

Protocol for Medication Management of Early Pregnancy Loss: Mifepristone/Misoprostol

Eligibility

Patients with a nonviable pregnancy up to 12 weeks gestational age are eligible for medical management.

Non-viable pregnancy is diagnosed by ultrasound and/or falling quantitative hCG levels. Gestational age is based on ultrasound findings rather than last menstrual period (LMP). Ectopic pregnancy must be excluded, as medical treatment for ectopic pregnancy differs from that of nonviable intrauterine pregnancy.

Exclusionary criteria include severe anemia, allergy to mifepristone or misoprostol, bleeding disorders, and liver disease.

Procedure

1. **Labs:** Necessary labs include Rh screen, hematocrit, and quantitative serum hCG level. If prior knowledge of Rh status is available, Rh typing need not be repeated. Serum hCG level may be deferred in patients who can follow-up with ultrasound, if the initial diagnosis was made by ultrasound. Consider gonorrhea and chlamydia screening for those at risk.
2. **Counseling:** Clinically stable patients should be counseled on all options for managing early pregnancy loss including expectant, medical management, and uterine aspiration.
3. **Consent forms:** For patients who choose medical management with mifepristone and misoprostol, the patient and clinician must sign the [Danco mifeprex patient agreement form](#) (required by FDA). Consider signing an additional, [evidence-based consent form](#) explaining use of mifeprex for pregnancy loss rather than abortion.
4. **Mifepristone:** One tablet of mifepristone 200 mg should be dispensed in the office as it is not available from commercial pharmacies. The patient should be instructed to swallow the mifepristone at a convenient time. (It does not need to be swallowed in the office.) Record the mifepristone NDC number in the medical record. If mifepristone is not available, the patient may begin the treatment with misoprostol alone.*
5. **Misoprostol:** Prescribe or dispense four tablets of 200 mcg misoprostol (800 mcg total) for the patient to use vaginally 24 hours following mifepristone. The patient should be instructed to lie down for 30 minutes following insertion of misoprostol. The misoprostol can be dispensed in the office, if available, or prescribed through a pharmacy. Consider prescribing a second dose of 800 mcg of misoprostol in case heavy bleeding does not occur within 12-24 hours of the first dose.
6. **Pain medications:** A prescription for ibuprofen 600 mg should be offered to the patient. Instruct the patient to take ibuprofen prior to misoprostol insertion, and then every 6

hours as needed for pain. A small supply of low-dose narcotic may also be prescribed for severe breakthrough pain.

7. **Patient Instructions** (see [RHAP take home instructions](#) to give to patient):
The patient should be given contact information for how to reach their provider and be provided with guidelines regarding when to call. Patients should be instructed to call for:
 - a. Heavy bleeding, defined as soaking through two thick maxi pads per hour for 2 hours in a row;
 - b. Fever or purulent vaginal discharge; or
 - c. Uncontrolled pelvic cramps or pain not improved with medication.

The patient does not need to bring products of conception back to the provider and should not be instructed to do so.

8. **Follow up:** Patients should schedule follow-up to ensure a complete passage of tissue in one of two ways: 1) repeat quantitative serum hCG level following passage of tissue (a drop of 80% by 7 days) or 2) a transvaginal ultrasound with absence of sac. Note: if one of these criteria has been met, no further follow-up of serum hCGs is warranted.

If no passage of tissue occurs (the patient has not bled as much as a period) within 12-24 hours of taking the misoprostol, the patient may use a second vaginal dose of 800 mcg misoprostol. If no passage of tissue occurs by 48 hours, the patient may resume expectant management or be referred for uterine aspiration.

9. **Documentation:** A chart note must be completed, to document the above and ensure a follow-up plan.

*If mifepristone is not available, misoprostol alone can be used, with a success rate of 67% instead of 84% by 2 days.

References

Prine LW, MacNaughton H. Office Management of Early Pregnancy Loss. Am Fam Physician. 2011;84(1):75-82.

Schreiber, CA et al. Mifepristone Pretreatment for the Medical Management of Early Pregnancy Loss N Engl J Med 2018; 378:2161-2170