

Week 6: Introduction

Early Pregnancy Loss and Course Conclusions

Jody Steinauer, MD, MAS
Associate Professor
University of California, San Francisco



University of California
San Francisco

advancing health worldwide™

Week 6: Overview and Objectives

After this week, learners will be able to

- Review the similarities between management of early pregnancy loss (EPL) and early abortion
- Describe patient-centered counseling for EPL
- Review global public health issues related to safe abortion
- Describe the clinical responsibilities of health care providers caring for women with undesired pregnancies

Early Pregnancy Loss Diagnosis and Counseling

Robin Wallace, MD, MAS

Clinical Assistant Professor,
Department of Family &
Community Medicine
University of Texas Southwestern



Early Pregnancy Loss Management

Robin Wallace, MD, MAS

Clinical Assistant Professor,
Department of Family &
Community Medicine
University of Texas Southwestern



Post-Abortion Care

Discussion with
Felicia Lester, MD, MPH

Assistant Professor
Obstetrics, Gynecology & Reproductive
Sciences
University of California, San Francisco



Review of Global Public Health Issues

Daniel Grossman, MD, MPH

Vice President for Research,
Ibis Reproductive Health
Assistant Clinical Professor,
Dept. Obstetrics, Gynecology and
Reproductive Sciences,
University of California, San
Francisco
Bixby Center for Global
Reproductive Health



Conclusion

Jody Steinauer, MD, MAS

Associate Professor,
Dept. Obstetrics, Gynecology and
Reproductive Sciences,
University of California San Francisco
Co-director, Fellowship in Family Planning
Director Ob-gyn Clinical Research, SFGH
Research Director, Ryan Residency Training
Program in Family Planning
Director, Innovating Education in
Reproductive Health



Expert Interviews

- Susana Chavez
 - The Center for the Promotion of Sexual and Reproductive Rights
- Vicki Saporta
 - The National Abortion Federation
- Alice Mark
 - Ipas
- Eva Lathrop
 - Emory University School of Medicine

Additional Resources

- Videos
 - Oprah’s Next Chapter, Beyoncé Opens up about Her Miscarriage
 - Ipas, Unsafe Abortion: A Neglected Crisis in Women’s Health
- Articles in Pop Culture
 - “I think she could have died”, *Salon*
 - “Losing the Baby: My weeks of gestational limbo”, *Slate*
 - “Why I Started a Podcast about Abortion”, *Cosmopolitan*



COSMOPOLITAN

Academic Literature

- Wallace R, Dehlendorf C, et al. Early pregnancy failure management among family physicians. *Fam Med.* 2013 Mar;45(3):173-9.
- Wallace RR, et al. Counseling women with early pregnancy failure: utilizing evidence, preserving preference. *Patient Educ Couns.* 2010 Dec;81(3):454-61.
- Lester F, Benfield N, Fathalla MM. Global women's health in 2010: Facing the Challenges. 2010 Nov;19(11):2081-9.

ORIGINAL ARTICLES

Early Pregnancy Failure Management Among Family Physicians

Ryan Wallace, MD, MMS, Christine Dehlendorf, MD, MMS, Eric Vittinghoff, PhD, MPH, Katherine J. Gold, MD, Vanessa K. Dalton, MD, MPH

BACKGROUND AND OBJECTIVES: Family physicians are primary care providers for most reproductive women. However, little is known about management of early pregnancy failure (EPF). Data on effective options for EPF treatment include treatment management, medical management with misoprostol, and aspiration in the office or operating room. Current practice data suggest an unclear patient preference or a shift in the most widely used management. We compared characteristics and practice patterns among family physicians who do and do not provide multiple options for EPF care.

METHODS: We performed a secondary analysis of a national survey of women's health providers to describe demographic and practice characteristics among family physicians who care for women with EPF. We used multivariate logistic regression to identify predictors of providing more than one option for EPF management.

RESULTS: The majority of family physicians provide only one option for EPF; misoprostol management was most frequently used among non-graduate physicians. Hospital and office-based aspiration was rarely used. Providers more than one option for EPF management were associated with more years in practice, greater family physician, higher proportion of Medicaid patients, lower insurance compensation, and providing a higher percentage of health care when women are treated according to their preferences.

CONCLUSIONS: Family physicians are capable of providing a complete range of options for EPF management in the outpatient setting but few providers currently do so. To create a more patient-centered and cost-effective model of care for EPF, additional research should be focused on education, skills training, and system change initiatives to support family physicians in offering misoprostol and office-based aspiration to women with EPF.

Fam Med 2013;45(3):173-9.

From the Department of Family and Community Medicine, University of California, San Francisco; Department of Obstetrics, Gynecology, and Reproductive Sciences, University of North Carolina; Department of Epidemiology, The University of North Carolina; and Department of Obstetrics, University of California, San Francisco.

Volume 81 Number 3 June 2010
Contents lists available at Sagepub.com

Journal of Patient Education and Counseling

Journal homepage: www.elsevier.com/locate/jpec

Counseling women with early pregnancy failure: Utilizing evidence, preserving preference

Rohin K. Wallace*, Suzan Goodman¹, Lori R. Freedman¹, Vanessa K. Dalton¹, Lisa H. Harris²

ABSTRACT

OBJECTIVES: To apply principles of shared decision-making to EPF management according to current patient treatment preferences. We conducted a literature review of evidence for patient preference, personal, emotional, physical and clinical factors that may affect patient preference for EPF management, and the clinical history, resources, and health insurance of these patients.

RESULTS: Women having early pregnancy failure (EPF) management and/or high satisfaction with the current practice does not reflect the evidence for safety and acceptability of all options, as patient preferences, multiple practice factors and factors that may be affecting provider confidence about options for EPF management.

CONCLUSIONS: Providers can integrate a counseling model for EPF management practice that utilizes principles of shared decision-making and is informed by evidence for clinical practice, preference, and current data treatment options.

© 2010 Elsevier B.V. All rights reserved.

1. Introduction

Early pregnancy failure (EPF) is a common occurrence, affecting approximately one in four women during her reproductive years [1,2]. EPF includes all first trimester pregnancies, ectopic and molar pregnancies, and pregnancies that are spontaneously aborted. The term "miscarriage" is often used to refer to this experience, but we will use both "miscarriage" and "EPF" as management options by medical and non-medical providers in the current environment of women's health care. EPF is managed primarily by medical and non-medical providers in the outpatient environment of women's health care and ambulatory care settings [3,4]. However, once these medical advances become readily available, providers appropriately begin to consider and offer other options in the past few decades, many primary care providers begin to offer more than one option for EPF management. In the past few decades, many primary care providers began to offer more than one option for EPF management. In the past few decades, many primary care providers began to offer more than one option for EPF management. In the past few decades, many primary care providers began to offer more than one option for EPF management.

JOURNAL OF REPRODUCTIVE HEALTH
Volume 19, Number 11, 2010
© 2010 Elsevier Inc.
DOI: 10.1016/j.jrwh.2010.09.008

Global Women's Health in 2010: Facing the Challenges

Felicia Lestor, MD, M.S., MPH,¹ Nerys Berfield, MD,² and Mohamed M.F. Fathalla, MD,³

Abstract

Women's health is closely linked to a nation's level of development, with the leading causes of death in women in resource-poor nations attributable to preventable causes. Unlike many health problems in rich nations, the cure rates are not only on the discovery of new medications or technology but also getting basic services to the people who need them most and addressing underlying causes. In order to do this, political and financial resources must be dedicated to developing and evaluating a scalable system to strengthen health systems, support community-based programs, and promote widespread campaigns to address gender inequality, including promoting girls' education. The Millennium Development Goals (MDGs) have highlighted the importance of addressing maternal health and promoting gender equality for the overall development strategy of a nation. We must capitalize on the momentum created by this and other international campaigns and continue to advocate for comprehensive strategies to improve global women's health.

Introduction

Women's health in resource-poor settings is tightly linked to poverty, with human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS) and maternal conditions constituting the leading causes of death of women aged 15-44. The tragedy is that the causes of death and disability for women in developing countries are preventable and are linked to inadequate access to quality health care and low status of girls and women, highlighting social rather than biological determinants of health. The risk, magnitude of the major causes of global women's health including pregnancy and disability, genital infection, abortion, family planning, HIV and sexually transmitted infections (STIs), cervical cancer, gender-based violence, and unsafe genital mutilation (FGM). By understanding the direct and indirect causes of women's death and disability, we hope to add momentum to the global call to action to improve women's health worldwide.

Pregnancy and Childbirth

According to World Health Organization (WHO) estimates from the year 2000, approximately 193,000 women die each year from pregnancy-related causes, and >17 million suffer long-term disability. A recent publication, however, uses modeling to estimate maternal mortality from 1980 to 2008 and estimates 842,296 deaths in 2008, down from 526,300 in 1980. Although the exact number of maternal deaths is not known, by all accounts the figure is unacceptably high. The leading direct causes of maternal mortality are hemorrhage, sepsis, unsafe abortion, obstructed labor, and hypertensive disorders of pregnancy and indirect causes include anemia, HIV, and malaria [5, 6]. The vast majority of these deaths take place in the developing world, where women suffer a high risk of death and disability with each pregnancy and because of high fertility rates, women experience many pregnancies in their lifetime. The global disparity in maternal mortality is striking: 1 of 4 women in the poorest parts of the world will die from a pregnancy-related cause, whereas only 1 in 3,500 women in northern Europe will suffer the fate. The proportion of deaths in sub-Saharan Africa is estimated to be 50% of all global maternal deaths. The children of women who die are left vulnerable to premature death, adding to the pain and suffering of the families left behind.

The Millennium Development Goals (MDGs) were adopted in the year 2005 by 191 heads of state as a framework for development. The sustainable goal eight with corresponding targets to reach by the year 2015 and identified key indicators by which progress could be measured (MDG 8), to improve maternal health, highlighted the need for strategies to reduce maternal mortality and disability rates by which to measure progress, as including maternal mortality by 75% by 2015 was established as the target for this goal. The best way to capture accurate estimates for maternal mortality is to conduct a complete and accurate review of all deaths in a country, which is difficult to capture across the globe. By all accounts,