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DEPARTMENT OF OBSTETRICS & GYNECOLOGY

Title: **Medical management of early pregnancy loss**	**Protocol**

SCOPE/APPLICABILITY:

This protocol applies to women with early pregnancy loss (also called miscarriage, missed abortion and anembryonic pregnancy) who desire medical management. Medical management of early pregnancy loss should occur in OB Triage or the UNM Center for Reproductive Health because mifepristone is readily available in both places.

- The combination of mifepristone and misoprostol is more effective than misoprostol alone; all women desiring medical management should receive the combination treatment.
- Misoprostol alone may be sufficient for some women, but data on which women are currently lacking.
- For women who desire medical management, uterine aspiration (suction D&C) is used as a back-up for removal of the intrauterine products of conception if complete expulsion does not occur with medical treatment in a timely fashion.

Women who desire uterine aspiration for management of early pregnancy loss should be referred to the UNM Center for Reproductive Health for same-day or next-day care. Women who are clinically unstable due to bleeding should be treated urgently with uterine aspiration in the operating room. Women who are bleeding heavily and clinically stable may be treated with uterine aspiration either in OB Triage or in the operating room.

DEFINITIONS:

Ultrasound diagnosis of early pregnancy loss:

- Embryo $\geq$ 7 mm with no heart motion
- Irregular gestational sac with mean sac diameter > 25 mm and no embryo
- Absence of embryo with heartbeat $\geq$ 2 weeks after a scan that showed a gestational sac without a yolk sac
- Absence of embryo with heartbeat ≥11 days after a scan that showed a gestational sac with a yolk sac

In the setting of declining serum beta hCG and no intrauterine pregnancy, please consult with Family Planning beta book fellow/attending.

Incomplete Pregnancy Loss

Note: A 2017 Cochrane review suggested that among women with incomplete tissue passage, use of misoprostol does not result in higher rates of complete evacuation over expectant management. At 7–10 days, success rates were 80–81% for misoprostol and 52–85% for expectant management. A shared decision making process is warranted when choosing between misoprostol or expectant management of incomplete pregnancy loss. Mifepristone is not indicated for medical management of incomplete pregnancy loss.

Eligibility:

Women are ineligible for medical management of early pregnancy loss in the following circumstances:

- Pregnancy loss measuring > 12 weeks by ultrasound
- Molar or ectopic pregnancy
- Hemoglobin < 9.5 mg/dL
- Bleeding disorder
- Coagulopathy or currently anticoagulated
- Poorly controlled hypertension (systolic BP >160 or diastolic BP >95)
- Clinically significant cardiovascular disease (angina, valvular disease, arrhythmia, or congestive heart failure)
- IUD in place (IUD must be removed prior to treatment)
- Uncontrolled seizure disorder (>1 seizure/week)
- Chronic systemic corticosteroid use
- Adrenal disease
- Sickle cell anemia with frequent/recent crises
- Glaucoma
- Known allergy/intolerance to mifepristone or misoprostol
- Any other condition, that in the opinion of the clinician, would contraindicate medical treatment

CONSULTATION:

Twenty-four hour consultation is available by calling the Division of Family Planning (Reproductive Health PALS) service at the University of New Mexico Hospital through UNM PALS (272-2000).

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PROCEDURES:

1. After diagnosis of early pregnancy loss, determination of clinical eligibility, and appropriate counseling:
    a. The patient must sign the Mifeprex Patient Agreement Form
    b. Administer 200mg mifepristone orally in OB Triage or in clinic.

2. Instruct the patient to place 800 mcg (4 tablets) of misoprostol in the vagina 24 hours after taking mifepristone.

3. Give the patient the following instruction sheets:
    a. Medical management of miscarriage (written instructions)
    b. How to take your pills (picture sheet)
    c. When to call (picture sheet)
    d. How much am I bleeding? (picture sheet)
    e. Mifeprex Medication Guide

4. Obtain Rh(D) blood type.
    a. Give Rh(D) immune globulin to women who are Rh(D) antigen negative and unsensitized within 72 hours of misoprostol administration.

5. Schedule follow up in 7-14 days to confirm miscarriage completion. At the follow-up visit:
    a. Obtain interim history
    b. Perform vaginal ultrasound and triage based on the results:
        i. No gestational sac in the uterus: treatment is complete and the patient should be given appropriate instructions; follow up as clinically indicated
        ii. Gestational sac present without cardiac activity: the patient may be given the following options:
            1. Uterine aspiration
            2. Expectant or medical management with follow-up arranged as indicated

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REFERENCES:

- ACOG Practice Bulletin: Early Pregnancy Loss, Number 150, May 2015
- ACOG Practice Bulletin: Prevention of Rh D Alloimmunization, Number 181, August 2017
- Schreiber CA, Creinin MD, Atrio J, Sonalkar S, Ratcliffe SJ, Barnhart KT. Mifepristone pretreatment for the medical management of early pregnancy loss. NEJM 2018;378(23)2161-2170.
- Kim C et al. Medical treatments for incomplete miscarriage. Cochrane Database of Systematic Reviews, January 2017. CD007223.

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APPROVAL

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