

CHALLENGING CASES

Facilitator Guide

Purpose

The purpose of this activity is to provide participants with challenging medical abortion cases at or after 13 weeks gestation and to understand that even in these situations, medical abortion may still be the best option for women to obtain a safe abortion.

Depending on the baseline knowledge and experience of the group, these cases may be above and beyond the discussion that needs to be included in a training or the discussion may need to be done in large groups versus smaller groups. Of note, these cases are drawn from real-life experiences. As these cases are uncommon, published evidence may be scant or non-existent; thus the treatment and management are based on expert opinion and shared-decision making with the patient. There is often more than one way to manage a complicated case but generally there is a course of action that balances the risk/benefits to the woman.

Materials

- Make photocopies of cases (below) to give to participants
- Flipchart (for taking notes and highlighting any key points)
- Markers

Timeline

1 hour

Instructions

Give participants the opportunity to evaluate and discuss management options for each case. This activity can be completed in the large group or by dividing the participants into four smaller groups (described here). Divide the participants into small groups. Once the participants are in their groups, give each group a challenging case handout and assign each group a case to discuss. Give groups 30 minutes to discuss their case and ask them to assign one person to present back to the larger group. Let them know that their presenter will have 5 minutes.

After each groups presents, solicit feedback and thoughts from the larger group. If the course of action listed in the trainer's guide has not been discussed, review that information with the group.

Case 1

27 year-old-woman with one prior pregnancy that ended in miscarriage has a known lethal fetal anomaly at 28 weeks. The anomaly includes hydrocephaly and oligohydramnios (little amniotic fluid) with a biparietal diameter consistent with 39 weeks in breech position.

Overall discussion points: Providers with an obstetrical background may want to manage this case as they would for a preterm viable pregnancy but given that the fetus is non-viable, be sure to focus on options that decrease the risk to the woman's health and her future pregnancies. Hysterotomy is not recommended as it involves anesthesia, surgical risk and complicates future pregnancies. In this case, medical abortion is preferred. Because of the larger uterine size, lower doses of misoprostol are appropriate (see page 26 of the *Medical Abortion Reference Guide: Induced abortion and postabortion care at or after 13 weeks gestation ['second trimester']*.) Perform an exam including fundal height and estimate the uterine size and base misoprostol dosing off of uterine size. In this case, uterine size is likely >28 weeks gestation due to the hydrocephaly and thus, local protocols for term induction of labor should be used. Mifepristone should be used if it is available. External cephalic version may be attempted but the lack of amniotic fluid means success is unlikely. This case successfully expelled without this maneuver. Head entrapment is possible but options for management are available as the fetus is nonviable. Options include allowing additional time for complete expulsion, placing more pressure on the cervix (weight fetus with an IV bag), trial of piper forceps, and/or cephalocentesis. Cephalocentesis is the decompression of the head via the vagina (either with a spinal needle or by piercing the base of the skull with pointed mayo scissors to create a small space, then place a cannula into the space and use vacuum aspiration to collapse calvarium). Choose a method to extract the fetus that is least likely to harm the woman.

Guiding questions:

- What mode of delivery would you offer this woman to end her pregnancy?
- What medications and in what doses would you offer this woman to end her pregnancy?
- What if the pregnancy remains breech and during expulsion the head is trapped?
- Would external cephalic version be appropriate in this case?

Case 2

19-year-old woman gravida 2, para 1 is now 16 weeks pregnant. Her first delivery was by cesarean section after a labor complicated by a "lack of cervical dilation." She desires an abortion as this

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pregnancy is the product of a rape. She takes 200mg of mifepristone and then 48 hours later is admitted to hospital. After 5 doses of misoprostol, her cervix has yet to soften and dilate.

Overall discussion points: Although most women will expel within 6-9 hours after initiating misoprostol, not ALL women will (see pages 16 & 22 of the *Medical Abortion Reference Guide: Induced abortion and postabortion care at or after 13 weeks gestation ['second trimester']*). Providers must have patience but also monitor for the possibility of complications. If a woman is not responding as expected, reassess her – perform an exam and check her vital signs. The most common reason for not expelling:

- More time is needed
- Timely dosing of misoprostol is not occurring (every 3 hours)
- Poor drug quality (www.ipas.org/clinical-updates/general/miso-quality)

Rarely, expulsion may not be occurring due to uterine rupture, extrauterine pregnancy, abdominal mass, or an HCG-secreting tumor. If no expulsion occurs after five doses of misoprostol and the client is doing well, we recommend continuing the misoprostol dosing (see Appendix 5, page 34 of the *Medical Abortion Reference Guide: Induced abortion and postabortion care at or after 13 weeks gestation ['second trimester']*). However, experts use several different approaches, including: 1) continuing the misoprostol dosing, 2) switching to an alternative uterotonic like oxytocin, 3) providing a “drug holiday” where all uterotonics are stopped during 12-24 hours and then restarted, 4) redosing mifepristone and then restarting misoprostol immediately or after an arbitrary amount of time (12, 24, or 48 hours), or 5) offering D&E if enough cervical dilation is present, and the facilities, equipment, and expertise are available. In this case, the woman successfully expelled after 12 consecutive doses of misoprostol.

Guiding Questions:

What would you do next?

What medical abortion regimen would you continue with?

No expulsion occurs after another additional 5 doses. What are you concerned about and what would you do next?

Case 3

30 year-old woman who has had three pregnancies and two live vaginal births presents for an abortion at 22 weeks gestation. She had an ultrasound that was consistent with her last menstrual period for dating the pregnancy. An additional finding was a complete placenta previa.

Overall discussion points: Providers with an obstetrical background may want to manage this case as they would for a preterm viable pregnancy but given that the woman desires an abortion, be sure to focus on options that decrease the risk to the woman’s health and her future pregnancies. A provider must weigh their ability to respond to heavy bleeding, with transfusion, and/or emergent laparotomy in their setting (see page 26 of the *Medical Abortion Reference Guide: Induced abortion and postabortion*

care at or after 13 weeks gestation ['second trimester']). Both medical abortion and D&E can be successfully performed in women with placenta previas but the risk for heavy bleeding is greater than for women without abnormal placentation. An alternative is laparotomy with hysterotomy but future risks to a woman's health is increased, as it includes anesthesia, surgical risks and makes future pregnancies more complicated (especially if a vertical uterine incision is needed). As this training is focused on medical abortion, the remainder of the discussion points will focus on medical treatment. A provider must be prepared for heavy bleeding with medical abortion in a woman with a previa. The placenta should expel before or with the fetus. Once the placenta expels, the risk of hemorrhage is minimal. If heavy bleeding occurs and the placenta has not expelled, examine the woman and determine whether the placenta can be manually extracted or even extracted using vacuum aspiration. If unable to resolve the bleeding with these less-invasive methods, then depending on resources the following can be considered: 1) immediate referral (attempt to tamponade bleeding and perform other stabilizing efforts), 2) D&E (if trained provider and appropriate equipment available), 3) laparotomy/hysterotomy. In this case, the woman successfully expelled with 750mL of blood loss at the time of placental expulsion. She did not require a transfusion.

Guiding questions:

- How would you manage this woman?
- What resources do you have in your setting to manage heavy bleeding?
- A decision is made to proceed with a medical abortion. What happens if the woman starts bleeding heavily during the medical abortion?

Case 4

A 32 year-old woman G6P5 presents for an abortion due to anencephaly at 24 weeks by last menstrual period and recent ultrasound; on exam, however, she has a uterine size of 34 weeks.

Overall discussion points: Prior to performing an abortion at or after 13 weeks gestation, confirmation of gestational age is critically important for several reasons including legal issues, need to adapt the medical abortion dosing regimen, transient or actual fetal survival, and/or if D&E is available; client eligibility, provider capability, and adequate cervical preparation for the given gestational age (**See page 12 of the Medical Abortion Reference Guide: Induced abortion and postabortion care at or after 13 weeks gestation ['second trimester']**). Confirm why this gestational age discrepancy exists and if ultrasound is available, then consider performing one again. Some reasons for uterine size greater than dates are: multiple gestations, uterine masses (fibroids), polyhydramnios, and gestational trophoblastic disease. Maternal obesity can make assessment of uterine size challenging. Adapting the MA regimen for gestational age or uterine size over 24 weeks is noted on **page 26 of the Medical Abortion Reference Guide: Induced abortion and postabortion care at or after 13 weeks gestation ['second trimester']**. Due to her overextended uterus and multiparity, this woman is at higher risk for hemorrhage (**see page**

39 for management of hemorrhage in the *Medical Abortion Reference Guide: Induced abortion and postabortion care at or after 13 weeks gestation* ['second trimester']).

Guiding questions:

- What is the differential diagnosis for the discrepancy in dates?
- Polyhydramnios is diagnosed. A decision is made to proceed with an medical abortion, what regimen would you use and why?
- For what complication is this woman at high risk and how would you manage it?