

WHAT YOU NEED TO KNOW

The Difference Between Medical Abortion and Emergency Contraceptive Pills

There is considerable confusion, even among experienced health care providers, about the difference between medical abortion (also known as “medication abortion” or “mifepristone”) and emergency contraceptive pills (also known as “morning-after pills”). Medical abortion terminates an established pregnancy; emergency contraceptive pills help prevent pregnancy.

According to general medical definitions of pregnancy that have been endorsed by ARHP, the American College of Obstetricians and Gynecologists,¹ and the US Department of Health and Human Services,² pregnancy begins when a pre-embryo completes implantation into the lining of the uterus.

What is medical abortion?

Medical abortion is the use of medications that can induce abortion. Currently three treatment regimens are available in the United States for this purpose: mifepristone combined with misoprostol, methotrexate combined with misoprostol, and misoprostol by itself.^{3,4} Regimens that contain mifepristone and misoprostol are more commonly used because they are more effective and predictable.^{5,6} In the small percentage of cases in which medical abortions fail, other abortion procedures are required to end the pregnancy.

Medical abortion (medication abortion or mifepristone) terminates an established pregnancy.

Emergency contraceptive pills help prevent pregnancy.

What are emergency contraceptive pills (ECPs)?

Women may use ECPs as a means of preventing pregnancy after unprotected intercourse. ECPs are especially useful in cases of unanticipated sexual activity, contraceptive failure, or sexual assault. Nearly half of America’s annual average of 6.3 million pregnancies are unintended; widespread use of emergency contraception could prevent an estimated 1.7 million unintended pregnancies and 800,000 abortions each year.⁷ ECPs contain hormones that reduce the risk of pregnancy if started within 120 hours of unprotected intercourse. The treatment is more effective the sooner it begins. Plan B® is currently the only product marketed specifically as an emergency contraceptive pill in the United States. Preven® is still available in some pharmacies but is no longer being manufactured. Certain oral contraceptives taken in increased doses also may be used as ECPs.

References

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Medical Abortion		Emergency Contraceptive Pill
Other names	Medication abortion Methotrexate Mifeprex® Mifepristone RU-486	Morning-after pill Plan B® Preven
Usage	The FDA-approved regimen of mifepristone is 600 mg orally followed 2 days later by misoprostol 400 µg orally for women up to 49 days' gestation. A small percentage (2% to 5%) of women may abort before taking misoprostol, ^{8,9,10} so it is reasonable to administer Rh immune globulin to appropriate patients at the time of the first visit. Evidence supports the safety and efficacy for women up to 63 days' gestation with use of vaginal misoprostol. ¹¹ For women beyond 49 days' gestation, the use of vaginal, rather than oral, misoprostol increases the efficacy of medical abortion. ¹²	ECPs are generally taken in two doses, ¹² hours apart. Levonorgestrel-only regimen: 1.50 mg levonorgestrel in a single dose or in two doses of 0.75 mg taken up to 12 hours apart. Combined estrogen-progestin (Yuzpe) regimen: two doses of 100 mcg ethinyl estradiol plus 0.50 mg of levonorgestrel taken 12 hours apart. ECPs are effective up to 120 hours after intercourse. ¹³ Treatment should be initiated as soon as possible after intercourse, because efficacy declines substantially with time. ^{14,15}
Mechanism of Action	Mifepristone ends pregnancy by blocking the hormones necessary for maintaining a pregnancy. Methotrexate stops the implantation process from continuing. Misoprostol causes the uterus to contract and empty.	Depending on the time during the menstrual cycle that they are taken, ECPs may inhibit or delay ovulation, inhibit tubal transport of the egg or sperm, interfere with fertilization, or alter the lining of the uterus inhibiting implantation of a fertilized egg.
Safety	Millions of women around the world have used medical abortion safely. ³ Among the estimated 400,000 US women who have used mifepristone for early abortion, three deaths have occurred—two from rare infections associated with childbirth and abortion and one from a ruptured ectopic pregnancy. Three infection-related deaths have been reported to the US Food and Drug Administration; the death rate is comparable to that of surgical abortion and miscarriage and lower than the death rate from a delivery.	Millions of women around the world have used ECPs safely. ^{16,17} There are no evidence-based contraindications for either combined or progestin-only ECPs. ECPs will not induce an abortion in a woman who is already pregnant, nor will they affect the developing pre-embryo or embryo. ¹⁸
Efficacy	Medical abortion regimens are highly effective at ending very early pregnancies. Complete abortion will occur in 92-96% of women who receive the methotrexate regimen. Complete abortion will occur in 96-97% of women who receive the mifepristone regimen. ⁴	ECPs are very effective at reducing the risk of pregnancy. ECPs reduce the risk of pregnancy when taken up to 120 hours after unprotected intercourse, but the sooner the dosing begins, the more effective the treatment.
Side Effects	Most common side effects are similar to those of a spontaneous miscarriage (abdominal pain, bleeding, and gastrointestinal distress). ^{19,20}	Most common side effects include nausea and vomiting. Breast tenderness, fatigue, irregular bleeding, abdominal pain, headaches, and dizziness may occur. Side effects are less common using progestin-only ECPs than combination hormone ECPs.
Cost	In the United States, the price of medical abortion ranges between \$250 and \$575, which includes two or three office visits, testing, and exams.	In the United States, the price of ECPs ranges from \$10 to \$50 per use.
Additional Resources	www.abortionaccess.org www.earlyoptions.org/mifepristone.html	www.arhp.org/ec www.not-2-late.com

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²⁰ Schaff EA, Fielding SL, Westhoff C, et al. Vaginal misoprostol administered 1, 2, or 3 days after mifepristone for early medical abortion: a randomized trial. *JAMA* 2000;284:1948-1953.