NICE National Institute for Health and Care Excellence

Ectopic pregnancy and miscarriage (update)
Consultation on draft guideline - Stakeholder comments table
04/02/2026 to 17/02/2026

Stakeholder	Document	Page No	Line No	Comments	Developer's response
British Society for Haematology	Guideline	General	General	Would it be possible to also cover molar pregnancy as this is associated with bleeding and loss at similar gestation	Thank you for your comment. Molar pregnancy is outside the scope of this guideline.
British Society for Haematology	Guideline	003	001	1.7.2 There is no available dose of 250 I.U. This may cause confusion. The wording should be amended to something like "…at a dose of at least 250IU (eg 500IU or 1500IU depending on the preparation available)	Thank you for your comment, the committee agreed and the recommendations now state 'at a dose of at least 250 IU (50 micrograms)'
British Society for Haematology	Guideline	003	003	1.7.3 Same point as comment 1	Thank you for your comment.
British Society of Abortion Care Providers (BSACP)	Guideline	General	General	We endorse the amendments to the guidance as drafted for patients with pregnancies of less than 12 weeks' gestation	Thank you for your comment.
British Society of Abortion Care Providers (BSACP)	Guideline	General	General	We endorse and welcome the use of gender-expansive language in the drafted guidance	Thank you for your comment.

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British Society of Abortion Care Providers (BSACP)	Guideline	General	General	We endorse and welcome recommendations advising that risks of anti-D administration, as well as benefits, should be discussed with patients prior to initiating treatment.	Thank you for your comment.
British Society of Abortion Care Providers (BSACP)	Guideline	003	001 - 009	For both recommendations 1.7.2 and 1.7.3 – the dose recommendation of 250international units may be the evidence based dose, however, this dose is not available commonly in the UK and appears to have been discontinued by manufacturers. Indeed the only preparations listed on the BNF are for 500 or 1500 units and these are the preparations you have included for cost impact analysis. We are of the understanding that doses of Anti-D cannot be 'split' due to the non-homogenous nature of Anti-D immunoglobulin (i.e. half the volume of a 500 unit ampoule does not reliably provide 250 units). In order to make the recommendations practicable, we suggest noting that 250IU preparations may not be available due to supply chain issues and so that 500 units could be administered instead. Or perhaps wording as a 'minimum 250IU dose'.	Thank you for your comment, the committee agreed and the recommendations now state 'at a dose of at least 250 IU (50 micrograms)'
Dignity Care	Guideline	General	General	Section 1.1.1 - Guideline States 'Treat all women with early pregnancy complications with dignity and respect.' However, women who miscarry at home are not routinely provided with appropriate equipment to	Thank you for your comment, which is outside the scope of this guideline update. This update only reviewed evidence and made recommendations on anti-D prophylaxis.

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				safely and respectfully collect pregnancy tissue. As a result, many women resort to improvised household items such as sieves, slotted spoons, or miscarry directly into the toilet. This can require women to manually search through blood, urine, and faeces to retrieve pregnancy tissue, or place them in a situation where flushing pregnancy tissue becomes the only perceived option. This removes patient choice regarding cytogenetic testing and prevents the opportunity for respectful burial or cremation. It also represents a loss of clinical and personal autonomy at a time of significant physical and emotional vulnerability. This experience is distressing, undignified, and inconsistent with the stated principle of respectful care.	We have passed the details of your device onto the topic selection team at NICE for consideration of routing to the appropriate guidance programme.
Dignity Care	Guideline	General	General	Section 1.5.1 - Threatened miscarriage Evidence indicates that approximately 1 in 3 women experiencing miscarriage attend A&E with uncomplicated miscarriage[1], and around 1 in 5 are discharged without medical treatment [2]. This suggests that many women attend not due to clinical necessity, but because they lack practical support, guidance, and appropriate resources to manage miscarriage safely at home. Clinical interviews indicate the true scale may be	Thank you for your comment, which is outside the scope of this guideline update. This update only reviewed evidence and made recommendations on anti-D prophylaxis. We have passed the details of your device onto the topic selection team at NICE for consideration of routing to the appropriate guidance programme.

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				significantly higher, as many women seek reassurance, dignity, and support during an uncertain and distressing experience. Women presenting with symptoms of threatened miscarriage are frequently discharged home without practical guidance or equipment to manage potential pregnancy loss. Many will miscarry at home, often into the toilet, which can cause significant psychological trauma, distress, and loss of dignity. Providing an appropriate pregnancy tissue collection device would enable women to manage miscarriage at home safely and with dignity. It would also preserve patient choice, including the option for cytogenetic testing and respectful burial or cremation, and aligns with national policy commitments to improve compassionate miscarriage care, including the Pregnancy Loss Review (2023)[3]. [1] https://digital.nhs.uk/data-and-information/publications/statistical/hospital-accident--emergency-activity/2024-25 [2] Health Tech Enterprise 2026 Available on request [3] https://www.gov.uk/government/publications/pregnancy-loss-review/pregnancy-loss-review-summary-	

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				report#:~:text=not%20always%20followed.-,Recommendation%2036,-The%20NHS%2C%20in	
Dignity Care	Guideline	General	General	Section 1.5.4 – 1.5.5 - Expectant and and Medical Management Expectant and medical management frequently occur at home. However, the guideline does not address how women should safely and respectfully collect pregnancy tissue during this process. Without appropriate equipment, women may miscarry into the toilet or use improvised methods, which can be distressing and undignified. NICE should recommend provision of an appropriate collection device for home use. This would improve patient experience, support dignity, and align with recommendations from the UK Pregnancy Loss Review (2023), which identified the need for appropriate receptacles for pregnancy remains.	Thank you for your comment. This update only reviewed evidence and made recommendations on anti-D prophylaxis. We have passed the details of your device onto the topic selection team at NICE for consideration of routing to the appropriate guidance programme.

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Dignity Care	Guideline	General	General	Section 1.5.20 – 1.5.21 - Surgical Management Women awaiting surgical management may wait days or weeks, during which time miscarriage may occur at home. Currently, women are not routinely provided with appropriate equipment to safely and respectfully collect pregnancy tissue if miscarriage occurs while awaiting surgery. Provision of an appropriate pregnancy tissue collection device during this waiting period would ensure dignified and compassionate care, reduce psychological distress, and preserve clinical options such as cytogenetic testing where appropriate. It would also support patient choice regarding respectful burial or cremation. This recommendation aligns with the UK Pregnancy Loss Review (2023), which identified the need for appropriate receptacles and miscarriage care kits to support women experiencing pregnancy loss at home or while awaiting clinical management.	Thank you for your comment, which is outside of the scope of this guideline update. This update only reviewed evidence and made recommendations on anti-D prophylaxis. We have passed the details of your device onto the topic selection team at NICE for consideration of routing to the appropriate guidance programme.
Dignity Care	Guideline	General	General	I appreciate these comments may fall outside the immediate scope of this guideline update. However, they highlight a significant gap in current miscarriage care. Women are not routinely provided with appropriate equipment to safely and respectfully collect	Thank you for your comments, as you noted they are outside the scope of this guideline update. This update only reviewed evidence and made recommendations on anti-D prophylaxis.

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				pregnancy tissue when miscarriage occurs at home or while awaiting treatment. This can result in avoidable psychological harm, loss of dignity, and removal of patient choice In standard medical practice patients are given a pot to collect urine. When women need to collect their babies, they are given nothing. We must do better, and there is no clinical or practical justification for failing to address this avoidable gap in care.	We have passed the details of your device onto the topic selection team at NICE for consideration of routing to the appropriate guidance programme.
NHS England	Guideline	General	General	I do not have an issue with the recommendations which are obviously based on best evidence. For clarity I suggest that 1.7.1 you reiterate that this applies to both threatened and complete miscarriage as well as any surgical or medical management. Or accentuate that it includes all pregnancies up to 11+6 under any circumstances. There is likely to be a challenge to implementation as there is a strong historical precedent. It will need strong comms out to the system via both RCOG and abortion services. We can assist with making links when needed.	Thank you for your comment. We have changed the wording to 'for any pregnancy up to and including 11+6 weeks gestation'.
Royal College of General Practitioners	Guideline	General	General	We consider the recommendations to be clear, proportionate and clinically reasonable. We have no additional suggestions for change to the proposed updates regarding Anti-D immunoglobulin prophylaxis.	Thank you for your comment.

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Royal College of General Practitioners	Guideline	General	General	The quality statement on timely referral to early pregnancy assessment services is clear and clinically appropriate. However, the section outlining what the statement means for different audiences would benefit from greater specificity.	This was not part of the consultation but has been reviewed by the NICE Quality Hub team who will consider this suggestion and the need for any amendments.
Royal College of General Practitioners	Guideline	General	General	For primary care and for women, the current wording does not fully capture the practical constraints of referral pathways. In many areas, GPs are unable to refer directly to early pregnancy assessment services outside of the unit's opening hours. For example, if a patient is assessed in primary care late in the day, when the early pregnancy unit is closed, referral may not be possible until the following working day. Although the patient may then be seen within 24 hours of referral, this does not reflect the total time from first clinical assessment. We therefore recommend that the quality measure considers timeliness from the point of first assessment in primary care, rather than from the point of referral. Measuring time to secondary care assessment from initial primary care contact would more accurately reflect the patient experience and avoid penalising clinicians where referral is unavoidably delayed due to service operating hours.	This was not part of the consultation but has been reviewed by the NICE Quality Hub team who will consider this suggestion and the need for any amendments.
Royal College of Nursing	Guideline	General	General	*We noticed on the report, the document doesn't use consistent language. Initially it says women and then later on it says "women, trans and non-binary"*	Thank you for your response. The mix of terminology reflects the different times parts of the guideline were developed and the NICE style in use at that time. For the

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					content reviewed as part of this update, inclusive language covering wider populations - which is now standard NICE style - was used from the start of development. As such the evidence was reviewed and expert opinion given with this in mind, so we are confident the recommendations apply to all population groups. For content not being reviewed as part of this update we have not amended the wording, as there may be reasons why it would not be appropriate or correct to do this and we cannot be sure the recommendations would be applicable without expert input or an evidence review. If other sections are updated or if the guideline is reviewed as a whole, the wording in those sections may be reviewed at that time.
Royal College of Obstetricians and Gynaecologists (RCOG)	Guideline	Question	Question	Response to question - In addition to feedback on the update we would be grateful for a view from the RCOG as to whether there is potential conflict here around decision making to administer anti-D based on gestational age by LMP or US scan. This was raised as an issue by the guidance executive team. The revised guidance isn't clear as to whether they are making this recommendation based on ultrasound findings or LMP. Using LMP would not	Thank you for your comment. The committee agreed with your comment and amended the recommendation to reflect that the decision should be based on ultrasound findings. We are aware that there is currently different guidance from the British Committee for Standards in Haematology, and that these are currently being updated.

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				make sense. Using ultrasound findings would mean the statement needs to be more explicit – an ectopic with a gestational sac equivalent to 12 – 12+6 weeks gestation? Either way, the recommendation is contrary to the British Committee for Standards in Haematology guidance. As the RCOG ectopic guideline is currently being updated, we will refer to the NICE guidance published at the time of our final review before the updated RCOG guideline is published.	
Royal College of Obstetricians and Gynaecologists (RCOG)	Guideline	General	General	Instead of giving the exact dose of anti-d at each gestation it might be better to give as a minimum dose as a few years ago there was a shortage of one of the doses so everyone was getting a higher dose to cover.	Thank you for your comment, the committee agreed and the recommendations now state 'at a dose of at least 250 IU (50 micrograms)'

**None of the stakeholders who comments on this clinical guideline have declared any links to the tobacco industry.*