Patient Decision Making About Abortion After the First Trimester

D&E or Induction Termination

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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

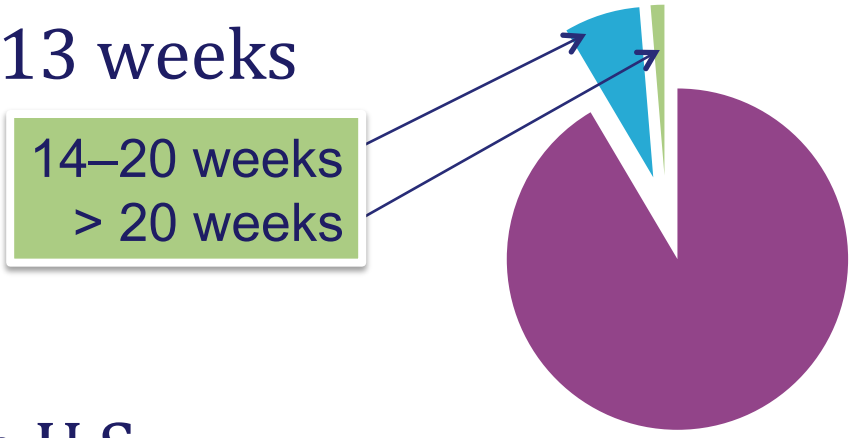
How should she be counseled regarding method of termination?

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

RCOG
WHO

Pazol et al. 2011; Tang et al. 2002; Jones et al. 2008; Peterson et al. 1983; Strauss et al.2007; Grimes et al.1977; Kafrissen et al. *JAMA* 1984

D&E *versus* Induction

	D&E	Induction
Anesthesia	Local + IV sedation	IV narcotics, regional
Duration	5–20 min (+ 1 day)	6–11 hours (+ 1 day)
Location	Outpatient	Inpatient (L&D)
Cost	$3,530 ($1K–$5K)	$5,029 ($3K–$9K)
Contact with fetus	Partial viewing, footprints	Full viewing, holding
Providers	Specialized training	No extra training
Fetal autopsy	Often adequate (esp. intact)	Yes
Involvement	Patient < provider	Patient > provider

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O'Connell et al. 2008; Paul et al. 2009; Newmann et al. *Contraception* 2008; Jones et al. *Perspect Sex and Reprod Health* 2008; Cowett et al. *AJOG* 2006

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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

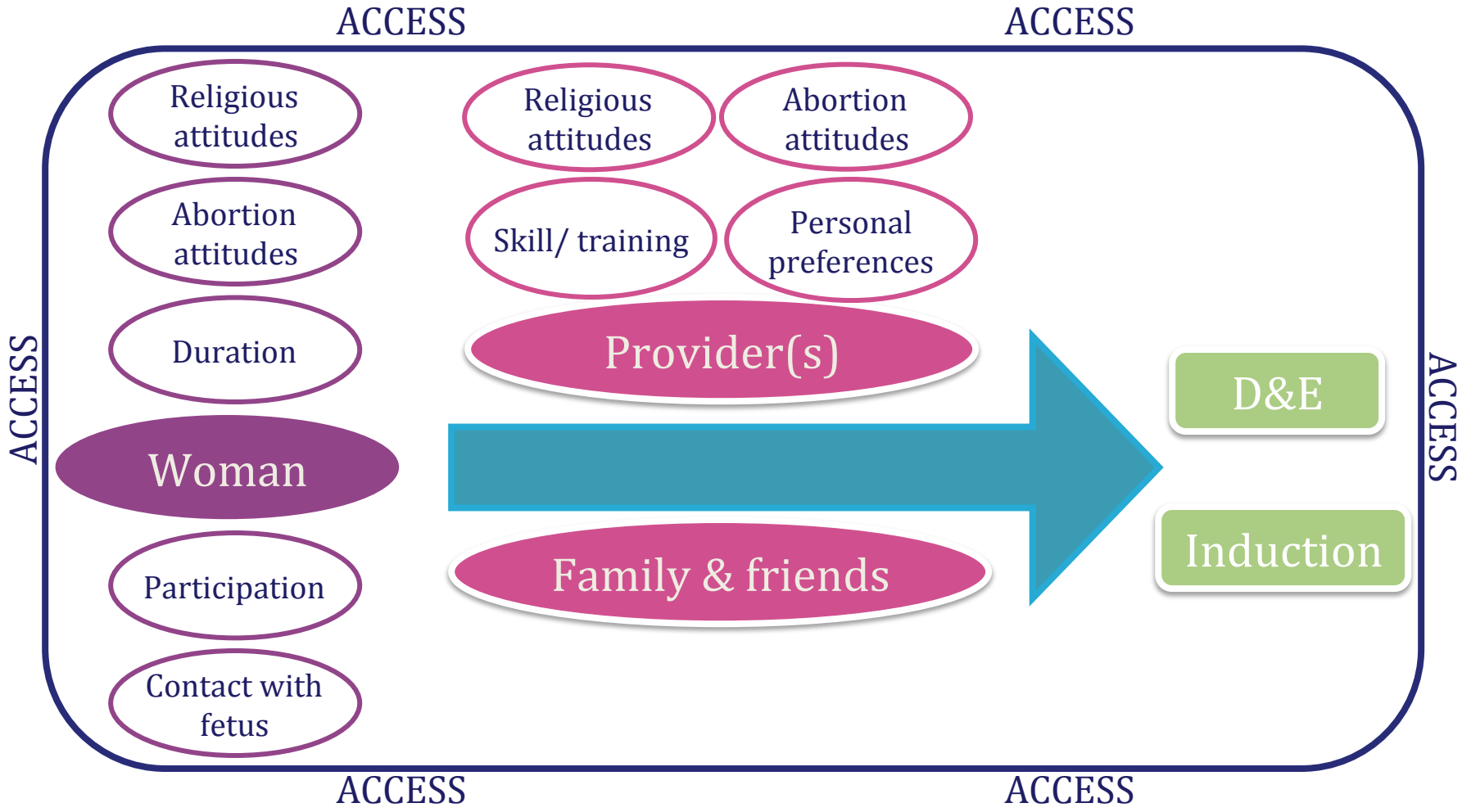
Complications with D&E vs. Induction

	Cervical laceration	Retained placenta
D&E only		
Peterson 1983	0.6%	------
Ben-Ami 2009	4%	------
Frick 2010	1.3%	------
Induction only		
Ashok 2004	------	8% (mife + miso)
Both		
Autry 2002	0.7%	21%
Turok 2008	0-1%	31%
Kelly 2010	12%	12%
Whitley 2011	15%	28%
Bryant 2011	3%	24%

Making a Choice

"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



Patient Preferences

- Shouldn't be a guessing game
- What do we know?
- What do we need to know?

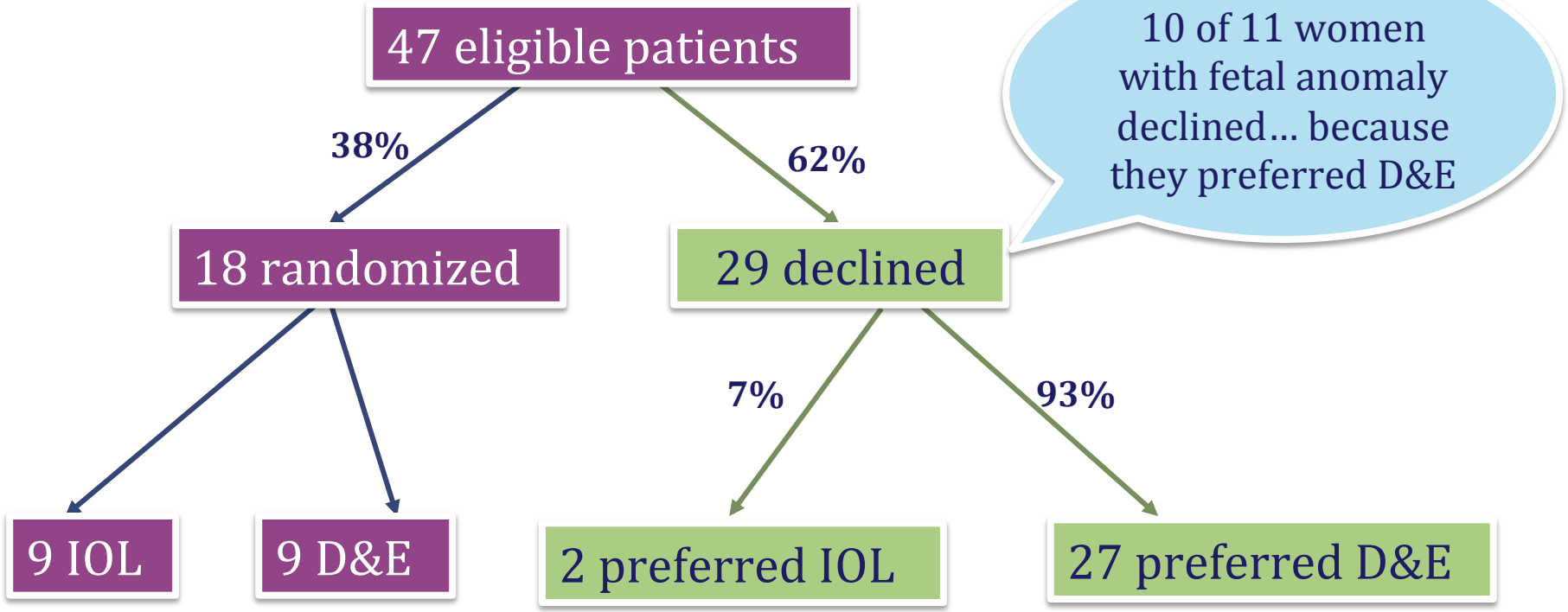
Acceptability: 1st Trimester Literature

- ***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

Henshaw et al. *BMJ* 1993; Harwood et al. *BJOG* 2008; Creinin et al. *Contraception* 2000

Patient Preference

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



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

• General anesthesia • Psychologically less traumatic	• No general anesthesia • Shorter wait

- 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

Steinauer et al. *AJOG* 2008
Kerns et al. *Am J Perinatology* 2010

Availability of 2nd 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
  - Transportation
  - Raising funds
  - Finding a provider
  - Obesity
  - Substance abuse
- D&E access versus induction access
  - Service delivery systems as barriers
  - Academic center vs. community
- Are we giving patients a true choice?

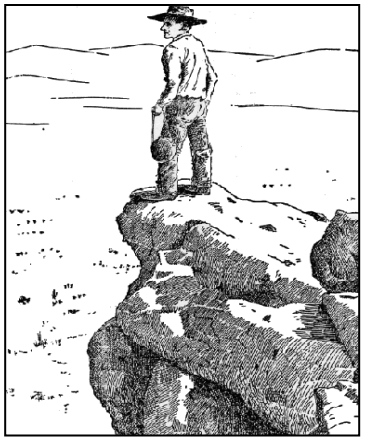
Jones et al. *Perspectives on Sexual and Reproductive Health* 2008; Finer et al. *Contraception* 2006; Drey et al. *Obstet Gynecol* 2006

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

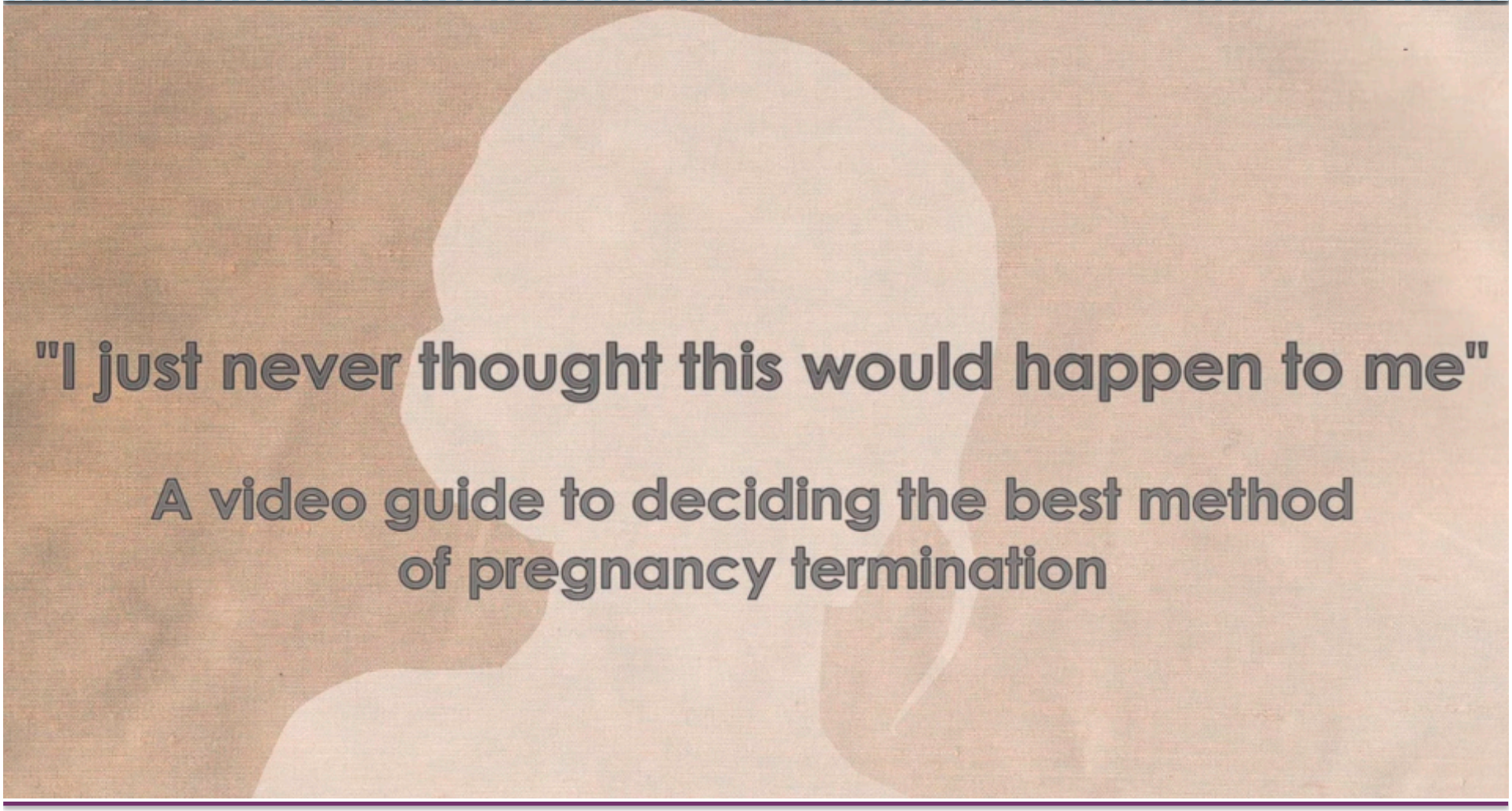
Patient Preference

Case 2

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

Patient Preference

Video Decision Aid



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Video Decision Aid

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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**