Approved by Quality & Patient Safety Committee
16 April 2015

MISCARRIAGE – SURGICAL MANAGEMENT

This LOP is developed to guide clinical practice at the Royal Hospital for Women. Individual patient circumstances may mean that practice diverges from this LOP.

1. AIM

- To offer women with early pregnancy loss an alternative to medical or expectant management of miscarriage
- To complete a miscarriage by surgical treatment

2. PATIENT

- Woman with non progressive, anembryonic pregnancy or incomplete miscarriage (up to 20 weeks gestation).

3. STAFF

- Nursing staff
- Medical staff
- Sonographers

4. EQUIPMENT

- Ultrasound

5. CLINICAL PRACTICE

- Discuss with the woman suffering miscarriage all available options for management of miscarriage including medical, conservative/expectant and surgical.
- Give the woman information leaflet for Dilatation and Curettage/Evacuation of Retained Products of Conception when she indicates a preference for surgical management.
- Offer the woman referral to the Social Work Department for bereavement support or if the woman is distressed or struggling with any aspect of her care.
- Document the woman's Rhesus status.
- Discuss with admitting Consultant and coordinate with the Bed Manager and Operating Theatres regarding the timing of patient admission.
- Notify Operating Theatres and book patient for Evacuation of Retained Products of Conception (ERPC) procedure (state if ultrasound guidance also required) as per emergency/unplanned procedure. Indicate the Clinical Priority appropriate for timeframe of procedure pending woman's clinical urgency.
- Admit the woman after discussion with the Bed Manager as follows:
  - if less than 12 weeks gestation – admit to Day Surgery Unit (DSU) (with or without Misoprostol)
  - if greater than 12 weeks gestation - admit to Macquarie Ward
  - if patient clinically unstable regardless of gestation or actively bleeding admit direct to Macquarie Ward or arrange direct transfer to operating theatres pending patient condition.
- Advise the woman of admission day and time.
- Advise the woman of fasting time (minimum 6 hours for solids, a glass of water or clear apple juice may be consumed up to 3 hours prior to procedure).

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- If the woman is admitted to DSU or Macquarie Ward:
  - commence relevant Day Surgery Clinical Pathway,
  - commence Standard Adult General Observation Chart
  - include pain score
  - document vaginal bleeding/loss if any
  - monitor observations hourly or more frequently pending patient's clinical condition until transfer to theatre.
  - any variation in the woman's care or extra information is to be documented into Continuation notes.
  - accommodate the woman in a comfortable recliner chair or bed and preferably in a separate area from other patients where possible. Offer a warm blanket
  - advise the woman to notify staff should her condition change and she feels unwell, experiences worsening pain/abdominal cramps or heavier vaginal bleeding.
- Consider intravenous fluid administration if fasting time is greater than 12 hours, or oral fluids if the delay is known and the patient may drink. The Anaesthetic team and Operating Theatres should be notified if this occurs.
- If Misoprostol is prescribed preoperatively:
  - Discuss with the EPAS Consultant to approve use. The woman should be >10 weeks gestational size at ultrasound.
  - Discuss the use of Misoprostol with the woman, exclude contraindications for use and document on medication chart. The usual dose of Misoprostol is 400mcg administered per vagina, 2-3hours preoperatively.
  - Prescribe analgesia as required and document on medication chart.
  - Coordinate time of Misoprostol administration with Operating Theatres prior to insertion and ensure booked patient clinical priority category is prioritised to avoid delay of procedure.
  - Administer Misoprostol via vaginal examination by an appropriate medical officer.
  - Vaginal examination findings including the state of the cervix must be documented at the time of insertion of Misoprostol. If the cervix is already dilated, Misoprostol should not be administered.
  - Advise the woman of the procedure, and to remain lying on a bed for approx 30 minutes post Misoprostol insertion. Offer a warm blanket. For toileting following Misoprostol insertion the woman should preferably use a bed pan or place a witches hat container into the toilet bowl to prevent the very rare complication of the fetus being expelled into the toilet.
  - Monitor the woman's general clinical observations including pain score and per vagina bleeding every 30 minutes until transfer to Operating Theatre.
  - Should there be any subsequent delay in procedure the woman should be closely monitored and clinical review undertaken with view to escalating transfer to Operating Theatre should the woman's clinical condition deteriorate and to avoid potential, unplanned vaginal miscarriage occurring.

6. DOCUMENTATION

- EPAS notes
- Recommended for Admission Booking and Consent forms
- Medication Chart
- Standard Adult General Observation (SAGO) Chart
- Integrated Clinical Notes
- Day Surgery Clinical Pathway

MISCARRIAGE – SURGICAL MANAGEMENT cont'd

7. EDUCATIONAL NOTES

- The menstrual cycle usually recommences 4 – 8 weeks following miscarriage.
- Most women can attempt another pregnancy following one normal menstrual cycle and ensuring miscarriage is complete.
- Women should be advised re the benefit of pre-conception folate and be advised to continue or start this supplement if they are planning to try and conceive in the next few months.
- Misoprostol is a synthetic prostaglandin E1 analogue. It is similar to Gemeprost but is cheaper, easier to store and has been shown to have fewer side effects[1].
- Misoprostol is not approved for use in pregnancy by the Australian TGA. Use is "off label" in obstetrics and gynaecology, although it has been used extensively both within Australia and worldwide for this purpose. The woman should be informed of this.
- The purpose of Misoprostol prior to surgical ERPC is to prepare the cervix and allow easier dilatation. The usual dose used is 400mcg administered per vagina, 2- 3 hours prior to surgery for optimal effect.
- Complications of surgical ERPC may be reduced with the use of Misoprostol. Studies pertaining to the use of Misoprostol for cervical priming prior to surgical termination in the 1st trimester have shown a decrease in incomplete abortion needing re-evacuation[2].
- Cervical priming prior to surgical termination in 2nd trimester is routinely used to prevent complications due to forceful dilation of the cervix[3].
- Side effects of Misoprostol include: nausea, vomiting, diarrhoea, fever, pain and bleeding
- Surgical risks associated with uterine curettage may include:
  1. Infection (less common – 1/50)
  2. Adhesions (common) up to 10%, although resolution is usual and amenorrhea and the need for subsequent surgical intervention is uncommon at <1/100
  3. Uterine perforation (uncommon - 1/100)
  4. Injury to another organ (bowel or bladder) rare -1/500

  Appropriate discussion and counselling with women prior to a surgical procedure is mandatory.

8. RELATED POLICIES / PROCEDURES / CLINICAL PRACTICE LOP

- Vaginal pessaries and cream administration
- Patient information leaflets: After Early Pregnancy Loss (1) Info for parents whose baby has miscarried and/or (2) After Early Pregnancy Loss – Social Work Department

9. RISK RATING

- Low

10. REFERENCES

1. Cervical priming with prostaglandin E1 analogues, Misoprostol and Gemprost. The Lancet, Volume 343, Issue 8907, Pages 1207-1209, 14 May 1994
2. Complications of first-trimester abortion by vacuum aspiration after cervical preparation with and without Misoprostol: a multicentre randomised trial. Olav Meirik et al. The Lancet, Volume 379, Issue 9828, Pages 1817-1824, 12 May 2012
3. Uses of Misoprostol in Obstetrics and Gynaecology. Allen et al. Rev Obstet Gynecol. 2009 Summer; 2(3): 159-168.

REVISION & APPROVAL HISTORY
June 2018 – risk rating changed from high to low and review date from 2017 to 2020
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