



MISOPROSTOL-ONLY RECOMMENDED REGIMENS 2017

<13 weeks' gestation	13–26 weeks' gestation	>26 weeks' gestation ^a	Postpartum use
Pregnancy termination^{a,b,1} 800µg sl every 3 hours <i>or</i> pv*/bucc every 3–12 hours (2–3 doses)	Pregnancy termination^{1,5,6} 13–24 weeks: 400µg pv*/sl/bucc every 3 hours** 25–26 weeks: 200µg pv*/sl/bucc every 4 hours ^f	Pregnancy termination^{1,5,9} 27–28 weeks: 200µg pv*/sl/bucc every 4 hours ^{5,9} >28 weeks: 100µg pv*/sl/bucc every 6 hours	Postpartum hemorrhage (PPH) prophylaxis^{1,2,10} 600µg po (x1) <i>or</i> PPH secondary prevention ^{1,11} (approx. ≥350ml blood loss) 800µg sl (x1)
Missed abortion^{5,2} 800µg pv* every 3 hours (x2) <i>or</i> 600µg sl every 3 hours (x2)	Fetal death^{1,9,1,5,6} 200µg pv*/sl/bucc every 4–6 hours	Fetal death^{2,8} 27–28 weeks: 100µg pv*/sl/bucc every 4 hours ^f >28 weeks: 25µg pv* every 6 hours <i>or</i> 25µg po every 2 hours ^b	PPH treatment^{1,2,10} 800µg sl (x1)
Incomplete abortion^{5,2,3,4} 600µg po (x1) <i>or</i> 400µg sl (x1) <i>or</i> 400–800µg pv* (x1)	Inevitable abortion^{5,2,3,4,7} 200µg pv*/sl/bucc every 6 hours	Induction of labor^{5,2,9} 25µg pv* every 6 hours <i>or</i> 25µg po every 2 hours	
Cervical preparation for surgical abortion^d 400µg sl 1 hour before procedure <i>or</i> pv* 3 hours before procedure	Cervical preparation for surgical abortion^d 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 FIPAC abstract
- c Gemzell-Danielsson et al. *IJGO*, 2007
- d Sliay et al. *Human Reproduction*, 2016; Kapp et al. *Cochrane Database of Systematic Reviews*, 2010
- e Dabesh et al. *IJGO*, 2015
- f Perillit 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 Redhwan 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^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 transverse 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

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

FIGURE 1 The FIGO misoprostol-only recommended regimens 2017 chart.





2017單獨使用米索前列醇misoprostol(Cytotec)

推薦方式及劑量



<13 孕周	13-26 孕周	>26 孕周 ⁸	產後出血
<p>妊娠中止¹</p> <p>800µg sl every 3 hours or pv*/bucc every 3-12 hours (2-3 doses)</p>	<p>妊娠中止^{1,5,6}</p> <p>13-24 weeks: 400µg pv*/sl/bucc every 3 hours*^a 25-26 weeks: 200µg pv*/sl/bucc every 4 hours^f</p>	<p>妊娠中止^{1,5,9}</p> <p>27-28 weeks: 200µg pv*/sl/bucc every 4 hours^{1,9} >28 weeks: 100µg pv*/sl/bucc every 6 hours</p>	<p>產後出血 (PPH)</p> <p>第一線預防^{2,10}</p> <p>600µg po (x1)</p> <p>or 產後出血第二線預防¹¹</p> <p>(approx. ≥350ml blood loss) 800µg sl (x1)</p>
<p>萎縮性流產²</p> <p>800µg pv* every 3 hours (x2) or 600µg sl every 3 hours (x2)</p>	<p>死胎^{1,5,6}</p> <p>200µg pv*/sl/bucc every 4-6 hours</p>	<p>死胎^{2,9}</p> <p>27-28 weeks: 100µg pv*/sl/bucc every 4 hours^f >28 weeks: 25µg pv* every 6 hours or 25µg po every 2 hours^a</p>	<p>產後出血的治療^{2,10}</p> <p>800µg sl (x1)</p>
<p>不完全流產^{2,3,4}</p> <p>600µg po (x1) or 400µg sl (x1) or 400-800µg pv* (x1)</p>	<p>脅迫性流產^{2,3,5,6,7}</p> <p>200µg pv*/sl/bucc every 6 hours</p>	<p>引產^{2,9}</p> <p>25µg pv* every 6 hours or 25µg po every 2 hours</p>	
<p>流產前的子宮頸準備</p> <p>400µg sl 1 hour before procedure or pv* 3 hours before procedure</p>	<p>流產前的子宮頸準備</p> <p>13-19 weeks: 400µg pv 3-4 hours before procedure >19 weeks: needs to be combined with other modalities</p>		

注意事項：

1. 如果有米菲司酮 (RU486) 可用，應使用米菲司酮+米索前列醇用藥方案
2. 收錄於《世界衛生組織基本藥物標準清單》
3. 對於不完全流產/脅迫性流產，其具體用藥劑量應根據胎兒大小而定，而不是末次月經的時間
4. 1~2 周後使用仍有效，除非大量出血或感染
5. 在胎兒組織排出後 30 分鐘仍未見胎盤組織排出，可加量
6. 許多研究中提到用藥的最大劑量不應該超過 5 次，大多患者在用藥劑量 5 次前就能完全排出胎兒及其所有附屬組織，少許研究發現即使超過 5 次劑量給藥仍能獲得較高的成功排出率且無安全顧慮
7. 胎膜已破，且有生產指徵時也可以使用
8. 對於前胎剖腹產或既往子宮肌瘤切除手術既往史，應遵循該醫院醫囑流程用藥
9. 如果只有 200ug 片劑，可以將片劑溶解在水中分量使用 (www.misoprostol.org)
10. 當宮縮素缺乏或存儲條件有限時可替代使用
11. 社區型醫療機構為主的建議方案

給藥途徑

pv: 經陰道給藥
sl: 舌下含服
po: 口服
bucc: 口腔頰粘膜給藥

*有陰道出血或感染跡象時避免經陰道給藥

建議的給藥途徑並未包含經直腸給藥，主要是因為經直腸途徑給藥的藥代動力學效率不高