

Vaginal Misoprostol for Early Failed Pregnancy

BY CARL SHERMAN
Contributing Writer

NEW YORK — Vaginal misoprostol is an effective alternative to surgical intervention for management of early pregnancy failure, with a high degree of patient acceptability, according to a study reported at an obstetrics symposium sponsored by Columbia University and New York Presbyterian Hospital.

The more tissue present, the higher the success rate; surgical intervention is less often needed for embryonic or fetal demise and incomplete abortion than for anembryonic gestations.

Failed pregnancy in the first trimester is followed by spontaneous uterine expulsion of the products of conception in up to 80%

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of cases, but this may take 2 months, and many women don't want to wait. "About 60% prefer treatment to expectant management," Carolyn Westhoff, M.D., professor of obstetrics and gynecology, epidemiology and population and

family health at the university, said at the meeting.

The standard of care has become dilatation and curettage (D&C), increasingly done as an office procedure using vacuum aspiration.

Use of the synthetic prostaglandin analog misoprostol for early pregnancy failure has been reported since 1983, usually involving hospital admission and repeated administration by various routes. Definitions of success have varied (depending on time allowed for effect), and few have involved comparison groups.

It appears that vaginal administration is most effective; in four trials involving a total of 123 women, the drug in this form resulted in expulsion of 60%-90% of embryos of up to 13-week size, Dr. Westhoff said.

In a 2004 NIH pilot trial of vaginal misoprostol for anembryonic gestation and fetal/embryonic demise, a single application (repeated if necessary, after 48 hours) was successful (expulsion by 1 week, without the need for D&C) in 94% of 51 cases of embryonic/fetal demise, and in 69% of 29 anembryonic gestations.

Dr. Westhoff reported findings of a randomized multicenter trial conducted under the auspices of the National Institutes of Child and Maternal Health, which enrolled 652 women with early pregnancy failure (at less than 12 weeks' gestation or size).

Two-thirds of the women were given a single 800-mcg dose of vaginal misoprostol—the other women had D&C—with a second administration if a sac or lining of more than 30 mm was still present on transvaginal ultrasound examination at day 2. Vacuum aspiration was provided on request for medical indications such as

heavy bleeding, or when expulsion had not occurred within 1 week.

Expulsion was most likely to be complete by day 3 among the 30 women who had had incomplete or inevitable abortion, a pattern that held on day 8, when 93% in this group had successfully expelled the products of conception, compared with 87% of the 281 women with embryonic or fetal demise and 81% of the 177 women with anembryonic gestation.

"Women with incomplete/inevitable

abortion and intrauterine fetal demise did very well with misoprostol alone; most required only one dose. The results were less impressive for anembryonic gestation," Dr. Westhoff said.

More than 80% of participants in every category said they would recommend the procedure to a friend, if the need arose, and more than 75% said they would opt for it themselves. "Acceptance was highest in the incomplete-abortion group," she said.

One lesson from the trial was the clin-

ical importance of a follow-up visit 2 days after misoprostol insertion. "A number of patients had tissue in the internal os, with attendant bleeding. It needed just ring forceps for removal, but if this had not been done, some [cases] would have turned into an emergency," Dr. Westhoff said.

Only 28% of women telephoned their medical providers during the trial, perhaps reflecting the value of counseling on what symptoms to expect, she said. ■

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