Medical management of abortion

World Health Organization

human reproduction programme hrp research for impact
UNDP·UNFPA·UNICEF·WHO·WORLD BANK

Summary chart of recommendations on medical management of abortion

RECOMMENDATIONS	COMBINATION REGIMEN[a]		MISOPROSTOL-ONLY
	MIFEPRISTONE ›› 1–2 DAYS ››	MISOPROSTOL	MISOPROSTOL
27a. **INDUCED ABORTION** <12 WEEKS	200 mg PO once	800 µg PV, SL or B[b]	800 µg PV, SL or B[b]
27b. **INDUCED ABORTION** ≥12 WEEKS[c]	200 mg PO once	400 µg PV, SL or B every 3 hours[b]	400 µg PV, SL or B every 3 hours[b]
31. **MISSED ABORTION** < 14 WEEKS	200mg PO once	800µg B,PV or SL[b]	800µg B,PV or SL[b]
32. **INTRAUTERINE FETAL DEMISE** ≥14–28 WEEKS[c]	200 mg PO once	400 µg PV or SL every 4–6 hours[b]	400 µg SL (preferred) or PV every 4–6 hours[b]
36a. **INCOMPLETE ABORTION** <14 WEEKS UTERINE SIZE	Use misoprostol-only regimen		600 µg PO or 400 µg SL[b]
36b. **INCOMPLETE ABORTION** ≥14 WEEKS UTERINE SIZE	Use misoprostol-only regimen		400 µg SL, PV or B every 3 hours[b]
	LETROZOLE	**MISOPROSTOL**	
27c. **INDUCED ABORTION** < 12 WEEKS[d]	10mg PO daily for 3 days	800µg SL on day 4	
	TIMING OF POST-ABORTION CONTRACEPTION		
	IMMEDIATE INITIATION		
4a. **HORMONAL CONTRACEPTION**	Immediately after the first pill of the medical abortion		
4b. **IUD**	With assessment of successful abortion		

B: buccal; PO: oral; PV: vaginal; SL: sublingual

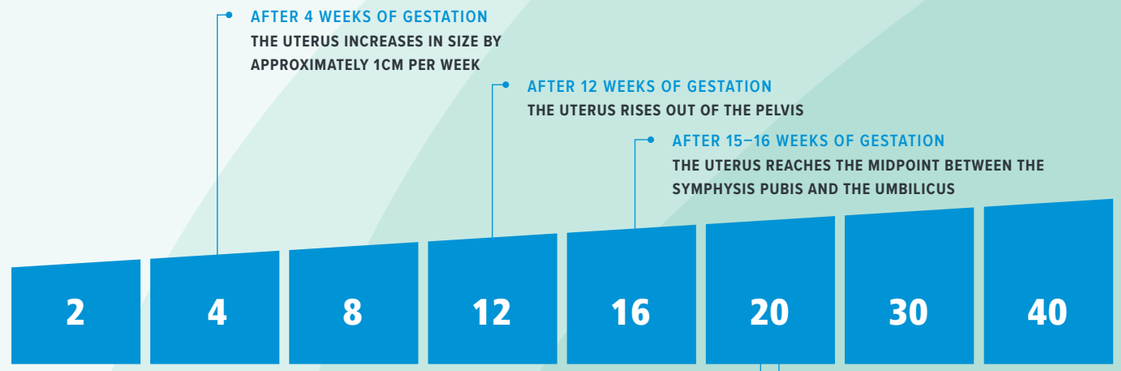
a The combination regimen of mifepristone plus misoprostol is slightly more effective than misoprostol alone.

b Repeat doses of misoprostol can be considered when needed to achieve success of the abortion process. The Abortion care guideline does not include a recommendation for a maximum number of doses of misoprostol. Health-care providers should use caution and clinical judgement to decide the maximum number of doses of misoprostol in pregnant individuals with prior uterine incision. Uterine rupture is a rare complication; clinical judgement, adequate referral mechanisms and health system preparedness for emergency management of uterine rupture must be considered with advanced gestational age.

c The dose of misoprostol should be reduced for induced abortion beyond 24 weeks and IUFD beyond 28 weeks due to limited data. Clinical judgement should be used to determine the appropriate dosage, recognizing the greater senstivity of the uterus to prostaglandins.

d Further evidence is needed to determine the safety, effectiveness and acceptability of the letrozole plus misoprostol combination regimen at later gestational ages, especially in comparison with that of the mifepristone plus misoprostol combination regimen (the available evidence focused on comparison with the use of misoprostol alone).

Pregnancy dating by physical examination* (bimanual pelvic and abdominal examination)



KEY CONSIDERATIONS

LIMITATIONS TO DATING BY UTERINE SIZE ON PHYSICAL EXAMINATION	A UTERUS THAT IS SMALLER THAN EXPECTED MAY INDICATE:	A UTERUS THAT IS LARGER THAN EXPECTED MAY INDICATE:
• uterine malformations/fibroids • multiple gestation • marked uterine retroversion • obesity • molar pregnancy	• the woman is not pregnant • inaccurate menstrual dating • ectopic pregnancy or abnormal intrauterine pregnancy, e.g. spontaneous or missed abortion	• inaccurate menstrual dating • multiple gestation • uterine abnormalities, such as fibroids • molar pregnancy

* Pregnancy dating can be done based on last menstrual period alone or in combination with use of a validated tool. When LMP is uncertain, a clinical exam may be warranted. In general, the least invasive method that is appropriate in the circumstances and available in the setting should be used.

Adapted from: Clinical practice handbook for safe abortion. Geneva: World Health Organization; 2014, p. 17 (http://www.who.int/reproductivehealth/publications/unsafe_abortion/clinical-practice-safe-abortion/en/); adapted from Goodman S, Wolfe M; TEACH Trainers Collaborative Working Group. Early abortion training workbook, third edition. San Francisco (CA): UCSF Bixby Center for Reproductive Health Research and Policy; 2007 (http://www.teachtraining.org/trainingworkbook/earlyabortiontrainingworkbook.pdf).

Principles underlying the process of improving the access to and quality of abortion care include the right of access to relevant evidence-based health information, so that individuals who can become pregnant can have control over and decide freely and responsibly on matters related to their sexuality and reproduction (including their sexual and reproductive health) free of coercion, discrimination and violence[1].

1. The WHO strategic approach to strengthening sexual and reproductive health policies and programmes. Geneva: World Health Organization; 2007 (https://www.k4health.org/sites/default/files/WHO%20Strategic%20approach.pdf, accessed 15 July 2022).

Information is a necessary component of any medical care and should always be provided to individuals considering abortion (see details in the full guideline).

Counselling is a focused, interactive process through which one voluntarily receives support, additional information and guidance from a trained person, in an environment that is conducive to openly sharing thoughts, feelings and perceptions.

Pain management should be offered routinely (e.g. non-steroidal anti-inflammatory drugs [NSAIDS]) and that it should be provided to those who want it.

Routine follow-up is not necessary following an uncomplicated medical abortion using mifepristone and/or misoprostol. However, information should be provided about the availability of additional services if they are needed or desired.

The Abortion care guideline and supportive materials are available for download at https://www.who.int/publications/i/item/9789240039483