ED Management of Early Pregnancy Loss

EPL Diagnosis*
- Crown rump length (CRL) ≥7mm with no FCA.
- Mean sac diameter of ≥25mm with no embryo.
- H/o bleeding with no visible pregnancy after prior US showing IUP.
- Absence of embryo with cardiac activity if ≥2w after TVUS showing GS with yolk sac.
- Prior transvaginal ultrasound (TVUS) demonstrating fetal cardiac activity (FCA) with current TVUS showing absence of FCA or absence of embryo.

Diagnosis of EPL, hemodynamically stable, under 12-13w gestational age

Share Decision
Expectant v. Medication v. Procedural Management

IF PROCEDURE PREFERRED & AVAILABLE

Consider Expert Consultation
- Bleeding disorder, Hgb <7, fever, possible ectopic, unstable.

Patient Education
- Bleeding: Varies, may be heavy, usually lightens over weeks.
- Use NSAID, acetaminophen, and heating pads for pain.

Helpful Counseling
- EPL management does not affect future fertility.
- EPL is not your fault - not caused by stress, activity, sex, drugs, food.

Discharge Instructions
- No routine follow-up required.
- See PCP/OBGYN if home pregnancy test still positive in 5 weeks.
- Return to ED if: Soaking 4 maxipads in 2h not improving with miso, persistent fever >100.4F, uncontrolled pain, feeling ill, or other concerning symptoms.

Post-Treatment
- Routine follow-up US not needed.
- If follow-up US done: Finding of “uterine debris” is normal; only requires D&C for “retained products” if severe pain or if bleeding > 2 pads/h not improving with miso. Heavy bleeding distressing to patient can be treated with additional miso.

Expectant Management:
- ~80% effective & may take up to 8w.
- At home, will have cramping & bleeding.
- BENEFITS: Inexpensive.
- RISKS: Uncertain time to completion, possible increased anxiety, return visits, and/or hemorrhage; 28% require further procedural management.

Medication Management:
- In emergency department (ED) or at home.
- 70-80% effective within 3d (84% w mife).
- BENEFITS: Effective, shorter, fewer return visits, inexpensive.
- RISKS: Bleeding, cramping.
- Side effects of meds: Nausea, vomiting, diarrhea (give comfort meds).

Procedure Management:
- Manual uterine aspiration (MUA) or dilation and curettage (D&C).
- In ED, or OR/procedure suite.
- BENEFITS: Effective, safe, fast (5 minute) procedure, lower risk of ongoing bleeding.
- RISKS: Instrumentation risks (rare infection/injury); use of OR adds significant expense and time.

No heavy bleeding? Give mifepristone 200 mcg po now or to take home. Take miso in 24-48h (sooner if pt distressed by bleeding). Start miso in ED if heavy bleeding (2 pads/h or pt distress).

<9W BY ULTRASOUND
Rx miso 200 mcg #8 plus NSAID and anti-ematic.
1. Take NSAID and anti-ematic; repeat pm.
2. Take 4 miso tablets buccally** or vaginally; repeat #4 pm bleeding ≥4 maxipads/2h OR (if treating nonviable intact pregnancy), no bleeding 24h after miso dose.

9-11 6/7W BY ULTRASOUND
Rx miso 200 mcg #12 plus NSAID and anti-ematic.
1. Take NSAID and anti-ematic; repeat pm.
2. Take 4 miso tablets buccally** or vaginally; repeat #4 in 4 hours; Repeat #4 again pm bleeding ≥4 maxipads/2h OR (if treating nonviable intact pregnancy), no bleeding 24h after miso dose.

12W+ BY ULTRASOUND
Rx miso 200 mcg #12 (400 mcg q3h until tissue passes and bleeding slows) plus NSAID, acetaminophen, and anti-ematic.
For pts preferring to avoid procedure, Consult Gyn. Rhogam*** needed if Rh negative; confirm placental location if history of C/S (risk of accreta if low anterior).

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*Early Pregnancy Loss, The American College of Obstetricians and Gynecologists
*Ectopic Pregnancy: Diagnosis and Management
**Buccal dose instructions: Hold between cheek and gums for 30 min, then swish and swallow.
***Rhogam administration for <12w is optional, not strongly supported by evidence.