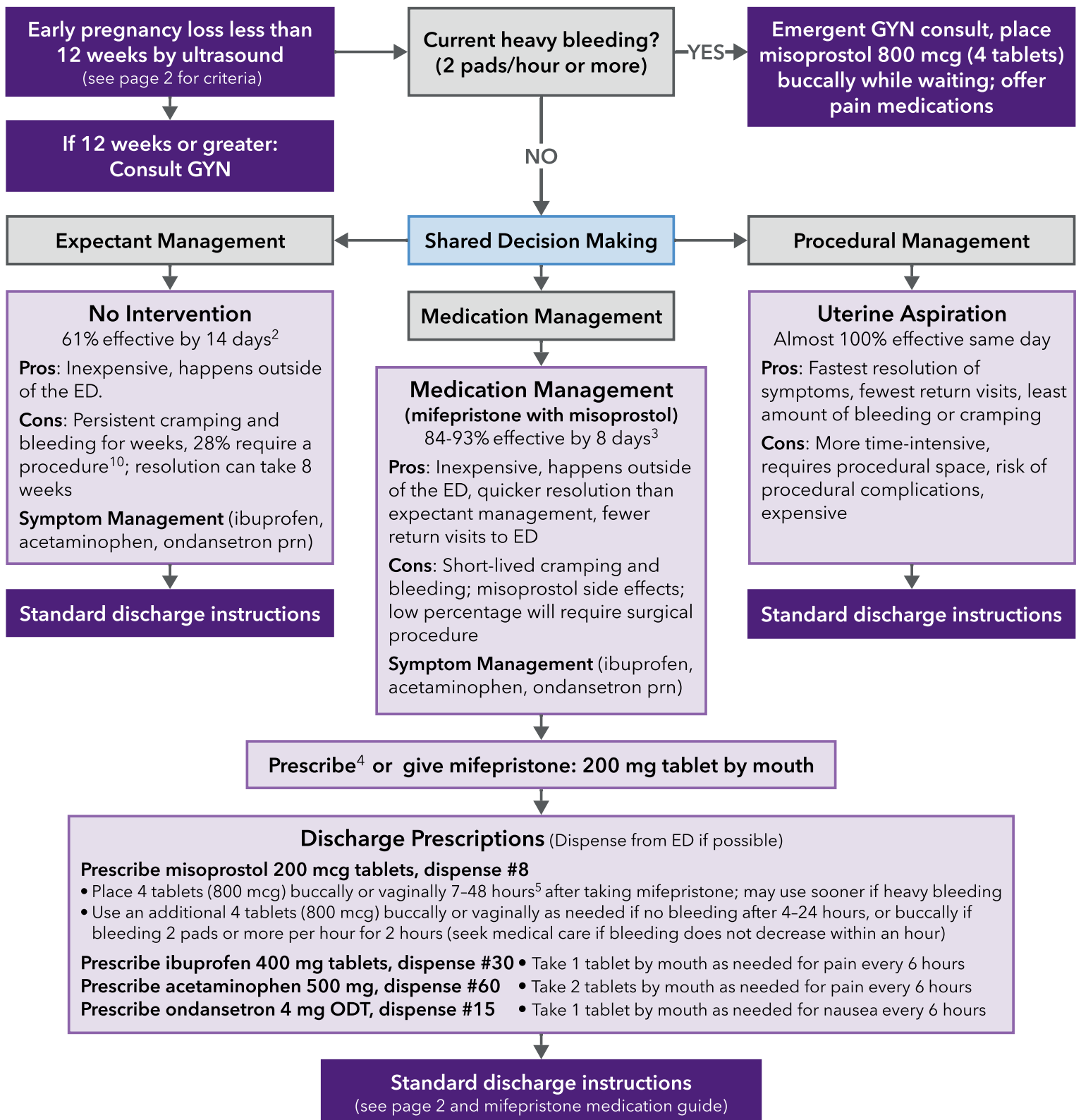


This protocol should be used in settings where mifepristone is available. Misoprostol alone is effective in incomplete EPL (active bleeding). (See [misoprostol-only protocol](#)). The addition of mifepristone is superior in anembryonic and missed EPL.¹

April 2026



The Reproductive Health Hotline (1 844-REPROHH or 1 844-737-7644)

Free, confidential, nationwide, evidence-based hotline for health care providers.

Access Bridge disseminates resources developed by an interdisciplinary team based on published evidence and medical expertise. These resources are not a substitute for clinical judgment or medical advice. Current best practices may change. Providers are responsible for assessing the care and needs of individual patients.

EPL criteria:**Definitive confirmation of nonviable pregnancy⁶**

- hCG falls, or rises less than 11% over 48 hours, if initial US showed IUP
- No pregnancy on ultrasound, and visible fetus passed by patient report or on physical exam
- By Transvaginal Ultrasound (TVUS):
 - Crown rump length (CRL) greater or equal to 7mm with no fetal cardiac activity (FCA)
 - Mean sac diameter greater or equal to 25 mm with no embryo
 - Absence of embryo with cardiac activity at least 2 weeks after TVUS with empty gestational sac (GS) or at least 11 days after TVUS showing GS with yolk sac (YS)
 - Prior TVUS demonstrating fetal cardiac activity (FCA) with current TVUS showing no FCA or no embryo

EPL criteria:**Probable nonviable pregnancy by TVUS⁶**

- CRL less than 7mm with no FCA
- Mean sac diameter 16-24mm with no embryo
- Absence of embryo with FCA 7-13 days after US shows GS
- Absence of embryo with FCA 7-10 days after US shows GS with YS
- Absence of embryo 6 weeks or more after first day of last menstrual period (if patient is sure of date, normal cycles, not on hormonal contraception or breastfeeding)
- Empty sac seen adjacent to yolk sac with no embryo
- Yolk sac greater than 7mm
- Less than 5mm difference between mean sac diameter and CRL

Helpful Patient Counseling

- EPL is not your fault – not caused by stress, activity, sex, drugs, food, or anything else you did or didn't do.
- EPL management does not affect future fertility.
- Misoprostol can be used buccally or vaginally, even though the paperwork from the pharmacy only mentions the buccal route.
- Buccal misoprostol instructions: Hold between cheek and gums for 30 minutes, then swish with liquid and swallow.
- Misoprostol commonly causes fever/chills, nausea/vomiting/diarrhea, pelvic pain/cramping, vaginal bleeding.
- RhoGAM administration for pregnancies less than 12 weeks in duration is not recommended, regardless of Rh status.⁷

Contraindications to Mifepristone/Misoprostol Protocol

- Allergy to mifepristone or misoprostol
- Porphyria
- Chronic adrenal failure
- Chronic systemic steroids (inhalers/sprays/creams OK)
- Severe symptomatic anemia (hemoglobin not required if asymptomatic)
- Known coagulopathy or current use of anticoagulant therapy (aspirin OK)
- IUD in place (remove prior to treatment)⁸

Post-Treatment

- Routine follow-up US not needed.
- If re-presents to ED and follow-up US done: finding of "uterine debris" is normal. Intervention only needed if retained products of conception (RPOC) are present and patient is symptomatic, including bleeding more than 2 pads/hour or persistent pain. If heavy bleeding or significant pain, taking 2-4 misoprostol tablets can help the uterus evacuate retained tissue and slow bleeding. If no improvement after 1-2 hours, consult GYN. If patients have RPOC but are asymptomatic, expectant management may be appropriate. hCG can be positive for up to 5 weeks.

Discharge Instructions

- Can start contraception anytime. IUD may be placed after confirming no longer pregnant.
- If treating EPL that is a confirmed IUP, no formal follow up required, but recommend home pregnancy test to confirm completion of pregnancy loss 5 weeks later (urine pregnancy test can be positive for up to 5 weeks).
- If treating EPL that is a PUL (never had ultrasound confirming IUP), follow serial hCGs every 2-7 days until negative or refer to OB/GYN for further care (shared-decision-making).⁹
- Patient should follow up if pregnancy symptoms persist after a week, the home pregnancy test is still positive 5 weeks later, or if desires earlier confirmation of miscarriage completion.
- Urgent re-evaluation if:
 - Unilateral pain (US to rule out ectopic)
 - Severe abdominal pain
 - Excessive bleeding (heavier than a regular period) and not improving with misoprostol
 - Fever ≥ 100.4 F for more than 4 hours
 - The patient is feeling ill or having any concerning symptoms, such as syncope

Scan or click link
for more shared
decision making
resources



[Early Pregnancy Loss Treatment Options](#)

Scan or click link
for more patient
discharge
instructions



[Patient Treatment and Discharge](#)

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For additional Access Bridge resources, visit bridgetotreatment.org/access-bridge/.

Access Bridge is a program of the Public Health Institute's Bridge Center.

See page 3 for endnotes.

ENDNOTES:

April 2026

- 1 ACOG and Society of Family Planning recommend use of mifepristone for EPL, if available. The addition of mifepristone to misoprostol increases success rates and decreases time to completion in patients with missed EPL and anembryonic pregnancies. Studies specifically showing the relative benefit of mifepristone/misoprostol vs misoprostol alone for patients with active bleeding were not identified at the time of this publication (April 2026).
- 2 61% overall (71% for incomplete EPL, 53% for empty sac and 35% for missed EPL). Casikar 2010.
- 3 See Sonalkar 2020 and Schreiber 2018. Zhang 2005 found a 93% success rate with incomplete EPL using misoprostol-only.
- 4 Prescribers and pharmacies must be REMS-certified; one prescriber can register for the group. For more information, see REMS 101. Prescribing to an outpatient pharmacy is an option; each prescriber must be registered with that particular pharmacy. To find list of nearby certified pharmacies stocking mifepristone and misoprostol, visit <https://www.earlyoptionpill.com/how-do-i-get-mifeprex/find-a-certified-pharmacy/> or review GenBioPro list: <https://genbiopro.com/prescribing/>.
- 5 When to take misoprostol should be determined by the patient preference; it has significant side effects including vomiting, diarrhea, and bleeding; therefore many patients prefer to take at home, with easy access to a toilet. 2024 SFP EPL guidelines.
- 6 Criteria based on ACOG guidelines. Note updated criteria allow earlier diagnosis: CRL 5.3mm or more, empty GS of 21 mm, and/or hCG less than 11% over baseline after 48 hours, after an ultrasound showing IUP of uncertain viability, are all 100% diagnostic of nonviable pregnancy. 2024 SFP guidelines.
- 7 Rh testing and RhoGAM administration are not recommended before 12 weeks' gestation for EPL and medical or procedural abortion (ACOG 2024, SFP 2022). No changes have been made to ectopic pregnancy recommendations. Following institutional guidance is recommended.
- 8 Immediate removal of IUD in pregnancy is standard of care. If the string is visible in the os, IUDs can be removed easily with ring forceps during a speculum exam; see here for 58-second how-to video. For desired pregnancies, immediate IUD removal decreases the chance of miscarriage (ACOG Committee Opinion #672 2016). For EPL management, the IUD must be removed before giving mifepristone and misoprostol. It is best to remove the IUD immediately, but if the patient desires a procedure, the IUD can be removed at the time of the procedure.
- 9 ACOG recommends following hCGs until negative with PULs. Use shared decision-making with patient weighing relative risks, costs, and availability of follow-up. ACOG Practice Bulletin #193.
- 10 Rates of need for surgical procedure after expectant management vary widely amongst studies, the mean of studies examined was 28%. Nanda 2012.

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