EARLY INTRAUTERINE PREGNANCY

Early intrauterine pregnancy failure: Outpatient management with misoprostol

SUMMARY: Missed abortion in the first trimester at less than 12 weeks 0 days estimated gestational age can be effectively managed with misoprostol (Cytotec).

Rationale: This document addresses misoprostol for the use of nonviable pregnancy management only and does not address medical abortion. Treatment options for pregnancy loss include expectant management, medical treatment or surgical evacuation. Serious complications are rare regardless of management. Treatment with misoprostol (prostaglandin E1 analogue) is useful in women who are interested in shortening the time to pregnancy expulsion but wish to avoid surgical management. Potential complications of misoprostol use include hemorrhage, infection and failure of procedure. Medical management for first trimester loss is not contraindicated in women with a history of cesarean section and available data suggest no significant increase in uterine rupture rates.

Misoprostol is considered a teratogen and congenital defects following early exposure can affect multiple organ systems. This is thought to be due to vascular disruption caused by uterine contractions. The overall risk of malformations/disruptions is estimated to be 1%. Therefore, certain diagnosis of pregnancy loss is critical prior to prescription of this medication for early pregnancy failure.

Eligible patients: Women diagnosed with definitive diagnosis of pregnancy loss in the first trimester. Women with prior cesarean section(s) and placenta previa are eligible for this management.

Contraindications:
- Viable pregnancy
- Any contraindication to prostaglandins or NSAID use
- Active bleeding
- Concern or evidence for invasive placentation
- Active inflammatory bowel disease
- Pelvic infection, sepsis, or shock
- History of clotting disorder or current use of anticoagulation
- Ectopic or molar pregnancy
- Gestational age ≥ 12 weeks (refer to protocol for management after first trimester)
- Inability to follow up or history of poor compliance

Technique:
First Trimester missed abortion (<12 weeks)- OUTPATIENT MANAGEMENT
- Nonviable pregnancy confirmed by usual criteria (ultrasound, beta HCGs)- includes embryonic demise, anembryonic demise or blighted ovum. (See document “Early Intrauterine Pregnancy: Transvaginal Ultrasound Diagnosis of a Nonviable Intrauterine Pregnancy Early in the First Trimester” for additional information)
- Counsel regarding options, and confirm patient desires medical management after surgical or expectant management offered
- Confirm documentation of Rh status (administer Rhogam if indicated)
- Provide prescription for misoprostol 200 mcg tablets, #8 dispensed, 1 refill, with detailed instructions for use.
• Provide prescription for pain medications if needed: primarily ibuprofen, consider Tylenol #3.
• Provide written instructions (in addition to verbal) to patient including expected side effects, bleeding precautions, clinic phone number, after-hours on call physician phone number.
• At home, patient inserts four 200 mcg misoprostol tablets (total dose 800 mcg) into posterior vaginal fornix and waits for 48 hours to pass tissue (Day 1). Alternatively, two 200 mcg misoprostol tablets (400 mcg) can be placed in each cheek (buccal route, 800 mcg total) for 30 minutes, swallowing the remainder at the end of 30 minutes.
  o Expected side effects include: nausea, vomiting, abdominal cramping, diarrhea, fever/chills
  o Patient should call for “heavy bleeding” defined as soaking two pads every hour for 2 hours
• If no bleeding occurs within 48 hours and patient tolerating medication without significant side effects, patient may repeat the same dose (Day 3)
• Follow up ultrasound should be performed in 7 days to ensure complete passage of tissue
• If incomplete abortion diagnosed at follow-up visit (e.g. tissue at os or bleeding with open os), suction D&C should be performed
• If gestational sac still within uterus by Day 8 after 2 x 800 mcg doses of misoprostol, patient should be offered D&C for failed medical management

Special Considerations:
• Common symptoms of pregnancy loss can also be found in normal gestation, therefore confirmation of loss is necessary prior to initiating treatment
• Women who are Rh(D) negative and unsensitized should receive Rh(D)Ig (Rhogam) within 72 hours of the diagnosis of pregnancy loss or first misoprostol administration
• Suggested single doses for incomplete abortions: 600 micrograms orally, 800 micrograms vaginally, or 400 micrograms sublingually.

References:

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