



Medical Guidelines for Providers of Emergency Care

This information is to assist providers who work in health facilities where women might present for emergency care following treatment with Medabon®. Women who receive medical abortion are encouraged to first seek follow-up advice or evaluation from their original providers. However, in some cases that will not be possible, and women may seek emergency care from another source.

Background

Medabon® is a combination therapy for medical abortion in pregnancies through nine weeks, or up to and including 63 days since a woman's last menstrual period (LMP). Medical abortion refers to the process of ending a pregnancy by taking medication, rather than through surgical intervention.* It may also be referred to as medication abortion, the abortion pill, non-aspiration abortion, or non-surgical abortion. The term "medical abortion" does not mean that a physician needs to be involved or that the procedure is performed out of medical necessity.

Medabon® consists of two medications: mifepristone (an antiprogestin) and misoprostol (a prostaglandin analog). Both drugs are licensed separately in many countries and have been widely used for medical abortion. Medabon® is the first product to register them together as a specific medical abortion product.

When performed by trained providers with appropriate technology, abortion is safe and effective, and complications are rare.¹

Medabon® regimen and medical abortion process

The Medabon® regimen consists of one 200-mg tablet of mifepristone given orally, followed 24–48 hours later by four 200-µg tablets of misoprostol (given vaginally or sublingually). A follow-up visit two weeks after taking mifepristone will confirm termination of pregnancy. It will be helpful to identify when women took mifepristone and/or misoprostol if they report for emergency care.

Medical abortion with Medabon® presents similarly to a spontaneous abortion, with vaginal bleeding and cramping expected in the hours after taking misoprostol, when the actual abortion is most likely to happen. Lighter vaginal bleeding generally lasts about two weeks, but may last longer. Cramping is typically strongest in the hours after misoprostol is taken, then eases off after the pregnancy is expelled.²

After the pregnancy passes, which the woman may not differentiate from other blood and/or clots, she will likely experience a persistent decrease of bleeding and cramps until the bleeding ends.

Side effects

Uterine contractions can be painful and some women will experience side effects, including nausea, vomiting, diarrhea, headache, chills, shivering, and transient fever lasting less than a day. There are no long-term health effects of Medabon®, nor will the medication impact any future pregnancies.³

* The term "surgical abortion" is often used to refer to procedures such as vacuum aspiration (electric or manual source of vacuum) and sharp curettage, also known as dilatation and curettage (D&C).

Serious complications: signs and symptoms

Medabon® is safe for most women. In rare cases, serious complications that require emergency follow-up care do occur. These include heavy or prolonged bleeding and pelvic infection. Providers should also be on the alert for undiagnosed ectopic pregnancy.

Health care providers in settings where Medabon® is available should be watchful for the following signs and symptoms:

- Persistent heavy bleeding to the point where the woman feels sick or weak. Many providers advise women to contact their health care provider if they saturate two or more sanitary pads per hour for more than two consecutive hours.
- Fever of 38°C/100.4°F or higher, continuing for more than the day following misoprostol use.
- Persistent vomiting or diarrhea for more than the day on which misoprostol was administered.
- Very severe, continuous, or increasing abdominal pain that is unrelieved by medication, rest, a hot water bottle, or a heating pad.

Little to no bleeding 24–48 hours following medical abortion is not an emergency, but is cause for seeking follow-up as it may be a sign of continued pregnancy, a known outcome in approximately 0.5 percent of women.^{4,5} Ongoing pregnancy can be treated on a routine—not emergency—basis, usually by the original provider.

Ectopic Pregnancy

An ectopic pregnancy is a pregnancy located outside the uterine cavity. Medabon® does not treat ectopic pregnancy, a preexisting condition rather than a complication of the abortion procedure. Therefore, ectopic pregnancy may be diagnosed when a woman seeking a medical abortion undergoes clinical assessment before the procedure. However, ectopic pregnancy can go undetected during clinical assessment and even remain undetected after a medical abortion is performed. A woman may still experience bleeding and cramping after taking Medabon®, even if she has an ectopic pregnancy, and a provider is unlikely to examine the expelled tissue to confirm termination of pregnancy. Therefore, diagnosis and treatment of ectopic pregnancy may take place in the course of follow-up.

Typical symptoms of ectopic pregnancy are abdominal or pelvic pain—often one-sided—and vaginal bleeding. Pain and bleeding may be persistent or erratic and, in some cases, absent.⁶

High risk factors for ectopic pregnancy are: tubal surgery, tubal sterilization, previous ectopic pregnancy, in utero exposure to diethylstilbestrol, use of an intrauterine device,* and documented tubal disease.⁸

Ectopic pregnancy can sometimes be confirmed with an ultrasound, but often an ultrasound can only confirm the absence of an intrauterine pregnancy. With serial β -hCG measurements and ultrasound showing an empty uterine cavity in an asymptomatic patient, ectopic pregnancy can be strongly suspected. It is rare to actually see the ectopic pregnancy on ultrasound, unless a very good unit, a transvaginal probe, or a highly skilled sonographer is available and the patient's pelvic anatomy and location of the ectopic pregnancy permit visualization. If ultrasound is not available and ectopic pregnancy is suspected, or if the woman is symptomatic for ectopic pregnancy, she should be referred to an appropriate gynecology service for urgent treatment.

* Women with an intrauterine device (IUD) in place and those who have had tubal ligation are more likely to have an ectopic than intrauterine pregnancy if conception does occur, but their baseline risk of pregnancy is far lower than that of women not using contraception.⁷

Treating serious complications

Heavy or prolonged bleeding

If bleeding is heavy or prolonged—as described above—or causes anemia or symptoms of anemia, such as dizziness, faintness, or significant loss of energy, then vacuum aspiration, fluid replacement, or transfusion might be required. For example, if the products of conception are trapped in the cervix, women feel severe pain and experience heavy bleeding. Removing the products through vacuum aspiration or with forceps normally stops the pain and bleeding. The risk of bleeding requiring intervention (transfusion and/or aspiration) ranges from 0.02–1.8 percent.^{4,9,10}

Pelvic infection

The genital tract is more susceptible to infection when the cervix is dilated, after abortion or childbirth. Women with persistent and severe pelvic pain or abdominal/adnexal tenderness and fever of 38°C/100.4°F or higher should have a uterine evacuation and be treated with antibiotics, if there is evidence of residual tissue. The severity of the infection should determine what treatment is provided; most treatments for infection or presumed infection use oral antibiotics.

For more information on Medabon®, please visit www.medabon.info.

References

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