Abortion After the First Trimester

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Abortion by Gestational Age

- ≤8 weeks: 65.9%
- 9-13 weeks: 26.0%
- 14-15 weeks: 3.3%
- 16-17 weeks: 1.8%
- 18-20 weeks: 1.8%
- ≥21 weeks: 1.2%

Pazol et al., 2013 (2010 data)
Overview of Abortion After the 1\textsuperscript{st} Trimester

- 11\% of U.S. abortions are after the 12\textsuperscript{th} 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

Torres and Forrest, 1988
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

Drey et al, 2006
Abortions by Gestational Duration

Procedures

89% 1st Trimester
10% 13-20 Weeks
1% 21+ Weeks

Guttmacher 2014
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

Ashok et al, 2004
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