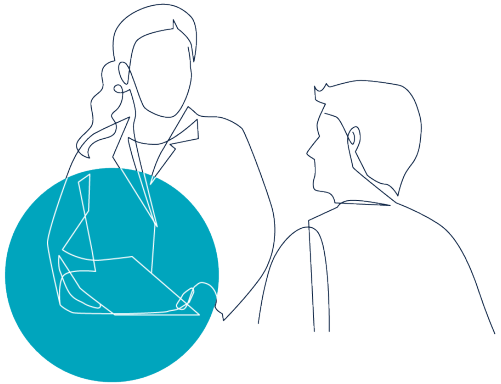
Early Pregnancy and Pregnancy Loss in Primary Care: Confident, Compassionate Care

January 27, 2026 | 1830–2000 PT



Ask your questions: slido.com | #perinatal

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LAND ACKNOWLEDGMENT

We acknowledge that UBC CPD work on the traditional, ancestral and unceded territory of the Skwxwú7mesh (Squamish), xʷməθkwəy̓əm (Musqueam), and Sə́lílwətaʔ/Selilwitulh (Tsleil-Waututh) Nations.

What is your relationship to the territory or the land that you're on?

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FUNDING ACKNOWLEDGEMENT

Funding for this webinar has been provided by the Perinatal Community of Practice, an initiative of the Shared Care Committee and Joint Collaborative Committees.

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SharedCare
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DR. KATHLEEN ROSS

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INTERESTED? STAY CONNECTED!

The Perinatal Community of Practice (CoP) works to unite physicians, midwives, and perinatal care providers across BC by equipping them with practical tools, skills, and resources. Through collaboration and knowledge, they work to advance culturally safe, high-quality care for all patients.

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Scan the QR code to stay informed about:

- Perinatal care forums and networking opportunities
- Educational webinars hosted with UBC CPD
- Project highlights

LEARNING OBJECTIVES

1. Apply practical, primary-care-focused approaches to diagnosing and managing early pregnancy concerns, increasing comfort and clinical confidence.

2. Interpret and integrate updated Society of Obstetricians and Gynaecologists of Canada (SOGC) and Perinatal Services BC guidelines on early pregnancy and pregnancy loss, with clear answers to commonly misunderstood areas.

3. Identify and confidently use bereavement and support resources for individuals and families experiencing pregnancy loss.

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DISCLOSURES

Speakers

- **Dr. Hayley Boss:** Received payments from Pfizer for presentations for local community advisory board for RSV vaccination. These topics will not be discussed in this webinar.
- **Dr. W. Kim MacDonald:** Nothing to Disclose
- **Dr. Charlene Lui:** Received payments from the Doctors of BC as President in 2025 and Committee and Board of Directors work in 2026.
- **Dr. Tracy Monk:** Received payments from PathwaysBC as Medical Director.
- **Dr. Kathleen Ross (moderator):** Received payments from the Perinatal Community of Practice, Shared Care Committee as Co-Chair and PathwaysBC as the Co-Chair of their Board.

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DISCLOSURES

Planning Team

- **Dr. Bruce Hobson:** Has received funding from UBC CPD, Doctors of BC, PHSA, PainBC, Cowichan Valley Division of FP, Qathet Division of FP as a Medical Lead, Director, and Committee Member. There is **no potential conflict of interest** between this funding and this webinar.
- **Dr. Shelley Ross:** Has received funding from the Federation of Medical Women of Canada, Pfizer related to RSV advocacy. There is **no potential conflict of interest** between this funding and this webinar.
- **Stephanie Din, Shreyasi Dutiya:** Are employees of UBC CPD.

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DR. HAYLEY BOS

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First Trimester Ultrasound

- Hayley Bos, MD, MPH
- FRCPS MFM/OBGYN
- Co-Chair – Community of Practice (Perinatal)
- Medical Director, Perinatal – Island Health

Common clinical senarios

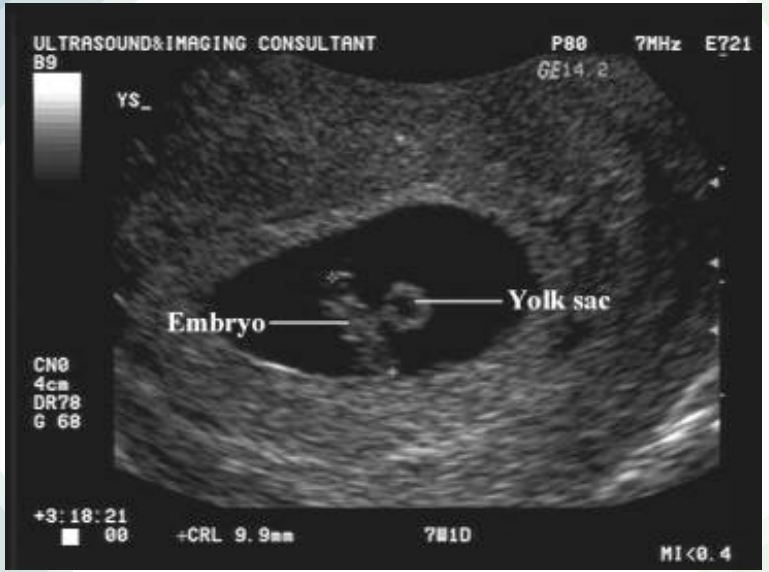
- Patient experiences spotting in early pregnancy
- Uncertain dates
- Cramping or pain early in pregnancy

Dating Ultrasound Recommendations

- Ultrasound a <7 weeks 0 days or CRL <10mm should not be used for dating

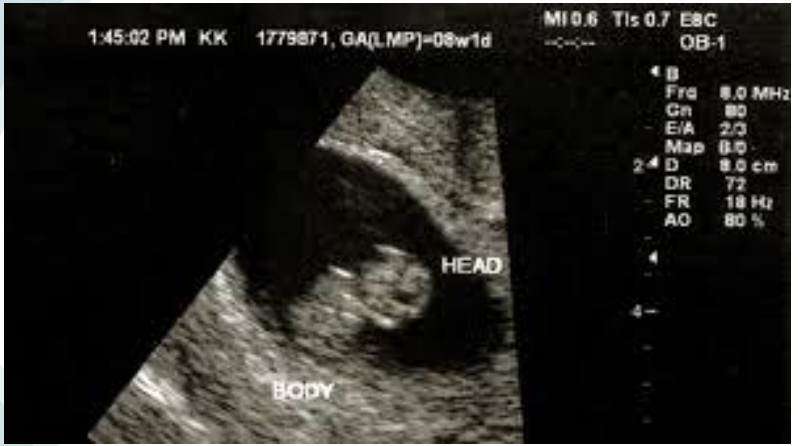
- Early dating ultrasound can be considered when there is uncertainty to the gestational age
  - Irregular cycle
  - Unknown LMP
  - Recent pregnancy

- Otherwise, it is recommended that the scan be between 11+0 and 13+6 weeks gestation



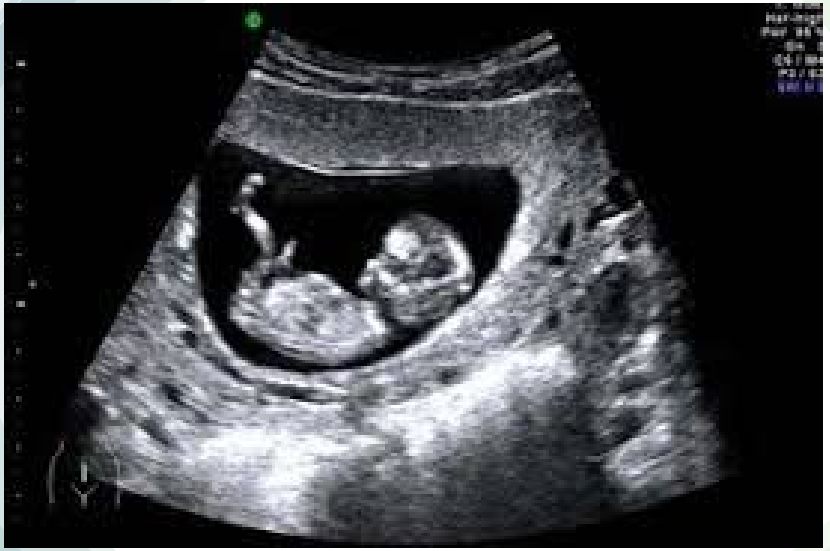
Timing of Dating Scan

- Early T1 (7-9 weeks)
- Variation +/- 3-5 days
- Assessment of location of pregnancy
- Assessment of viability
- Assessment of twin pregnancy
- Recommended basis on clinical concern (bleeding, pain, uncertain dates)



“Late” Dating Scan

- Late T1 (11-13 weeks)
- Variation +/- 5-7 days
- CRL plus other biometry
- Early anatomical assessment
- NT when indicated
- Cardiac axis has better prediction for congenital heart disease
- Other anomalies (anencephaly, omphalocele, etc)
- Diagnosis of miscarriage potentially later
- Offered to all pregnant patients



NIPT and NT scan

- Non-invasive prenatal test (screen)
  - **Sensitivity: ≈ 99%**
  - **Specificity: ≈ 99.9%**
  - **False-positive rate:** ~0.1%
  - **Detection rate:** 99–99.7% in large meta-analyses
- Can be used with ultrasound at 11+0-13+6

- Nuchal Translucency
  - **Sensitivity:** ~70–75%
  - **Specificity:** ~95%
  - False-positive rate: ~5%
- Better as part of first trimester or serum screening
- If elevated (>3.0mm) for fetal echo

Rh Immune Globulin (RhIG) in Early Pregnancy

Routine administration under 12 weeks is not recommended

- Termination or spontaneous abortion
- Bleeding in viable pregnancy

Therefore, routine blood group testing is not require in first trimester

- Risk of ThD sensitization is low in the first trimester

Patients may still request treatment, and it can be given

DR. W. KIM MACDONALD

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Early Pregnancy Loss

Dr. W Kim MacDonald, MFM, OBGYN
Victoria, BC

Early Pregnancy Loss

- defined as an empty gestational sac or a gestational sac with embryo without fetal cardiac activity before 13 weeks' gestation
- *occurs in 15%–20% of all clinically recognized pregnancies (**all comers**)*
- *occurs in 31% of pregnancies with BhCG screening*
- can be further divided into:
  - missed (ultrasound) – 30-40%
  - bleeding/cramping – 60-70%
    - incomplete
    - complete

ectopic pregnancy, pregnancy of unknown location, molar pregnancy, other

British Columbia: 7000-10000 early losses per year
Canada: 62000-88000 early loss per year

Patient Experience: Pain and Bleeding

- **pain**
  - 85% of pregnant patients have abdominal pain during the first 7 weeks of pregnancy
- **vaginal bleeding in the 1st trimester**
  - occurs in 25% of normal pregnancy outcomes
  - 14-25% will proceed to a complete miscarriage
  - 4-10% with bleeding and normal cardiac activity will proceed to a complete miscarriage

  i.e. >90-96% of 7-11w pregnancies with bleeding and fetal cardiac activity remain ongoing pregnancies

- risk of early pregnancy loss is ***5 times greater*** among patients who have **both bleeding and cramping** (hazard ratio 5.03, 95% confidence interval [CI] 2.07–12.20), compared with those who have cramping only

Diagnosis of EPL

1. Serum BhCG

- 48h BhCG: a ratio greater than 1.63 suggests an intrauterine pregnancy
- a ratio below 0.5 indicates a failing pregnancy that will resolve naturally
- ratios between 0.5 and 1.63 suggest ectopic pregnancy

2. Ultrasound

Findings diagnostic of pregnancy loss	Findings suspicious for (but not diagnostic of) pregnancy loss*
Crown-rump length **≥7mm**, no heartbeat	Crown-rump length **<7mm**, no heartbeat
Mean sac diameter **≥25mm**, no embryo	Mean sac diameter **16 to 24mm**, no embryo
Absence of embryo with heartbeat **≥2 weeks** after a scan that showed a gestational sac **without** a yolk sac	Absence of embryo with heartbeat **7 to 13 days** after a scan that showed a gestational sac **without** a yolk sac
Absence of embryo with heartbeat **≥11 days** after a scan that showed a gestational sac **with** a yolk sac	Absence of embryo with heartbeat **7 to 10 days** after a scan that showed a gestational sac **with** a yolk sac
	Absence of embryo for ≥6 weeks after the last period
	Empty amnion (amnion seen adjacent to yolk sac, with no visible embryo)
	Enlarged yolk sac (≥7mm)
	Small gestational sac in relation to the size of the embryo (<5mm difference between mean sac diameter and crown-rump length)

*When there are findings suspicious for pregnancy loss, follow-up ultrasonography at 7 to 10 days to assess the pregnancy for viability is generally appropriate.

Time

Management of EPL

Expectant

- *50% of patients with early pregnancy loss will spontaneously pass all pregnancy tissue within 1 week of miscarriage without medical or surgical intervention, particularly if the patient is already bleeding and cramping*
- *in a 2002 observational study, around 80% of patients with incomplete miscarriage passed remaining pregnancy-related tissue by 14 days, and 91% passed all tissue by 46 days*
- *expectant management is considered safe for up to 8 weeks after pregnancy loss is confirmed, as long as the patient remains clinically well, without ongoing bleeding, anemia, or evidence of infection*

Management of EPL

Medical

- *medical management achieves completed miscarriages earlier than expectant management and should be offered to all hemodynamically stable patients with a known intrauterine pregnancy experiencing early pregnancy loss*
- *benefits include its noninvasive nature and the ability to self-administer at home*
- *the combination of oral mifepristone (200 mg) with oral misoprostol (800 mg, taken 24–48 h after mifepristone) is considered first-line treatment for medical management of early pregnancy loss, with better outcomes than use of misoprostol alone*
- *in an RCT, **8.8%** (95% CI 4.8%–14.6%) of participants who were treated with both mifepristone and misoprostol required further surgical intervention by vacuum aspiration 1 month after initiating medical treatment*
- *light bleeding can last for an average of 9–16 days post expulsion*
- *passage of tissue and resolution of bleeding should be confirmed using ultrasonography*

Management of EPL

Surgical

- *surgical management (suction D&C) requires the fewest health care interactions for the patient*
- *it is the first-line treatment for patients with hemodynamic instability, low hemoglobin (< 95 g/dL), or a drop in hemoglobin of 20 g/dL.*
- *it is also the standard of care for patients with suspicion of molar pregnancy, an intrauterine device that cannot be removed, or signs of infection*
- *uncommon risks of surgical management include cervical laceration (1.03%) and pelvic infection (1.5%–5.3%)*

RhD Alloimmunization

Who should get tested and receive WinRho if RhD negative?

	<8w0d gestation	8w0d-12w0d gestation	>12w0d gestation
ACOG	not recommended - ICD	not recommended - ICD	test and administer
NAF	not recommended	not recommended	test and administer
SMFM	test and administer	test and administer	test and administer
SOGC	not recommended	not recommended - ICD	test and administer

Progesterone

Is there a role for progesterone in threatened miscarriage?

- with early pregnancy bleeding (threatened miscarriage) and *no prior history of miscarriage*, progesterone supplementation—whether oral or vaginal—**probably makes little or no difference to the live birth rate compared to placebo**.
- **in women with threatened miscarriage who have a history of one or more previous miscarriages**, vaginal micronized progesterone (400 mg twice daily, started at presentation and continued to 16 weeks gestation) **probably increases the live birth rate**.
- the PROMISE trial provides high-quality evidence that **vaginal micronized progesterone, at a dose of 400 mg twice daily, does not improve live birth rates in women with unexplained recurrent miscarriage**

Recurrent Pregnancy Loss

- RPL defined as 2 or more failed clinical pregnancies before 20-24w gestation
  - 1-4% of all women who achieve pregnancy (definition, self-reporting, early assessment)
  - <5% of women have 2 consecutive EPLs
  - <1% of women have 3 or more consecutive EPLs
- does not include ectopic or molar pregnancies
- controversy whether includes non-consecutive or biochemical

Practice Committee of the American Society for Reproductive Medicine. Definitions of infertility and recurrent pregnancy loss: a committee opinion. Fertil Steril. 2020 Mar;113(3):533-535.

RPL Approach

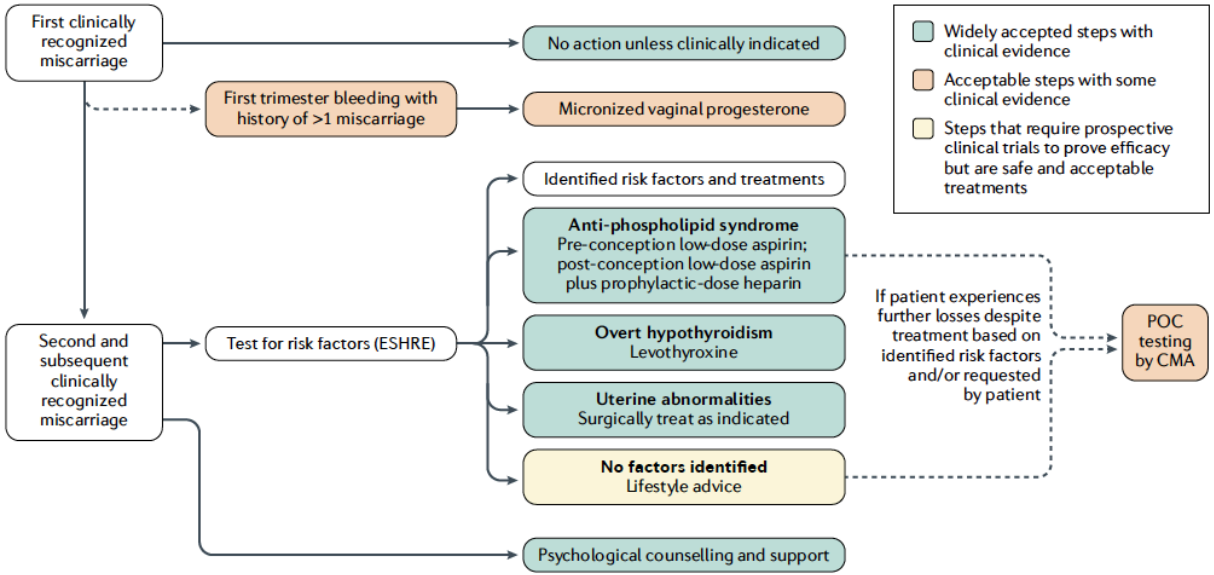

Fig. 5 | **An example of a clinical protocol for the management of recurrent pregnancy loss.** Treatment of recurrent pregnancy loss depends on the modifiable risk factors, which differ between patients. Importantly, the efficacy of different clinical protocols to improve the prognosis of affected couples has not been tested in well-designed prospective studies. CMA, chromosomal microarray; ESHRE, European Society of Human Reproduction and Embryology guidelines 2017; POC, products of conception. Data from REFS[1,2,151].

Dimitriadis E, Menkhorst E, Saito S, Kutteh WH, Brosens JJ. Recurrent pregnancy loss. Nat Rev Dis Primers. 2020 Dec 10;6(1):98.

DR. CHARLENE LUI

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Compassionate Care in First-Trimester Pregnancy Loss

The Role of EPAC & a Vision for BC Physicians

First-Trimester Pregnancy Loss: A Common Clinical Reality

Pregnant patients with pain or bleeding seek care with a family doctor, walk-in clinic, UPCC or ER
(15y Ontario study found 80% seen in ER)

Most patients in ER are seen as non-urgent and have longer than average stays, wait in shared public areas for care, have poor or no follow-up, often bounce back

Emotional Impact

Fear, grief, shock, sadness, guilt, anxiety

Loss of future expectations and identity

Feel dismissed because the pregnancy was 'early'

Trauma can be shaped by how care is delivered

Emotional Impact

8-20% moderate depression

18-32% anxiety

25-29% PTSD

Recovery to baseline takes a full year

System Challenges in BC

- Variable access to ultrasound and timely assessment/diagnostics
- Some communities have dedicated EPAC; others rely on ED or primary care triage
- Fragmented care across providers and settings
- Over-reliance on emergency departments
- Language, cultural and geographic barriers may delay care
- Patients may not know where to turn for support

How EPAC Improves Care

Reduces fragmentation across services

Reduces repeated ED visits

Provides **timely and focused attention to early pregnancy concerns**

Supports **shared decision-making for management options**

Creates space for **compassionate care and follow-up plans**

When patients do not require urgent emergency care, they still often need:

- Reassurance and emotional support
- Clear guidance on what is normal vs concerning
- Help navigating next steps (ultrasound, labs, follow-up)
- A calm, knowledgeable human connection
- This support is **not equitably available** across BC.

What Care Should look like

Future State in BC:

- EPACs as regional hubs where available
- Provincial early pregnancy support service
- Seamless communication across care settings
- Trauma-informed, culturally safe care as standard
- Care that is timely, compassionate, culturally safe, and consistent

Key Takeaways

- First-trimester pregnancy loss is common and impactful
- How we respond shapes patient experience and trust
- EPACs improve care but are not universally available
- A provincial support service could transform care in BC