CANADIAN PROTOCOL FOR THE PROVISION OF MEDICAL ABORTION VIA TELEMEDICINE

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This protocol aims to describe the provision of medical abortion (MA) in a setting where direct access to abortion providers may be difficult, particularly during a period of social disruption or a pandemic. This protocol may deviate from approved indications or previous clinical practice.

When a request for abortion is received:

1. Confirm patient identity and ensure patient has privacy and safety to discuss
2. Provide written information (for example, by email or fax) on medication and surgical abortion as well as instructions on medication abortion (https://www.shorecentre.ca/wp-content/uploads/NEW-Mifegymiso-Information-Brochure-min.pdf), in advance of consultation
3. If not already done, ask the patient to obtain and take a qualitative urine high sensitivity pregnancy test from pharmacy
4. Schedule a first virtual visit via telephone or video to provide consultation

Pre-abortion assessment via telephone or video (consultation):

1. Review pregnancy options counselling[1]
2. Establish pregnancy and gestational age:
    a. Review date of last menstrual period (LMP), and date of positive qualitative pregnancy test
    b. Review relevant medical history, particularly risk factors and signs/symptoms for ectopic pregnancy and method of contraception used at the time of conception if any
    c. If either intrauterine device (IUD) or intrauterine system (IUS) is present, arrange an ultrasound and appointment for IUD/IUS removal or consider surgical abortion
3. Determine need for an ultrasound;[1-4] obtain an ultrasound and arrange a follow-up visit prior to MA provision if:
    a. LMP is uncertain
    b. LMP is over 70 days ago
    c. Presence of symptoms and signs of ectopic pregnancy[1]
    d. Presence of risk factors for ectopic pregnancy[1]
    e. Presence of an IUD/IUS at any point in pregnancy
4. Exclude contraindications to combination mifepristone/misoprostol medication abortion:
    a. Confirmed or suspected ectopic pregnancy
    b. Chronic adrenal failure
    c. Inherited porphyria
    d. Uncontrolled asthma
    e. Concurrent long-term use of corticosteroid therapy
    f. Haemorrhagic disorder or concurrent anticoagulant therapy
    g. Severe anemia

h. Allergy to mifepristone, misoprostol or other prostaglandins

5. Determine the need for laboratory investigation prior to MA (a 2nd pre-abortion assessment via telephone or video may be required):
    a. Complete blood count is required if suspected severe anaemia or hemoglobinopathy
        i. Hemoglobin should be over 9,5 g/dl before starting MA
    b. Rhesus (Rh) status can be considered if not documented elsewhere (e.g. donor card, previous results) AND if patient would accept Rh immunoglobulins: according to current evidence, Rh testing is required when gestational age (GA) is over 56 days.[5,6] However, during the COVID-19 pandemic, expert opinion recommends that Rh testing may be withheld up to 70 days GA.[7,8]
    c. Sexually transmitted infection (STI):
        i. If the patient must come to the office for any reason, offer screening of Chlamydia and gonorrhea
        ii. If the patient does not have to be seen in person, but there are risk factors for STI, consider remote testing if available, and discuss the potential need for antibiotic prophylaxis (such as Doxycycline 100 mg twice a day for 7 days, starting the same day as mifepristone[1])
    d. Review post-abortion contraception options
    e. Obtain verbal informed consent and document it in the patient's chart[9]

Prescription:

1. Prescribe the following medications:
    a. Mifepristone 200 mg orally and misoprostol 800 mcg buccally or vaginally
    b. Additional dose of misoprostol 800 mcg buccally or vaginally
    c. Analgesics and antiemetics as per health provider/facility protocol
    d. Antibiotic prophylaxis as per health provider/facility protocol, if needed
    e. Contraceptive method
2. Ask patient (or include on separate instructions for pharmacist) to obtain **TWO** high sensitivity urine pregnancy tests from pharmacy
3. Give the following instructions :
    a. The patient should take mifepristone 200 mg orally on a day agreed by the patient and the health professional (document in patient's chart)
    b. The patient should take a first dose of misoprostol buccally or vaginally 24-48 hours after taking mifepristone
    c. **Patients with gestational age 63 days or less** should take the second dose of misoprostol if no bleeding occurs within the first **24 hours after** the first misoprostol dose or as instructed by the clinician[10]
    d. **Patients with a gestational age over 63 days** should take a second dose of misoprostol **4 hours after** the first dose[7,8]
4. Review when to initiate contraception, depending on the method selected[1]
5. Review the instruction sheet with the patient, which include:
    a. Side effects
    b. Warning signs of a complication of a MA (signs of ectopic pregnancy, signs of pelvic infection, hemorrhage, excessive pain)

c. Schedule **follow up #1** and whom to contact for advice or urgent assessment

Follow-up #1 – 7 days post-treatment via telephone or video:

1. Review abortion experience and progress with patient:
    a. Dates of taking mifepristone and misoprostol
    b. Side effects of medication
    c. Bleeding pattern since taking mifepristone and misoprostol
    d. Pain during the process and current pain, if any
    e. Whether or not expulsion occurred
    f. Presence of current symptoms of pregnancy
    g. Warning signs of ectopic pregnancy or infection
2. Advise an urgent assessment or emergency visit if signs of ectopic pregnancy, signs of pelvic infection, heavy bleeding, excessive pain
3. Obtain an ultrasound if history suggests failed abortion or ongoing pregnancy and consider additional dose of misoprostol or surgical aspiration as needed
4. If history suggest successful abortion, no current symptoms of pregnancy, normal bleeding and pain, and no warning signs, instruct the patient to perform a **first** qualitative urine pregnancy **3 weeks from now**, which is 4 weeks after taking misoprostol. Ensure that the patient will have her **first** pregnancy test result available at the time of **follow-up #2**

Follow-up #2 – 4 weeks post-treatment via telephone or video:

1. Review the date **first** pregnancy test was done. Ensure test was performed at least 3 weeks after misoprostol was taken
2. If **first** pregnancy test is negative, reassure the patient that abortion is complete. Do not repeat pregnancy test
3. If **first** pregnancy test is positive, review signs and symptoms of retained product of conception, ongoing pregnancy or ectopic pregnancy:
    a. If present, consider evaluation with ultrasound and/or serum hCGs and:
        i. Retained product of conception: consider additional dose of misoprostol or surgical aspiration
        ii. Ongoing pregnancy: consider surgical aspiration
        iii. Ectopic pregnancy suspected or confirmed: manage accordingly and refer to gynecologist as needed
        iv. Negative ultrasound: consider new pregnancy, have the patient repeat urine pregnancy test (**second**) in one week. Ensure that the patient will have her **second** pregnancy test result available at the time of **follow-up #3**
    b. If no warning signs and no ultrasound: have the patient repeat urine pregnancy test (**second**) in one week. Ensure that the patient will have her **second** pregnancy test result available at the time of **follow-up #3**

Follow-up #3 – 5 weeks post-treatment via telephone or video:

1. Review the date **second** pregnancy test was done. Ensure test was performed 1 week after last (**first**) pregnancy test
2. If **second** urine pregnancy is negative, reassure the patient that abortion is complete.

3. If the **second** urine pregnancy test is positive, in-person urgent assessment with ultrasound and serum hCG is needed, as surgical intervention is more likely to be required. Possible diagnosis at this stage include failed or incomplete medical abortion, pregnancy of unknown location or ectopic, new pregnancy and gestational trophoblastic neoplasia

Contraception provision of long acting reversible contraception:

1. Plan an in-clinic follow-up contact for insertion of implant, IUD or IUS once abortion is deemed completed or according to clinician's advice, and following patient's preference and consent for long acting reversible contraception (LARC).

References:

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