Managing Undesired Pregnancy After Dobbs

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Although both medication abortion (MAB) and aspiration procedures are safe and effective, the Supreme Court decision in *Dobbs v. Jackson Women's Health Organization* removed federal protection of access to abortion services. Abortion access is now illegal or severely limited in many states, leading to delays in abortion care for patients in all states. In this rapidly evolving landscape, primary care physicians (PCPs) must be familiar with laws surrounding abortion care in their own and neighboring states. PCPs must also be prepared to expedite abortion care by sharing resources, obtaining testing when needed, and counseling patients about expected outcomes following abortion.

KEY WORDS: abortion; pregnancy options; reproductive health.

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INTRODUCTION

By age 45, 1 in 4 US women (24%) will have had an abortion.[1] Most women seeking abortion in the USA have previously given birth. With the overturn of Roe v. Wade, access to abortion in 26 states is now illegal or severely limited for the first time in two generations.[2,3] Patients in restricted states will seek out-of-state or self-managed abortions and patients in all states will experience increased wait times for abortion care.[4] As abortion services are time sensitive, primary care physicians (PCPs) must be prepared to facilitate and expedite needed care. In this special report, we outline resources to overcome barriers to abortion access and provide primary care before and following abortion.

ABORTION ACCESS

Patients should be counseled on all pregnancy options, including parenting, adoption, and abortion. Resources to support PCPs in providing pregnancy options counseling are included in Table 1.

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Geography, local policies, financial burdens, and access to trained providers currently present barriers to equitable abortion access. Although many general internists have expressed willingness to provide medication abortion (MAB), relatively few PCPs have been trained to offer these medications.[5,6] Clinicians interested in providing MAB to their patients can access free CME training (Table 1).

PCPs should be familiar with the laws surrounding abortion and resources for abortion care in their own and neighboring states as restrictions vary widely. The Guttmacher Institute maintains current information on states where abortion remains legal, which are consequently likely to see a "surge" of patients seeking care from surrounding states where abortion is restricted.[7] In Pennsylvania (PA), for example, abortion is currently legal until 24 weeks, but the potential for a full abortion ban exists pending upcoming elections. In neighboring West Virginia, a Pre-Roe "trigger" ban restricts all abortion, and in neighboring Ohio, a 6-week abortion ban severely restricts access.[5] An increase in patients seeking abortion care in PA will create longer wait times for both local residents and those forced to travel. This may cause some patients to "time out" of accessing desired MAB, which accounted for > 50% of abortion care provided prior to the *Dobbs* decision.[8]

Insurance coverage for abortion care varies by state and insurer. The Hyde Amendment prohibits use of federal funds to pay for abortion except in cases of life endangerment, incest, or rape. Medicaid programs in 16 states allocate state funds to pay for abortion for those living at low incomes; however, this is not the case in the remaining states.[9] Private insurance obtained from the ACA exchange often does not cover abortion care and patients may need financial help with out-of-pocket costs, including travel (Table 1). Telehealth MAB allows people to avoid travel costs, but costs may still be high depending upon patients' insurance coverage. Most freestanding clinics that offer abortion care set rates well below hospital costs and work with nonprofit funds to provide services on a sliding scale. Costs increase with gestational age as the resources and legal requirements to end a second trimester pregnancy may become more complicated. As wait times increase, patients will be pushed to later gestation and their out-of-pocket costs will increase.

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Table 1 Abortion Resources for Patients and PCPs

Locating abortion care	• Plan C: https://www.plancpills.org/find-pills • National Abortion Federation: https://prochoice.org/patients/find-a-provider/ • Planned Parenthood: https://www.plannedparenthood.org/health-center • Abortion Care Network: http://www.abortionclinic.org/ • Ineedana: https://www.ineedana.com/ • Abortion Finder: https://www.abortionfinder.org/ • Reproductive health access project: https://www.reproductiveaccess.org/abortion/ • Hey Jane (telehealth): https://www.heyjane.com • Choix (telehealth): https://www.mychoix.com • Abortion on demand (telehealth): https://abortionondemand.org/
FAQs about abortion	• Medication guide (Danco): https://www.earlyoptionpill.com/wp-content/uploads/2016/01/DAN_MedGuideEng_FINAL.pdf • Genbiopro: https://genbiopro.com/resources-provider/ • Plan C: https://www.plancpills.org/guide-how-to-get-abortion-pills#faq-overview • Planned Parenthood: https://www.plannedparenthood.org/learn/abortion • Bedsider: https://www.bedsider.org/abortion • Reproductive Health Access Project: https://www.reproductiveaccess.org/abortion/
Pregnancy options counseling and support	• Pregnancy Options: https://www.pregnancyoptions.info/ • All Options: https://www.all-options.org/ • Catholics for Choice: https://www.catholicsforchoice.org/ • Exhale: https://exhaleprovoice.org • Abortion resolution workbook: https://www.pregnancyoptions.info/abortion-resolution-workbook. • 2+ abortions: https://www.2plusabortions.com/
Financial/legal resources	• Plan C: https://www.plancpills.org/guide-how-to-get-abortion-pills#can-i-get-in-trouble-for-using-abortion-pills • Abortion funds: https://abortionfunds.org/ • Repro Legal Helpline: https://www.reprolegalhelpline.org/sma-contact-the-helpline/
Clinician training and toolkits	• Teach Training (free CME): https://abortionpillcme.teachtraining.org/ • Clinician Warmline (1-877-432-7596) for questions about medication abortion • Making Medication Abortion a Part of Internal Medicine[30] • Genbiopro: https://genbiopro.com/resources-provider/ • Medication to Manage Abortion and Miscarriage[14] • UW and Plan C: https://familymedicine.uw.edu/accessdelivered/ • Reproductive health education in family medicine program: https://rhedi.org/education/medication-abortion/ • Source for Science podcast: https://www.societyfp.org/about-sfp/podcast/

ABORTION OPTIONS AND ELIGIBILITY

Both MAB and abortion procedures are highly effective (93 to 99% depending on gestational age) with a low risk for complications.[10–12] Patient preference should guide choice of MAB or aspiration procedure. Options are impacted by gestational age (determined from the first day of the patient's last menses), local service availability, wait times, and rare contraindications to medication use.

Medication Abortion

The recommended regimen for MAB includes mifepristone (oral) followed by misoprostol (buccal or vaginal).[13,14] MAB is FDA approved up to 70 days gestation, with evidence of efficacy to 77 days.[14,15] Pills can be taken wherever the patient chooses. Contraindications to MAB include ectopic pregnancy, IUD in uterus, adrenal insufficiency, long-term systemic corticosteroid therapy, coagulopathy, anticoagulation therapy, inherited porphyria, and intolerance/allergy to mifepristone or misoprostol.[13] Ectopic pregnancy should be ruled out in patients with vaginal bleeding, unilateral pelvic pain, an IUD in uterus, or a history of ectopic pregnancy, pelvic inflammatory disease, or tubal ligation. Potential risks from MAB are rare at ~1% and include bleeding and infection.[16]

Self-Managed Abortion

Self-sourced, self-administered MABs have increased in the wake of recent restrictions on legal abortion.[17] MAB is available from many telehealth providers collated by PlanCPills.org (Table 1). Self-managed abortion with mifepristone and misoprostol (or the less effective use of misoprostol alone) is safer than continuing a pregnancy.[15]

People who have self-managed abortion may hesitate to seek medical care for fear of being reported, arrested, and prosecuted. PCPs can direct patients to resources to minimize these legal risks (Table 1).[18,19] There is currently no federal or state law that requires a clinician to report someone suspected of or admitting to self-managed abortion.[18] On the contrary, such reporting is a HIPAA violation. Patients without the knowledge and resources to safely self-manage their abortions may resort to unsafe means of pregnancy termination, such as insertion of objects or caustic substances into the uterus, ingesting poisons, or intentional abdominal trauma. Prior to *Roe*, these approaches caused pelvic infections, potentially leading to sepsis, infertility, hemorrhage, hysterectomy, and death.

Abortion Procedures

Aspiration procedures take place in a medical office, clinic, or operating room. Approximately 4% of abortions in the USA

occur after a gestational age of 16 weeks and require dilation and evacuation or induction of labor.[14,20] Abortion procedures may be preferred for patients who desire completion within 1 day or close monitoring, or are anemic (hgb < 9.5 g/dL), gestational age > 10 weeks, or unable to follow-up.[10] Abortion procedures are indicated over MAB for patients who are clinically unstable, infected, or hemorrhaging. Potential risks include bleeding, infection, and rarely, uterine perforation. All of these outcomes are less common when pregnancies are terminated than carried to term.

PRE-ABORTION TESTING

PCPs should limit testing that will increase out-of-pocket costs without changing management. During the COVID-19 pandemic, protocols for MAB that do not require laboratory testing or ultrasonography for appropriate patients became widespread.[21] If a patient has risk factors for ectopic pregnancy, this should be ruled out by ultrasound. Otherwise, after pregnancy is confirmed with a urine pregnancy test, other laboratory testing is only needed for those with risk factors for anemia (CBC). Rhogam is no longer routinely given to people terminating early pregnancies (< 12 weeks).[22–26]

Some states have testing requirements that are not supported by medical evidence. For example, PA currently requires patients seeking abortion to undergo urine glucose and protein testing. Although ultrasound can be omitted for patients with no ectopic risk factors, many clinics continue to require them.[21] Understanding the specific requirements of the state and clinic where the individual will go for care is crucial for streamlining care, avoiding delays, and decreasing expenses.

POST-ABORTION EXPECTATIONS AND CARE

Medication Abortion

The most common side effects with misoprostol are nausea, vomiting, diarrhea, headache, dizziness, and fever/chills.[10,15] If a patient vomits after taking misoprostol, repeat dosing is not needed if the medication was in place for at least 15 min. Bleeding is usually heavier than a period, starts 1 to 24 hours after taking misoprostol, and peaks within 4–6 hours after this medication.[27] Bleeding typically occurs for up to a week; however, spotting can be expected for 4–6 weeks. Although risks with using MAB are low, ~5% of patients are concerned enough to visit an ER.[16] Patients should be urgently evaluated if they have a temperature > 100.4 °F more than 24 hours after taking misoprostol, bleeding through 2 overnight pads/hour for more than 2 hours in a row, clots larger than an egg, syncope, and/or symptoms of presyncope or anemia.

Patients who experience no bleeding 24 hours after taking misoprostol should contact their abortion provider and may require a repeat dose of misoprostol or procedure. Patients should be re-counseled about the potential teratogenic effects of misoprostol if deciding to continue a pregnancy after a failed MAB. While patients may be instructed to take a pregnancy test 4 weeks after MAB, these tests are highly sensitive and may remain positive for up to a month after abortion even without continued pregnancy.

Abortion Procedures

Spotting and light vaginal bleeding are common for up to a week after an abortion procedure, and may continue for a few weeks. Completion is confirmed at the time of the procedure. Patients experiencing pain, persistent bleeding, or signs of infection may require use of either misoprostol or another procedure.

PRIMARY CARE FOLLOW-UP

Almost all forms of contraception, when desired, can be started immediately following abortion. With the potential for irregular and prolonged bleeding in the post abortion period, calendar methods may be less effective in preventing pregnancy. Combined hormonal contraceptives (pill, ring, or patch) and progestin only methods (progestin only pills, depot medroxyprogesterone acetate (DMPA) injections, and contraceptive implants) can be started the same day as misoprostol or immediately following an abortion procedure.[28] IUDs can be placed after confirmation of a successful MAB or the same day as a procedure. Barrier methods and emergency contraception can be used immediately.

People experience a range of emotions following abortion, although the large majority feel it was the right decision (95%) when asked over multiple years of follow-up.[29] Talk lines can be helpful for patients desiring support after abortion (Table 1).

CONCLUSION

Following the *Dobbs* decision, PCPs are positioned to support patient access to timely abortion care. Patients will increasingly need guidance to overcome geographic, financial, and testing barriers to this care. PCPs should also be prepared to discuss patient preferences for abortion and expected symptoms following abortion as a part of primary care.

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Declarations:

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