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**FAQ**

**FREQUENTLY ASKED QUESTIONS  
IN ABORTION CARE**



# Disclosures

- Phillipe Faucher:
  - Ellen Wiebe: none to declare
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A vertical bar on the left side of the slide, consisting of several colored segments: a thin black line at the top, followed by a thin blue segment, a thin yellow segment, and a thick pink segment at the bottom.

Will it hurt?

# Pain control





# **SURGICAL ABORTIONS**

# Who is doing what?


- North America (2009 NAF survey): 46% local anesthesia with oral meds, 33% IV sedation, 21% deep sedation or general anesthesia
- Europe (2013 FIAPAC informal survey): deep sedation most common, general anesthesia and deep sedation varied from 85% (UK) to 15% (Spain)

## AMERICAN SOCIETY OF ANESTHIOLOGISTS CONTINUUM OF DEPTH OF SEDATION: DEFINITION OF GENERAL ANESTHESIA AND LEVELS OF SEDATION/ANALGESIA

	Minimal sedation/ anxiolysis	Moderate sedation/ analgesia (conscious sedation)	Deep sedation/ analgesia	General Anesthesia
<b>responsiveness</b>	Normal response to verbal stimulation	Purposeful** response to verbal or tactile stimulation	Purposeful** response following repeated or painful stimulation	Unroutable even with painful stimulus
<b>Airway</b>	Unaffected	No intervention required	Intervention may be required	Intervention often required
<b>Spontaneous ventilation</b>	Unaffected	Adequate	May be inadequate	Frequently inadequate
<b>Cardiovascular function</b>	Unaffected	Usually maintained	Usually maintained	May be impaired

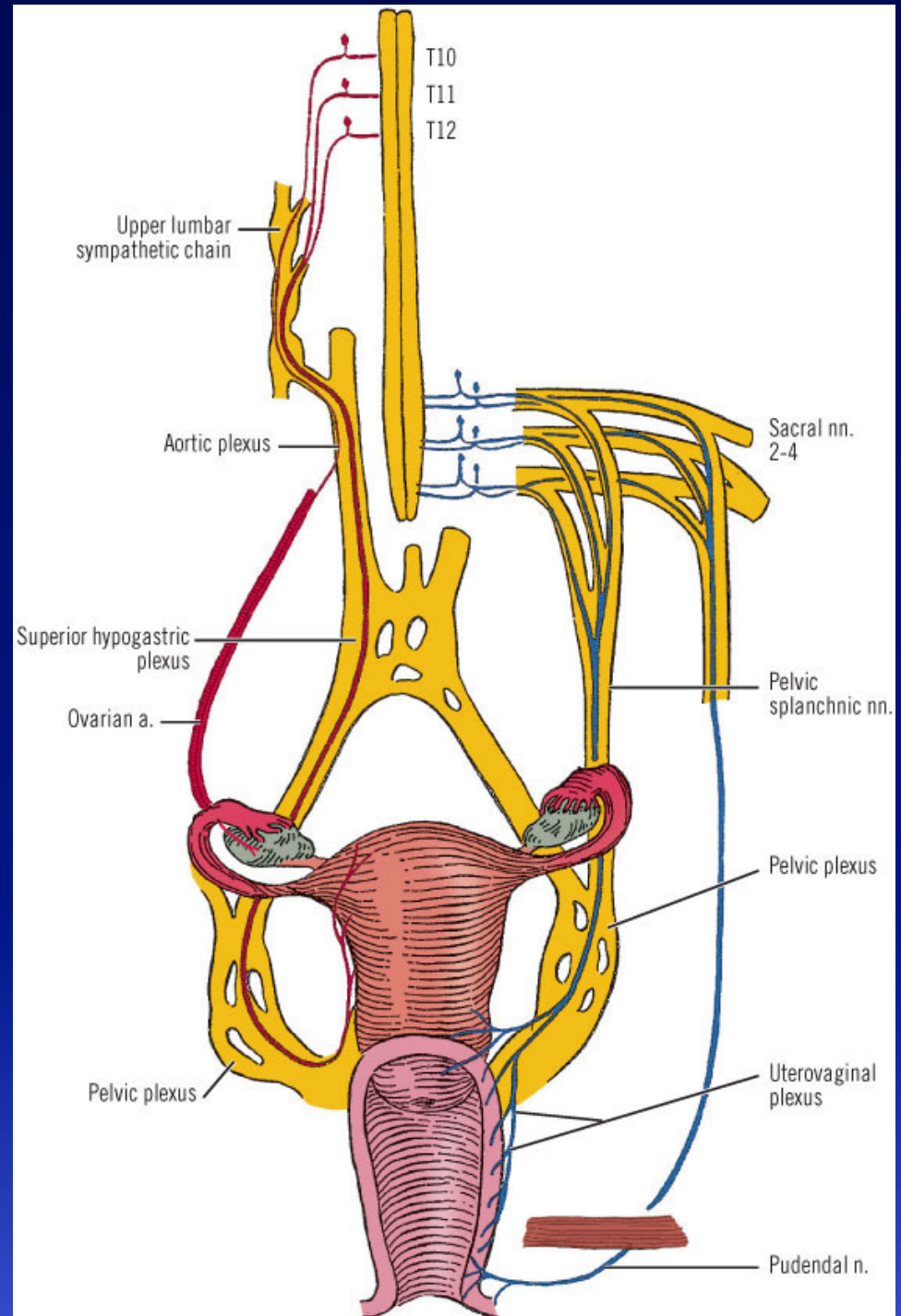


# Factors associated with increased pain

- Nulliparity
  - History of dysmenorrhea
  - Retroverted uterus
  - Pre-procedure anxiety/depression
  - Lack of provider experience
- 



# Local anesthesia



Renner RM, Jensen JT, Nichols MD, Edelman A. Pain control in first trimester surgical abortion. *Cochrane Database Syst Rev.* 2009:CD006712.

### ***Agents:***

- 20mL 1% lidocaine decreased cervical dilation and uterine aspiration pain compared to sham injection
- Buffered lidocaine was superior to plain lidocaine
- No difference between 0.5% lidocaine and 1% lidocaine
- Adding ketorolac to 1% lidocaine decreased dilation, but not aspiration pain

Renner RM, Jensen JT, Nichols MD, Edelman A. Pain control in first trimester surgical abortion. *Cochrane Database Syst Rev.* 2009:CD006712.

### ***Injection technique:***

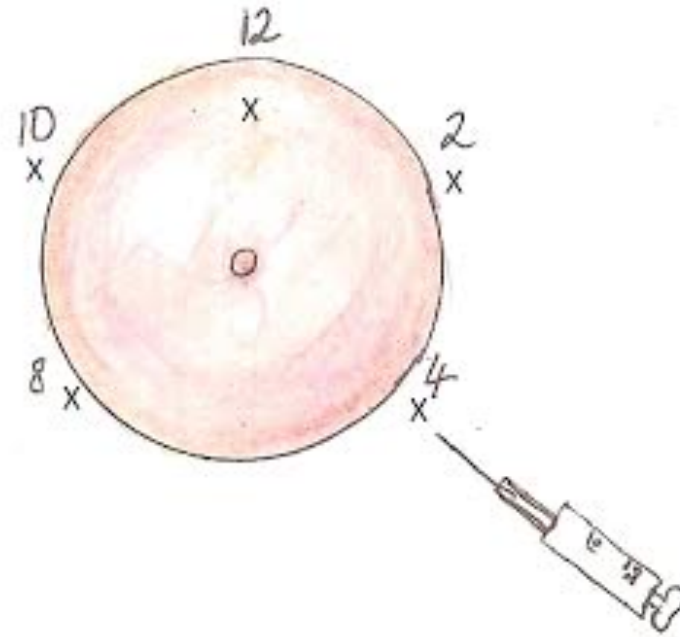
- Deep injection (3cm) decreased dilation and aspiration pain more than superficial injection.
- Two versus four-site injection and wait time between injection and cervical dilation have conflicting evidence.
- Slow injection (60 seconds) decreased pain with PCB administration compared to fast injection.

Renner RM, Jensen JT, Nichols MD, Edelman A. Pain control in first trimester surgical abortion. *Cochrane Database Syst Rev.* 2009:CD006712.

### ***Injection site:***

- Cervical versus para-cervical injection has conflicting evidence
- 4% intrauterine lidocaine decreased dilation and aspiration pain compared to intrauterine normal saline.

2 cc tenaculum site, 8 cc superficial, 10 cc deep at 4 and 8 o'clock.




# IV sedation

- North America: usually minimal or moderate sedation with IV fentanyl (50-200 mcg) and midazolam (1-3 mg)
- IV fentanyl 100mcg and midazolam 2mg decreased pain compared to oral oxycodone 10mg and sublingual lorazepam 1mg in women who all received a PCB

Allen RH, Fitzmaurice G, Lifford KL, Lasic M, Goldberg AB. Oral compared with intravenous sedation for first-trimester surgical abortion: a randomized controlled trial. *Obstet Gynecol.* 2009 Feb; **113**:276-83.




# Deep IV sedation

- Europe and Australia: usually deep sedation with IV propofol (100-200 mg) and fentanyl (50-100 mcg) with or without midazolam (2.5-5 mg)
- 



# Post-operative pain

- NSAIDS: ibuprofen, ketorolac, diclofenac have been shown to be effective IM> PO
  - Narcotics
- 



# Non-pharmacological pain management


- Anxiety increases pain but an RCT of 1 mg lorazepam had no effect
- Placebo decreases pain
- Music +/-
- “Vocal anaesthesia” works well including distraction (talking about her last vacation), guided imagery (“imagine yourself at the beach on a sunny day”), deep slow breathing, progressive relaxation, music, low lighting, and humour.




# MEDICAL ABORTIONS




# MEDICAL ABORTIONS

- About 30% in the UK, 20% in the US, 70% in Portugal, 15% in Spain, 55% France
  - Mean worst pain about 6/10
  - >90% women use analgesics
- 




Jackson E, Kapp N. Pain control in first-trimester and second-trimester medical termination of pregnancy: a systematic review. *Contraception*. 2011 Feb;83:116-26.

- Prophylactic analgesics do not work
  - Counseling about using drugs and other methods are helpful
  - Expect increased pain with increased gestation
  - Use NSAIDs and narcotics
  - For 2<sup>nd</sup> trimester, patient-controlled analgesia and epidurals may be used
- 




# Communicating with patients

- Using the right words (pressure, cramping)
  - Comforting environment
  - Teaching pain management skills
  - Reminding her of her own coping skills
- 

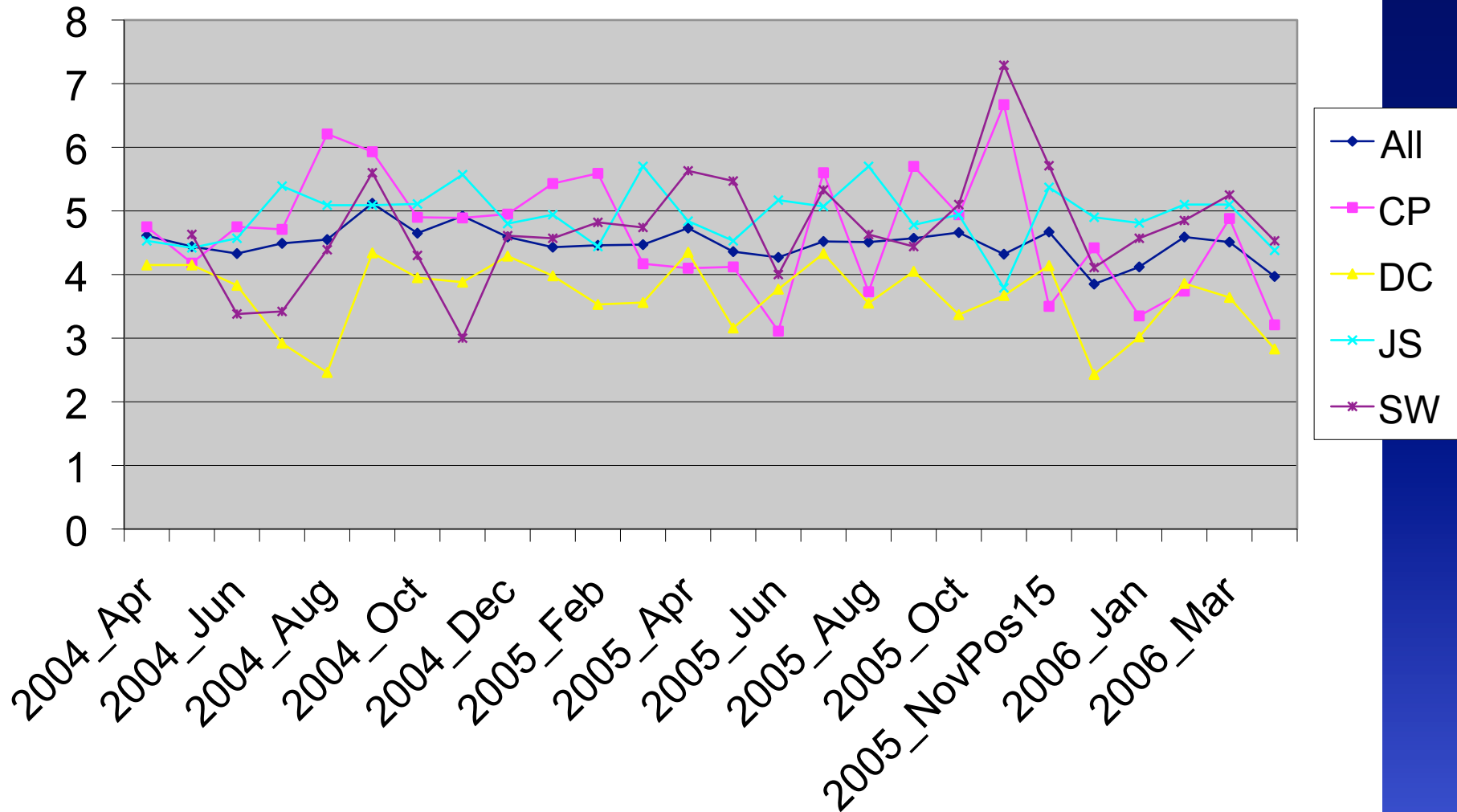


# Communicating with providers

- Measure surgical pain levels
  - Give feedback
  - Discuss techniques/observe one another
- 

**Pain Ratings Apr 2004 to Apr 2006**  
**May 2005 lidocaine changed from 1% to 0.5%,**  
**Nov 2005 ibuprofen added**


Average Pain Rating (0 to 10)





# Pain

Pain is a complex and individual experience including:

- physical (sensory)
  - psychological (affective, motivational, interpretive)
  - social (context, support) features
  - the constant interplay of the above
- 





# REPRODUCTIVE SEQUELAE

# Misconceptions about risks


A woman having an abortion in the first 3 months of pregnancy is MORE likely to have difficulty getting pregnant in the future.

Yes No

Canada n=233	US n=223	UK n=230	France n=221	Australia n=221
35.7%	35.3%	34.4%	32.3%	34.9%



# What evidence do we have?

- Secondary infertility
  - Miscarriage
  - Ectopic pregnancy
  - Pre-term labor/ low birth weight
  - Abnormal placentation
- 

Frank P, et al

The effect of induced abortion on subsequent fertility

Br. J. Obstet. Gynecol. 1993

- Women who had undergone one induced abortion before recruitment into the retrospective study experienced essentially the same fertility as those in the nonabortion group (FRR - 1.02).
- Further, women who had had at least two induced abortions experienced essentially the same fertility as those who had had at least two natural pregnancy outcomes (FRR = 0.93).
- These results indicated that induced abortion does not significantly affect subsequent fertility.

Zhou et al

Risk of spontaneous abortion following induced abortion is only increased with short interpregnancy interval.

J Obstet Gynecol 2000

- Cohort study of 15 727 women in the abortion cohort, 46 026 women in the reference cohort.
- 11.0% vs 9.4% miscarried
- the study did not show an increased risk of spontaneous abortion following one or more induced abortions

Skjeldestad et al,  
Multiple induced abortions as risk factor for ectopic pregnancy  
Acta Obstetricia et Gynecologica Scandinavica 1997

- Prospective cohort study.
- 3754 women, 164,167 women-months, 24 ectopic pregnancies
- No excess risk of ectopic pregnancy was associated with multiple previous induced abortions compared with one previous induced abortion.

Raatikainin et al

Induced Abortion: Not an Independent Risk Factor for Pregnancy Outcome, But a Challenge for Health Counseling

Ann Epidem 2006

- Preterm birth (OR, 1.19; 95% confidence interval, 1.01–1.41) in women with one prior abortion (7.3% versus 6.2%) and LBW (OR, 1.54; 95% confidence interval, 1.02–2.32) in women with two or more prior abortions (7.0% versus 4.7%) appeared to be more common, but after logistic regression analysis, we found:  
no evidence of adverse pregnancy outcomes.




Bouyer et al

Risk Factors for Ectopic Pregnancy: A Comprehensive Analysis Based on a Large

Case-Control, Population-based Study in France.

American Journal of Epidemiology 2003

- This case-control study included 803 cases of ectopic pregnancy and 1,683 deliveries
  - No association with ectopic pregnancies was observed for surgical abortion (adjusted odds ratio = 1.1, 95% CI: 0.8,1.6)
- 






Ananth et al

The association of placenta previa with history of Cesarean delivery and abortion: a meta-analysis.


Am J Obstet Gynecol 1997

- 3.7 million women 1950-1996
  - Women with a history of abortion have a relative risk of placenta previa of 1.7 (95% confidence interval 1.0 to 2.9)
- 




# Competing risk factors

Induced abortions are associated with:

- Maternal age older than 35 years
  - Unemployment
  - Unmarried status
  - Low educational level
  - Smoking
  - Alcohol consumption
  - Obesity
  - Chronic illnesses
- 



# Selective recall

- Women with a poor pregnancy outcome are more likely to be truthful about previous abortions
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# Control group comparability

- Women giving birth are often the comparison group but are healthier than other cohorts

# How do we educate our patients about risks?



Willow  
Women's Clinic

Home

Choosing Between  
surgical and medical  
abortion

Medical abortion with  
Methotrexate / Misoprotol

Surgical abortions

Making an abortion  
appointment

Medical Abortion Booking  
Form

What do abortions cost?

Medical Abortion at a  
Distance

Medical Abortion –  
Frequently asked  
questions

Myths and Facts about  
Abortion

IUD – Frequently Asked  
Questions

IUD Booking Form

IUD Information /

## Myths and Facts about Abortion

**Myth #1. Having an abortion has a higher risk to your health than having a baby.**

**Fact: Continuing a pregnancy and going through childbirth has 10 x higher health risks than having a first trimester abortion.**

Paul M & Stewart F (2007) Abortion. In: Hatcher RA et al. Contraceptive Technology, 19<sup>th</sup> revised edition. Ardent Media, Inc, New York, NY, p664

Grimes DA (2006) Estimation of pregnancy-related mortality risk by pregnancy outcome, United States, 1991to 1999. Am J Obstet Gynecol,194, 92-94

Danel I, Berg C, Johnson CH, Atrash H (2003) Magnitude of maternal morbidity during labor and delivery: United States, 1993-1997. Am J Public Health, 93, 631-634

Hakim-Elahi E, Tovell HM, Burnhill MS (1990) Complications of first trimester abortion: a report of 170,000 cases. Obstet Gynecol, 76, 129-135

Raymond EG, Grimes DA. The comparative safety of legal induced abortion and childbirth in the states. Obstet Gynecol. 2012 Feb;119(2 Pt 1):215-9. PMID: 22270271

**Myth #2 A woman is more likely to have mental health problems (like depression) if she has an abortion instead of continuing an unplanned pregnancy.**

**Fact: Among women with an unplanned pregnancy, women who have a single, first-trimester abortion are not at greater risk for mental health problems than if they deliver that pregnancy.**

This information comes from the American Psychological Association (APA) Task Force on Mental Health and Abortion, which recently completed a comprehensive review of the best research about mental health and abortion.

What that means is that for all the women who have an unplanned pregnancy: some will continue that pregnancy and have a baby; others will have an abortion. From the women choosing to continue that pregnancy—most of them will be fine, some may have difficulty,