Safety and effectiveness of one-day later abortion procedures: A retrospective chart review

S. Chandrasekaran [a,*], C. Gerdts [b], Y. Robinson [c], C. Hannum [d], K. Blanchard [a], M. Paul [e]

[a] *Ibis Reproductive Health, Cambridge, MA, USA,* [b] *Ibis Reproductive Health, Oakland, CA, USA,* [c] *Alabama Women's Center for Reproductive Alternatives, Huntsville, AL, USA,* [d] *The Women's Center, Cherry Hill, NJ, USA,* [e] *Beth Israel Deaconess Medical Center, Boston, MA, USA*

*Corresponding author.
E-mail: schandrasekaran@ibisreproductivehealth.org

Introduction: The abortion process at later gestational ages—from placement of dilators, to completion of procedure—can have a duration of up to three days. Coupled with mandatory waiting periods in many states, later-abortion procedures often place undue burdens on patients (increased travel, accommodation, and administrative costs). We present evidence on the safety of later-abortion protocols that are carried out in one day, which can result in reducing client burden.

Method: We conducted a retrospective review of 379 patient medical charts from two different clinics (in four states) that provide abortions for gestational ages 18–24 weeks, in one day. Data was collected using an online data collection platform. We used Stata 15 to clean and perform preliminary descriptive analyses.

Results: We found that, on an average, complications occurred in 0.79% (n = 3) of the total procedures. Literature suggests that for D&E procedures occurring between 14 and 24 weeks, complications occur in 4% of cases (Autry et. al, 2002). In our study, cervical tear was the only incident. All the incidents were resolved in the procedure room on the day of the procedure.

Conclusions: One-day procedures result in a low occurrence of complications—lower than what has been reported for longer procedures and have not needed hospital admission. By adopting shorter procedures, financial burden on patients, especially those traveling long distances, can be reduced, and access to later abortion care can be expanded.

doi:10.1016/j.contraception.2020.03.012

Immediate versus delayed insertion of the IUD following medical abortion at 17–20 weeks' gestation: Preliminary results from a randomized controlled trial

D. Constant [a,*], M. Endler [a,b], M. Patel [a], G. Petro [a], D. Grossman [c]

[a] *University of Cape Town, Cape Town, Western Cape, South Africa,* [b] *Karolinska Institutet, Stockholm, Sweden,* [c] *University of California, San Francisco, California, USA*

*Corresponding author. Email: deborah.constant@uct.ac.za

Introduction: The risk-benefit ratio of immediate compared with delayed insertion of an intrauterine device (IUD) following medical abortion (MA) at 17-20 weeks gestation is largely unknown. We report preliminary findings from a randomized controlled trial on IUD use at 6 weeks after immediate compared to delayed insertion, following medical abortion at this gestation.

Method: This 2-arm randomized controlled trial was conducted in Cape Town, South Africa. Between August 2018 and June 2019, we consented and randomized 114 women admitted for MA. The immediate arm had an IUD inserted prior to discharge; the delayed arm was referred for insertion 3 weeks later at a primary healthcare facility. Follow-up involved in-person clinical examination and ultrasound 6 weeks after MA. Non-attendees were contacted by phone. Follow-up at 6 months is ongoing. Our main outcome was use of the original IUD at 6 weeks, defined as adequate placement without indication for removal, according to intention-to-treat (ITT). Secondary outcomes include 1) use of any IUD after the 6-week follow-up period (ITT) and 2) expulsion, intracervical and symptomatic malposition at 6 weeks after MA (per protocol [PP]).

Results: There were 55 women in the immediate arm and 57 in the delayed arm (ITT). At 6 weeks we followed up 98/112 women (88% in each study arm). There was adequate placement of the original IUD in 53% of women in the immediate arm versus 23% in the delayed arm. At the end of the 6-week follow-up period 73% in the immediate arm versus 40% in the delayed arm had either the original IUD, a replacement IUD, or an IUD placed for the first time at follow up. Of those who had an IUD placed, 36% (immediate) versus 14% (delayed) had complete expulsion, or removal of the IUD due to malposition (PP).

Conclusions: Insertion of an IUD immediately after late second trimester MA results in increased use after 6 weeks compared to delayed insertion. Expulsion rates are higher than interval insertion and higher than for immediate insertion after MA at earlier gestational ages.

doi:10.1016/j.contraception.2020.03.013

Evaluating the impact of working on the NAF hotline: A qualitative study with former staff members

A.M. Foster *, S. Frappier, L. Crich, K. Messier

University of Ottawa, Ottawa, ON, Canada

*Corresponding author. Email: angel.foster@uottawa.ca

Introduction: For more than a decade, the National Abortion Federation (NAF) has operated a Hotline to improve access to abortion care in the US. Each year NAF Hotliners work with thousands of low-income women living in states in which abortion is not covered by state-level Medicaid to obtain subsidized abortion care. Through in-depth interviews with former NAF Hotliners we aimed to understand better their experiences working on the Hotline as well as explore the impact working on the Hotline has had on both the Hotliners themselves and other people in their lives.

Method: In 2019 we conducted 31 telephone/Skype interviews with former NAF Hotliners. All people who had formerly worked on the NAF Hotline, at any period and in any position, were eligible to participate. We recruited participants through social media, conference announcements, and NAF listservs and networks. We analyzed our interviews for content and themes using deductive and inductive techniques.

Results: Overwhelmingly, Hotliners reported that working on the NAF Hotline was a transformative experience. Although most participants did not know much about NAF before working on the Hotline, all identified as abortion rights activists or as being pro-choice when in college; working on the Hotline solidified that commitment. Participants repeatedly identified exposure to later abortions as especially impactful, shaping their views on abortion regulations and abortion funding. More recent NAF Hotliners struggled with how to talk about their work with others and generally felt uncomfortable sharing callers' stories. Those who worked on the NAF Hotline more distantly talked more openly about their work with others. They felt these discussions influenced the abortion-related

opinions of partners, family members, friends, and later co-workers, especially with respect to later abortion and funding restrictions.

Conclusions: The NAF Hotline serves an important and transformative role in the lives of those who work for it. However, the NAF Hotline has the potential to play a much stronger role in shaping hearts and minds and social movement building in the US. Exploring ways to facilitate NAF Hotliners' engagement in ethical storytelling and advocacy appears warranted.

doi:10.1016/j.contraception.2020.03.014

Transcutaneous electrical nerve stimulation (TENS) for pain control during first-trimester abortion: A single-blinded randomized controlled trial

K. Lerma *, L.M. Goldthwaite, P.D. Blumenthal, K.A. Shaw

Stanford University, Stanford, CA, USA

*Corresponding author. Email: klerma@stanford.edu

Introduction: High-frequency, high-intensity transcutaneous electrical nerve stimulation (TENS), pulsating electrical currents that activate underlying nerves, is an inexpensive and non-invasive pain control approach. We sought to compare TENS to intravenous sedation (IV) for pain control in first-trimester surgical abortion.

Method: We conducted a non-inferiority, single-blinded, randomized controlled trial of participants undergoing surgical abortion up to 11 weeks' gestation. Participants received TENS (electrodes parallel to the spinal cord at the T10-L1 and S2-S4 levels) or IV (100mcg fentanyl and 1mg versed). Providers administered the IV sedation and research staff administered the TENS and were therefore not blinded. The primary outcome was self-reported pain with aspiration (visual analogue scale, VAS 100mm, 0 "no pain" and 100 "worst pain imaginable"). Non-inferiority limit was defined as 15mm. We also assessed participant demographics and blinding.

Results: A total of 109 participants were enrolled (55 TENS, 54 IV) between January 2018 and October 2019. Participants had a mean gestational age of 56-days across groups (p = 0.88); groups were similar with regard to age, race and ethnicity, parity, and BMI. Nine (16%) in the TENS group were given IV sedation and excluded from the per-protocol analysis. 100 participants were included in the per-protocol analysis (46 TENS, 54 IV). Mean reported VAS for aspiration was 64.78 mm (SD24.16) and 60.35mm (SD26.06) in the TENS and IV groups, respectively, with a mean difference of 4.43mm (95% CI −5.6 to 14.47). One IV group participant received additional IV medications (2%). Post-procedure, in both groups the majority of participants identified their correct assignment (p = 0.96); one in five in both groups incorrectly identified their assignment (21.7%, n = 10 TENS; 22.2%, n = 12 IV). Intention-to-treat analysis (n = 109) yielded non-inferior results for the primary outcome.

Conclusions: TENS for pain control during first-trimester surgical abortion is non-inferior to IV sedation with respect to the primary outcome of pain with aspiration. TENS could be a pain control option for patients without access to IV sedation or for those who are ineligible to receive IV sedation due to additional cost, lack of sedation provider or restrictions, including the need for a designated driver. Expanding pain control options improves quality of care and access to abortion.

doi:10.1016/j.contraception.2020.03.015

Advanced practice clinicians and medication abortion safety: A 10-year Retrospective Review

L. Porsch [a,*], M. Dragoman [a], H. Jones [b], K. Steinle [a], I. Dayananda [a]

[a] *Planned Parenthood of New York City, New York, NY, USA,* [b] *CUNY Graduate School of Public Health and Health Policy, New York, NY, USA*

*Corresponding author. Email: lauren.porsch@ppnyc.org

Introduction: Expanding the pool of trained, competent medication abortion providers is critical to filling gaps in access to safe abortion across the U.S. Despite a compelling public health argument for advanced practice clinicians (APCs) as abortion providers and the recent label change to mifepristone, 34 states currently mandate that clinicians providing medication abortion must be physicians.

Method: We performed a retrospective observational cohort study of medication abortion and clinician personnel data from the electronic medical record (EMR), quality management incident tracking, and human resources records at a large, urban-based sexual and reproductive health care provider between January 2009 and December 2018 to describe medication abortion outcomes when provided by APCs. We calculated descriptive statistics to assess overall abortion outcomes and complications. In order to assess complications by provider years of experience, we ran a negative binomial regression on total complications, using an offset term of the natural log of the total number of procedures with follow up to estimate a rate ratio.

Results: A total of 59,189 patients initiated medication abortion during the observation period under the supervision of 47 APCs. Among the 37,909 (64%) patients who completed follow up, outcomes included: 98.4% complete abortion, 1.1% failed abortion, 0.4% incomplete abortion, and 0.1% ectopic pregnancy. There were no meaningful differences in characteristics among patients who completed or failed to complete follow-up. 246 (0.6%) patients experienced complications requiring in-clinic management, ED referral, or hospital admission. .Most common interventions included aspiration (n = 112), blood transfusion (n = 36), and/or IV fluids (n = 34). We found no association between provider years of experience and complication rates (RR = 1.00, 95% CI 0.97, 1.04), restricting analyses to providers for whom there was follow-up data on at least 60% of cases in a given year.

Conclusions: Outcomes of medication abortion provided by APCs in our study are well within published benchmarks for medication abortion effectiveness (95–99%) and safety (<1% complications) when managed by physicians. Restricting provision to physicians serves only to impede access by excluding a large group of competent clinicians from offering this service.

doi:10.1016/j.contraception.2020.03.016

Certainty and Intention in Pregnancy Decision-making: an exploratory study

B. Rowland [a,*], C. Rocca [b], L. Ralph [b]

[a] *UC Berkeley – UCSF Joint Medical Program, Berkeley, CA, USA,* [b] *Advancing New Standards in Reproductive Health (ANSIRH), UCSF, Oakland, CA, USA*

*Corresponding author. Email: brenly.rowland@ucsf.edu

Introduction: Abortion is often characterized as an inherently difficult decision, despite previous research finding high levels of