Welcome to Project ECHO Population Health Network: Reproductive Health Series

Series 1: Session 9

Project ECHO WVPHN Hub Population Health Network - Reproductive Health Series

"Early medical abortion: clinical care provision in regional Victoria"

Supporting general practice, commissioning health services into gaps and driving service integration.

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Acknowledgement of Countries

Ask the question. Do you identify as Aboriginal or Torres Strait Islander?

I'd like to begin by acknowledging the Traditional Owners and custodians of the unceded lands and waterways

- the Wadda Wurrung, Gulidjan, Gadubanud, Keeray Wurrung, Peek Wurrung, Gunditjmara, Djab Wurrung, Wotjobaluk, Dja Dja Wurrung, Jadawadjarli, Wergaia, Jupagalk and Jaadwa peoples.

We recognise their diversity, resilience, and the ongoing place that First Peoples hold in our communities. We pay our respects to the Elders, both past and present and commit to working together in the spirit of mutual understanding, respect and reconciliation. We support self determination for First Nations Peoples and organisations.

What problem are we trying to solve?

Women and people with uteruses who experience unintended and unwanted pregnancies may want to exercise their rights to access early medical abortion, but they face challenges and barriers:

- What barriers do they face
- What barriers do we face as providers and across the system
- What can be done to support consumers along the care continuum

Session 9 Learning outcomes

- Describe how to prescribe MS-2 Step
- Discuss when referral to tertiary services is required for people seeking abortion services
- Describe how to manage bleeding or ongoing pregnancy in the case of management of MS-2 Step
- Participate in a community of practice to discuss health systems challenges

Don’t forget to fill out our session evaluation at the end of the session.

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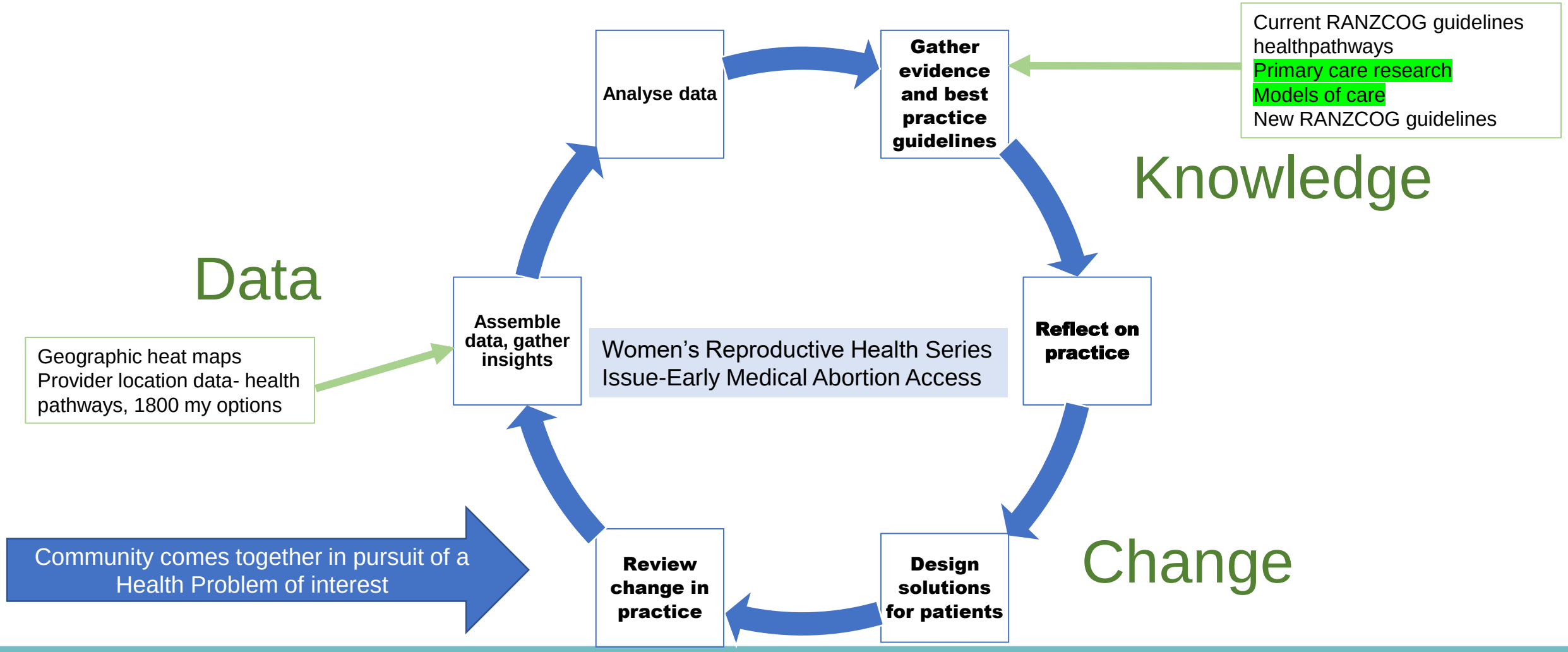
Understanding Early Medical Abortion Access using a Learning Health Systems approach



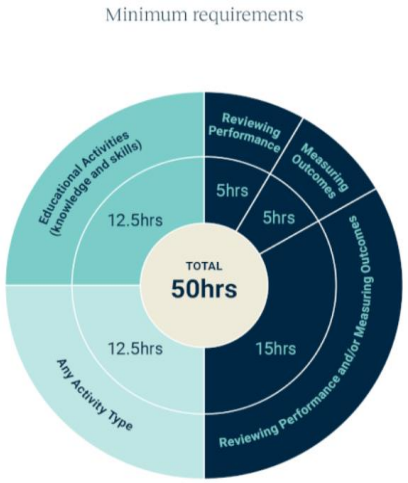
Community of Learning and Practice – Ground Rules

1. We ensure that all conversations about service access are framed up in relation to the consumer journey or the patient pathway
2. That our conversations maintain a focus on the patients needs and rights to access this intervention
3. That we commit to maintain the privacy of members of our community of practice by attributing this discussion to the group and not to individual members of the group (and as such we won't be answering questions in the didactic as this part of the recording will be shared broadly)
4. That we will work together to seek that tricky balance between the subjective (socio-cultural) and objective (scientific and technical) nature of the work

Etiquette/Zoom use

- Clearly name yourself with first name and surname.
- Introduce yourself / Role / Region / Organisation in “chat”
- Use chat to ask questions
- Please remain on ‘mute’ except when speaking
- Please turn video on
- In-session Evaluation at the end

- These sessions will be recorded for ongoing training and quality improvement purposes.
- The didactic presentations ONLY will be disseminated on our learning channel.
- Discussions will be de-identified where used for QI or research purposes.
- Please let us know if you would not like your comments recorded.



WVPHN Your CPD Centre

ECHO is a Peer Group Learning Activity
EA- Passive activity
RP- Interactive activity
MO- QI activity supported by ECHO

Agenda– Reproductive Health Series 1: Session 9
"Early medical abortion: clinical care provision in regional Victoria"

Facilitator: Dr Bianca Forrester, Clinical Lead of Innovation and Learning, Western Victoria Primary Health Network

Dr Alexandra Bonner, Obstertrician & Gynaecologist, Barwon Health

- **Overcoming barriers to providing early medical abortion access, care and support in Western Vic**

Panelists and SMEs for this series: Juliana Betts (Public Health Reg GPHU) , Shannon Hill (Womens Health Promotion), Alex Bonner (Gynaecology, Barwon Health), Kate Graham (GP Clinical Advisor WVPHN)

Case presentation: Anonymous GP.

Network Co-ordinator: Jemma Missbach, Western Victoria Primary Health Network

Session 3- Overcoming barriers to providing early medical abortion access, care and support in Western Vic

Dr Alexandra Bonner

Obstetrician & Gynaecologist

Barwon Health

Overview

- How to assess and prescribe
- Manage complications
  - Endometritis & Retained Tissue
- When to refer; Western Victorian abortion services & support
- When to offer surgical abortion

Early Medical Abortion

MS2Step Composite pack: Mifepristone/Misoprostol

- 200mg Mifepristone (Mifepristone Linepharma) tablet oral
- 800mcg Misoprostol (GyMiso) Buccal (between cheek & gum for 30mins)
  - 36-48 hours later

TGA approved and PBS listing:

- Up to 63 days (9 weeks) gestation
- Confirmed Intrauterine Pregnancy : Gestational sac with yolk sac

(ectopic excluded)

  - BHCG >1500- should see IUP
- Medication cost: Medicare card holder $39.50; Healthcare Card holder $6.80

Mifepristone/misoprostol regimen General protocol

- Day 1 (Clinic)
  - Clinician counsels the woman, takes a medical history and performs an exam and lab tests
  - USS to confirm intrauterine site and gestational age
  - Mifepristone is orally administered (in clinic/or home)
- Day 2-4 (Home or clinic)
  - Misoprostol is administered and progress of miscarriage is monitored with recourse to medical care as/when necessary
- Day 7-14 (Clinic)
  - Patient returns to the clinic for follow-up /phone contact and bhcg
  - Clinician assesses for the completion of the abortion
    - Including Clinical History, Repeat BHCG(quantitative) +/_ USS

How to assess and prescribe?

- MS2Step website & resources

- Ensure no coercive control
- Assess for Contraindications(*)
- Support person/access to A&E
- Emergency steps/plan
- No rules around supervised prescribing etc
- MS2Step SMS registration

Patient acceptability 90%

POTENTIAL POSITIVE FACTORS

- ⊡ Choice
- ⊡ Ability to avoid anaesthesia
- ⊡ Privacy
- ⊡ Convenience

POTENTIAL NEGATIVE FACTORS

- ⊡ Prolonged bleeding
- ⊡ No of clinic/Dr visits
- ⊡ Uncertainty as to whether complete
- ⊡ Timing of contraception

What to consider before prescribing

- Confirm pregnancy and gestational age (not more than 63 days) via ultrasound, remove any intrauterine device and ensure ectopic pregnancy is excluded.[2]
- Exclude contraindications to mifepristone and misoprostol, eg:[2]
  - chronic adrenal failure
  - severe disease requiring steroid administration
  - hypocoagulation diseases
  - anticoagulation therapy
  - allergy to mifepristone, misoprostol or other prostaglandin.
- Consider any conditions in which medical termination is not recommended (eg, anaemia, renal failure, hepatic impairment, malnutrition or cardiovascular disease).[2]

Complications: expectations vs complications

Expectations

- Success Rates

⊡ 93-98% leads to complete abortion

⊡ In the remainder curettage necessary to evacuate the uterus

⊡ Expectant management of RPOC is appropriate up to 2 – 4 weeks

⊡ Clinical point

  - DO not USS everyone who has bleeding >7 days * similar to miscarriage management

Mifepristone/misoprostol regimen
Side effects

Effects of abortion process

- Cramping
  - Often described as similar to menstrual cramps
- Vaginal bleeding
  - Median bleeding time 9-13 days
  - Often described as similar to a heavy period or spontaneous miscarriage

Common side effects

- Nausea
- Vomiting
- Diarrhea
- Headache
- Dizziness
- Fever, chills, hot flashes, warmth

Complications

- Pain and bleeding
  - Usually NSAIDS effective
  - Bleeding heavier than a period
    - Occasionally greater than 1 soaked pad per hour
    - Usually self limiting once products have been passed
- Infection
  - Rarely severe
  - As significant as for surgical procedures
  - Warrants "screen and treat" or prophylactic antibiotics at time of misoprostol admin.
- ? teratogenicity : Several reports misoprostol and limb defects, Mobius syndrome
- Severe bleeding requiring curette 1%
- Transfusion rate 0.1%
- 2-5% require aspiration of retained products of conception
- similar to outcomes in expectant Management of miscarriage

Endometritis & Retained POC

Appendix 7. EPAS Endometritis and/or Retained Products of Conception

Signs and symptoms

- Increasing abdominal pain
- Prolonged bleeding >2weeks Fluctuating bleeding, Heavy bleeding (>2pads in 2 hours)
- Offensive vaginal discharge.
- Afebrile

- Offensive discharge
- Significant pelvic tenderness
- Fever (>38C),
- or with less specific features such as persistent nausea, vomiting, diarrhoea, dizziness and/or fainting, with or without fever.

Haemodynamic compromise
Haemorrhage/Anaemia
Severe infection/Sepsis

Urgent Gynae Review

- Resuscitation
- Consider Cervical shock – remove POC from cervix
- Assess for peritonism – suggestive of uterine perforation or rupture or ectopic pregnancy, or sepsis

IX: FBE, G&H, (consider Xmatch 2 units); TV US

Clinical examination and investigations

Haemodynamics; Abdo, PV, Spec,
Investigations:serum bCHG G & H, FBE, CRP, Blood cultures if febrile/unwell, HVS/PCRI
TV Ultrasound to assess for **Retained Products of Conception**

Endometritis Treatment is Antibiotics

Therapeutic Guidelines Antibiotics: Postprocedural Pelvic infection

Non-Severe Endometritis

Outpatient management
Oral antibiotics Consider OPD TV US at 7 days if ongoing bleeding or not improving

Severe Endometritis

Inpatient management IV antibiotics

Retained Products of Conception Management

Consider concurrent Endometritis with RPOC and have low threshold for antibiotic management

RPOC

Retained Products of Conception Management
Consider concurrent Endometritis with RPOC and have low threshold for antibiotic management

Expectant Management	Medical Management	Surgical Management
Consider if POC < 1.5cm; systemically well Allows for spontaneous passage of POC and avoids potential surgical and anaesthetic risks. Timeframe for resolution and outcome are unpredictable. Allow up to 2 weeks for spontaneous resolution and expect ongoing pain and bleeding over this time. EPAS midwife phone call at 2 weeks:	Consider if POC < 35mm Avoids potential surgical and anaesthetic risks with the option for treatment at home if desired and suitable Disadvantages: same as expectant + Medication side effects: nausea, vomiting, diarrhoea. Ensure patient is aware of transient gastrointestinal disorders, chills and fever, pain and bleeding post misoprostol. Ensure at home supports are available; Consider inpatient care **Prescribe:** misoprostol 800microg (4 x 200microg tablets) buccal followed by a repeat dose of 400microg (2 x 200microg tablets) 4 hours later. Prescribe analgesia and anti-emetics EPAS midwife phone call at 1 week	Surgical management is strongly recommended if: • If POC >35mm • hemodynamically unstable • evidence of infection (surgery under antibiotic cover) • unacceptably heavy bleeding Allows for a planned procedure with predictable time frame. The relief from symptoms are immediate with less blood loss and shorter duration of bleeding than expectant or medical management. If an IUD is in situ, surgical management is required with replacement of the IUD. ***Arrange Theatre*** *as per Surgical management of Miscarriage* Evidence of infection with significant RPOC may require curettage 12-24 hours after IV antibiotics are initiated.

Be aware
Management of RPOC is based on symptoms or patient preference.
Asymptomatic or incidental findings of RPOC do not routinely require management.

When to refer?

- Contraindications to MS2Step – both social and medical
- Considering inpatient Medical abortion or surgical abortion

- Advice from community of practice in AUSCAPPS
- Phonecall to another GP or local Gynae for second opinion
- Local EPAS service for pregnancy complication or Surgical Abortion service for ongoing pregnancy

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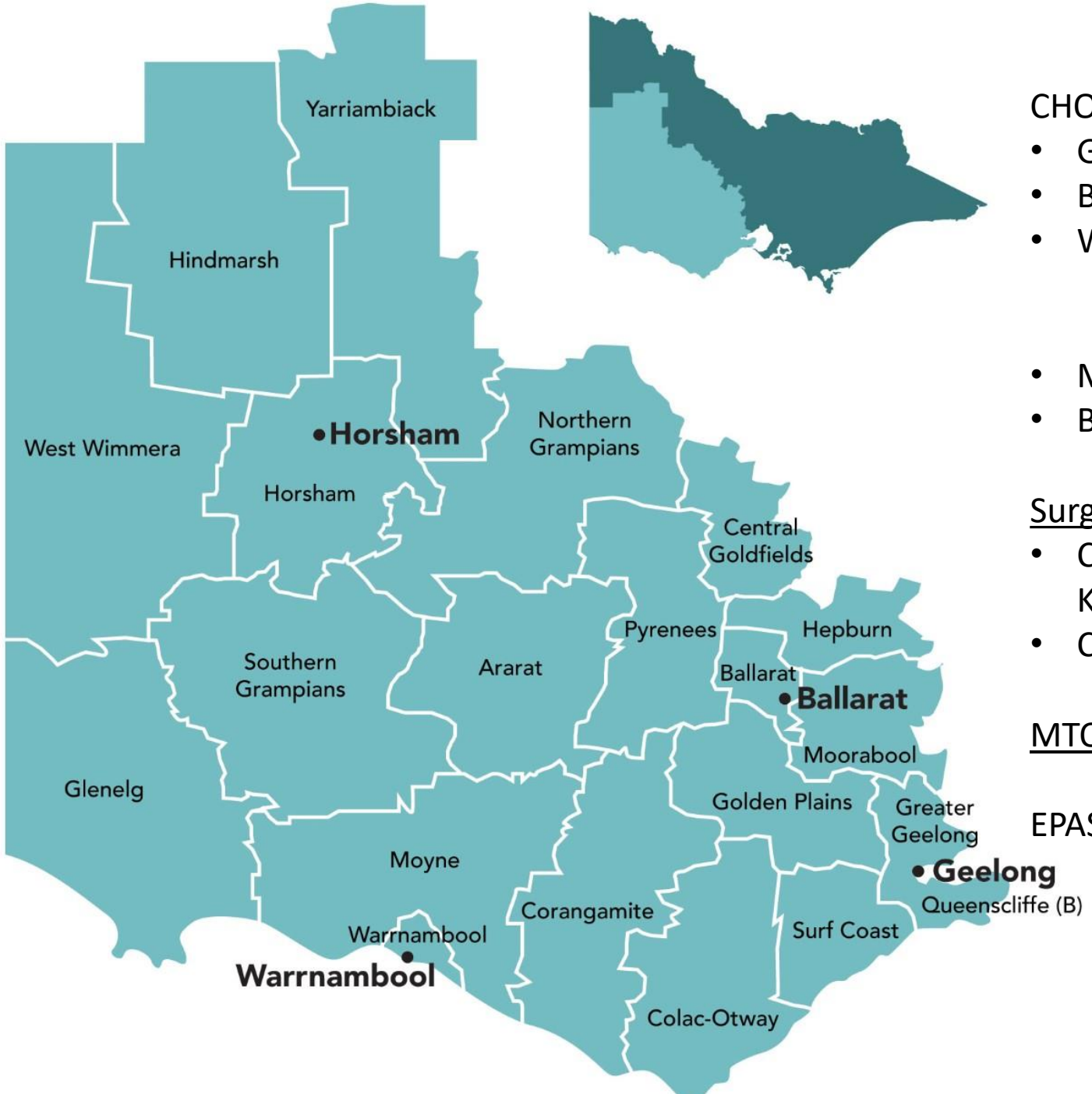

CHOICES CLINICS:

- Geelong (<14-16 week)
- Ballarat (<12 week)
- Warrnambool (<12 week)

- Mildura
- Bendigo

<u>Surgical TOP</u>

- Castlemaine/Maryborough/ Kyneton
- Colac

<u>MTOP</u>

EPAS clinics *for complications

When to offer surgical?

- Patient preference
- Contraindication to Medical abortion
- Gestation > 10 weeks

Coordinated care with

- ⊡Standardised protocols
- ⊡Clear follow up
- ⊡Access to 24 hr advice
- ⊡Availability of emergency services if necessary
    - ⊡Clear follow-up arrangements with the women
- ⊡Engagement of /agreement with other service providers – Local EPAS & Choices service

Quick case: 38 yo lady, 2 children - completed her family

Background: Suffering depressions secondary to grief – Mother passed away 1 year ago. Having psychotherapy, supportive husband.

Assessment: Unplanned pregnancy – 6 weeks pregnant, not sure if she wants to continue with pregnancy. Wants medical termination, but feels guilty when looks at her beautiful children. Teary & low mood.

Recommendation: Discuss pros and cons with husband. Discuss with psychologist, review in a week.

Question: What are the support options available to this woman?
What should my management be when she already feels guilty about having a termination but doesn't think she can cope with another pregnancy.

Case Presentation: 32yo woman, mother of 2 school aged children

Situation: Unexpected pregnancy discovered at 5 weeks gestation. Rural location, approximately 1h from nearest health service with obstetric and gynae capacity (no surgical terminations provided at this site).

Background: Due to small community, accessed telehealth via Marie Stopes online telehealth. Able to get initial bloods and ultrasound in a timely manner. Provided with e-script for medication and information about pharmacies stocking MS 2-step. Posted out high sensitivity urine tests for follow up and provided with emergency contact number.

Initial bleeding with what she felt was RPOC. 1 week later, increased heavy bleeding, soaking through 1 pad every 2 hours. Not otherwise unwell. No fevers, mild cramping. Called MS 2-step / Marie Stopes advice line and was told to go to A+E

Assessment: Came into GP as appointment available and not keen to go to closest A+E as had friends who worked there. Wanting to know what should she do. Haemodynamically stable. No obvious products in os, Afebrile. No high sensitivity urine tests in clinic

Recommendation: Called ultrasound – immediate appointment available otherwise no bookings available for next 1 week. Required negotiation with ultrasound as distance meant that she may not get there in time for the allocated spot. Urgent bloods also ordered. Results – Hb 94, RPOC on ultrasound present in cervical canal. Gynae not able to review or admit directly and advised to go to A+E

Questions to the group

- Questions from the patient – does she have to tell A+E that this was an EMA?
- Questions from the GP – if there was an ongoing pregnancy in this setting, how can we arrange review for urgent STOP?
- What about if it was just a failed EMA without bleeding and ongoing pregnancy?
- What are the pathways for STOP?
- Will all patients in this setting have to go to Melbourne due to service capacity in Western Vic?

HealthPathways
Reproductive Health

HealthPathways Western Victoria

CLINICAL

Termination of Pregnancy (TOP)

Follow-up for Termination of Pregnancy (TOP)

Contraception and Sterilisation

Contraceptive Implant

Intrauterine System or Device (IUD)

Contraceptive Injection

Persistent Pelvic Pain

Endometriosis

Cervical Screening

Cervical Cancer

Cervical Polyps

REFERRAL

colposcopy

non-acute gynaecology assessment

gynaecology advice

acute gynaecology assessment

Referral for termination of Pregnancy

CONTACT

•New to HealthPathways?
Visit https://westvic.communityhealthpathways.org/ and select 'register now'

•Use the "send feedback" button on the website or email: healthpathways@westvicphn.com.au

•The HealthPathways team can arrange for passwords to be bypassed if you provide your practice IP address.

WHO CAN USE HEALTHPATHWAYS?

•GPs and Health Professionals within the Western Victoria region can access HealthPathways. The portal is not designed to be used by the general public and can only be accessed by using a secure login and password. There is no cost to access.

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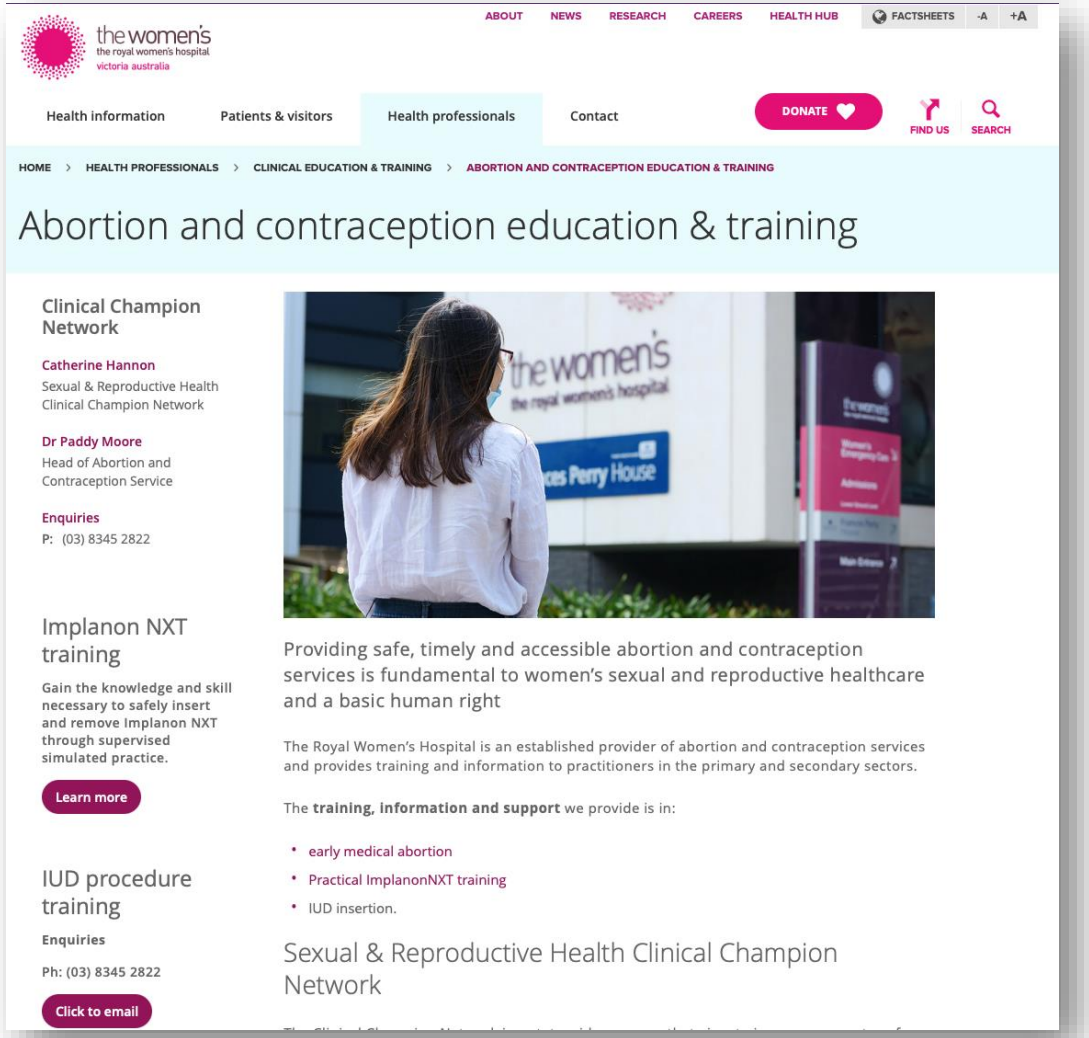
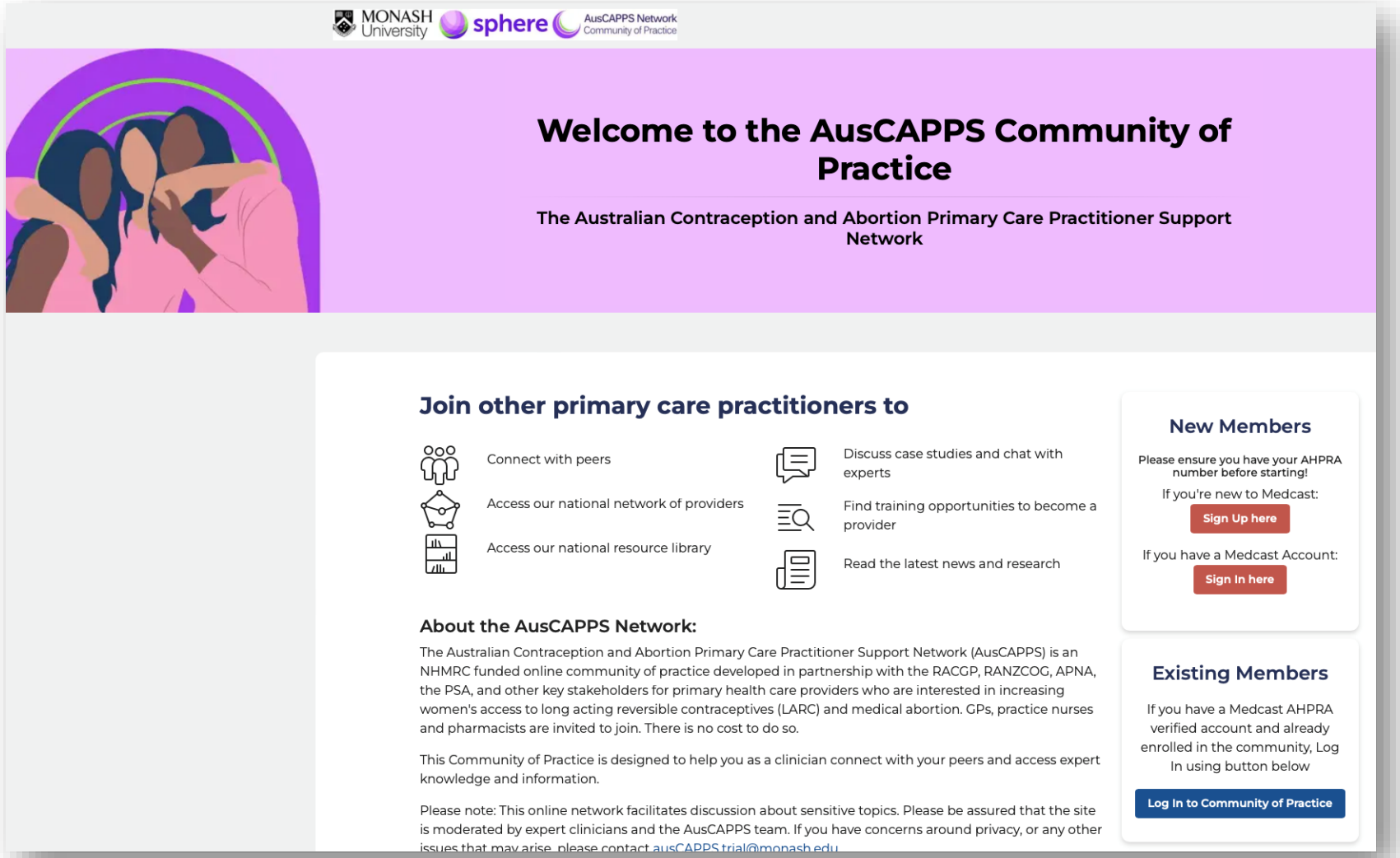
RWH clinical Champions project and network



https://www.thewomens.org.au/health-professionals/clinical-education-training/abortion-and-contraception-education-training

SPHERE and the AUSCAPPS Network



https://medcast.com.au/communities/auscapps

Professional development

SHV: https://shvic.org.au/professional-learning-support

Includes:

- **Implanon NXT training (virtual and face-to-face)**
- **IUD insertion training**
- **Online self-paced courses such as Vulvovaginal health, Unplanned pregnancy, Introduction to IUDs**

Other

- **The Women's Hospital**
- **Gender affirmation training:**
  - **ASHM online https://ashm.org.au/training/**
  - **RCH education days**
  - **AUSPath https://auspath.org.au/2021/06/13/e-learning-module-trans-incl-gender-diverse-and-non-binary-primary-care/**

Session Evaluation

- Please take the time to evaluate this **session**
- **Link** pasted into the chat

Upcoming Sessions

- **Thursdays @ 7.30am**
- Weekly til 7 September

Clinical training, support and resources are available now:

The Royal Women's Hospital Sexual & Reproductive Health Clinical Champion Network training, resources, clinical guidelines

Victorian Clinical Network for Abortion and Contraception quarterly online meetings

AusCAPPS Community of Practice open to Nurses, Pharmacists, GPs – practice support, training, peer networking

Microcredential: Abortion, Contraception and Sexual Health: Supporting Client Access free short course for anyone needing a good base knowledge

CERSH: Centre of Research Excellence in Rural Sexual Health events, resources, training

Please send us your cases

If you have a case, you would like to discuss with the group:

- **Case template** here
- Email projectechocovid19@westvicphn.com.au
- Use the comment box in the evaluation form