

## Notes:

- Studies of misoprostol for IUFD often include a mix of live and demised fetuses. Data related specifically to demised fetuses are not extensive. The proposed regimens reflect the available data and expert consensus.
- A loading dose of misoprostol has no apparent clinical benefit.
- Vaginal administration of misoprostol is not recommended if there is blood or other fluids in the vagina.
- Starting misoprostol less than 24 hours after taking mifepristone may result in a shorter overall time from mifepristone administration to expulsion of the fetus but longer time between first dose of misoprostol and fetal expulsion. The interval between mifepristone and misoprostol can be selected based on the preference and convenience of the woman, the provider and the healthcare system. Mifepristone can be offered for the woman to take at home, and she can return to the facility for the misoprostol.
- Pain medication can be started at the same time as misoprostol. NSAIDs specifically do not counteract misoprostol's mechanism of action.
- IUFD is itself a risk factor for coagulation disorders, particularly if the fetus has been demised for more than 2 weeks.

### SUGGESTED CITATION

Instructions for Use: Mifepristone plus Misoprostol or Misoprostol - Alone for Treatment of Intrauterine Fetal Death 12 - 24 Weeks' LMP. Gynuity Health Projects. February 2014.

For more information, refer to [www.gynuity.org](http://www.gynuity.org)

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February 2014



# INSTRUCTIONS FOR USE

## MIFEPRISTONE PLUS MISOPROSTOL OR MISOPROSTOL-ALONE FOR TREATMENT OF INTRAUTERINE FETAL DEATH 12 - 24 WEEKS' LMP

### BACKGROUND

Mifepristone (an antiprogesterin) and misoprostol (a prostaglandin) are often used together to induce fetal and placental expulsion in cases of intrauterine fetal death (IUFD). Mifepristone induces cervical softening and facilitates uterine contractions while misoprostol induces uterine contractions. Both are marketed under various trade names and are available individually or together. Misoprostol-alone is used to induce fetal and placental expulsion in cases of IUFD where mifepristone is not available.

### INDICATION AND USAGE

The following information applies to the use of mifepristone and misoprostol or misoprostol-alone to induce fetal and placental expulsion with a demised fetus\* estimated to be between 12 and 24 weeks since the first day of the last menstrual period (LMP). Using these drugs, almost all women will successfully expel the pregnancy. Mifepristone with misoprostol results in a median fetal expulsion time of under 10 hours; misoprostol-alone regimens take longer, with a median fetal expulsion time of around 16 hours.

### CONTRAINDICATIONS

History of allergy to mifepristone or misoprostol.

\* For information on live fetuses, please refer to Instructions for Use on Abortion Induction with Mifepristone and Misoprostol or Misoprostol-alone in Pregnancies between 12 and 24 weeks' LMP

## PRECAUTIONS

- Prior cesarean delivery and/or advanced gestational age should not be contraindications for use. As pregnancy advances, the uterus becomes more sensitive to misoprostol, so for gestations beyond 24 weeks and for women with multiple uterine surgeries, the misoprostol dose can be reduced to 200 mcg. Uterine rupture is a rare event.
- There is no evidence that the medicines used to induce fetal and placental expulsion are harmful to nursing infants. However, most medicines in a woman's blood do get into breast milk in very small amounts, and some women may choose to discard breast milk for a few hours after taking the pills.
- When a total placenta previa is diagnosed, alternative methods of evacuation should be considered.

## EFFECTS AND SIDE EFFECTS

Most women find side effects manageable. Serious side effects are rare.

### BLEEDING

Bleeding after mifepristone administration is unusual but is typically light if it occurs.

Bleeding may occur as early as 30 minutes after the first dose of misoprostol or may take several hours to start. Heavier bleeding can be expected just prior to and immediately after passage of the fetus.

Excessive bleeding is rare, but if it occurs is most likely between expulsion of the fetus and placenta. Although less common than at term delivery, bleeding emergencies should be managed similarly to excessive postpartum bleeding.

Women should be instructed to contact their providers if any of the following occur: (1) soaking more than two maxi sanitary pads an hour for more than two consecutive hours, (2) bleeding continuously for several weeks with faintness or light-headedness. Bleeding typically lasts 7 to 14 days after the procedure with spotting up to the next menstrual period. Menses usually occurs 4 to 6 weeks after misoprostol administration and may be preceded by fertile ovulation.

### PAIN

Uterine pain and cramping are typical features of an induction with these medications. Pain may occur as early as 30 minutes after the first dose of misoprostol or may take several hours to develop. Pain can be

moderate to severe depending on the duration of the process and the intensity of the contractions. The duration of the process tends to be longer later in pregnancy. Pain relief should be offered to all women and can include nonsteroidal anti-inflammatory drugs (NSAIDs), narcotics and/or regional anesthesia. These medications can be started at the time of misoprostol administration. A combination of approaches may be appropriate to ensure the woman's comfort. Pain will resolve after the fetus and placenta have been expelled.

### CHILLS AND/OR FEVER

Chills are common but transient side effects of misoprostol. Fever is less common, also usually transient, and does not necessarily indicate infection. Fever or chills persisting beyond 24 hours after the last dose of misoprostol may indicate infection and the woman should seek medical attention. Routine use of antibiotic prophylaxis is not necessary.

### NAUSEA AND VOMITING

Nausea and vomiting may occur and will resolve 2 to 6 hours after taking the last dose of misoprostol. An antiemetic can be used if needed.

### DIARRHEA

Diarrhea may also occur following administration of misoprostol but should disappear within a few hours.

### BREAST ENGORGEMENT

Breast engorgement may occur after expulsion of the fetus in this gestational age range and may last a few days to a week. Analgesics, ice packs and breast compression with a tight bra, binding, or other garment may be helpful.

## DOSAGE AND ADMINISTRATION

**The recommended regimen is mifepristone followed in 12 to 48 hours by misoprostol every 3 hours until expulsion.** (If mifepristone is not available, misoprostol can be administered every 3 hours until expulsion)

**MIFEPRISTONE DOSE:** 200 mg oral

**MISOPROSTOL DOSE:** 400 mcg (two 200 mcg tablets) buccal (in the cheek), sublingual (under the tongue) or vaginal

For sublingual and buccal routes, hold pills in position for approximately 30 minutes, then swallow remaining fragments.

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February 2014