Victorian Rural Clinical Network for Unintended Pregnancy and Abortion

Case Study Discussion Notes from meeting held on 7 April 2020

Case study:	Patient LS Age 26 yo
Obstetric history:	G2P1 NVD x1, age 5yo
Consultation Day 1:	certain in her decision for a medical abortion
• Ultrasound:	6+2/40, singleton IUP, Yolk Sac, Crown rump, Fetal Heart all +ve.
• HVS:	taken, later returned as all negative
• bhCG taken	taken, later returned as 20,000 IU/L
• Contraception plan	Mirena at follow up
• Outcome	Keen to proceed with medical abortion
Medical abortion procedure:	
Day 1	Mifepristone
Day 2 (approx. 24hours later)	Misoprostol, as pt wanted procedure over the weekend Agreed plan to return on Day 14 for follow up +/- Mirena insertion
Events at procedure:	
Day 2:	heavy bleeding within 2 hours of misoprostol. Pt felt she had "passed it all very quickly", did not see POC.
Day 5:	phone call from Clinic recovering well, ongoing PV loss, reassured.
Day 14:	follow up bHCG 5000 IU/L, reports feeling well with ongoing daily PV loss, brownish increases to red on exercise. Afebrile. Prescribed 7/7 course of antibiotics
Day 21:	reports persistent PV loss as before, tired & upset, "I want it all over" bhCG 2500 IU/L. Ultrasound scan report: anteverted uterus, 7X4X3cms, Endometrium: endometrial thickness 10mm with a small amount of echogenic material seen near the fundus measuring 14x18x12mm = 2.5 mls representing probable RPOC with low flow vascularity associated.

For discussion:	
What to do next?	At D14, post procedure course has been routine & reassuring - β hCG approx. 75% from pre-mife D1 to D14 (20,000 to 5,000 IU/L). - Clinically well - Option to repeat β hCG in 5-7 days
Does she need a D&C?	Pt sent to ED for surgical management, had an expectation of the need for surgery
List pros & cons	*Cons* In Covid19 context exposing all to increased infection risk, objective to reduce number of interactions with health care system Risk of Asherman syndrome increases with repeat curette, effect of uterine or cervical scarring & adhesions with questionable need for D&C. *Pros* Some women want to complete the procedure & gain closure. In this case prefer conservative management. However, for some women closure is a priority vs unnecessary anaesthetic & risks associated with procedure
Was there any significance in the timing of her miso?	No, 24 hours between mifepristone & misoprostol acceptable. Range is 24 to 48 hours.
What was the rationale for the use of abs at day 14	Unclear. Routine antibiotics not indicated though are commonly prescribed. No evidence of infection, condition stable, afebrile, HVS swabs negative, PV loss not offensive/non odourous. Abs not indicated for PV loss alone. Average PV loss following MA 16 – 30 days in normal course. Ultrasound not indicated at this stage.
What other strategies could be considered for alleviation of symptoms ie ?Repeat miso, ?COCP, ?Progesterone ?Insert mirena	At Day 21 emotionally drained & disturbed by ongoing PV loss Assess level & description of bleeding – amount, colour, odour At D21 would expect PV loss to be lighter – ie scant & brownish, non offensive. Pt. reports light bleeding. Option to repeat β hCG. In this case returned as 2500 IU/L, reassuring as reduction from previous reading. Medical management of bleeding, an attempt to stablise the endometrium may be helpful & acceptable to pt. • Norethisterone alone or combined with oestrogen as a contraception dose • Mirena insertion, the uterus in not completely empty, however reducing bhCG & scant bleeding is reassuring. Safe to insert Mirena.

	• Misoprostol, although clinicians reported limited effectiveness • Cyklokapron (tranexamic acid) to decrease blood flow
Should she have had an ultrasound?	Report states- *"anteverted uterus, 7X4X3cms, Endometrium: endometrial thickness 10mm with a small amount of echogenic material seen near the fundus measuring 14x18x12mm = 2.5 mls representing probable RPOC with low flow vascularity associated"* Scan report inconclusive. Chase symptoms not scan result Uterine volume <25mmx25mmx25mm is usually insignificant at ≤ Day 30
Does she need an Hb?	Option to check Hb (with β hcCG) provides objective information to guide management & reassure pt. Low Hb may indicate vascular involvement.
Discussion	• Recommendation from RANZCOG, the clinician may choose not to administer anti-D following medical abortion, particularly when an additional visit may increase exposure of women and staff. https://ranzcog.edu.au/news/covid-19-anti-d-and-abortion • Recommendation to include syphilis & HIV serology in STI screen for all pregnant people https://www.health.gov.au/resources/pregnancy-care-guidelines/part-f-routine-maternal-health-tests/syphilis