,

268
00:10:13.560 --> 00:10:14.480
treat the pain

269
00:10:14.480 --> 00:10:16.690
and assess for complications.

270
00:10:16.690 --> 00:10:19.420
So MM receives misoprostol sublingually

271
00:10:19.420 --> 00:10:21.610
for about 90 minutes before the procedure

272
00:10:21.610 --> 00:10:22.980
and is now ready.

273
00:10:22.980 --> 00:10:26.150
She has chosen IV

sedation for pain control.

274
00:10:26.150 --> 00:10:29.370
What other measures can we
take to prevent complications?

275
00:10:29.370 --> 00:10:31.160
We also have level A evidence

276
00:10:31.160 --> 00:10:33.230
that antibiotic prophylaxis

277
00:10:33.230 --> 00:10:36.040
prevents infection after
procedural abortion.

278
00:10:36.040 --> 00:10:39.240
So she also receives 500
milligrams of azithromycin

279
00:10:39.240 --> 00:10:42.430
to take with dinner on the
same day of her procedure.

280
00:10:42.430 --> 00:10:44.100
Should we perform MM's abortion

281
00:10:44.100 --> 00:10:45.700
with an intraoperative ultrasound

282
00:10:45.700 --> 00:10:48.340
to reduce uterine perforation?

283
00:10:48.340 --> 00:10:49.830
We have level B evidence

284
00:10:49.830 --> 00:10:51.640
regarding intraoperative ultrasounds

285
00:10:51.640 --> 00:10:53.840
for second trimester procedures.

286
00:10:53.840 --> 00:10:54.673
One study found

287
00:10:54.673 --> 00:10:56.970
that routine use of
intra-operative ultrasound

288
00:10:56.970 --> 00:10:59.320
in 16 to 24 week procedures

289
00:10:59.320 --> 00:11:01.940
significantly reduced the
rate of uterine perforation.

290
00:11:01.940 --> 00:11:05.560
MM has her abortion completed
under ultrasound guidance

291
00:11:05.560 --> 00:11:07.383
without complications thus far.

292
00:11:08.220 --> 00:11:11.003
Should MM's cervical block
contained vasopressin?

293
00:11:11.890 --> 00:11:13.790
For this, we have level A evidence

294
00:11:13.790 --> 00:11:16.650
from a randomized control
trial that found vasopressin

295
00:11:16.650 --> 00:11:19.240
to be an intraoperative
measure that reduces hemorrhage

296
00:11:19.240 --> 00:11:22.950
in second trimester dilation
and evacuation procedures.

297
00:11:22.950 --> 00:11:25.120
This decrease in blood
loss was most pronounced

298
00:11:25.120 --> 00:11:26.980
with later gestations.

299
00:11:26.980 --> 00:11:29.220
While we don't have evidence
that specifically shows

300
00:11:29.220 --> 00:11:31.970
a reduction in hemorrhage
rates in the first trimester

301
00:11:31.970 --> 00:11:33.580
with vasopressin use,

302
00:11:33.580 --> 00:11:35.590
many providers still use vasopressin

303
00:11:35.590 --> 00:11:38.640
for first trimester
procedures prophylactically.

304
00:11:38.640 --> 00:11:42.010
So we decide to use vasopressin
in MM's cervical block.

305
00:11:42.010 --> 00:11:43.930
After her procedure is complete,

306
00:11:43.930 --> 00:11:46.720
her provider inspects the
products of conception.

307
00:11:46.720 --> 00:11:48.960
What does the evidence say about this?

308
00:11:48.960 --> 00:11:50.560
Although there is level C evidence

309
00:11:50.560 --> 00:11:53.360
for visual inspection of
products of conception,

310
00:11:53.360 --> 00:11:54.710
it remains the standard of care

311
00:11:54.710 --> 00:11:57.100
for ensuring that abortion is complete.

312
00:11:57.100 --> 00:11:59.790
If the procedure is completed
under ultrasound guidance,

313
00:11:59.790 --> 00:12:01.760
the visualization of an empty uterus

314
00:12:01.760 --> 00:12:02.940
without fluid collection

315
00:12:02.940 --> 00:12:04.740
is also a helpful confirmation

316
00:12:04.740 --> 00:12:07.680
in addition to the visual
inspection of products.

317
00:12:07.680 --> 00:12:08.750
In conclusion,

318
00:12:08.750 --> 00:12:12.260

complications after procedural
abortion are incredibly rare,

319
00:12:12.260 --> 00:12:14.020
regardless of the trimester,

320
00:12:14.020 --> 00:12:15.500
with second trimester procedures

321
00:12:15.500 --> 00:12:17.030
occurring slightly more often

322
00:12:17.030 --> 00:12:19.490
than with first trimester procedures.

323
00:12:19.490 --> 00:12:21.350
Regardless of your clinical setting,

324
00:12:21.350 --> 00:12:24.220
it is important to be aware
of your emergency carts,

325
00:12:24.220 --> 00:12:27.820
protocols and transfer
agreements with nearby hospitals.

326
00:12:27.820 --> 00:12:30.680
Don't underestimate the
importance of good team dynamics

327
00:12:30.680 --> 00:12:32.140
and communication.

328
00:12:32.140 --> 00:12:34.140
We've reviewed the evidence
for measures to take

329
00:12:34.140 --> 00:12:37.540
preoperatively, intraoperatively

and postoperatively

330
00:12:37.540 --> 00:12:40.620
to help prevent complications
for our patient MM.

331
00:12:40.620 --> 00:12:41.790
For more information,

332
00:12:41.790 --> 00:12:44.157
please visit innovating-education.org.