PROVIDING EARLY OPTIONS

Volume 2, No. 1
May 2003

A Publication of The National Abortion Federation's Medical Abortion Education Initiative

A Model for Abortion Care in Academic Medicine: Columbia University

by Nassim Assefi, MD

In December 2000, spearheaded by Dr. Carolyn Westhoff, Columbia University opened a hospital-based abortion unit that provides first-rate clinical care while operating in an academic context. Integrating abortion care with teaching and research has been extremely successful at Columbia and can provide an inspiring model for other academic institutions that are seeking to improve their reproductive health services.

Clinical Practice

The clinic is staffed by an ob/gyn attending four full days per week, in addition to family planning fellows, ob/gyn residents, medical students, nurses, medical assistants, and a research coordinator. Both medical and surgical abortions are offered. Manual vacuum aspirations are performed up to nine weeks gestation (generally without conscious sedation) and second trimester terminations are performed one day per week in the operating room. Currently, medical abortions are offered as part of clinical trials, but they will soon be offered routinely once the trials are complete. Nonviable pregnancies (miscarriages) are also treated in this unit. The patient clientele is predominantly Hispanic (mostly Dominican) and African-American, and many are Medicaid or self-paying patients.

Generally, procedures take place in two rooms. There is one on-site ultrasound machine and one suction machine. Laboratory work is also done on-site. The patient has a telephone screen conducted by a medical assistant who triages medical versus surgical abortions, although there is flexibility in the system if the patient changes her mind once counseled by the physician. Physicians do all of the pre-procedure evaluation (counseling, physical examination, ultrasound) on the same day before doing the surgical abortions. A research coordinator assists with the medical abortion process, resulting in a greater than 95% follow-up rate. The nursing staff assists patients in obtaining same-day Medicaid coverage for their abortions (New York State is among the minority of states that funds all medically necessary abortions for women on Medicaid). The existing hospital security systems and procedures are sufficient for providers, clinic staff, and patients for this site.

Approximately two-thirds of the referrals originate from the Title X Family Planning Clinic in the same hospital, of which Dr. Westhoff is medical director. The other one-third of patients are referred from other sites within Columbia University, from physicians outside of the academic setting, and self-referral. Public advertising is not done to attract patients, but Columbia-affiliated providers are informed about the service. Family planning fellows take night calls (of which there are very few due to excellent counseling; approximately 45 minutes is spent with each medical abortion patient). The patients rarely utilize the Emergency Department, but when they do, there are good relations between emergency physicians and ob/gyns. This model has been cost effective despite its focus on poor patients. The medical abortion study helps pay for mifepristone and the research coordinator, and billing can be done for an office visit versus ambulatory surgery depending on the services required.

Teaching

Because the abortion unit is a part of Columbia University, medical students on their ob/gyn rotations, women's health rotations, and family planning electives routinely rotate through the clinic. Ob/gyn residents and Family Planning fellows receive excellent technical clinical training. The volume of patients is high enough to provide these physicians-in-training with the clinical exposure they need to be competent in providing medical and surgical abortions upon graduation from their program (although probably only fellows do enough 2nd trimester procedures to be comfortable with them). Thus far, advanced practice clinician students and non-ob/gyn students and residents don't get their teaching at this clinic.

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INSIDE THIS ISSUE

Slight Revisions to NAF's Mifepristone/Misoprostol Protocol Recommendations to Expand Flexibility of Use

In October 2002, a few slight revisions were made to NAF's mifepristone/misoprostol protocol to incorporate terminology changes and data published since the protocol was last revised in October 2000. Specifically, we have 1) substituted the more current wording of "evidence-based alternative regimens" for "variations based on accumulated scientific studies" and "alternatives that are supported by scientific studies"; 2) we have revised Option 5 of the "Evidence-Based Alternative Regimens". Option 5 of the protocol previously stated that equal efficacy is achieved through 56 days' gestation whether vaginal misoprostol is given 1, 2, or 3 days after 200 mg mifepristone. The revision reflects new published data supporting the use of vaginal misoprostol 1 and 2 days after 200 mg mifepristone *through 63 days' gestation*. Efficacy data for use of vaginal misoprostol 3 days after mifepristone is still limited to 56 days' gestation; and 3) the list of selected studies on regimens with mifepristone/misoprostol now includes: Schaff EA, Fielding SL, & Westhoff C. Randomized trial of oral vs. vaginal misoprostol at one day after mifepristone for early medical abortion. *Contraception* 2001; 64:81-85. This study supports the revision of Option 5 of the evidence-based alternative regimens discussed above.

This slightly revised protocol is included in the newly published *Early Medical Abortion with Mifepristone and Other Agents: Overview and Protocol Recommendations.* This resource is an updated edition of our January 2001 publication *Early Medical Abortion with Mifepristone and Methotrexate: Overview and Protocol Recommendations* and includes a detailed summary by Mitchell Creinin, MD of the published literature through August 2002 on the use of mifepristone, methotrexate, and misoprostol for medical abortion, and also reprints NAF's protocol recommendations for the use of methotrexate/misoprostol for early medical abortion. See the Early Options resource list and order form included in this newsletter if you would like to order this publication.

A Model for Abortion Care in Academic Medicine

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Research

There are currently two large clinical trials ongoing at the abortion unit: a study of miscarriage management (medical versus surgical evacuation) and a trial of misoprostol timing after mifepristone (6-8 hours versus 23-25 hours). However, Dr. Westhoff has participated in many previous trials of medical abortion (particularly the Abortion Rights Mobilization studies of medical abortion before the FDA's approval of mifepristone). She directs the family planning fellowship at Columbia and recruits 1-2 fellows per year who obtain their MPH and conduct clinical research related to contraception or abortion. She also holds a joint appointment in the department of epidemiology. Funding sources for abortion are generally private foundations, but the miscarriage trial has National Institutes of Health support.

Vision

Dr. Westhoff hopes that the graduates of her family planning fellowship will start similar abortion units in academic medical centers throughout the country. If the model at Columbia can be readily replicated, the abortion provider shortage may soon become a problem of the past, and reproductive health will finally gain the respect in academic medicine that it deserves.

A bi-annual publication
of the National Abortion Federation
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NAF is the professional association of abortion providers in the US and Canada. We serve those who make choice a reality: physicians, nurses, counselors, administrators, advanced practice clinicians and other health care professionals at medical facilities and offices in 48 states, the District of Columbia, Puerto Rico and 8 Canadian provinces. NAF is unique among reproductive health care organizations in that our mission is focused specifi-

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The National Abortion Federation (NAF) is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to sponsor continuing medical education for physicians.

New Data on Abortion Incidence and Services in the U.S.

In 2001-2002, The Alan Guttmacher Institute (AGI) conducted its 13th survey of all known U.S. abortion providers. The AGI survey is widely believed to be the most accurate and comprehensive survey of U.S. abortion providers and services. Data from this survey, which covers information from 1999, 2000, and the first six months of 2001, appears in the recently published study, Finer LB, & Henshaw SK. Abortion incidence and services in the United States in 2000. *Perspectives on Sexual and Reproductive Health* 2003; 35(1); 6-15. What follows is an overview of some of the central findings.

Abortion Incidence: Data from the survey indicate the annual number of abortions performed in the U.S. in 1999 and 2000 was 1.31 million. This abortion volume represents a decrease of 3% from 1996 and is the lowest annual abortion incidence since 1976. While previous surveys also revealed decreases in the number of abortions over time, the decline seen from the previous study period to this study period was smaller than the declines that occurred earlier in the decade. The abortion ratio declined 5% since the last study to 24.5 abortions per 100 pregnancies.

Abortion Providers: The AGI survey defines an abortion provider as any *facility* where abortions are performed. Thus, a clinic, physician's office, or hospital is counted as one provider even if more than one clinician provides abortions at that site. Likewise, an agency with several sites staffed by one clinician who travels from site to site would be recorded as multiple providers. The survey identified 1,819 abortion providers who performed at least one abortion in 2000. This represents an 11% decline in the number of providers from the 1996 survey. However, as with the number of abortions, the decline in the number of providers was less steep than in previous years. The decline in the number of providers with small caseloads was more pronounced than the decline among larger providers. As with previous surveys, the vast majority (87%) of counties in the U.S. have no identifiable abortion provider.

In 2000, clinics represented 46% of all abortion providers (an increase from 43% in 1996), and yet they provided 93% of all abortions—an increase from 90% in 1996. Thirty-three percent of providers were categorized as hospitals. Hospitals provided a smaller percentage (5%) of the total number of abortions performed in the U.S. than in previous years (7%). Physicians (defined as physicians' offices providing less than 400 abortions per year) represented 21% of all providers and performed only 2% of abortions, down from 3% in 1996. Thus, this survey documents an increased migration, or what the researchers termed "consolidation," of abortion services into clinics and out of physicians' offices and hospitals.

Medical Abortion: Since the U.S. Food and Drug Administration's approval of mifepristone occurred during the study period, researchers surveyed providers about their provision of medical abortion services in the first half of 2001. Researchers estimated that 37,000 medical abortions, the majority (72%) of which were performed using mifepristone/misoprostol regimens, occurred in the first half of 2001. This represents about 6% of all abortions provided during that time. One-third of all providers performed at least one medical abortion. A larger percentage of abortion clinics (51%) and non-specialized clinics (45%) reported offering medical abortion services in the first months after availability of mifepristone than physicians' offices (23%) and hospitals (19%). Sixty percent of large volume providers (i.e. those providing more than 1,000 abortions annually) offered medical abortion services, in contrast to 23% of smaller volume providers offering 400 or fewer abortions annually. All providers of medical abortion also provided surgical abortion. More than half (53%) of non-hospital providers who didn't yet offer medical abortion during the survey period indicated that they "probably will" or "maybe" will offer this service in the future.

The researchers suggest that high profile cases of violence against abortion providers (the murder of a security guard during a clinic bombing and the shooting death of a doctor, as well as two other shootings of doctors) since the last survey may have contributed to the decline in the number of providers. They point to increased legal constraints on the provision of abortion services, such as targeted zoning, licensing and inspection requirements, as one possible explanation for the trend toward a higher percentage of clinic providers, since these providers may be more willing or able to comply with such requirements. Increased state restrictions on women's access to abortion (e.g. waiting periods) and out-of-state travel to seek abortions in states with fewer barriers may have contributed to declines in abortion rates in some states and to increases in abortion rates in others. The study appears in its entirety at www.guttmacher.org/pubs/journals/3500603.pdf.

The NAF Early Options E-newsletter

This is a free service dedicated to creating awareness and educating health care professionals. The newsletter covers current issues pertaining to medical abortion and reproductive choice, as well as NAF programs and initiatives on medical abortion. For your convenience, we have archived past medical abortion e-newsletters on our website. To receive future issues–sent approximately every two months–you may sign up on the Early Options homepage: www.earlyoptions.org.

Ask An Expert!

*Here are the perspectives of two experienced health care professionals on two common questions about medical abortion. Keep in mind, there are many different approaches to setting up medical abortion protocols and managing medical abortion patients, depending on your practice size and setting, your staffing, your clientele, your experience-level, and many other factors. We welcome your suggestions for an "Ask An Expert" question for our next issue.**

Katy Shannon, MSW is an independent consultant and former counselor. She has served as faculty for numerous NAF trainings on medical abortion counseling. She holds a masters degree in social work with a specialization in women's health.

Marcy Bloom is the executive director of Aradia Women's Health Center in Seattle and has worked in the field of reproductive health and abortion since 1970. Her current interests include cross-cultural competency and effectively serving women with limited English abilities.

1. Given the importance of a follow-up visit to confirm a complete medical abortion, what are your strategies for maximizing follow-up rates among women undergoing medical abortion?

Katy Shannon, MSW: When discussing medical abortion, always frame the procedure as *a process* that begins with taking mifepristone and ends with a confirmation of the completed abortion at the follow-up visit. Ensure that all women know what will happen during the follow-up and why it is so important to have this appointment. Also, in discussing the follow-up with a woman, assume the best and prepare for the worst. For example you might say, "It is clear that you take excellent care of yourself and therefore I know you will return for your follow-up appointment. However, because of the importance of this visit, I'm obligated to tell you our clinic's protocol for contacting you in the event of a missed appointment." Be sure each woman knows what steps you will take to reach her if she misses her follow-up (especially those methods that might include breaches of confidentiality). When scheduling follow-ups with women who are using vaginal misoprostol, aim to schedule the visit within one week of the day mifepristone is taken. Limiting the time between appointments may increase follow-up rates. Also, if you have a connection with a woman on her first appointment, tell her you plan to seek her out during her follow-up visit to hear about her experience. If she knows you are expecting her she may be more likely to return. Finally, be sure to document that you informed each woman of the importance of returning for her follow-up appointment.

Marcy Bloom: No matter how thorough one is in counseling, some women will always be lost to follow-up, but it is very rare at Aradia Women's Health Center for this to occur. We are very clear with the women choosing medical abortion that this abortion procedure is a process and may require multiple visits and that it is not truly "over" until she returns to us for a follow-up exam with ultrasound, hCG, etc. In the screening and information-sharing session, our health advocates emphasize why it is so critical for a woman to return to be sure that she is no longer pregnant and that the abortion is truly complete. We will call and write to the woman if she is a no-show for her follow-up(s). Keeping in touch with her is key!

2. How do you educate and counsel women about medical abortion without marginalizing surgical abortion?

Marcy Bloom: Our phone counselors and health advocates are very clear about what medical abortion is and is not. Many women believe that they take a pill and-voila!-the pregnancy is gone. We emphasize that this is not the case; that medical abortion is a process and how it contrasts with the surgical abortion experience. Assuming her medical background does not rule out either abortion method as a choice, we ask the woman what type of abortion experience she is seeking. After all, taking pills may seem preferable and "easier" to many women, but the bleeding and cramping may be severe, and it is difficult to predict the intensity and length of each. We review the "pros" and "cons" of both medical abortion and surgical abortion. A woman may dislike and even be frightened of the idea of a surgical procedure, but she is no longer pregnant when she leaves the clinic, and that is certainly not the case with medical abortion. On the other hand, medical abortion may seem more private and more "natural" in many ways, and the woman can attempt to be in the physical location of her choice while she is experiencing cramping and bleeding. We clearly communicate that both abortion procedures are safe and that they represent different abortion experiences and choices for different women and the many emotional and medical needs that women have when choosing abortion.

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Medical Abortion Education Project

The Medical Abortion Education Project (MAEP) is a collaboration of NAF, the American Medical Women's Association's Reproductive Health Initiative (AMWA/RHI), the Association of Reproductive Health Professionals (ARHP), and Physicians for Reproductive Choice and Health (PRCH) whose goal is to increase the number of healthcare professionals who are knowledgeable about medical abortion. NAF has trained a cadre of faculty from our partner organizations to present education programs on the early option of medical abortion in a variety of venues such as grand rounds programs, medical schools, and conferences. Faculty are chosen from diverse geographic regions and medical specialties, so that they can increase awareness and expand the number of health care professionals outside of the current abortion providing community who are knowledgeable about medical abortion, and who can provide, refer, and advocate for medical abortion training and service delivery within their communities.

In late February, NAF hosted the 2003 Training of MAEP Faculty, moving this valuable program into its third year. After the Training of Faculty, AMWA/RHI, ARHP, and PRCH publicize the availability of trained faculty for medical abortion programs, work with their faculty to identify sites for MAEP programs, organize the logistics of those programs, and support their faculty to present MAEP programs. NAF provides CME/CE for MAEP programs when requested by the host site. Since 2001, trained MAEP faculty members have delivered over 90 educational programs to audiences including medical students, advanced practice clinicians and general practitioners. The programs cover the topics of Medical Abortion Regimens; Expected Side Effects & Management of Complications in Medical Abortion; and Medical Abortion in Historical Context and in Practice.

For more information about MAEP programs, call NAF's Medical Abortion Education Director at 919-967-1673.

NAF SITINGS

NAF exhibits at numerous professional conferences each year. The following is a tentative list of upcoming conferences where our medical abortion and other resources will be available:

National Rural Health Association (NRHA)	May 14-17, 2003
American Academy of Pediatrics (AAP) Super CME 2003	May 14-16, 2003
American College Health Association (ACHA)	May 28-31, 2003
Primary Medicine (Pri-Med) Midwest	June 19-21, 2003
National Family Planning and Reproductive Health Association (NFPRHA)	June 24-27, 2003
Society of Obstetricians and Gynecologists of Canada (SOGC) Annual Meeting	June 25-30, 2003
National Medical Association Annual Meeting	August 2-7, 2003
American Academy of Family Physicians (AAFP)- Residents & Students Conference	August 6-10, 2003
Association of Reproductive Health Professionals (ARHP)	September 10-12, 2003
ACOG District 3,6,9 Meeting	September 16-20, 2003
ACOG District 4 Meeting	October 18-20, 2003
Contraceptive Technology -Quest For Excellence	October 22-25, 2003
ACOG District 2 Meeting	October 24-26, 2003
Pri-Med Northeast	November 7-9, 2003
AAFP/Society of Teachers of Family Medicine-Patient Education Conference	November 20-23, 2003

Ask an Expert: *Continued from page 4*

Katy Shannon, MSW: When you counsel/provide education for women who are trying to decide between medical and surgical abortion, what is your goal? One might say the goal is to give each woman the information and safe space she needs to determine which method is best for her at this time in her life. Doing this without marginalizing one abortion method or the other requires the same skills we use to do quality options counseling. First, you must be informed about both methods. Do you know the facts? The common myths? Can you speak to these things comfortably and confidently? Second, you must trust that a well-informed and well-supported woman can determine which method of abortion is best for her at this time. By trusting a woman in this way you will not be tempted to influence her decision with your beliefs. However, it is only possible to avoid this influence when you are first *consciously* aware of your personal beliefs and opinions about medical and surgical abortion. Having your own opinions is a good thing; it is why you are in this work to begin with! But, you must acknowledge and explore these beliefs or they may creep into your work with patients. Start by simply paying attention to the language (verbal, body, etc.) that you use to discuss medical and surgical abortion. Are there messages inherent in this communication? If so, what are they? Try to find language that relates only the facts and then allow each woman to place her own value on that information.

* Neither the National Abortion Federation, its officers, employees, or members are responsible for adverse clinical outcomes that might occur in the course of delivery of abortion services in which they are not expressly and directly involved in the role of primary caregiver.

NAF Celebrates the 30th Anniversary of *Roe v. Wade*

Pro-choice and abortion rights groups across the nation banded together on January 22, 2003 to celebrate the 30th anniversary of one of the most historic court cases in American history—*Roe v. Wade*. The National Abortion Federation recognized this momentous event by hosting a special evening to celebrate the accomplishments of the NAF Hotline and observe the important contribution of the Hotline staff in keeping abortion safe and accessible for women.

The stories of some of the women who have called the Hotline were posted on the walls to illustrate the overwhelming need for the Hotline's services. For example:

> When "A" called the NAF Hotline, she was almost too weak to talk. The South Carolina resident was a brain cancer patient whose doctors had told her that both she and her partner were sterile. When "A" discovered she was pregnant she intended to abort immediately; she was precluded from taking chemotherapy drugs while pregnant. Her physicians, however, considered "A's" pregnancy a "miracle" and refused to cooperate. NAF Hotline staff members helped "A" set up an appointment for an abortion at a NAF member clinic in North Carolina, but she was too ill to keep it. The member clinic, going above the call of duty, formed a liaison with Duke University Medical Center, where "A" was already booked for cancer treatment. In spite of her condition, "A" made the trip to Duke UMC and had her abortion, which was completely (thanks to intervention by the clinic) covered by Medicaid. NAF Hotline staff members stayed in touch with "A" and bolstered her until she was safely at home again.

Or

> "T" called the NAF Hotline on behalf of her 18-year-old daughter, "L." "L" had been using birth control pills when she became pregnant. It turned out that the local pharmacy had given her a prescription that had expired, which she didn't realize until she had missed a period. "L" had ceased working when her pregnancy made her too sick to stand at her cashier's station. As a result, the only income for the household was "T's" disability check. "T" provided childcare for "L's" 2-year-old, but her disability prevented her from leaving the house. NAF Hotline staff members were able to raise the funds "L" needed. When her abortion was complete, "L" called to thank the NAF Hotline for assisting her.

The challenges facing women who call the NAF Hotline include locating an abortion provider in their area or one who provides services at their stage of pregnancy, overcoming the legal restrictions in place in their state, and working out how to pay for their travel expenses and the cost of the services they need. The Hotline staff works diligently to help women obtain the abortion services they need and the economic assistance that is necessary for many of them to access that care. The 30th anniversary of *Roe v. Wade* provided an opportunity to recognize the enormous contribution of the NAF Hotline staff in ensuring that women receive the reproductive health care they need.

The NAF Hotline (800-772-9100) is staffed Monday through Friday from 8AM to 10PM eastern time and on the weekends from 9AM to 5PM.

Earn CME Credit and Learn Cutting-edge Abortion Information

The Early Options Online Continuing Medical Education (CME) Program, the first interactive web-based CME program on medical abortion, is now available on NAF's medical abortion website, www.EarlyOptions.org. Click on the "Online CME" logo to start the program.

This online CME Program:

? *Will offer health care professionals comprehensive information about the safe and effective administration of medical abortion*

? *Includes 5 modules focusing on the topics of:*

- *medical abortion regimens*
- *counseling*
- *service delivery issues*
- *ultrasound*
- *management of side effects and complications*

? *Incorporates specific learning objectives, interactive questions and video clips from NAF's Early Options Video Series featuring expert medical abortion providers and women who have had a medical abortion to educate health care providers in the administration of medical abortion*

? *Is designated for up to 5.0 hours in Category 1 credit towards the AMA's Physician Recognition Award*

Designing and Implementing a Medical Abortion Program: One Clinic's Experience

by Susan Osborne, Project Manager, Choice Medical Group

Choice Medical Group has been specializing in surgical abortions under general anesthesia for over 25 years. With the increased awareness of, and patient demand for, the "abortion pill," we realized it was time to change, enhance, and challenge our existing model to meet the changing needs of our patients. In September 2002, we set a January 2003 deadline for offering medical abortion services in each of our six Northern California locations.

With all of the NAF resources available—expert staff, sample protocols, training videos, and the many NAF members who willingly shared their experiences—finding the necessary support was never an issue. The more daunting task—and one that I have heard echoed by other NAF members—was getting the entire staff, from the receptionists, to the billing department, counselors to clinicians, to believe in and support the value of offering medical abortion, and to be adequately trained to offer it.

Long before introducing the protocol, we started talking about medical abortion. At every chance—site visits and staff trainings—we held informal "Medical Abortion 101" type trainings. We wanted to get people familiar with medical abortion and allow time to explore their values, comfort level, and questions concerning medical abortion. Our staff talked about how it might impact our other services, how it might change the daily clinic flow, and whether or not they would recommend it to a friend. We found that this approach really helped build the support, reassurance, and excitement necessary to successfully launch medical abortion services. And, their observations and feedback helped to create the clinic model we are using.

NAF's Medical Abortion Technical Assistance number was on my speed dial throughout this process. We were encouraged to (and we did) take full advantage of NAF's entire training program. Deb VanDerhei and Katy Shannon came to San Jose for a day-long set of trainings. Our counselors, clinicians, and Center Managers worked with Katy in the Counseling Workshop, while our receptionists and appointment schedulers worked with Deb.

Those trainings, along with the continuous and open conversations throughout the process were the most valuable part of preparing to offer this service. We saw our first patients in early January, and so far both the staff and the patients feel very well prepared and informed about offering and using this option. One of our clinics, in fact the one whose staff was initially the most skeptical about medical abortion, scheduled over 8 medical abortion appointments in the first two weeks, and is really excited about their role in offering this service.

Does your clinic need medical abortion technical assistance and training?

Since our Medical Abortion Technical Assistance Program began in late 2001, we have provided training and assistance to dozens of NAF member clinics across the country. NAF members interested in initiating or improving their medical abortion services have taken advantage of this specialized training by bringing NAF faculty to their clinics for half- or full-day in-services. For those members who simply have needed technical assistance over the phone, we have provided contacts to leading medical abortion experts in the field.

If you have a training need, you can contact NAF's Medical Abortion Education Department at (202)667-5881.

Possible areas for technical assistance and in-services:

- ? Developing/refining protocols
- ? Patient volume and/or patient flow
- ? Medical abortion pricing/drug costs
- ? Paperwork (Patient Agreement, consent forms, etc)
- ? After hours triaging
- ? Patient screening
- ? Billing and reimbursement
- ? Legal/regulatory issues
- ? Ultrasound training
- ? Phone counseling/intake
- ? MVA training
- ? Managing side effects/complications
- ? Buy in from Medical Director, Owner, or others
- ? Staff values clarification
- ? Emergency back up

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Keeping Abortion Safe, Legal, and Accessible

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Mifepristone Found Highly Effective in Relieving Psychotic Depression

Over the years, researchers have studied mifepristone as a possible treatment for a wide range of conditions including ovarian, breast, and endometrial cancers, meningioma, uterine fibroids, and Cushing's syndrome. Most recently, researchers at Stanford University found that mifepristone quickly and effectively improved symptoms of psychotic depression.

The study (Belanoff JK, Rothschild AJ, Cassidy F, DeBattista C, Baulieu EE, Schold C, Schatzberg AF. An open label trial of C-1073 (mifepristone) for psychotic major depression. *Biological Psychiatry* 2002; 52(5): 386-392) examined 30 patients who received a low, medium, or high dose of mifepristone each day for a week, in addition to their standard medications. *Within seven days*, more than two-thirds of patients in the medium and high dose groups had significant improvement in psychotic symptoms, and more than 40% in these groups saw their symptoms of depression reduced by half or better. Traditional treatments, such as the combination of antidepressants and antipsychotic drugs or electroconvulsive therapy improve symptoms for approximately 60% and 80% of patients, respectively, but results can take weeks or months.

Symptoms of psychotic depression include paranoia and hallucinations. High levels of cortisol from over-active glands of the hypothalamic-pituitary-adrenal axis contribute to the extreme symptoms of the illness. Mifepristone blocks cortisol receptors and is also theorized to reset the activity level throughout the axis, which may explain why improvement in symptoms persists even after mifepristone is stopped. Mifepristone treatment also produces significantly fewer side effects compared to antidepressants and antipsychotics.

Additional research regarding the use of mifepristone to treat psychotic depression continues, and the FDA has announced that it is reviewing data for possible approval of mifepristone for this use.