



## Commentary

# When patients change their minds after starting an abortion: Guidance from the National Abortion Federation's Clinical Policies Committee ☆,☆☆



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## 1. Introduction

Although “abortion reversal” is widely discussed in the press and anti-choice legislation [1,2], there is little evidence-based guidance for clinicians about how to help those few patients who may want to stop an abortion procedure once it has started. This National Abortion Federation Clinical Policies Committee guidance discusses certainty around abortion decision making, the frequency with which patients wish to interrupt an abortion procedure once it has started, pregnancy outcomes, and clinical guidance for practitioners should this unlikely event occur.

## 2. Abortion certainty

Most people who present requesting an abortion are sure of their decision. Patients seeking abortion are as or more certain of the decision to have an abortion as patients are about other health decisions, including knee surgery, mastectomy, or prostate cancer treatment [3]. In a multi-year study of 667 American women who had an abortion in the first and second trimester, 99% reported that it was the right decision five years after the procedure [4]. In a one-year follow-up of 742 women who had a first-trimester abortion in Finland, patients had significantly reduced anxiety and overall improvement of quality of life compared to before their abortions [5]. Although tales of abortion uncertainty or regret are prevalent in anti-abortion rhetoric, such reactions are uncommon when abortion patients are asked about their experiences and followed over time [6].

## 3. Frequency of first-trimester abortion interruption

The precise frequency with which patients wish to interrupt an abortion once started is not well established in part because, in first-trimester medication abortion, patients typically take mifepristone at home and some patients do not follow up. In a cohort study of 15,890 first-trimester Planned Parenthood patients using medication abortion with mifepristone and misoprostol, 27 patients did not complete the medication abortion because they changed to an aspiration procedure, were ineligible due to gestational age, or did not take all the prescribed medications [7]. The study does not specify the reasons for not completing medication abortion. Even if all 27 patients took mifepristone and decided not to use misoprostol, of those 13,373 patients in the study with follow-up, the proportion of patients who took mifepristone and not misoprostol would be 0.2%.

In most clinical trials of early medication abortion, the number of subjects taking mifepristone without misoprostol is not reported. Finding this information in published clinical trials is difficult. One international, prospective, multi-center medication abortion trial reported that two of 714 women did not take misoprostol after mifepristone, for a rate of interruption of 0.27% [8].

## 4. First-trimester clinical considerations

Mifepristone alone is not as effective for abortion in the first trimester as mifepristone plus misoprostol. In the only trial of a single dose of mifepristone 200 mg used alone, the continuing pregnancy proportion was 23%, with higher likelihood of continuing pregnancy among patients who were later in pregnancy [9,10]. A French pharmacovigilance registry that tracked 46 pregnancies exposed to mifepristone without misoprostol showed that, of the 37 live births, two had congenital anomalies for a rate of 5.2% [11]. Both may have resulted from other causes, and the reported rate was close to the expected 6% range of major and minor anomalies in the general population [12]. In short, if a person wishes to continue a pregnancy after mifepristone alone, they

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should be counseled that overall there is an approximately 25% chance of continuing a pregnancy, but continuing pregnancy is more likely at higher gestational ages. There does not appear to be an excess risk of congenital anomalies due to mifepristone exposure should the pregnancy continue.

Because mifepristone is a potent progesterone receptor antagonist, some researchers have theorized that giving high-dose progesterone could counter the abortifacient effect of mifepristone, increasing the likelihood of continuing pregnancy. A systematic review of progesterone after mifepristone yielded only one published account of six patients who used progesterone after mifepristone [13,14]. Four out of six people carried the pregnancy to term. It is unclear in this publication what the baseline incidence of miscarriage was or whether patients with non-viable pregnancies were excluded [14]. Therefore, it cannot be concluded that progesterone treatment increases the likelihood of a continuing viable pregnancy compared to expectant management alone. More recently, the author of the six-person account published a retrospective review of data from an “abortion reversal” hotline in a journal known for publishing anti-abortion papers [15]. Patient selection, methods, and protocols were absent. The study was temporarily retracted due to lack of information about ethical approval [16]. Results of this inadequate study are suspect and cannot be used to counsel patients about using progesterone to increase the likelihood of continuing pregnancy [17].

A recent IRB approved randomized controlled trial sought to understand whether taking a regimen of high-dose oral progesterone after mifepristone increases the rate of continuing pregnancy compared to placebo [18]. The trial planned to enroll forty subjects but was stopped after twelve were enrolled due to safety concerns. Three of the twelve subjects went to the Emergency Room for bleeding. Two had emergent aspiration and one had a blood transfusion. The three subjects with unscheduled bleeding were over 56 days gestation and their bleeding episodes occurred two to three days after ingesting mifepristone. The authors could make no conclusions about the efficacy of progesterone due to the small number of enrolled patients. The authors raised concerns about not completing an evidence-based regimen of mifepristone and misoprostol, especially in patients at later gestational ages.

At this time, there is no evidence that high-dose progesterone increases the likelihood of continuing pregnancy compared to expectant management alone. Any progesterone protocol used for the purpose of increasing the likelihood of continuing pregnancy after mifepristone has been used should be considered experimental and patients should understand potential risks. Laws requiring providers to counsel people about “abortion reversal” with progesterone infringe on evidence-based practice and violate medical ethics.

Patients who interrupt a first-trimester abortion should be counseled about the range of outcomes including unscheduled bleeding, the need for emergency care, incomplete abortion, complete abortion, and continuing pregnancy. They should be reassured that exposure to mifepristone is unlikely to be associated with congenital anomalies. They should be given the option to return later to complete the abortion, referred to another abortion provider as appropriate, or referred for prenatal care. All patients need emergency contact information. There is insufficient evidence to recommend any medication or intervention to increase the likelihood of continuing pregnancy.

## 5. Frequency of later abortion interruption

The decision to interrupt an abortion, while still very low, may be more likely later in pregnancy because increased difficulty with the abortion decision is associated with later presentation for care

[19]. There are case reports of second-trimester patients who decide to continue their pregnancies after osmotic dilators have been placed [20–23]. A 2019 series of 2532 second-trimester patients treated at the University of Maryland showed that 20 (0.8%) had osmotic dilators removed [23].

## 6. Later abortion clinical considerations

Patients who have osmotic dilators removed have a range of outcomes, including returning to complete an abortion, term delivery, preterm delivery, and pregnancy loss [23]. Preterm delivery and pregnancy loss may be complicated by preterm premature rupture of membranes and chorioamnionitis, indicating that osmotic dilator placement and removal might precipitate infection that threatens pregnancy [20]. In the 2019 series of 20 patients who had osmotic dilators removed, 13 patients had outcomes data. The thirteen patients were between 15 weeks 2 days and 19 weeks 6 days and had their osmotic dilators removed prior to the scheduled dilation and evacuation. One went on to have an induced abortion. Of the 12 remaining, eight (67%) had pregnancy complications. Half of the continuing pregnancies ended in spontaneous abortion or fetal or neonatal death [23].

Patients who request osmotic dilator removal and interruption of the abortion process should be counseled about the range of possible outcomes, referred for prenatal care, and given the option of returning if they wish to complete the abortion later. There is no evidence that any potential intervention improves the likelihood of term delivery. Although antibiotics have been used for some patients in the case reports cited here, general conclusions about their effect on pregnancy outcome cannot be made based on small numbers of patients in the case reports. Antibiotic use should be based on a patient's risk factors and the discretion of the clinician and patient. Cervical cerclage and bedrest have not been studied for patients after removal of osmotic dilators.

## 7. Summary of recommendations

Patients are free to make their own decisions about abortion at any time, even in cases where this might be a risk to their health. If patients want to stop procedures, those caring for them should understand the reasons for the decision. Pain, anxiety, or fear may indicate a wish to complete the procedure but under different circumstances. In this case, either interventions to allay anxiety and build trust or rapid referral are warranted. If patients want to continue the pregnancy after starting an abortion process, the treatment already received should dictate counseling and management. The presence or absence of ruptured membranes, mechanical dilation, bleeding, partial evacuation, or medication (e.g., mifepristone, misoprostol, digoxin, uteronic medications) will all impact the potential outcomes to the patient's health and the pregnancy.

Evidence does not support using progesterone, antibiotics or other medications or interventions to increase the rate of continuing pregnancy. Antibiotics may be prudent in the presence of cervical dilation, ruptured membranes, or incomplete abortion. The patient should be counseled about potential risks, given contact information in the event of an emergency, referred for prenatal care or to another abortion provider, and given the option to return to complete the abortion later.

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