Early Abortion in Ontario: Options and Costs

To the Editor:

I read with interest the report by Limacher et al.[1] I believe the authors did an outstanding job of evaluating cost differentials based on societal, provider, and patient perspectives. The report did have two methodologic flaws that I believe the authors should address for clarification; addressing these issues will strengthen the integrity of the work.

First, the hypothetical female patient could have been as much as 63 days' gestation. Accordingly, the efficacy of methotrexate and misoprostol is significantly overstated. The efficacy rates the authors quote for this regimen apply to women up to 49 days' gestation. I believe that the authors meant to state that their hypothetical patient was up to 49 days' gestation. A hypothetical patient of up to 63 days' gestation could be used to compare surgical abortion and the mifepristone and misoprostol regimen; this would require greater stratification of the cost assessments.

Second, the authors assumed equal indirect costs for methotrexate and misoprostol, and mifepristone and misoprostol regimens. One of the advantages of the mifepristone and misoprostol regimen is that it works much more quickly than the methotrexate and misoprostol regimen[2]; the authors even state so in their own estimates of first misoprostol dose efficacy (92.5% and 72.8%, respectively). Accordingly, fewer office visits will be required for the mifepristone and misoprostol regimen. The differences in indirect costs can be estimated, as we have shown in a cost analysis of mifepristone and misoprostol versus misoprostol alone.[3]

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2. Creinin MD, Potter C, Holovanisin M, Janczukiewicz L, Pymar, HC, Schwartz JL, Meyn L. Mifepristone and misoprostol and methotrexate and misoprostol in clinical practice for abortion. Am J Obstet Gynecol 2003;188:664–9.
3. Creinin MD, Shore E, Balusubramanian B, Harwood B. The true cost differential between mifepristone and misoprostol compared to misoprostol alone for medical abortion. Contraception 2005;71:26–30.

Competing Interests: Dr Creinin receives compensation from Danco Laboratories, LLC for providing third party telephone consults to clinicians who call for expert advice on mifepristone.

In Response

To the Editor:

We are gratified by Dr Creinin's interest in our article,[1] and we appreciate his thoughtful comments.

He quite correctly notes that the efficacy of methotrexate is such that from 49 days to 63 days' gestation only the mifepristone medical option and the two surgical options are available to our hypothetical patient. We chose 63 days as the maximum gestation for which there would be *both* medical *and* surgical options for early abortion, even though late in that time period only one of the medical options would be available. This is an important clarification and we thank Dr Creinin for drawing our attention to it.

We have no disagreement with Dr Creinin's observation that the indirect (time loss) cost associated with the mifepristone regimen would likely be less than with methotrexate because the former agent acts more quickly. In fact, we acknowledged in the article that our model did not capture this relative indirect cost advantage of mifepristone. Having stated this caveat, however, we felt there was merit in grounding our time loss estimates in published empirical data, even if the absence of such data for mifepristone led to an assumption of equal time losses for mifepristone and methotrexate in the model.

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