Postpartum Contraception in Unintended Pregnancy and Prevention Care
Colette’s Contraception (Patient Situation #2)

The Patient

Colette is 20 years old and gave birth three months ago to a baby boy. At the time of discharge she was advised to call her midwifery office to discuss her contraceptive options. Her vaginal soreness resolved, her bleeding stopped, and she resumed intercourse at six weeks postpartum, using lactational amenorrhea. She breastfed exclusively for the first 6 weeks and began supplementing with formula to ease her transition back to work.

The Setting

A women’s health clinic that provides comprehensive reproductive health care and related preventative health services, including a full range of contraceptive options that are available on site. A sliding fee scale is available for patients in need of financial assistance.

What Happened

Colette scheduled a six-week postpartum visit, but she missed the appointment because she did not have transportation to the clinic. Colette was able to make another appointment and secure transportation at eight weeks postpartum. When she arrives, Colette tells the nurse that she became nervous about getting pregnant and used an over the counter pregnancy test at home. The test was positive. The nurse asks Colette how she feels about a pregnancy and Colette states that she is not ready to have another baby right now. The nurse then performs the urine pregnancy test and confirms the positive pregnancy test.
PREGNANCY TEST HISTORY

Name: _________Colette_________ Age: _____20_____

I identify as:  X Female  __Male __Transgender __Specify: __________________________

Gender pronoun: X She  __He  __Specify: __________________________

Would you like a companion in the room with you for your visit?
 __Yes     X No     If so, whom? __________________________

With whom can you talk with for support?
 X Partner(s)  X Parent(s)  __Family Member(s)  X Friend(s)  __No One

Pregnancy History:

Pregnancies _______1_____
Births _______1_____
Miscarriages _______0_____
Abortions _______0_____

Have you already taken a pregnancy test? X Yes  __No
What were the results _______Positive_____

When was the first day of your last menstrual period? _______4 weeks ago_____

Are you using any form of birth control? X Yes __No
If so, what are you using? ___I’m breastfeeding_____

If you are pregnant, which options would you like to discuss?
 X Adoption     X Abortion     X Parenting

Case: Colette is a 20-year old woman who gave birth to a baby boy 13 weeks ago. She
missed her 6-week postpartum visit. She resumed intercourse at 6 weeks postpartum
using lactational amenorrhea as contraception. Her menses returned at 9 weeks
postpartum and was light. Colette took a home pregnancy test that was positive. She is
open to discussing abortion, adoption, and parenting.

Common Concern: “I don’t think I can have another baby right now.”

Personality: Just returned to work full time. Loves hiking and cooking.
Giving pregnancy test results

When giving pregnancy test results it is important for nurses to understand that the results belong to the patient and it is the nurse’s responsibility to provide the results and what they mean without bias. Hearing the results of a pregnancy test can be a life changing moment; women may be delighted, regretful, anxious, and sometimes ambivalent about the being pregnant. Since it is difficult to predict how someone will feel when receiving the results, it is important not to congratulate the patient and to allow time for the information to “sink in” before asking if she would like more information.

This presentation, Giving Pregnancy Test Results: A Primer for Nursing Students, serves as a guide for nursing students on giving pregnancy test results, identifying immediate health concerns, providing referrals, and an overview of laboratory pregnancy tests is provided. Recommendations are given on specific questions to ask and counseling language to use when providing negative and positive test results, and working with a patient who is ambivalent about the test results.

Colette’s Contraception (Patient Situation #2)

What happened (continued)

Since Colette has been breastfeeding and supplementing with formula, her periods have been highly irregular. She is uncertain when she became pregnant.
How can the nurse confirm the pregnancy and determine length of pregnancy?

Health providers use the first day of the last menstrual period (LMP) to date pregnancies. One reason for not dating pregnancies from the day of conception is that most women find it difficult to know the exact date of conception and the first day of LMP is more typically known. Early pregnancy ultrasounds that use a crown rump measurement (which can generally be calculated only to 14 weeks) are the most accurate for assessing the gestational age of pregnancies.

Pregnancy wheels are commonly used to determine the due date or estimated date of confinement (EDC). Wheels are based on Nagel's rule which estimates the EDC by adding one year, subtracting three months, and adding seven days to the first day of a woman's LMP. The result is approximately 280 days (40 weeks) from the LMP. Wheels may vary by a day or two or it is easy for a health care provider to miss read a wheel by a day or two. Electronic calculation is considered more accurate.

There are several types of pregnancy tests. Immunometric tests, also known as ELISA or monoclonal antibody tests, have become the most common type of test, both at home and in clinical settings, because they are easy to use, non-invasive, highly sensitive and inexpensive. Results can be accurate as early as the time of the missed period. Some serum tests are accurate within 7-10 days of conception. It is rare to have false negatives, and even rarer to have false positive tests. However, it is important to understand that if a test is negative, it may not be a false negative but may simply be too early in pregnancy to be positive. If this is a concern, the test must be repeated in a few days to a week.

The accuracy of test results is enhanced in very early pregnancy and in first morning urine collection as a more concentrated specimen will have higher levels of hCG. Home pregnancy tests may have a decreased accuracy rates related to specimen collection techniques (e.g. residue in collecting container), errors in timing or errors in interpretation of the test. An older type of test, agglutination tests, are no longer common because monoclonal antibody tests provide positive results much earlier and at comparable cost, although the agglutination tests remain available for specific indications.

Serum monoclonal antibody pregnancy testing are more than 99% accurate in diagnosing pregnancy. Beta HCG hormone can be measured quite accurately as a qualitative test (positive or negative) or as a quantitative test with a specific value of milli-international units per milliliters. Serial quantitative tests are repeated every 2 to 3 days in special conditions of pregnancy: to assess the viability of a pregnancy, to determine if a miscarriage is occurring or to diagnosis an ectopic pregnancy. Beta HCG testing is more expensive than urine testing and in most settings, must be ordered through a laboratory.
Colette’s Contraception (Patient Situation #2)

What happened (continued)

When Collete discussed her reproductive life plan, she confirms that she does not want another baby right away. The nurse facilitates non-directive, patient center early pregnancy decision-making so Colette can make a choice that feels right to her.

What are Colette’s options?

In this case, Colette has expressed that she does not want to have another baby right now, so the nurse must be prepared to facilitate patient-centered, non-directive options counseling after delivering the pregnancy test results. Please see the Options Counseling Nursing Education Module for further information and skills building for options counseling.

Colette could decide to have an abortion, she could continue with the pregnancy, or she could make an adoption plan. Options Counseling for Unintended Pregnancy is a presentation designed to give nurses and APRNs information on attitude, skills, and knowledge needed to provide options counseling to patients who experience unintended pregnancy.

Colette has already indicated that she does not want to have another baby, so the she and the nurse discuss adoption and abortion. Colette indicates she is not interested in the option of adoption. Since Colette is less than 10 weeks pregnant she can chose to have a medication abortion or an aspiration procedure. In the article Mifepristone for Medical Abortion: Exploring a New Option for Nurse Practitioners, Taylor and Hwag introduce Mifespristone and provide clinical considerations including a chart comparing regimens and a chart comparing medication abortion with vacuum aspiration. Note that the FDA has extended medication abortion to 70 days since the publication of this article.
**Facts About Mifepristone (RU-486),** a fact sheet from the National Abortion Federation (NAF), discusses medication abortion and defines Mifepristone, a medication that blocks the action of progesterone, discusses how it works, effectiveness as an abortifacient when combined with Misoprostol, possible side effects, and what women can expect when using it. Another fact sheet *What is Medical Abortion?* from NAF provides detailed information on the medications including how they work, how long they take, possible complications, and follow-up care for medication abortions.

In the article *Care for Women Choosing Medication Abortion* Taylor et al. discuss the nurse practitioner’s role in providing medication abortions and use case studies to present counseling, complications and potential side effects, and confirming complete abortion.

In “Part 2 — Tools for Clarifying Our Values” of *The Abortion Option* from the National Abortion Federation there are exercises designed to help nurses critically examine factors that might influence their beliefs about parenting, adoption, and abortion and, for some, their desire to work in abortion care. There are tools and case studies for clarifying values related to abortion, views about the role of health care providers, and to identify and examine potential biases. Please also visit the [Professional Ethics Nursing Education Module](#) for more information and values clarification related to the role of nurses in providing abortion care.

### What happened (continued)

Colette decides to have a medication abortion. Because the site does not offer medication abortion, the nurse offers to make a referral to a facility where Colette can receive this health care. Colette wants to discuss the unintended pregnancy with her partner. She is certain that he will agree that they are not ready to have another baby at this point. Colette and the nurse make a plan to speak on the phone the next day.

The next morning Colette calls the nurse and requests a referral. Local clinics vary as to how quickly they can offer Colette an appointment for an early abortion using medication. The nurse is familiar with the resources in the community and knows which local facility can usually offer an appointment within 24 hours. The nurse is able to schedule an appointment for later that day.
Making abortion referrals

When a woman chooses to have an abortion, and if the health center cannot do the procedure on site, it is essential to provide her with a referral that will facilitate her getting the care she needs quickly. One major barrier to providing effective referrals is that clinicians are unaware of where abortion services are offered. In this case, the nurse is familiar with the local facilities and even knows which one will be able to schedule an appointment the soonest. This web page from the National Abortion Federation includes an interactive map that gives state-specific information on abortion services and clinic contact information for each state.

Another barrier to providing abortion care and/or referrals is nurses’ willingness to participate. A small qualitative study in 2004 showed that more than one third of physician respondents reported that they had to postpone abortion services due to a lack of nurses willing to assist (Kade et al., 2004).

The culture of a work environment can have an impact on a nurse’s decision to participate or not participate in the care of a patient. In some settings, the nurse who agrees to provide abortion care may experience negative comments from her/his colleagues. A 2008 review of the literature by Lipp on nurses who participate in abortion care reports that nurses who participate in abortion care, as well as those whose refused, had been criticized by their co-workers.

To provide high quality patient care, it is vitally important that nurses are either able to participate in the care of the patient or to provide effective referrals so the patient can receive the health care she needs as soon as possible.

Colette’s Contraception (Patient Situation #2)

What happened (continued)

The nurse schedules a follow-up visit for Colette for an IUD insertion in one week. In the meantime, Colette is worried about breastfeeding once she takes the medication for the abortion.
Making abortion referrals

According to TOXNET of the U.S. National Library of Medicine limited information indicates that breastfeeding need not be interrupted after a single dose of mifepristone. Misoprostol is a prostaglandin E1 analogue, and prostaglandin E1 along with other prostaglandins, appear normally in colostrum and milk. Because of the extremely low levels of misoprostol in breastmilk, amounts ingested by the infant are trivial and would not be expected to cause any adverse effects in breastfed infants. No special precautions are required.

What if Colette missed her postpartum visit altogether and found out she was four months pregnant?

The nurse can provide Colette with information and nonjudgmental options counseling whereby she explains the benefits and risks to having an abortion procedure (dilation and evacuation), continuing with the pregnancy, or making an adoption plan. Truly non-directive options counseling can be difficult because of one’s own beliefs, especially when there is a strong feeling that we know what the best option would be for a woman. In Options Counseling: Techniques for Caring for Women with Unintended Pregnancies Singer (2004) provides guidance for clinicians to examine their own beliefs and values to improve their skills in providing nonjudgmental and nondirective options counseling for women experiencing unplanned pregnancy.
References


