**MANAGEMENT OPTIONS FOR EARLY PREGNANCY LOSS**

**Sierra Women’s Health May 2019**

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Early pregnancy loss is defined as a non-viable pregnancy in the uterus, either an empty gestational sac or a sac containing a fetus without a heartbeat, in the first 13 weeks of pregnancy. The terms miscarriage, spontaneous abortion, and early pregnancy loss all mean the same thing. Until recently, there were only two management options: waiting indefinitely for a natural miscarriage to occur, or surgically-evacuating the uterus. Recently, a third management option has been deemed safe and effective: medical management, or medically-assisted miscarriage. The safety profile of all three treatment options is similar---the risk of hemorrhage, transfusion, or serious infection is very small, and about the same with all three.

*If your blood type is Rh-negative (A-negative, B-negative, AB-negative, or O-negative), you need to get an injection of Rh D immune globulin as soon as possible after any early pregnancy loss, to prevent formation of dangerous antibodies.*  If you have surgical management, the medicine will be given to you in the surgery center. If you have a natural or medically-assisted miscarriage, the medicine should be given as soon as possible after the miscarriage, the next day our office is open (or in the E.R. if you need to go there).

Here is a brief description of the three options:

1. **Surgical Management** D and E (Dilatation and Evacuation) is a short outpatient procedure. General anesthesia is required, and we also inject local anesthesia around the cervix. A small sterile vacuum tube and some other instruments are used to empty the uterus. This procedure is reportedly 99% successful at completely evacuating the uterus, though Drs. Farringer and Najima have never had an unsuccessful D and E in a combined 53 years of experience (as of 2019). Complications are rare. There is a small chance of adhesions forming in the uterus after D and E, which could impede fertility in the future. ***D and E will be required if either of the other two options don’t work.***
2. **Medical Management** Two medical regimens are approved, either misoprostol-alone or mifepristone followed by misoprostol. Misoprostol-alone has a 70-85% chance of leading to completed miscarriage, and the mifepristone+misoprostol regimen works about 90% of the time. ***If either regimen fails to completely empty the uterus, D and E will be required.*** Ultrasound is crucial afterwards, to confirm completed miscarriage. It is not OK to travel until completed miscarriage is proven by ultrasound. Mifepristone is not available in pharmacies because of U.S. Food and Drug Administration (F.D.A.) restrictions. Sierra Women’s Health is licensed by the F.D.A. to dispense mifepristone. We keep both mifepristone and misoprostol in our office, so there’s no need to go to a pharmacy for either drug.
3. **Expectant Management** This means waiting indefinitely for a natural miscarriage, without medical or surgical intervention. There is about an 80% chance of having a completed miscarriage within 8 weeks of diagnosis. Timing is quite unpredictable---some women will miscarry within days of diagnosis, and some women will carry a non-viable pregnancy for many weeks without any bleeding or cramping. It is not OK to travel until completed miscarriage is proven, as heavy bleeding and severe cramping could start anytime, anywhere. Keeping the recommended appointments for followup ultrasounds is important, even if you feel certain that you have miscarried---some women have classic symptoms of miscarriage, and ultrasound shows that the sac is still in the uterus. Up to two hours of heavy bleeding, clots, and pain are normal with a miscarriage, and do not require a phone call or a trip to the office or hospital. ***If you are soaking two maxi-pads per hour for two consecutive hours, you need to call the doctor---you need to be seen, and will likely need a D and E.***