ACOG
The American College of Obstetricians and Gynecologists

Society of Family Planning

ACOG PRACTICE BULLETIN SUMMARY

Clinical Management Guidelines for Obstetrician–Gynecologists

NUMBER 225 *(Replaces Practice Bulletin Number 143, March 2014)*

For a comprehensive overview of these recommendations, the full-text version of this Practice Bulletin is available at http://dx.doi.org/10.1097/AOG.0000000000004082.

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Medication Abortion Up to 70 Days of Gestation

Medication abortion, also referred to as medical abortion, is a safe and effective method of providing abortion. Medication abortion involves the use of medicines rather than uterine aspiration to induce an abortion. The U.S. Food and Drug Administration (FDA)-approved medication abortion regimen includes mifepristone and misoprostol. The purpose of this document is to provide updated evidence-based guidance on the provision of medication abortion up to 70 days (or 10 weeks) of gestation. Information about medication abortion after 70 days of gestation is provided in other ACOG publications (1).

Clinical Management Questions

- ▶ *How should patients be counseled about abortion methods?*
- ▶ *What information and counseling should be provided to patients who are considering medication abortion?*
- ▶ *What evaluation and ancillary testing are needed before a medication abortion?*
- ▶ *What regimens are used for medication abortion, and how do they compare in effectiveness for treatment?*
- ▶ *Who is qualified to provide medication abortion, and in what settings can medication abortion be provided?*
- ▶ *Should prophylactic antibiotics be used in medication abortion?*
- ▶ *What is the recommended pain management approach for patients undergoing medication abortion?*
- ▶ *What kind of assessment is recommended after medication abortion?*

- *How is incomplete medication abortion or ongoing pregnancy managed?*
- *What is the recommended timing of contraception initiation after medication abortion?*
- *How should patients be counseled about the effect of medication abortion on future fertility and pregnancy outcomes?*

Recommendations

The following recommendations are based on good and consistent scientific evidence (Level A):

- Combined mifepristone–misoprostol regimens are recommended as the preferred therapy for medication abortion because they are significantly more effective than misoprostol-only regimens. If a combined mifepristone–misoprostol regimen is not available, a misoprostol-only regimen is the recommended alternative.
- Clinicians should counsel patients that medication abortion failure rates, especially continuing pregnancy rates, increase as gestational age approaches 10 weeks.
- Any clinician with the skills to screen patients for eligibility for medication abortion and to provide appropriate follow-up can provide medication abortion.
- Patients can safely and effectively use mifepristone at home for medication abortion.
- Patients can safely and effectively self-administer misoprostol at home for medication abortion.
- Nonsteroidal anti-inflammatory drugs are recommended for pain management in patients who undergo a medication abortion.
- Routine in-person follow-up is not necessary after uncomplicated medication abortion. Clinicians should offer patients the choice of self-assessment or clinical follow-up evaluation to assess medication abortion success. If medically indicated or preferred by the patient, follow-up evaluation can be performed by medical history, clinical examination, serum human chorionic gonadotropin (hCG) testing, or ultrasonography.
- If an ultrasound examination is performed at follow-up after medication abortion, the sole purpose is to determine whether the gestational sac is present or absent. The measurement of endometrial thickness or other findings do not predict the need for subsequent uterine aspiration.

The following recommendations are based on limited or inconsistent scientific evidence (Level B):

- Medication abortion is not recommended for patients with any of the following: confirmed or suspected ectopic pregnancy, intrauterine device (IUD) in place (the IUD can be removed before medication abortion), current long-term systemic corticosteroid therapy, chronic adrenal failure, known coagulopathy or anticoagulant therapy, inherited porphyria, or intolerance or allergy to mifepristone or misoprostol.
- Before undergoing medication abortion, patients should be counseled regarding the teratogenicity of misoprostol in the event of an unsuccessful medication abortion.
- Before medication abortion is performed, the clinician should confirm pregnancy and estimate gestational age. For patients with regular menstrual cycles, a certain last menstrual period within the prior 56 days, and no signs, symptoms, or risk factors for ectopic pregnancy, a clinical examination or ultrasound examination is not necessary before medication abortion.
- Most patients with clinical indications for an ultrasound examination before medication abortion can be initially screened with transabdominal ultrasonography, reserving transvaginal ultrasonography for situations in which further clarification is required.
- Medication abortion can be provided safely and effectively by telemedicine with a high level of patient satisfaction.
- The routine use of prophylactic antibiotics is not recommended for medication abortion.
- An incomplete medication abortion can be treated with a repeat dose of misoprostol, uterine aspiration, or expectant management, depending on the clinical circumstances and patient preference.
- Ongoing pregnancy after medication abortion can be treated with a repeat dose of misoprostol or uterine aspiration, depending on the clinical circumstances and patient preference.
- Patients undergoing medication abortion who desire contraception should be counseled that

- almost all contraceptive methods, except IUDs and permanent contraception, can be safely initiated immediately on day 1 (mifepristone intake) of medication abortion.
- all contraceptive methods can be safely initiated after successful medication abortion.

▶ Patients who select depot medroxyprogesterone acetate (DMPA) for contraception should be counseled that administration of DMPA on day 1 of the medication abortion regimen may increase the risk of ongoing pregnancy.

▶ Patients can be counseled that medication abortion does not have an adverse effect on future fertility or future pregnancy outcomes.

The following recommendations are based primarily on consensus and expert opinion (Level C):

▶ Patients who choose abortion should be counseled about all methods available as well as the risks, advantages, disadvantages, and the different features of these options.

▶ Most patients at 70 days of gestation or less who desire abortion are eligible for a medication abortion.

▶ Patient counseling before medication abortion should include discussion of when patients should contact their clinician in the case of heavy bleeding (soaking more than two maxi pads per hour for 2 consecutive hours) and when to access urgent intervention.

▶ All patients with a continuing pregnancy after using mifepristone and misoprostol should be provided with all pregnancy options and a thorough discussion of the risks and benefits of each.

▶ In the very rare case that patients change their mind about having an abortion after taking mifepristone and want to continue the pregnancy, they should be monitored expectantly.

▶ Rh testing is recommended in patients with unknown Rh status before medication abortion, and Rh D immunoglobulin should be administered if indicated. In situations where Rh testing and Rh D immunoglobulin administration are not available or would significantly delay medication abortion, shared decision making is recommended so that patients can make an informed choice about their care.

▶ Clinicians who wish to provide medication abortion services should be trained to perform uterine evacuation procedures or should be able to refer to a clinician who has this training.

Reference

1. Second-trimester abortion. Practice Bulletin No. 135. American College of Obstetricians and Gynecologists. Obstet Gynecol 2013;121:1394–406. (Level III)

Studies were reviewed and evaluated for quality according to the method outlined by the U.S. Preventive Services Task Force. Based on the highest level of evidence found in the data, recommendations are provided and graded according to the following categories:

Level A—Recommendations are based on good and consistent scientific evidence.

Level B—Recommendations are based on limited or inconsistent scientific evidence.

Level C—Recommendations are based primarily on consensus and expert opinion.

Full-text document published online on August 14, 2020.

Published concurrently online on August 14, 2020, in *Contraception*.

American College of Obstetricians and Gynecologists
409 12th Street SW, Washington, DC 20024-2188

Official Citation
Medication abortion up to 70 days of gestation. ACOG Practice Bulletin No. 225. American College of Obstetricians and Gynecologists. Obstet Gynecol 2020;136:e31–47.

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