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Editorial

Medical abortion for an early pregnancy

Unintended or incidental pregnancy is still a major health issue because it poses appreciable medical, emotional, social, and financial costs on women, their families, and society [1]. Although surgical abortion through either vacuum aspiration or dilatation and curettage has been a well-known method to successfully manage an early pregnancy since the 1960s, the risk of the surgical procedure and anesthesia is often considered. Alternative therapy, including medical treatment, for early pregnancy termination, is always welcomed. The combined use of misoprostol, a prostaglandin analog that had a strong uterotonic effect in the 1970s, and mifepristone, an antiprogestogen, which was used to block the receptors for progesterone and glucocorticosteroid and increase the sensitivity of the uterus to prostaglandins in the 1980s, has been found to be more effective than single agents [2]. Therefore, the use of medical abortion has the potential to expand abortion services and expand the woman's choice of abortion method and experience [2], although there is still inadequate evidence to comment on the acceptability and side effects of medical compared with surgical first-trimester abortions [3].

Because the use of medical abortion to terminate early pregnancy is already widely available in some countries and increasingly available throughout the world, it is important to identify the best available agents and regimen for use. In this issue, Dr. Li et al [4] decreased the dose of misoprostol from 800 to 600 μg and wanted to minimize the potential side effects of medical abortion after the use of a combination of mifepristone and misoprostol, and the results were impressive. For example, the incidence of cramping was decreased from nearly 100% to 72%, compared with the conventional dosage of 800 μg reported in the literature. In addition, gastrointestinal discomfort, such as nausea and vomiting, was also dramatically decreased (32% *vs.* 60% and 15% *vs.* 30%, respectively). The striking effect was dizziness. The incidence in the present study was less than 10% compared with more than 40% in previous studies [5,6]. The success rate of the combination of 600 μg misoprostol and 200 mg mifepristone in this study was around 95%, which was not significantly inferior to that of previous studies [5,6]. It is reasonable to suppose that this combination might be an appropriate treatment for women at less than 49 days of gestational age in Taiwan, although some questions need further clarification.

A head-to-head comparison between the combination of 600 μg misoprostol and 200 mg mifepristone and the combination of 800 μg misoprostol and 200 mg mifepristone would be worthwhile. In addition, it is not clear whether the presence or absence of a positive fetal heart will affect the occurrence of side effects or therapeutic outcome. Finally, it is unclear whether this regimen can be applied to more advanced gestational age, such as 63 days of gestational age. In fact, the comparison between the present study and other published studies might not be fair because the populations of the other studies, except for the study by Murthy et al [5], had a more advanced gestational age [6,7].

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