Troublesome bleeding following early medical abortion

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INTRODUCTION

Early medical abortion (EMA) (ie, using combination mifepristone and misoprostol to terminate pregnancies of less than 10 weeks' gestation) is the the most common method of induced abortion in the UK.[1]

The majority of EMAs in the UK are completed by patients in their own homes. Success of abortion can be confirmed with self-performed low-sensitivity urinary pregnancy tests (LSUPTs). LSUPTs are used 2–3 weeks after misoprostol administration, depending on local protocol. LSUPTs turn positive at concentrations over 1000 iU human chorionic gonadotrophin (hCG).[2]

In response to the 2020 novel coronavirus (COVID-19) outbreak, UK guidance was issued to encourage telemedicine where possible (figure 1), and minimise the use of ultrasound[3] scanning, in keeping with existing Royal College of Obstetricians and Gynaecologists (RCOG) guidance.[4] Telemedicine for abortion care is also encouraged by National Institute for Health and Care Excellence (NICE) guidance and is likely to remain the standard of care beyond COVID-19.[5]

CLINICAL CASE

Ms X calls her general practitioner for advice – she has been experiencing light continual bleeding without pain for the last 4 weeks.

Four weeks ago she had an EMA at home to terminate a pregnancy of 9 weeks' gestation. She took her medicines as directed and had a heavy vaginal bleed with clots and passed tissue. At the time of the abortion she had a negative test for the sexually transmitted infections (STIs) chlamydia and gonorrhoea, using a self-sampling kit. Over the next few days the bleeding got progressively lighter and her pregnancy symptoms (including morning sickness and breast tenderness) resolved. She received a supply of the desogestrel progestogen-only pill (POP) and commenced this the day after her treatment. Two weeks after her treatment she performed a LSUPT which was negative.

Key messages

- Retained products of conception (RPOC) are diagnosed clinically – in the absence of symptoms, post-abortion ultrasound is not necessary.
- Infection may be responsible for troublesome bleeding following abortion.
- Ensure post-abortion contraception needs are met – including an acceptable bleeding profile.

HISTORY

Experiences of vaginal bleeding at medical abortion can vary between patients. The median duration of vaginal bleeding following an EMA at 8 weeks' gestation is 12 days.[5]

When discussing post-abortion bleeding it is important to quantify this, for example, how often is Ms X changing sanitary wear. If she were bleeding very heavily with flooding, particularly if associated with dizziness or light-headedness, she should have urgent clinical assessment using an ABCDE approach[6] and, rarely (less than 1% of cases), may require emergency care.[5] If the bleeding is lighter, as in the case of Ms X, this may represent normal post-abortion bleeding. Passing clots and variable volumes of bleeding may suggest retained products of conception (RPOC) (ie, pregnancy tissue remaining in the uterus following abortion).

Asking about symptoms of infection (such as pain and malodorous discharge) or risk of infection (such as a new partner) may be helpful as sometimes light bleeding can be an indication of an STI or endometritis. Endometritis can be caused by

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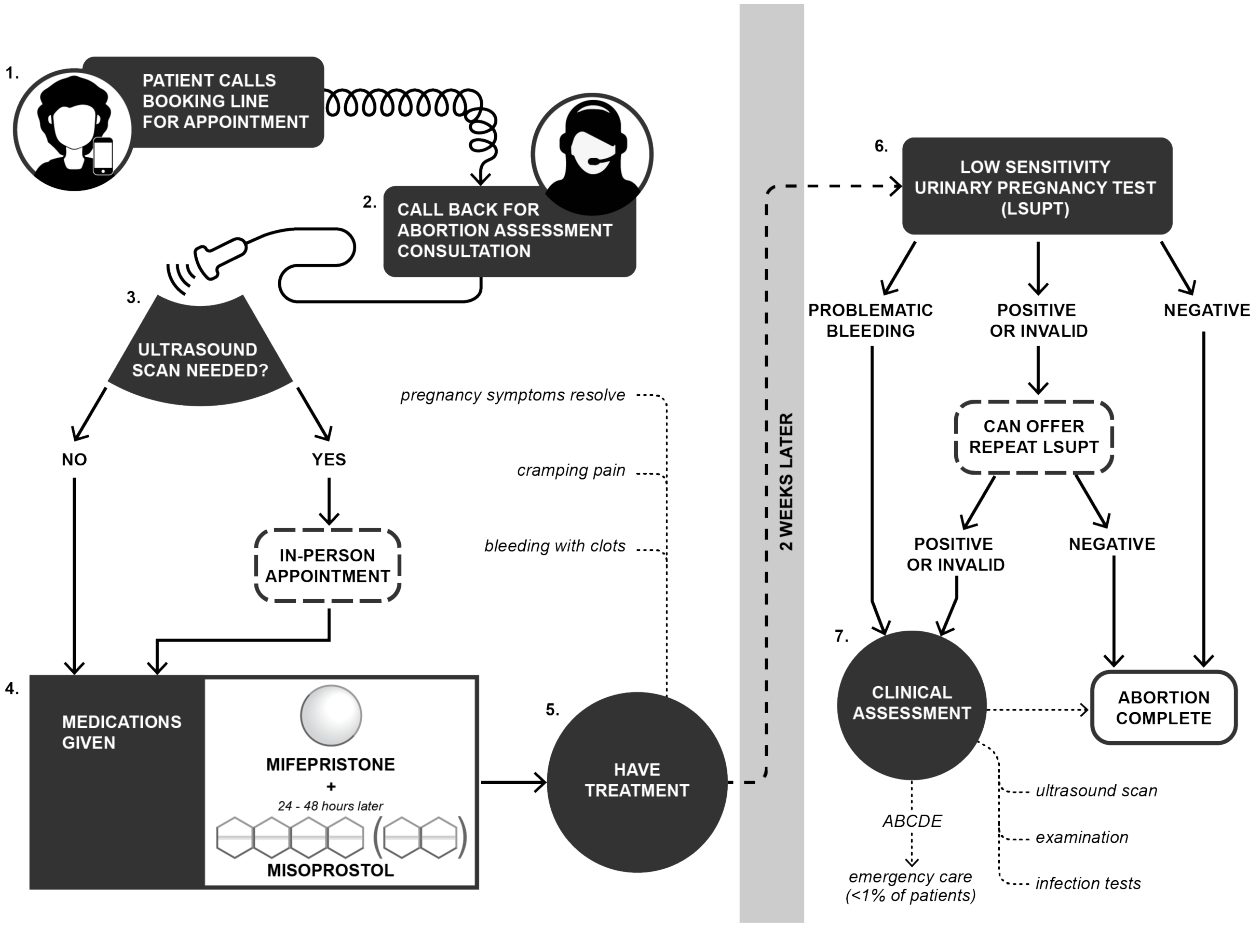

Figure 1 Patient journey through telemedicine early medical abortion (CCBY4.0 John Reynolds-Wright available from https://flic.kr/p/2j8HtKK).

a variety of different bacteria and so broadspectrum antibiotics should be used to treat this if suspected. Local guidelines and protocols will advise on the specific treatment regimens to use.

EXAMINATION

Pelvic examination can be helpful to exclude RPOC in women who are reporting troublesome bleeding after abortion. Speculum examination revealing an open cervical os with heavy bleeding or visible pregnancy tissue (that could be removed from the os) is indicative of RPOC. Bimanual examination might reveal a tender, enlarged, boggy uterus.[7] With such findings, it may be appropriate to liaise with the abortion care provider as further treatment may be required, for example, surgical evacuation of the uterus or further misoprostol. On examination, Ms X has a closed cervical os and reports only very minimal tenderness on uterine compression without cervical excitation. This is consistent with her clinical history that she has likely had a successful abortion.

INVESTIGATIONS

A LSUPT is helpful to exclude ongoing pregnancy. A positive LSUPT could indicate a continuing pregnancy, RPOC (that may or may not be clinically important) or indeed a successful EMA (a false-positive). High-sensitivity urinary pregnancy tests (that turn positive between 25 and 50 iU hCG) may still turn positive for several weeks following a successful EMA and so are less helpful in this situation. Ms X's LSUPT result is negative, and when considered with her history, continuing pregnancy is very unlikely.

Testing for common STIs should be offered to all patients prior to abortion care;[5] however, this is sometimes not available or declined. If a patient returns with problematic bleeding and a test has not been performed, it should be offered as the result can help select appropriate antibiotic treatment as per local antimicrobial protocols. If an STI test is positive, partner notification and treatment should be arranged. In the case of Ms X, she had a baseline negative test and has no new partner, so further testing is not required.

Ultrasound can reliably exclude continuing pregnancy; however, ultrasound alone cannot diagnose RPOC as this is a clinical diagnosis and there is no endometrial measurement or ultrasound characteristic that mandates further treatment, including surgical intervention.[8] If a patient is scanned and a continuing pregnancy is identified, the patient should be referred back to the abortion care provider as a matter of

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urgency to receive further medical or surgical treatment, if desired.

ADVICE

If there are no other causes found it is possible that post-abortion bleeding can be attributable to a new method of hormonal contraception. Ms X has recently initiated the POP – if the method is new to her or she had not used hormonal contraception previously, the bleeding pattern may not meet her expectations.

Additionally, she may not be adhering well to the treatment – erratic pill takers are more likely to have erratic bleeding patterns.

She may be reassured by an explanation that around half of POP users experience prolonged bleeding and that this becomes less frequent with greater duration of use.[9] It may be helpful to reiterate pill-taking rules and general clinical advice for this contraceptive method.

Alternatively, she may wish to consider alternative methods of contraception including long-acting reversible methods. If choosing to switch, provide information on alternative methods – consider using an evidence-based decision aid such as www.contraceptionchoices.org and try to facilitate seamless switching to minimise risk of further unintended pregnancy.

CONCLUSIONS

Troublesome bleeding can occur following EMA. Detection of continuing pregnancy (ie, failed EMA) is vital. Other causes can include infection and RPOC, and these should be considered alongside potential hormonal contraception side effects.

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Editor's note The details of this case are fictitious. Any resemblance to actual persons, living or dead, or actual events is coincidental.

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