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Surgical abortion in patients with opioid dependence: Disparities in demographic factors, procedural pain, and post-abortion contraception

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Introduction**:** The US opioid epidemic is a major public health crisis and there has been a notable increase in opioid use among women of reproductive age. Women who use opioids have high rates of unintended pregnancy and low contraceptive use. They also experience social stigma that puts them at risk for lower-quality healthcare. Despite their high rates of unintended pregnancy and resultant higher need for abortion care, no previous study had explored the abortion experiences of women in this population. Our objective was to compare demographics, procedural pain, and post-abortion contraception between surgical abortion patients with and without opioid dependence (OD).

Methods**:** An anonymous post-procedure survey was offered to all surgical abortion patients at a high-volume, multi-site, ambulatory abortion practice, 2017-2018. Participants reported medical and demographic information, completed the Rapid Opioid Dependence Screen (RODS) and answered questions regarding intraoperative pain using a 0-100 scale, post-abortion contraception, and perceived provider support of contraceptive autonomy.

Results: Of 1,888 patients approached, 1,553 completed the survey (82% response), 1,525 completed the RODS and 88 (5.9%) screened positive for OD. Patients with OD had more abortions after 15 weeks (18.4% vs. 5.9%), higher rates of chronic pain (21.6% vs. 7.9%), depression (40.0% vs. 16.4%) and anxiety (35.0% vs. 21.1%) and were more likely to receive post-abortion LARC (37.5% vs. 24.7%) (all $p<0.05$). Patients with OD had higher median pain scores versus those without (35.0 vs. 22.5, $p=0.002$). In multivariable linear regression modeling accounting for gestational age (GA), prior pregnancies, chronic pain and mental health factors, individuals with OD had a mean pain score 7.8 points higher than those without ($p=0.023$). Intravenous (IV) sedation significantly reduced pain in all patients but did not significantly modify the effect of OD status on pain. For contraceptive use, a multivariable model accounting for GA, prior pregnancies, demographics, and insurance status found that patients with OD remained more likely to receive post-abortion LARC (aOR 1.71,95% CI 1.05, 2.78) than those without. Measures of contraceptive autonomy did not differ according to OD status.

Conclusions: Patients with OD report higher levels of intraoperative pain during surgical abortion and procedural pain is reduced with IV sedation. Patients with OD are more likely to receive post-abortion LARC and do not experience differences in perceived contraceptive autonomy.

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Mifepristone and sublingual misoprostol versus sublingual misoprostol alone for missed abortion: Results of a randomized placebo-controlled trial

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Introduction**:** Medical management of missed abortion has been demonstrated to be a safe and effective alternative to uterine aspiration. Regimens for medical management subjected to clinical trials using pretreatment with mifepristone followed by misoprostol have generally employed vaginal misoprostol. However, misoprostol-only regimens recommended by the World Health Organization also include sublingual misoprostol. We compared the efficacy and safety of pretreatment with mifepristone followed by sublingual misoprostol with the efficacy and safety of sublingual misoprostol alone for the management of missed abortion.

Method**:** 287 women with an anembryonic gestation or in whom embryonic or fetal death was confirmed were randomly assigned to receive either 200mg oral mifepristone followed in 24h by 800mcg sublingual misoprostol (mifepristone-misoprostol group) or placebo followed in 24h by 800mcg sublingual misoprostol (misoprostol-alone

group). Women in both groups could administer a second dose of 800mcg sublingual misoprostol at home after 12h if they did not experience any bleeding. Participants returned after 7 days for evaluation including ultrasound examination. Our primary outcome was gestational sac expulsion at the follow-up visit and no additional surgical intervention.

Results**:** Gestational sac expulsion at the follow-up visit with no additional surgical intervention occurred in 107/126 women (85.0%) in the mifepristone-misoprostol group and 120/ 143 women (83.9%) in the misoprostol-alone group (relative risk 1.0, 95% CI 0.9-1.1). Women assigned to mifepristone-misoprostol were significantly less likely to use the additional dose of misoprostol (26/126 women or 20.6%) than women who received misoprostol alone (50/143 women or 34.9%) (relative risk 0.6, 95% CI: 0.4-0.9). Women who received misoprostol alone were more likely to report that side effects were "bad" or "very bad" (65/142 or 45.8%) compared to women who received mifepristone-misoprostol (47/125 or 37.6%) (relative risk 0.82, 95% CI: 0.61-1.09).

Conclusions: Pretreatment with mifepristone did not significantly improve the effectiveness of sublingual misoprostol for treatment of missed abortion when women were allowed to use additional doses of misoprostol if they believed bleeding was too scanty. However, women who received mifepristone-misoprostol were significantly less likely to self-administer an additional dose of misoprostol and reported that side effects were more tolerable than women who received misoprostol alone.

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Using telemedicine to reduce the cost of medical abortion to patients and extend the reach of providers to rural areas and across state lines

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Introduction: In May 2016, we launched the TelAbortion Project, which enables women in participating states to obtain medical abortion from home by telemedicine and mail without coming in person to an abortion facility. We will present updated service statistics and discuss the implications of this model for improving abortion access in the U.S.

Methods: To obtain a TelAbortion, a woman contacts a project site and receives counseling and instructions by videoconference. She has screening tests at facilities close to her. If she is eligible, the site mails or prescribes a standard medical abortion regimen. She obtains follow-up tests and speaks with TelAbortion staff to confirm complete abortion. Women or their insurance carriers pay for all services received outside project sites, and since late 2017, also for services obtained directly from the project. TelAbortion is currently implemented by providers in Hawaii, Oregon, and Maine, some of whom are also licensed to practice in New York and Washington.

Results: Through December 2018, TelAbortion clinicians provided treatment to 250 women. Of women in the continental U.S., 39% lived more than 100 miles from the treating facility, and 27% received treatment across state lines. In Hawaii, 65% of women were treated across islands. Abortion outcomes did not vary by distance or by cross-state or cross-island dispensing. Of 36 women who paid out-of-pocket for the abortion itself, 52% used or planned to use Medicaid or private insurance to cover the costs of the screening tests. We are initiating TelAbortion in Colorado, New Mexico, and Georgia soon and will report results from those states at the meeting.

Conclusion: Direct-to-patient telemedicine is safe and acceptable for providing abortion over long distances and may particularly benefit women with limited ability to access the service locally. Cross-state prescribing may be a valuable strategy for scaling up this type of service quickly. Separating the screening and follow up testing from the abortion itself can allow women without coverage for abortion to use insurance for part of their care, such that the cost is comparable and in some cases less expensive than paying out of pocket for an in-clinic medical abortion.

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Characteristics of patients using telemedicine compared with in-person visits for state-mandated informed consent before abortion in Utah

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Introduction: Utah requires abortion patients to wait at least 72 hours between attending mandatory information sessions and having an abortion. In 2015, Planned Parenthood Association of Utah (PPAU) began offering telemedicine as a way for patients to attend state-mandated information visits in order to avoid an unnecessary clinic visit. This study examines demographic and abortion differences between in-clinic patients and patients using telemedicine for the informed consent visit.

Method: We used data from PPAU's practice management database and electronic health records that included all informed consent and abortion encounters from January 2015 – March 2018. We compared patient characteristics by informed consent visit type and calculated the distances from the patient's residential zip code to the nearest PPAU health center offering state-mandated informed consent visits. We also matched the informed consent visits with corresponding abortion visits and compared the time interval between the informed consent visit and abortion visit, and the gestational age at the time of abortion for the two groups.

Results: Of the 9,175 informed consent visits, 91% were in-clinic (n=8,395) and 9% were telemedicine (n=780). Compared to in-clinic patients, telemedicine patients were slightly older (27 vs. 26 years on average, p=.002), more likely to live out of state (47% vs. 4%, p<.001) and live further away from PPAU clinics offering informed consent visits (92 miles vs. 19 miles on average, p<.001). Sixty-eight percent (n=6,223) of the informed consent visit patients obtained an abortion at the Salt Lake City clinic (68% of in-clinic patients (n=5,709), 67% of telemedicine patients (n=524), p=.64). A higher proportion of telemedicine patients obtained abortions greater than 14 weeks gestation (13% vs. 7%, p<.001). There were no differences in abortion method (surgical vs. medication) as well as the number of days between the informed consent visit and the abortion visit (11.7 vs 11.4 days on average, p=.47).

Conclusions: Although a small proportion of patients used telemedicine for the informed consent visit, our findings indicate that telemedicine can reduce the burden of multiple clinic visits, especially for those living far from clinics, including those from out of state.

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