Clinical Guideline

LATER MEDICAL ABORTION IN HOSPITAL

SETTING St Michaels Hospital [redacted]

FOR STAFF All Clinical staff involved in late medical abortions(LMA)

PATIENTS Patients who are having a later medical abortion at St Michael's hospital

Guidance

This is a nurse delivered service at St Michael's hospital with the option to involve medical staff as necessary. Patients will attend hospital on 2 separate days. On the first day they will be given the abortion pill called **mifepristone** which works by blocking the hormone progesterone to the pregnancy. This is followed 48 hours later by tablets called **misoprostol** which enables the uterus to contract causing cramping and bleeding similar to a miscarriage.
On the first visit they should expect to be in hospital for around half an hour and the second visit at least 6 hours with the possibility of staying overnight. It is important patients having a later medical abortion are booked for the second part of the procedure during the week when there is additional medical support if needed.
The definition of a later medical abortion is from 10 weeks and 1 day gestation up to and including 18 weeks and 0 days gestation.
This guideline is designed to be used alongside the 'checklist for nurse's clinical pathway for Medical Abortion in Hospital'

Informed consent

All patients will be consented for the procedure in PAS and given the UHBW patient information leaflet 'later Medical Abortion in Hospital up to 18 weeks of pregnancy'

- The earlier in pregnancy an abortion is performed, the safer it is.

- Risk of infection – approximately 4 in 100
- Retained products – approximately 13 in 100 women may need evacuation of retained products (ERPC)
- Severe bleeding (that may require a blood transfusion) - 14 in 1000
- Rupture of the uterus(usually only occurs in women who have had a previous caesarean section)- less than 1 in 100

Exclusions to a Later Medical Abortion

- Known adverse drug reaction to **mifepristone** or **misoprostol**
- Known ischaemic heart disease or any other serious cardiovascular disease
- Severe asthma
- Chronic adrenal failure
- Porphyria (a group of rare metabolic disorders)
- Intrauterine device seen on ultra sound scan (needs to be removed before administration of mifepristone)

- Bleeding disorder or on anticoagulants including **warfarin** and direct acting oral anticoagulants (DOACs) e.g. **dabigatran**
- Known placenta praevia or accreta

Cautions:

- Kidney/Liver disease
- Malnutrition

Check list for nursing staff

- Pregnancy Advisory Service(PAS) consultation paperwork with clinical details relating to the pregnancy
- Checklist for nurse's clinical pathway for Medical Abortion in Hospital
- Signed Consent form
- Haemoglobin (Hb) and blood group result, If Hb is lower than 100g/l inform doctor and ensure Iron tablets are prescribed to be given at the first visit appointment
- HSA1 form complete with 2 signatures (Legal requirement).
- Prescription chart with :

Mifepristone 200mg for the 1st visit followed by:

:

- 800 micrograms **misoprostol**[4], given vaginally, **or**
- 600 micrograms of **misoprostol**[4], given sublingually, for women who decline vaginal misoprostol.

Follow the initial dose with 400 microgram doses of **misoprostol**[4] (vaginal or buccal), given every 3 hours until expulsion.

*. Analgesia and anti-emetics

* **Doxycycline** 100mg(if required according to risk assessment)

* **Depo-Provera** (if required)

Procedure at first visit

Patients are advised by PAS to arrive on the ward between 9.30 and 10.00 and expect to be on the ward for approximately 1 hour. They are able to go home immediately following administration of mifepristone.

- Nurse administering the **mifepristone** should check the patient still wishes to proceed with the abortion and then sign the 'confirmation of consent 'section on the consent form
- Check Hb and blood group before administration of mifepristone
- Order anti D if patient has a rhesus negative blood group (given at the second visit)

- Baseline observations (only if clinically indicated)
- Give anti- emetic
- Supervise **mifepristone** 200mg given orally.
- Advise if vomiting occurs within 1 hour of taking **mifepristone** they should contact the ward for a repeat dose. ward staff should administer IM anti- emetic 20 minutes prior to the repeat dose of **mifepristone**
- Reiterate the information, which has already been given to the patient at PAS, regarding bleeding and contact numbers
- Check they have a responsible adult for 24hrs following discharge from hospital after the second visit
- Ensure the nurse led check list is complete

Procedure at second visit

Patients are told by PAS to expect to be in hospital for 6 hours or longer.

- Check the patients' medical condition following the **mifepristone**
- Complete baseline observations
- If the patient has any medical co-morbidities inform the Gynaecology Senior house office (SHO), and Senior Registrar that the patient is in the department as these patients have a greater risk of bleeding or retention of placenta potentially requiring medical input. Consider Intravenous access.
- Discuss the route of **misoprostol.** Offer vaginal route as a preferred option(nurses may need to assist with this) if this is not acceptable give buccal dose:
  * Vaginal dose 800micrograms
  OR :* Buccal dose 600micrograms
- Give analgesia- **diclofenac** (voltarol) 100mg PR is first line. If this is declined or unsuitable offer alternative oral analgesia
- **Pethidine** is also prescribed and can be given if required
- Give anti-emetic if required
- Check the blood group and if rhesus negative ensure anti- D 500/1500IU is prescribed ready to give prior to discharge
- Continue to administer **misoprostol** as a buccal or vaginal dose every 3 hours until the pregnancy has been expelled- if the patient is unable to tolerate multiple doses of misoprostol discuss with Senior Registrar
- Nurses must observe all products which are passed so it can be confirmed the abortion is complete

- Occasionally there is a delay between delivery of the fetus and delivery of the placenta
- Ensure patient has completed sensitive disposal form for pregnancy remains

Complications during admission

Heavy vaginal bleeding

- The cause is usually products of conception (POC) in the cervical os. A doctor should be contacted for review and to consider a speculum examination to remove any POC visible at the os
- **Syntometrine** (5 units of **oxytocin** + 500mcg **ergometrine**) or **syntocinon** (5 units **oxytocin**) if **ergometrine** contraindicated, can be prescribed and given as required

- Obtain intravenous access (16G cannula is preferable) and ensure they are suitable for e-issue of blood if required. This needs two separate historical group and save samples in the laboratory, one of which must have been taken within the last 3 days.
- If very heavy bleeding, take blood tests for full blood count (FBC) clotting and fibrinogen at time of cannulation
- Occasionally the above actions fail to control the bleeding and the woman will require an urgent evacuation of retained products of conception (ERPC)

DNA Protocol

Refer to PAS DNA policy which covers the following information.

- If a patient does not attend the 1st appointment she **should not** be contacted by ward staff. PAS should be informed of her failure to attend by calling [redacted]
- If a patient does not attend the 2nd appointment, ward staff should make every attempt to contact the patient. If this is unsuccessful PAS should be informed as soon as possible on [redacted], If this is out of hours a message should be left on the answer phone.
    - If the patient still wishes to proceed with the abortion but unable to come in on the specified day, they could come in up to 48 hours following administration of **mifepristone** if the ward has capacity. If this is not possible, the procedure should start again with the administration of mifepristone
- If, after taking **mifepristone** and/ or **misoprostol**, the patient decides they no longer wish to proceed with the abortion, there should be a documented consultation with the ward Dr and referral to fetal medicine for follow up. PAS should be informed of this. See appendix 1.

Discharge information after 2nd visit

- All patients who have passed identifiable POC can be allowed home provided the bleeding has settled and they have a responsible adult to support them for the next 24hrs
- If the patient experiences problems over the next few weeks, they should either contact the ward or access their own GP for advice. Refer to the patient information leaflet given at PAS
- Discuss contraception
    - **Depo-provera** –can be administered immediately as prescribed regardless of whether products of conception have been seen. (Refer to Faculty guidelines)
    - **Combined oral contraceptive pill** (COCP), progesterone only pill (POP)and the contraceptive patch may start immediately
    - I**mplant** may be fitted immediately
- Advise no sexual intercourse until the bleeding has settled (approx. 2 weeks)
- **Antibiotic prophylaxis**- women who are asymptomatic but at a higher risk for infection and their results are not available prior to the abortion will be given the following prophylaxis in line with National guidance and local data:
  Doxycycline 100mg twice a day for 7 days
- Check anti- D has been given if appropriate

- Reiterate the contact number for the ward
- Complete HSA4 online

REFERENCES	
RELATED DOCUMENTS AND PAGES	The Care of Women Requesting Induced Abortion, RCOG Nov 2011 https://www.rcog.org.uk/globalassets/documents/guidelines/abortion-guideline_web_1.pdf DNA SOP Pregnancy Advisory Service- June 2019 NICE guidelines for Abortion Care(NG140) September 2019 https://www.nice.org.uk/guidance/ng140/chapter/Recommendations
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