Chemical Abortion and Abortion Pill Reversal in 2023: Impacts on the Patient and the APR Treatment Team

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Topics to be Covered

Availability of Chemical Abortion

- Prevalence
- Current status of REMS
- Telehealth and more on access

Chemical Abortion Procedures

- Medications Used
- Eligibility Criteria
- Complications

Abortion Pill Reversal

- How it works
- How to access care for your clients/patients
- Safety

Impact of Increased Televisit Access to Chemical Abortion

For Patients, APRN Providers/Pregnancy Centers

Emotional Weight of Abortion Reversal

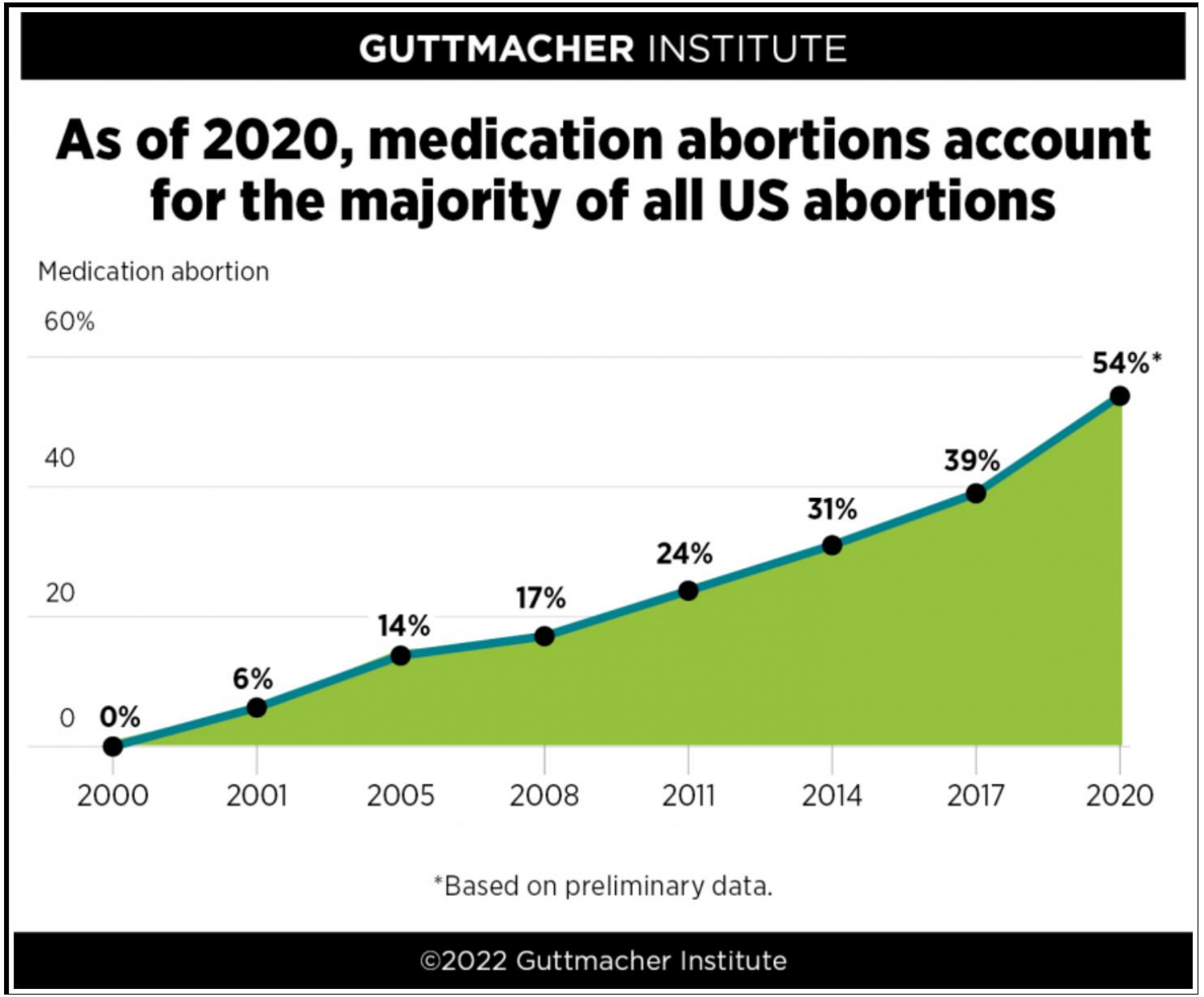
- Patients, Hotline Clinicians, Pregnancy Centers

Medical Abortions

FDA approved up to 10 weeks estimated gestational age (EGA)—70 days after last menstrual period (LMP) in 2016. (was 7 weeks prior.)

Nationally using CDC data from 2020, 53.4% of all abortions were medical abortions (51% of abortions ≧ 9 weeks' gestation)

Rate of Rise of Medical Abortions

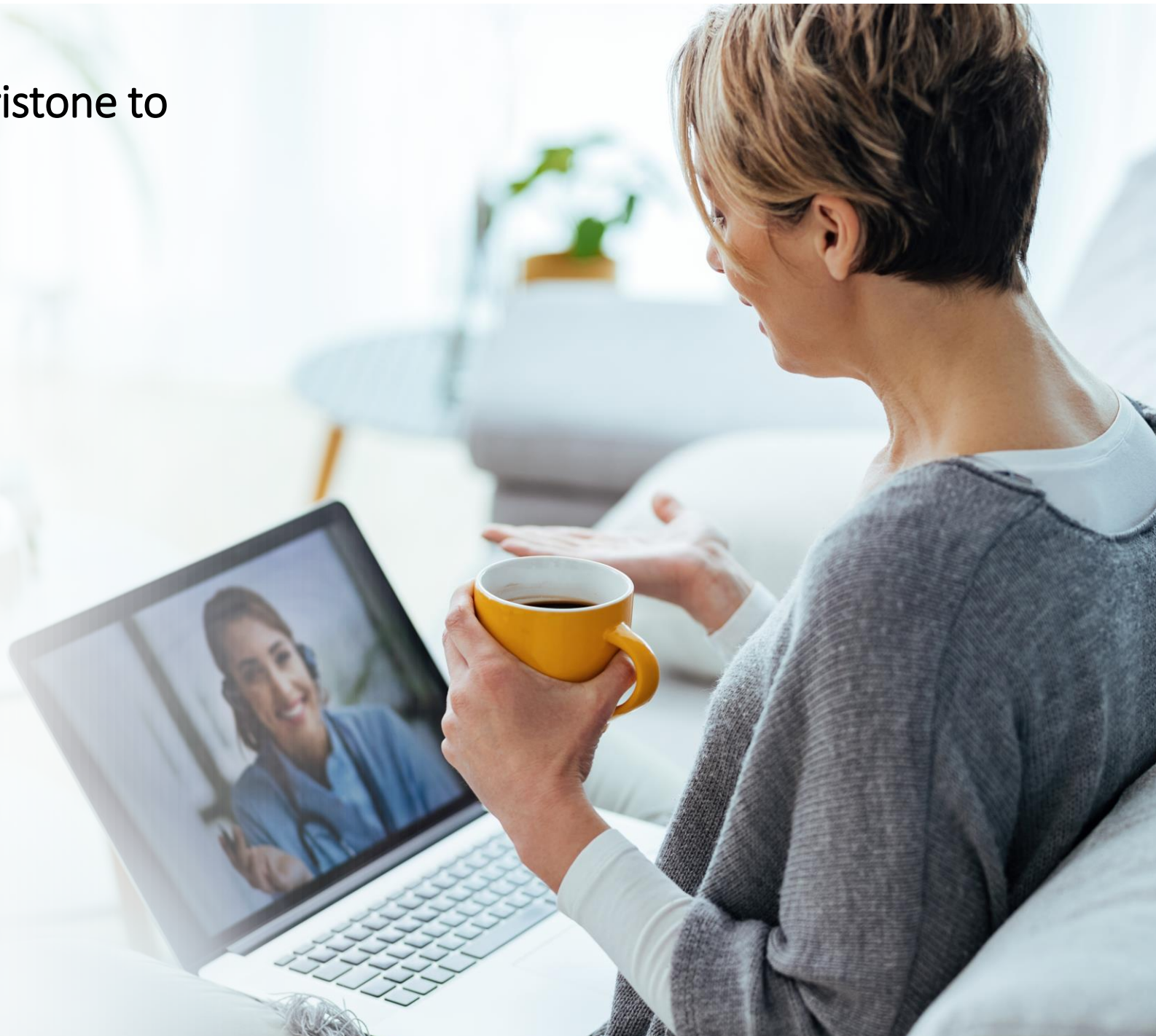


- REMS
  - “A Risk Evaluation and Mitigation Strategy (**REMS**) is a drug safety program that the U.S. Food and Drug Administration (FDA) can require for certain medications with serious safety concerns to help ensure the benefits of the medication outweigh its risks.
- ETASU
  - Elements to Assure Safe Use (**ETASU**) are required medical interventions or other actions by healthcare professionals prior to prescribing or dispensing the drug. Some actions may also be required in order for the patient to have treatment.
    - Only given in certain settings
    - Manufacturer agreement that the provider can assess pregnancy timing, diagnose ectopic pregnancies and provide surgical abortion if needed
    - Patient agreement form prior to dispensing the drug.

REMS modification allowing mifepristone to be written outside clinics/hospitals approved 1/3/2023.

- Can be written by certified prescriber and dispensed by certified pharmacy
- Can be mailed via certified prescribers or pharmacies

Note: FDA does not “recommend” buying mifepristone online outside of the REMS program



Movement to Remove Mifepristone from REMS

ACOG
The American College of Obstetricians and Gynecologists

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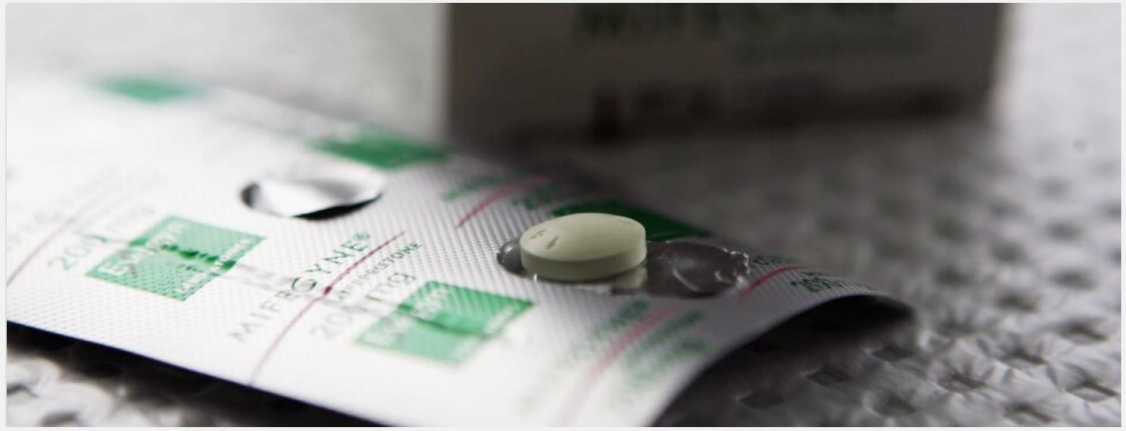


Some of the Biden's administration's policies may be getting in the way of its goal of expanding access to the abortion pill mifepristone.
Photo by Phil Walter/Getty Images

FDA's Own Rules Hamper Access to Abortion Pill Biden Touts (1)

June 30, 2022, 3:29 PM Listen

- White House gives few details on smoothing path to pills
- FDA rules stand in way of dispensing by retail pharmacies

Shira Stein
Reporter

The Biden administration says it's taking steps to increase access to medication

Celine

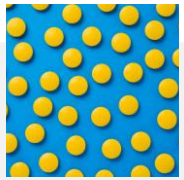
Telemedicine abortions—pitfalls

- No accurate dating of the pregnancy
- No confirmation of intrauterine pregnancy
- No confirmation of any pregnancy—just reported LMP
- No verification of blood type to rule out Rh issues
- No chance for the pregnant woman to speak confidentially with a health care provider
  - No chance to ascertain abuse
  - No chance to intervene if sex trafficking
- No way to verify that the woman for whom the pills were prescribed is the one taking them

Medications used in Medical Abortion

Mifepristone (RU-486) A derivative of norethindrone which binds to the progesterone receptors of the uterus with high affinity and keeps progesterone from them.

Causes necrosis of the placenta, softening of cervix, and uterine contractions



Misoprostol (Cytotec) A prostaglandin analogue initially for preventing gastric ulcers, approved by FDA for medical abortion.

Causes softening of cervix and uterine contractions

Methotrexate (rarely used in US) blocks an enzyme in DNA synthesis and cell division (used in cancer treatment, rheumatoid arthritis and psoriasis when other treatments fail)

Stops process of implantation

Medical Abortion Eligibility Criteria

- ✓Up to 70 days gestational age
- ✓Most studies of safety excluded women with anemia
- ✓No ectopic pregnancy suspected
- ✓No IUD in place
- ✓No current long term steroid therapy
- ✓No chronic adrenal failure
- ✓No anticoagulants or blood clotting disorder
- ✓No allergy or intolerance to mifepristone
- ✓Is able to follow instructions and follow-up contact

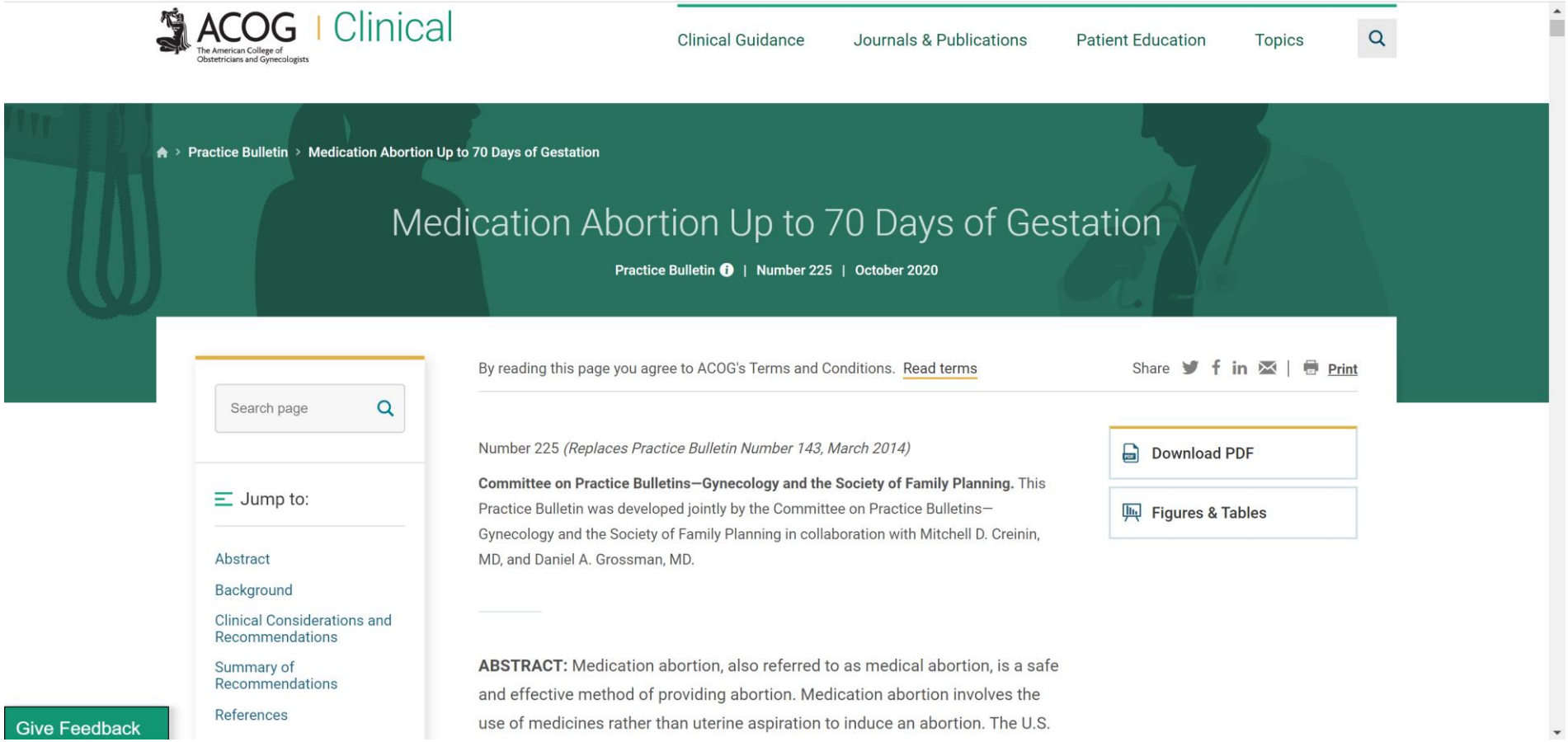
Studies that ***have been*** historically recommended prior to medical abortion

Confirmation of pregnancy

Assessment of hemoglobin or hematocrit if anemia suspected

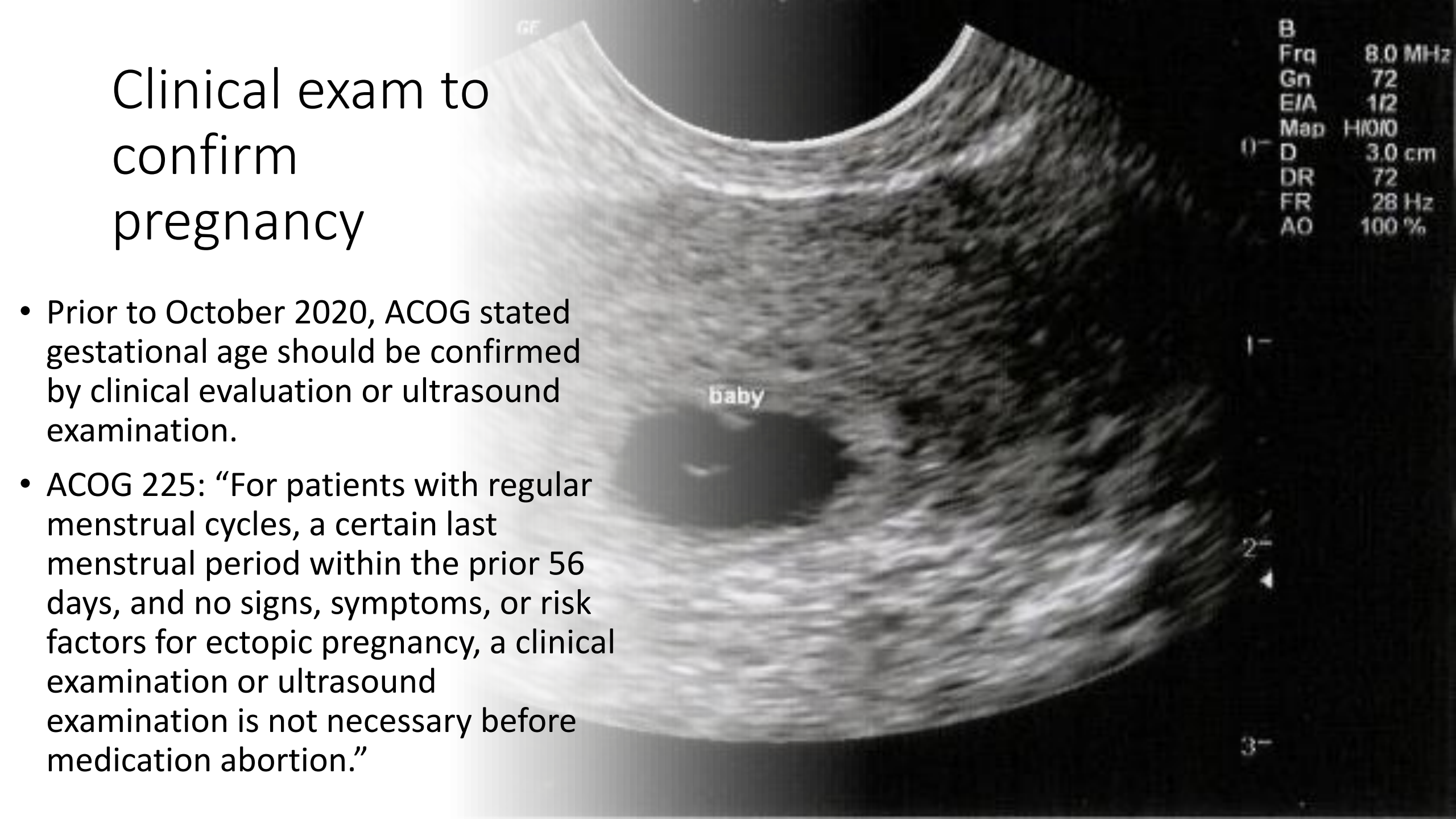
Rh testing to rule out need for RhoGAM

Then enters ACOG Bulletin 225 (replacing 143)



Clinical exam to confirm pregnancy

- Prior to October 2020, ACOG stated gestational age should be confirmed by clinical evaluation or ultrasound examination.
- ACOG 225: “For patients with regular menstrual cycles, a certain last menstrual period within the prior 56 days, and no signs, symptoms, or risk factors for ectopic pregnancy, a clinical examination or ultrasound examination is not necessary before medication abortion.”



Share

What is an ectopic pregnancy and how do you know you have one?

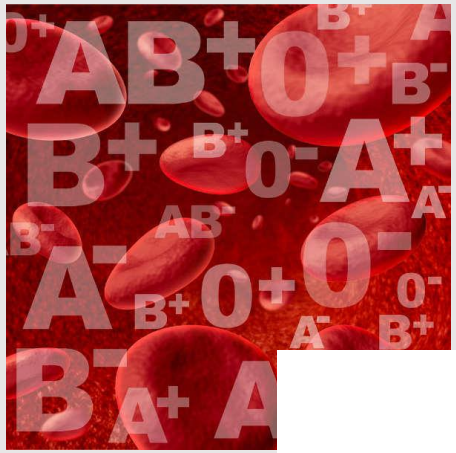
An ectopic pregnancy is a pregnancy that grows outside the womb, usually in a fallopian tube. It can be a life-threatening situation if left untreated because if the pregnancy grows too large it can cause the tube to burst. This must always be treated with an operation or medicines. A medical abortion does not affect a pregnancy outside the womb!

You can make sure that your pregnancy is inside the womb by having an ultrasound. If you use Mifepristone and Misoprostol to end a pregnancy and you do not do an ultrasound first, there is always a chance that you could have an undetected ectopic pregnancy. If you do not pass tissue and blood after taking the Misoprostol, you might have an ectopic pregnancy. If you have sudden severe pain in your belly or back (mostly on one side), if you feel you might faint or if you do faint, or if you feel pain in the shoulder area, you might have an ectopic pregnancy that has burst and you should go to a hospital immediately. Ectopic pregnancies are treated everywhere, even in places where abortion is severely restricted.

ACOG Bulletin 225 on Rh Testing in Medical Abortion

- Rh testing is recommended in patients with unknown Rh status before medication abortion, and Rh D immunoglobulin should be administered if indicated. In situations where Rh testing and Rh D immunoglobulin administration are not available or would significantly delay medication abortion, shared decision making is recommended so that patients can make an informed choice about their care.

ACOG Practice Bulletin 181 on Rh D Alloimmunization (Aug 2017)



Rh D immune globulin should be given to Rh D-negative women who have pregnancy termination, either medical or surgical. Most consensus guidelines have recommended 50 micrograms or 120 micrograms of anti-D immune globulin up to 12 weeks of gestation ([25, 30, 31, 62]), and a dose of 300 micrograms after 12 weeks of gestation ([31]).

From ACOG Bulletin 200 (November 2018)

Protocol for the Medical Management of Early Pregnancy Loss

- Misoprostol 800 micrograms vaginally, with one repeat dose as needed, no earlier than 3 hours after the first dose and typically within 7 days if there is no response to the first dose*
- A dose of mifepristone (200 mg orally) 24 hours before misoprostol administration should be considered when mifepristone is available.†
- Prescriptions for pain medications should be provided to the patient.
- Women who are Rh(D) negative and unsensitized should receive Rh(D)-immune globulin within 72 hours of the first misoprostol administration.

More from Bulletin 200

How should patients be counseled regarding prevention of alloimmunization after early pregnancy loss?

Although the risk of alloimmunization is low, the consequences can be significant, and administration of Rh D immune globulin should be considered in cases of early pregnancy loss, especially those that are later in the first trimester. If given, a dose of at least 50 micrograms should be administered. Because of the higher risk of alloimmunization, Rh D-negative women who have surgical management of early pregnancy loss should receive Rh D immune globulin prophylaxis [55].

Timing of Medical Abortion Protocol

FDA Protocol (2016)

1. Mifepristone 200mg as single dose
2. Misoprostol 800 mcg buccally (placed in cheek to dissolve) as a single dose 24-48 hours later.
3. Follow-up with health care provider 7-14 days after mifepristone administration (still on the FDA website as of 8/6/2023)

https://www.fda.gov/Drugs/DrugSafety/ucm111323.htm

Risks of Medical Abortion

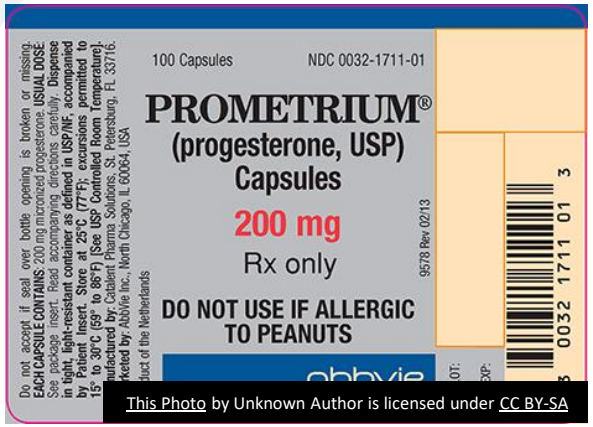
Gastrointestinal effects—nausea/vomiting/diarrhea
Headache/dizziness
Thermoregulatory effects (fever/chills/sweats)
Heavy bleeding (defined as soaking two maxi pads per hour for two consecutive hours)
Need for emergency D&C (less than 1%)
Need for surgical evacuation for non-complete abortion (<5% for patients up to 63 days)
Continuing pregnancy (<1% for procedures up to 63 days)
Infection (0.9%)

Pitfalls in Looking at Abortion Complications

- Only deaths are required to be reported after the 2016 REMS change
- Where are abortion complications seen?
  - Majority are NOT seen by the abortion clinic, but rather in ER or OB-GYN
  - Patients can be told not to mention the abortion
- Best data is from countries with uniform medical records
  - A study from Finland showed that adverse effects occurred 4x more in medical vs surgical (20% vs 5.6%)
  - Another Finnish study showed 7.9% of women required surgical evacuation in first trimester medical abortions
- With no ultrasound, underestimation of gestational age will lead to higher rate of medical abortion failures
  - 7.9% in first trimester up to 84 days vs 38.5% in second trimester

What can we do if a mom changes her mind?

- Abortion Pill Reversal (APR)
  - Women who have taken only the mifepristone are eligible to attempt to reverse its effects on the uterus and placenta by taking large doses of progesterone
  - Now over 3500 lives saved
  - Network of over 1000 health care providers (physicians, NPs and PAs) nationally in private practices and clinics, two hospital systems, and 200 consulting centers



How does abortion pill reversal work?

- **Mifepristone** (the first pill in the abortion pill protocol) binds to the progesterone receptors in the uterus where the placenta develops.
  - Because the progesterone can't get to the placenta and uterus receptors, the placenta breaks down as well as causing softening of the cervix and contractions
- If the woman has not yet taken the second medication (misoprostol), we can give large doses of **progesterone** to attempt to outcompete the mifepristone and get more progesterone to the placenta and the baby
  - Shown to be effective in a rat study in 1989

Abortion Pill Reversal Effectiveness Data

- Latest review of cases from the hotline was published in 2018
- https://issuesinlawandmedicine.com/wp-content/uploads/2018/04/Effects-of-Mifepristone-Article-6.pdf
- Study numbers:
  - 754 patients initiated progesterone
  - 207 excluded from analysis
    - 38 took progesterone >72 hours after mifepristone or ingested misoprostol pre-progesterone (5%)
    - 112 lost contact <20 weeks gestation (15%)
    - 57 chose to complete abortion (8%)
  - 547 left for analysis

- 547 patients took progesterone and met criteria and adequate follow-up
  - 257 births (47%)
  - 4 lost to followup after 20 weeks but were viable at that point (0.7%)
  - Overall rate of reversal of mifepristone was 48%
  - Two subgroups had the highest reversal rates
    - Group using progesterone IM initially or exclusively 64% successful
    - Group using high-dose oral medication and continuing to end of first trimester 68% successful

What do we compare these numbers to? Is this really "prolife theatrics"?

There are claims that the progesterone makes no difference, that if the woman just didn't take the misoprostol that she would have similar success.

There are studies where mifepristone was taken alone without misoprostol, highest survival rate was 23% using the single 200mg dose now in the FDA protocol. Study physicians selected a 25% survival rate to see if there was statistical difference in survival when progesterone was added.

The difference is real!

- 64-68% is statistically different than 25%

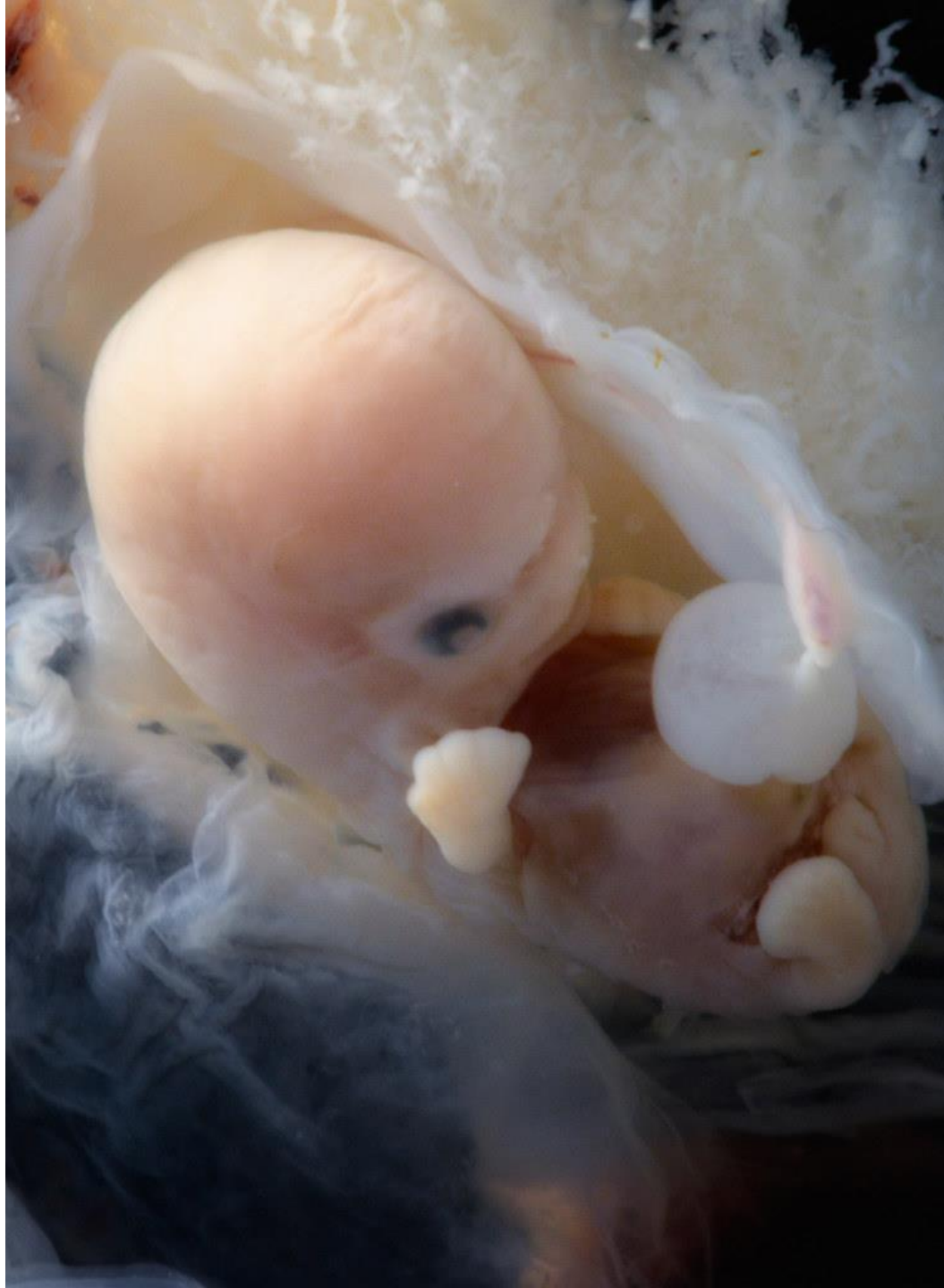
“If you don’t complete the abortion, you’re going to have a damaged baby…”

Mifepristone effects on embryo

- The American College of Obstetrics and Gynecology (ACOG) in their bulletin on medical abortion states that “no evidence exists to date for a teratogenic effect of mifepristone.”

- However, misoprostol can cause birth defects--limb abnormalities with/without Mobius syndrome (nerve palsies in cranial nerves and other abnormalities).

- Methotrexate can cause growth restriction, limb defects, and craniofacial abnormalities.



Looking at Progesterone

- Progesterone is a naturally occurring hormone produced by the corpus luteum and the placenta.
- Progesterone has been used safely in pregnancy for over 50 years.
- The American Society of Reproductive Medicine states no long-term risks when progesterone is used in pregnancy.
- FDA rates progesterone a category B medicine for pregnancy safety (same as Tylenol) as compared to synthetic progestins.

Outcome of babies in the study

- Rate of birth defects for women who had taken ONLY mifepristone and then progesterone in follow-up after delivery was 7/257 (2.7%) which compares favorably to the 3% rate in general population.

How do you find help if a client/patient contacts your center seeking a reversal?

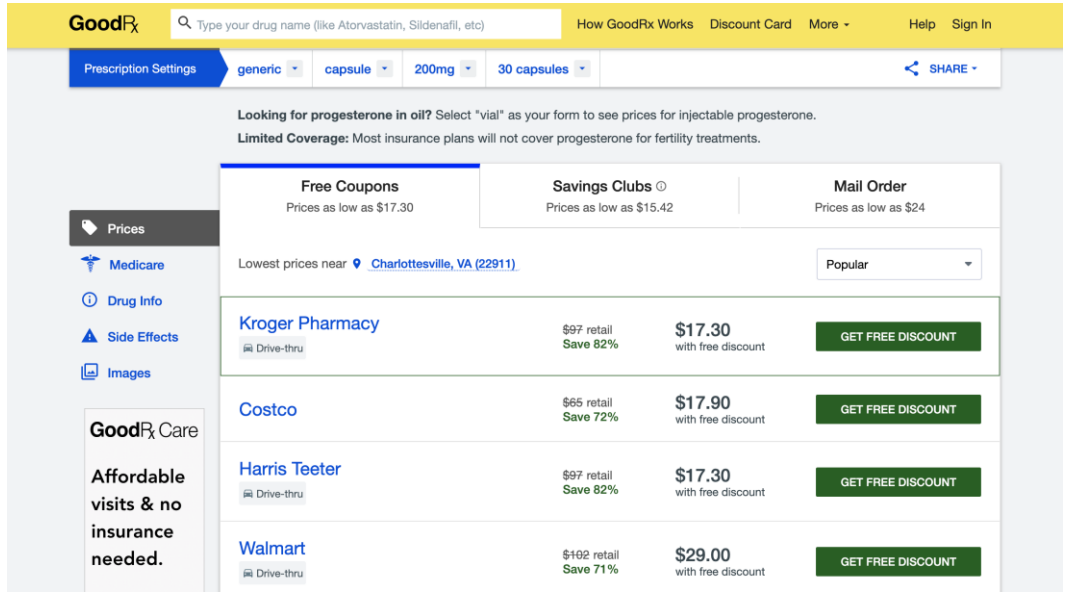
- Abortion Pill Reversal hotline
  - Abortionpillreversal.com
- Hotline is staffed 24/7 by nurses who will get the patient in touch with one of the health care professionals who volunteer to provide services through the hotline. The nurse collects information on when the meds were taken, any allergies, blood type and other information needed for the provider.
- The nurse calls to find the nearest provider who will accept the patient
- The provider calls the patient directly to initiate treatment

What Happens Next?

- Ideally, the doctor will see the patient as soon as possible to examine her, get an ultrasound that at least suggests viability and rules out ectopic pregnancy, does blood work for pregnancy hormone levels and starts progesterone treatment.

- The oral regimen is easiest to start quickly, and cost is reasonable. Sometimes the doctor will start the medication before seeing the patient if there is a delay, but we always need to see the patient for evaluation and treatment.

- Cost of progesterone is 17.00-41.00 using goodrx.com for the first 12 days of treatment.



What about the study in 2019?

TREATMENTS

Safety Problems Lead To Early End For Study Of 'Abortion Pill Reversal'

December 5, 2019 · 5:02 PM ET

MARA GORDON

The study

- Principal author is a consultant for Danco Laboratories providing medical consultation on mifepristone
- Another author is an employee of Planned Parenthood
- Study was funded by Society for Family Planning Research Fund

Study methodology

- 40 patients were planned, only 12 enrolled before study stopped
  - All patients received mifepristone
  - 6 received progesterone, 6 received placebo
    - Two patients (one in each group) withdrew from study for side effects (nausea/vomiting/bleeding)
  - 5 patients left in each group
    - 4 (80%) of the patients receiving progesterone still had cardiac activity for two weeks
    - 2 (40%) of the patients receiving placebo still had cardiac activity for two weeks
  - 3 of the 10 patients left (two in placebo and one in progesterone group) went to ER for severe bleeding
    - Progesterone patient was found to have completed abortion
    - Placebo patients required aspiration to complete abortion; one needed blood transfusion
  - Study was stopped for safety concerns about the bleeding episodes

What can we take from this?

- Number in study was small as a caveat
  - Progesterone did improve the survival rate as determined by cardiac activity at two weeks (80% vs 40% in progesterone vs placebo groups)
  - The patient who received progesterone who went to the ER was found to have completed the abortion and needed no further treatment
  - The patients who received placebo who went to the ER had hemorrhages requiring treatment
  - Does this point against the safety of progesterone?

What was the study that should have been done?

From Guttmacher Institute website accessed 8/6/2023

Highlights

- 46 states and the District of Columbia require hospitals, facilities and physicians providing abortions to submit regular and confidential reports to the state.
- 8 states require providers to indicate the method of payment, such as insurance or self-pay, for the procedure.
- 28 states require providers to report postabortion complications.

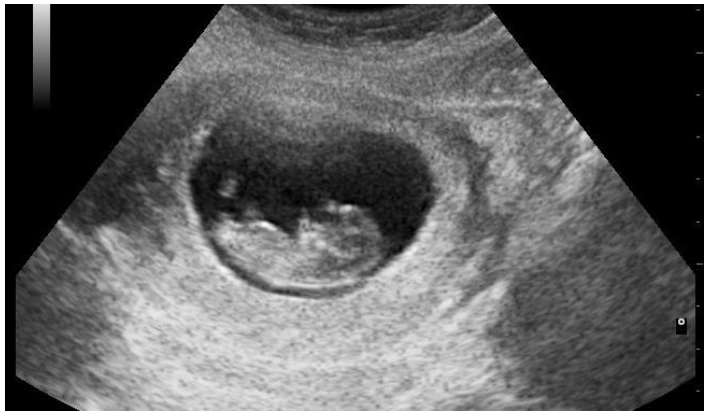
- Comparing the safety of the usual abortion pill protocol (mifepristone/misoprostol) with the reversal (mifepristone/progesterone)
  - ACOG medical bulletin states that the rate of emergency surgery (curettage) required after medical abortion is <1%
  - Surgical abortion for incomplete abortion occurs in <5%
- Are these reported correctly?

Methotrexate Abortions: Are they reversible?

- Methotrexate is teratogenic—can cause craniofacial, skeletal and cardiac malformations
- Per APR, used in DC, Canada and parts of Florida
- Anecdotal reports
  - A doctor who has attempted reports he's aware of only 6 attempts being successful
  - Two of the six have one toe missing on each foot as only noted birth defect
- Careful counseling and documentation is needed due to risk of birth defects
- Medications
  - Leukovorin (used in chemotherapy for "rescue" after using methotrexate for cancer treatment)
  - Folic acid high dose used after leukovorin
  - Progesterone can be used with leukovorin

Impact on patients and hotline/APRN providers of Increased televisits for procuring abortion

- Patients
  - No verification of IUP
  - No verification of gestational age
  - No Rh testing or treatment
  - Unable to verify consent, trafficking, assault, minors
- APRN providers/hotline/pregnancy centers
  - No verification of IUP or dating before beginning reversal if you can't get ultrasound first
  - Women contacting you to ask if their abortion was complete and wanting ultrasound



Emotional Weight of APR for Patients, Clinicians, and Pregnancy Centers

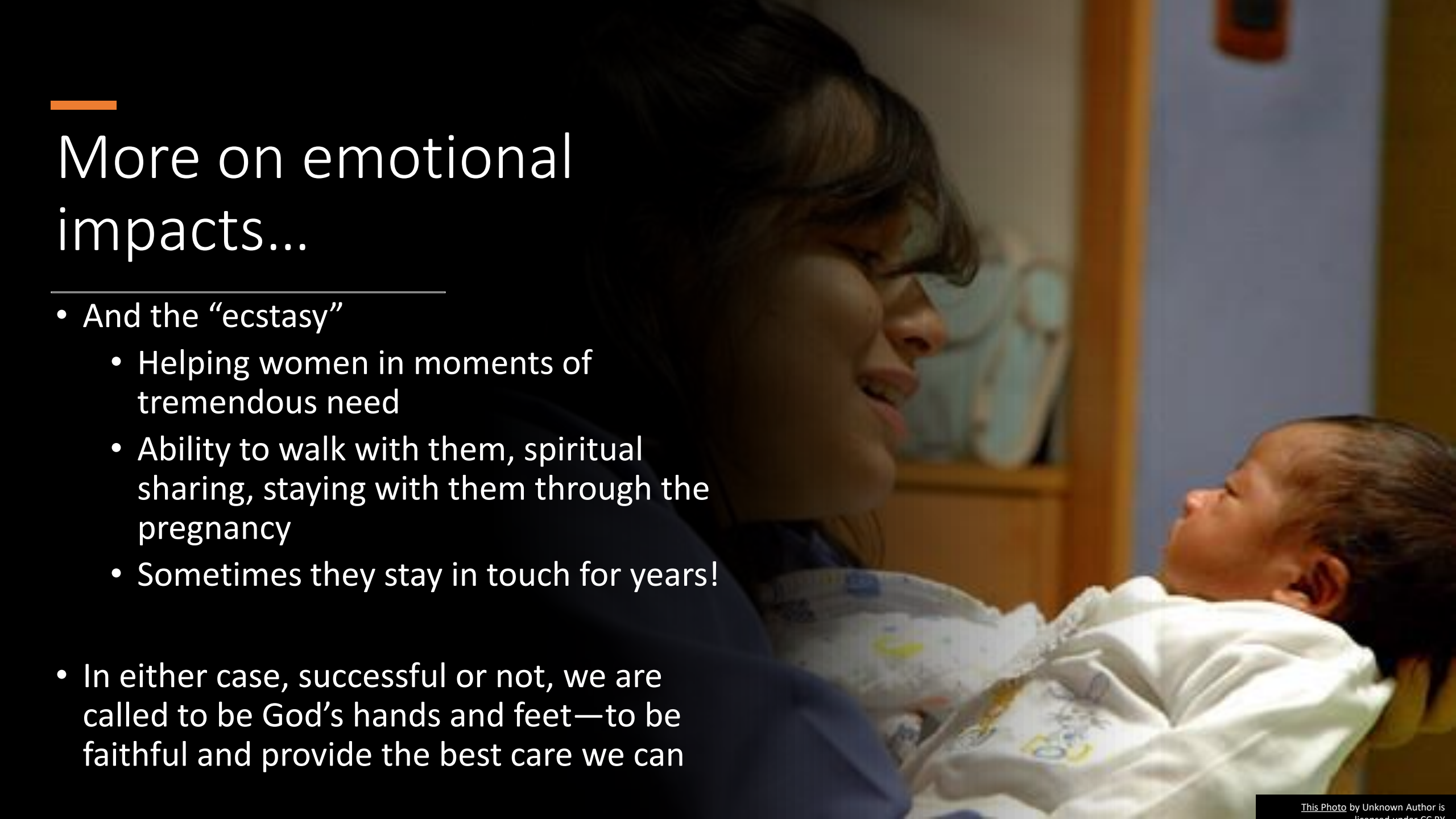
- The “agony”
  - Women calling hotline and then dropping contact either before starting or in process of the reversal
  - ”Failures”—about 1/3 are not successful.
    - Can fail abruptly after a reassuring ultrasound
    - Can fail at later gestational ages when it would seem to be more chance for success
  - A few stories…

- How to support patients and staff
  - For the patients—refer to pregnancy loss resources (Bible studies, etc)
  - For the staff—prayer hotlines, debriefings afterwards, strong prayer life

More on emotional impacts…

- And the “ecstasy”
  - Helping women in moments of tremendous need
  - Ability to walk with them, spiritual sharing, staying with them through the pregnancy
  - Sometimes they stay in touch for years!

- In either case, successful or not, we are called to be God’s hands and feet—to be faithful and provide the best care we can



So how can YOU help?

Suggest to your medical directors and other physicians, nurse practitioners and physician assistants in your area to volunteer for the hotline.

Make sure your staff and volunteers know about the hotline and give the patient/client the information she needs to access it.

Your sonographers may want to volunteer to help the APR provider if he/she cannot access a scan before beginning treatment or early in the treatment course.

Questions?