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Case Report

Options for Teens with No Options: A Self-Managed Second Trimester Abortion



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ABSTRACT

Background: Several states have deemed abortions as nonessential services, effectively calling for a halt to abortion care during the COVID-19 pandemic. In response, women might elect for self-managed abortions by obtaining abortion medications online.

Case: A 15-year-old girl presented with abdominal cramping and vaginal discharge after taking misoprostol obtained from an online retailer for a self-managed abortion in her second trimester during the COVID-19 pandemic. Her exam showed products of conception protruding from the vagina. The patient was emergently evaluated for an incomplete and possible septic abortion and underwent a dilation and evacuation procedure.

Key Words: Adolescents, Teens, Self-managed abortion, Induced abortion, Family planning, Telemedicine

Introduction

The response to the COVID-19 pandemic has prompted several states, including Texas, Louisiana, Mississippi, Alabama, and Oklahoma, to place restrictions that have effectively banned the availability of abortion services. Adolescents already face unique and diverse challenges when accessing abortion services, including parental consent requirements, need for ultrasound examinations, and mandatory wait periods. These new restrictions have further compounded the burden that adolescents experience when accessing comprehensive family planning services.

In response, women might select for self-managed abortions without clinical supervision by obtaining abortion medications online. Although not a new phenomenon, self-managed abortions have increased during the COVID-19 pandemic.¹ Self-managed abortions have serious implications for adolescents, because of either lack of or varied level of education on methods, safety, effectiveness, and complications.

We describe a case of an incomplete, self-managed abortion in a female adolescent who used misoprostol obtained via the internet.

Case

Accompanied by her mother, a 15-year-old pregnant, healthy girl presented to an adolescent clinic with abdominal cramping and vaginal discharge for 2 days, 16 weeks after her last menstrual period. She was informed she was pregnant approximately 10 weeks earlier. After receiving options counseling and electing to terminate the pregnancy,

she was asked to return to obtain insurance through the Prenatal Care Assistance Program. However, she failed to return despite multiple outreach attempts. Instead, the patient and her mother opted to consult an online retailer, Aid Access, to obtain misoprostol. Five days before the presentation, she ingested 4 pills of misoprostol 3 times a day for 2 days. Within 2 days, she developed diarrhea, abdominal pain, vaginal bleeding, and discharge. Symptoms progressively worsened and she began to expel large amounts of tissue vaginally. One day before the presentation, she experienced subjective fevers and chills.

At presentation, she was afebrile, normotensive, and had a heart rate of 100. Examination revealed a distended abdomen and suprapubic tenderness. Suspected products of conception protruding from the vagina were described as a grey, gelatinous mass measuring 2 cm by 10 cm on external visualization. She was sent to the emergency department for evaluation of incomplete and possible septic abortion.

Obstetrics/gynecology was consulted in the emergency department. On pelvic exam, the umbilical cord was found protruding from the vaginal introitus. No active bleeding or additional products of conception were noted. Bedside ultrasound examination showed a gestational age consistent with 15 weeks and 1 day, absence of fetal heartbeat, and no amniotic fluid. Laboratory values included a serum human chorionic gonadotropin of 26,776 mIU/mL, white blood cell count of $15.4 \times 10^3/\mu\text{L}$, hemoglobin of 11.5 g/dL, and hematocrit of 34.2%. Per hospital protocol, COVID-19 testing was done and returned negative. Blood culture obtained ultimately returned negative. Prophylactic cefoxitin and doxycycline were started for septic abortion. After receiving counseling, an emergent dilation and evacuation was performed successfully with findings notable for products of conception consistent with 15 weeks' gestation. No cultures or DNA amplification tests were obtained at the time of the dilation and evacuation procedure. Social work was not

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contacted during the patient's hospitalization because there was no suspicion of abuse. She was discharged within 24 hours after an uncomplicated postoperative course and instructed to complete 3 days of doxycycline. She failed to return for her 1-week follow up appointment despite multiple outreach attempts.

Summary and Conclusion

Because of lack of access, stigma, and preference for privacy and self-care, the internet has become a source for self-managed abortion services among many individuals including adolescents. In fact, a study of individuals seeking information about self-managed abortion online showed that 41% were under the age of 17 years.² Despite the demand, limited options for online abortion services exist in the United States outside of online pharmacies. Women considering these sites often expressed concerns they might be scammed, sent fake pills, or receive unsafe products.² In a study of the experience of buying abortion pills through online pharmacies, only 30% of pills contained misoprostol within 10% of the labeled dose with the rest containing a lower amount.³ Additionally, products lacked instructions for use, and users questioned the security of sensitive information.⁴

In other countries, telemedicine abortion services with physician oversight are available, safe, and effective. In Ireland and Northern Ireland, telemedicine abortion services have been available for more than a decade and have rates of effectiveness similar to in-clinic medication abortion services.² This model of telemedicine abortion service is not available widely in the United States because of multiple obstacles. According to Guttmacher Policy Review on Access to Abortion via Telehealth, 17 states currently require the prescribing clinician to be physically present when abortion medication is dispensed. Some state laws also require an established physician-patient relationship or an in-person exam before a prescription can be supplied remotely. Furthermore, mifepristone may only be dispensed by certified prescribers and only in clinics because of a Food and Drug Administration (FDA)-imposed regulation.⁵ These barriers essentially eliminate the option for true remote self-managed abortions in the United States.

In 2018, Aid Access was introduced as a telemedicine service providing prescription abortion pills by mail-order to the United States with physician-supported consultation, instruction, and help desk support. However, the introduction of this service was quickly followed by an FDA warning letter accusing Aid Access of violating federal law by misbranding and facilitating the improper distribution of the drugs.⁶ Despite being ordered to cease telemedical abortion services in 2019, Aid Access continues to provide

abortion services even during the COVID-19 pandemic. To date, the only FDA-approved telehealth abortion service in the United States is a pilot study called TelAbortion. However, availability is limited because participants are only accepted from 12 states.⁵

Adolescents require developmentally appropriate education and guidance before choosing self-managed abortion. Adolescents might incorrectly self-identify as candidates, pick unreliable and/or unsafe resources, and/or fail to recognize when to access medical care for complications.⁷ Furthermore, adolescents might be even more disenfranchised during the COVID-19 pandemic when seeking medical abortions because of financial instability and processing delays. According to Plan C, a Web site dedicated to researching routes of access to abortion services, the average cost of pills is about \$235 for an “abortion kit” containing mifepristone and misoprostol. Plan C users also reported online suppliers as unreliable during the COVID-19 pandemic referencing order delays and lack of response to inquiries.⁴

Despite these barriers, adolescents might prefer or be forced to end their pregnancies without clinical supervision.⁸ Patients must weigh the risks of contracting COVID-19 in a clinic setting vs obtaining abortion services online. In New York, a state in which abortion services are readily available to adolescents without parental consent, a recent study revealed the requests of self-managed abortions in New York increased by 60.4% from baseline trends during the COVID-19 pandemic.¹ The use of mifepristone and misoprostol is not without rare complications such as pregnancy continuation, infection, retained products of conception, hemorrhage, and future infertility.⁸ To better serve adolescents, medical providers need to become knowledgeable of the expected course and potential complications of self-managed abortions.

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