



Family Planning

Contraceptive Provision after Medication and Surgical Abortion



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A B S T R A C T

Objective: This study sought to compare contraception provided to patients after medication and surgical abortion.

Study Design: Women who underwent first trimester induced abortion at a university-based urban clinic between May 2009 and May 2014 were identified. Medical records were reviewed to determine the method of contraception provided by the clinic to patients after medication and surgical abortion. Postabortal contraception was defined as any contraception administered or prescribed from our health system within 4 weeks of surgical abortion or mifepristone administration.

Results: We reviewed 824 women who were 9 weeks gestational age or less and able to choose between medication and surgical termination of pregnancy. Overall, 587 (71.1%) had a surgical abortion and 237 (28.9%) had a medication abortion. Women who had surgical abortions were more likely to initiate long-acting reversible contraception (41.9% vs. 23.2%; $p < .0001$) and more likely to be provided with any type of contraception overall (83% vs. 64.6%; $p < .0001$). The overall follow-up rate after medication abortion was 71.7%.

Conclusions: Women who had surgical abortions had a greater odds of receiving long-acting reversible contraception than those who had medication abortions. Surgical abortion patients were also more likely to be provided contraception overall. Further prospective research is needed to determine the reasons for this difference and to ensure that all patients obtain the contraception that they desire.

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Twenty-one percent of all pregnancies in the United States end in abortion, resulting in approximately 1.3 million abortions performed annually (Sonfield, 2011). Although the number of abortions is at its lowest rate since 1973, the proportion of medication abortions has increased from 6% of all abortions in 2001 to 23% in 2011 (Jones & Jerman, 2014). Providing women with postabortal contraception is an integral part of abortion care. World Health Organization guidelines reinforce that all women should receive contraception information and be offered counseling on all methods of post-abortion contraception (World Health Organization, 2012). Women return to ovulation on average 6 to 12 days after surgical abortion (Marrs, Kletzky, & Howard, 1979) and 3 weeks after medication abortion (Schreiber, Sober, Ratcliffe, & Creinin, 2011); thus, providing early

postabortal contraception is necessary to prevent repeat unintended pregnancy.

The use of effective methods of contraception leads to both fewer unintended pregnancies and fewer repeat abortions. The Contraceptive CHOICE Project showed that the unintended pregnancy rate was 17-fold greater among all women using contraceptive pills, patch, or ring versus long-acting reversible contraception (LARC) methods at the 2- to 3-year follow-up (Buckel et al., 2012). Two studies have shown that women who choose postabortal LARC have the lowest rates of repeat abortions (Goodman, Hendlish, Reeves, & Foster-Rosales, 2008; Rose & Lawton, 2012). These results have also been verified in a decision model that showed immediate postabortal LARC decreased repeat pregnancy and abortion rates (Reeves, Smith, & Creinin, 2007). Immediate postabortal LARC has been also proven to be a cost-effective intervention (Salcedo, Sorensen, & Rodriguez, 2013). Although surgical abortion patients can have intrauterine devices (IUDs) placed at their initial encounter, medication abortion patients have to wait for IUDs to be placed at a return visit. The extra visit is significant as studies have shown that needing a return visit for IUD insertion is a barrier to

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IUD uptake (Stanek, Bednarek, Nichols, Jensen, & Edelman, 2009). Newer studies show that the contraceptive implant may be placed at the first medication abortion visit (Raymond et al., 2015), but this was not the standard of care during this study period. The difference in ability to place LARC immediately after surgical versus medication abortion, along with other factors not yet explored, may lead to overall differences in postabortion contraception provision.

Owing to the increasing national proportion of medication abortions, it is important to understand patterns of contraception provision among these patients. The objective of this study is to compare the postabortal contraception method provided to women undergoing first trimester medication and surgical abortions at a university-based urban clinic. This low-volume clinic is staffed by resident physicians and supervising attending physicians. The costs of medical and surgical abortions are equivalent for all our patients. In our state, abortion is a covered Medicaid benefit if the abortion is deemed “medically necessary” or after sexual assault or incest. During this study period, LARC was covered under Medicaid after abortion. For patients who had no insurance coverage for LARC or could not afford their copay, a grant provided LARC devices at no cost. The patients were aware of this LARC program at the time of contraceptive counseling. We hypothesized that surgical abortion patients would be provided more LARC than medication abortion patients, and medication abortion patients would be provided less postabortal contraception overall.

Materials and Methods

We performed a retrospective analysis of all women at 9 weeks gestational age or less presenting for induced abortion in the Department of Obstetrics and Gynecology the University of Illinois at Chicago between May 1, 2009, and May 1, 2014. Gestational age was determined by ultrasound. These patients were offered medication or surgical abortion. Women were excluded if they were greater than 9 weeks gestational age or had a spontaneous abortion as documented by no fetal cardiac activity on ultrasound. This study was approved by the University of Illinois Institutional Review Board. Our primary aim was to determine if there is a difference in postabortal contraception method provided after medication versus surgical abortion. Our secondary aim was to determine if LARC use is more likely to be provided after surgical abortion than medication abortion.

Medication abortion patients are given 200 mg of mifepristone in the office and then given the option of 800 µg misoprostol buccally 24 to 48 hours or vaginally 6 to 72 hours later at home. All medication abortion patients are given a follow-up appointment in our clinic 7 to 14 days after the initial treatment. If the patient does not return for her follow-up appointment, three phone calls are made, followed by a certified letter if necessary. Ultrasound is performed at follow-up to determine if the abortion is complete. If the abortion is not complete, as defined by retained products or ongoing pregnancy, the patient is offered dilation and curettage, repeat course of misoprostol, or expectant management.

During this study period our clinic administered medroxyprogesterone acetate injections (DMPA) and placed etonogestrel subdermal implants (implant) or IUD on the day of confirmed completed medication abortion. The IUDs available were the copper IUD (Paragard) and 5-year levonorgestrel IUD (Mirena). Oral contraceptive pills, the contraceptive patch, and the vaginal ring were prescribed on the initial day of treatment if

the patient had decided on that method. If she was undecided, a contraceptive could be prescribed at the follow-up visit. Patients were instructed not to begin these contraceptives until after the completed medication abortion had been confirmed.

Surgical abortion patients received DMPA, subdermal implants, or IUDs on the same day as the aspiration. Oral contraceptive pills, the contraceptive patch, and the vaginal ring were also prescribed on the same day as the surgical abortion. The results of this study are based on prescriptions provided to the patient; however, we were unable to determine whether these prescriptions were filled. This study did not evaluate contraception provided at other clinics or barrier methods (such as condoms and sponges) that were not supplied by our health system. No patients in this study used a diaphragm.

For the purpose of our study, we defined postabortal contraception as any contraception administered or prescribed from our health system within 4 weeks of surgical abortion or mifepristone administration. This timeline was chosen to allow medication abortion patients time to return for their follow-up visits. Surgical abortion patients did not routinely follow-up after their procedure, but if they returned at a later date, all contraceptive options, including LARC, were offered. Contraception administered after surgical and medication abortion was documented routinely in the electronic medical record as part of a template.

Our independent variables were type of abortion, gestational age, maternal age, race/ethnicity, gravidity/parity, and number of prior abortions. Our dependent variable was postabortal contraception administered. We used χ^2 tests for categorical variables and *t* tests for continuous variables. All tests were performed using SAS 9.3 (SAS Institute, Cary, NC).

Results

There were 824 women who were 9 weeks gestational age or less and underwent a first trimester abortion. There were 587 women (71.2%) who had a surgical abortion and 237 (28.8%) who had a medication abortion. There were 10 patients who initially received a medication abortion and then required a dilation and curettage for bleeding or an incomplete abortion. These patients were kept in the medication abortion group for analysis. The demographics of the patients included in the study are listed in Table 1. There was no difference in race/ethnicity, insurance, gravidity, or parity between medication and surgical abortion patients. The insurance listed is the method of payment used for the abortion.

Figure 1 shows the type of contraception provided after medication and surgical abortions. A total of 77.7% patients were provided some type of postabortal contraception. The odds of receiving contraception after surgical abortion was over twice as high as the odds of receiving contraception after medication abortion (odds ratio [OR], 2.67; 95% confidence interval [CI], 1.90–3.77). Of the medication abortion patients, 35.4% received no postabortal contraception.

Overall, the rate of LARC uptake after abortion was 36.5%. Surgical abortion patients were provided LARC at more than twice the rate of medication abortion patients (OR, 2.39; 95% CI, 1.70–3.38). The levonorgestrel IUD was the most common LARC method provided overall, with 30.5% of surgical abortion patients and 14.3% of medication abortion patients receiving this method. DMPA was also more common after surgical abortion than medication abortion (OR, 2.26; 95% CI, 1.33–3.84). The most common types of contraception provided after medication

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