

# Week 4: Introduction

Abortion After the First Trimester  
Obstacles to Accessing Safe Abortion in the U.S. and Worldwide

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# Week 4: Overview and Objectives

After this week, learners will be able to

- Recognize common reasons why women have abortions after the first trimester
- List and review attributes of high quality, safe abortion care
- Discuss unique challenges for women seeking abortion after the first trimester
- Identify opportunities to improve global access to abortion care after the first trimester
- Discuss complications associated with abortion and common abortion myths

# Abortion After the First Trimester

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# Contextualizing Who Has Abortions After the First Trimester

*Panel with*

**Daniel Grossman, MD**

Vice President of Research,  
Ibis Reproductive Health

*and Eleanor Drey, MD, EdM*

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# Guidelines for Safe Abortion Care

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# Improving Access to Safe Abortion Care After the First-Trimester

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# Patient Decision Making About Abortion After the First Trimester

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# Managing Complications of Procedural Abortion

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# Myths About Abortion

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# Expert Interviews

- Parker Dockray, Backline
- Joanna Erdman, Schulich School of Law
  - Harm Reduction
- Caitlin Gerdts, Advancing New Standards in Reproductive Health (ANSIRH)
  - mHealth Projects
- Anne Davis, Physicians for Reproductive Health

# Additional Resources

- Videos
  - Willie Parker, The Complexity of Choice
  - Center for Reproductive Rights, In Harm's Way: The Video Project
- Articles in Pop Culture
  - “Meet One of the Only Abortion Providers Left in Mississippi”, *Esquire*
  - “No, Abortion Does Not Cause Breast Cancer,” *Huffington Post*

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POST

# Academic Literature

- Kerns J, Vanjani R, Freedman L, Meckstroth K, Drey EA, Steinauer J. Women's decision making regarding choice of second trimester termination method for pregnancy complications. *International Journal of Obstetrics and Gynecology*. 2012;116(3):244-8.
- ACOG Practice Bulletin 135: Second-Trimester Abortion. *Obstetrics & Gynecology*, June 2013, Vol 121, Issue 6, pg 1394-1406.
- Fox MC, Krajewski CM. Cervical preparation for second-trimester surgical abortion prior to 20 weeks' gestation: SFP Guideline 2013-14. *Contraception*. 2014 Feb; 89(2): 75-84.

International Journal of Gynecology and Obstetrics 116 (2012) 244–248

Contents lists available at ScienceDirect

International Journal of Gynecology and Obstetrics

Journal homepage: www.elsevier.com/locate/ijgo

CLINICAL ARTICLE

Women's decision making regarding choice of second trimester termination method for pregnancy complications

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ARTICLE INFO

Keywords: Second trimester abortion; Decision making; Pregnancy complications

ABSTRACT

Objective: To describe how women terminating a pregnancy for fetal or maternal complications decide between surgical (dilation and evacuation [D&E]) and medical abortion (mifepristone). A qualitative study was conducted among women who addressed D&E or medical abortion before 26 weeks of gestation for fetal or maternal complications. Methods: Semi-structured interviews were conducted with 20 women who were interviewed by phone 1 week after the procedure. About their decision-making process and reasons for choosing a particular method, their own and their partner's views, and their satisfaction with their approach, and interviewees were grouped into thematic categories. Results: Of the 20 women, 13 (65%) chose D&E and 7 (35%) chose medical abortion. Decision factors that emerged from the interviews were: access, safety, effectiveness, and timing. Women's preferences for a method were largely based on their individual medical status and their own and their partner's views. Decision-making for second-trimester abortion is a complex process that involves many factors. Women should be offered counseling about and access to both methods. Understanding their decision process may help when counseling women about both methods. *© 2012 International Federation of Gynecology and Obstetrics. Published by Elsevier Ireland Ltd. All rights reserved.*

1. Introduction

Termination of pregnancy in the first trimester is a common procedure in the United States. Approximately 100 000 women in the USA are terminated in the first trimester of pregnancy each year [1]. The 2 methods of second-trimester termination, dilation and evacuation (D&E) and medical abortion, are similar in safety and efficacy [2], but are very different experiences for women [3]. D&E is done and typically done in an outpatient setting with anesthesia [3]. Medical abortion, also referred to as labor abortion, is most often done in a home and often requires a provider to be available for 24 h. Both methods affect the choice of contact with the fetus.

2. Materials and methods

postpartum stress symptoms are not uncommon after termination of fetal demise [10,11] and undergoing a procedure that is painful and delays recovery.

Women who have been terminated in the USA are more likely to be interviewed in their own homes than those who were terminated in a hospital setting. A qualitative study was conducted of women who were interviewed at home. The study was designed to explore women's decision-making process for a second-trimester abortion. The study was designed to explore women's decision-making process for a second-trimester abortion. The study was designed to explore women's decision-making process for a second-trimester abortion.

The American College of Obstetricians and Gynecologists

WOMEN'S HEALTH CARE PROFESSIONALS

PRACTICE BULLETIN

CLINICAL MANAGEMENT GUIDELINES FOR OBSTETRICIAN–GYNECOLOGISTS

Number 135, June 2013

Second-Trimester Abortion

In the United States, more than one half of pregnancies are unintended, with 8 to 10 women having an abortion by age 45 years [1]. In 2008, 1.2 million abortions occurred in the United States, of which 6.2% took place between 13 weeks of gestation and 19 weeks of gestation and 4.0% took place at 20 weeks of gestation or later [1, 3]. Only 1.3% of abortions are performed at 21 weeks of gestation or later [4]. The proportion of abortions performed in the second trimester, usually defined as between 13 weeks of gestation and 26 weeks of gestation (as calculated from the last menstrual period), has remained stable during the past two decades [4]. The purpose of this document is to provide evidence-based guidelines for the medical and surgical methods of second-trimester termination as well as for the management of associated complications.

Background

Indications for Second-Trimester Abortion

Second-trimester abortion is an important component of comprehensive women's health care, and women seek termination later in pregnancy for a variety of medical and social reasons. Circumstances that can lead to second-trimester abortion include delays in suspecting and testing for pregnancy, delay in obtaining insurance or other funding, and delay in obtaining referral, as well as difficulties in locating and traveling to a provider [5]. Poverty, lower education level, and having multiple disruptive life events, have been associated with higher rates of seeking second-trimester abortion [1]. In addition, major anatomical or genetic anomalies may be detected in the fetus in the second trimester and women

although first-trimester screening and chorionic villus sampling can enable first-trimester diagnosis of aneuploidy. Some obstetric and medical indications for second-trimester termination include pre-eclampsia and preeclampsia, gestational diabetes, among other conditions. Additional indications for elective evacuation in the second trimester are pregnancy failure before 20 weeks of gestation and fetal demise. In 2008, the U.S. fetal mortality rate was 2.21 fetal deaths at 20 weeks of gestation or more per 1,000 live births and fetal deaths, and this rate was higher for teenagers, women aged 35 years and older, and among non-Hispanic black, Hispanic, and American Indian or Alaska Native women [6].

Methods of Second-Trimester Abortion

Both surgical and medical methods of pregnancy termination can be used in the second trimester. A medical

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Clinical Guidelines

Cervical preparation for second-trimester surgical abortion prior to 20 weeks' gestation

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Abstract

For a dilation and evacuation (D&E) procedure, the cervix must be dilated sufficiently to allow passage of operative instruments and products of conception without lacerating the os or cervical canal. Preoperative preparation of the cervix reduces the risk of cervical laceration and undue perforation. The cervix may be prepared with osmotic dilators, pharmacologic agents or both. Dilapan-SM and laminaria are the two osmotic dilators currently available in the United States. Laminaria are made from dehydrated seaweed (size 12–24) to achieve osmotic dilation. Dilapan-SM is made of synthetic hydrogel, achieves significant dilation within 4 h and is less painful for osmotic preparation. A straight rod of osmotic dilators is usually adequate for D&E before 20 weeks' gestation. Misoprostol, a prostaglandin E<sub>1</sub> analogue, is an uterotonic used instead of osmotic dilators. It is generally regarded as safe and effective; however, misoprostol achieves less dilation than osmotic agents. The literature supports use of osmotic preparation with misoprostol or Dilapan-SM up to 16 weeks' gestation. As the evidence regarding alternative regimens increases, highly experienced D&E providers may consider same-day regimens as their preparation strategy. Choice of management or a combination of osmotic and pharmacologic agents. Misoprostol use as an adjunct to osmotic dilators is not significantly beneficial before 16 weeks' gestation. Limited data demonstrate the safety of misoprostol after D&E in addition with a prior osmotic dilator. Misoprostol, a prostaglandin analogue, is also effective for cervical preparation prior to D&E, although data to support its use are limited. The Society of Family Planning recommends preoperative cervical preparation to decrease the risk of complications when performing D&E. Since no single protocol has been found to be superior to all situations, clinical judgment is warranted when selecting a method of cervical preparation.

Keywords: Dilation and evacuation; Cervical dilation; Dilapan; Laminaria; Dilapan; Laminaria; Misoprostol; Cervical prep

Background

This document reviews and replaces the previous version, originally published in 2005. Approaches to cervical preparation prior to dilation and evacuation (D&E) have changed over the past 4 years, with increased emphasis on regimens that avoid overnight placement of osmotic dilators. These practice recommendations have been updated to reflect increasing evidence demonstrating the safety of regimens that accept overnight preparation and D&E within a single day. The use of Dilapan-SM and misoprostol for cervical preparation on the same day as D&E has increased. Medical evidence now supports the use of misoprostol and Dilapan during D&E, the cervix must be dilated sufficiently to allow passage of operative instruments and fetal parts without injuring the cervical canal. The minimum dilation