

# MISOPROSTOL-ONLY RECOMMENDED REGIMENS 2017

<13 weeks' gestation	13–26 weeks' gestation	>26 weeks' gestation <sup>8</sup>	Postpartum use
<b>Pregnancy termination<sup>a,b,1</sup></b> 800µg sl every 3 hours <u>or</u> pv*/bucc every 3–12 hours (2–3 doses)	<b>Pregnancy termination<sup>1,5,6</sup></b> 13–24 weeks: 400µg pv*/sl/bucc every 3 hours <sup>a,e</sup> 25–26 weeks: 200µg pv*/sl/bucc every 4 hours <sup>f</sup>	<b>Pregnancy termination<sup>1,5,9</sup></b> 27–28 weeks: 200µg pv*/sl/bucc every 4 hours <sup>f,g</sup> >28 weeks: 100µg pv*/sl/bucc every 6 hours	<b>Postpartum hemorrhage (PPH) prophylaxis<sup>i,2,10</sup></b> 600µg po (x1) <u>or</u> <b>PPH secondary prevention<sup>i,11</sup></b> (approx. ≥350ml blood loss) 800µg sl (x1)
<b>Missed abortion<sup>c,2</sup></b> 800µg pv* every 3 hours (x2) <u>or</u> 600µg sl every 3 hours (x2)	<b>Fetal death<sup>f,g,1,5,6</sup></b> 200µg pv*/sl/bucc every 4–6 hours	<b>Fetal death<sup>2,9</sup></b> 27–28 weeks: 100µg pv*/sl/bucc every 4 hours <sup>f</sup> >28 weeks: 25µg pv* every 6 hours <u>or</u> 25µg po every 2 hours <sup>h</sup>	<b>PPH treatment<sup>k,2,10</sup></b> 800µg sl (x1)
<b>Incomplete abortion<sup>a,2,3,4</sup></b> 600µg po (x1) <u>or</u> 400µg sl (x1) <u>or</u> 400–800µg pv* (x1)	<b>Inevitable abortion<sup>g,2,3,5,6,7</sup></b> 200µg pv*/sl/bucc every 6 hours	<b>Induction of labor<sup>h,2,9</sup></b> 25µg pv* every 6 hours <u>or</u> 25µg po every 2 hours	
<b>Cervical preparation for surgical abortion<sup>d</sup></b> 400µg sl 1 hour before procedure <u>or</u> pv* 3 hours before procedure	<b>Cervical preparation for surgical abortion<sup>a</sup></b> 13–19 weeks: 400µg pv 3–4 hours before procedure >19 weeks: needs to be combined with other modalities		

## References

- a** WHO Clinical practice handbook for safe abortion, 2014
- b** von Hertzen et al. Lancet, 2007; Sheldon et al. 2016 FIAPAC abstract
- c** Gemzell-Danielsson et al. IJGO, 2007
- d** Sääv et al. Human Reproduction, 2015; Kapp et al. Cochrane Database of Systematic Reviews, 2010
- e** Dabash et al. IJGO, 2015
- f** Perritt et al. Contraception, 2013
- g** Mark et al. IJGO, 2015
- h** WHO recommendations for induction of labour, 2011
- i** FIGO Guidelines: Prevention of PPH with misoprostol, 2012
- j** Raghavan et al. BJOG, 2015
- k** FIGO Guidelines: Treatment of PPH with misoprostol, 2012

## Notes

- 1** If mifepristone is available (preferable), follow the regimen prescribed for mifepristone + misoprostol<sup>a</sup>
- 2** Included in the WHO Model List of Essential Medicines
- 3** For incomplete/inevitable abortion women should be treated based on their uterine size rather than last menstrual period (LMP) dating
- 4** Leave to take effect over 1–2 weeks unless excessive bleeding or infection
- 5** An additional dose can be offered if the placenta has not been expelled 30 minutes after fetal expulsion
- 6** Several studies limited dosing to 5 times; most women have complete expulsion before use of 5 doses, but other studies continued beyond 5 and achieved a higher total success rate with no safety issues
- 7** Including ruptured membranes where delivery indicated
- 8** Follow local protocol if previous cesarean or transmural uterine scar
- 9** If only 200µg tablets are available, smaller doses can be made by dissolving in water (see [www.misoprostol.org](http://www.misoprostol.org))
- 10** Where oxytocin is not available or storage conditions are inadequate
- 11** Option for community based programs

## Route of Administration

- pv** – vaginal administration
  - sl** – sublingual (under the tongue)
  - po** – oral
  - bucc** – buccal (in the cheek)
- \* Avoid pv (vaginal route) if bleeding and/or signs of infection
- Rectal route is not included as a recommended route because the pharmacokinetic profile is not associated with the best efficacy