Early Medical Abortion (EMA)

Practicalities, pitfalls and possibilities.

Dr Janet Downs, August 2008

EMA

THE “ABORTION PILL”

Medically inducing, in effect, an ***early*** miscarriage.

EARLY ie < 63/7 gestation

Relies on the referrers to inform & refer women ***early***

EMA: HOW IT WORKS

MIFEPRISTONE (200 mg orally)

- Anti-progestogenic activity (SPRM)
  - Causes Decidua to shed
  - Cervical ripening
  - Increases myometrial sensitivity to Prostaglandins

MISOPROSTOL 36-48 hrs later (800 mcg PV)

- Synthetic Prostaglandin E1 analog

  -> expulsion of gestation sac

Advantages of EMA (1)

- It avoids surgery
- It avoids anaesthesia
- It reduces the risk of infection

Advantages of EMA (2)

Women may also prefer it because

- It feels more natural to the woman
- And it feels less invasive
- Women feel more in control
- Women can be (& need to be) more active participants in the process

Disadvantages of EMA

- It is an *EARLY* option <63/7
- Women can expect *more bleeding & pain over a longer period of time* than with a surgical abortion
- The pattern of bleeding can be unpredictable
- The woman may not want to be an ‘active’ participant in the process

ABSOLUTE MEDICAL CONTRAINDICATIONS

- Chronic Adrenal Failure
- Porphyria
- Ectopic Pregnancy
- Allergy to mifepristone/misoprostol

RELATIVE MEDICAL CONTRAINDICATIONS

- Long term steroid medication
- Severe anaemia
- Anti-coagulant Px or bleeding disorder
- Severe CVS disease or 2 or more CVS risk factors eg hypertension and smoking

RELATIVE SOCIAL CONTRAINDICATIONS

- Ambivalent
- Unwilling to proceed to STOP if indicated
- Lives >2hrs from unit
- Lack of direct telephone access
- Lack of reliable transport
- Unsuitable home environment/lack of support
- Unlikely to be able to cope with heavy cramping/ bleeding
- Unable to commit to full treatment schedule
- "At risk" behaviour eg illicit drug use

EMA - Referrers Role

- Confirm pregnancy
- Advise of options
- Woman sure of decision for TOP
- Gestation <63/7
- Woman wants to be considered for EMA

Then

- Discuss & give information handout
- Refer
  - Tel for appointments
  - Fax referral

At the 'Clinic'

- Initial assessment/counselling: ?suitable for EMA
- USS appointment to confirm gestation
- Certification, medical assessment & administration of mifepristone as appropriate
- Woman goes home with written & verbal information & 24hr 'help-line' number
- Woman returns 36-48 hrs later for misoprostol administration
- Woman goes home after 4-6 hrs with written & verbal information.

EMA - Follow Up

MANDATORY follow-up of woman with referrer 2 week after EMA (unless follow up already in place with Abortion Unit)

What to Expect

BLEEDING

Heavy clotty bleeding for 4-5 days

Ongoing bleeding for 14 days +

Heavier than a period & more like a miscarriage

PAIN

Strong crampy period-like pain

Like a miscarriage

EMA: Bleeding & Pain

- Bleeding & pain peak with expulsion of gestation sac (4-6hrs after misoprostol) & then settle
- Hotties, Paracetamol/Panadeine, NSAIDS is usual level of analgesia required
- The bleeding may be erratic or prolonged (77% spotting at 15 days, 9% at 30 days, 1% at 60 days)

Side Effects of Drugs

• Nausea		50%
• Vomiting		20%
• Diarrhoea		15%
• Headaches	}	
• Dizziness	}	20%
• Thermo-regulatory disturbance	}	

Most evident while in hospital after high dose misoprostol

What to watch out for after EMA

- INCOMPLETE ABORTION (1.4-2.9%)
  - More bleeding & pain than expected
- ECTOPIC PEGNANCY (0.05-0.1%)
  - Severe persistent pain
- ONGOING PREGNANCY (0.1-2.3%)
  - Little or no bleeding & ongoing pregnancy symptoms

Similar efficacy to surgical abortion

EMA IN THE FUTURE

POSITIVE SIDE

- Greater access to safe abortion
- Home Use
- More choice for women

NEGATIVE SIDE

- Cheaper *Alternative* (*instead* of surgical)?
- ?Less choice for NZ women