DOSAGE AND ADMINISTRATION

The recommended regimens for abortion induction with misoprostol in pregnancies through 9 weeks' LMP are **3 doses (800 mcg each), 3 to 12 hours apart administered vaginally, sublingually (under the tongue) or buccally (in the cheek).**

For sublingual and buccal routes, hold the pills in position for 20-30 minutes and swallow any remaining fragments.

Notes:

- Sublingual misoprostol used in shorter intervals results in increased efficacy but higher levels of side effects.
- Oral (immediately swallowed) administration of misoprostol for this indication is not recommended. It is not as effective and causes more side effects.
- For more information on termination of pregnancies over 9 weeks, please refer to: WHO/RHR. Safe abortion: technical and policy guidance for health systems (2nd edition), 2012. This document can be accessed at: http://www.who.int/reproductivehealth/publications/unsafe_abortion/9789241548434/en/

SUGGESTED CITATION

Instructions for Use: Abortion Induction with Misoprostol Alone in Pregnancies Through 9 Weeks' LMP. Gynuity Health Projects. October 2013.

For more information, refer to www.gynuity.org

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INSTRUCTIONS FOR USE

ABORTION INDUCTION WITH MISOPROSTOL ALONE IN PREGNANCIES THROUGH 9 WEEKS' LMP

BACKGROUND

Misoprostol is a prostaglandin analog widely marketed under various trade names. Misoprostol was originally registered for use to prevent gastric ulcers resulting from chronic administration of nonsteroidal anti-inflammatory drugs (NSAIDs). As misoprostol induces uterine contractions, some formulations are now registered for obstetric indications. It is often used for pregnancy termination.

INDICATION AND USAGE

The following information applies to the use of misoprostol for termination of pregnancies estimated to be up to 9 weeks (63 days) since the first day of the last menstrual period (LMP). It is important to know the approximate duration of the pregnancy in order to determine if it is appropriate for the woman to use this method. Use of misoprostol results in a range of complete abortion rates (75-90%) within 2 weeks without surgical intervention. If needed, treatment for completion can include waiting (except in cases of ongoing pregnancy), more medication and/or uterine aspiration.

CONTRAINDICATIONS

- Confirmed or suspected ectopic pregnancy or undiagnosed adnexal mass
- History of allergy to misoprostol or other prostaglandin

If an IUD is in place, it must be removed before misoprostol is administered.

PRECAUTIONS

- Caution is recommended when administering misoprostol for abortions beyond 9 weeks' LMP. As pregnancy progresses, the uterus becomes more sensitive to misoprostol, so dose and regimen may need to be adjusted. With increasing gestational age, both the time required to expel the pregnancy and the quantity of blood loss will increase.

- There is no evidence that misoprostol used for medical abortion is harmful to nursing infants. However, most drugs in a woman's blood do get into breast milk in very small amounts, and some women choose to discard breast milk for a few hours after misoprostol administration.

- Some studies have found a connection between attempted unsuccessful abortion with misoprostol and congenital defects. The absolute risk of teratogenicity with misoprostol exposure appears low, on the order of 1 to 2 per 100 exposed fetuses. Nonetheless, completion of termination is recommended if pregnancy is ongoing after exposure to misoprostol.

EFFECTS AND SIDE EFFECTS

Most side effects are transient and typically do not require special management. Prolonged or serious side effects are rare.

BLEEDING

Bleeding often starts within the first day, generally within a few hours after taking misoprostol. Several hours of heavy bleeding with passage of clots is not unusual. Bleeding typically lasts 7 to 14 days with additional days of spotting that can last until the next menstrual period. Menses usually occurs 4 to 6 weeks after misoprostol administration. Bleeding alone does not indicate a successful abortion.

Women should be instructed to contact their providers if any of the following occur: (1) soaking more than two maxi sanitary pads an hour for more than two consecutive hours, (2) experiencing a sudden onset of extremely heavy bleeding two weeks or longer after taking misoprostol, (3) bleeding continuously for several weeks with faintness or light-headedness.

Women should be told to contact the provider to see if the pregnancy is still present if there has been no or only scant bleeding for 7 days after misoprostol administration.

CRAMPING

Cramping usually starts within the first day and may begin as early as 30 minutes after misoprostol administration. The pain may be much stronger than that experienced during a regular period. Nonsteroidal anti-inflammatory drugs (NSAIDs) or other analgesia can be used for pain relief without affecting the success of the method.

CHILLS AND/OR FEVER

Chills are common but transient side effects of misoprostol. Fever is less common, also transient, and does not necessarily indicate infection. Fever or chills persisting beyond 24 hours after misoprostol may indicate infection and the woman should seek medical attention.

NAUSEA AND VOMITING

Nausea and vomiting may occur and will resolve 2 to 6 hours after taking misoprostol. An antiemetic can be used if needed.

DIARRHEA

Diarrhea may also occur following administration of misoprostol but should disappear within a day.

REFERENCE LIST FOR "INSTRUCTIONS FOR USE: ABORTION INDUCTION WITH MISOPROSTOL ALONE IN PREGNANCIES THROUGH 9 WEEKS' LMP"

Vauzelle C, Beghin D, Cournot MP, Elefant E. Birth defects after exposure to misoprostol in the first trimester of pregnancy: prospective follow-up study. Reprod Toxicol. 2013 Apr; 36:98-103.

Blum J, Raghavan S, Dabash R, Ngoc NT, Chelli H, Hajri S, Conkling K, Winikoff B. Comparison of misoprostol-only and combined mifepristone-misoprostol regimens for home-based early medical abortion in Tunisia and Vietnam. Int J Gynaecol Obstet. 2012 Aug; 118(2): 166-71.

Kulier R, Kapp N, Gülmezoglu AM, Hofmeyr GJ, Cheng L, Campana A. Medical methods for first trimester abortion. Cochrane Database Syst Rev. 2011 Nov; (11):CD002855.

Ngoc NT, Blum J, Raghavan S, Nga NT, Dabash R, Diop A, Winikoff B. Comparing two early medical abortion regimens: mifepristone+misoprostol vs. misoprostol alone. Contraception. 2011 May; 83(5):410-7.

Fekih M, Fathallah K, Ben Regaya L, Bouguizane S, Chaieb A, Bibi M, Khairi H. Sublingual misoprostol for first trimester termination of pregnancy. Int J Gynaecol Obstet. 2010 Apr; 109(1):67-70.

Chawdhary R, Rana A, Pradhan N. Mifepristone plus vaginal misoprostol vs vaginal misoprostol alone for medical abortion in gestation 63 days or less in Nepalese women: a quasi-randomized controlled trial. J Obstet Gynaecol Res. 2009 Feb; 35(1):78-85.

von Hertzen H, Piaggio G, Huong NT, Arustamyan K, Cabezas E, Gomez M, Khomassuridze A, Shah R, Mittal S, Nair R, Erdenetungalag R, Huong TM, Vy ND, Phuong NT, Tuyet HT, Peregoudov A; WHO Research Group on Postovulatory Methods of Fertility Regulation. Efficacy of two intervals and two routes of administration of misoprostol for termination of early pregnancy: a randomised controlled equivalence trial. Lancet. 2007 Jun; 369(9577):1938-46.

Moreno-Ruiz NL, Borgatta L, Yanow S, Kapp N, Wiebe ER, Winikoff B. Alternatives to mifepristone for early medical abortion. Int J Gynaecol Obstet. 2007 Mar; 96(3):212-8.

Salakos N, Kountouris A, Botsis D, Rizos D, Gregoriou O, Detsis G, Creatsas G. First-trimester pregnancy termination with 800 mcg of vaginal misoprostol every 12 h. Eur J Contracept Reprod Health Care. 2005 Dec; 10(4): 249-254.

Carbonell JL, Rodriguez J, Velazco A, Tanda R, Sanchez C, Barambio S, Chami S, Valero F, Mari J, de Vargas F, Salvador I. Oral and vaginal misoprostol 800 mcg every 8 h for early abortion. Contraception. 2003 Jun; 67(6):457-462.

Singh K, Fong YF, Dong F. A viable alternative to surgical vacuum aspiration: repeated doses of intravaginal misoprostol over 9 hours for medical termination of pregnancies up to eight weeks. BJOG. 2003 Feb;110(2):175-80.

Jain JK, Dutton C, Harwood B, Meckstroth KR, Mishell DR Jr. A prospective randomized, double-blinded, placebo-controlled trial comparing mifepristone and vaginal misoprostol to vaginal misoprostol alone for elective termination of early pregnancy. Hum Reprod. 2002 Jun; 17(6):1477-82.

Tang OS, Miao BY, Lee SW, Ho PC. Pilot study on the use of repeated doses of sublingual misoprostol in termination of pregnancy up to 12 weeks gestation: efficacy and acceptability. Hum Reprod. 2002 Mar; 17(3):654-8.

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