HEALTH HOLDING
HAFER ALBATIN HEALTH CLUSTER
MATERNITY AND CHILDREN HOSPITAL

Department:	Obstetrics and Gynecology (Ward)		
Document:	Departmental Policy and Procedure		
Title:	Misoprostol for Termination of Early Pregnancy		
Applies To:	All Obstetrics and Gynaecology Staff		
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1. PURPOSE:

1.1 To standardize the method and use of misoprostol in first and second trimester abortion and PPH.

2. DEFINITIONS:

2.1 **Misoprostol**- sold under the brand name Cytotec among others, is a medication used to prevent and treat stomach ulcers, start labor, cause an abortion, and treat postpartum bleeding due to poor contraction of the uterus. For abortions it is often used with mifepristone or methotrexate.

3. POLICY:

3.1 Introduction: Misoprostol (cytotec) drive from Prostaglandin E1. It is an effective myometrial stimulant of the pregnant uterus selectively binding EP-2/ EP-3 Prostanoid receptor (Senior 1993). It is rapidly absorbed orally or vaginally. Misoprostol is supplied in a tablet form of 200 microgram. It is stable at room temperature and the fact that it is not expensive makes it as one of drug of choice for termination of early pregnancy.

3.2 Side Effects of Misoprostol

3.2.1 Bleeding usually starts within the first day of treatment generally within one hour after taking Misoprostol that may last for 7-10 days that can sometimes last till the next menstrual period. Menses usually return 2-6 weeks after Misoprostol administration.

3.2.2 Pain may occur as early as 30 minutes after Misoprostol administration and the pain might be stronger and may require NSAID or narcotics. Pain relief does not interfere with the action of Misoprostol.

3.2.3 Fever and chills are common side effects and they usually transient. Fever is less common and does not indicate infection. They may respond to antipyretic but if fever lasts for 24 hours one should suspect infection.

3.2.4 Nausea and vomiting usually occur within 2 to 5 hours after taking Misoprostol and patient may require anti-emetics.

3.2.5 Diarrhea can occur after administration of misoprostol but usually disappear within 24 hours.

3.2.6 Rupture of uterus.

3.3 Contraindications of Misoprostol:

3.3.1 Confirmed or suspected ectopic pregnancy or undiagnosed adenexal mass.

3.3.2 Intrauterine contraceptive device (IUCD) this has to be removed before administration of Misoprostol.

3.3.3 History of allergy to Misoprostol or other prostaglandins.

3.4 Caution:

3.4.1 Patient with scarred uterus including myomectomy scars.

3.4.2 Grand multipara patient.

3.4.3 Large uterus (late second trimester termination).

3.5 Dispensing of misoprostol:

3.5.1 Misoprostol must be considered as a controlled drug and it should be kept in double locked cabinet (Controlled drug cabinet). Unused tablets must be returned to the narcotic cabinet.

3.5.2 The prescription of a Misoprostol, dosage and a route of administration should only be done strictly under the physician guidance. That entails writing very clear information and instruction on the patient clinical notes.

3.5.3 Misoprostol should only be prescribed to inpatient, and under no circumstances should be dispensed to an outpatient or even in Emergency Room.

3.6 Dosage and route of administration:

3.6.1 The vaginal route is recommended, it should be inserted deep in the posterior fornix.

3.6.2 Oral route is considered on few occasions as alternative route e.g. if patient has per vaginal bleeding or if patient refused vaginal route.

3.6.2.1 400 microgram tablets to be inserted in the posterior vaginal fornix every 12hours. Maximum of 48 hours or till expulsion of the conceptus takes place. This should be prescribed to women:

3.6.2.1.1 Para 5 or less.

3.6.2.1.2 No previous caesarean section scar and no previous uterine surgery.

3.6.2.1.3 Fetal size less than 22 weeks of gestation, 200microgram vaginally every 12 hours for a maximum of 48 hours. This include patient with:

3.6.2.1.3.1 Fetal size up to 24 weeks.

3.6.2.1.3.2 Parity up to para 7 with no previous scarred uterus.

3.6.2.1.3.3 Women with previous one caesarean section scar or a myomectomy with open cavity, or parity up to 5 with no more than 1 lower segment caesarean section scar.

3.6.2.2 200 microgram to be inserted into posterior vagina fornix every 24 hours for a maximum of 3 doses and this include:

3.6.2.2.1 Women with 2 or more previous uterine scar.

3.6.2.2.2 Fetal size of 24-26 gestations.

3.6.2.2.3 Para 7 or more.

3.6.2.2.4 Women with parity more than 5 and previous single caesarean section scar.

4. PROCEDURE:

4.1 Patient should be admitted, vital signs checked, necessary blood is taken and results are verified. The diagnosis of the condition is made and supported by Ultrasound scans.

4.2 The exact dose of the Misoprostol and its expiry date is verified and checked with the nurse in charge by the administrating physician. The tablet is handed over to the physician and should be kept in its seal.

4.3 The physician in-charge should check the patient identity tag and also confirm with the patient that she is having the medication. This is to avoid accidental giving of the medication to the wrong patient.

4.4 When the vaginal route is to be used, then vaginal examination should be carried out before inserting the Misoprostol. The state of the cervical dilatation, length of cervix and the uterine size must be assessed. This is particularly important in giving a repeated dose of expulsion of the fetus may have already occurred inside the vagina.

4.5 For the vaginal route, the exact number of tablet should then be inserted in the posterior fornix.

4.6 The patient is instructed to be in bed for at least 2 hours on her side or semi sitting position. This is to avoid losing the tablet if the patient mobilizes quickly. Physician then should complete the patient record, documenting the findings very clear in the patient clinical notes including, the time of administration of the medication, and the time for the next dosage.

4.7 In-charge nurse should check the vital signs every 4-6 hours, and observe for any side effects mentioned above.

4.8 There is no need to keep the patient NPO. It may be prudent to keep her on liquid diet for the first 3 hours. If moderate to severe amount of bleeding occur then the patient should be kept NPO. I.V. fluid instituted and immediate vaginal examination should be performed.

4.9 Women having heavy bleeding may require an emergency evacuation of the uterus if the cervix is open. Products in the cervix should be removed to stop bleeding.

4.10 An antiemetic should be prescribed PRN if needed.

4.11 Analgesic should be prescribed PRN such as non-steroidal anti-inflammatory drugs but in case of intolerable pain then narcotic should be prescribed.

4.12 If the expulsion of the conceptus occurred then vaginal examination must be carried out, tissue should be sent for histology. The patient when discharged home to be reviewed in Outpatient Clinic, should be warned that a slight bleeding on and off might occur till next period. Those Rhesus negative blood group should receive and anti D immunoglobulin as per protocols.

4.13 When an oral route have been chosen, the physician in-charge must be present at the time i.e., to confirm that the patient has swallowed the tablet and this should be recorded clearly in the patients clinical notes.

4.14 400 microgram either vaginally 3 hours prior to surgical termination of pregnancy (TOP) or other Gynecological procedures.

4.15 Vaginal route is recommended oral route is alternative.

4.16 The use of misoprostol in severe post-partum hemorrhage as third line in management of uncontrolled hemorrhage caused by atonic uterus.

5. MATERIAL AND EQUIPMENT:

N/A

6. RESPONSIBILITIES:

6.1 Physician

6.2 Nurses

6.3 Pharmacist

7. APPENDICES:

N/A

8. REFERENCES:

8.1 Guidelines for Obstetrics and Gynecology/ Ministry of Health, General Directorate of Health Centers-Riyadh, 2013

9. APPROVALS:

	Name	Title	Signature	Date
Prepared by:	Ms. Atheer Al Ajmi	Head Nurse of OBS-1 Ward		January 08, 2025
Prepared by:	Dr. Abdalla Mohamed Albasha	Obstetrician and Gynecologist		January 08, 2025
Reviewed by:	Dr. Mohannad Yaghmour	Head of the Department		January 12, 2025
Reviewed by:	Mr. Mutlaq Khelaif Aldhafeeri	Pharmacy Director		January 12, 2025
Reviewed by:	Mr. Sabah Turayhib Al - Harbi	Director of Nursing		January 13, 2025
Reviewed by:	Dr. Thamer Naguib	Medical Director		January 14, 2025
Reviewed by:	Mr. Abdulellah Ayed Al - Mutairi	QM&PS Director		January 15, 2025
Approved by:	Mr. Fahad Hazam Al - Shammari	Hospital Director		January 22, 2025