Early medical abortion procedure summary

Information for EMA providers

the women's
the royal women's hospital

Request

- Request for early medical abortion and early medical abortion medication provider.

- If service unable to provide EMA or greater than 63 days gestation, refer to 1800My Options 1800 696 784

70

For complete guidelines see:

PGP Abortion: Medical management up to 9 weeks of pregnancy
EMA Abortion: Medical abortion without ultrasound protocol

Initial assessment

- Assess gestational age and clinical suitability for EMA.
- Confirm choice for early medical abortion method.
- Establish informed voluntary choice for medical abortion.

- Consider eligibility criteria for medical abortion without ultrasound.

Clinical assessment

Baseline investigations

- Determine the gestational age by clinical history or by pelvic ultrasound. -Ultrasound to confirm gestational age, visualisation of YS confirms IUP -Clinical history such as LNMP and certainty of the date of conception
- Consider STI screen - gonorrhoea, chlamydia, syphilis.
- If using serum βhCG for follow up, take a baseline level ideally within 72 hours of Mifepristone administration.
- Use clinical judgement to evaluate need for haemoglobin and iron studies tests.
- Review history – medical, gynaecological, obstetric, contraceptive, sexual.
- Psychosocial assessment – include screening for family violence and reproductive coercion.
- Exclude contraindications.

Script and consent to proceed

Administration of early medical abortion medication

- Step 1 – Mifepristone, 200mg oral, followed 24 to 48 hours later by
- Step 2 – Misoprostol 800mg buccal.

Medications

- Pre-load medications (30 minutes prior) to Misoprostol dose and in the first 24 hours with a maximum 4000mg per 24 hours.
- Offer a single dose of Ibuprofen 1600mg (off label), then Ibuprofen 400 to 600mg 8 hourly, (maximum 2400mg per 24 hours), with Paracetamol 1000mg 4 to 6 hourly PRN, (maximum 4000mg per 24 hours).
- Metoclopramide 10mg 8-hourly PRN or Ondansetron 4-8mg 8-12 hourly.
- Consider selective use of opiate analgesia - exercise caution in women who are breastfeeding.

Managing the procedure

- Side effects – establish accurate expectations for pain and bleeding

Pain management

- Anticipate double usual menstrual period.
- Use of therapeutic techniques such as rest, heat packs, massage.
- Consider graduated pain relief strategy.
- Pre-load medications prior to Misoprostol dose.

Bleeding

- Onset of bleeding and cramping within 1 to 6 hours of Misoprostol, Settles once products expelled.
- Average bleeding 16 days, can be up to 30 days.

Identify available supports

Discuss and plan for access to emergency care

Establish follow-up plan

Follow-up

Day 3-5 following misoprostol, via telephone

Assess:

- experience of bleeding and cramping the first 24 hours post Misoprostol
- persistent heavy bleeding
- signs of infection

and

Day 21 direct or telephone

Assess for:

- heavy or persistent bleeding
- signs of infection
- signs and symptoms of pregnancy (failed).

Use serum or low sensitivity urine hCG test to confirm the procedure

Follow signs and symptoms to resolution

Confirm contraception plan See PGP: Abortion or Miscarriage: Management of presentation following abortion or miscarriage

Revised guidance for Anti D

The National Blood Authority guidance states there is insufficient evidence for the routine use of Rh immunoglobulin before 10 weeks gestation. EMA is no longer listed as a sensitising event requiring immunoprophylaxis.

View guideline at: www.blood.gov.au/guideline-prophylactic-use-rh-d-immunoglobulin-pregnancy-care

For policies, guidelines and procedures (PGPs) on abortion care, visit *www.thewomens.org.au/EMA*