

Safety and acceptability of telemedicine for medical abortion in first trimester

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Introduction

- Abortion is a commonly sought medical procedure among re women, and safely performed first trimester abortions are con risk procedures
- Common barriers to abortion services include cost, distance, provider-depletion, and moral opposition.
- More women are electing to seek web-based telemedicine al services as they offer timely, efficient, safe and accessible ter options
- Opponents of telemedicine abortion services cite safety conc including lack of follow up, detection of retained products of and misuse of medication
- Once a comparable safety profile is established, safe and effe abortion telemedicine services has the potential to reach of exact of the services has the potential to reach of exact of the services has the potential to reach of the p who experiences an unplanned pregnancy regardless of geog location and access to resources

Objective

Can a telemedicine provided abortion performed within the first (12 weeks gestation or less) provide a safe platform to increase early abortion compared to in-person standard of care?

- Aim 1: To assess the safety of a telemedicine provided service to in-person care appointments for first trimester abortions.
- Aim 2: To determine provider and patient acceptability of tel as an alternative to standard care.

Methods

- Databases used include PubMed, Ovid Medline, CINAHL, and
- Search terms: "(Telemedicine) AND Women's health" = 297 res "(Telemedicine) AND Women AND Abortion"=14 results. (eHe abortion" = 60 results.
- Inclusion criteria: Telemedicine for medical abortion services in assessment and screening, treatment, and follow up, success rate (adverse events or hospitalization) or acceptability (satisfaction) dissatisfaction with care experience).
- **Exclusion criteria**: Non-English studies, older than ten years, and second trimester or later.

Telemedicine Abortion Proce







Telehealth services



Medication mailed directly Co or remote prescription

			Results		
oductive	Author, Year	Sample, Setting	Intervention description	Data collection, attrition	Main outcomes
dered low source and tion nation	Endler et al., (2018)	N= 615 women requested medical abortion using WoW telemedicine service Polish study On-line, telemedicine	 Retrospective cohort study design >9 weeks gestation <9weeks gestation (200mg mifepristone) + (800 + 400 + 400µg misoprostol) 	 5 weeks post-abortion follow-up email evaluation of symptoms, experience and bleeding events 35% loss to follow-up (LTFU) 	 Safety: Heavy bleeding (more than 2 pads/hr for 2 hrs Clinical visits or hospitalizations for complication day 0-1 post-abortion Acceptability: Unmet expectations Low satisfaction
ns, onception ve y woman ohical	Kopp Kallner et al., (2015)	N= 1180 women requesting early medical termination of pregnancy (TOP) Swedish study Out-patient family planning clinic	 Randomized control design Examination, counseling, treatment from either nurse-midwife or gynecologist Efficacy of TOP 	 In-person ultrasound, counseling, abortifacient medication provision, follow-up Arm one: Nurse-midwife, LTFU 9% Arm two: Standard care (gynecologist), LTFU 13% 	 Efficacy of TOP Safety and AE's Patient provider preference
imester	Dunn et al., (2015)	N=129 women requesting medical abortion at ≤7 weeks Toronto, Canada Sexual health clinics	 Non-randomized design Intervention: Remote f/u questionnaire and B-HCG at local lab Control: Standard care follow-up in-clinic assessment and ultrasound 	 Survey data Intervention: Remote care, LTFU 6% Control: Standard care, LTFU 14% 	 Adherence (failure to completed scheduled f/u within 7 days) Acceptability questionnaire Adverse events
compared	Grossman, D. & Grindlay, K. (2017)	N= 8,765 telemedicine provided abortion N= 10,405 in-person provided abortion Planned Parenthood of Iowa	 Retrospective cohort study design Adverse events assessed for telemedicine and in-person abortions 	 Data from Planned Parenthood's practice management database Required reporting forms on AE events Hospital ER visits 	 Adverse Events: Hospital admissions Surgery Blood transfusion ER treatment Death
aedicine as base. s. a) AND	Doran, F. & Nancarrow, S. (2015)	N= 38 articles screened and reviewed on perceived barriers & facilitators to accessing medical abortion	 Systematic review Hand searching and grey literature 	 Content assessed by thematic analysis Two authors independently reviewed Quality assessment with validated tool 	 Provider barriers: Moral opposition, lack of training, understaffing, harassment, insufficient resources. Women's Barriers: Lack of access, negative attitudes from staff, costs of service Recommend increase training, telehealth provided, referral protocols
iding fety bortions	Endler et al., (2019)	N= 13 articles assessed for success rate, safety, and acceptability of medical abortion provided from telemedicine	 Systematic review Adapted search-construct for each database 	 GRADE approach Consensus decision Separated by >10weeks GA and <10weeks GA Synthesized quantitative data; median rates Qualitative narrative 	 Primary outcomes success rate and safety Secondary outcomes clinical symptoms not pertaining to safety (unscheduled clinic visits, outpatient treatment, bleeding)
	Gomperts et al., (2013)	N=602 Brazilian women who completed online request for medical abortion from Women on Web telemedicine services	 Retrospective case review <9 weeks gestation, but contained instructions if >9 weeks Helpdesk available 7 days a week 	 5 week post follow-up email evaluation Initial consult and helpdesk correspondence evaluated 	 Surgical intervention. Increased with greater gestational age Complication rates Continuation of pregnancy after medication
nation testing	Kerestes et al. (2019)	N= 650 healthcare provider respondents to questionnaire assessing the practice of self-managed abortion (outside traditional healthcare system)	 On-line survey to members of Society for Family Planning, Association of Reproductive Health Providers, and the Abortion Care Network 	 Anonymous secure survey: providers knowledge of mifepristone/ misprostol, witnessed complications, reasons for women electing abortion Likert scale questions 	 Provided care for patient who self-managed abortion Complications witnessed (incomplete abortion, retained products of conception, sepsis/ shock)

•	Current research has d	em

- misoprostol for first trimester abortions
- expectations with telehealth services
- of training, and insufficient resources
- and cost of service
- and mailing prescriptions
- abortion are unsupported by the evidence

Implications for NP Clinical Application

- licensing
- disadvantaged patients
- telemedicine in resource poor areas.

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Summary

Current research has demonstrated that telehealth services have equitable safety profiles as in-person provided medical abortion with mifepristone/

• Patient reported acceptability rates reflect high satisfaction and met

• Provider perceived barriers to telemedicine include moral opposition, lack

• Women's perceived barriers include negative attitudes from clinical staff

• Countries where mifepristone is illegal, methotrexate is an acceptable alternative but carries additional risks if incomplete or unsuccessful • Providers need to be licensed in the state where they are remoting managing

• Arguments against the safety, misuse, and complication rates of telehealth

• The direction of clinical care is moving towards e-services and remote platforms to triage, manage, and screen for women's health concerns • Nurse Practitioners are uniquely positioned to meet this growing need • Telemedicine has potential to extend the capacity and reach in states with restrictions to abortion services, depending on prescribing provider state

• Based on the evidence, recommendations to increase provider training, expand eligible scope of practice for midlevel practitioners in states with current restrictions, and develop more cost effective referral protocols for

• Opportunities in future research to clearly define the parameters of telemedicine provided abortion services (using serial HCG serum draws versus ultrasound to confirm gestational age) and the feasibility of using

References