
Background Traditionally, evacuation of retained products of conception (EPC) was the only management available for early pregnancy failure. Today, women can be offered a choice of expectant, medical or surgical treatment. As the efficacy and safety of medical management improves, it is likely to become more widely offered by clinicians and chosen by women. This study looked at the Quality of Life (QOL) and treatment acceptability of women randomised to misoprostol versus vacuum aspiration for primary treatment of early pregnancy failure (EPF). It was a planned secondary analysis from a multicentre randomised clinical trial of misoprostol versus surgical treatment of early pregnancy failure conducted at four urban university hospitals in the US (Columbia, Miami, Pennsylvania and Pittsburgh).

Methods A total of 652 patients were randomised in a ratio of 3:1 between misoprostol and surgical treatment. For this secondary analysis the sample size provided 80% power to detect a 2.9–3.5 point difference in each of the Short Form 36 Health Survey Revised (SF-36R) QOL scales. Randomisation occurred on the day of medical treatment or within 24 hours of surgical treatment. Participants completed a diary prospectively of symptoms experienced for the 2 weeks after treatment. A questionnaire was administered on visit study day 15 (2 weeks after treatment) including QOL, depression, stress and treatment acceptability. The QOL questionnaire was the SF-36R (good validity and US norms established). A separate scale was used for depression-happiness instead of the mental health scale in the SF-36 (also stated to have good internal consistency and test-retest reliability).

Results There was a good response rate for this analysis: 93% completed each of the study instruments and 93% completed QOL and well-being questionnaires and 93% completed questionnaires on acceptability and recovery.

Women receiving medical treatment for EPF reported greater bodily pain and lower symptom-related acceptability than those undergoing surgical treatment. All other dimensions of QOL and overall acceptability for both procedures were similar. Women with medical treatment reported a greater number of symptoms, and medical treatment was also associated with a greater number of treatment failures. Symptoms did not affect overall acceptability of procedure but treatment failure did. Overall QOL was not affected in either case.

Limitations Expectant management was not a treatment arm: this is something that is offered more often in the UK. There was a single measurement period 2 weeks after treatment; no long-term data are available. This may not be particularly relevant, as most women would have been expected to complete treatment by the end of the 2 weeks. It would have been interesting to note the occurrence of complications thereafter and their impact on the women's QOL. This is less representative of non-urban population (the