

## **In Vietnam, Telephone Follow-up for Medication Abortion Is Feasible**

Telephone follow-up using a semiquantitative pregnancy test is a feasible, safe and acceptable alternative to clinic follow-up after early medication abortion, suggests a randomized controlled trial conducted in Vietnam.<sup>1</sup> Eighty-five percent of women followed up by telephone were able to avoid returning to the clinic, and the complication rate did not differ between women monitored by telephone and those who returned to the clinic for an examination and ultrasound. In addition, telephone follow-up was highly sensitive and specific for detecting ongoing pregnancy, and was associated with a sharply reduced risk of women being lost to follow-up.

The trial, conducted at four Vietnamese hospitals, examined outcomes among women who underwent an early medication abortion (i.e., within nine weeks' gestation) using oral mifepristone followed by buccal misoprostol taken at home. The women were randomly assigned to clinic follow-up (standard care) or telephone follow-up. Those in the former group were asked to return two weeks after mifepristone administration for a clinic visit, during which their abortion status was assessed by interview, bimanual examination and transvaginal ultrasound. Women in the telephone follow-up group took a semiquantitative urine pregnancy test before swallowing the mifepristone to determine their approxi-

mate baseline level of human chorionic gonadotropin (hCG), and were given a second test kit and a symptom checklist to complete at home before a follow-up call two weeks later. Clinic staff reviewed the results during the call and asked women who screened positive for ongoing pregnancy (by answering “yes” to any of the three checklist questions or having a pregnancy test that was invalid or showed an increase or no change in hCG level) to return to the clinic. The investigators compared characteristics of the two study groups using various bivariate tests, calculated relative risks for abortion outcomes and assessed the sensitivity and specificity of telephone follow-up for detecting ongoing pregnancy.

The 1,433 study participants were 27 years old, on average. Most had at least a secondary school education, and two-fifths had attended university. About one in three had previously had a surgical abortion, and one in six had previously had a medication abortion.

The vast majority of women in each group (95%) were found to have had a complete medication abortion and did not require or have a surgical evacuation. Of the remaining women, about half had a surgical evacuation for an ongoing pregnancy and half had an evacuation for other reasons (retained products of conception, missed abortion, heavy bleeding or patient’s request). None of these outcomes differed between groups. However, only 1% of women in the telephone follow-up group could not be reached for their scheduled call, whereas 8% of their counterparts in the clinic follow-up group failed to return for their appointment; this difference translated to a 90% lower risk of loss to follow-up in the former group (relative risk, 0.1).

Among women who had not made an interim visit to the clinic, 85% of those in the telephone follow-up group screened negative for ongoing pregnancy during their call and were released from the study because no additional follow-up was necessary. The remaining 15% were asked to return to the clinic, and all did. Three-fourths of these women had not had a decline in hCG levels on the pregnancy test, had had at least one “yes” response on the symptom checklist or both; the others had screened negative on both tests but were asked to return because of persistent bleeding, anxiety, pregnancy symptoms not covered by the checklist or other reasons.

The combination of the pregnancy test and the symptom checklist during telephone follow-up had 93% sensitivity and 91% speci-

ficity for detecting ongoing pregnancy. Use of the pregnancy test alone had the same sensitivity, but higher specificity (96%). Of the 14 women in the telephone follow-up group who had an ongoing pregnancy, 10 had positive results on both the pregnancy test and checklist, three had only a positive pregnancy test and one had negative results on both.

Nearly all women in the telephone follow-up group completed the pregnancy test and the checklist (99% and 98%), and most of these women reported that these tasks were easy (98% and 97%). Eighty-eight percent of women who were followed up by telephone said they would prefer the same approach if they ever needed another medication abortion; however, only 40% of those in the clinic follow-up group indicated that they would prefer telephone follow-up to clinic follow-up in the future.

The researchers caution that the study’s results may not apply outside Vietnam or to women who are less well educated, and that

it is possible (although unlikely) that some women in the telephone follow-up group sought abortion care elsewhere. They note that telephone follow-up using the semiquantitative urine test alone was effective for identifying women with ongoing pregnancy, and that the addition of the symptom checklist provided no clear additional clinical benefit. Replacing routine clinic follow-up after early medication abortion with such a urine test would simplify care and might reduce costs for women and the health care system alike, the researchers maintain. “Such efforts may be especially beneficial in resource-poor countries, where clinics may be overcrowded and understaffed with limited access to serum hCG testing and transvaginal ultrasonography,” they conclude.—S. London

#### REFERENCE

1. Ngoc NTN et al., Acceptability and feasibility of phone follow-up after early medical abortion in Vietnam: a randomized controlled trial, *Obstetrics & Gynecology*, 2014, 123(1):88-95.