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Standard Operating Procedure

Early Pregnancy Loss – up to 13 completed weeks of pregnancy

Document History

Document Location

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Revision History

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Approvals

This document requires the following approvals:

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Distribution

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INTRODUCTION

All healthcare professionals involved in the care of women with early pregnancy complications should be aware that it can be a stressful and distressing time. We should be mindful that women will react to complications or the loss of a pregnancy in different ways, and provide all women with information and support in a sensitive manner whilst taking in to account their individual circumstances and emotional responses.

AIMS

This guideline provides information to allow staff involved in the care of women experiencing early pregnancy loss to make an accurate clinical diagnosis based on ultrasound findings. The methods of management of miscarriage which are offered to the women are detailed, as well as information on Anti-D Rhesus prophylaxis and standards of record keeping.

DIAGNOSIS

When performing an ultrasound scan to determine the viability of a pregnancy, transabdominal US should be used in the first instance to identify fetal heart activity. If there is a visible fetal pole but no fetal heartbeat, offer transvaginal scan.

- If CRL is less than 7mm on TV scan and there is no visible heartbeat, perform a second scan a minimum of 7 days later before making a diagnosis.

- If CRL is 7mm or more on TV scan and there is no visible fetal heart, miscarriage can be confirmed. If preferred by the woman a second scan may be performed a minimum of 7 days later to confirm the diagnosis.

If the fetal pole is not identifiable on transvaginal scan then measure the mean sac diameter.

- If the mean sac diameter is less than 25mm on TV scan and there is no visible fetal pole, perform a second scan a minimum of 7 days later before making a diagnosis.

- If the mean sac diameter is 25mm or more on TV scan and there is no visible fetal pole miscarriage can be confirmed. If preferred by the woman a second scan may be performed a minimum of 7 days later to confirm the diagnosis.

Women with a confirmed diagnosis of missed or incomplete miscarriage should have an assessment of their pain and bleeding carried out. If she has significant pain or bleeding, she should have her pulse and BP measured and bloods including FBC and group & save should be taken. A medical review should be requested from the on-call GPST/FY2.

METHODS OF MANAGEMENT

The options for management of miscarriage are expectant, medical or surgical management. The women should be counseled on each of these options, supported by written information.

Expectant Management
This is the passage of the products of conception naturally.

Contra-indications – evidence of infection, increased risk of haemorrhage (eg. coagulopathies)
Cautions – previous traumatic experience associated with pregnancy (eg. IUD or APH), late first trimester (after 10 weeks).

The woman should be counseled on what to expect regarding pain and bleeding, and that it can take a variable length of time (2-6 weeks). She should be offered analgesia and given contact numbers of PAU and ward 16 (out of hours). She should be advised to phone if her bleeding is excessive, pain is severe or if there is evidence of infection.

PAU staff should make contact with the woman after around 1 week. If the miscarriage is complete within 7-14 days, advise the woman to take a pregnancy test after 3 weeks and contact PAU if it is positive. If the process of miscarriage has not stared in this time, or if the pain and/or bleeding is persistent, she should be re-scanned.

Medical Management

This is the administration of medication to aid the passage of the products of conception.

Contra-indications – severe asthma, cardiovascular disease/hypertension, chronic renal, hepatic or adrenal failure, bleeding disorders, long term use of corticosteroids, anticoagulants or NSAIDs, known allergy to misoprostol, suspected trophoblastic disease.
Cautions – heavy smokers (>20 per day), age > 35.

Women who are considered low risk may be offered medical management at home. The criteria for this are –

- < 10 weeks gestation
- Adult present at home
- Access to transport to attend hospital in case of heavy bleeding
- Hb >100 g/dL
- Able to speak and read English

If the woman does not fit these criteria then she should be offered the option of inpatient management in ward16.

Women should be counseled regarding what to expect in relation to pain/bleeding. Advise to make contact with PAU or ward 16 if she is soaking a maternity pad in less than an hour, or if the pain is perceived as severe.

Bloods should be taken prior to treatment – FBC and group and save.

The doctor should prescribe

- Misoprostol 800 micrograms to be taken sublingually at home or as inpatient
- Paracetamol 1g PRN
- Dihydrocodeine 30mg (5 tablets if going home)
- Offer anti-emetic if needed

The woman should be contacted after 24 hours to ensure the woman gives a good history of miscarriage. If any doubt or if bleeding has not started offer follow up scan in PAU.

Advise to take pregnancy test in 3 weeks and contact PAU if positive.

Surgical Management

This is surgical removal of the products of conception. It can be performed in theatre under general anaesthetic or under local anaesthetic in ward 16 (manual vacuum aspiration).

Women who chose surgical management should be reviewed by the on call registrar and counselled on the risks associated with the procedure. Bloods should be taken for FBC and group & save.

The doctor to prescribe

- Misoprostol 400 micrograms sublingually 1 hour before procedure
- Azithromycin 1g stat
- Metronidazole 800mg orally

ANTI – D RHESUS PROPHYLAXIS

Offer anti-D prophlaxis to all rhesus negative women who have surgical management or miscarry after 12 weeks

It is not necessary if –

- They are receiving medical management of miscarriage
- Threatened miscarriage
- Complete miscarriage
- Pregnancy of unknown location

RECORD KEEPING

If the woman has booked with her community midwife, the loss should be documented on her Badgernet record, and the pregnancy should be closed. A viewpoint letter should be produced and filed in her blue notes.

If she has not booked it should be documented on viewpoint and a letter filed in her blue notes.

In all cases the community midwife and outpatient dept should be informed by email, and GP informed by letter. The loss should also be recorded in the PAU 9a folder. The ICP for the chosen method of management should be completed and filed in the blue notes.

Ref: NICE Clinical Guideline (CG154) Ectopic Pregnancy and miscarriage. Diagnosis and Initial management December 2012

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