MSF Guidance for abortion at 13-22 weeks gestational age

This document provides guidance which is complementary to the MSF Policy of reproductive health and sexual violence care (2014) and to the Essential obstetrics and newborn care guide (2015) – Chapter 12 which covers abortion up to 12-14 weeks gestational age and will be revised including below recommendation regarding abortion in the 2nd trimester.

Approved by DirMed October 2017

The MSF policy relevant to abortion states[1]:
"*MSF will respond to girls' and women's needs for the termination of pregnancy on request (TPR); it is part of the organization's actions aimed at reducing maternal mortality and preventing unsafe abortion. Termination of pregnancy on request in MSF projects is supported until the end of the first trimester; TPR at later gestational age is considered on a case-by-case basis."*

Experience over the past 2 years has shown that the above statement "*TPR at later gestational age is considered on a case-by-case basis*" is insufficient in its guidance for teams and therefore clarified as follows:

"Case-by-case" refers to the **feasibility** in terms of the type of health structure, level of care available, and the capacity of staff in the project. The patient's circumstances, such as age, socio-economic status, or reason for requesting the abortion (e.g. rape) are NOT determining factors in the decision whether or not TPR will be provided at any gestational age.

Abortions (13-22 weeks gestation) can be provided in MSF projects when the following conditions are ensured:

1) Availability of medical staff who are able to manage complications of second trimester abortions (see protocol below for more information)
2) Surgical capacity and blood transfusions available on site or reasonable access by referral
3) Infection prevention and control (IPC) measures and waste management systems adequate for disposal of products of conception

Most projects with obstetrical services should already have the necessary staff and systems in place to provide second trimester abortions. For example:

- ✓ Projects where MSF ensures obstetric care for vaginal deliveries should already have adequate IPC measures and biomedical waste management systems in place.
- ✓ A referral system for Caesarean sections, which require surgical capacity and blood transfusions, should be in place; that same referral system can be used to manage complications of second trimester abortions.
  Note: The referral health structure does not need to know that MSF provides TPR and does not need to agree to the provision of TPR. In case of complication, the patient can be referred with the diagnosis of post-abortion complication (eg. incomplete abortion with severe hemorrhage, spontaneous miscarriage, septic abortion, etc.).

Projects without obstetrical services (such as vertical sexual violence projects) can also provide second trimester abortions as long as the above requirements are met.

[1] MSF Policy for Reproductive Health and Sexual Violence Care, International Working Group on reproductive health and sexual violence care. Final Version. Approved by the MedOp platform – March 2014

Medical Protocol for Second Trimester Abortion

The only safe and effective methods of second trimester abortion are medication abortion and Dilatation and Evacuation (D&E).

- **<u>Medication abortion is the method of choice for second trimester abortions in MSF projects</u>**.
- Manual vacuum aspiration (MVA) is contraindicated for termination of pregnancy > 12 weeks gestational age.
- D&E is different than Dilatation & Curettage (D&C). D&E is a technically complex surgical procedure requiring specialized skills and instruments; it can only be performed by health providers with advanced training in this particular skill and in projects that offer full CEmONC services.

1. Contra-indications for medication abortion and estimation of gestational age :

- Contraindications are identical to the ones stated for first trimester abortions (see *Essential Obstetric and Neonatal Care*, Chapter 12).
- Gestational age can be estimated using last menstrual period and physical exam. Ultrasound may be used as needed, but is not required before providing a second trimester medication abortion.

2. Protocol for medication abortions between 13-22 weeks gestation:

The treatment includes:

– A combination of abortion medications:

mifepristone PO: 200mg as a single dose
followed 24-48 hours later by
misoprostol vaginally or sublingually: 400 micrograms every 3 hours until fetal and placental expulsion

– And a combination of analgesics[2]:

ibuprofen PO: 800 mg every 8 hours as needed (maximum 2400 mg/day); start with administration of misoprostol and continue as needed after expulsion

in case of severe pain add

codeine PO: 30 to 60 mg every 6 hours (maximum 240 mg/day)
or
tramadol PO: 50 mg if < 60 kg; 100 mg if > 60 kg

– In case of nausea/vomiting (not routinely):

metoclopramide PO: 5 mg/dose for women < 60 kg; 10 mg/dose for women > 60 kg. The interval between each dose should be at least 6 hours.

[2] The protocol includes minor variations for the pain management protocols for MVA (OGL Chapter 9) and for 1st trimester abortion (OGL Chapter 12). The proposed adjustments are based on evidence regarding abortion related pain management and should be adjusted accordingly in the next update of the **O**bsteric **G**uide**L**ine of MSF.

Note:

- If mifepristone is unavailable, misoprostol alone can be administered as above, but is less effective.
- Second trimester abortions typically require multiple doses of misoprostol. There is no maximum number of repeat doses of misoprostol.
- For nulliparous women, the vaginal route of misoprostol is more effective and should be considered.

It is recommended that women who have second trimester medication abortions stay in a health facility during the expulsion of the products of conception to allow for timely management of potential complications. However, severe complications such a hemorrhage, blood transfusion, or the need for unanticipated surgery are rare (<1%). Another possible complication is retained placenta, which can be managed by manual removal and/or MVA.

In exceptional situations and up to 16 weeks gestational age, if access to a health facility is fast and reliable, the woman may also expulse at home. In this case, she needs to be thoroughly counseled and understand what to expect during the abortion, how to dispose of the products of conception, and when to seek emergency medical care (red flag signs).

3. Patient information :

- Pre and post abortion counseling should be provided as for first trimester abortions (MSF Essential obstetrics and newborn care 2015. Patient information, Chapter 12, Section 12.2.3.).
- Patients and staff should be aware that, compared to the first trimester, the fetus will be larger and more developed in the second trimester.
- Immediate initiation of contraception following second trimester abortion prior to discharge is encouraged and considered safe. (MSF Essential obstetrics and newborn care 2015. Offer contraception, Chapter 11, Section 11.5).

Justifications and evidence for this protocol on second trimester abortions:

Recent studies using the recommended regimen of mifepristone and misoprostol in the second trimester show complete expulsion rates of approximately 90% at 24 hours and 95% at 48 hours (Dabash et al, 2015; Abbas et al, 2016). In the largest study, when women were able to continue misoprostol until expulsion with no cut off time, 99% of women eventually had a successful abortion (Ashok et al, 2004). This is why there is no maximum number of doses of misoprostol for second trimester abortions.

The combined regimen in the second trimester has an average induction-to-abortion time of 6-10 hours and major complication rates of < 1%. In the largest cohort study of second trimester abortions, 81 of 1,002 women (8.1%) needed an intervention for uterine evacuation, the majority for retained placenta; serious complications such a hemorrhage, blood transfusion, or the need for unanticipated surgery occurred in eight women (less than 1%) (Ashok et al, 2004).

As the combined regimen at any timing is more effective than misoprostol alone, simultaneous dosing of mifepristone and misoprostol can be a useful strategy if medical or social issues require an even shorter time interval.

Where mifepristone is not available, a misoprostol-only regimen can be used (dosing is the same as the combined regimen). It is safe and effective with expulsion rates of over 90% at 48 hours, average induction-to-abortion time around 12 hours, and major complication rates of < 1%.

A randomized trial found that prophylactic NSAIDs reduce the need for narcotics when compared with treatment with paracetamol and codeine during second trimester medication abortions (Fiala, Swahn, Stephansson, & Gemzell-Danielsson, 2005).

References

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