**Title:** EMTC Early Pregnancy Loss Protocol

**Purpose:** To facilitate appropriate care for patients experiencing early pregnancy loss including expectant, medical, and surgical management.

**Eligibility:**

Patients must carry one of the following diagnoses:

* *Incomplete/Inevitable Abortion:* patient is having vaginal bleeding and cervix has dilated but products of conception have not yet passed (inevitable) or have only partially passed (incomplete)
* *Missed abortion (non-viable intrauterine pregnancy):* embryo or fetus is no longer viable but cervix has not opened and products of conception have not passed (patient may or may not be having any vaginal bleeding). Missed abortion may be diagnosed by inappropriate bhcg rise, prior transvaginal ultrasound (TVUS) demonstrating fetal cardiac activity (FCA) with current TVUS showing absence of FCA, CRL >/= 7mm with no FCA, mean sac diameter of >/= 25mm with no embryo, or inappropriate growth on TVUS (absence of embryo 2 weeks or more after TVUS with empty gestational sac or 11 days or more after TVUS with gestational sac with yolk sac).[[1]](#footnote-0)
* *Retained products of conception:* patient is having vaginal bleeding without infection or with infection (*septic abortion)* due to uterus containing residual products of conception after any type of abortion medical or surgical management (i.e. after induced abortion or management of miscarriage by either medical or surgical methods)

Patients with the following characteristics should be excluded from this protocol:

* Bleeding disorder
* Unstable medical condition
* Hemodynamically unstable and an operation room is immediately available
* Hgb <7
* Opinion of attending that ED care is inappropriate and patient requires alternative management

**Protocol:**

Once a patient has been deemed eligible for this protocol after complete history, physical, exam, and transvaginal ultrasound, the patient should be counseled on expectant, medical, and surgical management of her miscarriage. See appendix 1 for counseling material. The protocols for each are as follows:

**Expectant Management:**

1. Counsel patients on expectations for bleeding (initially heavy followed by light-medium bleeding for up to a few weeks), pain (initially moderate-severe, followed by lighter cramping up to a few days), and potential complications.
2. Discharge patient with instructions to return to the ED if soaking 2 pads per hour, x 2 hours (4 pads total in 2 hours), fever, foul smelling discharge, or other concerning symptoms. Nothing in the vagina x1 week including no sex, no tampons, no douching.
3. Refer to PCP or gyn for repeat bHCG or ultrasound in 1-2 weeks, or if follow up is not feasible, instruct to repeat home pregnancy test in 4-6 weeks and to return for care in the event of a positive pregnancy test.
4. Patients should be offered contraception, as ovulation will typically return 2-3 weeks after completion of miscarriage. Immediately available options include ED administration of depot-medroxyprogesterone acetate (DMPA) or a prescription for contraceptive pills, patches, or rings.

**Medical Management:**

1. Administer 800 mcg misoprostol in the emergency department or provide prescription for initial and repeat dose of misoprostol, preferably to be administered vaginally but alternatively buccally..
2. Counsel patients on expectations for bleeding (initially heavy followed by light-medium bleeding for up to a few weeks), pain (initially moderate-severe, followed by lighter cramping up to a few days), and potential complications.
3. Discharge patient with prescriptions for 1) repeat dose of 800 mcg vaginal misoprostol (2 doses if initial dose not provided in ED), 2) analgesics, and 3) antiemetics. Instruct patient to return to the ED if soaking 2 pads per hour, x 2 hours (4 pads total in 2 hours), fever, foul smelling discharge, or other concerning symptoms. Nothing in the vagina x1 week including no sex, no tampons, no douching.
4. Refer to PCP or gyn for repeat bHCG or ultrasound in 1-2 weeks, or if follow up not feasible, instruct to repeat home pregnancy test in 4-6 weeks and to return for care in the event of a positive pregnancy test.
5. Patients should be offered contraception, as ovulation will typically return 2-3 weeks after completion of miscarriage. Immediately available options include ED administration of depot-medroxyprogesterone acetate (DMPA) or a prescription for contraceptive pills, patches, or rings.

**Surgical Management:**

1. Request OB/GYN consult
2. Order CBC, type and screen, and surgical tissue exam.
3. Order antibiotics, possible regimens include:
	1. Azithromycin 500mg PO x 1 pre-op
	2. Doxycycline 100mg PO x 1 pre-op, 200mg PO x 1 post-op
	3. Flagyl 500mg PO x 1 pre-op
4. Order 20cc 1% lidocaine with or without epinephrine for paracervical block
5. Order supplies to bedside including (likely in a gyn cart)
	1. Disposable Manual Vacuum Aspirator kit (aka Ipas kit) with manual vacuum syringe, cannulas (sizes 6-9), & cervical dilators (size 5/6, 7/8, 9/10)
	2. Speculums (prefer metal)
	3. Ringed forceps (metal)
	4. Tenaculum
	5. Supplies for paracervical block
		1. 22g spinal needle
		2. 20cc syringe
		3. 18g needle for drawing up lidocaine
		4. 20mL 1% lidocaine
	6. Gauze 4x4s
	7. Specimen cup
	8. Betadine (swabs or bottles) or Hibiclens (for iodine-allergic patients)
	9. Sterile & non-sterile gloves (all sizes)
6. Provide analgesia as determined by consultation between OB/GYN and patient, including PO analgesia, IV analgesia, or procedural sedation.
7. Administer RhoGam for RH-negative patients
8. Patients should be offered contraception as ovulation will typically return in 2-3 weeks. Immediately available options include ED administration of depot-medroxyprogesterone acetate (DMPA) or a prescription for contraceptive pills, patches, or rings.
9. Counsel patients on post-operative expectations for bleeding (initially moderate followed by light bleeding for up to a few weeks), pain (initially moderate, followed by lighter cramping up to a few days), and potential complications.
10. Discharge patient with instructions to return to the ED for soaking 2 pads an hour, x2 hours (4 pads total in 2 hours), fever, foul smelling discharge, or other concerning symptoms. Nothing in the vagina x1 week including no sex, no tampons, no douching.

**Consents:**

* OB/Gyn resident will obtain procedural consent for Manual vacuum aspiration
* OB/Gyn resident will offer disposition of products of conception including hospital (cremation with no ability to collect ashes) or funeral home (patient will need to coordinate with funeral home for plans)
* ED physician will obtain consent for procedural sedation, if indicated

Appendix 1

*Counseling:*

Expectant management counseling: Pregnancy will pass on its own at home

* ~80% effective but may take up to 8 weeks
* Will have cramping (may take ibuprofen or other pain medication) & bleeding, which will cause passing of the pregnancy at home
* Inexpensive, avoids procedure, sedation, or medication

Medical management counseling: Misoprostol is given to cause uterine contractions & passing of pregnancy at home

* ~70-80% effective within 3 days when given 1 dose of 800mcg given buccally or vaginally (may repeat dose after 6-24 hours if no effect with first dose)
* Side effects of misoprostol include nausea, vomiting, diarrhea (may take anti-emetics/anti-diarrheals) & will have cramping (may take ibuprofen or other pain medication) & bleeding, which will cause passage of the pregnancy at home
* Inexpensive, avoids procedure or sedation

Surgical management counseling: Includes options for in-ER manual vacuum aspiration (MVA) or in-OR suction & currettage (S&C)

MVA counseling:

* May experience some discomfort (mostly uterine cramping during & for ~15 minutes post-procedure), but overall well-tolerated with options for mild or moderate sedation
* Fast (5 minute) procedure
* Avoids need for follow-up, NPO status, operating room, cost
* Ensures immediate removal of products of conception

S&C counseling:

* Patient will be asleep with anesthesia (usually MAC, not general), requiring NPO status & additional risks of anesthesia
* May need to be scheduled if not urgent
* Ensures removal of products of conception
* May have IUD inserted at time of procedure
1. https://www.acog.org/-/media/Practice-Bulletins/Committee-on-Practice-Bulletins----Gynecology/Public/pb150.pdf [↑](#footnote-ref-0)