TITLE: EPAC Medical Management of Early Pregnancy Loss (EPL)

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BACKGROUND: Early pregnancy loss is defined as nonviable intrauterine pregnancy as established by accepted clinical, laboratory and imaging guidelines within the first 12 completed weeks of gestation. Early pregnancy loss occurs in 10% of all clinically recognized pregnancies. Expectant, medical and surgical management of EPL are all safe and result in similar long-term outcomes. Medical management is safe and effective and should be offered to all appropriate candidates.

GOAL: To provide guidelines for the medical management of early pregnancy loss.

CANDIDATES: Patients with a nonviable pregnancy measuring 12 weeks gestation or less AND no contraindications to medical management

CONTRAINDICATIONS: IUD currently in place, Bleeding disorder, Current use of anticoagulation, Severe anemia, Porphyria, Long term chronic steroid use, Adrenal insufficiency, Liver disease, Allergy to Misoprostol or Mifepristone

CONSIDERATIONS: Ability to follow treatment protocol, Supportive social situation, Assistance at home, Availability of transportation in case of emergency

EVALUATION:

1. Ultrasound to confirm gestational age, viability, and intrauterine location of pregnancy.
2. Blood Type (Do not repeat if available in EPIC)
3. Hemoglobin level
4. HCG level (if planning to use HCG to confirm tissue passage)

MANGEMENT (SmartSet in HealthLink: Medical Management of Early Pregnancy Loss)

1. Administer Mifepristone 200 mg in clinic, prior to administering:
    a. Print patient agreement form, sign and scan to chart https://www.accessdata.fda.gov/drugsatfda_docs/rems/Mifepristone_2019_04_11_Patient_Agreement_Form.pdf
    b. Medication Guide: Print and give to patient https://www.fda.gov/media/72923/download
    c. Record the Serial Number in the MAR
2. Prescribe the following medications: (UW Health pharmacy preferred to assure patient access to medications)
    a. Misoprostol 800 mcg (4 tablets) self-administered 24-48 hours after Mifepristone, vaginal or buccal administration acceptable.
        i. Buccal administration: place tablets between the cheek and gum, wait 30 minutes, then swallow whatever remains of the tablets.

        ii. Vaginal administration: insert tablets into the vagina as far as they will go, lay down for 30 minutes following insertion.
        iii. A second dose of Misoprostol is provided, if no bleeding occurs within 24 hours of the misoprostol administration a second dose of misoprostol should be taken.
        iv. For gestations greater than 9 weeks consider repeat does of misoprostol 4 hours after the initial dose.
    b. Antiemetic- Phenergan 25 mg or Ondansetron 4mg PO, take 30 minutes prior to taking misoprostol
    c. Pain medication: Ibuprofen 800 mg PO Every 8 hours PRN pain, take first does 30 minutes prior to administering the misoprostol.
3. Provide Patient Instruction:
    a. In HealthLink .EPACPATIENTINSTRUCTIONSEPLMEDMANG
    b. Print from Smart Set: https://www.reproductiveaccess.org/wp-content/uploads/2016/07/2016-07_factsheet_mm-medication.pdf
4. Follow up to ensure complete passage of tissue
    a. HCG level in 7 days, if decreased by 80% or greater compared to HCG on the day of mifepristone administration the tissue passage is complete, no further HCGs need to be drawn. If less than 80% drop, transvaginal ultrasound should be performed
    b. Transvaginal ultrasound performed 7-14 days, to confirm passage of gestational sac. (Clinical presentation should be evaluated for evidence of retained POC, Endometrial thickness does not predict)

References

American College of Obstetrics and Gynecology Committee on Practice Bulletins-Gynecology, ACOG Practice Bulletin Number 200: Early Pregnancy Loss. Obstet Gynecol 2018 Nov;132(5):e197-e207. Nov 2018

Schreiber CA, Creinin MD, Atrio J, Sonalkar S, Ratcliffe SJ, Barnhart KT Mifepristone Pretreatment for the Medical Management of Early Pregnancy Loss. N Engl J Med. 2018;378(23):2161.