this & that

05

OBSTETRIC QUICK GUIDES · IF THIS, THEN THAT

NO.

Early Pregnancy Bleeding

& pregnancy of unknown location

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Obstetrics & Gynaecology

Diagnosis & management

Verified against ACOG · SMFM · RCOG · SOGC — October 2026

Early pregnancy bleeding & pregnancy of unknown location

At a glance: the numbers to remember

CRL ≥7 mm
no cardiac activity = loss confirmed

MSD ≥25 mm
no embryo = loss confirmed

>63% / 48 h
hCG rise that suggests a developing IUP (NICE)

<35 mm · <1500
tubal ectopic: NICE methotrexate first-line

<12^{+0} wk
anti-D no longer routine for miscarriage (ACOG 2024, NICE 2026)

hCG in IU/L (= mIU/mL). Where societies disagree, each position carries the society name; follow your local protocol. Gestations are completed weeks; doses are for the first trimester. **Local protocol:** no mifepristone; misoprostol-only regimens follow the FIGO 2023 chart. Mifepristone regimens are kept for reference.

Abbreviations: ART, assisted reproduction · CRL, crown–rump length · CSEP, caesarean scar ectopic pregnancy · EPL, early pregnancy loss · EVA, electric vacuum aspiration (pump, usually theatre) · GTD/GTN, gestational trophoblastic disease/neoplasia · IUP, intrauterine pregnancy · LMP, last menstrual period · MSD, mean sac diameter · MTX, methotrexate · MVA, manual vacuum aspiration (hand-held syringe, clinic, local anaesthesia) · PSTT/ETT, placental-site/epithelioid trophoblastic tumour · PUL, pregnancy of unknown location · RhIG, Rh immune globulin (anti-D) · TVS, transvaginal sonography · UAE, uterine artery embolisation · PO/PV/SL, oral/vaginal/sublingual.

01 Definitions

Term	Meaning
Threatened miscarriage	Bleeding with a live intrauterine pregnancy (IUP) and a closed os. About 1 in 4 pregnancies bleed in the first trimester (Williams).
Inevitable miscarriage	Os open, sac still in the uterus, no tissue passed.
Incomplete miscarriage	Partial expulsion: os open or tissue at the os; TVS shows heterogeneous tissue in the cavity with or without a sac.
Complete miscarriage	All tissue passed, os closed, empty uterus. Certain **only** if products were seen or a previous scan showed an IUP (Williams).
Early pregnancy loss (EPL)	Nonviable IUP in the first trimester (ACOG: to 12^{+6} wk): **anembryonic** (sac, no embryo) or **embryonic/fetal demise** (embryo, no cardiac activity). Replaces missed abortion and blighted ovum.
Septic miscarriage	Any miscarriage with uterine infection: fever, uterine tenderness, offensive discharge, retained tissue.
Pregnancy of unknown location (PUL)	Positive hCG with no IUP and no ectopic seen on TVS. A holding label, not a diagnosis: early IUP, failing IUP, completed miscarriage or ectopic.
Ectopic pregnancy	Implantation outside the endometrial cavity. Tubal (ampulla ~70%) or non-tubal: interstitial, cervical, caesarean scar, ovarian, abdominal. **Heterotopic** = IUP plus ectopic.
Molar pregnancy	Complete (46,XX, no fetus) or partial (triploid, fetal parts) hydatidiform mole; can progress to gestational trophoblastic neoplasia (GTN).

Words that change decisions (SRU first-trimester lexicon 2024, endorsed by SMFM)

- An intrauterine fluid collection in a pregnant woman is a **probable gestational sac**, not a pseudosac; a definite IUP needs a yolk sac or embryo.
- Use early pregnancy loss, cardiac activity and probable or definite ectopic. Avoid blighted ovum, missed abortion, heartbeat and pregnancy failure.
- Ask early whether the pregnancy is wanted; about half of pregnancies are unintended (Berek), and the answer changes how much diagnostic certainty is needed.

02 Triage & diagnosis

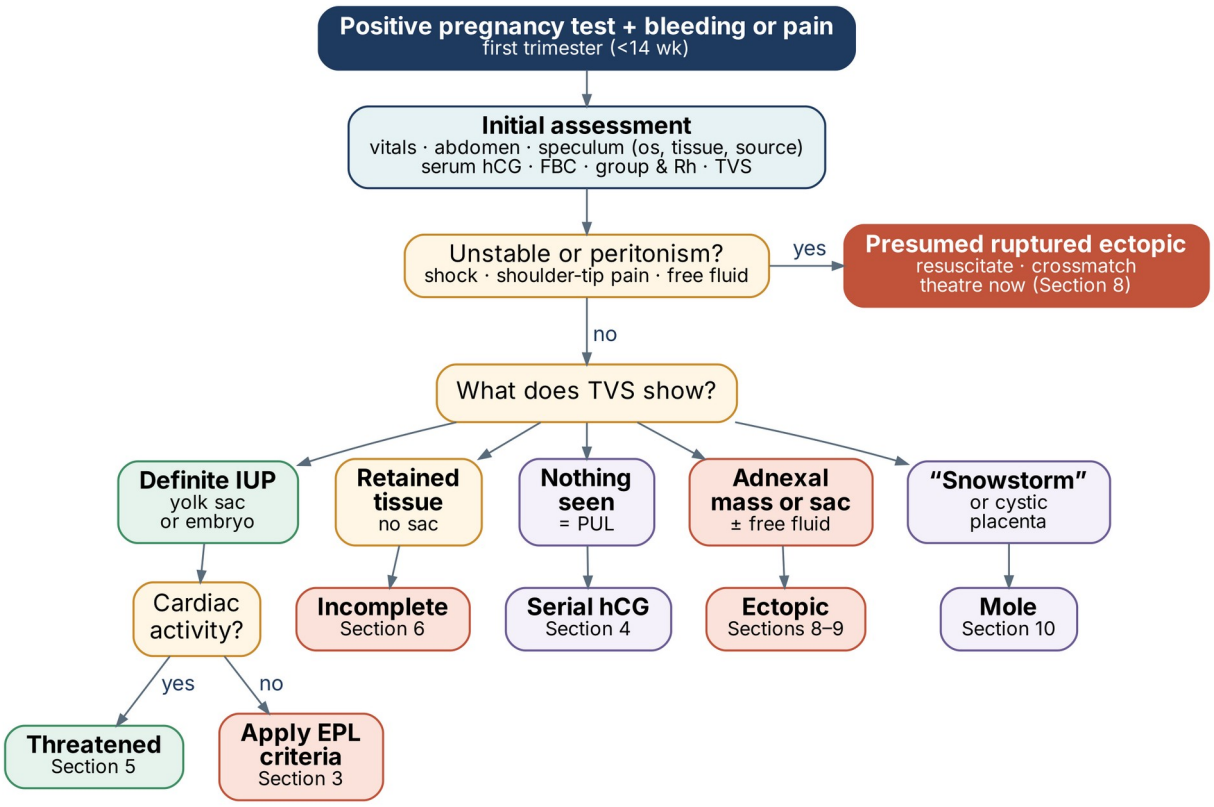


Figure 1. *First assessment of bleeding or pain with a positive pregnancy test.*

IF	THEN
Positive test with bleeding or pain	• Vitals, abdominal exam, speculum (source, os, tissue) • Serum hCG, FBC, group and Rh • TVS first; add a transabdominal view for free fluid and Morison pouch
Shock, peritonism, shoulder-tip pain or free fluid	• **Presumed ruptured ectopic**: two large-bore cannulae, crossmatch, senior and theatre now • Activate the massive haemorrhage protocol; O-negative blood while crossmatching • Do not wait for hCG; first Hb underestimates loss, so trend it • Fluid in Morison pouch means about 400–600 mL of blood (Williams)
Heavy bleeding, bradycardia, tissue in the os	Cervical shock: remove tissue with ring forceps under direct vision; the vasovagal response usually settles. Then evacuate if bleeding continues.
Fever, uterine tenderness, offensive discharge	Septic miscarriage → Section 7.

IF	THEN
Pain out of proportion to bleeding, or risk factors	• Previous ectopic (recurrence ~10%), tubal surgery or sterilisation, PID, IVF, IUD in situ, smoking • Keep ectopic on the list until the pregnancy is located
Bimanual examination	Gentle and limited; it can rupture a tubal pregnancy (Williams).
Low serum hCG (<1000) but negative urine test, before giving MTX	Consider a false-positive (phantom) hCG from heterophile antibodies; confirm with a urine test (Berek).
Stable, pregnancy located on TVS	Follow the pathway for that finding (Sections 3–10).

03 Is the intrauterine pregnancy viable?

IF	THEN
CRL ≥7 mm, no cardiac activity	• **Diagnostic of EPL** (ACOG, SRU) • NICE: second opinion and/or rescan ≥7 days before acting
MSD ≥25 mm, no embryo	• **Diagnostic of EPL** (ACOG, SRU) • NICE: second opinion and/or rescan ≥7 days
Sac without yolk sac, then no embryo with cardiac activity ≥2 weeks later	Diagnostic of EPL.
Sac with yolk sac, then no embryo with cardiac activity ≥11 days later	Diagnostic of EPL.
CRL <7 mm with no cardiac activity, or MSD <25 mm with no embryo	**Not diagnostic.** Rescan in ≥7 days (NICE) or 7–10 days (SRU). Give a clear return plan.
Concerning but not diagnostic	• Yolk sac >7 mm before 10 wk; embryonic heart rate <85 bpm • MSD minus CRL <5 mm; irregular sac • Empty amnion; no embryo ≥6 wk after LMP
Measured only transabdominally	Rescan in ≥14 days before any decision (NICE).
Subchorionic haematoma with a live embryo	Manage as threatened miscarriage. Williams finds no higher miscarriage risk (Naert 2019); a meta-analysis in Obstetric EBG reports OR 2.18 for loss and 5.71 for later abruption.
Cardiac activity seen	Threatened miscarriage (Section 5). Loss after cardiac activity at 10–13 wk is about 1% (Berek); risk rises with age.

Bedside rule

- If the pregnancy may be wanted, **never act on a scan that falls short of the diagnostic criteria**. A week's wait costs little; an evacuation of a live pregnancy cannot be undone.
- Use transvaginal measurements, M-mode for cardiac activity, and no routine pulsed Doppler on an early embryo (Williams).

04 Pregnancy of unknown location

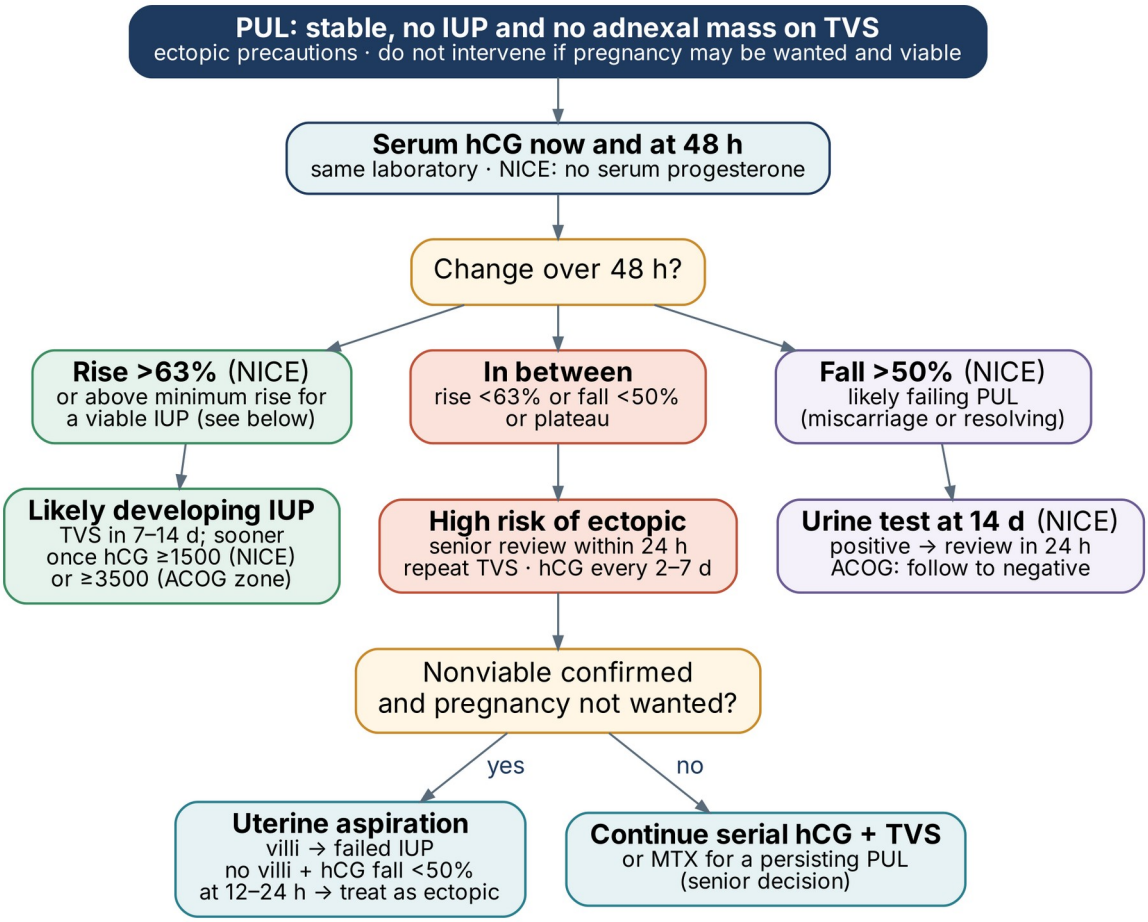


Figure 2. *Serial hCG pathway for a stable woman with a pregnancy of unknown location.*

IF	THEN
Stable PUL	• Serum hCG now and **48 h later (no earlier)**, same laboratory • Ectopic warning signs in writing; a phone number that is answered • NICE: do not use serum progesterone to locate the pregnancy
Minimum 48-h rise expected in a viable IUP	• NICE: rise **>63%** → probable developing IUP → TVS in 7–14 d, earlier if hCG ≥1500 • ACOG/US: the minimum rise depends on the starting hCG, lower when the start is higher (Barnhart 2016, in Berek): start <1500 → at least 49%; 1500–3000 → 40%; >3000 → 33%. Below this → suspect a failing IUP or ectopic (e.g. 2000 → 2600 is +30%, under 40%) • Most conservative cut-off 35% (Williams, citing Seeber 2006); a third of ectopics also rise ≥53%
Fall over 48 h	• NICE: fall **>50%** → probably failing → urine test 14 d after the second hCG; positive → review within 24 h • Failing PUL falls 35–50% by 2 d and 66–87% by 7 d (Butts, Williams) • Fall ≥85% by day 4 or ≥95% by day 7: ectopic risk near zero (Berek)
Suboptimal rise, slow fall or plateau	• Senior review within 24 h (NICE) • Repeat TVS; repeat hCG every 2–7 d (ACOG), sooner if symptoms • A declining hCG does not exclude rupture

IF	THEN
Single hCG above the discriminatory level, empty uterus	• Ectopic or failed IUP likely, but do not treat on one value if the pregnancy may be wanted • ACOG: set the level conservatively high, up to 3500; a sac is seen in 99% of viable IUPs above 3510 (Connolly)
Serum progesterone available (US practice)	• <5–6 ng/mL (<20 nmol/L): nonviable pregnancy, about 98% specific • ≥25 ng/mL: probable viable IUP • Neither value locates the pregnancy (Williams, Berek); NICE does not use it
Pregnancy confirmed nonviable and not wanted, location still unknown	• **Uterine aspiration** (not Pipelle, which misses villi) • Villi seen (float in saline, or frozen section, 95% accurate) → failed IUP • hCG 12–24 h after aspiration: fall ≥50% → failed IUP likely; smaller fall, plateau or rise → treat as ectopic or follow closely (ACOG, Berek)
Persisting PUL (plateau, no location after repeat scans)	Senior decision: aspiration, then MTX if no villi; MTX without histology misdiagnoses about 27% (Chung, Williams).

05 Threatened miscarriage

IF	THEN
Bleeding, live IUP, os closed	• Reassure: most pregnancies continue • Paracetamol for cramps; avoid intercourse until bleeding settles (Williams) • Return if bleeding gets heavier or lasts beyond 14 days (NICE)
Bleeding and a previous miscarriage, IUP confirmed	• **NICE:** offer vaginal micronised progesterone **400 mg twice daily**; continue to 16 completed weeks once cardiac activity is confirmed • RCOG GTG 17: consider the same regimen in recurrent miscarriage • ACOG: no recommendation
No previous miscarriage	No progesterone: PRISM showed no overall benefit (Williams).
Bed rest, hCG injections, uterine relaxants	Not recommended: no benefit, and bed rest adds VTE risk (Obstetric EBG).
Bleeding heavy enough to cause anaemia or hypovolaemia	Rare. Williams usually evacuates; transfusion with observation is an option if the pregnancy is wanted.
Pregnancy continues	Higher later risk of antepartum haemorrhage (OR 2.47), preterm birth (2.05) and PPROM (1.78) (Obstetric EBG); Williams adds no extra surveillance for this alone.

06 Managing miscarriage

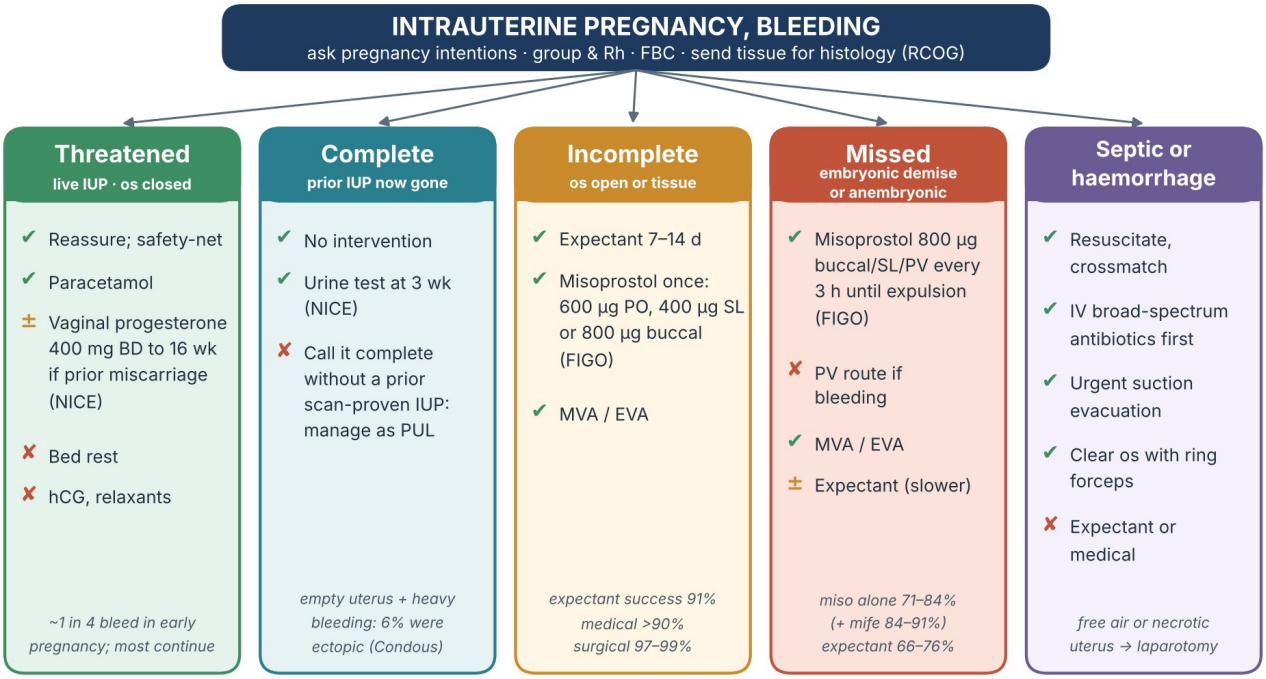


Figure 3. *Management by type of miscarriage, with success rates from Berek and Obstetric EBG.*

IF	THEN
Choosing a method	• Patient preference leads: safety and later fertility are similar (live birth at 5 years 79–82% with all three) • Not suitable for expectant or medical care: instability, infection or sepsis, suspected mole or ectopic, coagulopathy or anticoagulants; caution if Hb <9.5 g/dL (Obstetric EBG)
Expectant	• NICE: first-line for 7–14 days • Not first-line if higher bleeding risk (late first trimester), coagulopathy, cannot have a transfusion, infection, or a previous traumatic pregnancy experience (NICE) • ACOG: about 80% complete within 8 weeks • Versus surgery: more unplanned evacuation (28% vs 4%) and transfusion (Cochrane, Obstetric EBG)
Missed miscarriage (EPL), medical: our protocol (FIGO 2023, ≤12 wk)	• **Misoprostol 800 µg buccal, SL or PV every 3 h until expulsion**; usually 1–3 doses; no maximum dose • Not complete after 5 doses: continue, or rest 12 h and start again (FIGO) • Avoid the vaginal route if she is bleeding (FIGO) • Success with misoprostol alone: 71% after one dose, 84% with a second (Obstetric EBG); with mifepristone first, 84–91%
Uterus 13–17 wk size	Misoprostol 400 µg buccal, SL or PV every 3 h until expulsion (FIGO 2023).
Where mifepristone is available (reference)	• **ACOG:** mifepristone 200 mg PO, then **24 h** later misoprostol 800 µg PV • **NICE:** then **48 h** later misoprostol 800 µg PV, PO or SL · **WHO/FIGO:** interval 1–2 days
Incomplete miscarriage, medical: our protocol (FIGO 2023, ≤12 wk)	• **Single dose:** misoprostol 600 µg PO, **or** 400 µg SL, **or** 800 µg buccal • NICE uses 600 µg once (800 µg allowed); WHO 600 µg PO or 400 µg SL • Success >90% (Berek)

IF	THEN
Previous caesarean	Misoprostol is safe below 28 wk even with a previous caesarean (FIGO 2023).
No bleeding within 48 h of misoprostol	Contact the unit for review (NICE).
Surgical	• **Vacuum aspiration**, not sharp curettage: less blood loss, pain and time; success >97% • Manual vacuum aspiration (MVA, hand-held syringe) under local anaesthesia in clinic is preferred at 6–12 wk (Obstetric EBG); electric vacuum aspiration (EVA, pump) under GA in theatre; same success and complications • ACOG: doxycycline 200 mg PO 1 h before; no routine sharp curettage after suction • Indications: heavy bleeding, instability, infection, suspected mole, unreliable follow-up, patient choice
Counselling after medical management	• Bleeding lasts about 12 days, heaviest for 3–4 days; give analgesia • Return if soaking >2 large pads an hour for 2 hours, or fever or chills beyond 24 h after misoprostol (Obstetric EBG)
Follow-up	• ACOG: TVS at 7–14 d; success = no gestational sac; hCG if no ultrasound • NICE: urine pregnancy test 3 weeks after expectant or medical management; positive → review • RCOG GTG 38: send tissue for histology from all miscarriages when no fetal parts are seen
Sac gone, endometrium thick, no symptoms	No intervention: endometrial thickness does not predict the need for surgery (ACOG, Obstetric EBG).

Drugs for miscarriage

Drug	Regimen	Avoid if	Watch for
Mifepristone not stocked locally	200 mg PO once, before misoprostol (missed miscarriage only)	Suspected ectopic or mole, chronic adrenal failure, long-term steroids, inherited porphyria, IUD in situ (remove first), coagulopathy or anticoagulants	US access depends on the REMS, which is under litigation and FDA review in 2026
Misoprostol FIGO 2023	Missed ≤12 wk: 800 µg buccal/SL/PV every 3 h until expulsion. Incomplete ≤12 wk: 600 µg PO or 400 µg SL or 800 µg buccal, once. 13–17 wk: 400 µg every 3 h	Prostaglandin allergy; instability; infection (evacuate surgically); PV route if bleeding	Diarrhoea, nausea and vomiting (worse orally); fever or chills in the first 24 h; heavy bleeding
Doxycycline	200 mg PO 1 h before uterine aspiration (ACOG)	Tetracycline allergy	Take with water, upright
Methotrexate	**No role** in intrauterine EPL (Obstetric EBG)	—	—

07 Septic miscarriage & heavy bleeding

IF	THEN
Fever, uterine tenderness, offensive discharge, retained tissue	• Blood cultures, lactate, FBC, urinalysis; vaginal swabs add little (Williams) • **IV broad-spectrum antibiotics first**, then prompt suction evacuation • Most settle in 1–2 days; oral antibiotics after discharge are probably unnecessary

IF	THEN
Antibiotic choice	• No society sets a regimen. A common one: clindamycin 900 mg IV 8-hourly + gentamicin 5 mg/kg IV daily ± ampicillin 2 g IV 6-hourly • Alternative: ampicillin + gentamicin + metronidazole 500 mg IV 8-hourly • Follow local microbiology advice
Instrumentation or unsafe abortion suspected	• Ask directly; look for perforation, bowel injury or a retained foreign body (imaging, laparoscopy) • Check tetanus immunisation (WHO)
Hypotension, haemoconcentration, marked leucocytosis, may be afebrile	Think group A streptococcal toxic shock or Clostridium sordellii: ICU, early source control.
Peritonitis despite evacuation, free air or gas in the myometrium	Laparotomy; hysterectomy if the uterus is necrotic.
Heavy bleeding with incomplete miscarriage	• Resuscitate, crossmatch; clear the os with ring forceps • Urgent suction evacuation; expectant and medical care are unsuitable
Shock with a positive test and empty uterus	Ruptured ectopic until proven otherwise → Section 8.

08 Tubal ectopic pregnancy

Making the diagnosis

IF	THEN
Extrauterine sac with yolk sac or embryo	Definite ectopic; seen in only about 13% of cases (Williams).
Inhomogeneous adnexal mass separate from the ovary (60%) or hyperechoic tubal ring (20%), empty uterus	Probable ectopic. A ring of fire on Doppler is also seen with a corpus luteum.
Echogenic free fluid, or fluid reaching Morison pouch	Haemoperitoneum → surgery.
hCG value	Does not locate the pregnancy and does not predict rupture; ectopics rupture at low and falling levels.
Free fluid in the pouch of Douglas alone	Common and not proof of rupture (Berek); correlate with symptoms and Hb.

Choosing treatment

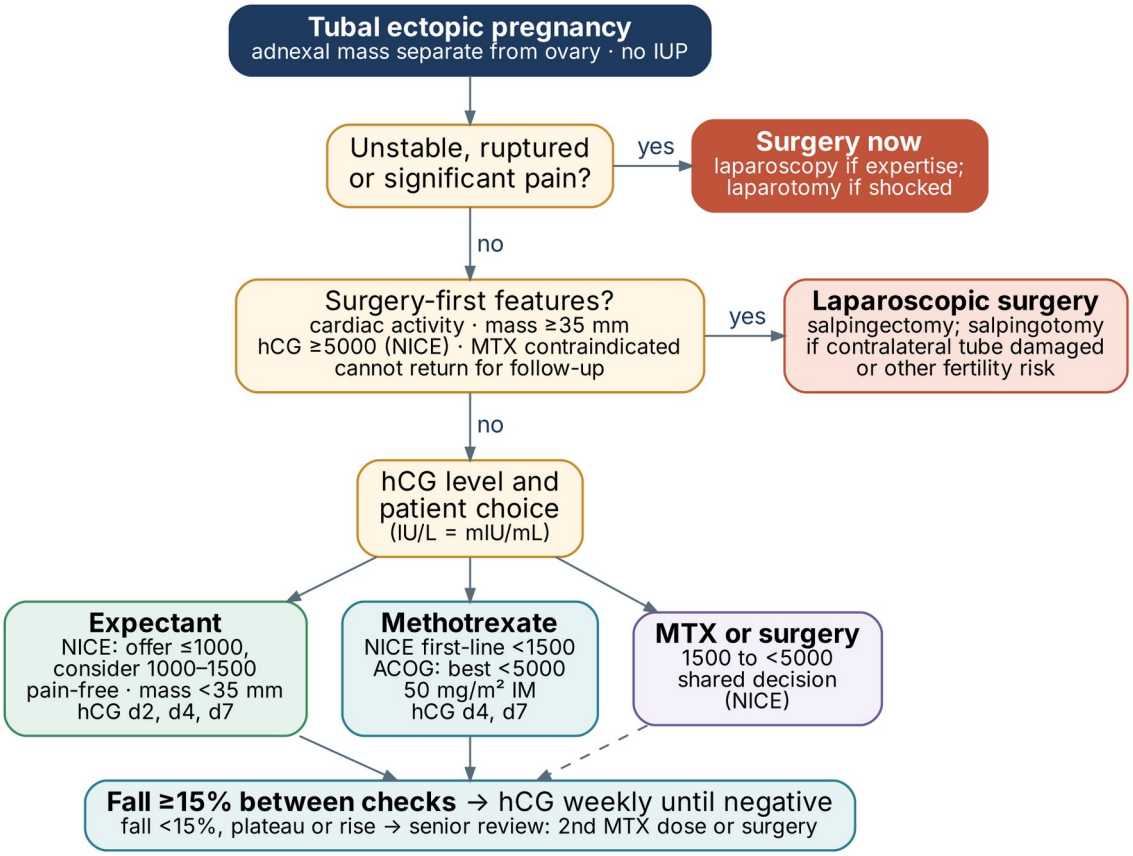


Figure 4. *Expectant, medical or surgical management of a tubal ectopic pregnancy.*

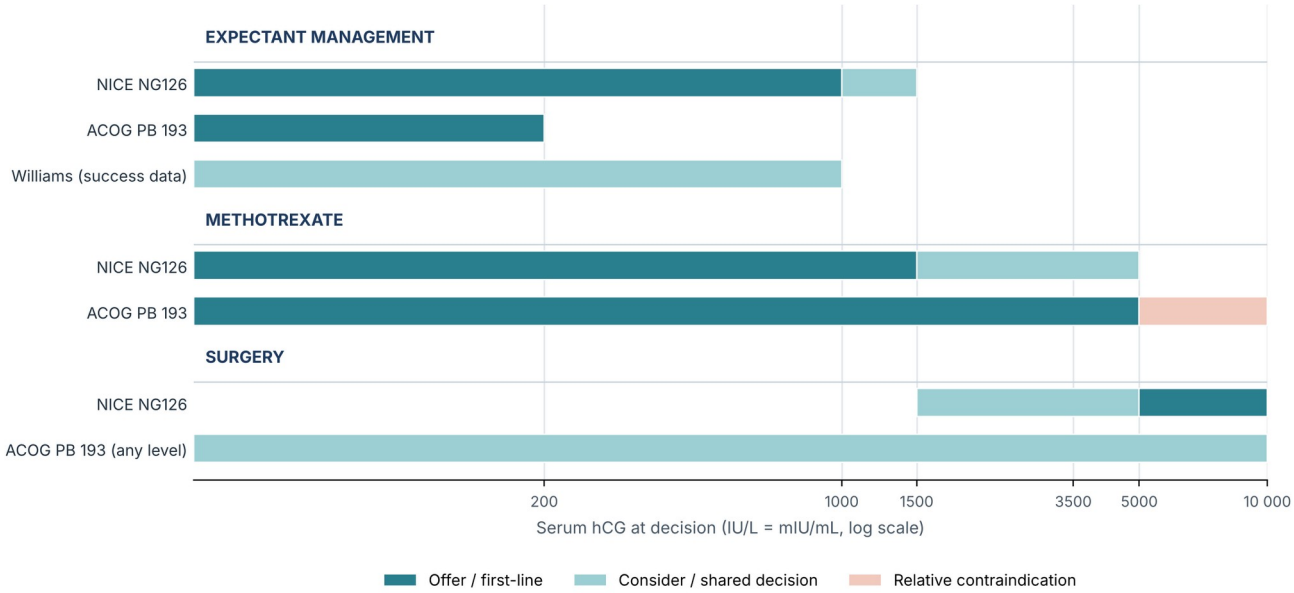


Figure 5. *hCG bands for each option, by society. Single-dose methotrexate failure by starting hCG (Menon 2007): <1000, 1.5%; 1000–2000, 5.6%; 2000–5000, 3.8%; 5000–10 000, 14.3%.*

IF	THEN
Unstable or ruptured	**Surgery now.** Laparoscopy if the surgeon is experienced and the patient can tolerate pneumoperitoneum; laparotomy if shocked.

IF	THEN
Expectant management	• **NICE offer:** stable, pain-free, tubal mass <35 mm, no visible cardiac activity, hCG ≤1000, able to return; **consider** if hCG 1000–1500 • hCG on days 2, 4 and 7 after the first; fall ≥15% each time → weekly until <20 IU/L; fall <15%, plateau or rise → senior review • Resolution: 88–96% if hCG <175; 71–92% if <1000 (Williams). ACOG: low and falling hCG
Methotrexate first-line	• **NICE:** no significant pain, unruptured tubal mass <35 mm, no cardiac activity, hCG <1500, no IUP on scan, able to return • **ACOG:** stable and reliable; success falls above hCG 5000 or with cardiac activity • Success about 90% overall (Williams)
hCG 1500 to <5000, otherwise suitable	Offer the choice of methotrexate or laparoscopy (NICE).
Significant pain, mass ≥35 mm, cardiac activity, hCG ≥5000 (NICE) or MTX contraindicated	**Laparoscopic surgery** first-line.
Surgery: which operation	• Healthy contralateral tube → **salpingectomy** (ESEP: ongoing pregnancy 56% vs 61% after salpingotomy; DEMETER: 2-year IUP rate 64% vs 70%; neither significant) • Damaged or absent contralateral tube, or other fertility risks → salpingotomy (NICE) • Wants sterilisation → remove or ligate the other tube at the same operation
After salpingotomy	• Persistent trophoblast in 5–15% (Williams) • hCG at 7 days, then weekly to negative (NICE) • Plateau or rise → single-dose MTX 50 mg/m² if no rupture
After salpingectomy	NICE: urine pregnancy test at 3 weeks. Williams does not repeat hCG after an uncomplicated salpingectomy.

Methotrexate protocols

Regimen	Dose	hCG checks	Extra dose if
Single dose **first choice (Williams, Berek, RCOG)**	50 mg/m² IM on day 1	Days 4 and 7, then weekly once falling	Fall <15% from day 4 to day 7 → repeat 50 mg/m² and restart the count (needed in 15–25%)
Two dose **(ACOG option)**	50 mg/m² IM on days 1 and 4	Days 4 and 7	Fall <15% → further doses on days 7 and 11, with hCG on days 11 and 14 (Berek)
Multidose	MTX 1 mg/kg IM days 1, 3, 5, 7 + folinic acid 0.1 mg/kg IM days 2, 4, 6, 8	Days 1, 3, 5, 7	Give the next pair until hCG falls ≥15% between two values; maximum 4 doses

IF	THEN
Before the first dose	• FBC, creatinine, LFTs, group and Rh; repeat before each extra dose • Confirm no IUP; weigh and measure for body surface area • Observe 30 min after injection (Williams) • Warn that hCG often rises from day 1 to day 4; judge response on the day 4 to day 7 fall

IF	THEN
While on treatment	• Avoid folic acid supplements, NSAIDs, alcohol, sunlight and intercourse until resolved (ACOG via Williams) • Check interactions: trimethoprim or co-trimoxazole (marrow suppression), penicillins, PPIs, nephrotoxic drugs • Paracetamol for pain
Pain after MTX	• Separation pain in 65–75%, usually mild, a few days after the dose • About 20% need assessment: vitals, Hb, TVS for free fluid; rupture → surgery
hCG still not falling after a second dose, or rupture	Surgery.
Resolution and the next pregnancy	• Mean time to hCG <15 IU/L is 34 days (up to 109) • Delay conception at least 3 months (Williams; the label says 3–6 months); earlier conception outcomes appear reassuring • Recurrence after an ectopic is about 10% (Williams) to 15% (Berek): early TVS next time

Methotrexate contraindications

- **Absolute:** IUP; haemodynamic instability or rupture; breastfeeding; immunodeficiency; moderate to severe anaemia, leucopenia or thrombocytopenia; MTX sensitivity; active pulmonary disease; active peptic ulcer; hepatic or renal dysfunction; unable to attend follow-up.
- **Relative (ACOG, ASRM):** embryonic cardiac activity; hCG >5000; mass >4 cm (ACOG; NICE uses ≥35 mm as a surgery-first feature); refusal of transfusion.

09 Non-tubal & heterotopic pregnancy

Site	Scan clues	Management
Interstitial	Empty cavity; sac >1 cm from the lateral edge of the cavity; myometrial mantle <5 mm; interstitial line sign. 3D TVS or MRI if unclear. Ruptures later (8–16 wk); mortality up to 2.5%.	Laparoscopic or open cornual resection or cornuostomy, with vasopressin. Early and stable: systemic MTX 50 mg/m² (94% success) or local MTX. Next pregnancy: planned caesarean at ≥37 wk. An angular pregnancy lies inside the cavity and is managed as an IUP (80% reach viability).
Caesarean scar (CSEP)	Empty cavity and canal; sac in the scar niche; thin myometrium towards the bladder; rich vascularity; negative sliding sign. About 1 in 2000 pregnancies.	**SMFM #63:** no expectant management; operative resection (transvaginal or laparoscopic) or ultrasound-guided vacuum aspiration; no sharp curettage alone; intragestational MTX alone or combined; **no systemic MTX alone**. If continued: placenta accreta risk; caesarean at 34^{+0}–35^{+6} wk with steroids. Refer to a specialist centre.
Cervical	Painless bleeding (90%); hourglass uterus with ballooned cervix; sac below the internal os; negative sliding sign; vascular on Doppler.	Stable: MTX first-line (systemic, or 50 mg into the sac); 91% preserve the uterus <12 wk. Failure risk: >9 wk, hCG >10 000, CRL >10 mm, cardiac activity → add KCl. Bleeding: 26F Foley with 30 mL balloon for 24–48 h, cervical stay sutures at 3 and 9 o'clock, UAE; hysterectomy last.
Ovarian	Mass within the ovary; not linked to PID or tubal disease (Berek).	Laparoscopic wedge resection or cystectomy; oophorectomy if large or ruptured (Williams Gynecology).
Abdominal	Fetus or placenta outside the uterus; no myometrium between fetus and bladder or abdominal wall; bowel around the sac; MRI.	Generally terminate once diagnosed (Williams). Remove the placenta only if its vessels can be controlled; otherwise leave it and follow hCG and imaging.

Site	Scan clues	Management
Heterotopic	IUP plus ectopic. About 1 in 30 000 spontaneous pregnancies; about 9 per 10 000 after ART. Villi on aspiration do not exclude it after ART (Berek).	MTX is contraindicated if the IUP is wanted. Tubal component: laparoscopic salpingectomy. Non-tubal component: specialist centre (local KCl has been used).

10 Molar pregnancy (recognise & refer)

IF	THEN
Suspect a mole	• hCG far above dates (complete moles often >100 000); snowstorm or cystic placenta on TVS • Large-for-dates uterus, theca-lutein cysts, hyperemesis, hyperthyroidism, pre-eclampsia <20 wk • Ultrasound is only 44% sensitive: many are found on histology of a presumed missed miscarriage
Before evacuation	FBC, hCG, creatinine, LFTs, TSH and free T4, group and crossmatch by uterine size, chest X-ray (Williams).
Evacuation	• **Suction evacuation** at any uterine size, ideally ultrasound-guided; large-bore cannula (Williams 10–14 mm; FIGO 7–12 mm) • No medical induction or hysterotomy (FIGO); RCOG: medical removal only for a partial mole with fetal parts too large for suction • Leave theca-lutein cysts; they regress
Oxytocin	**RCOG:** avoid until evacuation is complete, unless haemorrhage is life-threatening. **FIGO / Williams:** may start at the onset of suction.
Age 40 or over, family complete	Hysterectomy with ovarian conservation is an option; GTN follows in up to 50% at 40–49 years (Williams).
Rh-negative	Give anti-D after evacuation (RCOG, FIGO).
After evacuation	• Register with a GTD centre where one exists (RCOG) • hCG within 48 h, then every 1–2 weeks until normal • Partial mole: one confirmatory normal hCG 4 weeks later (RCOG, FIGO) • Complete mole: RCOG: normal within 56 days → follow to 6 months after evacuation, otherwise to 6 months after normalisation. FIGO: monthly for 6 months after normal. SGO: monthly for 3 months
Contraception during follow-up	Hormonal methods are safe. No IUD until hCG is normal (perforation risk with invasive mole).
hCG plateau or rise (FIGO 2026)	• **Plateau:** <10% change over 4 values across ≥3 weeks (days 1, 7, 14, 21) • **Rise:** >10% over 3 weekly values across ≥2 weeks • Or histology of choriocarcinoma, PSTT or ETT • = GTN → refer to a GTD centre. The old 6-month persistence criterion has been removed • GTN risk: complete mole 15–20%, partial 1–5%
Positive urine test 3 weeks after any miscarriage	Check serum hCG; consider retained tissue or GTD.

11 Anti-D & aftercare

IF	THEN
Rh-negative, miscarriage <12^{+0} wk (any management)	• Date the pregnancy by scan (CRL), not LMP, for the 12-week cut-off (NICE) • **ACOG 2024:** may forgo routine Rh testing and RhIG; offer by shared decision • **NICE 2026:** do not offer anti-D up to 11^{+6} wk, medical or surgical • **WHO:** recommends against for induced abortion <12 wk • **SMFM:** still offer where feasible
Rh-negative, ectopic <12^{+0} wk	• NICE 2026: none up to 11^{+6} wk • Society of Family Planning: 50 µg; ACOG 2024 wording on ectopic not confirmed for this guide • Follow local policy
Rh-negative, 12^{+0} wk or later	• NICE: at least 250 IU (50 µg) at 12^{+0}–12^{+6} wk for medical or surgical management • US: 50 µg acceptable up to 12 wk; 300 µg standard from 13 wk (Williams) • Within 72 h of diagnosis or procedure
Threatened miscarriage with heavy or recurrent bleeding	NICE: none up to 11^{+6} wk; at 12^{+0}–12^{+6} wk consider at least 250 IU. ACOG 2024: not routine before 12^{+0} wk.
Molar evacuation	Give anti-D (RCOG, FIGO).
After one miscarriage	• No investigations; >70–80% have a viable next pregnancy (Obstetric EBG) • No need to delay the next conception (Obstetric EBG) • Offer bereavement and mental-health support
Recurrent loss	Evaluate after ≥2 losses (ASRM; SOGC No. 464, 2025) or ≥3 (RCOG GTG 17).
Contraception	Hormonal methods can start at once; an IUD can go in immediately after surgical evacuation if there is no sepsis (Obstetric EBG).

12 Do not

- Act on a scan that misses the diagnostic criteria when the pregnancy may be wanted.
- Call an intrauterine fluid collection a pseudosac, or diagnose an IUP without a yolk sac or embryo.
- Diagnose complete miscarriage without seen products or a previous scan showing an IUP.
- Locate a pregnancy on a single hCG value, or give methotrexate for a PUL on one value.
- Use endometrial thickness to judge success after expectant or medical management.
- Use a Pipelle to look for villi.
- Give methotrexate with an IUP, rupture, instability, breastfeeding or no follow-up, or alongside folic acid or NSAIDs.
- Manage a caesarean scar pregnancy expectantly, with systemic methotrexate alone, or with sharp curettage alone.
- Give misoprostol vaginally while she is bleeding (FIGO), or methotrexate for intrauterine EPL.
- Prescribe bed rest, hCG or progesterone for threatened miscarriage without a previous loss.
- Insert an IUD during molar follow-up before hCG is normal.
- Discharge a PUL without a dated plan and written ectopic warnings.

13 Where the guidelines differ

Topic	ACOG / SMFM (USA)	RCOG / NICE (UK)	WHO / FIGO
Acting on EPL criteria	Criteria met → diagnosis	Second opinion and/or rescan ≥7 d even when met	—
PUL hCG	Minimum rise ~33–53% (start-dependent); zone up to 3500; serial every 2–7 d	>63% rise / >50% fall at 48 h; no progesterone	—
Expectant (miscarriage)	Option; up to 8 weeks	First-line for 7–14 d	—
Missed miscarriage	Mifepristone 200 mg → 24 h → misoprostol 800 µg PV	Mifepristone → 48 h → misoprostol 800 µg PV, PO or SL	Mifepristone → 1–2 d → misoprostol 800 µg buccal, SL or PV (WHO <14 wk; FIGO ≤12 wk). FIGO misoprostol only: 800 µg every 3 h until expulsion
Incomplete miscarriage	Misoprostol (Berek: 600 µg PO or 400 µg SL)	Misoprostol 600 µg (800 allowed); no mifepristone	600 µg PO or 400 µg SL (FIGO also 800 µg buccal)
Follow-up	TVS at 7–14 d	Urine test at 3 weeks; histology of tissue (RCOG)	—
Threatened miscarriage	No progesterone recommendation	Progesterone 400 mg BD PV to 16 wk if previous miscarriage	—
Ectopic: expectant	Low and falling hCG (<200 often cited)	Offer ≤1000; consider 1000–1500; mass <35 mm	—
Ectopic: methotrexate	Best <5000; single, two-dose or multidose	First-line <1500; choice 1500–4999; single dose 50 mg/m² (RCOG)	—
Anti-D <12 wk	ACOG 2024: may forgo; SMFM: offer	NICE 2026: none ≤11^{+6} (RCOG GTG 21, 2016, still says 250 IU after surgery)	WHO: against for induced abortion <12 wk
Molar follow-up (complete)	SGO, ACOG-endorsed: monthly ×3 after normal	6-month rule anchored to normalisation by day 56	FIGO: monthly ×6 after normal
Oxytocin at molar evacuation	Williams: start as evacuation begins	Avoid until complete (RCOG)	FIGO: may start at onset of suction

SOGC: No. 460 (2025, intrauterine early pregnancy loss), No. 414 (2021, PUL and ectopic), No. 408 (2021, GTD) and No. 448 (2024, Rh) are current; their full texts could not be accessed for this edition, so SOGC positions are not compared. Secondary sources report that No. 448 does not require RhIG for induced abortion <12 wk.

14 Sources

Textbooks

- Cunningham FG et al. Williams Obstetrics, 26th ed. Ch. 11 First- and second-trimester pregnancy loss; Ch. 12 Ectopic pregnancy; Ch. 13 Gestational trophoblastic disease (2022).
- Hoffman BL et al. Williams Gynecology, 4th ed. Ch. 6 First-trimester abortion; Ch. 7 Ectopic pregnancy (2020).
- Berek JS (ed). Berek & Novak's Gynecology, 16th ed. Ch. 32 Early pregnancy loss and ectopic pregnancy.
- Berghella V (ed). Obstetric Evidence Based Guidelines, 4th ed. Ch. 16 Early pregnancy loss.

Guidelines checked (October 2026)

- ACOG Practice Bulletins 200, Early Pregnancy Loss, and 193, Tubal Ectopic Pregnancy (both 2018; reaffirmed per secondary sources). ACOG Clinical Practice Update on RhIG <12 weeks (2024); ASRM position statement (2026).

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- NICE NG126, Ectopic Pregnancy and Miscarriage (2019; updated 2021, 2023, 2025; anti-D June 2026). RCOG Green-top 21 (2016; revision due 2027), 38 (2020) and 17 (2023).
- SOGC Guidelines 460 (2025), 414 (2021), 408 (2021), 448 (2024), 464 (2025). WHO Abortion Care Guideline (2022; 2nd ed. 2025). FIGO mifepristone–misoprostol and misoprostol-only dosing charts (2023), GTD update (2025), GTN staging (2026). ESHRE ectopic terminology (2020).

Decision aid only: it does not replace clinical judgement or local protocols. Verify drug doses against your formulary.