XXXVI SIMPOSI Societat Catalana de Contracepció

Organitza Societat Catalana de Contracepció

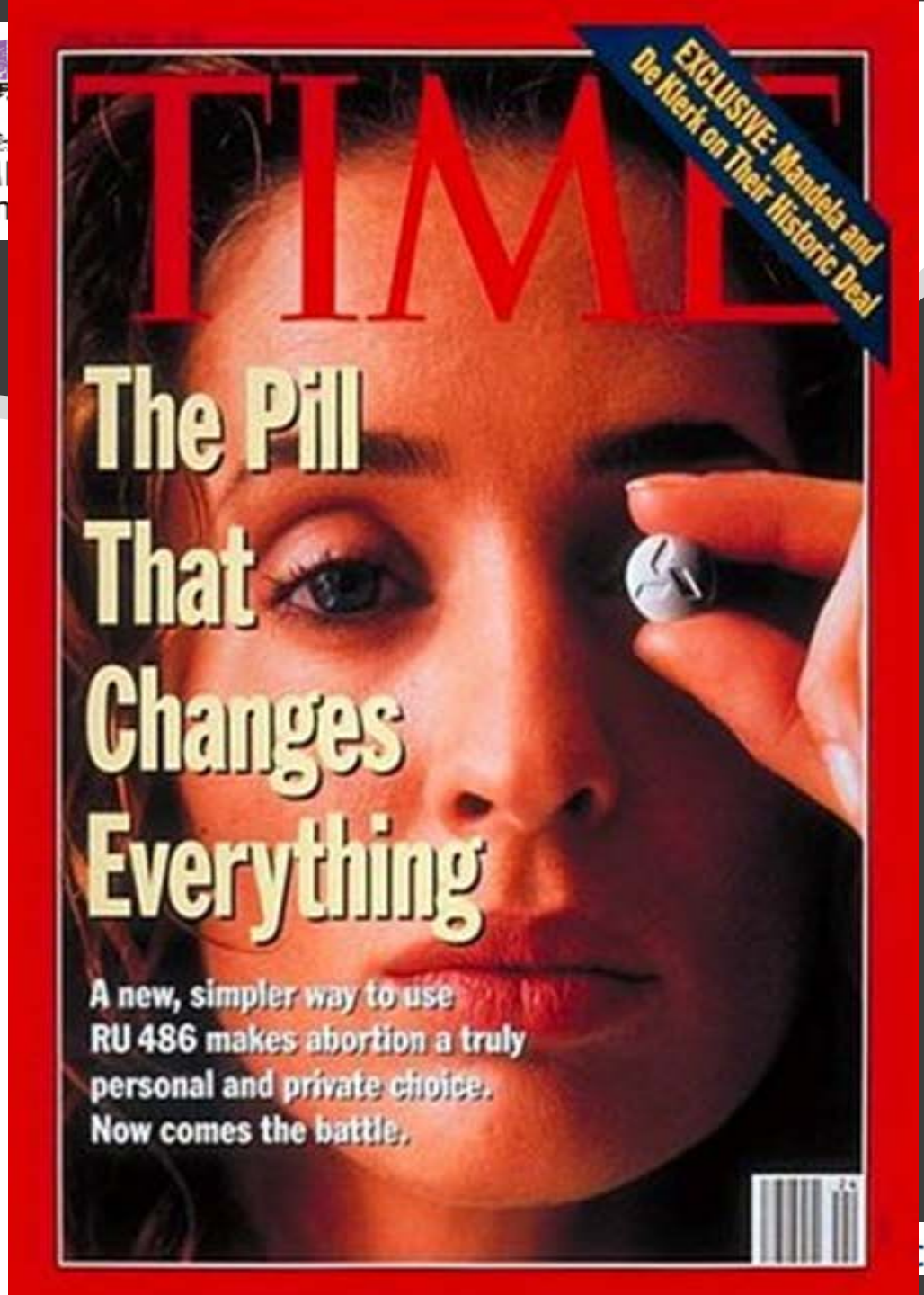
Dijous, 21 novembre'19
l'Acadèmia, Barcelona

IVE farmacològic
Present i futur
Hospital de Terrassa

La nostra experiència

Margarita Aznar

CST: Consorci Sanitari de Terrassa


TIME
EXCLUSIVE: Mandela and De Klerk on Their Historic Deal
The Pill That Changes Everything
A new, simpler way to use RU 486 makes abortion a truly personal and private choice. Now comes the battle.

1993

Canvi de paradigma

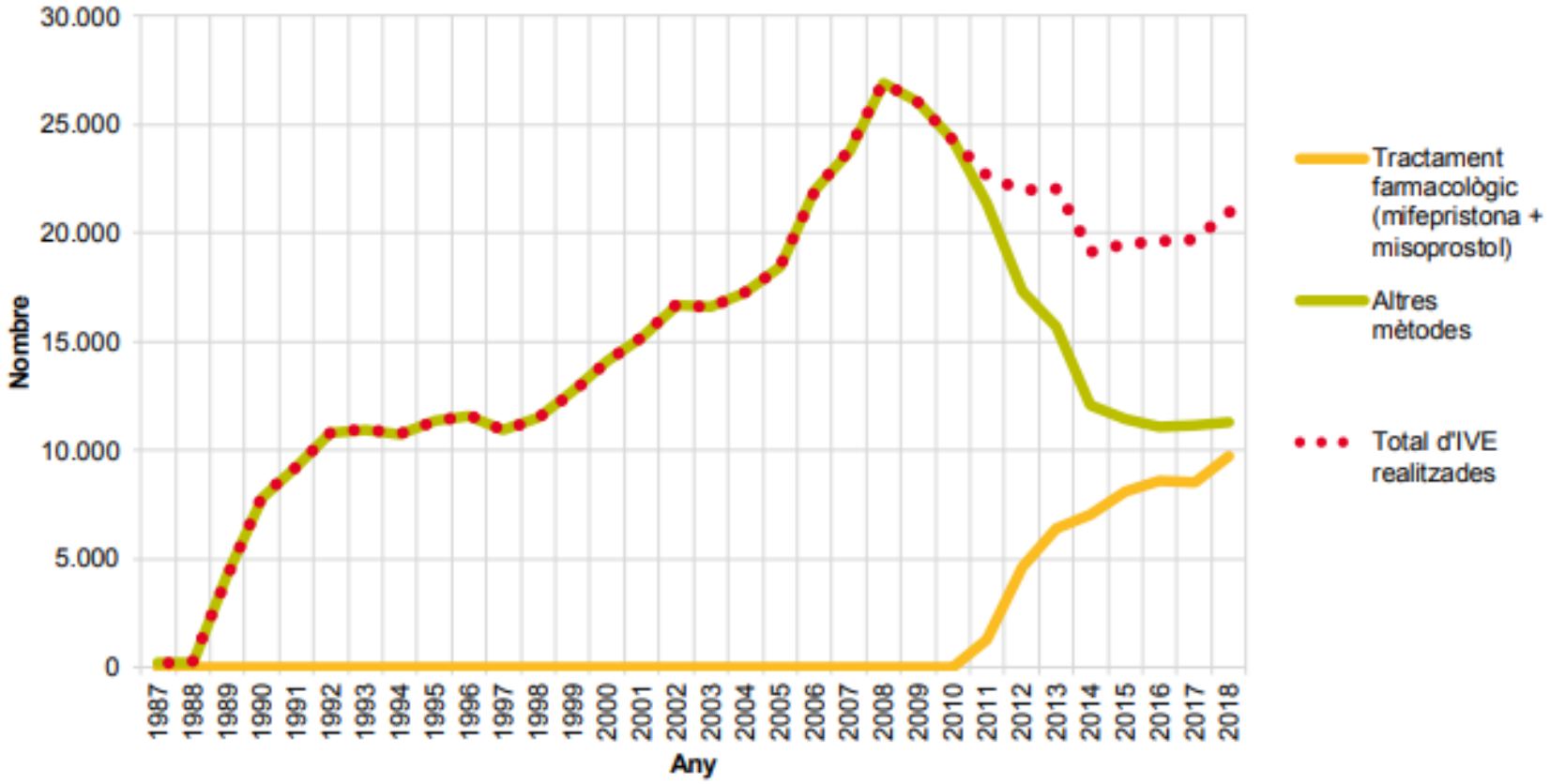
L'avortament quirúrgic requereix que els clínics es formin com a proveïdors d'atenció als ives i centralitzin els serveis a les instal·lacions.

En canvi, l'avortament mèdic convida a la descentralització, ja que no són necessàries instalacions per a ives mèdics precoços.

JELINSKA, Kinga; YANOW, Susan. Putting abortion pills into women's hands: realizing the full potential of medical abortion. Contraception, 2018, vol. 97, no 2, p. 86-89.

4.1.4 Evolució de les IVE realitzades a Catalunya en el període 1987-2018

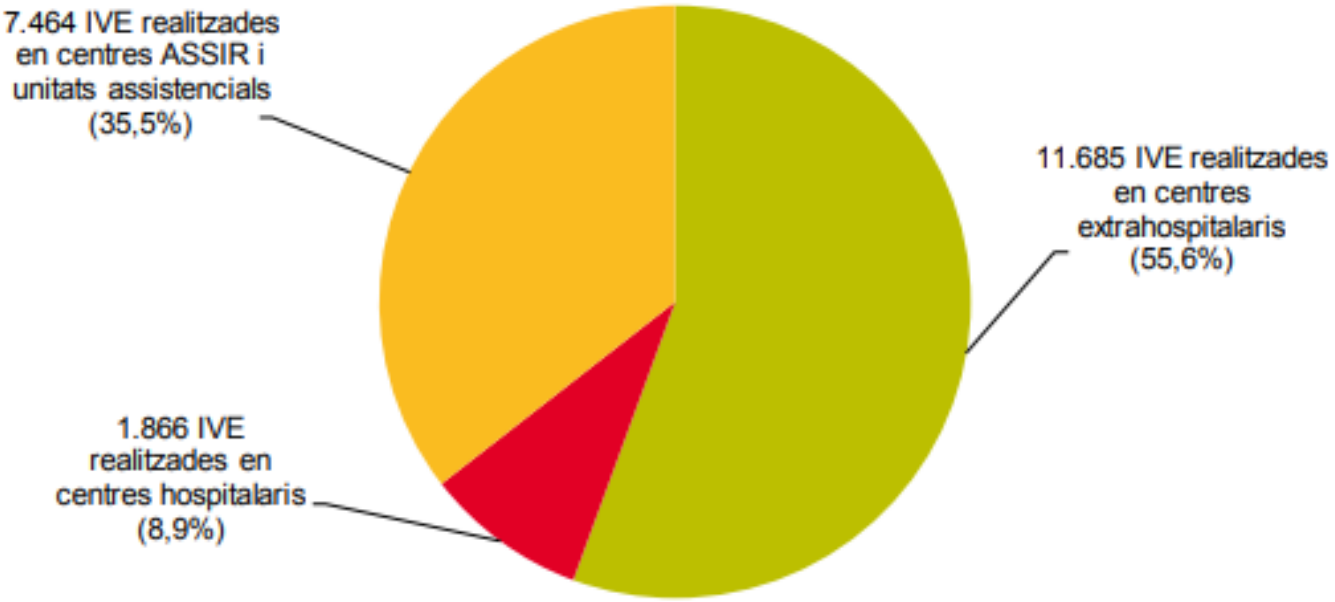
Figura 3. Evolució de les IVE realitzades segons mètode utilitzat. Catalunya, 1987-2018



Estadística de la interrupció voluntària de l'embaràs a Catalunya, 2018

On es fan els avortaments?

Figura 2. Distribució de les IVE realitzades segons el tipus de centre. Catalunya, 2018



Estadística de la interrupció voluntària de l'embaràs a Catalunya, 2018

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Societat Catalana de Contracepció
L'Acadèmia
Dijous, 21 novembre'19
l'Acadèmia, Barcelona

Protocol ive farmacològic de les 9 a les 14 setmanes *Hospital de Terrassa*

IVE farmacològic 9– 11 setmanes Hospital de Terrassa

1ª visita hospitalària

Mifepristona 200 mgrs via oral

A les 24-48 h.

domicili

Analgèsia

Als 30 minuts

800 mcgrs misoprostol vaginal

Seguit per 400 mcgrs misoprostol v.o. cada 3 hores (fins a 2)

Als 7-14 dies

2ª visita hospitalària

Comprovació ecográfica absència sac

Revisió anticoncepció

Ingrés a l'hospital – curta estada

IVE farmacològic 11- 14 setmanes Hospital de Terrassa

Analgèsia
- Dexketoprofeno ev/8 hores
- Tramadol ev de rescat

Misoprostol vaginal
- 800 mcgrs vaginal (4 compr.)

Misoprostol oral
- 400 mcgrs oral (2 compr.) cada 3 hores fins a 5 dosis

Diagrama de flux del circuit

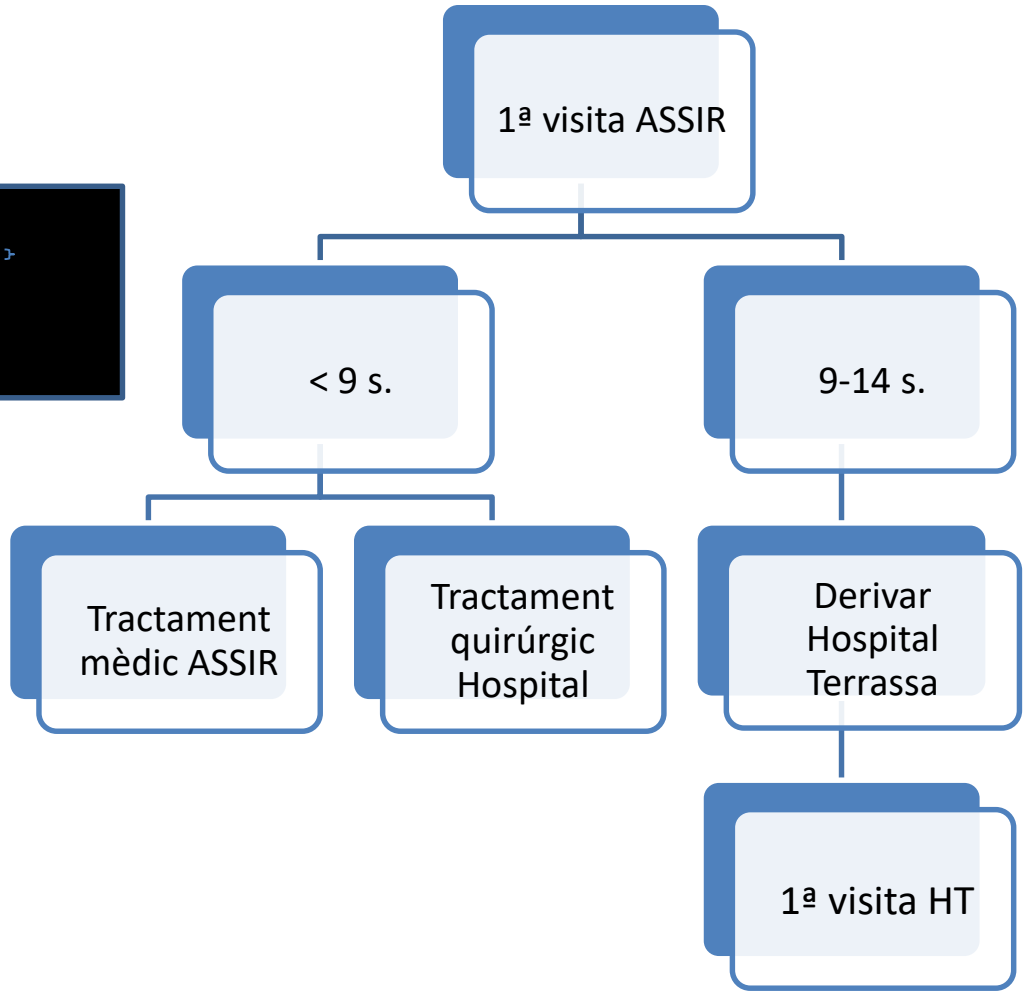
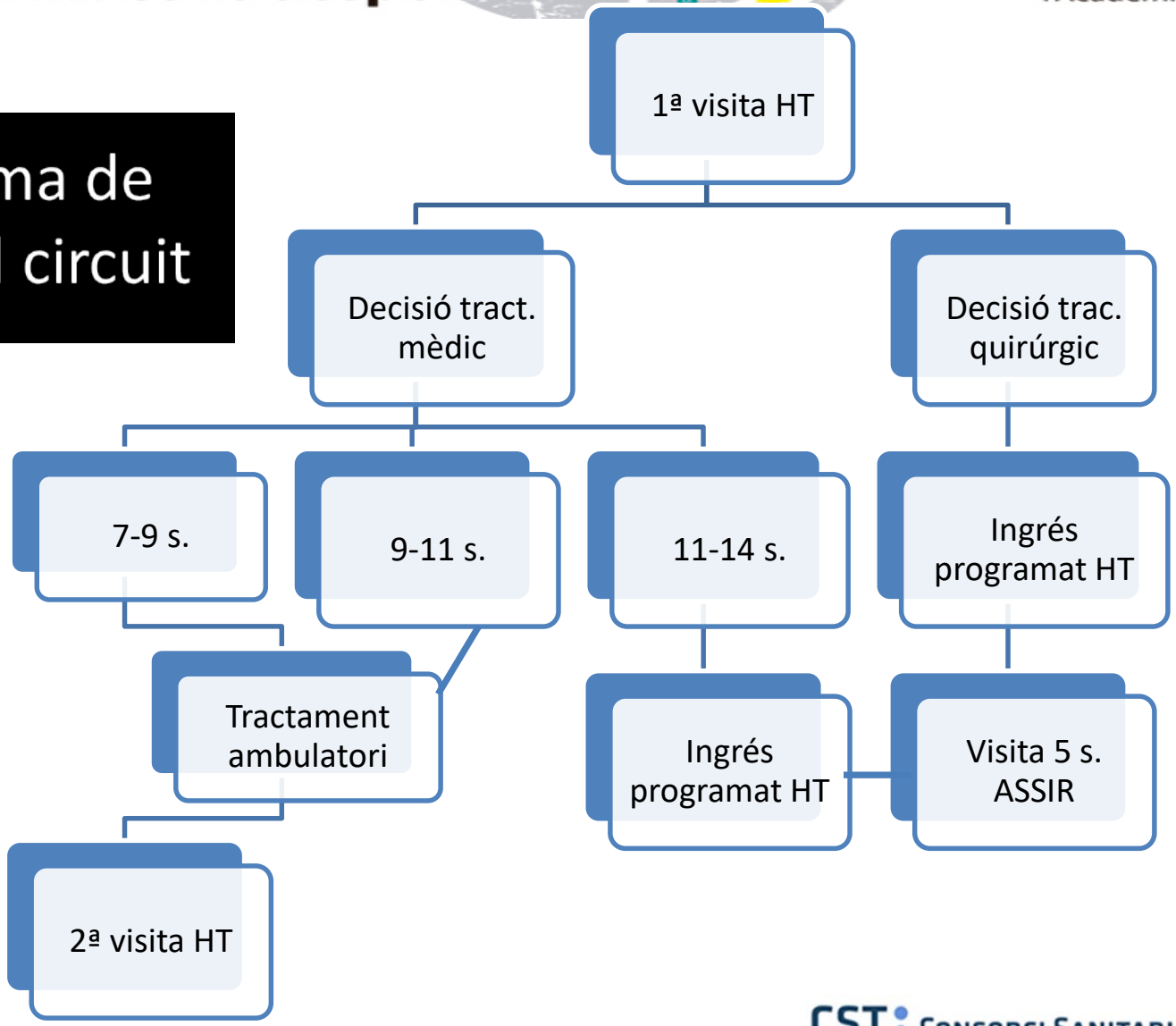
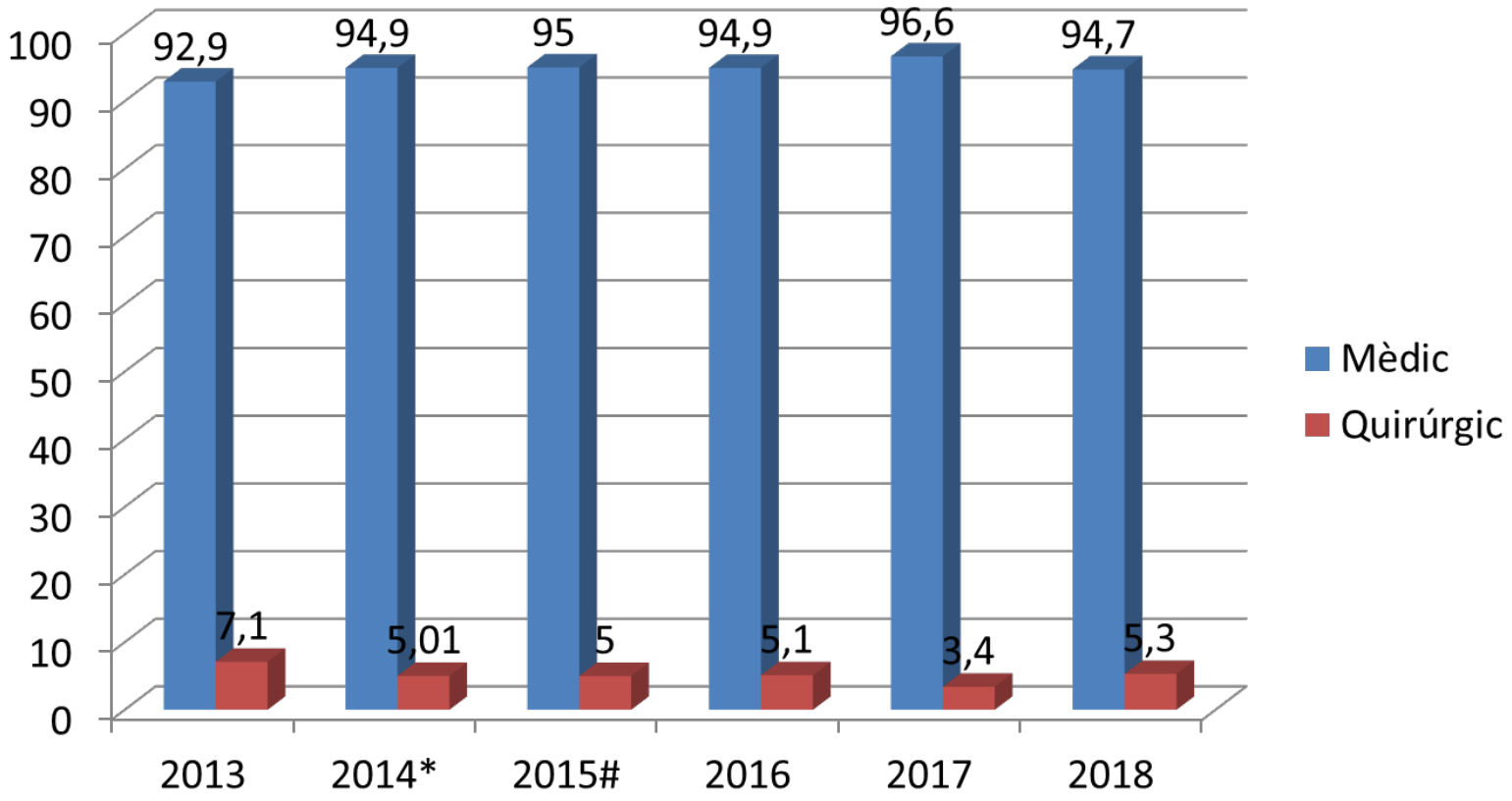


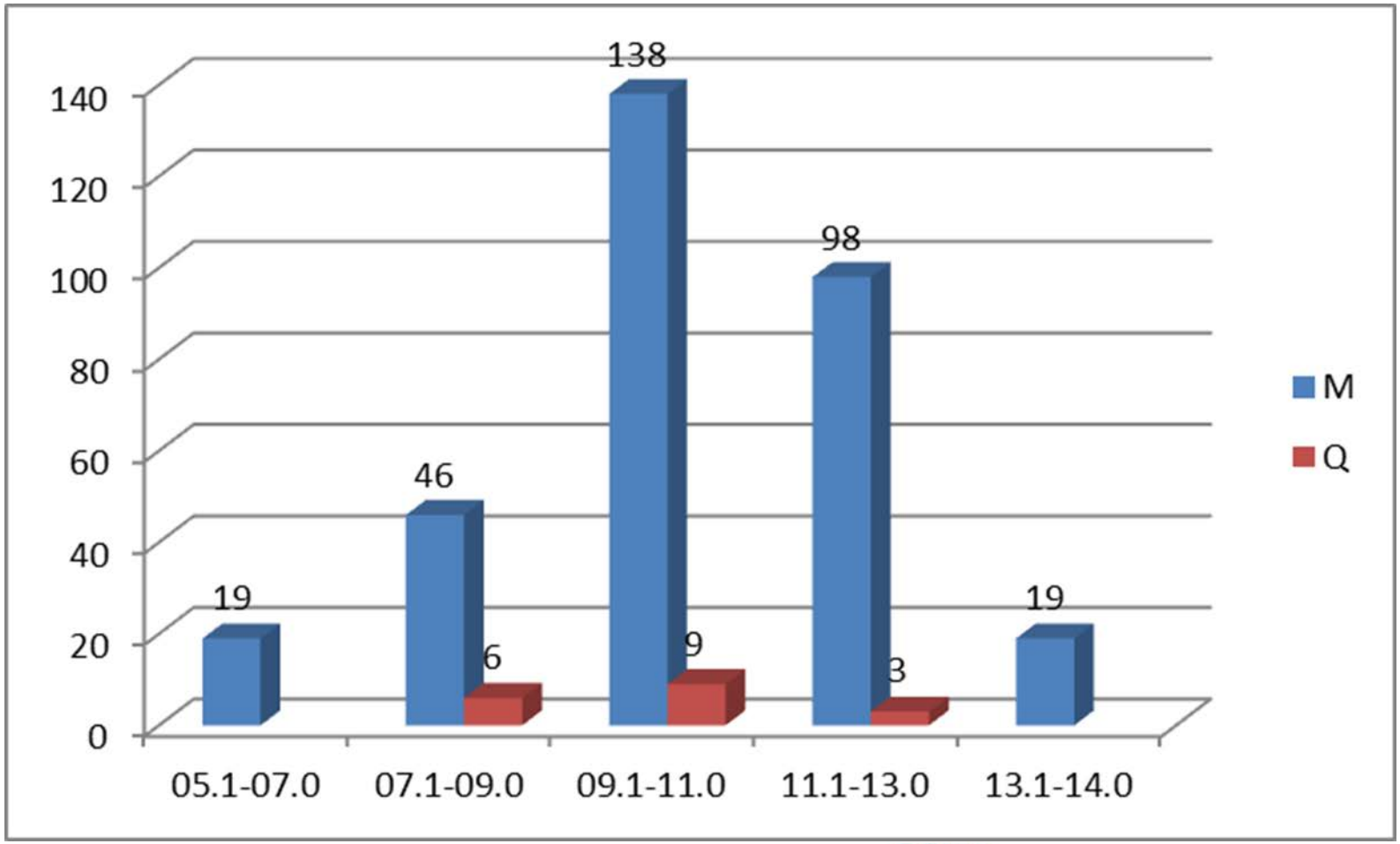
Diagrama de flux del circuit



Tipus de ive a l' Hospital de Terrassa



Tipus ive segons setmanes gestació



2018

Efectes secundaris	M	Q	Total
N	197 (61,6%)	18	215
S	123 (38,4%)	0	123
Total general	**320**	**18**	**338**
NAUSEES	80	0	80
VOMITS	73	0	73
DIARREES	28	0	28
FEBRE	16	0	16
ALTRES	28	0	28

2018

Complicacions	M	Q	Total
N	313	18	331
S	7		7
Total	**320**	**18**	**338**
INFECCIO	1	0	1
HEMORRAGIA	4	0	4
RESTES OVULARS	2	0	2

Fracàs de tractament

Definició:
Tractament farmacològic (mifepristona+ misoprostol) que han requerit una evaquació quirúrgica (aspirat o legrat uterí) per resoldre un avortament incomplet, un embaràs que continua o per controlar sagnat.

Total ive farmacològic……..320
Fracàs tractament……8 (**2,5%**)

- precoç (<48 h)……5 (> 11 setmanes)
  - ✓ 1 retenció de placenta
  - ✓ 4 no expulsió amb dosi completes
- tardà (>48 h)……3(< 11 setmanes)
  - ✓ 1 cas per restes
  - ✓ 2 no expulsió del sac
  - ✓ 1 cas de legrat+ transfusió

resum

- Mètode farmacològic: 94,9%
- Satisfacció del mètode:
  - 12% no recomanaria el ive mèdic
  - 7% no recomanaria el ive quirúrgic
- Un 55% tenen 1 ó més ives anteriors
- Efectes secundaris freqüents però en general lleus
- Complicacions molt poc freqüents (2,2%)
- Fracàs del tractament mèdic baix (2,5%)

eficiència

Taula 2. Anàlisi de minimització de costos

Atenció privada (sense visites)	Tractament	Completar IVE	Hemorràgia + cirurgia	Transfusió	ITU	Altres	TOTAL
IVE mèdica	100,00%	6,00%	0,71%	0,48%	0,21%	20,00%	
Cost	84,24 €	286,66 €	286,66 €	122,85	16,6	2,00 €	
Cost ajustat	84,24 €	17,20 €	2,04 €	0,59 €	0,03 €	0,40 €	**104,50 €**
IVE quirúrgica	100,00%	0,00%	0,00%	0,00%	0,00%	0,00%	
Cost	286,66 €						
Cost ajustat	286,66 €						**286,66 €**
DIFERÈNCIA							**-182,16 €**

ITU: infecció tracte urinari; IVE: interrupció voluntària de l'embaràs

Per a aquest càlcul s'han considerat els PVP dels fàrmacs i el cost (sense visita) de les proves complementàries, exploracions i tècniques mitjans al sector assegurador privat a Catalunya.

Atenció pública	Tractament	Completar IVE	Hemorràgia + cirurgia	Transfusió	ITU	Altres*	TOTAL
IVE mèdica	100,00%	6,00%	0,71%	0,48%	0,21%	20,00%	
Cost	16,12 €	495,10 €	495,10 €	291,00 €	4,11 €	2,00 €	
Cost ajustat	16,12 €	29,71 €	3,52 €	1,40 €	0,01 €	0,40 €	**51,15 €**
IVE quirúrgica	100,00%	0,00%	0,00%	0,00%	0,00%	0,00%	
Cost	495,10 €						
Cost ajustat	495,10 €						**495,10 €**
DIFERÈNCIA							**-443,95 €**

Sunyer B, Sola-Morales O. Interrupció farmacològica voluntària de l'embaràs. Barcelona: Agència d'Informació, Avaluació i Qualitat en Salut. Servei Català de la Salut. Departament de Salut. Generalitat de Catalunya; 2011.

Futur- ive precoç

- Informació i Accéss
  - Atenció telefònica
  - Telemedicina
  - Test orina HCG domicili per disminuir el número de visites
  - Escurçar l'Interval entre mifepristona i misoprostol

Contraception xxx (xxxx) xxx

Contents lists available at ScienceDirect

Study design: We offered the service in five states. Each participant had a videoconference with a study clinician and had pre-treatment laboratory tests and ultrasound at facilities of her choice. If the participant was eligible for medical abortion, the clinician sent a package containing mifepristone, misoprostol, and instructions to her by mail. After taking the medications, the participant obtained follow-up tests and had a follow-up consultation with the clinician by telephone or videoconference to evaluate abortion completeness. The analysis was descriptive.

Original research article

TelAbortion: evaluation of a direct to patient telemedicine abortion service in the United States☆,☆☆,★,★★

Elizabeth Raymond [a,*,1], Erica Chong [a,1], Beverly Winikoff [a,1], Ingrida Platais [a,1], Meighan Mary [a,1], Tatyana Lotarevich [a,1], Philicia W. Castillo [b], Bliss Kaneshiro [c], Mary Tschann [c,d], Tiana Fontanilla [c], Maureen Baldwin [e], Ariela Schnyer [e], Leah Coplon [f], Nicole Mathieu [f], Paula Bednarek [e,g], Meghan Keady [g], Esther Priegue [h]

[a] Gynuity Health Projects, 220 East 42nd Street New York, NY 10017
[b] Guttmacher Institute, 125 Maiden Lane, 7th Floor, New York, NY 10038, USA
[c] Department of Obstetrics, Gynecology, and Women's Health, University of Hawaii John A. Burns School of Medicine, 1319 Punahou Street, Suite 824, Honolulu, HI 96826
[d] Society of Family Planning, 225 South 17th Street, Suite 2709, Philadelphia, PA 19103-0046
[e] Oregon Health & Science University, 3181 SW Sam Jackson Park Road, UHN 50, Portland, OR 97239
[f] Maine Family Planning, PO Box 587, Augusta, ME 04332
[g] Planned Parenthood Columbia Willamette, 3727 NE Martin Luther King Jr. Blvd, Portland, OR 97212
[h] Choices Women's Medical Center, 147-32 Jamaica Ave, Jamaica, NY 11435

Conclusions: This direct-to-patient telemedicine abortion service was safe, effective, efficient, and satisfactory. The model has the potential to increase abortion access by enhancing the reach of providers and by offering people a new option for obtaining care conveniently and privately.

2019

BJOG An International Journal of Obstetrics and Gynaecology

DOI: 10.1111/1471-0528.15684
www.bjog.org

Systematic review

Telemedicine for medical abortion: a systematic review

M Endler,[a,b] A Lavelanet,[c] A Cleeve,[a] B Ganatra,[c] R Gomperts,[d] K Gemzell-Danielsson[a]

[a] Department of Women's and Children's Health, Division of Obstetrics and Gynecology, Karolinska Institutet, Stockholm, Sweden [b] Department of Public Health, Women's Health Research Unit, University of Cape Town, Cape Town, South Africa [c] Department of Reproductive Health and Research, UNDP-UNFPA-UNICEF-WHO-World Bank Special Programme of Research, Development and Research Training in Human Reproduction, World Health Organization, Geneva, Switzerland [d] Women on Web, Amsterdam, the Netherlands
*Correspondence: M Endler, Department of Women's and Children's Health, Division of Obstetrics and Gynecology, Karolinska Institutet, Tomtebodavägen 18b 171 77 Stockholm, Stockholm, Sweden. Email: margit.endler@ki.se

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Conclusions

Medical abortion through telemedicine seems to be highly acceptable to women. Rates of continuing pregnancy, complete abortion, haemorrhage and hospitalisation are similar to those reported in the literature for in-person abortion care. Surgical evacuation rates are higher. The compiled results in this review are based mostly on self-reported data and come with several methodological limitations. To inform future policy recommendations, abortion care through telemedicine needs to be defined and research is needed on the feasibility of using TM for abortion in low-resource settings.

Table 1. Urine pregnancy tests for self-assessment to exclude ongoing pregnancy after EMA.

Urine pregnancy test	Key features
Low sensitivity urine pregnancy test (1000iu)	• Conduct at two weeks • Approx. 10% test positive • Available from abortion provider
High sensitivity urine pregnancy test (25-50iu)	• Conduct at one month • Approx. 25 % test positive • Cheap, readily available in shops/pharmacies
Multi level urine pregnancy test (range of levels)	• Conduct before and after EMA • Can be used as early as three days • Multiple windows to read and interpret • Not currently available in EU

SHORT CO

Check for updates

Self-ass … elf-performed urine p…

Sharon Ca…

[a]Chalmers Se… , UK; [b]Centre of Postgraduate… …men's and Children's Health, Karol…

ABSTRACT

Purpose: The European Society of Contraception Expert Group on Abortion identified as one of its priorities the need to disseminate up-to-date evidence-based information on the use of urine pregnancy tests by women for the self assessment of the success of early medical abortion (EMA).

Methods and materials: A concise communication was produced which summarises the latest research in an easy-to-read format suitable for busy clinicians. Information about individual urinary pregnancy tests is presented in boxes for ease of reference.

Results: Urinary pregnancy tests (low sensitivity, high sensitivity and multilevel) can be used in combination with signs and symptoms of pregnancy to exclude an ongoing pregnancy after EMA.

Conclusion: Women are able to determine the success of early medical abortion (EMA) themselves using a combination of signs, symptoms and a urine pregnancy test. This simplifies EMA, expands the range of professionals able to provide EMA and most importantly gives women greater control over their bodies and treatment.

ARTICLE HISTORY
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Revised 1 May 2019
Accepted 9 May 2019

KEYWORDS
Medical abortion; low sensitivity urine pregnancy test; multilevel urine pregnancy test; human chorionic gonadotrophin; medical abortion follow up

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L'Acadèmia

Dijous, 21 novembre'19
l'Acadèmia, Barcelona

www.thelancet.com/lancetgh Vol 3 September 2015

ARTICLES | VOLUME 3, ISSUE 9, PE537-E545, SEPTEMBER 01, 2015

Self-assessment of the outcome of early medical abortion versus clinic follow-up in India: a randomised, controlled, non-inferiority trial

Dr Kirti Iyengar, MD • Mandira Paul, MSc • Sharad D Iyengar, MD • Marie Klingberg-Allvin, PhD • Birgitta Essén, MD • Prof Johan Bring, PhD • Sunita Soni, MSc • Prof Kristina Gemzell-Danielsson, MD • Show less

Summary

Background The need for multiple clinical visits remains a barrier to women accessing safe legal medical abortion services. Alternatives to routine clinic follow-up visits have not been assessed in rural low-resource settings. We compared the effectiveness of standard clinic follow-up versus home assessment of outcome of medical abortion in a low-resource setting.

Interpretation Home assessment of medical abortion outcome with a low-sensitivity urine pregnancy test is non-inferior to clinic follow-up, and could be introduced instead of a clinic follow-up visit in a low-resource setting.

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Temes a millorar:

- Dosis Mifepristona: 600, 200, 100, 50 ……
- Dosis misoprostol i via: oral, sublingual, bucal, vaginal
- Interval entre mifepristona i misoprostol…..

Available online at www.sciencedirect.com
SCIENCE DIRECT
Contraception
ELSEVIER
Contraception 71 (2005) 333–336

Original research article

A pilot study of mifepristone and misoprostol administered at the same time for abortion up to 49 days gestation

Amitasrigowri S. Murthy[1], Mitchell D. Creinin*, Bryna Harwood, Courtney Schreiber
Department of Obstetrics, Gynecology and Reproductive Sciences, University of Pittsburgh School of Medicine and Magee Womens Research Institute, Pittsburgh, PA 15213, USA

Received 15 September 2004; revised 14 October 2004; accepted 25 October 2004

Reproductive SCIENCES | SAGE
Reprod Sci. 2015 Jun; 22(6): 706–711.
doi: 10.1177/1933719114557897
PMCID: PMC4502804
PMID: 25394644

Effectiveness and Safety of Lower Doses of Mifepristone Combined With Misoprostol for the Termination of Ultra-Early Pregnancy

A Dose-Ranging Randomized Controlled Trial

Cui-Lan Li, MD, PhD,[1] Dun-Jin Chen, MD,[1] Li-Ping Song, MD,[1] Yan Wang, MD,[1] Zhong-Fang Zhang, MD,[1] Ming-Xing Liu, MD,[1] and Wei-Ling Chen, MD[1]

Obstetrics & Gynecology

Volume 103(5, Part 1) May 2004 pp 851-859

A Randomized Comparison of Misoprostol 6 to 8 Hours Versus 24 Hours After Mifepristone for Abortion

[Original Research]

Creinin, Mitchell D. MD*; Fox, Michelle C. MD, MPH*; Teal, Stephanie MD, MPH†; Chen, Angela MD, MPH‡; Schaff, Eric A. MD§; Meyn, Leslie A. MS*; the MOD Study Trial Group

CONCLUSION: Mifepristone 200 mg followed 6 to 8 hours later by misoprostol 800 μg vaginally is as effective for abortion and has significantly fewer side effects as compared with regimens using a 24-hour dosing interval.

In conclusion, the results of this study indicate that lower doses of mifepristone together with a lower fixed dose of misoprostol (200 μg, given 24 hours later) are as effective and safe as higher doses of mifepristone for termination of ultra-early pregnancy. In addition, lower doses of mifepristone (50 or 75 mg) offer the advantages of reduced vaginal bleeding and medication side effects.

THE JOURNAL OF Obstetrics and Gynaecology Research
doi:10.1111/jog.13716 J. Obstet. Gynaecol. Res. Vol. 44, No. 9: 1705–1711, September 2018

Early medical abortion with self-administered low-dose mifepristone in combination with misoprostol

Li-Ping Song[1]*, Shi-Yan Tang[1]*, Cui-Lan Li[1], Lee-Jaden-Gil-Yu-Kang Zhou[2] and Xue-Tang Mo[1]

[1]*Key Laboratory for Major Obstetric Diseases of Guangdong Province, Key Laboratory for Reproduction and Genetics of Guangdong Higher-Education Institutes, Guangzhou Institute of Obstetrics and Gynecology, Third Affiliated Hospital, Guangzhou Medical University, Guangzhou, China; and* [2]*Grade 10, Walt Whitman High School, Bethesda, Maryland, USA*

Abstract

Aim: The aim of the present study was to investigate the safety and efficacy of low-dose mifepristone combined with self-administered misoprostol for termination of early pregnancy.

Methods: A total of 533 women seeking medical abortion in early pregnancy (≤49 days since the last menstrual period) were divided randomly into hospital- (H-Mis, 250) and self- (S-Mis, 283) administered misoprostol groups. Women in two groups took 100 mg of oral mifepristone in hospital followed by 200 μg of sublingual misoprostol 24 h later in hospital or home. The primary outcome parameter was complete abortion without surgical intervention. Secondary outcomes were uterine bleeding, return of regular menses, side effects and patient acceptability.

Results: High rates of complete abortion were observed for both the H-Mis group (243/250; 94.8%) and the S-Mis group (266/283; 94.0%). No significant differences in outcomes (complete abortion/failure rates) or side effects were observed between the two groups. General satisfaction rates were similar for the two groups (H-Mis, 231/250, 92.4%; S-Mis, 263/283, 92.9%; $P > 0.05$). Higher convenience of administration (H-Mis, 211/250, 84.4%; S-Mis, 270/283, 95.4%; $P < 0.05$) and privacy protection (H-Mis, 214/250, 85.6%; S-Mis, 267/283, 94.3%; $P < 0.05$) satisfaction rates were obtained for the S-Mis group than for the H-Mis group.

Conclusion: Self-administered sublingual misoprostol is as safe and effective as hospital-administered misoprostol following low-dose mifepristone to terminate early pregnancy (≤49 days of amenorrhoea) with fewer side effects.

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CrossMark
Contraception
Contraception 97 (2018) 90–99

Original research article

Efficacy of medical abortion prior to 6 gestational weeks: a systematic review☆,☆☆

Nathalie Kapp[a,*], Maureen K. Baldwin[b], Maria Isabel Rodriguez[b]

[a]*Ipas, Chapel Hill, NC 27701*

[b]*Oregon Health & Science University, Department of Obstetrics & Gynecology*

Received 14 March 2017; revised 6 September 2017; accepted 11 September 2017

Discussion: These analyses support the use of medical abortion at gestational ages <42 days. Efficacy rates are high overall and appear to reflect those observed during the seventh week of pregnancy. Women who prefer to initiate treatment as soon as early pregnancy is diagnosed may do so without delay.

ELSEVIER

Contraception

Contraception 97 (2018) 287–291

Original research article

Exploring the feasibility of obtaining mifepristone and misoprostol from the internet☆,☆☆

Chloe Murtagh[a], Elisa Wells[b], Elizabeth G. Raymond[a,*], Francine Coeytaux[b], Beverly Winikoff[a]

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[b]*Plan C, c/o National Women's Health Network, 1413 K Street NW, 4th Floor, Washington, D.C. 20005*

Received 16 June 2017; revised 27 September 2017; accepted 29 September 2017

Abstract

Objectives: We aimed to document the experience of buying abortion pills from online vendors that do not require a prescription and to evaluate the active ingredient content of the pills received.
Study design: We searched the internet to identify a convenience sample of websites that sold mifepristone and misoprostol to purchasers in the United States and attempted to order these products. We documented price, shipping time and other aspects of ordering. We sent the samples received to a testing laboratory that measured the amount of active ingredient in individual tablets.
Results: We identified 18 websites and ordered 22 products: 20 mifepristone–misoprostol combination products and 2 that contained only misoprostol. We received 18 combination products and the 2 misoprostol products from 16 different sites. No site required a prescription or any relevant medical information. The time between order and receipt of the 20 products ranged from 3 to 21 business days (median 9.5 days). The price for the 18 combination products ranged from $110 to $360, including shipping and fees; the products without mifepristone cost less. Chemical assays found that the 18 tablets labeled 200 mg mifepristone contained between 184.3 mg and 204.1 mg mifepristone, while the 20 tablets labeled 200 mcg misoprostol contained between 34.1 mcg and 201.4 mcg of the active ingredient.
Conclusions: Obtaining abortion medications from online pharmaceutical websites is feasible in the United States. The mifepristone tablets received contained within 8% of the labeled amount of active agent. The misoprostol tablets all contained that compound but usually less than labeled.
Implications statement: Given our findings, we expect that some people for whom clinic-based abortion is not easily available or acceptable may consider self-sourcing pills from the internet to be a rational option.

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Dijous, 21 novembre'19
l'Acadèmia, Barcelona

Research

Current barriers, facilitators and future improvements to advance quality of abortion care: views of women

Jodie Louise Smith,[1] Sharon Cameron[2,3]

Research

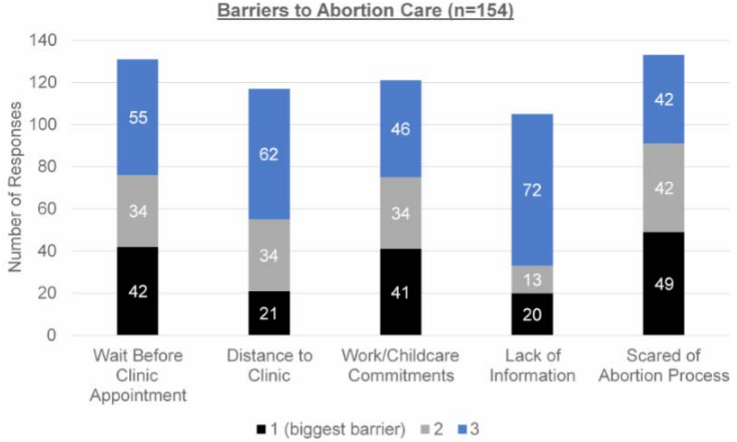

Figure 1 Graph showing the responses received from 154 women to Question 1 of the questionnaire, which asked them to rank the barriers they faced in the lead up to seeking abortion serivces; a ranking of 1 equates to the biggest barrier faced.

Key messages

- Women in Great Britain still experience personal and logistical barriers to accessing abortion services through the formal healthcare system.
- A major barrier in seeking abortion is fear of what abortion involves.
- Women would like shorter waiting times to access abortion care and to be able to receive it from a greater range of community providers, including general practitioners.

ELSEVIER
Contraception 97 (2018) 86–89
Contraception

Commentary

Putting abortion pills into women's hands: realizing the full potential of medical abortion☆,☆☆

Kinga Jelinska[a,*], Susan Yanow[b]
[a]*Women Help Women, The Netherlands*
[b]*Cambridge, MA, USA*

Received 28 February 2017; revised 4 May 2017; accepted 29 May 2017

Abstract

The promise of medical abortion to both reduce maternal mortality and morbidity from unsafe abortion and to expand the reproductive rights of women can only be realized if information and reliable medicines are available to all women, regardless of their location or the restrictions of their legal system. Activist strategies to actualize the full potential of abortion pills are highlighted.

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L'Acadèmia

Dijous, 21 novembre'19
l'Acadèmia, **Barcelona**

Moltes gràcies

maznar@cst.cat

CST: Consorci Sanitari de Terrassa

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