2017 CLINICAL POLICY GUIDELINES FOR ABORTION CARE

naf NATIONAL ABORTION FEDERATION

2017
Clinical Policy Guidelines for Abortion Care

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National Abortion Federation *Clinical Policy Guidelines* can be accessed on the Internet at www.prochoice.org.

The National Abortion Federation is the professional association of abortion providers. Our mission is to ensure safe, legal, and accessible abortion care, which promotes health and justice for women.

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INTRODUCTION

The mission of the National Abortion Federation (NAF) is to ensure safe, legal, and accessible abortion care, which promotes health and justice for women. An important part of this work is to develop and maintain evidence-based guidelines and standards as well as to educate providers in the latest technologies and techniques.(1) NAF's programs make it possible for women to obtain the highest quality abortion care.

Like its precursors, the 2017 edition of NAF's *Clinical Policy Guidelines for Abortion Care* (CPGs) serve to provide guidance for facilities to use in establishing their clinical policies. The CPGs are developed by consensus, based on rigorous review of the relevant medical literature and patient outcomes.(2-6) These guidelines are intended to provide parameters to ensure that patients have access to the highest quality abortion care.

NAF's *Clinical Policy Guidelines* were first published in 1996 and have been revised annually since then. Since inception, they have been based on the methodology described by David Eddy, MD, in *A Manual for Assessing Health Practices and Designing Practice Policies: The Explicit Approach*.(7) Clinical policy guidelines are defined as a systematically developed series of statements, which assist practitioners and patients in making decisions about appropriate health care. They represent an attempt to distill a large body of medical knowledge into a convenient and readily usable format. In this new edition for 2017, we have incorporated the Institute of Medicine's recommendations.(8)

When the outcomes of an intervention are known, practitioner choices are limited. But when the outcomes of an intervention are uncertain or variable, and/or when patients' preferences for those outcomes are uncertain or variable, practitioners must be given flexibility to tailor a policy to individual cases. This is addressed by having three types of policies according to their intended flexibility: standards, recommendations, and options:

1) **STANDARDS** are intended to be applied in virtually all cases. Deviations will be rare and difficult to justify.

2) **RECOMMENDATIONS** are steering in nature. They do not have the force of standards, but when not adhered to, there should be documented, rational clinical justification. They allow some latitude in clinical management.

3) **OPTIONS** are neutral with respect to a treatment choice. They merely note that different interventions are available and that different people make different choices. They may contribute to the educational process, and they require no justification.

NAF's *Clinical Policy Guidelines* include a list of references for each section, and include discussion material for clarification when appropriate. These guidelines are meant to be living documents, subject to revision every year as new medical evidence becomes available.

Medline was searched monthly on Pubmed. An automated search using the following terms was created: "dilation and evacuation" or "medical abortion" or "induced abortion" or “uterine aspiration.” Every month, the results of this search were reviewed. In addition, the table of contents of the following journals were reviewed:

- *American Journal of Obstetrics & Gynecology*
- *BJOG: An International Journal of Obstetrics and Gynaecology*
- *Contraception*
- *European Journal of Obstetrics & Gynecology and Reproductive Biology*
- *Fertility & Sterility*
- *Human Reproduction*
- *International Journal of Gynecology & Obstetrics*
- *JAMA*
- *Journal of Obstetrics and Gynaecology Canada*
- *The Lancet*
- *New England Journal of Medicine*
- *Obstetrics & Gynecology*
- *Perspectives on Sexual and Reproductive Health*
- *PLOS Medicine*
- *Ultrasound in Obstetrics & Gynecology*

These sources were checked throughout 2016. In addition, the references for new papers were reviewed to identify older research, which might have been missed in prior searches.

Inclusion criteria:

- Study addresses a topic in the NAF CPGs;
- Outcome is a relevant clinical endpoint; or
- Study design is adequate to assess impact of intervention.

Exclusions:

- Poor study methodology, e.g. a case-control study with a poorly selected control group.

In 2016, we identified 308 new studies. Of these, 16 were included in the 2017 CPGs because they changed one or more statements or substantially improved the level of evidence supporting a current statement. Changes to each policy statement were drafted by NAF’s Medical Director, Matthew Reeves, MD, MPH, based on the included papers. These papers were reviewed by the NAF Clinical Policy Committee and changes to each policy statement were edited and approved by the entire committee. A synthesis of how the new study altered the existing policy statement will be available in an online module.

NAF 2016 Clinical Policy Committee members:

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Note: The *Clinical Policy Guidelines* are not intended to educate members regarding legal and regulatory issues, which may affect abortion practice. It is expected that administrators, staff, and clinicians will be aware of pertinent local, state/provincial/territorial, and national law as well as the requirements and limitations of their individual duties and scope of professional practice. NAF provider members should ensure that all employees have access to appropriate resources for information and support.

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NOTES ON FORMATTING

As presented here, standards, recommendations, and options are hierarchical in nature. It is therefore expected that clinical practices will favor the highest level of guidance available on a given point. To clarify the relationships of Recommendations and/or Options that are subordinate to higher level Standards and/or Recommendations, NAF's guidelines are numbered and formatted according to the following scheme:

Within each section, Standards are numbered consecutively starting with the section number with the standard to the right of a decimal. For example, the first standard in Section 1 will be Standard 1.1.

Recommendations are also numbered consecutively within each main subject heading, with numbers that are placed to the right of a second decimal point. Where a recommendation follows a standard, it is indented below the standard and the number of that standard will be found to the left of the decimal point (e.g., Recommendation 1.1.1). Where the recommendation stands alone and is not related to a specific standard, it is not indented in its placement on the page, and there will be a zero in the position to the left of the decimal point (e.g., Recommendation 1.0.1).

The consecutive numbers denoting Options within each main subject heading are placed to the right of the third decimal point. Where an option follows a preceding standard or recommendation, it is indented below that standard or recommendation and the numbers identifying that option will be found to the right of a third decimal point added to the end of the standard or recommendation (e.g., Option 1.1.0.1 or Option 1.1.1.1). Where the option stands alone and is not related to a specific standard or recommendation, it is not indented in its placement on the page, and zeros will be placed in the position for the standard and recommendation (e.g., Option 1.0.0.1).

1. WHO CAN PROVIDE ABORTIONS

Policy Statement: Abortion is a safe procedure when provided by qualified practitioners.(1) The vast majority of abortions, including uterine aspiration, dilation and evacuation, and medical induction, can be safely provided in medical offices or freestanding clinics.

Standard 1.1. Abortion will be provided by licensed* practitioners. This category is intended to include physicians from various specialties as well as nurse midwives, nurse practitioners, physician assistants, registered nurses, and other health professionals.(2)

Recommendation 1.1.1. Documentation specifying privileges in accordance with each practitioner's scope of practice should be maintained.

Recommendation 1.1.2. Hospital admitting privileges are not needed to provide safe abortion care.(3)

Standard 1.2. All practitioners providing abortions must have received training to competency in abortion care, including the prevention, recognition, and management of complications.

Standard 1.3. All staff members providing patient services must have appropriate training, for example, in ultrasound, counseling, sedation, laboratory, infection control, and other patient-related services.

Standard 1.4. Appropriate referrals must be available for patients who cannot be cared for by a practitioner at your facility.†

References:

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* The term "licensed" is used here to indicate that a person is lawfully entitled to practice their profession in the place in which the practice takes place. The laws are different throughout the United States, Canada, Mexico, and Colombia.

† This may include the NAF Referral Line.

3. *Whole Woman's Health v. Hellerstedt*, 579 U.S. (2016).

2. PATIENT EDUCATION, COUNSELING, AND INFORMED CONSENT

Policy Statement: Obtaining informed consent and assessing that the decision to have an abortion is made freely by the patient are essential parts of the abortion process.

Informed Consent

Standard 2.1. The practitioner must ensure that appropriate personnel have a discussion with the patient in which accurate information is provided about the procedure and its alternatives, and the potential risks and benefits. The patient must have the opportunity to have any questions answered to her satisfaction prior to intervention.

Option 2.1.0.1. Information may be provided either on an individual basis or in group sessions.

Standard 2.2. Documentation must show that the patient affirms that she understands the procedure and its alternatives, the potential risks and benefits, and that her decision is voluntary. Although other risks may be addressed, at a minimum, the following risks must be included:

(1) Hemorrhage(1)

(2) Infection(1, 2)

(3) Continuing pregnancy(1, 3)

(4) Death(4, 5)

For abortion procedures (vacuum aspiration or dilation and evacuation), the additional risks must be included:

(5) Perforation(1)

(6) Damage to organs including hysterectomy(1)

Patient Education and Counseling

Standard 2.3. Each patient must have a private opportunity to discuss issues and concerns about her abortion.(6-10)

Standard 2.4. A patient must undergo the abortion as expeditiously as possible in accordance with good medical practice.

Standard 2.5. Information about aftercare and contraception must be available to patients at the facility.

Recommendation 2.5.1. The importance of contacting the facility for any concerns should be emphasized.

Recommendation 2.5.2. Evidence-based guidelines for contraceptive counseling should be followed.(11-14)

Standard 2.6. All reasonable precautions must be taken to ensure the patient's confidentiality.

Recommendation 2.6.1. The patient should be informed of the communication of information to any third party.

Recommendation 2.6.2. A discussion should take place about which individuals or agencies may receive communications regarding services. This discussion should include confidentiality implications of using insurance or governmental health care coverage.

Discussion: Informed consent and abortion counseling are two different processes. The goal of informed consent is to assure that the patient's decision is voluntary and informed. Patient education and counseling includes a discussion of the feelings and concerns expressed by the patient, which may include help with decision-making and contraceptive choices, values clarification, or referral to other professionals. A referral to community services should be available if that becomes necessary or the needs of the patient are outside the scope of training of clinic staff.

Where abortion is safe and legal, the risk of death overall is less than 1 per 100,000 abortions.(4, 15) While the risk of death from safe abortion has remained stable, the MMR in the U.S. has been rising steadily since 1987 when the Pregnancy Mortality Surveillance System was implemented.(16)

Risks of pregnancy-related death by country (16, 17)

Country	**Maternal mortality ratio***
Canada	7
United States	24
Mexico	38
Colombia	64

*deaths per 100,000 live births

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3. INFECTION PREVENTION AND CONTROL

Policy Statement: Patients and health care personnel are at risk for exposure to blood borne pathogens and other potentially infectious material. Infectious material may be transmitted to patients when proper engineering* and work practice controls,† which reduce exposure, are not followed. Proper handling of chemicals and other materials needed for proper disinfection is important to prevent harm to staff. Prevention and treatment of infection will reduce post-abortion morbidity.

Standard 3.1. Proper engineering and work practice controls must be in place to reduce exposure of patient and staff to infectious agents. Clinics must protect employees and patients from being exposed to biohazardous material.(1-3)

Standard 3.2. Hands must be washed or disinfected before and after patient contact.(4-6)

Standard 3.3. Personal protective equipment must be provided to all staff.(2, 7-10)

- Recommendation 3.3.1. New staff with potential exposure should have an initial training as part of orientation.
- Recommendation 3.3.2. Periodic facility-level training should occur at least every three years.
- Recommendation 3.3.3. Hepatitis B vaccine should be provided at no cost to the staff.

Standard 3.4. Exposure control plans must be established and followed.(7, 9, 11)

- Recommendation 3.4.1. Post-exposure evaluation, prophylaxis, and follow-up should be available to exposed patients or staff for any potentially infectious agent, regardless of source.

Standard 3.5. All instruments coming into contact with patients must be properly cleaned and disinfected between patients.(3)

Standard 3.6. All instruments entering the uterus must be sterile.

* Engineering control—available technology and devices that isolate or remove hazards from the work place, such as puncture-resistant sharps disposal containers.

† Work practice control—an alteration in the way a task is performed that reduces the likelihood that an employee will be exposed to blood or other potentially infectious materials.

Option 3.6.0.1. The cervix and vagina may be cleansed with a bactericidal agent though randomized trials have failed to show a benefit to this practice.(12)

Standard 3.7. Tubing and manual uterine aspirators must be high-level disinfected or sterilized.(3)

Standard 3.8. All tissue removed in the facility must be considered biohazardous and be handled, stored, and disposed of in a manner that minimizes the risk of exposure. A protocol for tissue handling, storage, and disposal must be in place.

Standard 3.9. Sharps containers must be readily available.

Standard 3.10. Routine antibiotic prophylaxis must be used for abortion procedures (vacuum aspiration and dilation and evacuation).(13, 14)

Recommendation 3.10.1. All patients having abortion procedures should receive antibiotics pre-procedure.(12, 15, 16)

Option 3.10.1.1. Antibiotics may be initiated at the time of insertion of osmotic dilators.

Option 3.10.1.2. Antibiotics may be given to patients choosing medical abortion.(17) Insufficient evidence exists to support routine antibiotic prophylaxis for medical abortion.

Recommendation 3.10.2. Additional antibiotics are not recommended for endocarditis prophylaxis in patients with heart murmurs or other cardiac conditions.(14, 18, 19)

Recommendation 3.10.3. Patients should be offered testing for chlamydia and gonorrhea.(20) Testing should not delay the procedure.

Option 3.10.3.1. Empiric treatment of chlamydia may be considered for patients with history, signs, or symptoms of current infection.

Standard 3.11. Diagnosed infection must be appropriately treated.

Recommendation 3.11.1. For documented infections of the reproductive tract, evidence-based regimens should be followed.(20, 21)

Discussion: Regulatory agency policies (see references) may be helpful in developing exposure plans that protect personnel and patients from potentially infectious material.

Proper techniques for collection, labeling, and disposal of biohazardous material and for the processing of instruments are integral to any complete plan.

The literature supports universal pre-procedure antibiotic prophylaxis for abortion procedures.(13) Only one large cohort analysis addresses the use of antibiotics in medical abortion.(17, 22)

Expedited partner treatment may be considered for patients with a known diagnosis of a sexually transmitted infection.

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4. LABORATORY PRACTICE

Policy Statement: Rh alloimmunization may jeopardize the health of a subsequent pregnancy.(1-8)

Standard 4.1. Rh status testing must be offered to all patients with unknown Rh status.

Standard 4.2. Rh status must be documented in all patients undergoing second-trimester abortion.

Recommendation 4.2.1. This documentation may be obtained by on-site testing, outside source, or self-report.

Recommendation 4.2.2. A patient whose Rh status is unknown and declines Rh testing should sign an informed waiver.

Recommendation 4.2.3. Additional testing for either sensitization or other antibodies is not required in patients undergoing pregnancy termination, including testing for Du ("weak D").

Standard 4.3. Rh immune globulin administration must be offered to patients known to be Rh (-).

Standard 4.4. If Rh immune globulin is not administered in the facility, one of the following is required:

(a) Informed waiver signed by a patient who declines Rh immune globulin; or

(b) Documentation of other arrangements for administration.

Standard 4.5. Anemia and the risk of bleeding must be evaluated.(9)

Recommendation 4.5.1. Hemoglobin or hematocrit testing should be readily available.

Recommendation 4.5.2. Prior to uterine aspiration and medical abortion in the first trimester, hemoglobin/hematocrit and other laboratory evaluation should be done as indicated by medical history and patient symptoms. Routine hemoglobin or hematocrit has not been shown to improve outcomes.

Recommendation 4.5.3. Prior to administration of methotrexate, a complete blood count (CBC) should be considered for patients with history of blood dyscrasia.

Recommendation 4.5.4. Hemoglobin or hematocrit should be checked before all abortions after the first trimester.

Discussion: No data supports the administration of Rh immune globulin in very early pregnancies (less than eight weeks) or indicate any harm associated with its administration. Until/unless such data is available, the NAF Rh testing standards must be applied to pregnancies of any gestation.

The use of approved slide/tube/spot methods is acceptable for on-site Rh testing.

Moderate or asymptomatic anemia is rarely a reason to delay abortion care.

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5. LIMITED SONOGRAPHY IN ABORTION CARE

Policy Statement: The use of ultrasound is not a requirement for the provision of first-trimester abortion care. Proper use of ultrasound may inform clinical decision-making in abortion care.

Standard 5.1. Staff members who perform ultrasound exams and clinicians who interpret those exams must either show documentation of proficiency or complete a program of training. Training must include a period of supervision. Documentation of this training must be maintained.

Option 5.1.0.1. The *Ultrasound Training in Abortion Care* CD-ROM developed by ARMS, NAF, and CAPS is a good resource for training and may be utilized as part of a training program.(1)

Standard 5.2. A system of proficiency review must be in place for staff members who perform ultrasound exams and clinicians who interpret those exams.

Standard 5.3. Patients must be informed of the purpose and limitations of the ultrasound exam in the abortion care setting.

Standard 5.4. Patients must be informed of the sonographic diagnosis, including early pregnancy failure.(2, 3)

Standard 5.5. The findings of all ultrasound exams and the interpretation of those findings must be documented in the medical record. This documentation must also include the name(s) of staff who performed and interpreted the exam.(4)

Recommendation 5.5.1. Ultrasound images should be included as part of the documentation, particularly for the purposes of proficiency review.

Recommendation 5.5.2. A standard form for documenting findings and interpretation should be used.

Standard 5.6. A limited ultrasound exam must include the following:

(1) a full scan of the uterus in both the transverse and longitudinal planes to confirm an intrauterine pregnancy;

(2) evaluation of embryo/fetal number;

(3) measurements to document gestational age (5, 6);

(4) evaluation of pregnancy landmarks, such as yolk sac or the presence or absence of fetal/embryonic cardiac activity; and

(5) placental location in second trimester.

Recommendation 5.6.1. When clinically indicated, evaluation of other pelvic structures (i.e., adnexal structures and the cul de sac) should be performed and documented or an appropriate referral should be made for further evaluation.

Standard 5.7. When a patient with a prior uterine scar is found to have placenta previa or a low anterior placenta, or when other placental abnormality is suspected, additional sonographic imaging should be performed on-site or an appropriate referral made.(7-9)

Standard 5.8. Ultrasound equipment must be properly maintained.

Standard 5.9. All ultrasound transducers must be disinfected between patients.

Discussion: According to the American Institute of Ultrasound in Medicine (AIUM), in collaboration with the American College of Obstetrics and Gynecology and the American College of Radiology, a "limited ultrasound examination" is performed when a specific question requires investigation.(4, 10, 11)

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6. EARLY MEDICAL ABORTION

Policy Statement: Medical induction is an effective method for early abortion.(1-8) Adequate counseling and follow-up care will enhance its safety and acceptability.

Standard 6.1. Initial evaluation must include pertinent medical history.

Standard 6.2. The patient must be informed about the efficacy, side effects, and risks, including excessive bleeding, infection, and teratogenicity of the medications used.(9)

Recommendation 6.2.1. Breastfeeding is not a contraindication to medical abortion with mifepristone and misoprostol. Patients should be informed that breastfeeding can continue uninterrupted without concern for side effects in infants.(11, 12)

Option 6.2.1.1. As appropriate, patients may be informed that no evidence-based way to reverse mifepristone exists.(10)

Standard 6.3. The patient must be informed that a uterine aspiration may be necessary.

Standard 6.4. Patient instructions must include written and oral information about use of medications at home and symptoms of abortion complications.

Standard 6.5. The facility must provide an emergency contact service on a 24-hour basis and must offer or assure referral for uterine aspiration if indicated.

Standard 6.6. Confirmation of pregnancy must be documented. Gestational age must be verified to be within the limits of the facility medical abortion protocol.

Recommendation 6.6.1. If an ultrasound has been performed and an intrauterine gestation has not been confirmed, the medical abortion regimen should be offered concurrently with evaluation for pregnancy of unknown location, as outlined in CPG section 8 Management of Pregnancy of Uncertain Location.

Standard 6.7. IUDs must be removed prior to proceeding with medical abortion.

Recommendation 6.7.1. If an IUD cannot be removed without delaying the medical abortion, the patient should be offered a uterine aspiration.

Standard 6.8. Combined mifepristone/misoprostol regimens are more effective than misoprostol alone or methotrexate and misoprostol. An evidence-based medical abortion regimen must be used.(13-15)

Recommendation 6.8.1. Where mifepristone is available, a combined mifepristone-misoprostol regimen should be used.(1-7, 16, 17)

Recommendation 6.8.2. If a misoprostol-alone or methotrexate-misoprostol regimen is offered when mifepristone is available, full information on the differences between the chosen regimen and mifepristone-misoprostol regimens should be addressed with the patient and informed consent obtained.(18)

Recommendation 6.8.3. A dose of 200 mg of mifepristone is recommended for combined mifepristone-misoprostol regimens.(7, 15)

Option 6.8.3.1. Mifepristone may be taken outside the clinic setting.(19)

Recommendation 6.8.4. When used for outpatient medical abortion, mifepristone and vaginal, buccal, or sublingual misoprostol are recommended for gestations up to 70 days.(20-26)

Recommendation 6.8.5. When used for outpatient medical abortion, mifepristone and oral misoprostol may be used for gestations up to 56 days.(27)

Recommendation 6.8.6. When used for outpatient medical abortion, misoprostol alone may be used by vaginal, buccal, or sublingual routes for gestations up to 63 days.(13-15, 28-32)

Recommendation 6.8.7. When methotrexate and misoprostol are used, an evidence-based regimen oral or intramuscular methotrexate followed in three to five days with vaginal misoprostol is recommended for gestations up to 63 days.(7, 33)

Standard 6.9. Patient comfort level during the medical abortion process must be considered. Analgesia or other comfort measures must be discussed and offered as needed.

Recommendation 6.9.1. Non-steroidal anti-inflammatories such as ibuprofen should be offered over acetaminophen for pain control.(34-36)

Standard 6.10. Patients must be offered a follow-up assessment to confirm absence of ongoing pregnancy. Confirmation can be established by ultrasonography, hCG testing, physical exam, or other evaluation in the office, by telephone, or electronic communication.(37-39)

Recommendation 6.10.1. Follow-up evaluation should be scheduled within 14 days after starting medical abortion.(7)

Recommendation 6.10.2. High-sensitivity urine hCG testing should not be checked within three weeks of medical abortion.(40-43)

Option 6.10.2.1. Multi-level urine pregnancy tests may be used.(43-46)

Recommendation 6.10.3. Endometrial thickness alone should not be used to guide management after medical abortion.(47, 48)

Recommendation 6.10.4. A second dose of misoprostol (800 mcg) may be given for persistent gestational sac or continuing pregnancy.(49, 50)

Recommendation 6.10.5. Prolonged courses of misoprostol should not be given routinely to improve success.(51, 52)

Standard 6.11. Medications dispensed and prescribed must be documented.

Standard 6.12. If the patient has failed to follow-up as planned, clinic staff must document attempts to reach the patient. All attempts to contact the patient must be documented in the patient's medical record.

Discussion: Many patients prefer pharmacological methods of terminating early pregnancies rather than uterine aspiration. Medical abortion regimens and follow-up evaluations have evolved rapidly over the past decade, and are likely to continue to improve.

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7. First-Trimester Aspiration Abortion

Policy Statement: Induced abortion is one of the safest procedures in medicine. The following guidelines are intended to outline steps that maximize this safety.

Standard 7.1. Pertinent medical history must be obtained.

Standard 7.2. Pregnancy must be confirmed and gestational age must be assessed.

Recommendation 7.2.1. When gestational age cannot be reasonably determined by other means, ultrasonography should be used.

Standard 7.3. Appropriate initial evaluation must be performed. Baseline blood pressure and pulse must be obtained for all patients.

Recommendation 7.3.1. Physical exam should be done as indicated by medical history and patient symptoms.

Standard 7.4. The cervix should be appropriately dilated for the gestational age.

Recommendation 7.4.1. Cervical dilation may be achieved through the use of rigid cervical dilators. Tapered dilators such as Pratt or Denniston dilators are recommended over non-tapered dilators such as Hegar dilators.(1)

Recommendation 7.4.2. When misoprostol is used for cervical preparation, a dose of 400 mcg should be used.(2-4) The cervical effects of misoprostol are variable but generally require administration more than 60 minutes prior to the procedure.

Option 7.4.2.1. The routine use of 400 mcg misoprostol before procedures may reduce rare complications but must be balanced against increased pain and other side effects for all patients.(5)

Option 7.4.2.2. Osmotic dilators may be considered when cervical dilation is expected to be difficult.(6)

Standard 7.5. First-trimester abortion procedures must be performed by aspiration of the uterus, not by sharp curettage.(7-9)

Recommendation 7.5.1. Uterine aspiration is effective throughout the first trimester including prior to confirmation of a definitive intrauterine pregnancy on ultrasound.(10)

Standard 7.6. The procedure and all medications given must be documented.

Discussion: Sharp curettage should not be routinely used after vacuum aspiration.

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8. MANAGEMENT OF PREGNANCY OF UNCERTAIN LOCATION

Policy Statement: The early identification of ectopic pregnancy will reduce morbidity related to rupture and increase the likelihood of successful non-surgical management. Failure to identify a definitive intrauterine pregnancy or presenting signs and symptoms, such as vaginal bleeding or pelvic pain, should alert providers to the importance of following policies and procedures for ruling out ectopic pregnancy.

Standard 8.1. The patient must be evaluated to assess for the risk of ectopic implantation in early pregnancy.(1-3)

Recommendation 8.1.1. Evaluation should involve assessment of the history in combination with one or more of the following: physical exam, sonography, serial quantitative hCGs, and/or uterine aspiration.(4)

Option 8.1.1.1. Abortion care can be provided even if pregnancy location is uncertain.(5-7)

Standard 8.2. Each facility must have a written protocol to evaluate suspected ectopic pregnancy. All relevant staff at the site must be familiar with the protocol.

Recommendation 8.2.1. This protocol may include referrals as appropriate.

Option 8.2.1.1. Posting a clinical algorithm for the evaluation of possible ectopic pregnancy may be useful.(4, 8)

Standard 8.3. All patients with a pregnancy of uncertain location must be informed of the options for evaluation and management. The symptoms and dangers associated with ectopic pregnancy, and a plan for when and how to seek emergency medical attention must be reviewed and documented.

Recommendation 8.3.1. Each facility should have a patient education handout describing ectopic warning signs and the medical record should reflect that the patient has received this handout.

Standard 8.4. When a medical or aspiration abortion is initiated for a patient with a pregnancy of uncertain location, resolution of the pregnancy must be verified and documented. This may be demonstrated by either the examination of aspirated tissue or by following serial hCG levels according to evidence-based regimens.

Standard 8.5. Patient follow-up must continue until one of the following:

(1) the diagnosis of ectopic pregnancy has been excluded;

(2) clinical resolution of a possible ectopic pregnancy has been ensured; or

(3) transfer of care to an appropriate provider has been made and documented.

Standard 8.6. Patients experiencing symptoms suspicious for ruptured ectopic pregnancy must be evaluated emergently.

Discussion: A combination of clinical assessment, pelvic ultrasound, serum quantitative hCG, and/or examination of uterine aspirate is often needed to distinguish between an early intrauterine gestation, a miscarriage, and an ectopic pregnancy.(1) With normal early gestations, pre-procedure ultrasound may fail to identify an intrauterine pregnancy, leaving the clinician uncertain about the viability and location of the pregnancy. Although a gestational sac can usually be seen four to five weeks from LMP on transvaginal ultrasound, it may be confused with a pseudo-sac associated with an ectopic pregnancy.(9, 10) Although visualization of a yolk sac or embryo is needed to definitely confirm an intrauterine pregnancy on ultrasound,(11) the lack of visualization of these structures should not delay abortion care.

In the emergency department, from seven to 20% of patients with a pregnancy of uncertain location are subsequently found to have an ectopic pregnancy.(9) Although it is an important cause of pregnancy-related morbidity and mortality, ectopic implantation has been reported to occur in less than 1% of pregnancies in patients presenting for induced abortion.(5, 12)

Following aspiration abortion, if sufficient products of conception (POC) are not identified, one option for additional evaluation is the use of quantitative hCG testing. A baseline hCG can be obtained and a second hCG can be done in 24-48 hours. If there is a decrease of 50% or more, no further ectopic follow up is necessary.(13-15) Otherwise, further evaluation should be initiated including consideration of ectopic pregnancy.

Similarly, following medical abortion, hCG can be used to rule out ongoing intrauterine and ectopic pregnancy simultaneously.(16, 17)

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9. ABORTION BY DILATION AND EVACUATION

Policy Statement: Abortion by dilation and evacuation (D&E) after 14 weeks from LMP is a safe outpatient procedure when performed by appropriately trained clinicians in medical offices, freestanding clinics, ambulatory surgery centers, and hospitals.(1-6)

Standard 9.1. Pertinent medical history must be obtained and relevant physical examination must be performed.

Recommendation 9.1.1. Obesity without other comorbidities should not be used to restrict access to D&E since complications do not increase with increasing body-mass index.(7)

Standard 9.2. Gestational age must be verified by ultrasonography, using a consistent and published table of fetal measurements, prior to the termination of a pregnancy clinically estimated to be more than 14 weeks from LMP.

Standard 9.3. The patient must be appropriately evaluated and prepared for the procedure.

Recommendation 9.3.1. Intravenous access should be established prior to evacuation.

Recommendation 9.3.2. When feticidal injections are employed, they should be provided through a standard protocol.(8-15)

Option 9.3.2.1. Intraamniotic or intrafetal injection of digoxin may be administered either transabdominally or transvaginally to cause fetal demise.(16-18)

Option 9.3.2.2. Intracardiac potassium chloride may be used to cause fetal demise.(15)

Standard 9.4. When osmotic dilators, mifepristone, misoprostol, and/or other cervical preparation agents are used, a plan for emergency care prior to the evacuation procedure must be in place and communicated to the patient.

Standard 9.5. Appropriate dilation of the cervix must be obtained gently and gradually.(19, 20)

Recommendation 9.5.1. Osmotic dilators, misoprostol, mifepristone and/or other cervical preparation agents should be used to facilitate adequate dilation.(21-24)

Recommendation 9.5.2. Each dose of misoprostol should not be more than 400 mcg.(24-28) Sublingual administration is associated with more pain than other routes of administration.(29)

Option 9.5.2.1. Dilapan and/or misoprostol may be used for same-day cervical dilation.(25, 27, 28, 30)

Standard 9.6. All instruments entering uterine cavity must be sterile.

Standard 9.7. Evidence-based practices must be used to lower the risk of complications.

Recommendation 9.7.1. Intra-procedure ultrasonography should be used to aid in visualizing instruments, locating fetal parts, verifying an empty uterus, reducing the risk of uterine perforation, and shortening the procedure.(31-33)

Recommendation 9.7.2. Inhaled anesthesia should be avoided if possible due to the increased risk of hemorrhage.(34, 35)

Standard 9.8. Uterotonics must be available to aid in control of uterine bleeding.(36)

Recommendation 9.8.1. A prophylactic vasoconstrictor, such as vasopressin, should be used intracervically or paracervically to reduce blood loss.(37)

Standard 9.9. Examination of the uterine contents must be performed to identify the placenta and all major fetal parts.

Recommendation 9.9.1. If the above are not identified, ultrasonographic evaluation and uterine exploration under ultrasound guidance should be considered.

Recommendation 9.9.2. The facility and/or clinician should continue care of the patient until completion of the abortion or transfer of care to an appropriate provider is made.

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10. LATER MEDICAL INDUCTION ABORTION

Policy Statement: Medical induction abortion is a safe and effective method for termination of pregnancies beyond the first trimester when performed by trained clinicians in medical offices, freestanding clinics, ambulatory surgery centers, and hospitals. Feticidal agents may be particularly important at later gestational ages.

Standard 10.1. Pertinent medical history must be obtained and relevant physical examination must be performed.

Standard 10.2. Gestational age must be verified by ultrasonography, using a consistent and published table of fetal measurements, prior to the termination of a pregnancy clinically estimated to be more than 14 weeks from LMP.

Standard 10.3. The patient must be appropriately evaluated and prepared for the procedure.

Recommendation 10.3.1. Intravenous access should be established prior to induction.

Standard 10.4. Facilities must have a policy that addesses whether and when to induce fetal demise.

Recommendation 10.4.1. When feticidal injections are employed, they should be provided through a standard protocol.(1-7)

Option 10.4.1.1. Intraamniotic or intrafetal injection of digoxin may be administered either transabdominally or transvaginally to cause fetal demise. (8-10)

Option 10.4.1.2. Intracardiac potassium chloride may be used to cause fetal demise.(7)

Standard 10.5. Evidence-based regimens of medical induction must be used.

Recommendation 10.5.1. Mifepristone 200 mg followed by misoprostol should be used, when available and feasible.(11-14)

Option 10.5.1.1. Misoprostol may also be used alone.(15)

Option 10.5.1.2. The initial dose of misoprostol may be more effective if administered vaginally,(15) particularly in nulliparous patients.(16)

Option 10.5.1.3. Subsequent doses of 400 mcg misoprostol may be most effective when given every 3-4 hours and are effective by vaginal, buccal, or sublingual routes.(15)

Option 10.5.1.4. Oxytocin may be used as an adjunctive agent to induce labor or alone when misoprostol is contraindicated.

Recommendation 10.5.2. Osmotic dilators should not be used as they do not shorten the induction time but increase pain.(12, 17-19)

Recommendation 10.5.3. Intraamniotic injection or instillation methods should be avoided as they are less effective and result in more complications than mifepristone-misoprostol or misoprostol-alone regimens.(20)

Standard 10.6. Once regular contractions have been confirmed, patients must be observed by health care staff trained to monitor contractions and expulsion, and who can recognize emergent situations.

Standard 10.7. A trained clinician must be available from initiation of induction until post-abortion discharge.

Standard 10.8. Access to surgical management or appropriate referral must be available in the event that surgical intervention is required.

Standard 10.9. The facility and/or clinician should continue care of the patient until completion of the abortion or transfer of care to an appropriate provider is made.

Discussion: An interval of 24-48 hours between mifepristone and misoprostol shortens the time to completion after starting misoprostol.

Numerous studies have found that the use of misoprostol does not increase the risk of uterine rupture in a previously scarred uterus in the second trimester compared to other induction agents, even with three or more prior Cesarean deliveries.(21) The risk of uterine rupture during second-trimester induction in patients with a scarred uterus is roughly 0.3%, and is not higher than among patients without a prior Cesarean delivery.(22)

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11. ANALGESIA AND SEDATION

Policy Statement: Anxiolysis, analgesia, or anesthesia should be provided during abortion procedures for any patient for whom the benefits outweigh the risks, with the aim of providing the appropriate level of analgesia and sedation required for each patient's needs. Patients should be involved in a shared decision-making process about pain control and sedation during the procedure.(1-14)

ON THE USE OF SEDATION IN GENERAL - All medications used in procedural sedation have the potential for serious risk. This risk may be reduced to a minimum by adherence to established practice guidelines. Guidelines developed by other organizations concern themselves with anesthesia and sedation delivered primarily in hospital settings and to patients varying widely in age and general health. Regardless of the drug or route of administration, the degree of central nervous system (CNS) depression is the basis for the NAF guidelines.

These guidelines do not address the use of deep sedation or general anesthesia except to identify basic monitoring practices and appropriate providers of such care, who are expected to follow their professional standards in the delivery of anesthesia services. It is expected that those individuals providing deep sedation or general anesthesia will have appropriate emergency medication and equipment in place to ensure the safe care of a patient in the event of an anesthesia complication.

The promulgation of guidelines for the delivery and monitoring of anesthesia care issued by organizations such as the American Society of Anesthesiologists (ASA)(15), the Canadian Anesthesiologists' Society (CSA)(16), the American Dental Society of Anesthesiologists (ADSA), American Society of Gastrointestinal Endoscopists, and others have clarified many of the issues related to anesthesia care.

Patient comfort and reduced anxiety are significantly affected by patient counseling and by the presence of family, friends, and supportive staff, and are not solely dependent on pharmacologic measures. Alternative modalities (such as relaxation techniques, acupuncture, hypnosis) may be helpful for some patients. The focus of NAF guidelines for analgesia and sedation, however, is on the safe provision of pharmacologic methods generally used in outpatient abortion facilities.

Definitions(10)

1. Local Anesthesia - Elimination or reduction of sensation, especially pain, in one part of the body by topical application or local injection of a drug. In the context of abortion practice, local anesthesia almost always involves a paracervical block.

2. Minimal Sedation (Anxiolysis) - A drug-induced state during which patients respond normally to verbal commands. Although cognitive function and physical

coordination may be impaired, airway reflexes, ventilatory, and cardiovascular functions are unaffected.

3. Moderate Sedation/Analgesia - A drug-induced depression of consciousness during which patients respond purposefully* to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained but may be impaired. This level of sedation was previously referred to as "Conscious Sedation." However, this term is no longer recommended.

4. Deep Sedation/Analgesia - A drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained but may be impaired.

5. General Anesthesia - A drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.

Because sedation is a continuum, it is not always possible to predict how an individual patient will respond. Hence, practitioners intending to produce any level of sedation should be able to rescue patients whose level of sedation becomes deeper than initially intended. *Rescue* corrects adverse physiologic consequences of the deeper-than-intended level of sedation (such as hypoventilation, hypoxia, and hypotension) and returns the patient to the originally intended level of sedation.

Standard 11.1. Pain control options must be discussed with the patient.

Standard 11.2. When minimal, moderate, deep sedation, or general anesthesia is to be given, patients must be given information about the risks, benefits, and side effects of the medications to be used.

Recommendation 11.2.1. Documentation should include precautions relevant to transient mental impairment.

* Reflex withdrawal from a painful stimulus is NOT considered a purposeful response.

Option 11.2.1.1. An informed consent form specific for analgesia and sedation may be used.

Standard 11.3. Prior to moderate sedation, a pre-sedation evaluation of the patient must take place.

Recommendation 11.3.1. Evaluation should include a relevant history and review of systems; medication review; targeted exam of the heart, lung, and airway; baseline vital signs; and last food intake.

Recommendation 11.3.2. For patients receiving moderate sedation who are not at increased risk of aspiration, time from last meal should not limit access to abortion care.(17-19)

Recommendation 11.3.3. A reduced level of sedation, an alternate abortion procedure, or provision of care by an anesthesia professional should be considered for patients with an atypical airway assessment or ASA P-3 or greater.

Standard 11.4. No additional evaluation is needed prior to paracervical block and/or NSAID administration.

Standard 11.5. The supervising practitioner must be immediately available when sedation is administered.

Standard 11.6. When local anesthesia or sedation is provided, the practitioner responsible for the treatment of the patient and/or the administration of drugs must be appropriately trained, with approval by the medical director or their designee.

Standard 11.7. To administer moderate sedation, a provider must have the following: licensure as appropriate, basic airway skills, the ability to monitor and effectively rescue patients in an emergency, and the ability to screen patients appropriately for sedation.

Standard 11.8. The potential need for intravenous access must be considered prior to administering any level of sedation.

Recommendation 11.8.1. When more than minimal sedation is intended, intravenous access should be maintained at least until discharge criteria are met (Standard 12.4).

Standard 11.9. Pulse oximetry, with appropriate alarms, must be employed when moderate or deeper levels of sedation are used.

Standard 11.10. When sedation is provided, monitoring must be adequate to detect the respiratory, cardiovascular, and neurological effects of the drugs being administered, and this monitoring must be documented.

Recommendation 11.10.1. The patient should be checked frequently for verbal responsiveness.

Standard 11.11. When moderate sedation or deeper is provided, a person other than the clinician performing the procedure, and who is trained to monitor appropriate physiological parameters, must be present. This person must not be performing duties other than monitoring the patient.

Moderate Sedation

Standard 11.12. When moderate sedation is intended, sedation medication must be started at a reasonable low dose and titrated as needed, based on individual circumstances, such as weight and drug tolerance.(18, 20-22)

Recommendation 11.12.1. The following table should be used for guidance for these commonly used drugs when used for moderate sedation. Similar ranges of other opioids and benzodiazepines may be used.

Drug	Usual initial dose	Max initial dose	Usual incremental Dose	Max incremental Dose
Fentanyl	50-100 mcg	200 mcg	50-100 mcg	100 mcg
Midazolam	1-3 mg	4 mg	1-2 mg	2 mg

Standard 11.13. When moderate sedation is administered, at least one individual with documented airway skills must be present in the procedure room.

Deep Sedation or General Anesthesia

Standard 11.14. Supplemental oxygen must be used with deep sedation and general anesthesia.

Standard 11.15. The practitioner administering deep sedation or general anesthesia must not be the practitioner performing the abortion.

Recommendation 11.15.1. For deep sedation and general anesthesia, the following should be monitored: continuous pulse oximetry, intermittent blood pressure,

electrocardiography, and respiration, either by measuring end-tidal CO_2 or clinical observation.

Recommendation 11.15.2. The capability to monitor temperature should be available.

Standard 11.16. Any individual responsible for administering, supervising, or monitoring a patient receiving any level of sedation must have current, health care provider level basic life support (BLS) certification.

Standard 11.17. The practitioner administering deep sedation or general anesthesia must adhere to established professional standards of care.(23)

Nitrous Oxide

Standard 11.18. N_2O must be self-administered by the patient or by a qualified anesthesia provider.

Standard 11.19. If not self-administered, the provision of N_2O must follow guidelines for patient monitoring for moderate sedation.

Standard 11.20. Equipment for the delivery of N_2O/O_2 must:

(1) provide a concentration of N_2O of no more than 70% inspired;

(2) provide a minimum of 30% O_2; and

(3) be checked and calibrated regularly.

Recommendation 11.20.1. The concentration of nitrous oxide should not routinely exceed 50% in the absence of qualified anesthesia personnel.

Recommendation 11.20.2. Equipment for the delivery of N_2O/O_2 should include an oxygen analyzer.

Recommendation 11.20.3. Due to the potential for occupational exposure, room or personnel monitoring for levels of N_20 should be conducted.

Emergency Equipment

Standard 11.21. Functioning equipment and current medications must be available on-site to handle medical emergencies and must include: an oxygen delivery system, oral airways, epinephrine, and antihistamines.

Standard 11.22. In settings where benzodiazepines and opioids are used, appropriate antagonists, bronchodilators, and bag-valve masks capable of delivering supplemental oxygen must be available.

Recommendation 11.22.1. Facilities should have a specified area for emergency equipment, which includes oxygen, medications, and supplies. A protocol and time schedule for checking equipment and removing expired medications must be in place.

Standard 11.23. In settings where deep sedation and general anesthesia are used, it is expected that providers maintain the appropriate medication and equipment required for an anesthesia emergency.

Recommendation 11.23.1. A defibrillator should be available.

Discussion: We now have several studies showing that food intake does not increase the risk of moderate sedation.(17-19)

ON THE USE OF N_2O/O_2 - Nitrous oxide has a long history of use for analgesia and sedation, as well as an excellent safety record in the hands of both anesthesiologists and non-anesthesiologists. Occupational exposure to N_2O has been associated with increased risks of neurologic impairment, spontaneous abortion, subfertility, and hepatic and renal disease. Recommendations for safe use of nitrous oxide can be found in the reference section, In addition to employing adequate ventilation and scavenger systems, it is also recommended to deliver 100% oxygen to the patient for five minutes before removing the mask. This will purge the system, and the patient, of any residual nitrous oxide. Occupational exposure can be monitored by asking staff members to wear personal dosimetry badges or by placing an infrared spectrophotometer in the room. Although there is no OSHA standard for N_2O, NIOSH recommends that airborne levels of N_2O be kept below 25 ppm (1995) through well-designed scavenger systems and other engineering controls, equipment maintenance, exposure monitoring, and safe work practices.

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12. POST-PROCEDURE CARE

Policy Statement: Appropriate and accessible post-procedure and follow-up care is essential to patients' wellbeing.

Standard 12.1. Contraception must be discussed.

Recommendation 12.1.1. When desired by the patient, intrauterine contraception or contraceptive implants should be initiated immediately after first-trimester uterine evacuation(1) or second-trimester D&E.(2, 3)

Recommendation 12.1.2. When desired by the patient after medical abortion, intrauterine contraception should be initiated as soon as expulsion of the pregnancy is confirmed.(4-6)

Recommendation 12.1.3. When desired by the patient, contraceptive implants should be initiated on the day of mifepristone administration for medical abortion.(7-10)

Option 12.1.3.1. Depot Medroxyprogesterone acetate (Depo-Provera®) may be given at the time of mifepristone with appropriate counseling.(10-12)

Standard 12.2. All patients receiving more than minimal sedation or in the second trimester must be continuously observed during the recovery period by a health care worker trained in post-procedure care.

Standard 12.3. Patients who received moderate or deeper sedation or exhibit signs of instability should continue monitoring until evaluated in the recovery room and determined to be no longer at risk for hemodynamic instability or respiratory depression.

Standard 12.4. A clinician must remain in the facility until all patients are medically stable.

Standard 12.5. The following criteria must be documented prior to discharge: the patient must be ambulatory with a stable blood pressure and pulse, and bleeding and pain must be controlled.

Standard 12.6. The patient must be given oral and written instructions outlining what to expect post-procedure, self-care, and signs and symptoms of complications.

Recommendation 12.6.1. Patients who receive sedation should have access to this information prior to the administration of medication.

Standard 12.7. The facility must provide an emergency contact service on a 24-hour basis, where calls are triaged in accordance with written policies. A recorded message alone is unacceptable.

Standard 12.8. Any non-clinician involved with first-call triage must be trained to take a post-abortion health history and follow clear written guidelines indicating when immediate consultation with a clinician is indicated.

Standard 12.9. Any patient who gives a history suggestive of a post-procedure complication must have access to a clinician. The facility must establish a pathway for physician referral if indicated.

Recommendation 12.9.1. Uterotonic agents should be given as indicated and not on a routine basis. When used, an evidence-based regimen should be followed.

Option 12.9.1.1. Routine post-procedure follow-up is not required. Clinicians may offer a visit for women who would like one.(13, 14)

Discussion: A recent study shows that Depot Medroxyprogesterone acetate (DMPA) (Depo-Provera®) given on the day of mifepristone may increase the risk of continuing pregnancy but does not increase the risk of needing aspiration to complete the abortion compared to when it is given at a follow-up visit (12). Patient satisfaction is higher with immediate DMPA but six-month use rates and pregnancy rates are the same due to high rates of discontinuation. If a woman understands the potential risk of ongoing pregnancy, DMPA may be offered and given at the time of mifepristone.

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13. Evaluation of Evacuated Uterine Contents

Policy Statement: Identification of appropriate products of conception (POC) following evacuation abortion procedures confirms termination of an intrauterine pregnancy.

Standard 13.1. Termination of pregnancy must be confirmed prior to the patient leaving the facility or further evaluation must be initiated.

Recommendation 13.1.1. Evacuated uterine contents should be examined before the patient leaves the facility.

Recommendation 13.1.2. In first-trimester terminations, flotation of tissue should be used to identify products of conception, including gestational sac.

Option 13.1.2.1. Backlighting of tissue may be useful.

Option 13.1.2.2. Sending the evacuated uterine contents for additional pathological examination is not required.(1, 2)

Standard 13.2. When insufficient tissue or incomplete products of conception are obtained, the patient must be reevaluated.

Recommendation 13.2.1. Re-aspiration, serial quantitative hCG, and/or ultrasonographic examination should be considered.(3-5)

Recommendation 13.2.2. In the first trimester, ectopic pregnancy should be considered.

Discussion: One option for additional evaluation if sufficient POC are not identified is the use of serum quantitative hCG tests. A baseline hCG can be drawn and a second hCG can be done in 24-48 hours. If there is a decrease of 50% or more, no further ectopic follow up is necessary. Otherwise, further evaluation should be initiated including consideration of ectopic pregnancy. In this situation, Section 8 (Management of Pregnancy of Uncertain Location) may be useful.

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14. EMERGENCY PROCEDURES

Policy Statement: Appropriate management of abortion emergencies reduces morbidity and mortality. Hemorrhage can be one of the most serious immediate complications of an abortion procedure. Early recognition of the source of bleeding can reduce morbidity and mortality. Uterine perforation is a complication of abortion that can lead to significant morbidity. Morbidity is related to site of perforation, instrumentation, and gestational age.

Standard 14.1. Protocols for the management of medical emergencies must be in place. These protocols must include indications for emergency transport and written, readily available directions for contacting external emergency assistance (e.g., an ambulance).

Recommendation 14.1.1. Protocols for the following topics should be in place: bleeding, perforation, respiratory arrest/depression, anaphylaxis, and emergency transfer.

Recommendation 14.1.2. Staff should review protocols annually.

Option 14.1.2.1. Annual drills of the emergency protocols are encouraged.

Recommendation 14.1.3. Clinics should consider developing a transfer agreement with a hospital outlining the means of communication and transport and the protocol for emergent transfer of care.

Standard 14.2. All staff must know their appropriate roles in the management of medical emergencies.

Standard 14.3. Emergency supplies must be in known, appropriate locations and regularly updated.

Standard 14.4. When abortion procedures are being performed, at least one medical staff member with health care provider level basic life support (BLS) training must be present.

Recommendation 14.4.1. All medical staff providing direct patient care should have current health care provider level BLS certification.

Standard 14.5. All facilities must have a protocol for the management of acute hemorrhage. This protocol must address the following items(1):
(1) establishment of intravenous access;

(2) administration of uterotonics;

(3) evaluation of the cause and/or source of bleeding; and

(4) criteria for hospital transfer.

Standard 14.6. The facility must have at least two uterotonics and/or mechanical methods of controlling bleeding.

Standard 14.7. If a perforation occurs or is suspected, even if the patient is asymptomatic, a protocol must address the following items:

(1) establishment of intravenous access

(2) additional observation

(3) plan for follow-up including plans for completing the abortion if needed

(4) criteria for transfer to a hospital such as the following:

(i) intra-abdominal viscera are detected in the uterine cavity, cervix, vagina, suction tubing, or on tissue examination;

(ii) fetal parts are detected in the abdominal cavity;

(iii) expanding intra-abdominal or retroperitoneal hematoma is detected; or

(iv) hemodynamic instability is present.

Recommendation 14.7.1. If the procedure is completed after a suspected perforation, uterine evacuation should be performed under direct ultrasound guidance or laparoscopic visualization.(2, 3)

Discussion: Excessive bleeding during the procedure and in the post-procedure period is almost always due to uterine atony, often caused by incomplete emptying of the uterus. Therefore, the most important initial efforts should be directed at assuring complete evacuation of the uterus and at increasing uterine tone through uterotonics or uterine massage. Problems arise when bleeding is ignored or its severity underestimated. Clinicians must always remember to do the simple things when confronted with a developing bleeding problem: continue assessment of the blood loss, measure and record vital signs frequently, and assure intravenous access.

The following measures may be used for treatment of post-abortion hemorrhage:

a. uterine massage;

b. methylergonovine (Methergine);

c. oxytocin (Pitocin);

d. vasopressin (Vasostrict);

e. misoprostol (Cytotec);

f. carboprost tromethamine (Hemabate);

g. intrauterine pressure using a Foley or Bakri balloon or vaginal pack; or

h. uterine re-aspiration.

When bleeding continues after assurance of complete uterine emptying and when there are no visible cervical or vaginal lacerations, the clinician must consider other complications such as perforation, coagulopathy, or placenta accreta. The patient may need immediate transfer to manage these conditions.

Perforations are often occult and may be difficult to identify.(4-6) If a perforation is suspected, it is safest to proceed as if there has been a perforation.

In the first trimester, perforations are often asymptomatic and self-healing.(7, 8) Most perforations are midline and/or fundal in location.(9) If they occur before suction, these usually can be managed with observation and close follow-up.(8) A lateral perforation may involve uterine blood vessels and, if so, will be more significant.

In the second trimester, even an asymptomatic perforation may warrant transfer to a hospital for evaluation depending on the instrumentation involved.(10, 11) There may be more significant morbidity due to increased uterine blood flow and the use of larger grasping instruments.

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