**MISOPROSTOL-ONLY RECOMMENDED REGIMENS 2017**

### <13 weeks’ gestation

- **Pregnancy termination**\(^{a,b,1}\)
  - 800μg sublingual (sl) every 3 hours
  - or vaginal (pv*) every 3–12 hours (2–3 doses)

- **Missed abortion**\(^{c,2}\)
  - 800μg pv* every 3 hours (x2)
  - or 600μg sl every 3 hours (x2)

- **Incomplete abortion**\(^{a,2,3,4}\)
  - 600μg po (x1)
  - or 400μg sl (x1)
  - or 400–800μg pv* (x1)

- **Cervical preparation for surgical abortion**\(^{a}\)
  - 400μg sl 1 hour before procedure
  - or pv* 3 hours before procedure

### 13–26 weeks’ gestation

- **Pregnancy termination**\(^{1,5,6}\)
  - 13–24 weeks: 400μg pv*/sl/bucc every 3 hours\(^{a}\)
  - 25–26 weeks: 200μg pv*/sl/bucc every 4 hours\(^{1}\)

- **Fetal death**\(^{1,5,6}\)
  - 200μg pv*/sl/bucc every 4–6 hours

- **Inevitable abortion**\(^{2,3,5,6,7}\)
  - 200μg pv*/sl/bucc every 6 hours

- **Cervical preparation for surgical abortion**\(^{a}\)
  - 13–19 weeks: 400μg pv 3–4 hours before procedure
  - >19 weeks: needs to be combined with other modalities

### >26 weeks’ gestation\(^{8}\)

- **Pregnancy termination**\(^{1,5,9}\)
  - 27–28 weeks: 200μg pv*/sl/bucc every 4 hours\(^{1}\)
  - >28 weeks: 100μg pv*/sl/bucc every 6 hours

- **Fetal death**\(^{2,9}\)
  - 27–28 weeks: 100μg pv*/sl/bucc every 4 hours\(^{1}\)
  - >28 weeks: 25μg pv* every 6 hours
  - or 25μg po every 2 hours\(^{h}\)

### Postpartum use

- **Postpartum hemorrhage (PPH) prophylaxis**\(^{1,10}\)
  - 600μg orally (po) (x1)
  - or PPH secondary prevention\(^{1,13}\)
  - (approx. ≥350ml blood loss) 800μg sl (x1)

- **PPH treatment**\(^{1,2,10}\)
  - 800μg sl (x1)

### 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

### Notes

1. If mifepristone is available (preferable), follow the regimen prescribed for mifepristone + misoprostol\(^{a}\)
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)
10. Where oxytocin is not available or storage conditions are inadequate
11. Option for community based programs

### References

a. WHO Clinical practice handbook for safe abortion, 2014
c. Gennet-Daniésson et al. IJGO, 2007
e. Dabash et al. IJGO, 2015
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

**www.figo.org**