Clinical Updates in Reproductive Health

What's new in 2020?

Ipas updated the *Clinical Updates in Reproductive Health* with the latest peer-reviewed evidence in 2020. Below you will find a summary of the changes made to our recommendations based on that evidence. If you are using a 2019 version of the *Clinical Updates*, please refer to this list of 2020 revisions.

You can download a PDF of the 2020 *Clinical Updates in Reproductive Health* or use the online version at www.ipas.org/clinicalupdates.

Clinical Updates in Reproductive Health: Summary of changes in 2020

Number	Title	Revised recommendation (changes in *italics*)	Reason for change
2.1	Pain management for medical abortion before 13 weeks gestation	• Offer pain medication to all women undergoing medical abortion. • Nonsteroidal anti-inflammatory drugs (NSAIDs) are recommended either prophylactically or at the time cramping begins. • Non-pharmacologic pain management measures may be helpful. • *Narcotic analgesics have not been demonstrated to be effective in relieving pain during the medical abortion process, and are not recommended for routine use.* • Paracetamol should not be used unless an allergy or contraindication to NSAIDs exists.	A high-quality, 2019 randomized controlled trial (Colwill et al., 2019) demonstrated no difference in median maximum pain scores, duration of pain, or additional analgesia between women who received oral oxycodone, compared to placebo, for medical abortion pain.
3.6.3	Abortion before 13 weeks gestation -> Medical abortion -> Mifepristone and misoprostol: Recommended regimen	• Up to 10 weeks gestation (70 days since last menstrual period (LMP)): Mifepristone 200mg orally followed 1-2 days later by misoprostol 800mcg buccally, sublingually or vaginally. • 10-13 weeks gestation: *Following mifepristone, women typically require two doses of misoprostol for a successful abortion.* o Mifepristone 200mg orally followed 1-2 days later by either misoprostol 600mcg sublingually or 800mcg vaginally, then 400mcg sublingually or vaginally every three hours until expulsion. o Alternatively, mifepristone 200mg orally followed 1-2 days later by misoprostol 800mcg buccally, sublingually or vaginally may be used; the dose of misoprostol may be repeated to achieve abortion success.	Medical abortion success rates decline as gestational age increases. Redosing of misoprostol beyond 10 weeks improves abortion success rates, and in one study, most women required two doses of misoprostol for abortion success. Providers should be prepared to administer, dispense or prescribe at least two doses of misoprostol for medical abortion after 10 weeks.

Number	Title	Revised recommendations (changes in italics)	Reason for change
3.6.5	Abortion before 13 weeks gestation -> Medical abortion -> Home use of medications up to *11 weeks* gestation	• Women may take mifepristone in a facility or at home. • Home use of misoprostol following mifepristone or in a misoprostol-only regimen may be offered up to *11 weeks* gestation. • After *11 weeks* gestation, misoprostol should be used in a facility.	A 2019 retrospective cohort study demonstrates that safety and effectiveness rates for medical abortion from 57-63 days is nearly the same as from 64-76 days when women take mifepristone in a health facility and self-administer multiple doses of misoprostol at home (Larsson & Ronnberg, 2019).
4.7.2	Abortion at or after 13 weeks gestation -> Medical abortion -> Mifepristone and misoprostol: Recommended regimen	• Mifepristone 200mg orally followed 1-2 days later by misoprostol 400mcg buccally, sublingually or vaginally every three hours until fetal and placental expulsion. • If the woman is stable and it is convenient for her to do so, providers should allow her at least four hours after fetal expulsion to expel the placenta *before intervening.*	Clarification of language regarding waiting for the placenta to expel.
4.7.3	Abortion at or after 13 weeks gestation -> Medical abortion -> Misoprostol only: Recommended regimen	• Misoprostol 400mcg sublingually or vaginally every three hours until fetal and placental expulsion. Vaginal dosing is more effective than sublingual dosing for nulliparous women. • If the woman is stable and it is convenient for her to do so, providers should allow her at least four hours after fetal expulsion to expel the placenta *before intervening.*	Clarification of language regarding waiting for the placenta to expel.
5.5	Postabortion care -> Postabortion hemorrhage: *Prevention and* management	• *Clinicians should consider measures to prevent or prepare for increased bleeding in women who are at high risk for hemorrhage and are undergoing abortion.* • Hemorrhage caused by atony may be treated with uterine massage, uterotonic medications, re-aspiration, tamponade or surgery. • Closely monitor hemorrhaging woman for signs of shock.	Added data from four studies about prevention of hemorrhage. A randomized controlled trial published in 2019 demonstrated that when administered prior to D&E procedures performed between 18-24 weeks, 30 units of oxytocin decreased blood loss and the incidence of hemorrhage compared to placebo (Whitehouse et al., 2019).
5.6	*Postabortion care: Managing uterine perforation*	• *Any woman with suspected uterine perforation, even if asymptomatic, should be informed of the complication and her clinical status should be observed.* o *If stable, women should be told warning signs for when to seek emergency care, if needed, and have a plan for follow-up before discharge from a health center.* o *If unstable or worsening clinical status is noted, transfer to tertiary-level facility for further management.* • *Any woman with a known uterine perforation with evidence of bowel injury should be transferred to tertiary-level facility for further management.*	New section on uterine perforation, which was identified as an area where Ipas staff desired more specific guidance.

References

Colwill, A.C., Bayer, L.L., Bednarek, P., Garg, B., Jensen, J.T., & Edelman, A.B. (2019). Opioid analgesia for medical abortion: A randomized controlled trial. *Obstetrics and Gynecology, 134*(6), 1163-1170.

Larsson, A., & Ronnberg, A.M. (2019). Expanding a woman's options to include home use of misoprostol for medical abortion up until 76 days: An observational study of efficacy and safety. *Acta Obstetricia et Gynecologica Scandinavica*, *98*(6), 7 47-752.

Whitehouse, K., Tschann, M., Soon, R., Davis, J., Micks, E., Salcedo, J., … & Kaneshiro, B. (2019). Effects of prophylactic oxytocin on bleeding outcomes in women undergoing dilation and evacuation. *Obstetrics & Gynecology, 133*(3), 484-491.

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