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Contraception following abortion and the treatment of incomplete abortion

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ABSTRACT

Family planning counseling and the provision of postabortion contraception should be an integrated part of abortion and postabortion care to help women avoid another unplanned pregnancy and a repeat abortion. Postabortion contraception is significantly more effective in preventing repeat unintended pregnancy and abortion when it is provided before women leave the healthcare facility where they received abortion care, and when the chosen method is a long-acting reversible contraceptive (LARC) method. This article provides evidence supporting these two critical aspects of postabortion contraception. It suggests that gynecologists and obstetricians have an ethical obligation to do everything necessary to ensure that postabortion contraception, with a focus on LARC methods, becomes an integral part of abortion and postabortion care, in line with the recommendations of the International Federation of Gynecology and Obstetrics and of several other organizations.

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1. Introduction

Contraceptive counseling and the provision of contraceptive methods should be an integrated part of any abortion care or postabortion care to help women avoid another unplanned or unwanted pregnancy and the risk, in many cases, of an unsafe abortion. It is for that reason that postabortion contraception is one of the strategies proposed by the International Federation of Gynecology and Obstetrics (FIGO) Initiative for the Prevention of Unsafe Abortion and its Consequences [1].

Recent evidence has shown that postabortion contraception should comply with two attributes to ensure maximum effectiveness in preventing a repeat unintended pregnancy and, possibly, a repeat safe or unsafe abortion. First, it should be provided before the woman leaves the healthcare facility where she received the abortion care, and second, preference should be given to long-acting reversible contraceptives (LARC), or at least depot-medroxyprogesterone acetate (DMPA). This paper reviews the evidence supporting these two recommendations.

2. Recovery of fertility after abortion

An uncomplicated abortion has no negative consequences on a woman's future fertility. Ovulation can occur as early as 8 days after an abortion and 83% of women ovulate during the first cycle following

an abortion [2,3]. Fertility after a surgical abortion does not differ from that following a first-trimester medical abortion. In addition, more than half the women have sexual intercourse within 2 weeks after the induced abortion, at least in some northern European countries [4]. Therefore, offering and initiating use of an effective contraceptive method without any delay after a pregnancy termination or following treatment of an incomplete abortion should be standard care. Notwithstanding, initiating use of hormonal or intrauterine contraceptives (IUDs, including both the copper-IUD and the levonorgestrel-releasing intrauterine system [LNG-IUS]), is often routinely delayed until the first postabortion menstrual period, with women then being referred for contraceptive counseling and to receive a contraceptive method, instead of receiving these services on site at the time of the abortion or postabortion care.

3. The safety of providing contraception immediately following an abortion

The World Health Organization's (WHO) medical eligibility criteria for contraceptive use states that the use of combined hormonal methods (pills, patch, vaginal ring, and injectable contraceptives) and progestin-only pills may be initiated immediately after an abortion [5]. The process involved in a medical or surgical first-trimester abortion, including postabortion bleeding, is unaffected by immediately initiating one of these contraceptive methods. Furthermore, use of these methods was not associated with more adverse effects or adverse vaginal bleeding outcomes, or with any clinically significant changes in coagulation parameters compared with women who used a placebo, a copper-IUD, a non-hormonal contraceptive method, or who delayed

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initiation of combined oral contraceptives (COCs) [6–13]. Therefore, these methods can and should be started on the same day as misoprostol is used for a medical abortion, on the day of surgery in cases of surgical abortion, or on the day of discharge from hospital following treatment of an incomplete abortion or spontaneous abortion. A possible exception is the vaginal ring. There is limited evidence on initiating use of the vaginal contraceptive ring immediately following a first-trimester medical or surgical abortion; however, no serious adverse events and no infection related to use of the ring were found during 3 follow-up cycles after an abortion [14]. However, if bleeding is heavy, insertion of the ring may be delayed, but for no longer than 5 days. If the delay exceeds 5 days, a back-up with barrier methods of contraception is recommended.

Implants are routinely inserted immediately after a first-trimester surgical abortion, although most studies on implants are limited to levonorgestrel (LNG)-releasing implants [15–17].

WHO's medical eligibility criteria states that IUDs can be inserted immediately after a first-trimester, spontaneous, or induced abortion [5]. However, it is important to note that all studies on postabortion insertion listed by WHO are limited to surgical evacuation or surgical abortion, with no data on medical abortions [18–22].

There was no difference in the risk of complications between immediate and delayed insertion of IUD after surgery. Furthermore, no differences were found with respect to safety or in the expulsion rate with the postabortion insertion of an LNG-IUS compared with a copper-IUD [23, 24]. In cases of septic abortion, IUDs should not be inserted until the infection has been successfully treated. In these cases, alternative contraceptive methods should be offered in the meantime.

In some studies, a slightly higher expulsion rate was observed with the immediate postabortion insertion of an IUD compared with delayed insertion [25,26]. However, immediate insertion results in an increase in the number of women who in fact receive the IUD, as discussed below.

The risk of IUD expulsion when the device is inserted immediately following surgical abortion or uterine evacuation seems to increase with gestational length and uterine size. The risk of expulsion is greater when the IUD is inserted following a second-trimester abortion compared with a first-trimester abortion [27,28].

It has also been shown that an IUD can be inserted as soon as expulsion has been confirmed in cases of medical abortion [29–31]. Expulsion rates were no higher if the IUD was inserted 1 week after a medical abortion or during a 3–4-week postabortion follow-up visit [31]. Furthermore, no correlation was found between endometrial thickness or ultrasound findings and expulsion [31]. In addition, early insertion of the LNG-IUS reduced the number of days of heavy bleeding following a medical abortion [31].

Progestin-only injectable contraceptives (DMPA or norethisterone enanthate) can be administered immediately following a surgical, medical, or spontaneous abortion [32,33].

While DMPA is frequently used following abortion and postabortion care, no studies have yet been published on the initiation of this contraceptive method on the day of misoprostol administration in cases of medical abortion.

With reference to sterilization, WHO's medical eligibility criteria states that this procedure can be performed after an uncomplicated abortion, but should be avoided in the case of any complication [5]. However, regret after sterilization is more common among younger women and men (<30 years of age) [34–36] and when sterilization is performed postpartum or within the first year after delivery [36]. In line with those findings, sterilization should not be performed routinely at the time of an abortion in young women, but other alternative forms of effective, acceptable contraception should be offered, and indeed, should always be available where abortion services are provided.

Barrier methods can be initiated as soon as required; however, according to WHO medical eligibility criteria, the diaphragm and cap are unsuitable until 6 weeks after a second-trimester abortion [5].

When there is a risk of transmission of a sexually transmitted infection (STI) or of HIV, it is important that dual protection be recommended, with the simultaneous use of condoms and another more effective contraceptive method. Emergency contraceptive pills should be offered to women relying on less effective methods.

Natural family planning methods cannot be used until the menstrual cycle has resumed.

4. The effectiveness of providing contraception immediately following abortion on method use and in preventing repeat pregnancies

A randomized study on the immediate versus delayed insertion of an IUD after a surgical abortion showed that all women scheduled for immediate insertion were indeed inserted with an IUD. On the other hand, 42% of the women who expressed a desire to use this method, but were scheduled to return for later insertion, ultimately failed to return for insertion of the method [25]. Furthermore, women who had a successful early insertion were more likely to still be using an IUD 6 months later compared with women who had an IUD inserted some weeks after an abortion [25].

A study carried out in New York City compared two cohorts of abortion patients, the first in which the women had to return to initiate use of an IUD, implants, or DMPA, and another in which the women could initiate these methods before leaving the clinic after the pregnancy termination. While 27.3% of the women whose initiation of contraception was delayed got pregnant within the following 12 months, only 15% of those who initiated use of the method immediately following abortion did so. Similarly, 17.7% of the women whose initiation of the method was delayed had a repeat abortion within the following year compared with 9.9% of those who initiated contraception immediately following the abortion [37]. Another study carried out in Finland also found a significantly lower rate of repeat abortion when any contraceptive method was provided immediately after abortion compared with scheduling the woman to return and initiate the method later [38].

After a medical abortion, common practice is to wait 3–4 weeks or until the first menstrual period following the abortion before inserting an implant or an IUD, thus incurring a potential risk of a new pregnancy. This has been considered a possible disadvantage of medical abortion compared with surgical abortion. The practice of delayed insertion may also discourage women from using a LARC method owing to the need to return for several follow-up visits. This applies particularly to settings where women have to travel long distances for abortion care or where services are poor or expensive. Changes are currently taking place in clinical practice in many settings so that implants are now inserted on the day of misoprostol administration in cases of medical abortions and postabortion care. However, few data are available on insertion performed at the time of mifepristone or misoprostol administration.

Significantly more women randomized to early initiation of use returned for IUD insertion compared with women scheduled for delayed insertion following a medical abortion, confirming the findings of immediate versus delayed insertion in cases of surgical abortion [31].

5. Preference for long-acting reversible contraceptives

Several studies have shown that LARC methods such as the IUD and contraceptive implants are significantly more effective in preventing unwanted pregnancy and repeat abortion than short-acting methods such as the combined pill, patch, and vaginal ring, or barrier methods such as the condom or diaphragm [33,38–42]. Studies conducted mostly in Northern Europe and North America involving LARC and pill users have found similar rates of unintended pregnancy and repeat abortion, with the rate among users of LARC methods being one-third to half of that found in users of the combined pill. In some studies, the risk of

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