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 2025

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 maxipads/hour or more)

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

NO

Shared Decision Making

Expectant Management

No Intervention
61%[2] effective by 14 days

Pros: Inexpensive, happens outside of the ED.

Cons: Persistent cramping and bleeding for weeks, nearly 1/3 return to ED and need a procedure

Offer medication for symptoms (ondansetron, ibuprofen)

Standard discharge instructions

Medication Management

Medical Intervention
81-93%[3] effective by 8 days

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 failure rate, but some will require follow-up

Offer medication for symptoms (ondansetron, ibuprofen)

Procedural Management

Uterine Aspiration
Almost 100% effective same day

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

Cons: Happens in ED/ OR/ procedure suite, risk of procedural complications, expensive

Standard discharge instructions

Discharge Prescriptions (Dispense from ED if possible)

Administer or prescribe misoprostol 200 mcg tablets
- Place 4 tablets (800 mcg) buccally or vaginally[4]
- Repeat 4 tablets (800 mcg) after 3 hours, if needed (ongoing heavy bleeding for an incomplete EPL, or no bleeding for a missed EPL)
- Repeat 4 tablets (800 mcg) every 3-4 hours if needed for heavy bleeding (greater than 2 pads an hour). Seek medical care if bleeding does not decrease within an hour.
- Dispense: 12 tablets

Prescribe ibuprofen 600 mg tablets
- Take 1 tablet by mouth as needed for pain every 6 hours
- Dispense: 30 tablets

Prescribe ondansetron 4 mg ODT
- Take 1-2 tablets by mouth as needed for nausea every 8 hours
- Dispense: 15 tablets

Standard discharge instructions
(see page 2)

See page 3 for endnotes.

The Reproductive Health Hotline (1 844-REPROHH or 1 844-737-7644)
Free, confidential, nationwide, evidence-based hotline for health care providers. Monday–Friday 6am–5pm PT / 9am–8pm ET.

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EPL criteria: Definitive confirmation of nonviable pregnancy[5]

- **Products of conception in os/vagina or patient reports passage of visible fetus**
- **hCG falls, or rises less than 11% over 48 hours, if initial US showed IUP**
- **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 Counseling

- Buccal misoprostol instructions: Hold between cheek and gums for 30 minutes, then swish with liquid and swallow.
- RhoGAM administration for pregnancies less than 12 weeks in duration is not recommended.[6]
- EPL management does not affect future fertility.
- EPL is not your fault – not caused by stress, activity, sex, drugs, food, or anything else you did or didn't do.

Contraindications to Misoprostol

- Allergy to misoprostol
- Known coagulopathy or current use of anticoagulant therapy (aspirin OK)
- Severe symptomatic anemia (hemoglobin not required if asymptomatic)
- 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 – only needs intervention if retained gestational sac/embryo, bleeding more than 2 pads/hour or persistent pain.
- If heavy bleeding/severe pain 24 hours after last misoprostol dose, additional 2-4 misoprostol tablets (400 - 800 mcg) can help the uterus evacuate retained tissue and slow bleeding. If no improvement after 1-2 hours, consult GYN.

Discharge Instructions

- Contraception: Can start anytime: IUD may be placed after confirming no longer pregnant.
- If confirmed IUP, no formal follow up required. Patient must take home pregnancy test to confirm completion of miscarriage (should be negative by 5 weeks).
- If treating EPL that is a PUL (never had ultrasound confirming IUP), follow serial hCGs until negative or refer (shared-decision-making)[8]
- Patient should follow up if pregnancy symptoms persist after a week, the home pregnancy test is still positive in 5 weeks, or if desires earlier confirmation of miscarriage completion.
- Urgent re-evaluation if:
  - One-sided pain (US to rule out ectopic)
  - Severe abdominal pain
  - Soaking 2 or more maxipads an hour for 2 or more hours not improving with misoprostol
  - Fever over 100.4 F over 24 hours after last misoprostol dose
  - The patient is feeling ill or having any concerning symptoms, such as syncope

Scan for more shared decision making resources

Scan for more patient discharge instructions

See page 3 for endnotes.

ENDNOTES:

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 2025).

2 61% overall (71% for incomplete EPL, 53% for empty sac and 35% for missed EPL). Casika1r 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 (vomiting, diarrhea, bleeding), 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 MAB, the IUD must be removed before giving mife/miso. 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.

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