Protocol for Medication Management of Early Pregnancy Loss:
Misoprostol Only

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. Patients who choose medical management with misoprostol alone should understand that mifepristone/misoprostol is more effective for treatment of nonviable intrauterine pregnancy.

3. **Misoprostol:** Prescribe or dispense four tablets of 200 mcg misoprostol (800 mcg total) for the patient to use vaginally. The patient places 800 mcg of misoprostol in the vagina at home at a convenient time. The patient should be given a second dose of 800 mcg of misoprostol in case passage of tissue does not occur with the first dose.

4. **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.

5. **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.

6. **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.

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

References

Chung TKH et al. Spontaneous abortion: a randomized, controlled trial comparing surgical evacuation with conservative management using misoprostol. Fertility and Sterility, 1999, 71(6)1054-1059.

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

Wood SL, Brain PH. Medical management of missed abortion: A randomized clinical trial. Obstetrics and Gynecology, 2002, 99(4)563-566.