ACCESS BRIDGE

Early Pregnancy Loss (EPL): Emergency Dept. Management

Misoprostol Only

BRIDGE Treatment. Equity. Connection.

Misoprostol alone is effective in incomplete EPL (active bleeding). The addition of mifepristone is superior in anembryonic and missed EPL.[1] (See mifepristone/misoprostol protocol).

April 2026

Early pregnancy loss less than 12 weeks by ultrasound (see page 2 for criteria)

If 12 weeks or greater: Consult GYN

Current heavy bleeding? (2 pads/hour or more)

YES → **Emergent GYN consult, place misoprostol 800 mcg (4 tablets) buccally while waiting; offer pain medications**

NO

Shared Decision Making

Expectant Management

No Intervention

61% effective by 14 days[2]

Pros: Inexpensive, happens outside of the ED.

Cons: Persistent cramping and bleeding for weeks, 28% require a surgical procedure[9];resolution can take 8 weeks

Symptom Management (ibuprofen, acetaminophen, ondansetron prn)

Standard discharge instructions

Medication Management

Medical Intervention

67-93% effective by 8 days[3]

Pros: Inexpensive, happens outside of the ED, quicker resolution than expectant management, fewer return visits to ED

Cons: Short-lived cramping and bleeding; misoprostol side effects; low percentage will require surgical procedure

Symptom Management (ibuprofen, acetaminophen, ondansetron prn)

Procedural Management

Uterine Aspiration

Almost 100% effective same day

Pros: Fastest resolution of symptoms, fewest return visits, least amount of bleeding or cramping

Cons: More time-intensive, requires procedural space, risk of procedural complications, expensive

Standard discharge instructions

Discharge Prescriptions (Dispense from ED if possible)

Administer or prescribe misoprostol 200 mcg tablets, dispense #8

- Place 4 tablets (800 mcg) buccally or vaginally[4]
- Repeat 4 tablets (800 mcg) after 3 hours, if needed (buccally or vaginally if no bleeding for a missed EPL; buccally if ongoing heavy bleeding for an incomplete EPL)

Prescribe ibuprofen 400 mg tablet, dispense #30 • Take 1 tablet by mouth as needed for pain every 6 hours

Prescribe acetaminophen 500 mg, dispense #60 • Take 2 tablets by mouth as needed for pain every 6 hours

Prescribe ondansetron 4 mg ODT, dispense #15 • Take 1 tablet by mouth as needed for nausea every 6 hours

Standard discharge instructions (see page 2)

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

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

See page 3 for endnotes.

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EPL criteria: Definitive confirmation of nonviable pregnancy[5]

- **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 with current TVUS showing absence of FCA or absence of embryo

EPL Criteria: Probable nonviable pregnancy by TVUS[5]

- CRL less than 7mm with no fetal cardiac activity (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.[6]

Contraindications to Misoprostol

- Allergy to misoprostol
- 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)[7]

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

- Contraception can start 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) [8]
- 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 misoprosotol
  - Fever over ≥100.4 F 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

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 Success rates at 8 days: Incomplete EPL 93%; embryonic demise 88%, anembryonic gestation 81%. Zhang 2005.

4 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 guidelines.

5 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 utrasound showing IUP of uncertain viability, are all 100% diagnostic of nonviable pregnancy. 2024 SFP guidelines.

6 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 institution guidance is recommended.

7 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 #672 2016). For desired medication management of EPL, the IUD must be removed prior to giving 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.

8 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.

9 Rates of need for surgical procedure after expectant management vary widely amongst sudies, the mean of studies examined was 28%. Nanda 2012.

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Repro Health Hotline: https://reprohh.ucsf.edu

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