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Hello and welcome to another episode of the APAOG Podcast. I'm the show's host and creator Morgan Bechtel, and today we'll be discussing a very important topic in obstetrics and gynecology, specifically abortion care and management. Abortions are common.

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One in four US pregnancy capable people will have an abortion over the last several years. The landscape surrounding abortion care has shifted dramatically, and there's still much that's up in the air. APAOG believes that patients have a right to access the full range of reproductive health services, including fertility treatments, contraception, sterilization and abortion for today's episode, we'll be sticking to the basics, defining what an abortion is discussing the various types of abortion.

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As well as reviewing the treatments both during and after an abortion, now trigger warning for anyone listening. I will be describing the general procedures of an abortion. If you find this triggering or upsetting, this may not be the episode for you. Without further ado, let's review abortion care.

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First, let's start by defining abortion and reviewing the various terminology. Abortion is defined as a pregnancy loss up to 20 weeks gestation, or an elective pregnancy termination at any gestational age. Early pregnancy loss is often referred to as miscarriage or spontaneous abortion, and this includes all non viable intrauterine pregnancies in the first trimester.

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This refers to things like an an-embryonic pregnancy, which refers to a non viable pregnancy.

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Etsy that has a gestational sack that does not contain any yolk sack or embryo. This can mean that the embryo was either never present or it was present and it was reabsorbed. This also includes things like embryonic demise, which is diagnosed when there's a visible embryo greater than 7mm in length that does not have any cardiac activity.

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The terminology applies to pregnancies measuring less than 10 weeks by ultrasound. Fetal demise is a very similar diagnosis, but this is for pregnancies measuring 10 weeks of gestation or greater without cardiac activity.

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Let's discuss some risk factors for pregnancy loss. They include things like maternal age. We know that extremes of age increase the risk of pregnancy loss with an age greater than 35 being the most significant risk factor because of the strong association with fetal chromosomal abnormalities, course of past history of pregnancy loss does increase the parents age for pregnancy loss.

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Certain maternal medical conditions like diabetes, hypothyroidism as well as acute bacterial and viral infections can increase the risk of pregnancy loss. Certain environmental exposures to things like excessive lead, arsenic, and air pollution have also been shown to increase the risk of pregnancy loss.

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Some studies show that anatomic anomalies such as uterine leiomyomas, polyps, adhesions and septa may be associated with pregnancy loss based on their size and position in relation to the developing pregnancy. And lastly, pregnancy loss between 10 and 20 weeks gestation was found to be nearly twice as common among black American women compared to white American women. This difference likely reflects the impact of the cumulative stressors of systemic racism, social determinants of health, and unavoidable occupational and or environmental exposures to potential toxins.

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Next, let's talk about the causes of pregnancy loss. First trimester causes include things like chromosomal abnormalities.

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Which include aneuploidy, partial deletion or duplication, and this makes up the majority of causes of pregnancy loss before 20 weeks as much as 70%. Although this prevalence does vary by gestational age. Significant trauma can cause pregnancy loss while the developing embryo is relatively protected within the uterus, and early pregnancy trauma that results in direct.

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Impact to the uterus can cause pregnancy loss. Each year, an estimated 324,000 pregnant people in the United States are battered by their intimate partners. If you or someone you know is experiencing intimate partner violence and it is safe for them to do so. Please have them call the national Domestic violence hotline at 1-800-799-7233. Second trimester causes of pregnancy loss include things like infection, resulting in chorioamnionitis and maternal viral infections, chronic stressors, and again, that can be related to racial, ethnic, financial or other disparities, things like chronic food or housing insecurity and other long term life stressors, uterine malformation and cervical insufficiency can also result in pregnancy loss. Same with fetal malformation or syndrome such as anencephaly, trisomies, renal agenesis, and hydroxyl.

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Double philias can also cause pregnancy loss as well as uterine abruption, premature preterm rupture membranes, and preterm labor.

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Now we'll move on and talk about the general evaluation for patients who come in for concerns of an early pregnancy loss or who are being seen for an elective abortion. In the history of course, we want to ask about the date of their last menstrual period as the first date of last menstrual period alone, plus or minus, you know, one week of certainty is an accurate means of estimating the gestational age.

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With low rates of over or under estimation up to 8 weeks from the last menstrual period.

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You also want to collect a full and accurate medical history to evaluate for things like hypertension, diabetes, asthma, bleeding disorders, renal or hepatic diseases, seizure disorders and depression and anxiety. As all of these conditions can really impact the treatment plan, you also want to assess for symptoms like abdominal or pelvic cramping, fever, chills and vaginal bleeding.

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And when asking about the vaginal bleeding, we want to be really specific as to when it started and quantify how much bleeding is occurring. Usually we measure this by pads or tampons per hour.

Lastly, you want to perform screening for intimate partner violence and human trafficking. To learn more about these screenings, check out my interview with Shantae Rodriguez back in Season 1, episode 11 during the physical exam. We want to be reviewing the vitals as well as looking for signs of possible intimate partner violence, acute hemorrhage, bacterial infections, and sepsis.

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We're also evaluating the cervix for things like dilation, bleeding, and evidence of products of conception. Evaluating the uterus helps us determine the stage of pregnancy.

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After about four weeks, years increases by approximately 1 centimeter per week. After 12 weeks, the uterus rises out of the pelvis and at 15 to 16 weeks, the uterus reaches the midpoint between the pubic symphysis and the umbilicus. At 20 weeks, the uterus reaches the umbilicus, and after that time period, the distance between the top of the fundus to the pubic symphysis that length in centimeters, is approximately the weeks gestation of patient is. So if there are 25 centimeters, they're approximately 25 weeks.

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Now, another general rule of thumb I was able to find is that if the uterus is the size of a lemon, it's approximately 5 to six weeks. Gestation fits about a medium orange 7 to 8 weeks gestation, and if it's about the size of a grapefruit, you're about nine to 10 weeks gestation. Diagnostic testing includes things like a urine, pregnancy or serum beta HCG to confirm the pregnancy.

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Sometimes the glucose is performed with patients who are an insulin dependent diabetic INRs can be performed on patients who are on certain anti-coagulants.

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The CBC might be ordered to look at hemoglobin in patients who present with signs and symptoms of anemia, or have a history of anemia testing for chlamydia and gonorrhea might be done in patients who

either are at increased risk or have symptoms of it. And of course, we're going to do a blood type across if we think you transfusion might be needed in a patient.

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An RH status may be performed to identify an RH D-negative individual.

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Who are at risk of developing RH alloimmunization as a reminder, this is when a mother's antibodies attack the antigens on a fetus's red blood cell, which can cause things like hemolytic disease, cardiac failure, and excessive fluid accumulation in the fetus. This is known as hydrops fatalis, and it can even result in death. One important thing to note.

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Is that there's no routine pre abortion lab testing that's needed in patients without any underlying conditions.

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Some labs are definitely indicated by history or exam finding, but lack of testing should not be a barrier to access for patients wishing to seek an elective abortion. A trans abdominal transvaginal ultrasound may be used to confirm the location and help with dating of the pregnancy and ultrasound.

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Is not a requirement, though for medication abortion or uterine aspiration. Certain findings on an ultrasound can help determine the gestational age. If we see a gestational SAC, then we know that it's been about 4.5 to 5 weeks since the last menstrual period. There's a yolk SAC presence it's been about 5 1/2 weeks since last menstrual period.

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If there is evidence of an embryonic pole that's between 6 and 6.5 weeks and same thing if we see evidence of cardiac activity, then we know it's between 6:00 at least 6 to 6.5 weeks since last menstrual period. Now that we've defined abortion and discussed the ways of diagnosing it.

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And working up a patient for an elective abortion.

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Let's move on and talk about the management of abortion. For patients who do not have a viable pregnancy, who are unable to safely continue their pregnancy, or who elect to have an abortion. The available treatments vary state to state and are constantly changing. Providers and patients need to stay up to date on the current laws, and I'm going to include a link on our website to resources.

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For helping patients and providers stay up to date on their current state legislation. Before treatment is given, there's usually an initial visit to determine the patients eligibility for treatment to educate them on treatment options to council on the abortion process and, of course, to gain informed consent.

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There are two main types of abortion care there is medication abortion and surgical abortion. Now, medication abortion has been used safely for over 25 years and is considered to be tenfold safer than continuing a pregnancy term. The medication abortion can be used up to 11 weeks in most US practices, but is used beyond 11 weeks in some countries.

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The effectiveness of medication abortions is based on gestational age, but it ranges from about 95% to 99% effective.

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During pregnancy, tests may be used after four weeks to monitor for completion of a medication abortion.

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There are certain advantages to having a medication abortion versus a surgical one.

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With the medication abortion patients have control over where the abortion takes place. It avoids procedures about 96 to 98% of the time. There is definitely more support options with loved ones, friends, etcetera. Sometimes they can be perceived as a more natural process, like a miscarriage. And there's options for personalizing the experience.

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Some disadvantages of a medication abortion include things like the length of time it takes. The process can take anywhere from one to two days, but sometimes it can last even longer. Sometimes patients experience heavier and longer bleeding and cramping than with surgical abortions. There's also less control over the time during which the bleeding and cramping occurs.

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Sometimes patients may see fetal tissue, and sometimes it does require a follow up.

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Up there are two main medications used to facilitate a medication abortion, mifepristone and misoprostol, often called Mifi and Mesos. Mifepristone is a progesterone antagonist that causes the breakdown of the decidua.

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Which is the mucous lining of the uterus that occurs during pregnancy as well as placental separation, softening and dilation of the cervix and sensitization of the Miami Trium 2 uterotonics, which are drugs that induce uterine contractions. Misoprostol is a prostaglandin E1 analog that acts as a uterotonic. Medication abortions generally involve taking a single dose of.

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Oral Mifepristone stone, 200 milligrams, followed by 800 micrograms of misoprostol administered either vaginally sublingually or likely 24 to 48 hours later, if a patient vomits within 30 minutes of the method prestone administration, the dose should be repeated for patients 9 weeks, 0 days gestation to 11 weeks, 0 days gestation and automatic second dose of misoprostol is administered three to six hours after the first dose. In areas where access to abortion.

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Providers is scarce. If the crystal only therapy can be used, but it's generally not preferred as it's considered to be less effective. This method involves taking 800 grams of the misoprostol every three hours for three doses until expulsion.

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Patients can expect mild to strong cramps after taking the misoprostol, which can last a few hours to a few days. It's possible for patients to have heavier bleeding with clots as well. This bleeding can persist on and off for one to two weeks, or even more. Pain is generally managed with NSAIDS.

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And red flag symptoms requiring in person evaluation by a medical professional include things like a sustained fever greater than 100.4 Fahrenheit chills, abnormal vaginal discharge, significant abdominal pain, as well as vaginal bleeding greater than two pads an hour for more than two consecutive hours. These symptoms could indicate an infection and or an incomplete or failed.

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Abortion. If an incomplete abortion is confirmed, usually via ultrasound or rising BHCG levels, a suction aspiration or subsequent dose of misoprostol is given. Important reminder that a rising beta HCG without evidence of pregnancy and an ultrasound could point to a possible ectopic pregnancy.

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Which is a potentially life threatening condition, and settings where an abortion is illegal or functionally inaccessible, the prevalence of self managed abortion is rising. Self managed abortion is where patients purchase abortion medications without the direct assistance of the formal medical system. Self managed abortions is part of this overall cultural shift towards direct to consumer medical services.

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Though the shift is being driven definitely more urgently by the restrictive abortion ban in the last several years, resources for self managed abortions.

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Will be listed in our show notes for listeners to check out. Next, we'll be talking about surgical abortions for the purpose of today's episodes, we'll be focusing on 1st trimester and 2nd trimester abortions and will not be diving into the management of late term abortions or stillbirths.

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Surgical abortions have been used safely for over 45 years, and similarly to medication abortions.

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Options are considered to be at least tenfold safer than continuing a pregnancy term. The effectiveness of surgical abortions is over 99% now there are advantages to surgical abortion versus a medication one, mainly the time the procedure itself takes approximately 5 to 10 minutes and the patient is able to leave the office not pregnant.

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Usually there is less post procedure bleeding.

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Than with a medication abortion and there's options for mild, moderate or even deep sedation. Plus there's medical and nursing staff there to support the patient. Some disadvantages of surgical abortions include that it requires an in person clinical setting and in states with stricter abortion bans, these clinical settings are further and further apart and may require more time and expense than they have.

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There are risks involved in a surgical abortion that come with the use of instrumentation, mainly perforation infection and damage to surrounding tissues. Patients of getting anesthesia will need a driver to take them to and from the appointment. There's also fewer options for personal support persons that can actually be there during the procedure and the sexual machine that's used may be audible, which can be particularly disturbing to some patient.

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Next, we'll talk about the two main types of surgical abortion, uterine aspiration and uterine dilation and evacuation, also known as D and E. Uterine aspiration can be performed up to 14 to 16 weeks gestation, and a D&E is performed when the gestation is greater than 14 to 16 weeks. One hour prior to the procedure prophylactic antibiotics are usually given.

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The preferred agent is a single dose of doxycycline 200 milligrams, but 500 milligrams of metronidazole, or 500 milligrams of azithromycin could also be used. Pain management during the procedure involves things like oral pain medications mainly NSAIDs,

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But local anesthesia, like a paracervical block or vaginal lidocaine, can also be used. And occasionally moderate or deep station is used, but this is usually reserved for second trimester denies and uterine aspiration the cervix is manually dilated so as to allow a plastic cannula or tube to be inserted through the cervical OSS and into the uterus.

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In uterine aspiration, the cannula is attached to either a manual or electric vacuum aspirator, which removes the products of conception via section. After the procedure is completed, the provider will examine the aspirated tissue and an ultrasound may possibly be done in order to evaluate that all products conception were removed.

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In uterine dilation and evacuation, the cervix is often dilated prior to the procedure, using medications. Again, that method Mifepristone and misoprostol and additional dilation is done manually if needed.

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Sometimes medications are injected in order to induce fetal demise before the evacuation procedure begins. However, this practice is controversial and we will not be reviewing it in further detail at this time. After cervical dilation, the fetal tissue and placenta is removed using forceps, curettage and aspiration reminder that curettage is the practice of scraping the walls of the uterus in order to of tissue.

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With both uterine aspiration and D&E, the healthcare provider will perform a careful tissue inspection to check for complete removal of the gestational SAC, placenta and fetal tissues, which will be visible on inspection after about 9 weeks gestation. If products of conception cannot be visualized and ultrasound can be used to identify or any retained tissue.

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The patient can expect mild to strong cramping during and just after the procedure. The heaviest bleeding often occurs during the procedure, but late bleeding can persist for one to two weeks or more, and the patient may also pass clots during this time. Some complications of surgical abortions include retained products of consumption, which occurs in less than 1% of cases.

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Uterine perforation can also occur, but again this is in less than 1% of cases. Sometimes our cervical laceration which occurs and up to 3% of cases post op infection and occurs in up to 4% of cases and hemorrhage and death can occur.

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Just as with a medication abortion, red flag, symptoms requiring urgent follow up with a medical professional include a sustained fever greater than 100.4 Fahrenheit, chills, abnormal vaginal discharge,

significant abdominal pain, or significant vaginal bleeding greater than two pads per hour for greater than two consecutive hours.