FAMILY PLANNING COVID-19 SURVEILLANCE TESTING (TESTING PRIOR TO PROCEDURAL TERMINATION OF PREGNANCY)

Background:

Termination of pregnancy is an essential component of comprehensive reproductive health care. In the United States, approximately 1 million women will choose to end a pregnancy each year. About 1 in 4 women will utilize abortion services by 45 years of age. As conception and pregnancy continues during the COVID-19 pandemic, so do the need for these services. While an overall safe procedure with low complication rates, the risk does increase with increasing gestational age. Associated mortality is 0.1 per 100,000 cases performed <8 weeks gestation compared to 8.9 per 100,000 cases at 21 weeks or higher.[1] Abortion restrictions can drive pregnant people towards unsafe alternatives. Delays in abortion care can also push pregnant people beyond legal gestational age limits on abortion and eliminate their option to choose whether or not to continue a pregnancy. The risk of death during pregnancy is 14 times higher than that of the abortion procedure.[2] The burden of these restrictions are not equitable, and will largely fall on low-income women and women of color.

To this end, the Massachusetts Department of Health has affirmed abortion as an essential medical procedure. DPH states "nonessential, elective invasive procedures as procedures that are scheduled in advance because the procedure does not involve a medical emergency; provided, however, that *terminating a pregnancy is not considered a nonessential, elective invasive procedure* for the purpose of this guidance. However, the ultimate decision is based on clinical judgement by the caring physician."[3] This stance is supported by the American College of Obstetricians and Gynecologists, the Society of Maternal Fetal Medicine, American Association of Gynecologic Surgeons, American Society of Reproductive Medicine, Society of Academic Specialists in General Obstetrics and Gynecology, and the Society of Family Planning.[4]

At UMass Memorial Medical Center, pregnant people seek pregnancy termination for fetal anomalies, fetal demise, and maternal medical conditions that make abortion care necessary in a hospital-based setting. These patients are referred and quickly scheduled for a pre-op clinic occurring on Monday in which they undergo a visit to review pregnancy options, sign surgical consents and undergo cervical preparation with misoprostol or cervical dilators (aka laminaria). Surgery is scheduled for the following day on Tuesday.

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[1] ACOG Practice Bulletin 125. Second Trimester Abortion. June 2013. https://www.acog.org/clinical/clinical-guidance/practice-bulletin/articles/2013/06/second-trimester-abortion

[2] ACOG Committee Opinion 424. Increasing Access to Abortion. November 2014. https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2014/11/increasing-access-to-abortion

[3] Kelly, Elizabeth. Nonessential, Elective Invasive Procedures in Hospitals and Ambulatory Surgical Centers during the COVID-19 Outbreak. March 15, 2020. https://www.mass.gov/doc/guidance-regarding-the-elective-procedures-order/download

[4] Joint Statement on Abortion Access During the COVID-19 Outbreak. https://www.acog.org/news/news-releases/2020/03/joint-statement-on-abortion-access-during-the-covid-19-outbreak (Epub: March 18, 2020)

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Once cervical preparation is initiated, the surgery cannot be delayed due to the risk of labor, spontaneous vaginal delivery, hemorrhage, or uterine infection. Cervical preparation is completed one of 2 ways. Misoprostol is used between 12'0 and 15'6 weeks gestational age and is administered by the patient 3 hours prior to surgery. Cervical dilators are placed during a pre-op visit on Monday for patients at gestational ages 16'0 to 23'6 and work to cause cervical dilation overnight, in preparation for surgery Tuesday. It is imperative that D&E follows cervical preparation as planned to avoid the above preventable complications.

The vast majority of D&C/D&E for the purposes of termination of pregnancy (TOP) are able to be completed safely under deep sedation without intubation.[5,6,7] Available evidence supports a 1.7% risk of conversion to general anesthesia with intubation. Given these data, we recommend the majority of D&C/D&E for TOP be classified as **Tier 3**.

Goals:

- Reduce risk of transmission of COVID19 between health care staff from asymptomatic or symptomatic patients carrying SARS-COV2
- Reduce unnecessary use of PPE

Strategies:

- Pre-op: Schedule pre-op visits on Monday morning to increase likelihood that tests results are complete by scheduled surgery time on Tuesday.
- Anesthesia: Limit aerosolizing procedures by utilizing MAC/MIVA, and avoiding intubation, whenever possible. Three retrospective chart reviews confirm safety of deep sedation without intubation in D&Es up to 23'6 weeks gestation with a low rate of anesthetic complications (<1.0%). Furthermore, cases using general anesthesia with intubation resulted in longer operative times and higher estimated blood loss.[8,9,10]

This clinical guidance is being put forth in concert with existing protocols:

- SARS-CoV2 (COVID-19) Testing: Recommendations for Surgeries and Procedures
- SARS-CoV2 (COVID-19) Testing: Recommendations for Surgical Procedural Workflow

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[5] Aksel S, et al. Safety of Deep Sedation without Intubation for Second-Trimester Dilation and Evacuation. Obstetrics and Gynecology 132 (1): July 2018.
[6] Mancuso A, et al. Deep sedation without intubation during second trimester termination in an inpatient hospital setting. Contraception (95) 2017.
[7] Dean G, et al. The safety of deep sedation without intubation for abortion in the outpatient setting. Journal of Clinical Anesthesia (23) 2011.
[8] Aksel S, et al. Safety of Deep Sedation without Intubation for Second-Trimester Dilation and Evacuation. Obstetrics and Gynecology 132 (1): July 2018.
[9] Mancuso A, et al. Deep sedation without intubation during second trimester termination in an inpatient hospital setting. Contraception (95) 2017.
[10] Dean G, et al. The safety of deep sedation without intubation for abortion in the outpatient setting. Journal of Clinical Anesthesia (23) 2011.

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Figure 1

- **Asymptomatic**

(regardless of exposure status)

- Never tested/COVID- previously

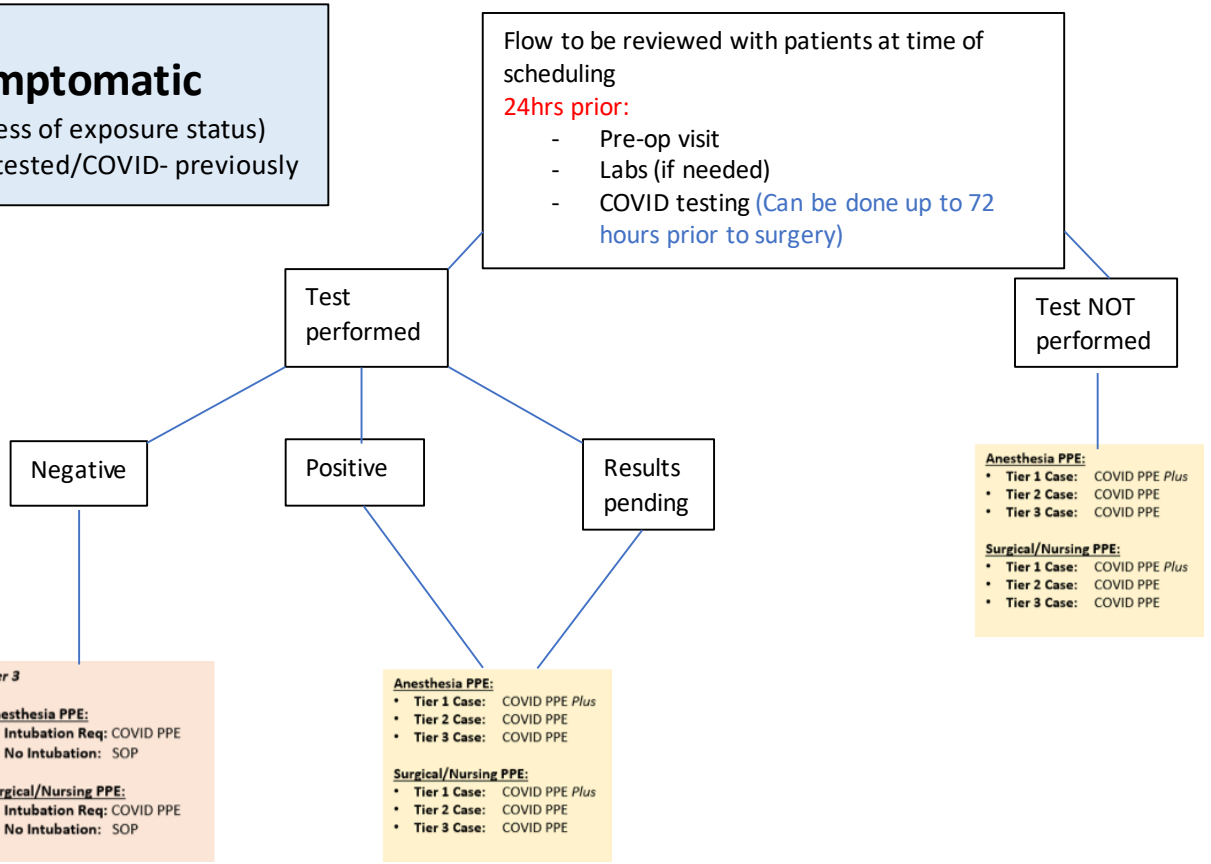

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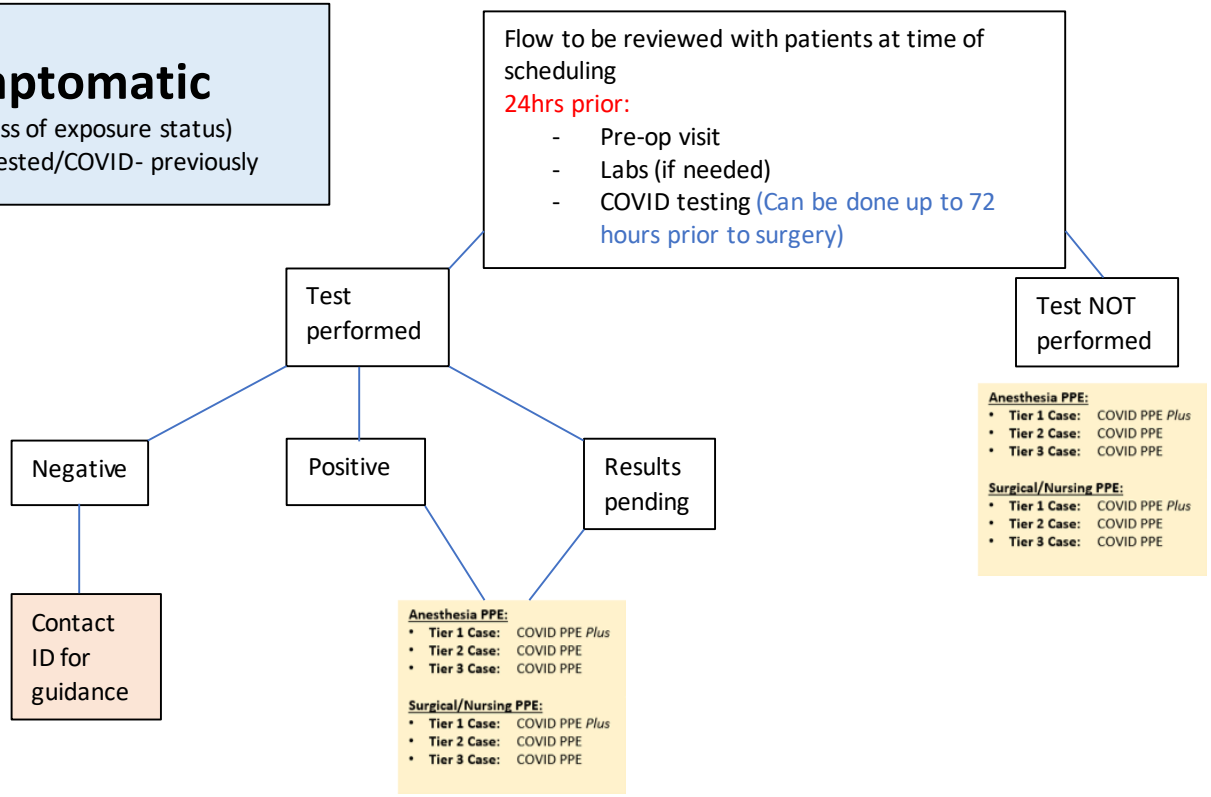
Figure 2:

- **Symptomatic**

(regardless of exposure status)
- Never tested/COVID- previously



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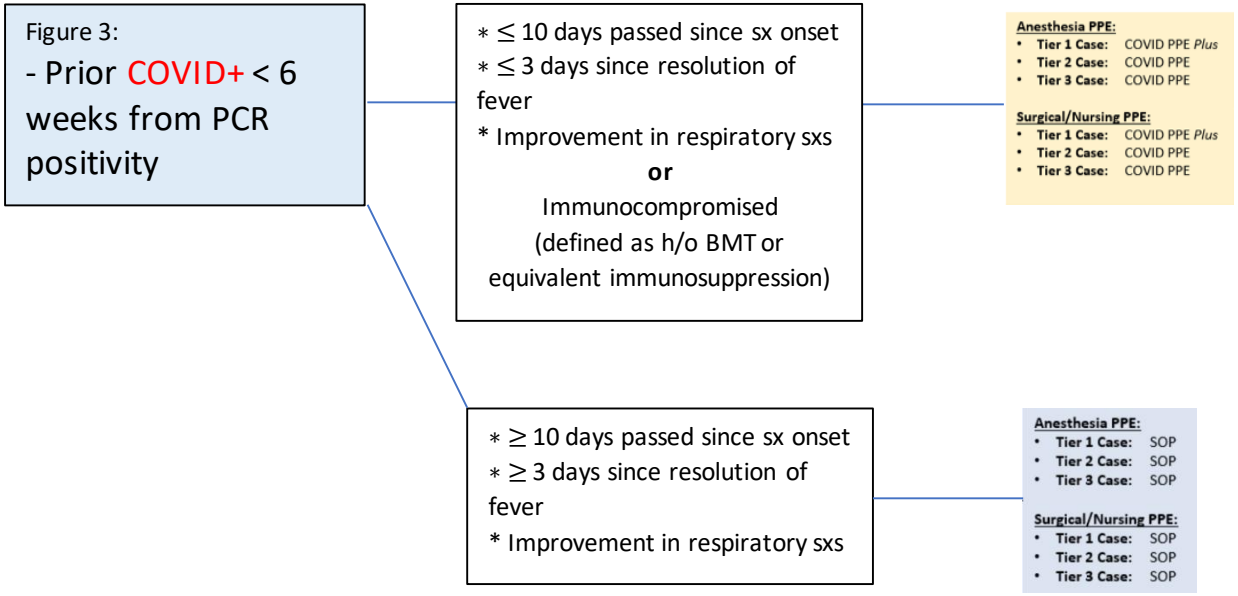

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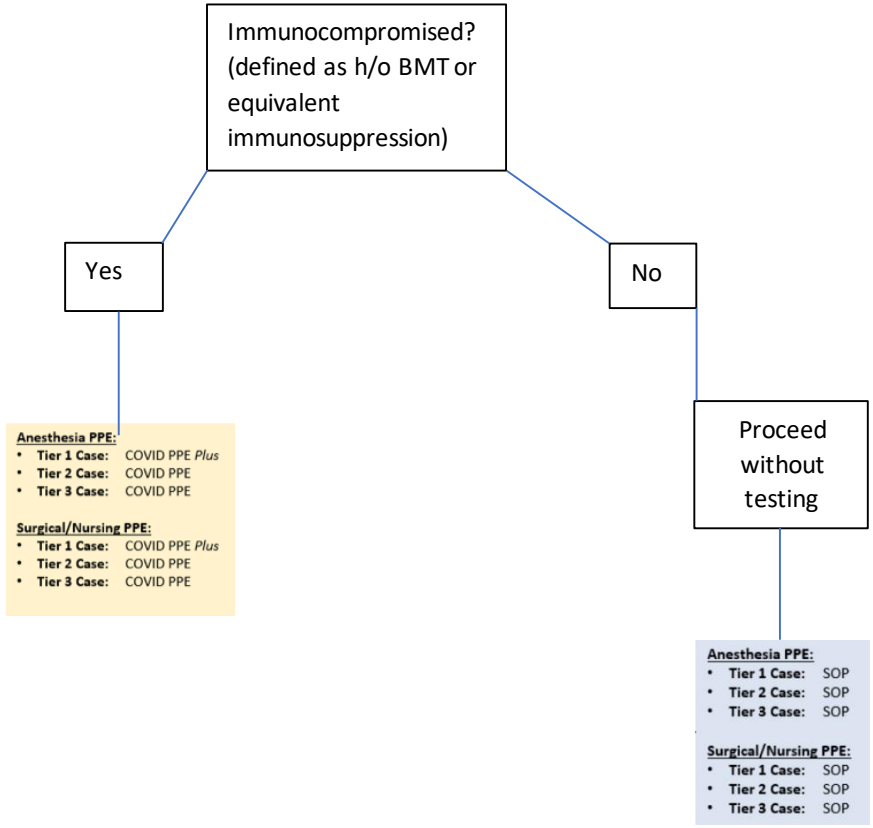
Figure 4:
- Prior COVID+ > 6 weeks from PCR positivity



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