Induced Abortion: Updated Guidance during Pandemics and Periods of Social Disruption

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Introduction

In 2020, the COVID-19 Pandemic has created rapid and significant social disruption, both through illness and social distancing practices. In order to create healthcare capacity, most clinical services have been reduced and many scheduled surgeries have been indefinitely postponed. Furthermore, supply chain disruptions and medication shortages are anticipated.

Preventing unintended pregnancy and accessing abortion may become more difficult during the COVID-19 pandemic, and the need for such services may, in fact, surpass normal demand. Therefore, contraception and abortion care remain essential and time-sensitive.

We wish to provide interim guidance to affirm best practices and, where evidence is limited, provide expert consensus on strategies to maintain abortion access during the COVID-19 pandemic or other periods of major social disruption such as natural disaster, wartime conflict, or significant supply-chain disruption.

Recommendations and Summary Statements

Induced Abortion

1. Induced abortion is an essential and time-sensitive medical service that must be maintained in any pandemic or during periods of social disruption.

Induced abortion is both a medical service and a human right[1]. The personal cost of experiencing unintended pregnancy is high, as are the costs borne by the healthcare system to manage people with unintended pregnancy[2]. However, any reduction of abortion services would magnify risk and place additional burden on the healthcare system[3]. Abortion is safer when performed at earlier gestational ages, therefore delays in abortion access increase risk to patients[4,5]. Abortion is also safer than childbirth, increasing risk to those who cannot access induced abortion when desired[6,7]. In countries where safe abortion is not available, unsafe abortion is a major contributor of maternal mortality[1].
The current pandemic impairs access to both contraception and abortion health care services. The result is increased demand on existing services, which must not only be maintained but must adapt to meet local need.

2. Clinicians and patients should select the most appropriate method of abortion. Clinicians should balance the risks and benefits of in-person procedural abortion with those of medical abortion, which can be provided in a virtual setting.

In early pregnancy, medical abortion (MA) and procedural (surgical) abortion are both first-line options for pregnancy termination[8,9]. While procedural abortion is slightly more effective with lower complication rates than medical abortion, it requires at least one in-person assessment in a healthcare facility[8-10]. As healthcare resources change, it may be difficult to obtain tests that are typically performed prior to MA in keeping with previous guidelines.

All clinicians providing abortion services should exercise resource stewardship regardless of the method of abortion chosen. MA can safely be provided by telemedicine or virtual visits[11]. Several "no-touch" or "no-test" medical abortion regimens have recently been developed, which guide clinicians in the provision of abortion care without testing (or when testing is unavailable)[12].

It is critical that patients have 24/7 access to a knowledgeable provider who can provide the appropriate care for those undergoing medical abortion. Because many emergency department visits can be avoided through telephone triage, clinicians able to support abortion patients (directly or through an on-call coverage model) should be the first point of contact for patient questions or concerns.

3. Patients and clinicians should adhere to local infection control regulations and strategies, including deferring appointments if a patient has influenza-like illness, or is suspected or confirmed to be COVID-19 positive.

While abortion is an urgent medical issue, the safety of other patients and healthcare workers is also important. Because most patients can defer an abortion for a two-week isolation period without significant risk of adverse outcomes, local infection control policies should be followed.
If a patient is ill and is suspected or confirmed to have COVID-19, and the abortion cannot be delayed, a hospital-based procedural abortion is recommended. This option will limit the required exposure to a single visit and should be performed by healthcare workers with adequate training and personal protective equipment to manage patients with SARS-CoV2 infection. Ultimately, an individualized approach is needed for such scenarios.

4. Where equipment and competent providers are available, hospitals and abortion facilities should extend gestational age limits by two weeks to ensure continued access to first and second-trimester abortion.

Most hospitals have a policy on whether abortions are permitted and stating their upper gestational age limit. Gestational age limits should be based on provider competence and available resources whenever possible. Therefore, if resources permit, hospitals should extend gestational age limits by two weeks to ensure continued access to patients whose care has been deferred due to the COVID-19 pandemic. Hospitals with skilled providers should increase the gestational age limit to 24 weeks as some second trimester services may be limited due to hospital constraints.

Procedural (Surgical) Abortion

1. Procedural abortion with a paracervical block and procedural sedation is NOT an aerosol-generating medical procedure. Procedural sedation should be strongly considered over general anaesthesia for surgical abortion.

When compared to general anaesthesia, local anaesthesia with procedural sedation is associated with lower pain and complication rates[9]. Furthermore, light procedural sedation with spontaneous respiration and avoidance of bag-mask ventilation is NOT considered an aerosol generating medical procedure, and therefore does not require the use of N95 respirators. Procedural sedation may permit fewer personnel and/or greater physical distancing than a traditional operating room[13]. It is inappropriate for hospitals to limit abortion access based on aerosolization risk or respirator conservation as an anaesthesia machine and ventilation should not be required.

2. Nitrous Oxide should NOT be used during procedural abortion, owing to the possible risk of contamination with SARS-CoV2.

Given emerging evidence of asymptomatic carriers, and uncertainty about the integrity of nitrous oxide/oxygen circuits, the use of Entonox may pose a health hazard to patients and healthcare workers. Furthermore, given that nitrous oxide is minimally effective for pain relief during procedural abortion, its use should be discontinued[9].

3. Repeat Rhesus Factor (Rh) testing is NOT required prior to procedural abortion.

Given the low probability of Rhesus alloimmunization, repeat Rh testing is not needed. The decision to administer Immune Globulin (RhIG) may be based on previous results.

4. Induction abortion should be considered for patients who are unable to access second-trimester surgical services.

If patients cannot access second-trimester (Dilation and Evacuation) programs, induction abortion remains an option for patients. Pre-treatment with mifepristone 200 mg PO 24-48 hours prior to misoprostol reduces time in hospital. A misoprostol regimen is described in the SOGC Induced Abortion guideline[9]. To minimize time in hospital, the first dose of misoprostol (which is provided with combination mifepristone/misoprostol) can be taken at home and the patient is admitted when contractions start, or a second dose is required.

Medical Abortion (MA)

1. Medical abortion with mifepristone and misoprostol should be offered as a first-line method of induced abortion for pregnancies up to 70 days.

Combination mifepristone/misoprostol is indicated for 63 days, and the existing SOGC guideline states that it can be used up to 70 days8. We continue to recommend these gestational age limits for the majority of MA providers.

2. For experienced providers where close surveillance is possible, medical abortion with mifepristone and misoprostol can be offered as an alternative to procedural abortion up to 77 days.

Emerging evidence and consensus opinion support the use of mifepristone medical abortion to 77 days (11 weeks) with repeated doses of misoprostol[10]. However, this should be reserved for experienced providers who can provide adequate coverage and backup should urgent care be needed. Patients should be informed that mifepristone use beyond 63 days is off-label, that they will likely expel and see an intact fetus, and that there is a higher risk of complication. For these reasons, and the possible higher risk of Emergency Department visits, we continue to recommend procedural abortion beyond 70 days in most cases.

3. Mifepristone 200 mg PO followed by 800 mcg misoprostol buccal/vaginal is the preferred method of medical abortion. If mifepristone is unavailable, procedural abortion services must be restored or increased to address demand.

As the proportion of induced abortions that are medical abortions increase, surgical services are decreasing in many jurisdictions. In the event of shortages of mifepristone, surgical services must be restored and/or expanded to ensure access to abortion on humanitarian grounds.

4. Clinicians should prescribe an additional dose of misoprostol 800 mcg (buccal or vaginal) to be used on direction of a healthcare provider in the event of suspected incomplete or failed abortion.

To minimize patient visits to pharmacies, and to reduce complications, MA prescriptions should include an additional dose of misoprostol 800 mcg so that patients have medication on hand if an additional dose is required. Typically, a second dose of misoprostol is given at higher gestational ages, if by history a failed MA is suspected (minimal bleeding or expulsion), or to manage an incomplete abortion or ongoing pregnancy[8].

Affirming best practice, the initial prescription should also include any contraception to be initiated at the time of medical abortion. Additional analgesics and STI prophylaxis can be prescribed based on clinician judgement and patient request.

5. Medical abortion can be provided based on a home pregnancy test and Last Menstrual Period (LMP) dating alone if the patient has no risk factors for ectopic pregnancy, is reasonably certain of her LMP, is not using hormonal contraception, has regular menstrual cycles, and has no other contraindications.

This statement affirms the current MA guideline[8]. Patients who are reasonably certain of their LMP and have regular menstrual cycles are very likely to accurately predict being within the gestational age limit for MA. No further testing is required.

6. All patients with uncertain pregnancy dating, risk factors for ectopic pregnancy, or symptoms consistent with ectopic pregnancy, should undergo ultrasound evaluation prior to medical abortion.

Ultrasound remains the gold standard for pregnancy assessment, regardless of pregnancy intention. Because unrecognized ectopic pregnancy is a rare but serious risk in periods of limited healthcare resources, it is important to remember that patients with risk factors (such as previous ectopic pregnancy or tubal surgery) or signs/symptoms of ectopic pregnancy should have an ultrasound. Those patients who are uncertain of their gestational age (by LMP or conception dating) should have further assessment of gestational age[8].

7. If ultrasound is not used prior to medical abortion, close surveillance and follow-up is required until completion.

All MAs performed without ultrasound are, by definition, pregnancies of unknown location (PULs). Though the risk of unrecognized ectopic pregnancy is low, close follow-up is required to ensure completion of the MA[8]. Clinicians should not initiate an MA if they are not reasonably certain that they will be available (directly or through an on-call service) to provide rapid assessment until confirmed completion of the abortion.

8. Rh testing and Immune Globulin (RhIG) administration may be withheld for medical abortion prior to 70 days.

Current evidence supports withholding Rh testing and RhIG for medical abortions up to 56 days (8 weeks) gestational age given the very low probability of Rh-antigen expression on fetal cells. There is only expert opinion evidence to guide Rh management for MA between 56 and 70 days[14,15]. In keeping with other national guidelines, the low probability of alloimmunization, and whereas testing and RhIG administration requires one or two additional patient visits, we recommend that Rh testing and RhIG may be withheld for MA during the COVID-19 pandemic.

We recommend a return to the current MA guidelines following resolution of the COVID-19 pandemic[8], and further guidance will be provided when this guideline is due for renewal.

9. Medical abortion can be provided a tiered approach (minimal resource, limited resource, and on-label provision with full resource utilization). The decision to offer medical abortion should be made based on clinician competence, resource availability, and patient preference.

"On label" provision of mifepristone medical abortion requires the most resources when compared to other evidence-based protocols[8]. However, resources such as imaging and laboratory testing may vary widely and in an unpredictable manner during a pandemic or period of social disruption. Clinicians should exercise resource stewardship when possible and recognize when a lack of resources or clinician comfort precludes the safe provision of MA.

Several new MA guidelines have been published to provide experienced providers with protocols to manage MA at higher gestational ages and using a "no-touch" or "no-test" approach[12]. Striking a balance, this interim guidance identifies tests that can be safely excluded while maintaining a high degree of safety. Providers must consider their own competence and experience with MA prior to using these protocols, must inform patients that these are new protocols based on low-resource availability and that this is an off-label indication. If a clinician does not feel that resources permit safe medical abortion, a procedural abortion or referral to a more experienced clinician is advised.

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