PREGNANCY LOSS AFTER FIRST TRIMESTER

Pregnancy loss after first trimester: Management with misoprostol

**SUMMARY:** Uterine evacuation in the setting of fetal demise beyond the first trimester (defined here as 12 weeks 0 days) can be effectively managed with misoprostol (Cytotec). Appropriate management depends on the estimated fetal gestational age at the time of demise. Inpatient care is recommended.

**Rationale:** This document addresses misoprostol for the use of nonviable pregnancy management only and does not address medical abortion. Treatment options for pregnancy loss beyond first trimester include medical treatment and surgical evacuation. Expectant management should be limited to gestations in the first trimester due to risks of hemorrhage and/or coagulopathy later in pregnancy. 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.

The optimal dose, schedule and route of misoprostol administration have not been established for medical management of second trimester pregnancy loss. The higher dosing regimens have been shown to decrease time to delivery. The most common complication with medical management of second trimester loss is retained placenta, which can occur in up to 50% of cases. Other complications include hemorrhage, infection and failure to evacuate the uterus. Medical management with misoprostol is NOT contraindicated in women with a second trimester loss (up to 28 weeks 0 days estimated gestational age) and history of cesarean section or those with placenta previa. Available data suggest no significant increase in uterine rupture rates for women with prior cesarean, although women with placenta previa should understand the increase in the risk of hemorrhage and higher likelihood for transfusion of blood products. Guidelines for misoprostol use in second trimester nonviable pregnancies are extrapolated from the Society for Family Planning guidelines on second trimester abortion.

**Eligible patients:** Women diagnosed with pregnancy loss beyond the first trimester. Women with prior cesarean section(s) or placenta previa are eligible if less than 28 weeks (see above).

**Contraindications:**
- Viable pregnancy
- Any contraindication to prostaglandins or NSAID use
- Active bleeding
- Concern for or evidence evidence of invasive placentation
- Active inflammatory bowel disease
- Pelvic infection, sepsis, or shock
- History of clotting disorder or current use of anticoagulation

**Technique:**

*Fetal demise- INPATIENT MANAGEMENT*
- *Second Trimester (12-28 weeks)*
• Confirm nonviable pregnancy by ultrasound and document confirmation of the gestational age.
  • Recommend 400 micrograms of misoprostol every 3 hours for a maximum of 5 doses.
    ▪ This dosing regimen may be repeated if not delivered after 24 hours.
    ▪ Vaginal and sublingual routes are more effective than oral administration and reduce side effects.
    ▪ For women with a prior cesarean section(s), beyond 20 weeks’ gestation, consider lower dose (200 micrograms) as starting dose. Continue at lower dose if patient is responding with appropriate symptoms such as contraction pain OR increase to 400 mcg dose if no response.
    ▪ Expected side effects include: nausea, vomiting, abdominal cramping, diarrhea, fever/chills and may be treated with appropriate medications.
    ▪ Expectant management of the placenta for up to 4 hours after delivery of the fetus has no serious adverse effects as long as there is no evidence of worsening bleeding. Failure to deliver the placenta beyond this time frame should prompt further assessment for possible D&C

• Third Trimester (>28 weeks)
  • Confirm nonviable pregnancy by ultrasound and document confirmation of the gestational age.
  • Apply tocodynamometer to assess uterine activity.
  • Recommend 50 mcg of misoprostol every 4 hours up to a maximum of 6 doses.
  • Assess maternal vital signs every 4 hours.
  • Reassessment of the clinical situation with documentation by the provider of progress toward delivery is necessary every 12 hours.
  • Additional misoprostol administration requires a note by the attending MD.
  • Usual contraindications to prostaglandins in the third trimester (>28 weeks), such as prior cesarean section, should be followed.
  • Expected side effects include: nausea, vomiting, abdominal cramping, diarrhea, fever/chills and may be treated with appropriate medications.
  • Expectant management of the placenta for up to 4 hours after delivery of the fetus has no serious adverse effects as long as there is no evidence of worsening bleeding. Failure to deliver the placenta beyond this time frame should prompt further assessment for possible D&C

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

References:


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