1. Background

1.1. Purpose

Early pregnancy loss (EPL), sometimes called miscarriage, spontaneous abortion, missed abortion, and early pregnancy failure, makes up 15% of all clinically recognized pregnancies [1]. Patients often present in the outpatient setting or emergency department (ED) with symptoms such as vaginal bleeding and cramping. However, with the increased availability of highly sensitive pregnancy tests and early ultrasonography, the diagnosis of EPL is often made before the onset of symptoms. Once diagnosed, a patient-centered approach should be used to counsel patients on their treatment options, including expectant management, procedural management via uterine aspiration, or medication management. All methods of EPL management have been found to be safe, effective, and accepted by patients [2]. Evidence demonstrates that patients offered their preferred management method through shared decision-making have higher satisfaction with care, improved quality of life scores, and better outcomes [3–6]. However, evidence suggests that patients may not be offered all options for EPL management depending on the practice setting; geographic location; state policies about abortion; and facility-, clinician-, and patient-level characteristics [7–11]. Standard gynecologic and emergency care should include access to prompt active management of EPL when indicated and desired by the patient. **We recommend that patients experiencing EPL have equal access to all available treatment options, including expectant, medication, and procedural management, when urgent treatment is not necessary (GRADE 1A) (Table 1).** Indications for urgent treatment may include but are not limited to hemorrhage and suspected intrauterine infection, which may necessitate prompt procedural management.

Medication management may be preferable to patients who prioritize control, predictability, privacy, or avoidance of procedural intervention during the pregnancy loss process [12]. Mifepristone followed by misoprostol is the most efficacious and cost-effective medication management regimen for EPL [13–18]. Despite mifepristone's excellent safety profile, it is highly regulated by the US Food and Drug Administration (FDA) Risk Evaluation and Mitigation Strategy (REMS) with patient- and clinician-directed requirements due to its use in abortion. At the time of publication of this guidance, mifepristone is subject to multiple abortion-targeted legal restrictions, which restrict access to the most evidence-based medication EPL regimen. Misoprostol-only regimens are also safe and effective for the treatment of EPL and should be offered when mifepristone is unavailable or restricted [19,20]. Even when EPL care is accessible, people may prefer to self-manage EPL, especially if they have experienced structural racism and stigma within the medical system. Although outside the original scope of this document, common self-managed approaches include sourcing mifepristone, misoprostol, or both outside the formal health care system or using herbal preparations to induce pregnancy expulsion [21].

Clinicians caring for pregnant people should be familiar with diagnostic considerations and patient-centered approaches to the management of EPL, as well as systemic and legal barriers that restrict access to safe and effective care. This Clinical Recommendation provides evidence-based guidance on outpatient medication management of EPL, including considerations for management in areas with abortion restrictions impacting access to medications used to manage EPL. It is based on a review of relevant literature, primarily including studies that assess EPL management outcomes but also including studies that address medication abortion when evidence is lacking for EPL, as they are managed similarly.

1.2. Definitions

EPL is a broad term that includes intrauterine pregnancies with findings that suggest the pregnancy may not progress or definitely will not progress, pregnancies with a gestational sac (GS) in the lower endometrial cavity or endocervical canal in the process of expulsion, residual pregnancy tissue or persistent GS, and complete passage of the GS without residual tissue. This document addresses medication management of EPL in which the complete passage of the GS has not yet occurred, including pregnancies concerning for and diagnostic of EPL (sometimes called "missed abortion") and EPL in progress. These recommendations do not specifically address incomplete EPL in which no GS is seen on ultrasonography (sometimes called retained products of conception [RPOC]). They also do not specifically address EPL with spontaneous passage of the GS prior to health care evaluation or expectant management of EPL with subsequent passage of the GS, although many of the treatment approaches, including indications for Rh testing, pain management, and confirmation of completed EPL, can also be employed in these clinical situations. EPL is most commonly defined as a pregnancy loss within the first 12 6/7 weeks of gestation [2,22,23]. However, there is no consensus on gestational duration in the definition of EPL in the literature, which can make comparing studies challenging. This document provides recommendations for medication management of EPL through 13 6/7 weeks of gestation.

Clinicians should use patient-centered language and individualized counseling to improve patient-clinician communication. In a survey of English-speaking patients in the US being treated for first-trimester pregnancy loss, the terms "miscarriage" and "early pregnancy loss" were preferred by patients and provided the most clarity; patient preferences varied by ethnicity and history of abortion [24]. Additionally, patients experiencing EPL value clear communication and emotional sensitivity during diagnosis and management [12,25]. The term "early pregnancy loss" may not translate into other languages and culture may influence terminology preference. While outside the original scope of this document, we do not recommend qualifiers such as "elective," "therapeutic," or "medically necessary" when referring to pregnancy loss or abortion care, as these terms further perpetuate abortion stigma [26]. Additionally, the Society of Family Planning (SFP) supports the use of language as outlined in *A lexicon for first-trimester ultrasound: Society of Radiologists in Ultra sound consensus conference recommendations* [23].

Table 1
Key for GRADE recommendations[a]

Symbol	Meaning
1	Strong recommendation
2	Weaker recommendation
A	High-quality evidence
B	Moderate quality evidence
C	Low-quality evidence, clinical experience, or expert consensus
Best practice	A recommendation in which either (1) there is an enormous amount of indirect evidence that clearly justifies a strong recommendation, direct evidence would be challenging and an inefficient use of time and resources to bring together and carefully summarize, or (2) a recommendation to the contrary would be unethical

[a] Society of Family Planning Clinical Recommendations use a modified GRADE system. The GRADE system is described in several publications, with a comprehensive set of articles in the Journal of Clinical Epidemiology (J Clin Epidemiology, [2011] 64:383–394, 64:395–400, 64:401–406, 64:407–415, 64:1277–1282, 64:1283–1293, 64:1294–1302, 64:1303–1312, 64:1311–1316, [2013] 66:140–150, 66: 151–157, 66:158–172, 66:173–183, 66:719–725, 66:726–735).