"No Touch" Telemedicine Abortions

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WCH WOMEN'S COLLEGE HOSPITAL Healthcare | REVOLUTIONIZED

Disclosures

- Medical Advisory Board, Bayer and Merck/Organon
- PI on clinical trial of Mifegymiso
- No financial or in-kind support was received from a commercial organization to develop this presentation

Off-label uses

- Expanded use of HC approved regimen based on evidence and expert opinion

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Acknowledgements

- Dr Julie Thorne (WCH) and Dr Erin Frotten (Choice in Health Clinic) for their collaboration and contributions
- Niru Bhanderi, NP (BCBC) for data support

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Objectives

- Review briefly the evidence and expert-supported approach to reducing contact during medication abortion visits
- Review outcomes of a telemedicine medication abortion program
- Explore the resources to support you in your practice for no-touch medication abortion

Terminology

- Telemedicine/Virtual

  VS
- No Touch

  VS
- Low Touch

Delivery of services vs testing required

No Touch Abortions in a Global Context

- Women on Web
  - Since 2006, providing MA by mail to patients in countries with no safe access
  - Advised to get ultrasound, but much of the time this does not occur
  - Outcomes comparable to standard protocols
- Raymond et al, 2018
  - 407 patients in Moldova, Mexico and USA in 2015-2016
  - 95% had successful abortion with no further treatment required
  - 90% were pleased with omitting the pretreatment u/s and pelvic exam
  - Conclusion: no adverse events that were likely to have been prevented by omitted testing

COVID-19 pandemic

- Abortion is essential care
- Hospitals have reduced capacity
- Cities in lockdown, people advised to stay home
- People afraid to leave their homes, unsure if they can access a clinic
- New home stressors affect ability to leave home for medical care

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Beginning with the pandemic…

Contraception 101 (2020) 361–366

Contents lists available at ScienceDirect

Contraception

journal homepage: www.elsevier.com/locate/con

Commentary: No-test medication abortion: A sample protocol for increasing access during a pandemic and beyond ☆,☆☆

Elizabeth G. Raymond [a,*], Daniel Grossman [b], Alice Mark [c], Ushma D. Upadhyay [b], Gillian Dean [d], Mitchell D. Creinin [e], Leah Coplon [f], Jamila Perritt [g], Jessica M. Atrio [h], DeShawn Taylor [i], Marji Gold [j]

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Expert-Supported Telemedicine Abortions

National Abortion Federation (NAF)

NAF Sample Guideline: Providing medication abortion with no pre-treatment testing

1. **Purpose**
   To enable provision of medication abortion without a pre-treatment ultrasound, lab testing, or exam, where medically appropriate.

*circulated April 9, 2020

Society of Obstetricians & Gynecologists of Canada (SOGC)

CANADIAN PROTOCOL FOR THE PROVISION OF MEDICAL ABORTION VIA TELEMEDICINE

Guilbert E, Costescu D, Wagner M-S, Renner R, Norman WV, Dunn S, Fitzsimmons B, Trouton K, Bernardin J, Black A, Thorne JG, Gomes MA

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.

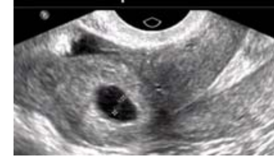
A typical medication abortion in Ontario would involve up to 6 in-person interactions with a health care provider, clinic, or lab:

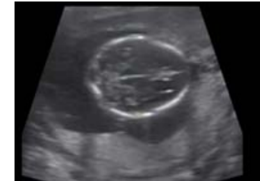
1. Ultrasound → gestational age & location of the pregnancy
2. Clinical Assessment → history and physical exam
3. Bloodwork → r/o severe anemia (Hb below 95 mmol/L) & Rh status
4. Anti-D prophylaxis → depending on RH status
5. Urine tests / swabs → common sexually transmitted infections
6. Ultrasounds / bloodwork → confirm abortion completion

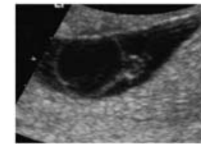
Updated guidelines confirm that in properly selected, properly consented individuals, all these interactions can be avoided.

Risks of foregoing pre-procedure ultrasound

1. Ectopic Pregnancy
   - Evolving ectopic pregnancy presentation can be complicated / masked by MA experience
   - MA does NOT treat ectopic, which can develop into a life-threatening emergency if not treated
2. Inaccurate pregnancy dating
   - Inaccurate dating may affect the success, side effects, and complication rate of the MA, which can be both emotionally and physically difficult for an individuals
3. Early pregnancy loss
   - May lose opportunity for other options for management (including expectant management)







1. Ultrasound → gestational age of the pregnancy
   - Of those 'certain' that LMP below 64 days, only 0.6% were greater than 77 days (current upper limit for safety with mife/miso)
   - Of those 'certain' that LMP below 77 days, only 1% were greater than 77 days
2. Ultrasound → intrauterine vs extrauterine (ectopic) pregnancy
   - Absolute risk for ectopic is low (<1%), and higher risk individuals can be excluded based on risk factors / symptoms. Half of all people with ectopic have no risk factors.
3. Bloodwork → severe anemia (Hb below 95 mmol/L)
   - Hb not routinely needed before first trimester abortion, testing can be performed as indicated by medical history and symptoms

4. Bloodwork → RH status
   - RH testing and anti-D immunoglobulin not needed in individuals undergoing MA under 70days LMP, not at risk for isoimmunization

5. Urine tests / swabs → common sexually transmitted infections
   - Little data exists regarding post-MA endometritis, the risk would approximate that for spontaneous abortions (and these people are not required to routinely test for STIs!)

6. Ultrasounds / bloodwork → confirm abortion completion
   - 7 day clinical follow-up (questions regarding amount/timing of bleeding, resolution of pregnancy symptoms etc.) has been validated → if both clinician and client think the pregnancy has been aborted, 99% of the time it has
   - 4 week high-sensitivity urine pregnancy test for absolute confirmation (5-25% false positive rate)

Take Aways

- If women are aware of their LMP, have regular cycles and are not on CHC, most of them time their GA estimate is accurate
- Risk of ectopic pregnancy is low and high risk patients can often be identified through history
- Clinical history of anemia is enough, do CBC if history concerning
- Recent guidelines recommend Rh testing/RhIG only if GA >12 weeks
- STI testing not necessary, empirical tx can be ordered if concerning hx
- 7 day phone followup combined with 4 wk urine HCG is reliable

Process at BCBC

- Patient calls clinic to book, verifies interest in no touch protocol
- Intake Questionnaire sent to patient through EMR
- RN reviews questionnaire responses and follows up with patient if necessary re: any clarification required, also sending link to webpage with consent and written instructions
- MD conducts video or phone visit for counselling and prescription/instructions
- Rx faxed to pharmacy of choice
- Phone f/u appointment booked

Process at BCBC

1-week follow-up visit

- Assess response, ongoing symptoms
- Evaluate if abortion was successful
- Determine need for further investigation
- Book 4-week follow-up
  - Home pregnancy test prior to visit

4-week follow-up visit

- Home pregnancy test (HPT)
- If negative – abortion is complete
- If positive and well – repeat HPT in one week
- If positive and symptomatic – ultrasound +/- serial bHCG

Back to Basics: History is Paramount

Menstrual / Pregnancy Hx:
- Regular menstrual cycles?
- Hx of PCOS?
- Use of hormonal contraception?
- Date of conception known?
- Timing/onset of pregnancy symptoms?
- Timing of pregnancy confirmation?

Ectopic RF / Symptoms:
- Vaginal bleeding or spotting
- Undiagnosed pelvic or abdo pain
- Prior ectopic pregnancy
- Prior tubal sterilization or other tubal surgery
- Presence of IUD/IUS at any point in pregnancy
  - Hx of PID?

Anemia Hx:
- Screen for anemia
- Bleeding disorders
- History of blood transfusion
- Hemoglobinopathy

& Hx regarding general candidacy for medication abortion

Intake Questionnaire - MyHealthRecord

MY Health RECORD

Personal Info · Medications · Allergies · Questionnaires

Bay Centre for Birth Control No/Low Touch Medical Abortion Intake

For an upcoming appointment with on 17/11/2020

To help us determine your eligibility for a No Touch or Low Touch Medical Abortion, please complete the following intake form. This form must be completed prior to your first online appointment.

We are committed to understanding the clients we serve, and to understand where our gaps in equity for care may lie. As such, some questions on this intake form are targeted towards understanding the diversity in our client population, and do not specifically relate to your abortion care.

*Indicates a required field.

Medical Information

*Have you ever been pregnant before? Yes No

If Yes, please indicate how many of the following types:
Vaginal Deliveries (VD), C-section Deliveries (CD), Surgical Abortions (SA), Medical Abortions (MA), Miscarriage (M), Ectopic Pregnancies (EP)

Did you have any any health problems as a result of these pregnancies? Yes No

If Yes, please describe

Did you ever experience hemorrhaging requiring blood transfusion as a result of one of these pregnancies? Yes No

*What was the first day of your last menstrual period? DD/MM/YYYY

*How sure are you about the day of your last menstrual period?

Intake Questionnaire - MyHealthRecord

MY Health RECORD

Michelle T...
Log Out

Fra

*How sure are you about the day of your last menstrual period?

Very sure | Fairly sure | Not very sure

*Do you have regular periods that come every 21 - 35 days?

Yes | No

If No, how often are your periods and how long do they normally last?

*Were your last 3 cycles prior to your last period the same length?

+/- 3 days

Yes | No

*Was this pregnancy confirmed with a urine pregnancy test?

Yes | No

*Have you had an ultrasound in this pregnancy?

Yes | No

If Yes, when did it occur and what were the results?

*Were you using hormonal contraception in the 3 months before you conceived?

Yes | No

*Do you currently have an intrauterine device (IUD) in place?

Yes | No

*Did you have an intrauterine device (IUD) in place when you conceived this pregnancy?

Yes | No

*Have you had any vaginal bleeding or spotting since your last menstrual period?

Yes | No

Progress to date:

- 95 virtual no/low-touch medical abortions (June 2020 – Sept 2022)
- Age 14 – 48, 30 – 68 d gestation (estimated)

  - Successful (urine or serum HCG/U/S): 71
  - Clinically successful: 17
  - D&C: (rpoc/ongoing bleeding) 2
  - Lost to follow-up 5

  - **88/95 (93%) successful** (objectively or clinically)
  - 2 failures/surgical interventions required thus far
  - 5 patients +HPT at 4 weeks
  - 0 ectopic pregnancies identified

Who is using this service?

- Covid + /isolating
- Covid concerned
- Caregiver responsibilities
- Domestic concerns/safety issues
- Geographical barriers
- Privacy issues

Who have we converted to in person or low touch?

- History of ectopic pregnancy +/- symptoms
- History of severe anemia +/- symptoms/complications
- Uncertain dates +/- CHC use/breastfeeding

Often this is a discussion around each patient's situation, risk tolerance and availability of resources

Regimens by gestation

Table 1: Efficacy of mifepristone 200 mg orally and misoprostol regimens by weeks (16, 20, 21, 43)

	Overall efficacy	Ongoing pregnancy
57-63 days gestation		
○ Misoprostol 800 mcg buccal x 1 dose	93.5%	3.1%
64-70 days gestation		
○ Misoprostol 800 mcg buccal x 1 dose	92.3%	3.6%
○ Misoprostol 800 mcg buccal q 4 hours x 2 doses	99.6%	0.4%
71-77 days gestation		
○ Misoprostol 800 mcg buccal x 1 dose	86.7%	8.7%
○ Misoprostol 800 mcg buccal q 4 hours x 2 doses	97.6%	1.6%

Who is offering no touch abortions?

- Bay Centre, Women's College Hospital
- Choice in Health Clinic
- SHORE Clinic
- Cabbagetown Clinic

Billing a virtual medication abortion

- Specialists and FP-focused practice:
  - K083>> 32 units
  - $160 (approx. A920 = $161.15)
- Family physicians:
  - K082, time based ($67.75 per unit)
  - 20 mins - $67.75
  - 46 mins - $135.50
- **AFTER DEC 1, 2022**
  - A920 ($161.15) can be billed regardless of whether it is conducted in person, by phone or video

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Further resources

- *NAF Abortion & COVID-19*

- *SOGC COVID-19 guidance*

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Reference List

- National Abortion Federation 2020 Clinical Policy Guidelines for Abortion Care
  - NAF Sample Guideline: Providing medication abortion with no pre-treatment testing
- Society of Obstetricians & Gynecologists of Canada – Canadian Protocol for the Provision of Medical Abortion via Telemedicine
- Using telemedicine for termination of pregnancy with mifepristone and misoprostol in settings where there is no access to safe services. (BJOG. 2008;115 1171–5, Gomperts RJ et al
- Simplified medical abortion screening: a demonstration project. (Contraception. 2018; 97: 292-296, Raymond et al
- The accuracy of using LMP to determine GA for first trimester MTA: systematic review (Contraception 2014 (90):480-487, Schonberg et. al)
- Early medical abortion without prior US (Contraception 2015;92:212-214, Bracken & Raymond)
- Alternatives to routine US for eligibility assessment prior to early termination of pregnancy with mifepristone-misoprostol (BJOG 2011, Bracken et. Al)
- Highly sensitive flow cytometry protocol shows fetal red blood cell counts in the first-trimester maternal cirulaiton well below the threshold for RH sensitization (Contraception 2018;98(4):332, Horvath et. al)
- Simplified follow-up after early medication abortion: 12 month experience of a telephone call and self-performed low-sensitivity urine pregnancy test (Contraception 2014;89:440-445)
- Feasibility of telephone MTA follow-up after medical abortion (Contraception 2010;81:143-149, Perriera et al)