Patient Decision Making About Abortion After the First Trimester

D&E or Induction Termination

Jennifer Kerns, MD, MPH
Assistant Professor
Obstetrics, Gynecology and Reproductive Sciences
University of California, San Francisco
Case 1: Maternal Morbidity

• 28 yo G1P0 at 22 weeks with severe IUGR and severe preeclampsia, currently an inpatient
  – Stably elevated BPs
  – No lab abnormalities

• After counseling, she decides on termination

*How should she be counseled regarding method of termination?*
Case 2: Severe Structural Anomaly

- 24 yo G5P2 at 21 weeks with severe CNS anomalies and an amniocentesis showing a normal karyotype

- She has decided on termination

_How should she be counseled regarding method of termination?_
Objectives

• There is a persistent and possibly growing need for abortion services after the 1st trimester

• D&E is at least as safe and probably safer than induction termination

• Choosing a method for termination after the 1st trimester is a preference-sensitive decision

• Improving access to termination after the 1st trimester is essential for improving the care of women facing devastating diagnoses
Abortion After the 1st Trimester in the U.S.

- 91.6% of all abortions < 13 weeks
- 140,000 per year in U.S.
- D&E accounts for 96% in U.S.
- Induction termination
  - Instillation, PGF2α
  - Mifepristone & misoprostol

References:
<table>
<thead>
<tr>
<th></th>
<th>D&amp;E versus Induction</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Anesthesia</strong></td>
<td>Local + IV sedation</td>
</tr>
<tr>
<td></td>
<td>IV narcotics, regional</td>
</tr>
<tr>
<td><strong>Duration</strong></td>
<td>5–20 min (+ 1 day)</td>
</tr>
<tr>
<td></td>
<td>6–11 hours (+ 1 day)</td>
</tr>
<tr>
<td><strong>Location</strong></td>
<td>Outpatient</td>
</tr>
<tr>
<td></td>
<td>Inpatient (L&amp;D)</td>
</tr>
<tr>
<td><strong>Cost</strong></td>
<td>$3,530 ($1K–$5K)</td>
</tr>
<tr>
<td></td>
<td>$5,029 ($3K–$9K)</td>
</tr>
<tr>
<td><strong>Contact with fetus</strong></td>
<td>Partial viewing, footprints</td>
</tr>
<tr>
<td></td>
<td>Full viewing, holding</td>
</tr>
<tr>
<td><strong>Providers</strong></td>
<td>Specialized training</td>
</tr>
<tr>
<td></td>
<td>No extra training</td>
</tr>
<tr>
<td><strong>Fetal autopsy</strong></td>
<td>Often adequate (esp. intact)</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Involvement</strong></td>
<td>Patient &lt; provider</td>
</tr>
<tr>
<td></td>
<td>Patient &gt; provider</td>
</tr>
</tbody>
</table>
Reasons for Termination After the 1st Trimester

- Done with childbearing
- Can’t afford a child
- No partner
- Interferes with education
- Unstable housing, partner violence
- Sexual assault
- Chorioamnionitis
- Early severe preeclampsia
- Pre-viable PROM
- Major maternal morbidity (pulmonary hypertension, renal failure, cancer)
- Genetic anomaly (lethal and non-lethal)
- Structural anomaly (lethal and non-lethal)
- Fetal demise

Schechtman et al. 2002; Drey et al. 2006; Foster et al. 2008; Wyldes and Tonks 2007; Diedrich and Vargas, 2009; Liu et al. 2002
Fetal Anomalies

- **Screening**
  - Serum screening
  - Ultrasound
  - Cell-free DNA

- **Diagnosis**
  - Amniocentesis
  - CVS (chorionic villus sampling)

↑ abortions at earlier gestation
↑ abortions for fetal anomaly
### Complications with D&E vs. Induction

<table>
<thead>
<tr>
<th>Method</th>
<th>Study Year</th>
<th>Incidence (%)</th>
<th>Additional Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>D&amp;E only</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peterson 1983</td>
<td>0.6%</td>
<td>-----</td>
<td></td>
</tr>
<tr>
<td>Ben-Ami 2009</td>
<td>4%</td>
<td>-----</td>
<td></td>
</tr>
<tr>
<td>Frick 2010</td>
<td>1.3%</td>
<td>-----</td>
<td></td>
</tr>
<tr>
<td><strong>Induction only</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ashok 2004</td>
<td>-----</td>
<td>8% (mife + miso)</td>
<td></td>
</tr>
<tr>
<td><strong>Both</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Autry 2002</td>
<td>0.7%</td>
<td>21% Retained placenta</td>
<td></td>
</tr>
<tr>
<td>Turok 2008</td>
<td>0-1%</td>
<td>31%</td>
<td></td>
</tr>
<tr>
<td>Kelly 2010</td>
<td>12%</td>
<td>12%</td>
<td></td>
</tr>
<tr>
<td>Whitley 2011</td>
<td>15%</td>
<td>28%</td>
<td></td>
</tr>
<tr>
<td>Bryant 2011</td>
<td>3%</td>
<td>24%</td>
<td></td>
</tr>
</tbody>
</table>
“A research gap is recognized in the area of patient choice and attitude toward the different modalities of second-trimester pregnancy termination procedures.”
Factors Affecting Method Choice

- Religious attitudes
- Abortion attitudes
- Duration
- Participation
- Contact with fetus
- Provider(s)
- Religious attitudes
- Abortion attitudes
- Skill/training
- Personal preferences
- Woman
- Family & friends
- ACCESS

D&E
Induction
Patient Preferences

• Shouldn’t be a guessing game

• What do we know?

• What do we need to know?
Acceptability:
1st Trimester Literature

- **Acceptability** similar for 1st trimester medical and surgical abortion
  - Patient choice correlated with acceptability

- **Quality of life** similar for 1st trimester medical and surgical treatment of early pregnancy failure

- Women randomized to surgical more likely to find it acceptable than those randomized to medical

Patient Preference

• RCT comparing D&E to induction (mife/miso)
  – 14–20 weeks gestation, any indication

47 eligible patients

18 randomized

9 IOL

9 D&E

29 declined

2 preferred IOL

27 preferred D&E

10 of 11 women with fetal anomaly declined... because they preferred D&E

Grimes et al. BJOG 2004
Patient Preference

• 122 women randomized to D&E or induction
  – 107 women declined randomization (87 had a preference)
    • 67% preferred surgical, 33% preferred induction

• Among women randomized to D&E
  – Fewer said it was worse than expected (0% vs. 53%)
  – More likely to choose the same method (100% vs. 53%)
  – Fewer post-traumatic symptoms
Patient Preference

- Women have strong preferences, most for D&E:
  - Older, white, earlier in pregnancy, lower gravity

- Women with fetal anomalies (10/11) and IUFD (4/4) strongly prefer D&E

- Induction patients are less satisfied about pain, less likely to choose again

- D&E patients display less depression, anger, guilt

- Method choice marks the beginning of their desired recovery

Kaltreider et al. AJOG 1979; Grimes et al. BJOG 2004; Kelly et al. BJOG 2010; Kerns et al. IJGO 2011
Importance of Options Counseling

“...he kind of just said that there was only two options and it was to **carry full term or have labor now**...”

“So I didn't know that D&E was even an option. So I was really upset and thought that I would have to give birth to my dead baby and I just, that was just so much...at that point, **I was really scared that that was my only option.**”
Preferred Emotional Coping Style Among Women Choosing Induction

“...it was important for me to be able to see the baby and baptize it and be able to go about it that way.”

“Sometimes I wish I didn't because I want to hold her again... But I would regret if I hadn't... I’d do the same thing and just like, and hold the baby, 'cause I definitely needed to see her.”

“I wanted the full effect of what it would be like to give birth, to have a baby--to feel the pain, the contractions, to be awake during all of that, so I can see when the baby came out... to be able to hold the baby. I didn't want to be asleep 'cause... then it would be like I was being robbed, like the baby was being taken out of me.”
Preferred Emotional Coping Style Among Women Choosing D&E

“I just couldn't imagine... going through birth and knowing that my baby’s not going to be alive... and me being awake. **I just wanted to be put out.** I felt that that **would be just a less aware way**, you know, of going through the whole process.”

“I mean, the induction... it seems more personal, I think that the **D&E is a faster, more impersonal procedure**. You’re in, you’re out. You don’t see anything.”

“And seeing little babies that weren't alive or something, oh, I couldn't live with that. It would be etched in my mind forever. **I didn't want to see it.**”
Preferred Emotional Coping Style Among Women Choosing D&E

“I didn't want to go through a live birth because I, it would've been harder for me mentally and emotionally.”

“I felt so connected to the baby throughout the pregnancy that it was really important to sort of protect myself emotionally... I just felt like if I hold the baby, I’m just never going to want to let him go. It would've been too much for me to handle.”

“...as much as I would've liked to see him, ...in a place where I felt so raw, to be presented with something, you know, so deep, I felt like I had to kind of push that away and just sort of protect myself.”
Provider Preferences for Method

• Emotional burden

PATIENT ➔ PHYSICIAN

• Personal bias

• Support from colleagues for D&E provision
  – Institutional, departmental, community

• Skill
  – Training in residency, fellowship
  – Predictors of abortion provision
Availability of 2\textsuperscript{nd} Trimester Abortion

Shaded areas:
Extremely limited availability after 15 weeks
Access

- 35% of U.S. women have no abortion provider in their county

- 60% of D&E patients could not obtain an early abortion

- D&E access versus induction access
  - Service delivery systems as barriers
  - Academic center vs. community

- Are we giving patients a true choice?

Effect of Restrictions on Access to Method Choice

• Choice is proportional to social status (economic, racial...)

• Disproportionate effect on all disenfranchised groups
Improving Access

• Training
  – Residency
  – Post-residency

• Building support

• Advocacy for protecting and expanding D&E services

• Extending a true choice to patients
Providing Coherent Care for Our Patients

“I’ve heard a lot of criticism about late term abortion and I’ve always thought now that’s a strange thing to do, you know, to make that choice so late. And now I see you can really get boxed in as a pregnant person... by the time you get all this testing done it’s like it’s really late.”
**Case 1**

28 yo G1P0 at 22 weeks with severe IUGR and severe preeclampsia, inpatient
- Stably elevated BPs
- No lab abnormalities

**Case 2**

24 yo G5P2 at 21 weeks with multiple anomalies and a normal karyotype

**Patient Preference**

**Patient Preference**
Video Decision Aid

"I just never thought this would happen to me"

A video guide to deciding the best method of pregnancy termination
Video Decision Aid

Alicia

Leila's story

innovating education in reproductive health
Conclusion

• D&E is probably the safest method of later termination

• Most patients prefer D&E

• Induction is an appropriate alternative to D&E

• Method of termination should be driven by patient preferences