Adolescent Girls and Abortion

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Abstract

Abortion is an extremely common procedure in the United States, with approximately 2% of women having an abortion before age 19 years. Although most pediatricians do not provide abortions, many will care for a young woman who is either considering an abortion or has already had one; therefore, the pediatrician should be able to provide accurate and appropriate counseling about this option. To provide the best care for adolescent patients considering abortion, pediatricians must be knowledgeable of aspects of abortion that are universal to all women and have an understanding of considerations specific to the adolescent patient. The purpose of this article is to (1) review recent statistics about teenagers and abortion, (2) explain the different types of abortion available to teenagers who desire to terminate an unwanted pregnancy, (3) discuss aspects of abortion unique to the adolescent population, such as insurance coverage and parental involvement laws, and (4) address common misconceptions about abortion. [Pediatr Ann. 2015;44(9):384-385,388,390,392.]

Although teenage pregnancy rates have declined in the recent past, unintended pregnancy in the teenage population remains a major public health issue. The most recent data indicate that 7% of girls age 15 to 19 years will become pregnant and 2% of girls in this age group will have an abortion. Al- though most pediatricians do not provide abortions, many will care for a teenage girl who is either considering an abortion or has already had one. To help the general pediatrician provide informed care and counseling for patients considering this procedure, this article (1) reviews recent statistics about teens and abortion, (2) explains the different types of abortion available to teens who desire to terminate an unwanted pregnancy, (3) discusses aspects of abortion unique to the adolescent...
population, such as insurance coverage and parental involvement laws, and (4) addresses common misconceptions about abortion.

ABORTION STATISTICS FOR ADOLESCENT GIRLS

In the United States, approximately 51% of pregnancies are unintended and 40% of unintended pregnancies end in abortion. Among girls age 15 to 19 years, however, approximately 82% of pregnancies are unintended, and approximately one-third of teens facing unintended pregnancy choose to have an abortion. In 2010, 614,000 girls ages 15 to 19 years and another 11,000 girls age 14 years and younger became pregnant. Teens between the ages of 15 and 19 years account for 17.6% of people seeking abortion, such that an estimated 8.3% of women will have an abortion by the age of 20 years. The most common reasons teenage girls report for choosing abortion are interference with school and/or career and difficulties with finances.

Approximately 90% of abortions in the United States are performed before 12 weeks gestation. Teenagers, however, are disproportionately represented in those patients obtaining abortion after 12 weeks gestation. A qualitative study of teens and adults presenting for abortion suggested that this timing is due to difficulties in making arrangements to obtain a termination and delays in discovering of pregnancy and/or gestational age. Teen participants in this study were likely to take at least 1 week longer than adult participants to suspect and confirm their pregnancies.

TYPES OF INDUCED ABORTION: MEDICATION VERSUS SURGICAL

First Trimester Medical Abortion

Medication abortion, also known as “the abortion pill,” was first approved for use in the United States by the US Food and Drug Administration (FDA) in 2000. Medication abortion is an option for patients with an unwanted pregnancy up to 10 weeks gestation and is used for approximately 25% of abortions before 9 weeks gestation. The most commonly used medication abortion protocols use both mifepristone and misoprostol. Mifepristone is a progesterone antagonist that causes shedding of the uterine lining and termination of pregnancy. Misoprostol is a prostaglandin analogue that causes contraction of the uterus and expulsion of the uterine contents.

Contemporary evidence-based medication protocols and the original FDA-approved protocol differ in several ways. Evidence-based medication abortion protocols are supported by both the American College of Obstetricians and Gynecologists and the Society of Family Planning. However, several states have restricted the use of medication abortion to the original FDA-approved protocol. According to the FDA-approved protocol, women take 600 mg of mifepristone orally and then return to the clinic 48 hours later to receive 400 mcg of misoprostol orally. This regimen was approved for women up to 7 weeks gestation and results in efficacy rates of approximately 92%. A large body of research supports several key modifications to the FDA protocol that have improved efficacy rates, decreased side effect rates, and decreased cost. In the most commonly used evidence-based protocols, women take 200 mg of mifepristone orally in the clinic and take 800 mcg of misoprostol vaginally, buccally, or sublingually in a setting of their choosing. If taken vaginally, misoprostol is slowly absorbed and can be used immediately after mifepristone; otherwise it is recommended that patients self-administer the misoprostol 24 to 72 hours after taking mifepristone via buccal or sublingual routes. Several studies support the use of medication abortion up to 10 weeks gestation.

Some reasons patients may prefer medical abortion include a sense of “privacy” associated with having the abortion at home, shorter clinical visits, and no requirement of a surgical procedure or anesthesia. This method allows patients to control the timing of their abortion by choosing when to take their misoprostol. This method, however, usually causes a longer period of bleeding and cramping and often requires more clinic visits than a surgical abortion. Most patients will experience significant bleeding and cramping 4 to 5 hours after taking the misoprostol, but bleeding and spotting can continue for up to 4 weeks. Women are routinely given prescriptions for nonsteroidal anti-inflammatory drugs for analgesia with the option of adding oral narcotic medications as needed.

Clinics usually require a follow-up appointment to confirm completion of the abortion. The most common adverse effects of medical abortion are heavy bleeding, nausea, vomiting, fever, chills, headache, and dizziness. Patients should be counseled to seek medical attention if they are soaking more than 2 pads each hour for more than 2 straight hours. Medication abortion using evidence-based protocols is highly effective. However, up to 5% of patients may need surgical evacuation (a dilation and suction curettage) due to incomplete emptying of the uterus or continuing pregnancy.

First Trimester Surgical Abortion

Early surgical abortion, also known as a dilation and suction curettage or vacuum aspiration, can be used for patients up to 14 weeks gestation and is more common than medication abortion. Surgical abortion accounts for approximately 75%
of all terminations under 8 weeks gestation. With surgical abortion, the entire abortion takes place in a single clinic setting. First trimester surgical abortion is most commonly performed while women are awake with the use of local anesthesia with or without sedation. A trained provider places a speculum and applies a cleansing agent and anesthetic to the cervix. The cervix is then dilated and a thin plastic tube (cannula) is inserted through the cervix into the uterine cavity. suction is applied to the end of the tube by a manual or electric vacuum to evacuate the uterine contents. Although the clinic visit for this procedure usually lasts between 3 and 6 hours, the procedure itself takes approximately 10 to 20 minutes. The suction portion usually takes 1 to 2 minutes. After this procedure, most patients do not require further clinic visits.

Patients may prefer a surgical abortion if it is important to have their procedure completed in a narrow timeframe, if they cannot attend multiple clinic visits, or if they feel cramping or bleeding at home would not be acceptable. Surgical abortion is also slightly more effective than medical abortion, with only 2% of patients requiring a subsequent suction procedure (compared to 5% of patients who receive medical abortions). The risks of surgical abortion include bleeding, infection from instrumentation of the uterus, and uterine perforation during the dilation or suction portion of the procedure.

Second Trimester Surgical Abortion

As noted before, teenage patients are at increased risk of seeking an abortion later in pregnancy due to a variety of factors, including delayed recognition of pregnancy, financial constraints, and difficulty accessing clinic appointments. The general pediatrician should be aware of their state’s guidelines on the gestational cutoffs for elective termination—most states use 20 to 24 weeks. Surgical abortions after 14 weeks gestation require specialized procedures and providers and require 1 to 3 days to complete, so obtaining these procedures may be more challenging. It is crucial that patients who desire termination at greater than 14 weeks gestation be referred as quickly as possible to a local abortion clinic such as Planned Parenthood to help them determine the appropriate clinical setting for their procedure.

ASPECTS OF ABORTION SPECIFIC TO TEENAGERS

Insurance and Cost

The cost of an abortion depends on the clinic setting, gestational age of the patient (with later gestational abortions being more expensive), the type of anesthesia used, and whether or not insurance covers abortion. Due to legislative restrictions under the Hyde amendment, federal funds cannot be used to pay for abortion, except in cases of life endangerment, rape, or incest. As Medicaid is a state-federal program, several states use their own funds to extend Medicaid coverage of abortion beyond what is covered under the Hyde amendment. Many clinics can offer a price estimate for patients over the phone. In 2005, the average amounts paid for 10-week and 20-week gestation abortions were $413 and $1,300, respectively. Teenage girls who have access to abortion coverage through private insurance may elect not to use it due to concern of bills being sent to their caregivers outlining their procedures. They should be counseled that although their abortion care is completely confidential, their insurance bill may indicate that they have received a termination.

Parental Involvement

All adolescents are legally entitled to confidential care for sexual health matters and to confidential options for counseling in case of unintended pregnancy. If a teen girl elects to have an abortion, however, she may be affected by parental involvement laws. Parental involvement laws vary from state to state and include parental notification and parental consent laws.

Parental notification. Currently, 13 states require at least one parent be notified prior to a minor’s abortion. The period of notification is usually defined as ranging from 24 to 48 hours prior to the procedure. Some states allow step-parents, adult siblings or relatives, and/or grandparents to be notified in place of a parent.

Parental consent. Presently, 21 states require that one or both parents provide consent for their teenage daughter’s abortion to perform the procedure, and five states require both parental notification and consent.

Bypass of consent laws. Most states that require parental notification or consent also allow for a judge, and in some cases a doctor, to excuse a teenager from these laws.

Patients and pediatricians can learn about their state’s parental involvement requirements on the websites for the Guttmacher Institute (http://www.guttmacher.org) and Planned Parenthood (http://www.plannedparenthood.org). Local abortion clinics may also have more specific information about the nuances of parental involvement laws in their states.

COMMON MISCONCEPTIONS ABOUT ABORTION

Misinformation about abortion is widespread. Many clinics that advertise themselves as pregnancy crisis centers and some websites provide medically inaccurate information to patients in an attempt to dissuade them from choosing abortion. The following subsections detail common myths about abortion that the general pediatrician should be prepared to discuss with patients considering, or status post, abortion.

Myth: Abortion Causes Mental Health Problems

Although every woman’s abortion experience will be unique, a meta-analysis of recent literature has shown that having an abortion presents no greater risk for de-
pression, anxiety, or other mental health problems than delivery of a child.33 In a study looking at teenagers specifically, patients who underwent abortion were no more likely than their peers to suffer from depression or low self-esteem in the year following or 5 years after their abortion.34

**Myth: Future Fertility Is Compromised by Having an Abortion**

Illegal or unsafe abortion practices can have devastating effects on a patient’s health, including loss of fertility. However, abortion completed in a safe and legal medical setting is not correlated with infertility.35

**Myth: Abortion Can Lead to Breast Cancer**

A meta-analysis of the relationship between abortion and breast cancer has shown that pregnancies ending in spontaneous or induced abortion do not increase a woman’s risk of developing breast cancer later in life.36

**Myth: Emergency Contraception Causes Abortion**

Emergency contraception, or “the morning after pill,” contains no mifepristone (the medication used to terminate pregnancy). Two types of emergency contraception are currently on the market—levonorgestrel and ulipristal. These medications work by delaying ovulation, but neither of them will cause harm to an intact pregnancy.37

**AVOIDING UNINTENDED PREGNANCY**

Approximately 50% of women seeking abortion were using some form of contraceptive when they became pregnant; 27% cited using condoms.38 This underscores the importance of providing adolescents access to highly effective methods of contraception. The most effective contraceptive methods are commonly referred to as long-acting reversible contraceptives (LARCs) and include intrauterine devices (IUDs) and contraceptive implants. The American College of Obstetricians and Gynecologists recommends IUDs and contraceptive implants as first-line contraception for sexually active teens.39 In patients who have had an abortion, those provided LARCs (such as an IUD, implant, or injections) are much less likely to require a repeat abortion within the next 2 years compared to those who receive short-acting contraceptives such as birth control pills.40 Therefore, ensuring that teens are informed about and offered LARC methods after an abortion is essential to helping them avoid a rapid repeat pregnancy.

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FEATURE

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