TABLE 1. Differential diagnosis of early-pregnancy vaginal bleeding

Differential diagnosis	Definition	Additional history	Physical examination	Diagnostic tests	Management
Spontaneous abortion (subtypes below)	Pregnancy loss at <20 weeks' gestation	Endocrine disorders, genetic aneuploidy, immunologic disorders, infection, chemical/radiation exposure, uterine abnormalities		*Transvaginal ultrasound (TVUS):* embryonic/fetal tissue without heart tones *β-human chorionic gonadotropin (β-hCG):* doubling rate <80% to 100% every 48 hours (failing intrauterine pregnancy [IUP]); deemed nonviable if <53%	β-hCG ratio <0.87 reliably predicts that the pregnancy will resolve spontaneously without intervention
Complete spontaneous abortion	All products of conception (POC) evacuated from uterus	Endocrine disorders, genetic aneuploidy, immunologic disorders, infection, chemical/radiation exposure, uterine abnormalities	Closed os		*Expectant:* observation, IV fluids; discharge home with obstetric (OB) follow-up and instructions to include no intercourse, bed rest, and return if bleeding worsens; repeat TVUS one week after initial presentation *Medical:* misoprostol (Cytotec) with follow-up appointment *Surgical:* dilation and curettage (D&C)
Incomplete spontaneous abortion	Some POC passed through dilated cervix	Endocrine disorders, genetic aneuploidy, immunologic disorders, infection, chemical/radiation exposure, uterine abnormalities	Open os with or without POC		*Expectant* (90% effective): observation, IV fluids, discharge home with OB follow-up and instructions to include no intercourse, bed rest, and return if bleeding worsens; repeat TVUS one week after initial presentation *Medical:* misoprostol with follow-up appointment *Surgical:* D&C
Inevitable spontaneous abortion	Bleeding and a dilated cervix with or without POC	Endocrine disorders, genetic aneuploidy, immunologic disorders, infection, chemical/radiation exposure, uterine abnormalities	Open os with or without POC	*Pathologic examination of POC:* chorionic villi observed	*Expectant:* observation, IV fluids, discharge home with OB follow-up and instructions to include no intercourse, bed rest, and return if bleeding worsens; repeat TVUS one week after initial presentation *Medical:* misoprostol with follow-up appointment *Surgical:* D&C
Septic spontaneous abortion	Incomplete spontaneous abortion plus infection	Peritoneal symptoms, fever	Peritoneal/adnexal signs, fever with or without dilated cervix and POC		Urgent antibiotic administration, uterine evacuation, and OB/GYN consult
Threatened abortion	Confirmed IUP, bleeding, cardiac activity, and closed os at <20 weeks' gestation		Closed os	*TVUS:* confirmed heart tones	*Expectant:* observation, IV fluids, discharge home with OB follow-up and instructions to include no intercourse, bed rest, and return if bleeding worsens; serial TVUS in place of serial β-hCG levels

Differential diagnosis	Definition	Additional history	Physical examination	Diagnostic tests	Management
Missed abortion	Embryo/fetus >5 mm, no heart tones, retained POC		Closed os	*TVUS:* intrauterine embryonic/fetal tissue without heart tones; β-hCG increase <53%	*Expectant:* observation, IV fluids, discharge home with OB follow-up and instructions to include no intercourse, bed rest, and return if bleeding worsens; repeat TVUS one week after initial presentation *Medical:* misoprostol with follow-up appointment *Surgical:* D&C or uterine aspiration
Ectopic pregnancy (EP)	A conceptus outside the uterus	Severe, sharp, unilateral, or bilateral adnexal pain; no passage of POC; amenorrhea; intrauterine device in place; history of EP; in utero exposure to diethylstilbestrol; genital infection; tubal surgery; in vitro fertilization; infertility; smoking	*Ruptured EP:* hypotension, absent/diminished bowel sounds, abdominal distension, hemodynamically unstable, ipsilateral shoulder pain *Unruptured EP:* uterus <8 weeks' gestational size, cervical motion tenderness, adnexal mass	*TVUS:* adnexal mass, free fluid in pelvis, cardiac activity detected outside of uterus, pseudogestational sac *Progesterone:* rule out EP with β-hCG values >2,000 IU/L and progesterone >22 ng/mL *β-hCG:* doubling rate <80% to 100% every 48 hours	*Ruptured EP:* IV fluids, monitor, oxygen, admission, open surgery *Expectant:* declining β-hCG values <1,000 mIU/mL, follow serial β-hCG levels to nonpregnant values *Medical:* methotrexate (Abitrexate, Folex, Mexate) if unruptured EP <3.5 cm, stable vitals, no fetal heartbeat, and β-hCG <15,000 mIU/mL *Surgical:* immediate hospitalization and stabilization if unruptured EP with β-hCG >15,000 mIU/mL
Gestational trophoblastic disease	Placental development without embryo	Hyperemesis, irregular and/or heavy bleeding, vaginal pain at <20 weeks' gestation	Uterus larger than gestational dates would suggest	*TVUS:* classic snowstorm appearance within uterine cavity	Surgery and close follow-up, urine β-hCG four to six weeks after pregnancy loss
Anembryonic pregnancy	Gestational sac >18 mm but no embryonic/fetal tissue	Regression of pregnancy symptoms		*TVUS:* lack of heart tones by 10 to 11 weeks' gestation and no tissue within gestational sac	*Medical:* misoprostol with follow-up appointment *Surgical:* D&C or uterine aspiration
Subchorionic hemorrhage	Blood between chorion and uterine wall			*TVUS:* blood between chorion and uterine wall; cardiac activity confirmed	Expectant management
Benign bleed of viable IUP	50% of all early-pregnancy bleeds		Minimal cervical/abdominal tenderness, benign adnexa, closed os, absence of POC, nonobstetric causes (e.g., polyps, sexually transmitted infection, vaginal trauma, cancer)	*TVUS:* yolk sac by 5 to 6 weeks' gestation, central blastocyst with chorionic villi and decidua, cardiac activity by 10 to 11 weeks' gestation with crown-rump length >5 mm *Progesterone:* >25 ng/mL *β-hCG:* 80% to 100% increase every 48 hours until 8 to 10 weeks' gestation	Expectant management