Abortion After the First Trimester

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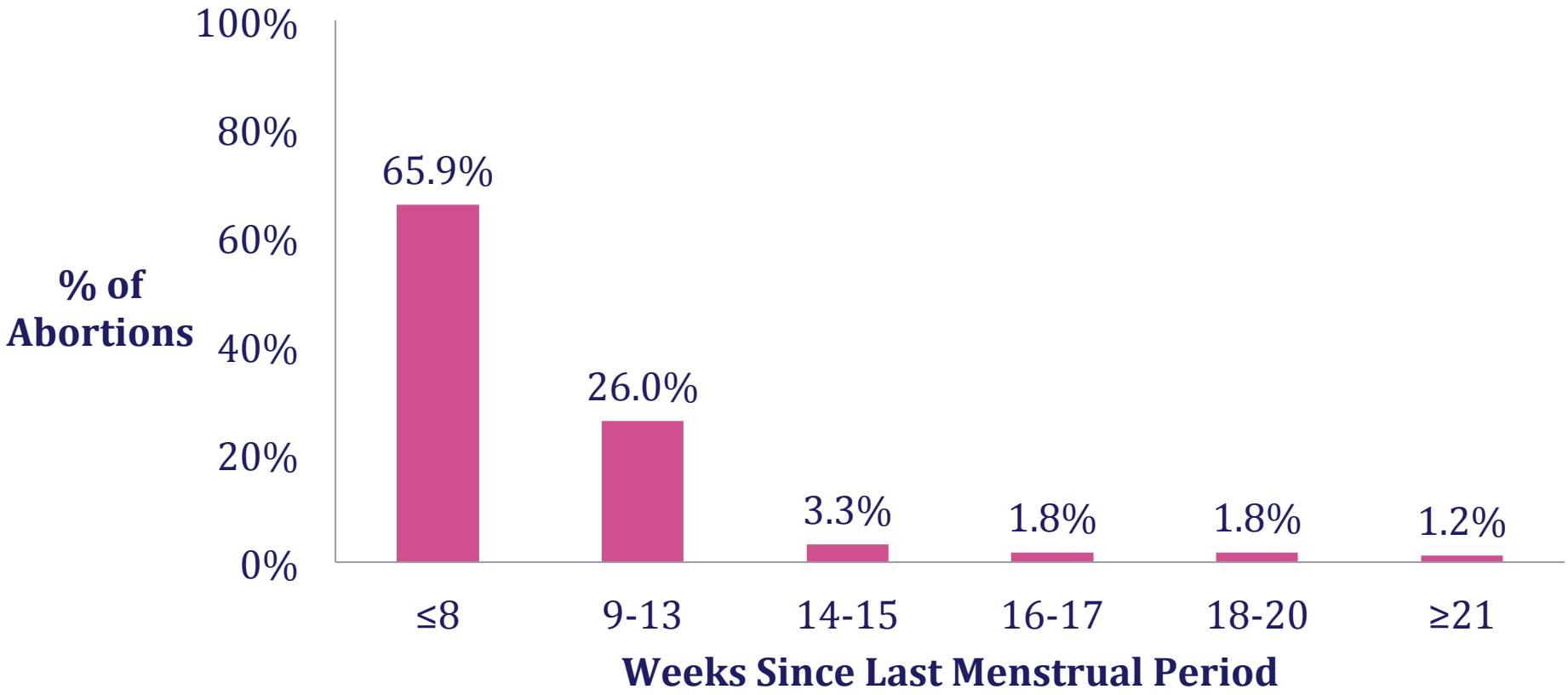
Abortions by Gestational Age



Pazol et al., 2013 (2010 data)

Overview of Abortion After the 1st Trimester

- 11% of U.S. abortions are after the 12th week
- 1% after 20 weeks
- 95% by dilation & evacuation, 5% by medical induction
- Varies by site; women often don't have a choice
- Over 100,000 D&E's in the US annually

Abortion Beyond the 1st Trimester

- Public often judgmental about patients seeking to end pregnancy after the 1st trimester
- Why do women seek care later in pregnancy?
- Relatively few abortions after the 1st trimester
  - Often the most vulnerable patients

Reasons for Abortion After 16 Weeks from Last Menstrual Period

Woman did not realize she was pregnant	71%
Difficulty making arrangements for abortion	48%
Afraid to tell parents or partner	33%
Needed time to make decision	24%
Hoped relationship would change	8%
Pressure not to have abortion	8%
Something changed during pregnancy	6%
Didn't know timing was important	6%
Didn't know she could get an abortion	5%
Fetal abnormality diagnosed late	2%

Average number of reasons given **2.2**

Patient Story

A patient from this week…

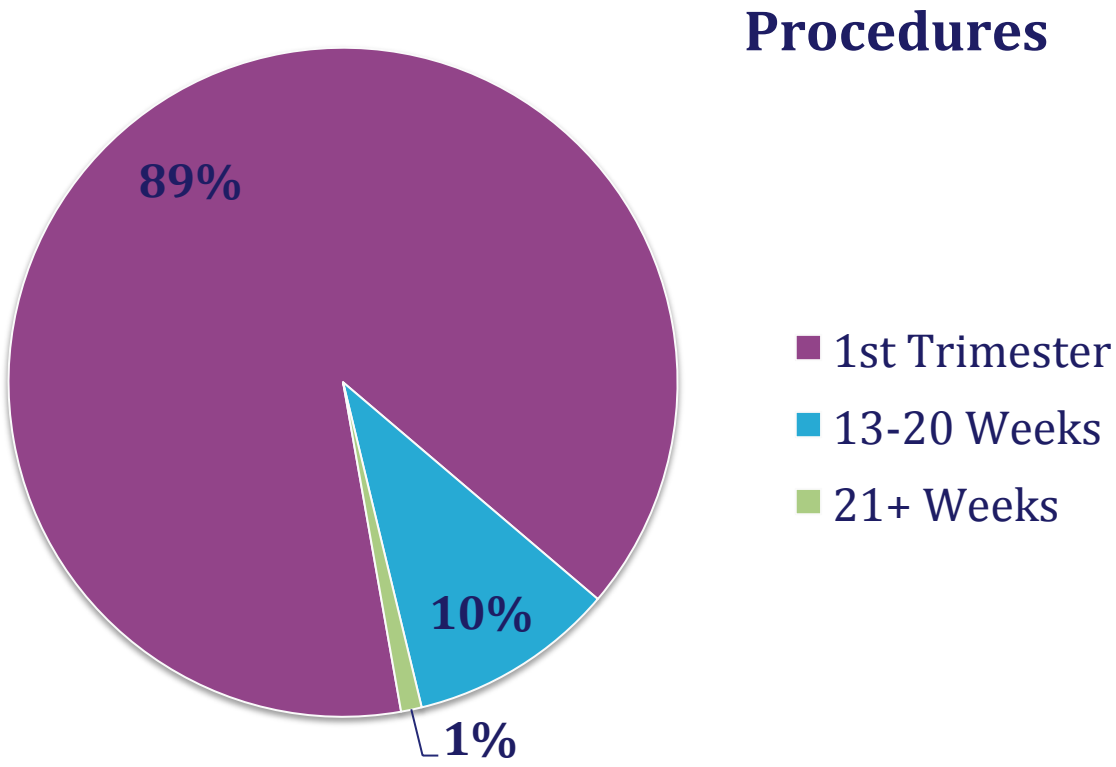
- 33yo G4P2E1 at 20 weeks
- Wanted sterilization after ectopic but told she was "too young"
- Irregular periods since her most recent birth
- Sure that she had completed her family
- Appts. at 3 previous clinics, but GA too advanced
- Traveled over 2 hours

Reasons for Delay in 2nd-Trimester Patients

Average number of reasons for delay cited: 3

- 58% already were in the 2nd trimester by the time they tested for pregnancy
  - Less likely to have pregnancy symptoms
  - More likely to be unsure of when their last period began
- 2nd-tri patients faced more logistic barriers
  - More were referred from other clinics
  - More had difficulty figuring out where to go
  - More had difficulty arranging transportation
  - More had difficulty getting state-funded insurance

Abortions by Gestational Duration



Clinical Overview

Preoperative Evaluation

- Counseling
- Ultrasound to determine gestational age
  - More uncertainty because longer since LMP
  - Emphasis because of gestational limits, D&E skills
- History and physical
- Informed consent

Procedure Types

- D&E—Most common procedural technique
- Medication abortion

Dilation & Evacuation (D&E)

- Cervical preparation critical
  - Osmotic dilators (Dilapan-S, laminaria)
  - Misoprostol, mifepristone
- Remove pregnancy with specialized instruments and suction
- Intravenous sedation used most commonly

Preventing Complications of D&E

- **Adequate cervical preparation and dilation**
- Use of vasopressin to decrease blood loss
- Skilled providers
- Some providers use real-time ultrasound guidance

Medication Abortion

- Also known as "induction abortion" or "induction termination"
- Medications to induce contractions
  - Most commonly 400mcg misoprostol q3-4h
    - Administered vaginally or buccally
  - Mifepristone 200mg PO given 12-14 hours before misoprostol
    - Decreases time between misoprostol and delivery
  - 8-20% require intervention for retained placenta

Medication Abortion

- Frequently done as an inpatient or on day unit
  - Mifepristone may facilitate use in clinics
- Misoprostol or other medication induces labor
- Success often defined as delivery of fetus, not complete evacuation
- Less skill needed to do D&C for placenta than D&E

Comparison of Methods

- Extremely different patient experiences
- Setting and timing differs
  - D&E generally outpatient, 10-15-minute procedure
  - Medication abortion usually inpatient, duration half day to several days
- Methods of pain control may differ greatly
  - Different levels of women's involvement

Special Issues with Abortion After the First Trimester

Safety Concerns

- Adequate cervical preparation central to D&E's safety
- Hemorrhage risk increases with abnormal placentation (accreta), prior c-sections
- Obesity may increase challenges of D&E, safe anesthesia provision
- Increasing risks at later gestational duration

Challenges to Access

- All risks increase at later gestations
  - **Decreased access increases morbidity**
- Patients face stigma from public, providers, themselves
- Lack of public empathy for this relatively small, vulnerable, marginalized population

In Conclusion

- Most patients have faced remarkable challenges trying to obtain services
- Patients make deeply moral decisions based upon trying to do the right thing given their individual circumstances
- Providers have a duty to advocate and care for our most politically and medically vulnerable patients
- At-risk women deserve compassionate and medically appropriate care