Managing Infection in Abortion Care – FAQ

Q: What should I do if a patient presents for a procedural abortion and has evidence cervicitis or I suspect a gonorrhea/chlamydia infection?
A: Many providers administer the treatment dose antibiotic pre-procedure and perform the procedure the same day (some with a delay of an hour).

Q: A patient came in for an abortion and stated that she just received a call that her gonorrhea or chlamydia test that she took last week was positive. She has not been treated yet. What should I do?
A: The patient should receive the treatment-dose antibiotic pre-procedure. Treatment should not delay the abortion procedure. No randomized trials have compared outcomes based on delay versus no delay after treatment for cervicitis. When treating a patient for chlamydia or gonorrhea, remember to instruct the patient to inform partners that they also need treatment.

Q: A patient has fishy-smelling vaginal discharge at the time of her procedural abortion but I was unable to do a wet mount to check for bacterial vaginosis. What should I do?
A: Many experienced clinicians believe it is appropriate to keep a low threshold for clinically-diagnosed BV on exam. In some clinics, providers dispense or prescribe metronidazole 2g by mouth once on the day of the procedure, particularly if the patent will be unable to complete a 7 day course of antibiotics.

Q: What do I do if a patient calls overnight after dilator placement reporting leaking of fluid?
A: Clinics may have their own protocols for dealing with this, so check in with the clinic manager and medical director about your clinic's protocols. In some clinics, the patient is assessed over the phone to confirm that she has no evidence of infection and her procedure is performed as early as possible in the morning (i.e. the first case of the day instead of waiting for her afternoon appointment).

Q: How do I find the alternative PID regimens in the CDC 2015 STD Treatment Guidelines?
A:
Step 1- Go to the following website
https://www.cdc.gov/mmwr/preview/mmwrhtml/rr6403a1.htm

Step 2- Search the page for the phrase, *Alternative IM/Oral Regimens* (i.e. type: command-F, or control-F, and then type *Alternative IM/Oral Regimens*). This will take you to the section within the Pelvic Inflammatory Disease Treatment section on alternative regimens.

Q: Can you provide a summary of the alternative PID regimens discussed in the CDC 2015 STD Treatment Guidelines?
A: (Please note- If a new CDC STD Treatment Guidelines report has come out, please refer to the updated guidance. This guidance summarizes the 2015 report.)
Some patients express that they have barriers to adherence to a twice daily medication for 14 days. If this is the case, another option is to prescribe azithromycin 1g PO and repeat this dose 7

days later. Reproductive infectious disease experts and the CDC states that this alternative is acceptable, but the provider should first engage in shared decision making with the patient regarding these options.
If a patient has a cephalosporin allergy, the alternative is to use a fluoroquinolone antibiotic. The CDC guidelines state that due to the emergence of quinolone-resistant gonorrhea infections, regimens that include a quinolone should only be given if the community prevalence and individual risk for gonorrhea are low. The patient must be tested for the presence of gonorrhea, and you should consult the guidance on the CDC website.

Q: I have heard of some providers giving augmentin for treatment of endometritis. Is there data to support this?
A: There was one study published in 2015 that reviewed evidence for oral and intramuscular treatment of endometritis in low-resource settings among postpartum patients. Some providers have extrapolated this data to the post-abortion context. There are no studies examining these treatment options directly in the setting of post-abortion endometritis, but the study concludes that in cases when IV antibiotics are not needed, the following antibiotic regimens are often successful:

- Amoxicillin-clavulanic acid (Augmentin) 875mg PO BID x 14 days, OR
- Amoxicillin 500 mg plus metronidazole 500 mg PO every 8 hours x 14 days, OR
- Clindamycin 600 mg orally every 6 hours plus gentamicin 4.5 mg/kg intramuscularly every 24 hours for 2-3 days; then transition to doxycycline to complete 14 days of therapy.

Patients would be eligible for an oral antibiotic treatment if they:

- Have a mild infection (i.e. no evidence of sepsis or hemodynamic instability)
- Are likely able to adhere to treatment
- Can tolerate the medication (no nausea/vomiting)
- Are immunocompetent
- Do not have a more serious disease process like tubo-ovarian abscess.
- And, if the patient fails to improve after 2-3 days of oral medication, IV medication is warranted.

(Meaney-Delman D, Bartlett LA, Gravett MG, Jamieson DJ. Oral and intramuscular treatment options for early postpartum endometritis in low-resource settings: a systematic review. Obstet Gynecol. 2015 Apr;125(4):789-800.)

Q: Should I expect that the clinic I work in have IV antibiotics available?
A: No. Some clinics do and some don't. Some freestanding clinics have the staffing and resources available to administer IV antibiotics. This capability might be utilized to treat a patient who spikes a fever in clinic and is otherwise clinically stable.

Managing Post-abortion Hemorrhage – Tricks of the Trade

More tips for management of an **intrauterine foley balloon**:

- The blood that accumulates in the intrauterine foley bag should be emptied into a measuring cup, because otherwise it's very hard to see the accurate quantity of blood that has come through. By emptying the bag every 30 minutes, you can track if the quantity of bleeding is increasing or decreasing.
- It is common to deflate by 1/3 or 1/2, then monitor for any increase in bleeding, prior to deflating fully. If bleeding resumes, the balloon can be re-inflated, using ultrasound to confirm it remains in an optimal position.
- Some providers have had success with leaving the balloon in place for longer periods of observation, including utilizing the option of sending patients home with the balloon in place and coming back to clinic the next day.

An experienced clinician has some additional tips for **temporizing bleeding**:

- One manual technique that helps to kink uterine vessels and temporize bleeding is to elevate the uterus as far as possible out of the pelvis, grasp 3 and 9 o'clock on the cervix and rotate a full 180 degrees.
- If a high cervical laceration is suspected, deep and high stay sutures at 3 and 9 o'clock will decrease blood loss from descending branches of uterine artery