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Comprehensive pain management in early medical abortion - a follow up

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Disclosure of financial relationships

- Medical director and owner of a clinic specialised in abortion and family planning
- Received honoraria for lectures and member of the European scientific advisory board TEVA and Exelgyn

Introduction

- Abortion is the most frequently performed intervention in obstetrics-gynaecology.
- Since introduction of the medical method, research has largely focused on improving efficacy, defining the lowest dose for mifepristone as well as the type of the PG and the necessary dose and route of administration.
- While the efficacy of medical abortion has clearly been established, the time has come to assess the tolerability of these regimens, in particular pain associated with different regimens (prostaglandins), since pain is an important and commonly reported side-effect of the procedure.

Women's perspective on pain in medical abortion

Medical abortion is favoured because of fear of surgery and a perception that it is easier, less painful and maintains privacy.

(RCOG 2011)

What we know about women's perception

Compared with women undergoing surgical abortion, women undergoing medical abortion at less than 14 weeks of gestation report significantly more pain ... This is hardly surprising.

(RCOG 2011)

Satisfaction with medical abortion may be limited by differences between women's expectations of pain and bleeding and their actual symptoms.

(RCOG 2011)

Impact of approval on pain in medical abortion

Misoprostol alone ... is more painful ... than when misoprostol is combined with mifepristone

(WHO 2012)

Gemeprost still is among the approved prostaglandins, although women have more pain with gemeprost

Svendsen et al.2005

What we know

Pain during medical abortion, the impact of the regimen: A neglected issue? A review

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The European Journal of Contraception and Reproductive Health Care, 2014

Neither pain nor its treatment are systematically reported in clinical trials of medical abortion; this shortcoming reflects a neglect of the individual pain perception.

When data are mentioned, they are too inconsistent to allow for any comparison between different treatment protocols.

Standardised evaluation of pain is needed and the correlation between the dosage of misoprostol and the intensity of pain must be assessed in future studies.

Pain in medical abortion – a neglected issue

No evidence-based comprehensive pain management protocol has been published. Therefore, a group of experts has developed recommendations based on the following principles:

- avoidance of pain
- medical pain treatment
- non-pharmacological strategies

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Questions

1. **Do you have a lower gestational age limit for medical abortion?**
   a)Yes
   b)No

Questions

2. Do you always give 800mcg misoprostol (4 tablets) to patients or do you give 400mcg (2 tablets) to women < 7 weeks gestation?

a) 800 mcg

b) 400 mcg

c) Other

Avoid pain induction

- Pain increases with gestational age
  - Improve access to abortion
  - Reduce restrictions to medical abortion
- Contractions lead to pain
  - Lowest possible dosage of prostaglandin analogues should be used at the optimal timing (36 - 48h)
- The method should be the woman's own decision
- Good information before and care during the procedure

What we know about pain treatment

- A huge majority of women report pain and more than half of women would take a pain treatment.
- Frequency of pain depends on many variables like gestational age, dose of misoprostol, parity, setting, cultural aspects etc. Several associations can be found. However the relative risk is rather low and not sufficient to draw a conclusion for a given patient.
- We should treat any discomfort a woman wants to relieve. In addition, due to increase in relaxation, sufficient pain relief may increase the efficacy of medical abortion.

Questions

3. Do all women receive routine prophylactic pain medication?

a)Yes

b)No

Questions

4. Do you give a back-up medication to women who need more than the baseline pain treatment?

a)Yes

b)No

What we know about pain treatment

- In most cases pain starts with uterine contractions shortly after intake of miso. This is sometimes delayed by a few hours. Usually intake of mifepristone does not lead to any pain. Except in those patients who start bleeding before intake of misoprostol.
- Treatment for pain should be systematic.
- Strength of analgesia given should be stepwise according to WHO recommendations. In addition, women should be informed about how to access additional analgesics, how to use them and they should have easy access to 2nd step pain treatment.

What we know about pain treatment

- The limited data do not show prophylactic treatment to be superior compared with curative administration. Furthermore the best prophylactic treatment is still to be determined. However experts' recommendation is to give prophylactic analgesia with NSAIDs as 1st line analgesics.
- 2nd line analgesics should be used if first line agent is not sufficient. Step-2 analgesic should unrestrictedly be provided to women who require it.

Questions

5. Is the back-up medication in the hands of women or do they have to ask someone to request it?

a) In the hands of women
b) They have to ask someone

What we know about pain treatment

- There is little evidence on the most appropriate pharmacological agents and protocols. Therefore, the expert consensus was as follows:
  - 1st line, prophylaxis: ibuprofen, 400 to 800 mg (use of 2nd line in case of contra-indications to NSAIDs)
  - 2nd line: opioids as codeine, dihydrocodeine, or morphine
- NSAIDs efficacy is dose dependent. Ibuprofen 400-800mg is widely used (the usual maximal daily dose is 1.200mg and should not exceed 2.400mg).
- In some countries legal restrictions prevent giving morphine; but codeine is associated with large inter individual variations, and should be replaced by oral morphine where possible.
- Paracetamol alone use is not recommended.

Medical pain management

- 1st line: NSAID (Ibuprofen, diclofenac, etc; for example Arthotec®: misoprostol/diclofenac)
- 2nd line: Codein (50mg), Tramaldol
- (Paracetamol) not sufficient

- Give medication early or as prophylaxis
- Make sure patient has analgesics at home
- 2nd step medication easily available

Non-pharmacological strategies

- Having someone present if misoprostol administration takes place at home
- Detailed information of women on the procedure = knowing what to expect
- Use of lowest effective doses of misoprostol
- Home intake of misoprostol
- Relaxing environment; supporting environment
- Hot water bottle

Summary: What can be done to reduce pain in early medical abortion

Reducing pain	- Unrestricted access to early abortion
	- Free choice of the method
	- Lowest dosage of prostaglandin
Non-medical pain management	- Pleasant atmosphere
	- Free choice of partner accompany
	- Knowing what to expect
	- Women should feel well and safe (at home/clinic)
Medical pain management	- asap/prophylaxis (Arthotec®)
	- 3-step increase, including NSAIDs
	- having drugs at home

„No woman can call herself free who does not control her body. “

Margret Sanger, 1921