GROW-WI
GATHERING THE RURAL OB WORKFORCE IN WI

Project ECHO®

Gathering the **R**ural **O**B **W**orkforce in **WI**
GROW-WI ECHO Program

How to Join:
https://iecho.org/public/program/PRGM17425658124325CC96FHKX3

For attendance purposes, please text the code YEGHAM to 608-260-7097.

Session Date: September 23, 2025
Facilitator: Allegra Ponshock, MD

	Topic	**Presenter**
Case Presentation	Pre-eclampsia, Manual Extraction of Placenta and Postpartum Hemorrhage	Beth Adsit, CNM Reedsburg Area Medical Center Reedsburg, WI Lee Dresang, MD, FM OB UW Department of Family Medicine and Community Health Madison, WI
Educational Presentation	Early Pregnancy Loss Management with Mifepristone and Misoprostol	Ashlyn Brown, MD, FM OB Jessica Dalby, MD, FM OB UW Department of Family Medicine and Community Health Madison, WI

Agenda:

7:30 – 7:35 AM – Welcome and Introductions

-Text-in your attendance, even if you do not plan to claim Continuing Education credits.

7:35 – 8:00 AM – Case Presentation

8:00 – 8:30 AM – Educational Presentation

Continuing Education Credits:

To claim CE credit, **you must complete the evaluation form after each session**.
ICEP will email you a link to the evaluation form after texting in for attendance.

Interprofessional Continuing Education Partnership
UNIVERSITY OF WISCONSIN-MADISON

GROW-WI ECHO (Gathering the Rural OB Workforce in WI)
2025-2026
Managing Early Pregnancy Loss with Mifepristone + Misoprostol
September 23, 2025
Ashlyn Brown, MD; Jessica Dalby, MD; Elisabeth Adsit, CNM; Lee Dresang, MD

Provided by the University of Wisconsin–Madison Interprofessional Continuing Education Partnership (ICEP)

Intended Audience:
MD/DO, RN, APRN, Physician Assistants, Certified Nurse Midwives, Students

Objectives:
1. Counsel patients on mifepristone and misoprostol for early pregnancy loss
2. Utilize the resources presented to deliver patient-centered EPL management with medications
3. Summarize access to medications for miscarriage management, including facilitators and barriers

Policy on Disclosure
It is the policy of the University of Wisconsin–Madison Interprofessional Continuing Education Partnership (ICEP) to identify, mitigate and disclose all relevant financial relationships with ineligible companies* held by the speakers/presenters, authors, planners, and other persons who may influence the content of this accredited continuing education (CE). In addition, speakers, presenters, and authors must disclose any planned discussion of unlabeled/unapproved uses of drugs or devices during their presentation. For this accredited continuing education activity, all relevant financial relationships have been mitigated and detailed disclosures are listed below.
** **Ineligible companies** are those whose primary business is producing, marketing, selling, re-selling, or distributing healthcare products used by or on patients. The ACCME does not consider providers of clinical service directly to patients to be ineligible companies.*

Name	Role	Financial Relationship Disclosures	Discussion of unlabeled/unapproved uses of drugs/devices in presentation	COI completion date
Ashlyn Brown, MD	Presenter	No relevant financial relationships with ineligible companies to disclose.	Yes	8/15/2025
Jessica Dalby, MD	Presenter	No relevant financial relationships with ineligible companies to disclose.	Yes	7/28/2025
Elizabeth Adsit, CNM	Presenter	No relevant financial relationships with ineligible companies to disclose.	No	9/15/2025
Lee Dresang, MD	Presenter	No relevant financial relationships with ineligible companies to disclose.	No	9/8/2025
Jillian Landeck, MD	RSS Chair	No relevant financial relationships with ineligible companies to disclose.	NA	3/25/2025
Jenny White	RSS Coordinator	No relevant financial relationships with ineligible companies to disclose.	NA	3/27/2025
Korina Bauer, RN, CPM, LM	Planner	No relevant financial relationships with ineligible companies to disclose.	NA	3/25/2025
Bonnie Brown, MD	Planner	No relevant financial relationships with ineligible companies to disclose.	NA	4/8/2025
Jensena Carlson, MD	Planner	No relevant financial relationships with ineligible companies to disclose.	NA	3/27/2025
Lee Dresang, MD	Planner	No relevant financial relationships with ineligible companies to disclose.	NA	4/17/2025
Rachel Hartline, MD	Planner	No relevant financial relationships with ineligible companies to disclose.	NA	4/15/2025
Ryan Luellwitz, DO	Planner	No relevant financial relationships with ineligible companies to disclose.	NA	3/26/2025
Rebecca Pfaff, MD	Planner	No relevant financial relationships with ineligible companies to disclose.	NA	4/6/2025
Allegra Ponshock, MD	Planner	No relevant financial relationships with ineligible companies to disclose.	NA	3/29/2025
Ryan Spencer, MD	Planner	No relevant financial relationships with ineligible companies to disclose.	NA	3/31/2025
Shannan Stephens, MD	Planner	No relevant financial relationships with ineligible companies to disclose.	NA	4/10/2025

Accreditation Statement

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The University of Wisconsin–Madison ICEP, as a member of the University Professional & Continuing Education Association (UPCEA), authorizes this program for 0.1 CEUs or 1.0 hour.

Welcome!

We will get started shortly.

Feel free to share your name, specialty/role, and practice location in the chat.

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American Nurses Credentialing Center (ANCC)

The University of Wisconsin–Madison ICEP designates this live activity for a maximum of 1 ANCC contact hour.

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- The planning committee has no conflicts of interest to disclose.

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Attendance

- For attendance purposes please text the code YEGHAM to 608-260-7097
- Please text for attendance, **even if you are *not* claiming** continuing education credit.

Continuing Ed Credit

To receive continuing education credit:

1. Log your attendance (as above)
   - Create an ICEP account if you don't already have one.

2. Fill out the session evaluation form to receive credit – **REQUIRED for credit.**
   - A link to the evaluation will be sent after you text the code.

**Continuing Education Units with the Midwifery Education Accreditation Council are coming!

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Planning Team

Korina Bauer, RN, CPM, LM – WI Guild of Midwives, Iola, WI

Bonnie Brown, MD – UW DFMCH

Jensena Carlson, MD – UW DFMCH

Lee Dresang, MD – UW DFMCH

Rachel Hartline, MD* – Upland Hills Health, Dodgeville, WI

Jillian Landeck, MD* – UW DFMCH

Ryan Luellwitz, MD – UW OB GYN

Rebecca Pfaff, MD – Forks Community Hosp, Forks, WA

Allegra Ponshock, MD* – Mile Bluff Med Ctr, Mauston, WI

Ryan Spencer, MD – UW OB GYN

Shannan Stephens, MD – Gundersen OB GYN, La Crosse, WI

Jenny White* – UW DFMCH

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* Core Facilitation Team

Friendly Reminders

- Video appreciated
- Use chat function to ask questions or raise hand if able
- Mute microphone when not speaking
- Maintain confidentiality, no PHI
- Didactic will be recorded
- Mission is to empower those working in rural settings
- Our diversity of perspectives, specialties, practice scopes are our strength
- **"Coming together is a beginning. Keeping together is progress. Working together is success." -** Henry Ford

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Announcements

- Next Month - October 28

  Evidence-Based Induction Methods

  Merritt McLean, MD – OBGYN

  Medical Director of Inpatient Obstetrics

  Kaiser Permanente - San Francisco
  Technology Lead for Inpatient OBGYN, OBGYN Hospitalist

- Looking for a case for October 28!
  - Reach out to Jenny White if interested at jennifer.white@fammed.wisc.edu

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Interested in sharing a case?

Email jennifer.white@fammed.wisc.edu

- Slide template shared, 10 min for details of case
- Priority to cases from rural and resource-limited settings
- No PHI
- Include on CV as a state presentation

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Rural OB Case Presentation

Beth Adsit, CNM

Reedsburg Area Medical Center

Lee Dresang, MD, Professor

University of Wisconsin Department of Family Medicine and Community Health

September 23, 2025

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Disclosures & Disclaimers

- No Disclosures

- PATIENT RELATIONSHIP DISCLAIMER
  - PLEASE NOTE that Project ECHO® case consultations do not create or otherwise establish a provider-patient relationship between any clinician and any patient whose case is being presented in a Project ECHO® setting.

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Case Introduction

- 31yo G1P0@39w6d by 1st trimester US induced because of pre-eclampsia based on mild range elevated BP and creatinine 1.16. Synthetic osmotic cervical dilator x5 and 50ug misoprostol placed night prior.

- Points for discussion:
  - Care for patients with high-risk conditions wanting minimal interventions
  - Co-management CNM/FMOB with surgical skills
  - Retained placenta>>manual extraction
  - PPH management in patient with hypertensive disorder and asthma
  - Worsening pre-eclampsia labs in rural setting
  - Prevention and treatment of endometritis

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Obstetrical/Prenatal History:	Past Medical History:
• Followed in midwife clinic • Declined GBS • Declined Tdap • Declined fetal doppler at prenatal visit • Planned no IV and no AMTSL unless necessary	• H/O abnormal paps • LEEP in 11/2019 – CIN III with pos margins • Normal pap 11/23 and 1/25

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Social History

- No tobacco, alcohol or illicit drug use

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Prenatal History

- 1/2025 Elevated BP noted
- Normal blood pressures other prenatal visits
- 7/29/25 – 38w2d BP 144/80; sent to L+D; labs normal (platelets 118K; Cr 1.02); no symptoms; repeat BP 125/80; Sent home
- 8/5/2025 – 39w2d BP 150/82; sent to L+D; labs normal (platelets 128K; Cr 1.03; AST 41); no symptoms; Repeat 136/91; Refused induction
- 8/8/2025 – 39w5d creatinine 1.16. Patient agrees to induction; cervix 1.5/50%/-2

Timeline/L&D details:

- CNM management (Beth) with FMOB surgical backup (Lee)
- Discussion of Magnesium as creatinine of >1.1 is severe feature per ACOG
- Patient not agreeable to IV or magnesium; agrees to lab recheck before epidural at 8pm (platelets 165K; cr 0.94; AST 44)
- Nipple stimulation with breast pump for augmentation
- 6-7cm at 11am
- AROM clear and 8cm at 6:30pm
- 8-9cm at 12pm

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Timeline/L&D details:

- One severe range pressure in labor with normal repeat 10 minutes later
- Complete at 23:19
- Delivery at 1:20am; APGARs 8,9
- 17 minutes after delivery, Beth, CNM could feel cord avulsing and called Lee, FMOB to room. Lee agreed and continued very gentle traction and fundal massage/Brandt maneuver. Patient who had refused oxytocin until that point, agreed with oxytocin. At approx. 40min, cord did avulse. Anesthesia called to dose up epidural. OR crew called in (not needed). 2 large bore IV.

Timeline/L&D details:

- 2g IV cefoxitin; DIC labs ordered
- Long non-sterile waterbirth glove under sterile glove/gown. Placenta removed in 2 pieces. ”Boggy” uterus. Bimanual massage. Max dose oxytocin, IV TXA, carboprost 0.25mg IM despite asthma history with patient consent (did not result in exacerbation), miso 800mg PR. Fundus firm. Bedside US to confirm nothing remaining. 2nd deg perineal lac repair.
- Bleeding minimal at this point. QBL 1100. Maternal HR 130s so agreed to transfusion 1U PRBCs. HR responded. H/H 13.3/38.9 at admission and 11.1/33.5 morning of discharge, day after delivery and transfusion.

Timeline/L&D details:

- Postpartum EPIC sepsis alert due to WBC 23K, elevated HR and RR 24.
- Postpartum temp 101.7; likely due to transfusion but blood cultures drawn and ampicillin/sulbactam 3g IV every 6 hours ordered; Defervesced by 5 hours after delivery.
- Postpartum partum normotensive; no HA; platelets 150K>>103K>>96K>>97K; Creatinine 1.10>>1.02>>1.09>>0.86; AST 51 (72 is 2x upper limit normal)>> 49K>>52K>>48K.
- DC home approx. 36 hours after delivery; Blood cultures neg. No fever>24 hours. Not home on antibiotics.
- Sent home on home BP monitoring program.
- Pt and baby doing well at 2 week FU appt.
- 6 week FU appt 9/22.

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Key learning points:

- It can be challenging to manage high risk conditions for patients wanting minimal interventions
- CNM/FMOB collaboration worked well!
- Manual extraction of placenta is valuable skill especially in rural area
- OK to give carboprost in patient with asthma if necessary, though could cause asthma exacerbation
- Pre-eclampsia labs can worsen postpartum
- Give antibiotics with manual extraction; treat for endometritis if postpartum fever

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Systems Issues/Area for Improvement:	Interdisciplinary/interprofessional team successes or areas for improvement:
• Working with patients who don't want interventions • Manual extraction of placenta important skill especially in rural hospital; develop training model; could use in ALSO	• CNM/FMOB collaboration worked well! • Great teamwork overall • OR crew activated but not needed

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Placenta Extraction Model

Clara Chow, Henry Hu, Katherine Lake, Ashley Mulchrone
Client: Dr. Lee Dresang, St. Marys Hospital
Advisor: Dr. Thomas Yen

UW BME Design

Abstract

The placenta is used to transfer nutrients between mother and fetus during pregnancy. Once the baby is delivered, the placenta is no longer needed and is expelled from the uterus. In 3% of cases, the placenta does not detach and the physician must use his or her hand to manually extract the placenta. As manual extraction is rare, many doctors in rural areas or developing countries do not have experience with this procedure. Current birthing models are expensive and complex, yet do not include manual placenta extraction, so this project aims to create an inexpensive add-in uterus and retained placenta. The uterus and placenta were molded from silicone, attached using neodymium magnets, and embedded with A1302 Linear Hall Effect Sensors to create a model of manual placenta extraction with visual feedback.

Introduction

Placenta
- Connects to fetus via umbilical cord
- Exchange site between mother and fetus
- Normally expelled 30-60 min after delivery
- Retained placenta can lead to postpartum hemorrhage

Manual Removal
- Doctor feels for edge of placenta attachment to uterus
- Placenta removed using side-to-side motion of fingers
- Placenta checked for completeness

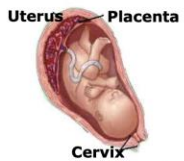

Figure 1: Typical orientation of placenta in uterus.

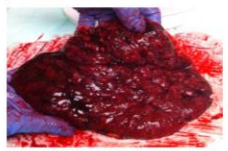

Figure 2: Real placenta after removal from the uterus.

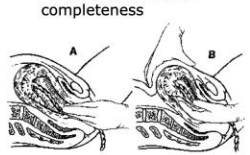

Figure 3: Diagram of placenta extraction.

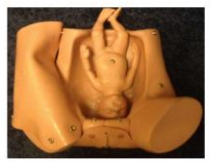

Figure 4: Current simulator used in client's training program; does not contain placenta.

Design Criteria

- The model must:
  - Be low in cost and compatible with currently used birthing simulator
  - Incorporate both a uterus and a retained placenta
  - Realistically mimic the uterus and placenta tissues
- Provide feedback about success of extraction

Testing

Silicone Molding: Uterus and Placenta
- Ecoflex and DragonSkin silicones were chosen by the client for their realistic properties
- Magnets of different strengths were embedded within the uterus and the placenta and optimal configuration was chosen by the client
- Full-scale uterus and placenta models were molded out of clay, checked for size accuracy, and used to create dental stone molds for the final uterus and placenta
- Magnets were attached to Power Mesh in a regular pattern and then bonded to uterus and placenta

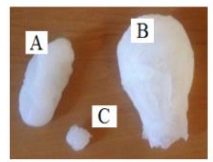

Figure 5: Three small-scale uterus models composed of different silicone mixtures.
A) DragonSkin and Slacker in 1:1 ratio with two drops of TinThix.
B) DragonSkin with two drops of TinThix.
C) A section of part A with a thin coating of A-564.

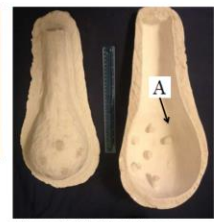

Figure 6: Final dental stone uterus mold with 12" (30.5 cm) ruler for scale. A) Cylindrical protrusions used to create sensor housings.

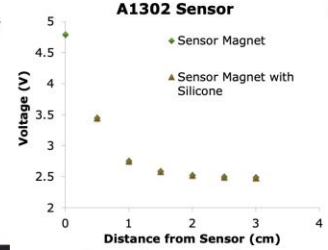

Figure 7: Sensor output voltage vs. magnet distance from center for the A1302 sensor. Largest standard deviation = 0.021 V.

Hall Effect Sensor Testing
- Sensors used to determine distance between placenta and uterus
- Two conditions used: Magnet only and Magnet with 4.5 mm silicone/power mesh between sensor and magnet
- Used n = 5 measurements per distance and n = 2 sets for the magnet per sensor
- A1302 sensor chosen for highest sensitivity

Survey Feedback
- 11 Family Medicine doctors and residents surveyed after using model
- 73% of the users agree or strongly agree the model improved their confidence and competence in performing the procedure
- Sensors believed to be helpful training tool
- Many users requested an umbilical cord in addition to current model

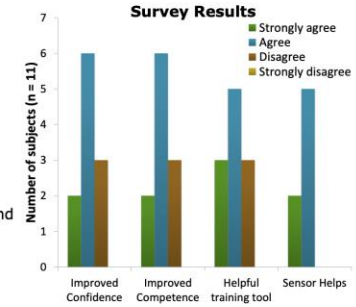

Figure 8: Overall positive model feedback showed that most users found the extraction model a helpful training tool for manual placenta extraction

Final Design

Figure 9 (above): Final design resting inside the current birthing simulator.

Figure 10 (above): The placenta is attached to the uterus wall with magnets.

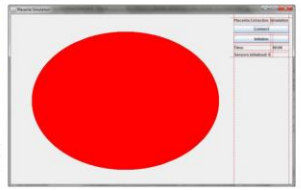

Figure 11 (Right): Output of sensor program when the placenta is fully attached to the uterus wall.

Future Work

- Integrate sensors into uterus model
- Devise placenta accreta mechanism
- Mold and attach umbilical cord to placenta
- Test device with more subjects

Acknowledgements

- Dr. Thomas Yen
- Dr. Amit Nimunkar
- Dr. Lee Dresang
- Greg Gion

References

[1] "ALSO® - Advanced Life Support in Obstetrics" The College of Family Physicians of Canada. Web. 21 Oct 2012. <http://www.cfpc.ca/also/>.
[2] "Functions and Roles of the Placenta." Pregnancy Calendars. Web. 20 Oct 2012. <http://www.pregnancy-calendars.net/>.
[3] "Management of the Third Stage of Labor." Medscape Reference. Web. 22 Oct 2012. <http://emedicine.medscape.com/article/275304-overview>.
[4] Weeks A. "The Retained Placenta." Best Practices & Research Clinical Obstetrics & Gynaecology 2008; 2(6): 1109-1117.

Open Discussion

- Care for patients with high-risk conditions wanting minimal interventions
- Co-management CNM/FMOB with surgical skills
- Retained placenta>>manual extraction
- PPH management in patient with hypertensive disorder and asthma
- Worsening pre-eclampsia labs in rural setting
- Prevention and treatment of endometritis

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Managing Early Pregnancy Loss with Mifepristone + Misoprostol

Ashlyn Brown, MD and Jess Dalby, MD
University of Wisconsin – Department of Family Medicine and Community Health
ashlyn.brown@fammed.wisc.edu
jessica.dalby@fammed.wisc.edu
9/23/25

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Disclosures

- We will be discussing off-label use of medications, specifically mifepristone and misoprostol

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Objectives

- Counsel patients on mifepristone and misoprostol for early pregnancy loss
- Utilize the resources presented to deliver patient-centered EPL management with medications
- Summarize access to medications for miscarriage management, including facilitators and barriers

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Guiding Case

- 28yo G3P1011 presents to clinic after 2 ER visits for vaginal bleeding after positive pregnancy test. She reports that she is about 7 weeks pregnant. She does not want to be pregnant and before the vaginal bleeding started, she had already sourced medication abortion pills online.

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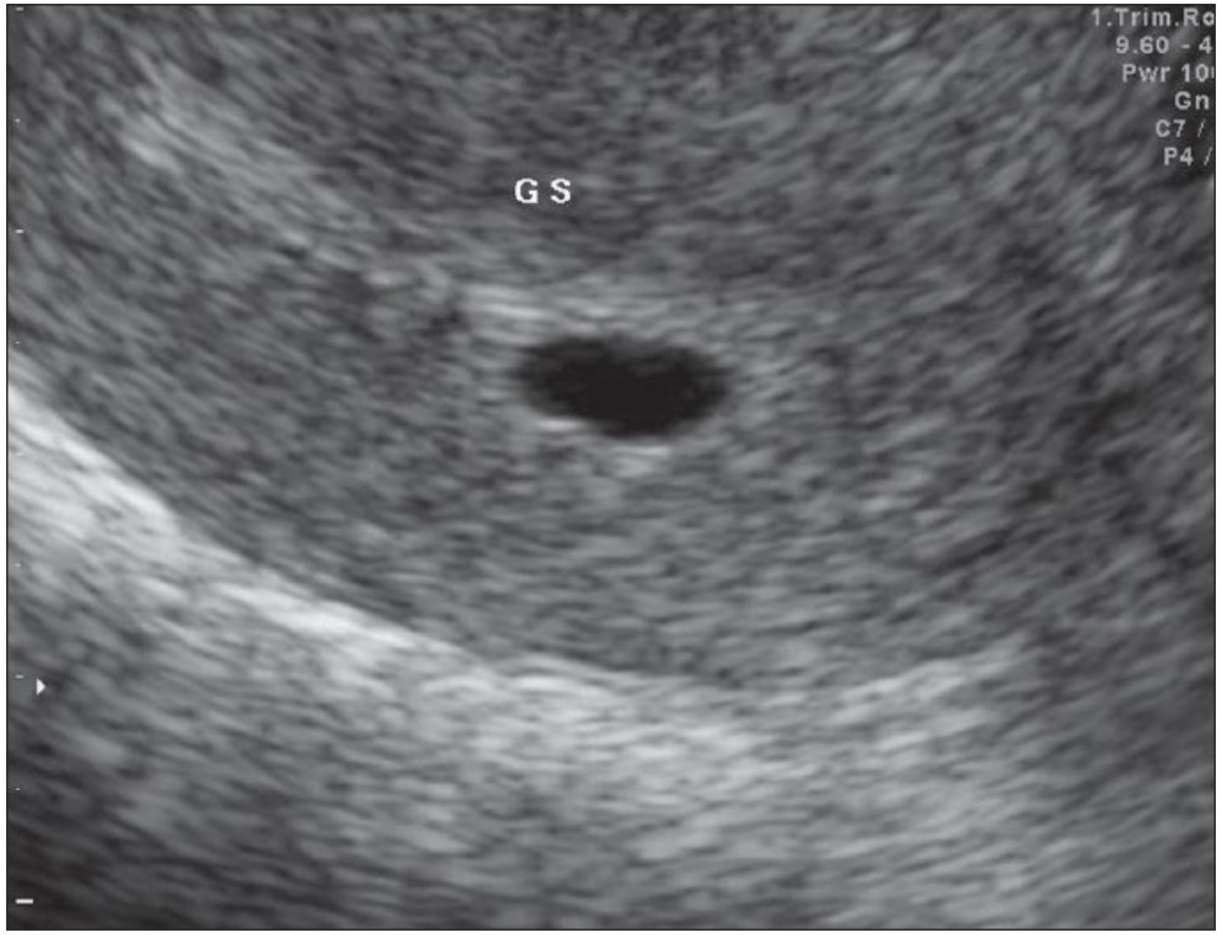
Guiding Case

- Initial ER visit:
  - ~7wks GA by LMP, TVUS has 12mm gestational sac, yolk sac, no embryo
  - bHCG 12,376
  - Told this is suspicious for EPL, advised to fu w repeat TVUS in 11 days



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Polling Question

- How comfortable are you diagnosing EPL on US?
  - Very comfortable
  - Somewhat comfortable
  - Somewhat uncomfortable
  - Very uncomfortable

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BetaHCG Guiding Criteria for EPL

The following minimum rates of increase of BhCG are expected over **48 hours**:

- 49% for an initial BhCG level of less than 1,500 mIU/mL
- 40% for an initial BhCG level of 1,500–3,000 mIU/mL
- 33% for an initial BhCG level of greater than 3000 mIU/ml

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Table 1. Guidelines for Transvaginal Ultrasonographic Diagnosis of Pregnancy Failure in a Woman With an Intrauterine Pregnancy of Uncertain Viability*

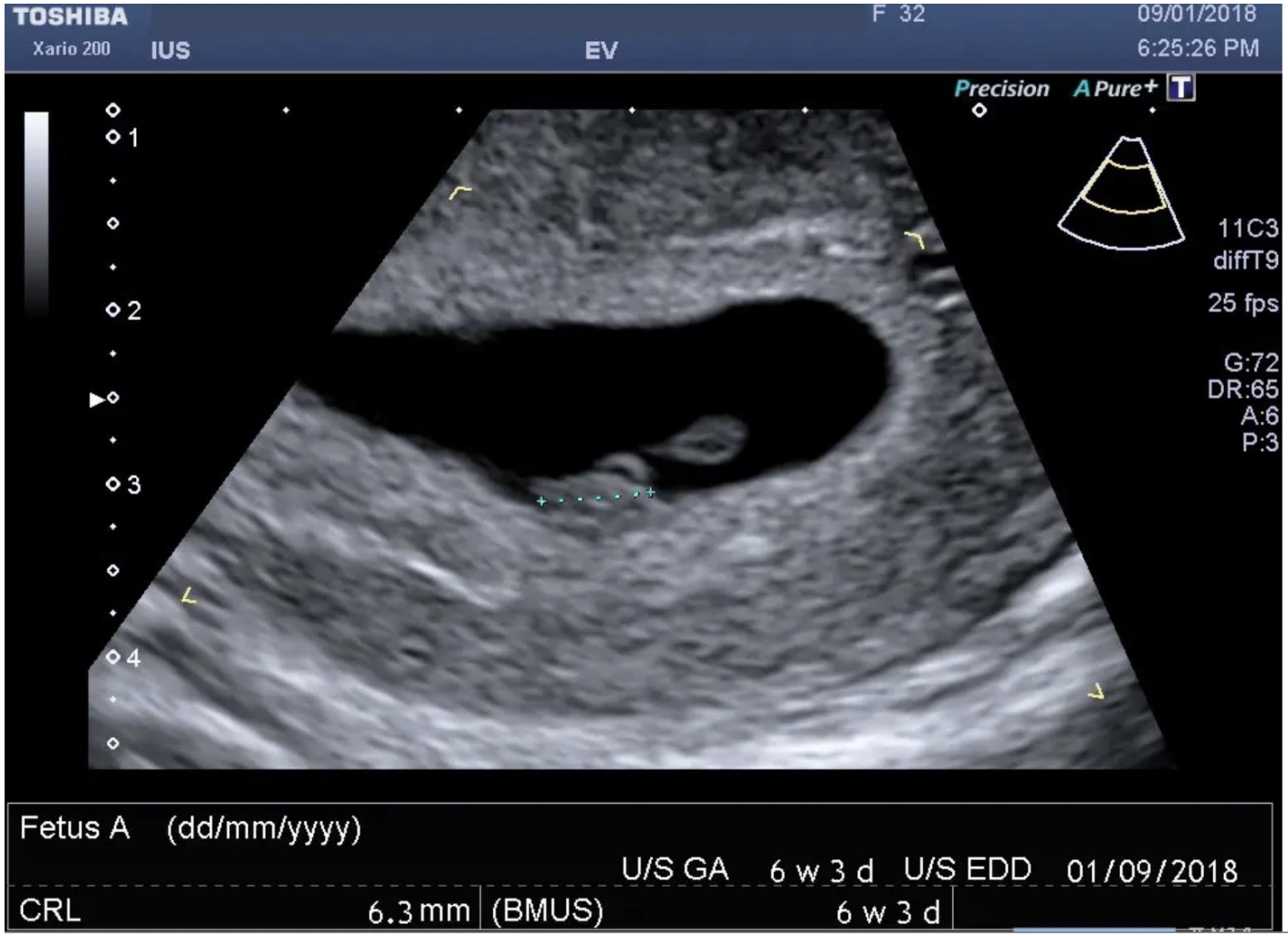
Findings Diagnostic of Pregnancy Failure	Findings Suspicious for, but Not Diagnostic of, Pregnancy Failure†
Crown–rump length of 7 mm or greater and no heartbeat	Crown–rump length of less than 7 mm and no heartbeat
Mean sac diameter of 25 mm or greater and no embryo	Mean sac diameter of 16–24 mm and no embryo
Absence of embryo with heartbeat 2 weeks or more after a scan that showed a gestational sac without a yolk sac	Absence of embryo with heartbeat 7–13 days after a scan that showed a gestational sac without a yolk sac
Absence of embryo with heartbeat 11 days or more after a scan that showed a gestational sac with a yolk sac	Absence of embryo with heartbeat 7–10 days after a scan that showed a gestational sac with a yolk sac
	Absence of embryo for 6 weeks or longer after last menstrual period
	Empty amnion (amnion seen adjacent to yolk sac, with no visible embryo)
	Enlarged yolk sac (greater than 7 mm)
	Small gestational sac in relation to the size of the embryo (less than 5 mm difference between mean sac diameter and crown–rump length)

Reference: Doubilet, Peter M., et al. "Diagnostic criteria for nonviable pregnancy early in the first trimester." *New England Journal of Medicine* 369.15 (2013): 1443-1451.

Guiding Case

Second ER visit, 4 days later:

- TVUS w CRL 2.2mm (5w5d), cardiac activity 94 bpm
- bHCG 15,897 (28% rise).
- Told she is likely having a miscarriage



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Case

- Patient shares she got pills online before the vaginal bleeding started as this was an undesired pregnancy.
- She wants to know if she should wait it out or just take the pills.
- She’s tired of having bleeding and cramping
- She’s feeling frustrated about the unclear diagnosis

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Management Options

- Expectant
- Medications (Mifepristone and Misoprostol)
- Procedural (uterine aspiration)

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Success Rates with Medication Management

- Medical management can be done with misoprostol alone or with the combination of mifepristone followed by misoprostol 24 hours later.
- Combo decreases risk of needing D&C for retained POC (18% vs 25%)
- Combo does NOT decrease risk of needing emergency D&C

Success Rate (expulsion of gestational sac)	Expectant (Day 7)	Misoprostol Alone (Day 2)	Mifepristone and Misoprostol (Day 2)
All EPL	40%	56-67%	71-84%
Embryonic demise	30%	68%	85%
Anembryonic	25%	65%	80%

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Polling Question

- Do you offer medications for EPL management in your outpatient clinic?
  - Yes, mife + miso
  - Yes, miso only
  - No
- Facilitators and barriers open discussion

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Medication Regimen

Mifepristone + Misoprostol

- Mifepristone 200mg, one dose orally
- Misoprostol 800 mcg 24 hours later
  - Vaginal or buccal (consider buccal if heavy bleeding)
  - Repeat in 24 hours if no bleeding occurs

Misoprostol Only

- Misoprostol 800 mcg every 3 hours, at least two doses
  - If still no tissue passage, repeat

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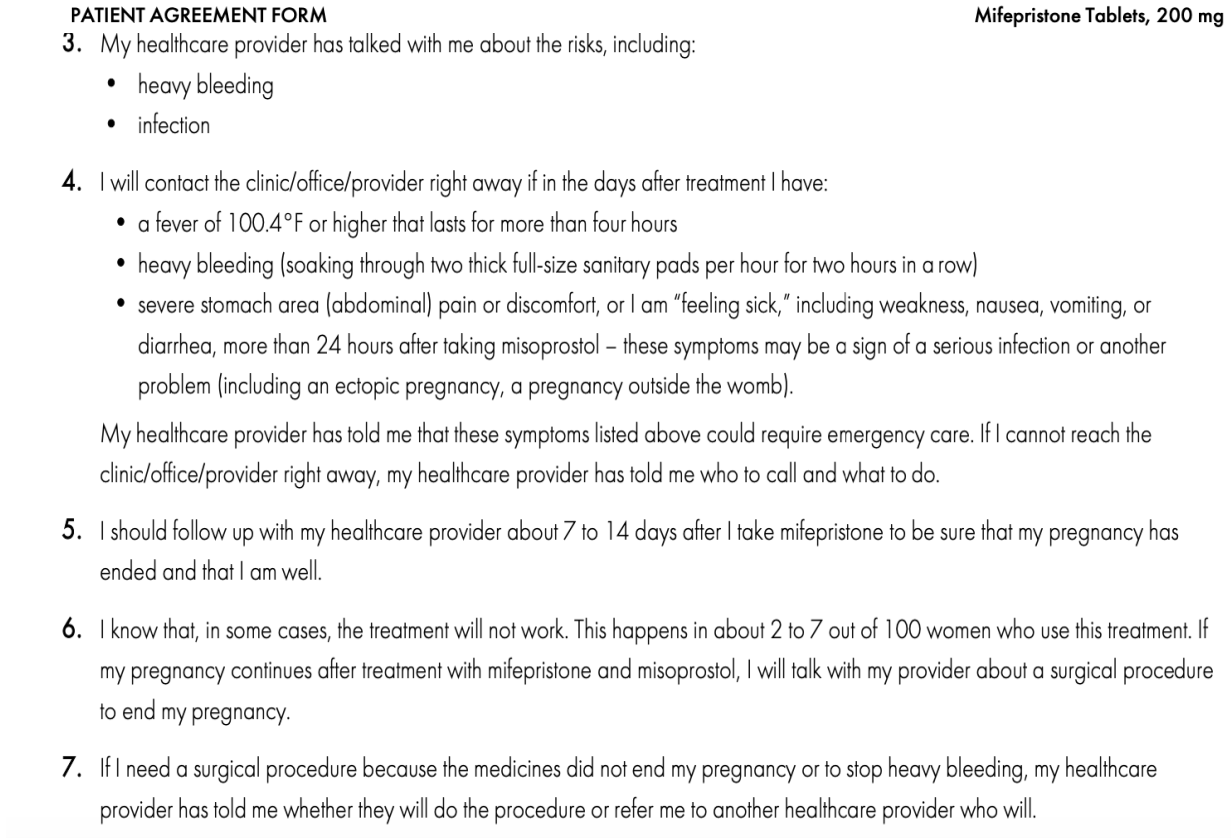
Prescribing Mifepristone in Clinic

REMS Requirements:

- Provider Agreement Form on file with dispensing company*
- Review and sign the Patient Agreement Form
- Provide the patient with a copy of the Patient Agreement Form and Medication Guide.
- Place the signed Patient Agreement Form in the patient's medical record.
- Record the serial number from each package of mifepristone in each patient's record.
- Report any deaths to the Mifepristone Sponsor that provided the mifepristone, identifying the patient by a non-identifiable reference and the serial number from each package of mifepristone.



PATIENT AGREEMENT FORM **Mifepristone Tablets, 200 mg**

3. My healthcare provider has talked with me about the risks, including:
   - heavy bleeding
   - infection
4. I will contact the clinic/office/provider right away if in the days after treatment I have:
   - a fever of 100.4°F or higher that lasts for more than four hours
   - heavy bleeding (soaking through two thick full-size sanitary pads per hour for two hours in a row)
   - severe stomach area (abdominal) pain or discomfort, or I am "feeling sick," including weakness, nausea, vomiting, or diarrhea, more than 24 hours after taking misoprostol – these symptoms may be a sign of a serious infection or another problem (including an ectopic pregnancy, a pregnancy outside the womb).

   My healthcare provider has told me that these symptoms listed above could require emergency care. If I cannot reach the clinic/office/provider right away, my healthcare provider has told me who to call and what to do.
5. I should follow up with my healthcare provider about 7 to 14 days after I take mifepristone to be sure that my pregnancy has ended and that I am well.
6. I know that, in some cases, the treatment will not work. This happens in about 2 to 7 out of 100 women who use this treatment. If my pregnancy continues after treatment with mifepristone and misoprostol, I will talk with my provider about a surgical procedure to end my pregnancy.
7. If I need a surgical procedure because the medicines did not end my pregnancy or to stop heavy bleeding, my healthcare provider has told me whether they will do the procedure or refer me to another healthcare provider who will.

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Prescribing Mifepristone in Clinic

- Someone to be responsible for clinic stocking
- At UW: patient takes mifepristone in presence of provider*
- A plan for when medication doesn't work (office aspiration or OB referral)
- Patient handouts – multiple languages at reproductiveaccess.org
- Danco/GenBioPro distributor consent form (also available in multiple languages)
- Clinical guidelines - available at reproductiveaccess.org

Pros: all done within the clinic, easy to re-stock with other in clinic dispensed meds (ie depo, toradol, etc.)

Cons: No flexibility for patient

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Pharmacy Dispensing

- Jan 2023 – FDA changed in person dispensing requirement to allow REMS certified pharmacies to prescribe mifepristone from a certified prescriber.
- Currently, we are unaware of any pharmacies in Wisconsin currently doing this because of the WI statutes that dictate in person dispensing for *induced abortion.* However, there is no explicit language about early pregnancy loss.

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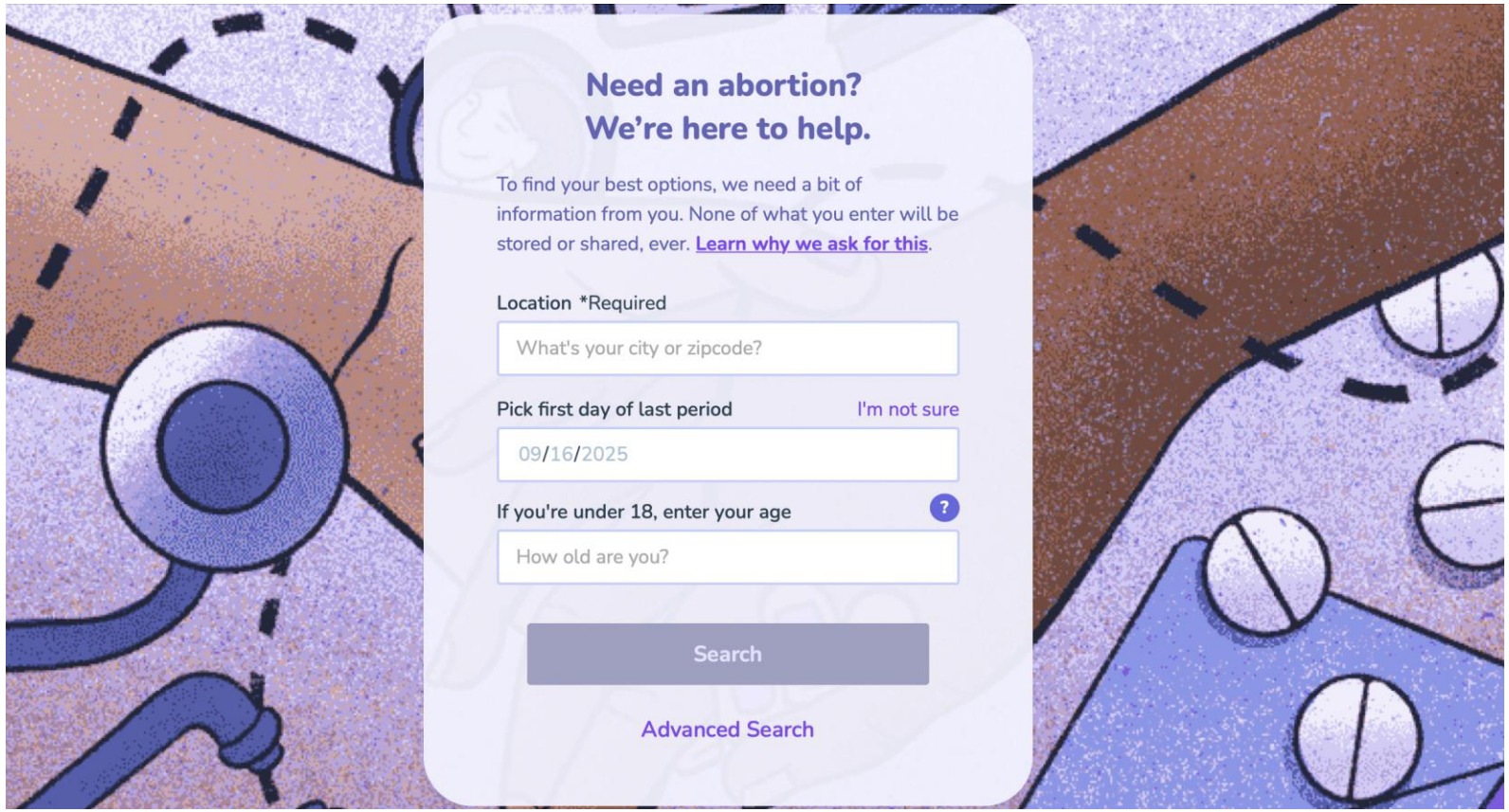
Online Clinic and Pharmacy Options



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Return to Case

- Patient ordered pills from Cambridge Reproductive Health Alliance
- Reviewed findings so far, pregnancy possibilities
- She opted to take the pills

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Patient Instructions

- Bleeding
    - Should start within 24 hours of misoprostol dose
    - Expulsion of tissue within 6-8 hours
- Nausea/Diarrhea/Chills
- Tissue disposition planning
- Prescribe ondansetron, ibuprofen, chux, tissue collection supplies.

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Patient Instructions

- Seek care if:
  - Fever (note: low grade fever is common with miso) *
  - If saturating 2 pads/hour for 2 hours in a row, seek care
- Alert provider if:
  - No bleeding/tissue passage after medications
  - Still feel pregnant (nausea/vomiting, breast tenderness)

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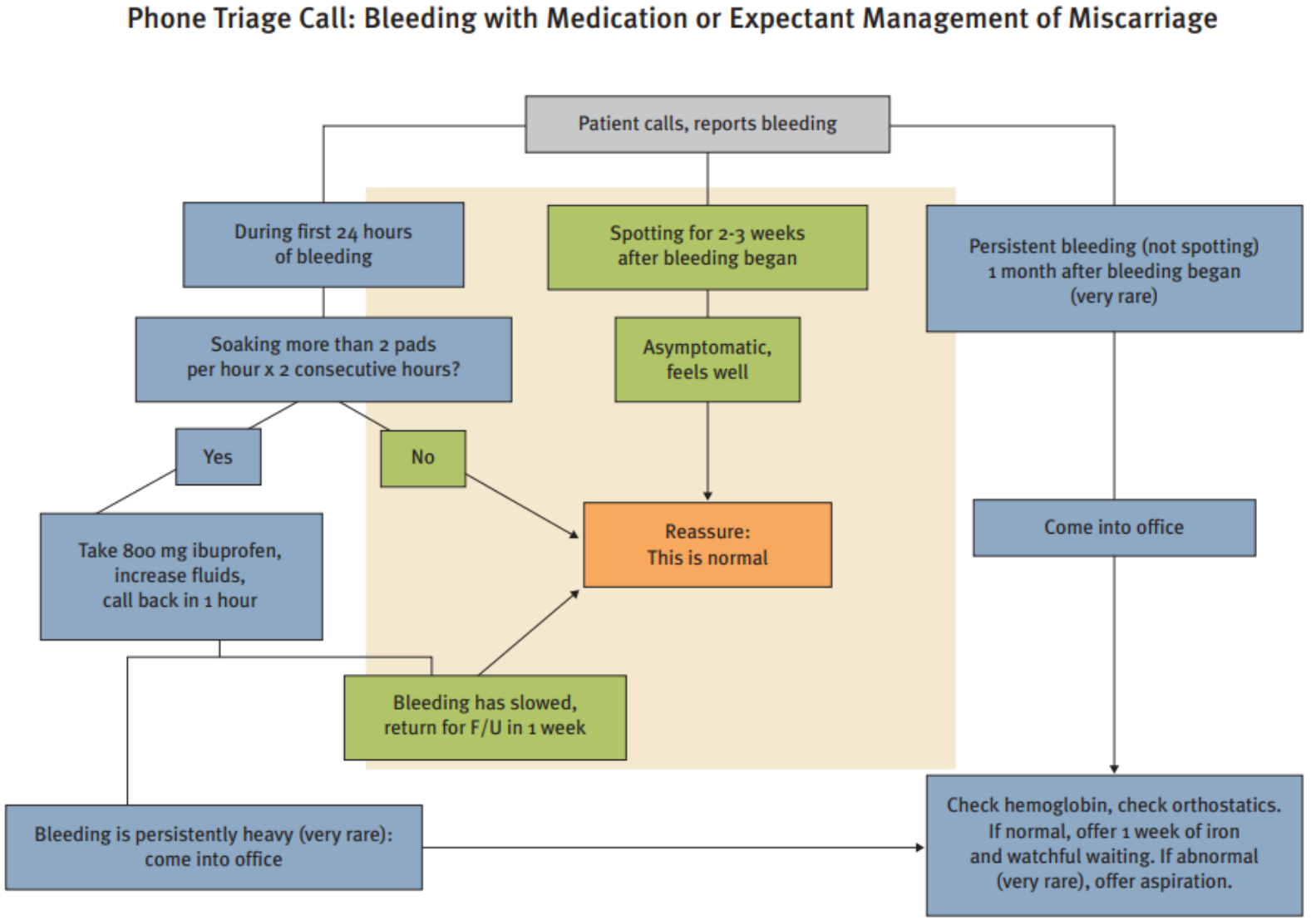
Case

- Patient calls, notes she has been having heavy bleeding and cramping. She took the misoprostol at 4pm, now woke up at 11pm with bleeding through pad and onto chux.



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Case

- You have her put in a new pad, take 800mg of ibuprofen, and call you in 30 minutes if she soaks through the pad or in 1 hour regardless.
- She calls 1 hour later to share she passed some tissue on the toilet and is feeling improved.

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Follow Up

- Confirm complete passage of tissue
  - HCG level on day of mifepristone admin and 7 days later
    - 80% drop ensures completion, if less than 80% TVUS needed
  - TVUS 7-14 days
    - Is there still a gestational sac? Are there concerning symptoms?
    - Endometrial thickness does not predict retained POC
- Mood check-in, emotional support as needed
- Planning for repeat pregnancy/contraception

Additional Resources

- Repro Legal Helpline*
- M+A Hotline
- Plan C Pills
- I Need An A
- Reproductive Access.org

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