

gastrointestinal and urinary tracts, and musculoskeletal and neurological systems. It often has psychological components. For some women, after years of diagnostic testing and inadequate relief from therapeutic measures, chronic pelvic pain itself becomes the diagnosis.

Irritable bowel syndrome (IBS), defined by criteria that have been established by experts in the field, can present with chronic pelvic pain as well as alterations in bowel habitus. IBS accounts for more than 10% of all digestive system diagnoses and is correlated with many gynecologic diagnoses. IBS has been associated with dysmenorrhea, dyspareunia, and endometriosis. The condition is diagnosed in 35% to 40% of women with chronic pelvic pain and in nearly 50% of women undergoing laparoscopy for pelvic pain.

This cross-sectional study examined characteristics of IBS in women with chronic pelvic pain, to determine if there are unique signs and symptoms to aid in diagnosis. The ability to clearly delineate similarities and differences between the two conditions would help to make the diagnostic picture clearer. This, in turn, should ultimately lead to more timely diagnosis and effective treatment.

In this study, 35% of women with chronic pelvic pain met the criteria for a diagnosis of IBS. Age 40 or older, muscular back pain, depression, higher levels of symptoms, pain in 6 or more sites, and a history of physical abuse were all associated with a diagnosis of IBS. Of note in this study is the high prevalence of many correlates of pelvic pain. Two thirds of women, whether or not they had IBS, reported "physical discipline" in childhood, one third reported childhood sexual abuse, and more than one quarter reported a history of rape. Physical and sexual abuse in adulthood were also reported by women in the overall group (34% and 16%, respectively), but both were reported more frequently in the women with IBS. Less than 20% of the women in the study had a clinical diagnosis of endometriosis, and 30% had clinical diagnosis of adhesions, demonstrating that the etiology of chronic pelvic pain may be secondary to other factors in a significant percentage of women with the condition. Women with IBS reported longer histories of chronic pelvic pain and more widespread pain than women without a diagnosis of IBS.

Given the very high prevalence of IBS coexisting with chronic pelvic pain, noted in this and other studies, it seems prudent to evaluate all women presenting pelvic pain for IBS. The Rome II criteria are consensus-established symptoms and include at least 12 weeks or more (which need not be consecutive) in the preceding 12 months, of abdominal discomfort or pain that has 2 of 3 features relieved by defecation, onset associated with a change in frequency of stool, and/or onset associated with a change in form (appearance) of stool.

If a diagnosis is made, treatment for IBS may help relieve symptoms. The associations of both chronic pelvic pain and IBS with a history of physical and sexual abuse

speak to the need for sensitive screening and referral for these problems as well.

ADDITIONAL REFERENCE

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MISOPROSTOL AS A SINGLE AGENT FOR INDUCTION OF MEDICAL ABORTION

Borgatta L, Mullally B, Vragovic O, Gittinger E, Chen A. Misoprostol as the primary agent for medical abortion in a low-income urban setting. *Contraception* 2004;70:121–6.

Use of medical abortion has increased since the approval of mifepristone in the United States in 2000. According to the authors of this study, an estimated 200,000 medical abortions have been performed to date in the United States. The most common method used for induction of abortion is a regimen of mifepristone in combination with misoprostol. This regimen is approved by the U.S. Food and Drug Administration. Mifepristone is not always available, especially for women with limited access to health care services (such as poor women or undocumented immigrants). In contrast, misoprostol is readily available and inexpensive. Indeed, in countries where abortion is illegal or available under very limited circumstances, misoprostol is apparently an often-used method for self-induced abortion. A 1998 study in Brazil found that, among women admitted to hospitals for pregnancy loss, approximately half reported terminating their pregnancies, and of these, 66% said they used misoprostol to self-induce abortion.¹ In some communities in the United States, where many women come from such countries and local pharmacists sometimes dispense prescription drugs over the counter (as would be done in their native countries), clinicians may be aware of similar use of this drug.

This retrospective chart review describes the outcomes of 440 women using misoprostol alone for medical abortion in a large urban institution in the United States. Women were eligible for this protocol if they were less than 8 weeks pregnant and had no medical contraindications. Two doses of 800 mcg misoprostol were administered vaginally 24 hours apart. The first dose was administered in the clinic; the second dose was dispensed to the woman with instructions for vaginal use at home the following day. The vast majority of women (more than 80%) used the second dose, even though the median time to abortion was 8.5 hours, and 75% of women had passed tissue by 24 hours. Follow-up ultrasounds were done 2 to 3 days after administration of the drug to ensure completion of the medical abortion.

Outcomes were documented for 411 of the women who received this regimen. Nearly 91% completed the abortion without additional intervention after the 2 doses of misoprostol; 9% had a uterine aspiration to complete the abortion. Not all of the aspiration procedures were medi-

cally necessary (women were free to request a surgical intervention electively); the authors estimate that approximately 2.7% of the aspiration procedures were necessary for reasons of persistent vaginal bleeding, incomplete abortion, or continuing viable pregnancy more than 2 weeks after the first dose of misoprostol. The rate of viable pregnancy persisting after 2 weeks was less than 1%. Similarly, the rate of medically necessary aspiration following mifepristone-misoprostol abortions ranges from 0.9% to 1.6%,² and the completion rate is about 96%.³

Use of misoprostol alone for medical abortion is not standard, although the authors of this report state that it has been the primary agent used for medical abortion in their institution since 2001. It is approved by the FDA for use in medical abortion only as part of a regimen that includes other drugs. Clinicians may encounter women who have used misoprostol to self-induce abortion, and in such cases, should ensure that the abortion is complete. Prenatal exposure to misoprostol is associated with an 8-fold increase in vascular disruption defects in infants (Moebius syndrome and limb defects).⁴ These are uncommon defects: limb

defects due to vascular disruption are estimated to occur in approximately 0.22 per 1000 infants; an 8-fold increase would raise the rate to 1 to 2 per 1000.⁵

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