TEAMM Training, Education, & Advocacy in Miscarriage Management

EPL Management Options: Advantages, Disadvantages, and Efficacy

A person's feelings about early pregnancy loss (EPL) can only be understood in the context of what being pregnant and having an EPL means to them. Patients and their partners have an entire range of emotions in response to their pregnancy loss. For all, but especially for those losing a much-desired pregnancy, it is important to encourage patients and their partners to take care of themselves and surround themselves with support.

	Advantages	Disadvantages	Efficacy
Expectant management	● Non-invasive ● Body naturally expels non-viable pregnancy ● Avoids anesthesia and surgery risks ● Allows for patient privacy and continuity of care ● Permits treatment at home and having near support people of their choice	● Unpredictable outcome and time-frame ● Process can last weeks ● Can have prolonged bleeding and cramping ● Despite waiting may still need uterine aspiration	● Highest with miscarriage already in progress ~85-91% ● Less successful with missed abortion ~76% ● 81% SABs complete within 4 weeks, most within 2wks ● ~66% success w/ anembryonic
Medical Management (misoprostol)	● Non-invasive ● Safe ● Can be highly effective ● Avoids anesthesia and surgery risks ● Highly cost-effective ● Allows for patient privacy and continuity of care ● Permits treatment at home and having near support people of their choice	● May cause heavier or longer bleeding ● May cause short-term gastrointestinal and other side effects (less with buccal or vaginal administration) ● May still need uterine aspiration	● Highest with loss in progress ~99% ● 88% with missed Ab ● 81% with anembryonic ● (by day 8 post miso w/ up to 2 doses; 84% success by day 8 for all types)
Aspiration in ED	● Offers fastest resolution of miscarriage ● Low risk (<5%) need for further treatment ● Pain control with local plus oral or IV meds if needed ● May allow improved patient access and continuity of care ● Less patient and staff time ● Resource and cost savings	● Rare risks associated with invasive procedure ● May need a driver for ride home if received conscious sedation	● ~99% effective without need for further treatment ● Discharged home same day ● Avoid risks of general anesthesia (compared to OR based care)

Counseling Steps for all methods

- Rule out ectopic pregnancy
- Inform patient about efficacy, side effects, risks and steps to take in the case of excessive bleeding or signs of infection
- Verbal and written instructions given to all patients

- Inform patient that an aspiration procedure may be recommended if medication/expectant management fails or bleeding is ongoing and hematocrit is dropping
- Explain recommendation for Rhogam if Rh negative (per ACOG 2024 guidelines, Rh negative patients no longer needs to receive Rhogam if receiving care for miscarriage < 12 weeks gestational age (*Obstetrics & Gynecology* 144(6):p e140-e143, December 2024.)
- Provide patient with strict ED return precautions
- Completion of miscarriage may be documented by ultrasonography, βhCG testing (two tests) or other clinical means. Remind pt that if at repeat OBGYN or family medicine visit, miscarriage found to be incomplete, pt may be offered additional medications, aspiration or re-aspiration
- Follow up hematocrit/hemoglobin done in women with significant anemia or ongoing bleeding
- Patient education - General
    - o Advise pelvic rest for 1 week (common practice but evidence is lacking that it is medically necessary)
    - o No evidence for delaying conception after a miscarriage, patients can try to conceive again as soon as they're ready (in the wake of miscarriage treatment with misoprostol with or without mifepristone it is safe to try to conceive without delay, but this is <u>not</u> to be confused with patients taking methotrexate for an ectopic pregnancy - after methotrexate patients should wait 3 months before trying to conceive again).
  - Future EPL risk
    - o 1 SAb – 20% (reassure that this is same risk as prior to first miscarriage)
    - o 2 SAb – 28%
    - o 3 SAb – 43%
- Can consider providing contraception if desired by patient, may begin day of aspiration or upon diagnosis of complete procedure if medical or expectant management
- Bleeding – what to expect:
    - o Expectant/medication: Your bleeding should lighten and lessen after 3-5 hours of having your miscarriage
    - o Medication: Advise patient to contact provider if there is no bleeding or cramping within 12-24 hours after misoprostol, advise 2nd dose. Heavy bleeding and cramping should not soak more than 2 pads an hour for 2 hours in a row and should not last more than 4 hours.
    - o All management options:
        - Expect light-moderate bleeding for 1-2 weeks, bleeding usually stops after 3 weeks
        - Menses return around 4-8 weeks/fertility may return as early as 2-3 weeks
        - Contraceptive use may impact expected bleeding patterns
        - Negative βhCG values after 2-4 weeks
        - Patients report high satisfaction with any method when they had options counseling and chose the method they preferred. Dissatisfaction highest in those preferring expectant management but requiring an aspiration procedure.
        - Advise to contact 24 hours a day for any questions or concerns, especially:
            - o too much bleeding (soaking more than 2 regular pads an hour for 2 hours in a row)
            - o fever over 100.4°F or if it is persistent more than 8 hours after a misoprostol dose
            - o Fainting

    - lower abdominal pain and feeling ill in the days after the cramping and bleeding are over
    - Pain that cannot be managed at home with prescribed pain medication
- Follow-up:
    - Schedule 1-2 week appointment if patient may need help assessing coping or if patient still having pregnancy symptoms after 1 week. Home pregnancy test should be negative 5 weeks after miscarriage treatment.

Rates of successfully completed miscarriage using expectant management or misoprostol by subcategory of early pregnancy loss from **day of diagnosis**: (adapted from Luise/Zhang)

	Completed miscarriage with EXPECTANT management			**Completed miscarriage after taking misoprostol by day 8**
Subcategory of Early Pregnancy Loss	**By day 7**	**By day 14**	**By day 46**	
Incomplete abortion	53%	84%	91%	93%
Embryonic demise	30%	59%	76%	88%
Anembryonic gestation	25%	52%	66%	81%
All categories	40%	70%	81%	84%

References:

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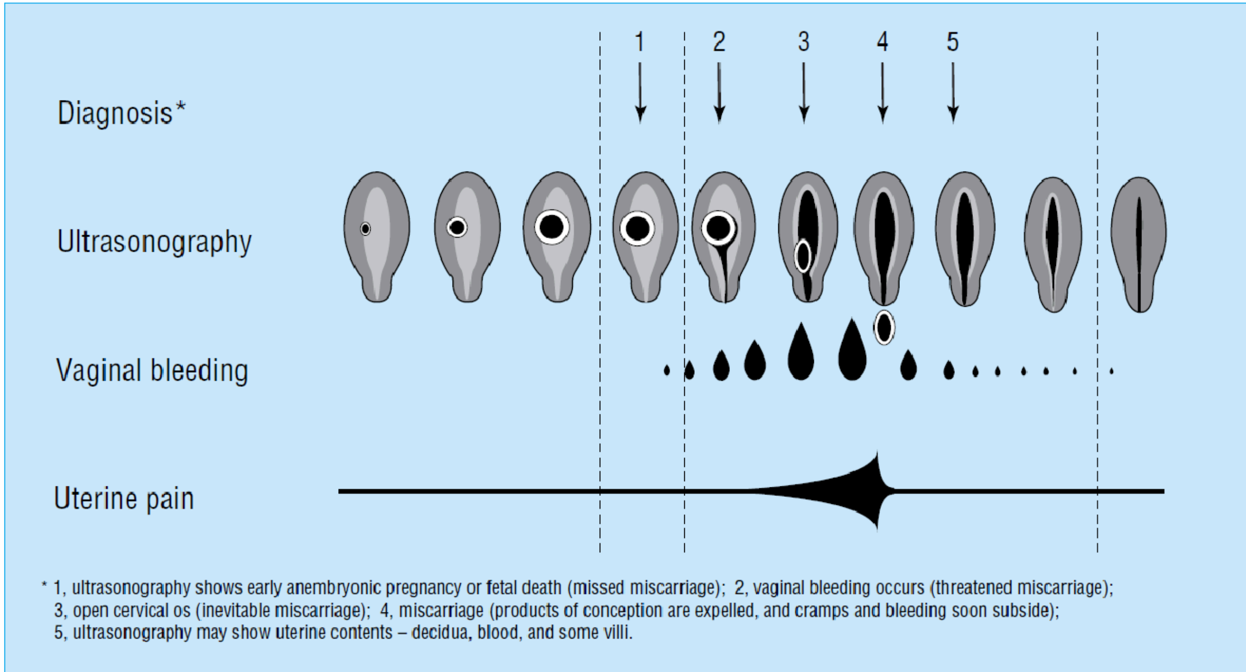

Natural course of miscarriage, with opportunities for intervention