NICE National Institute for Health and Care Excellence

Ectopic pregnancy and miscarriage (NG126) – Update to recommendations on the medical management of miscarriage

This guideline covers diagnosing and managing ectopic pregnancy and miscarriage in women and people with complications, such as pain and bleeding, in early pregnancy (that is, up to 13 completed weeks of pregnancy). It aims to improve how early pregnancy loss is diagnosed, and the support women and people are given, to limit the psychological impact of their loss.

These recommendations will update NICE guideline NG126 (published April 2019).

Who is it for?

- Healthcare professionals
- Commissioners
- women and people with complications in early pregnancy (up to 13 completed weeks of pregnancy), their families and carers

What does it include?

- revised recommendations on medical management of miscarriage
- rationale and impact information that explains why the committee made the 2023 recommendations and updates, and how they might affect practice and services.

Information about how the guideline was developed is on the guideline's webpage. This includes the evidence review, details of the committee and any declarations of interest.

Updated recommendations

We have reviewed the evidence on medical management of miscarriage. You are invited to comment on the revised recommendations only. These are marked as **[2012, amended 2023]**, or no change.

ID Number (please use to identify what comment relates to at consultation)	Existing recommendation in NG126	Proposed revised recommendation	Rationale for change	Impact of change
1	**Medical management** 1.5.11 Do not offer mifepristone as a treatment for missed or incomplete miscarriage. **[2012]**	1.5.11 Do not offer mifepristone as a treatment for incomplete miscarriage. **[2012, amended 2023]**	The committee reviewed new evidence relating to the use of mifepristone for missed miscarriage and amended subsequent recommendations, but agreed that there was no new evidence to support the use of mifepristone for incomplete miscarriage.	Mifepristone is still not recommended for the treatment of incomplete miscarriage but is now recommended for the treatment of missed miscarriage. As mifepristone is already used in clinical practice for missed miscarriage

				in many early pregnancy settings this will standardise practice for such settings across the NHS.
2	1.5.12 Offer vaginal misoprostol for the medical treatment of missed or incomplete miscarriage. Oral administration is an acceptable alternative if this is the woman's preference. **[2012]**	1.5.12 For the medical management of missed miscarriage offer: • 200 mg oral mifepristone, **and** • 48 hours later, 800 micrograms misoprostol (vaginal, oral or sublingual) unless the gestational sac has already been passed. **[2012, amended 2023]** In May 2023, this was an off-label use of mifepristone and misoprostol. See NICE's information on prescribing medicines.	There was evidence that the combination of mifepristone and misoprostol reduced the failure of the gestational sac to spontaneously pass by 7 days and reduced the need for surgical intervention to complete the miscarriage up to and after 7 days, compared to misoprostol alone.	The use of mifepristone for the treatment of missed miscarriage may increase. As mifepristone is already used in clinical practice for missed miscarriage in many early pregnancy settings this will standardise practice for such settings across the NHS. The use of combination treatment will reduce the need for surgical intervention so will reduce costs for the NHS. This has been shown to be a cost-effective treatment.
3	1.5.13 For women with a missed miscarriage, use a single dose of 800 micrograms of misoprostol. **[2012]**	The recommendation has been deleted.	The dosing information for the management of missed miscarriage is now included in the recommendation above.	Recommendations have been combined so no impact.
4	1.5.14 Advise the woman that if bleeding has not	1.5.13 Advise the woman or person that if bleeding has not	Time to bleeding was not an outcome reported in the	The change from 24 hours to 48 hours may

	started 24 hours after treatment, she should contact her healthcare professional to determine ongoing individualised care. **[2012]**	started within 48 hours after misoprostol treatment, they should contact their healthcare professional to determine ongoing individualised care. If there are concerns that they will not contact the service then there should be arrangements for the service to follow up with these individuals. **[2012, amended 2023]**	evidence, but the committee noted that the study described that bleeding usually started 2 to 3 days after misoprostol treatment, and that women and people were asked to report if bleeding had not started within 48 hours. The committee agreed that 24 hours was too short and that 48 hours would be a more realistic timeframe. Based on their knowledge and experience the committee noted that there may be some people who cannot easily contact early pregnancy services and that these individuals should be contacted pro-actively to check that bleeding has commenced.	reduce the number of people contacting early pregnancy services due to bleeding not having started. However, the recommendation to pro-actively follow up people who do not contact the service may increase resource use as staff time will be needed to contact these individuals.
5	1.5.15 For women with an incomplete miscarriage, use a single dose of 600 micrograms of misoprostol. (800 micrograms can be used as an alternative to allow alignment of treatment protocols for both missed and incomplete miscarriage.) **[2012]**	1.5.14 For incomplete miscarriage, use a single dose of 600 micrograms of misoprostol. 800 micrograms can be used as an alternative to allow alignment of treatment protocols for both missed and incomplete miscarriage.**[2012]**	No changes made	No changes made
6	1.5.16 Offer all women receiving medical	1.5.15 Offer all women and people receiving medical	No changes made	No changes made

	management of miscarriage pain relief and anti-emetics as needed. **[2012]**	management of miscarriage pain relief and anti-emetics, as needed. **[2012]**		
7	1.5.17 Inform women undergoing medical management of miscarriage about what to expect throughout the process, including the length and extent of bleeding and the potential side effects of treatment including pain, diarrhoea and vomiting. **[2012]**	1.5.16 Inform women and people receiving medical management of miscarriage about what to expect throughout the process. Include the length and extent of bleeding, potential side effects of treatment including pain, diarrhoea and vomiting, and when and how to seek help. **[2012, amended 2023]**	The committee agreed, based on their knowledge and experience, that women and people having a miscarriage should also be given advice on when and how to seek help during the miscarriage process.	This may increase the number of people seeking help during the miscarriage process and this may increase resource use for the NHS.
8	1.5.18 Provide women with a urine pregnancy test to carry out at home 3 weeks after medical management of miscarriage unless they experience worsening symptoms, in which case advise them to return to the healthcare professional responsible for providing their medical management. **[2012, amended 2021]**	1.5.17 Provide women and people who have had medical management of miscarriage with a urine pregnancy test to carry out at home 3 weeks after medical management of miscarriage unless they experience worsening symptoms, in which case advise them to return to the healthcare professional responsible for providing their medical management. **[2012, amended 2021]**	No changes made.	No changes made
9	1.5.19 Advise women with a positive urine pregnancy test	1.5.18 Advise women and people with a positive urine	The committee agreed, based on their knowledge and	This will not change the number of people who

	after 3 weeks to return for a review by a healthcare professional to ensure that there is no molar or ectopic pregnancy. **[2012]**	pregnancy test after 3 weeks to return for a review by a healthcare professional to rule out a retained pregnancy and assess the need for further investigations or treatment. **[2012, amended 2023]**	experience, that a complete molar or ectopic pregnancy (including a heterotopic pregnancy) would have been ruled out before the medical management of miscarriage began and therefore it is not appropriate to suggest they needed to be ruled out if the pregnancy test was still positive after 3 weeks.	need review for a positive pregnancy test after 3 weeks, so there will be no resource impact from this change.
10	**Expectant management** 1.5.8 If the resolution of bleeding and pain indicate that the miscarriage has completed during 7 to 14 days of expectant management, advise the woman to take a urine pregnancy test after 3 weeks, and to return for individualised care if it is positive. **[2012]**	1.5.8 If the resolution of bleeding and pain indicate that the miscarriage has completed during 7 to 14 days of expectant management, provide the woman or person with a urine pregnancy test to carry out at home 3 weeks after their miscarriage, and advise them to return for individualised care if it is positive. **[2012, amended 2023]**	The committee noted that this recommendation in the section of the guideline on expectant management of miscarriage required people to obtain a pregnancy test themselves, whereas the guidance following medical management of miscarriage advised that people should be supplied with a pregnancy test by their care team. To ensure parity of treatment between all groups having a miscarriage, the committee amended this section of the guideline to advise that a pregnancy test should be supplied by the care team to women and people having expectant management as well	This will increase the number of urine pregnancy tests supplied by the NHS which will have a resource impact.

			as those having medical management.	