



Frequently Asked Questions

What is Medabon®?

Medabon® is a combination therapy for medical abortion. Medical abortion refers to the process of ending a pregnancy by taking medication, rather than through surgical intervention (such as vacuum aspiration or dilatation and curettage). Medical abortion may also be referred to as medication abortion, the abortion pill, non-aspiration abortion, or non-surgical abortion.

The most effective and safest medical abortion regimen requires the use of two medications, mifepristone and misoprostol.¹ Medabon® is the first product to package and license these two medications together.

How does Medabon® work?

A woman first takes a mifepristone pill, which—when swallowed early in pregnancy—makes it difficult for the endometrial lining to sustain a growing embryo. This facilitates abortion.

Misoprostol tablets, inserted into the vagina or placed under the tongue (known as sublingual administration) a few days after taking mifepristone, makes the uterus contract and expel its contents, ending the pregnancy. Misoprostol is the preferred medication of its kind because of its efficacy, safety, low cost, and wide availability.²

When can women take Medabon®?

Medabon® is approved for pregnancy termination up to nine weeks (through 63 days after the first day of a woman's last menstrual period). Providers can determine length of pregnancy by taking the woman's history and with a physical examination. If signs of pregnancy are not clearly present, a blood or urine test can be used. Ultrasound is not necessary, but, where available, can help to determine the length of pregnancy in cases of uncertainty.

How effective is Medabon®?

An effective medical abortion is defined as a pregnancy terminated without surgical intervention. The Medabon® regimen has been shown to achieve complete abortion in about 98 percent of cases, and fewer than 1 percent of women continue to have ongoing, viable pregnancies after using the regimen.^{3,4} A small percentage will experience nonviable pregnancies that have not been expelled or residual tissue that might require further intervention—such as vacuum aspiration or a second dose of misoprostol.

How many visits to a health care provider are required?

Medical abortion with Medabon® involves two or three visits to a health clinic, depending on where misoprostol administration takes place. If a woman chooses medical abortion with Medabon®, she will take mifepristone at

the first clinic visit. After 24–48 hours, she will take misoprostol vaginally or sublingually, either at home or in the clinic. Ten to 14 days after taking mifepristone, she will return to her provider for confirmation that the abortion is complete.

How long does abortion take with Medabon®?

Most women will expel the products of conception within four to six hours of taking misoprostol.⁵ Vaginal bleeding or spotting generally lasts about two to three weeks, and other side effects (see below) tend to resolve sooner.¹

How safe is Medabon®?

Early medical abortion with Medabon® is safe. There is less risk associated with properly used modern methods of abortion, including medical abortion, than with the continuation of pregnancy.⁶ Neither mifepristone nor misoprostol have been associated with long-term effects on women's health or on future pregnancies.

Serious complications, including infection or excessive bleeding, are rare. The risk of excessive bleeding that requires transfusion and/or follow-up vacuum aspiration ranges from 0.02 to 1.8 percent.⁷⁻⁹

Medabon® will not end ectopic pregnancies (pregnancies that occur outside the uterus). Careful evaluation before treatment, and careful monitoring for symptoms after treatment, can help identify women with ectopic pregnancies so that they may be referred for appropriate treatment.

How does medical abortion compare with surgical abortion in pregnancy up to nine weeks?

Both procedures are safe and effective,^{4,10} acceptable to women,¹¹⁻¹⁴ and can be provided by trained mid-level providers. Women choose medical abortion or vacuum aspiration for a variety of reasons that reflect specific circumstances and cultural contexts. There are very few situations where a clear medical preference for either method exists.

Who cannot use Medabon®?

Medabon® is safe for virtually all women. Before a woman chooses Medabon®, she will need to discuss her medical history with her provider to rule out the few conditions that preclude her from using the medication. They include allergies to any of the drugs involved (mifepristone, misoprostol, or other prostaglandin analogs); inherited porphyria, a rare blood disorder;¹⁵ hemorrhagic disorders; and known or suspected ectopic pregnancy.

Other circumstances and conditions do not rule out use of Medabon®, but may require additional steps. For example, women with anemia, women with sexually transmitted infections, women who are breastfeeding, and women who use an intrauterine device for contraception (and who have experienced contraceptive failure) can use Medabon®. The "Medical and Service Delivery Guidelines" in this set of materials provide more information on treating women in these and additional situations.

What are the most common side effects of Medabon®?

Vaginal bleeding and cramping are normal and expected parts of the abortion process. These symptoms are often described as similar to a long, intense menstrual period with cramping. Some women may have bleeding and cramping that are lighter than a menstrual period.

Side effects may include nausea, vomiting, diarrhea, headaches, chills, shivering, and transient fever lasting less than a day.

What happens if a woman's pregnancy has not been terminated or expelled?

If a health care provider confirms during the two-week follow-up visit that a woman's pregnancy is ongoing and viable, vacuum aspiration is recommended. If there are signs that the pregnancy is terminated but all tissue is not yet expelled, and the woman feels well and is healthy, vacuum aspiration may not be needed. Additional options include waiting longer or administering more misoprostol to assist in expulsion of any residual tissue or clots. In this case, another follow-up visit will be needed.

Is there any concern about birth defects in case pregnancy is not terminated?

A very small percentage of pregnancies (generally less than 1 percent) may continue after administration of Medabon®. In such cases, if a woman changes her mind about her abortion, or in the rare instance that the clinician fails to diagnose an ongoing pregnancy at a follow-up visit, the pregnancy may continue to term. Although it is possible that either drug could cause deformities, there is no clear evidence.^{16,17} Women who use Medabon® should be counseled that abortion with vacuum aspiration is recommended if their medical abortion does not work.

Medabon® will not affect future pregnancies or the ability to get pregnant again.^{18,19}

What are the basic health system requirements for safe and effective delivery of Medabon®?

The basic requirements for medical abortion service delivery include trained staff, referral services for vacuum aspiration, blood transfusions, and fluid replacement in rare cases of emergency or incomplete abortion, as well as a consistent supply of Medabon®.²⁰ Antibiotics should be available to treat existing infection as well as in case an infection develops during the follow-up period.

Staff should include those who are able to determine eligibility, confirm that the woman is no longer pregnant after taking Medabon®, assess that her post-abortion condition is satisfactory and that bleeding is not excessive, and provide and/or refer women for emergency back-up care (these may include staff already in place).

Ultrasonography can be useful for gestational-age dating and identifying pregnancy abnormalities, but using it for confirming completion of abortion may lead to unnecessary interventions.²⁰ Ultrasound services should not be a prerequisite for abortion in settings where they are unavailable or make the procedure overly expensive.^{1,20}

Other recommended supplies include basic gynecological and medical instruments and supplies (e.g., open speculum, gauze, menstrual pads, gloves), and pain medications to help manage side effects. Facilities should consider private areas for counseling and for waiting after administration of misoprostol (if applicable). These facilities should be separate from where women may be giving birth.

When can women start contraception after a medical abortion?

Women should begin contraception as soon as possible after medical abortion, because it is possible to become pregnant again almost immediately. The timing will depend on what method a woman chooses. For example, she can begin taking oral contraceptives the day she takes misoprostol.²¹⁻²⁴ Or, if she prefers a barrier method, these can be used the next time she has sex.¹ Each woman will need to discuss options with her provider.

How does Medabon® differ from emergency contraception, also called the “morning after” pill?

Medabon® causes an abortion, or ends a pregnancy that has already begun. Emergency contraception is a different medication and prevents a pregnancy that has not happened yet. Emergency contraception does not cause abortion and won't work if a woman is already pregnant. Like other contraception, improved access to emergency contraception will often reduce the need for abortion.

Will women stop using contraception if abortion services become too easily available?

Prevention of unplanned pregnancy is generally desirable for policymakers, health providers, and women themselves, when compared with the possibility of abortion of an unwanted pregnancy. There is no evidence that abortion services cause women to stop taking contraception. Lack of abortion services, however, is strongly associated with increased rates of unsafe abortion and associated complications.

Even where contraception use is high, unplanned pregnancies still occur, and it is important that women have the option of safe abortion services.

References

- 1 World Health Organization (WHO). *Frequently Asked Questions about Medical Abortion: Conclusions of an International Consensus Conference on Medical Abortion in Early First Trimester, Bellagio, Italy*. Geneva: WHO; 2006. Available at: www.who.int/reproductivehealth/publications/unsafe_abortion/9241594845/en/index.html.
- 2 Ibis Reproductive Health. *Medication Abortion: A Training Module for Health Professionals*. Cambridge, MA: Ibis Reproductive Health; 2003. Available at: www.ibisreproductivehealth.org/downloads/Medication_Abortion_Training_Module.ppt.
- 3 Raghavan S, Comendant R, Digol I, et al. Two-pill regimens of misoprostol after mifepristone medical abortion through 63 days' gestational age: a randomized controlled trial of sublingual and oral misoprostol. *Contraception*. 2009;79(2):84–90.
- 4 Ashok PW, Templeton A, Wagaarachchi PT, Flett GM. Factors affecting the outcome of early medical abortion: a review of 4132 consecutive cases. *British Journal of Obstetrics and Gynaecology*. 2002;109(11):1281–1289.
- 5 El-Refaey H, Templeton A. Early induction of abortion by a combination of oral mifepristone and misoprostol administered by the vaginal route. *Contraception*. 1994;49(2):111–114.
- 6 Grimes DA. Estimation of pregnancy-related mortality risk by pregnancy outcome, United States, 1991 to 1999. *American Journal of Obstetrics & Gynecology*. 2006;194(1):92–94.
- 7 Ashok PW, Penney GC, Flett GM, Templeton A. An effective regimen for early medical abortion: a report of 2000 consecutive cases. *Human Reproduction*. 1998;13(10):2962–2965.
- 8 Hausknecht R. Mifepristone and misoprostol for early medical abortion: 18 months experience in the United States. *Contraception*. 2003;67(6):463–465.
- 9 Schaff E, Stadius L, Eisinger S, Franks P. Vaginal misoprostol administered at home after mifepristone (RU486) for abortion. *Journal of Family Practice*. 1997;44(4):353–361.
- 10 Hakim-Elahi E, Towell HM, Burnhill MS. Complications of first trimester abortion: a report of 170,000 cases. *Obstetrics & Gynecology*. 1990;76(1):129–135.
- 11 Creinin, MD. Randomized comparison of efficacy, acceptability and cost of medical versus surgical abortion. *Contraception*. 2000;62(3):117–124.
- 12 Winikoff B, Sivin I, Coyaji KJ, et al. Safety, efficacy, and acceptability of medical abortion in China, Cuba, and India: A comparative trial of mifepristone-misoprostol versus surgical abortion. *American Journal of Obstetrics & Gynecology*. 1997;176(2):431–437.

- 13 Tang OS, Miao BY, Lee SW, Ho PC. Pilot study on the use of repeated doses of sublingual misoprostol in termination of pregnancy up to 12 weeks gestation: efficacy and acceptability. *Human Reproduction*. 2002;17(3):654–658.
- 14 Ho PC. Women's perceptions on medical abortion. *Contraception*. 2006;74(1):11–15.
- 15 Cable EE, Pepe JA, Donohue SE, Lambrecht RW, Bonkovsky HL. Effects of mifepristone (RU-486) on heme metabolism and cytochromes P-450 in cultured chick embryo liver cells, possible implications for acute porphyria. *European Journal of Biochemistry*. 1994;225(2):651–657.
- 16 Sitruk-Ware R. Mifepristone and misoprostol sequential regimen side effects, complications and safety. *Contraception*. 2006;74(1):48–55.
- 17 Correspondence with Exelgyn Laboratories S.A. 2008.
- 18 Hogue CJR, Boardman LA, Stotland N. Answering questions about long-term outcomes. In: Paul M, Lichtenberg S, Borgatta L, Grimes DA, Stubblefield PG, Creinin MD, eds. *Management of Unintended and Abnormal Pregnancy: Comprehensive Abortion Care*. West Sussex, UK: Wiley-Blackwell; 2009.
- 19 Virk J, Zhang J, Olsen J. Medical abortion and the risk of subsequent adverse pregnancy outcomes. *New England Journal of Medicine*. 2007;357(7):648–653.
- 20 World Health Organization (WHO). *Safe Abortion: Technical and Policy Guidance for Health Systems*. Geneva: WHO; 2003. Available at: www.who.int/reproductivehealth/publications/unsafe_abortion/9241590343/en/index.html.
- 21 Martin CW, Brown AH, Baird DT. A pilot study of the effect of methotrexate or combined oral contraceptive on bleeding patterns after induction of abortion with mifepristone and a prostaglandin pessary. *Contraception*. 1998;58(2):99–103.
- 22 Tang OS, Gao PP, Cheng L, Lee SW, Ho PC. A randomized double-blind placebo-controlled study to assess the effect of oral contraceptive pills on the outcome of medical abortion with mifepristone and misoprostol. *Human Reproduction*. 1999;14(3):722–725.
- 23 Tang OS, Xu J, Cheng L, Lee SW, Ho PC. The effect of contraceptive pills on the measured blood loss in medical termination of pregnancy by mifepristone and misoprostol: a randomized placebo controlled trial. *Human Reproduction*. 2002;17(1):99–102.
- 24 Royal College of Obstetricians and Gynaecologists (RCOG). *The Care of Women Requesting Induced Abortion: Evidence-based Clinical Guideline Number 7*. London: RCOG Press; 2004.

Related resources

Berer M. Medical abortion: a fact sheet. *Reproductive Health Matters*. 2005;13(26):20–24.

Medical Abortion: Facts and Information for Healthcare Professionals website. www.medicationabortion.com. Ibis Reproductive Health. Accessed June 11, 2009. **Also available in Arabic, French, and Spanish.**

This document can be found online at www.medabon.info. To request additional copies, please contact Concept Foundation at medabon@conceptfoundation.org. This material may be adapted and distributed for nonprofit or educational purposes without obtaining permission. Please credit the Concept Foundation, Ipas, and PATH as the source of these materials.