Reference Number: **Version Number: V1**	**Date of Next Review: September 2022** **Previous Trust/LHB Reference Number:**

Guideline for Manual Vacuum Aspiration (MVA) as an Outpatient Procedure for Management of Miscarriage

Purpose

The purpose of this document is to provide a guideline for the care of women who choose to have a MVA procedure following a diagnosis of a miscarriage.

Introduction

Evidence has demonstrated that MVA Procedures are a safe alternative to ERPOC's, whilst avoiding a general anaesthetic.
This procedure offers additional choice to women who do not wish to proceed with conservative management, medical management or ERPOC of a miscarriage, and has additional benefits for the patient, both practical and logistical.

Is the document supporting a policy?
Prudent Healthcare
Patient's choice of treatments
What will it achieve?
Patients have further choice and access to an alternative management option of miscarriage.

Objectives

- To streamline the care of patients undergoing MVA for miscarriage
- To provide comprehensive instruction on the MVA procedure

Scope
This policy applies to all healthcare professionals in all locations including those with honorary contracts

Equality Health Impact Assessment	*An Equality Health Impact Assessment (EHIA) has not been completed.*
Documents to read alongside this Procedure	• *Ectopic Pregnancy and Miscarriage- Diagnosis and Management* • Sensitive Disposal of Remains of Pregnancies Less Than 24 weeks' (HTA GUIDELINES 2018)
Approved by	• *Gynaecology Professional Forum*

Accountable Executive or Clinical Board Director	*Ruth Walker, Executive Nurse Director*
Author(s)	*K Martin (GNP) / Dr Caroline Scherf*

Disclaimer

If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the Governance Directorate.

Summary of reviews/amendments			
Version Number	**Date of Review Approved**	**Date Published**	**Summary of Amendments**

INTRODUCTION

Manual Vacuum Aspiration (MVA) is a safe procedure which can be performed in the first trimester of pregnancy. MVA is particularly suitable for patients wishing a quick and effective procedure which does not involve general anaesthesia (GA). It is also suitable for patients with medical problems which make them unsuitable for treatment under GA.

Serious complications are extremely rare. Minor problems might arise more commonly and will be addressed below.

REFERRAL PROCEDURE

Patient Management System (PMS), and liaison with Early Pregnancy Unit staff and administration staff.

MVA EXCLUSION CRITERIA

- No absolute contra-indications

MVA may be used but with caution in cases of;

- Active pelvic infection
- Known structural uterine anomaly
- History of coagulation disorders
- Gestational age over 12 weeks on day of MVA procedure.
- Extreme anxiety

Patient selection and consent

Please refer to; *Ectopic Pregnancy and Miscarriage – Diagnosis & Management Guideline.*

Offer the patient MVA once definite miscarriage diagnosis has been made.

Consent: written consent is obtained in most cases using the Surgical Management Guideline.

Patients should be given;

- Patient Information leaflet about MVA
- Copy of consent form
- Copy of disposal form

1. Blood should be taken for Rhesus status (unless known Rh) and FBC
2. Provide date and time for MVA procedure (this may be the same day)
3. Advise patient to take suitable analgesia (such as Ibuprofen 400mg if not contraindicated) one hour before admission

DISPOSAL OF FETAL TISSUE (see separate protocol 'Sensitive Disposal of Remains of Pregnancies Less Than 24 weeks' (HTA GUIDELINES 2018)

Patients have the choice of how they wish to dispose of their pregnancy including; own arrangements, hospital incineration or communal cremation. They can also choose not to be involved in the decision. In this case the hospital would dispose of the fetal remains by means of sensitive incineration.

Patients, who would like more information about disposal options, can discuss these with EPAU or outpatient staff, and / or Consultant / Bereavement Advisor.

MVA Procedure

This procedure requires a lithotomy couch, an ultrasound machine, direct access to a sluice room and a resting area for recovery of the patient.

Arrival:

The patient is greeted by the Nurse who goes through consent and answers any questions. The nurse will check what oral analgesia has been taken already and offer additional analgesia, if required. 400 mcg Misoprostol (vaginal [pv] / buccal / sub-lingual administration possible) or 1 mg Gemeprost pv should be used for cervical preparation. A single dose of oral Metronidazole 800mg is provided for prevention of post-treatment infection.

All investigations must be checked and results entered into notes pre-op.
Action on abnormal results:

- Ensure Anti-D is given to Rhesus negative patients *within 72 hours*

Treatment room:

Please encourage bladder emptying prior to MVA treatment.

The treatment room staff greets the patient and introduces themselves. There is a doctor and a suitable qualified nurse to provide support, and assistance. The doctor confirms consent and addresses any further questions. The patient is shown how to place herself in the lithotomy position. Entonox may be used during treatment.

Pulse, BP and oxygen saturation are recorded at the start and the end of treatment.

Vagina and vulva are cleaned with a suitable disinfectant (Iodine, Tisept or Chlorhexidine solution). A vaginal examination confirms uterine orientation.

Lignocaine gel (Instillagel) is inserted into the cervical canal. 15-20 ml of 0.5-1% Lidocaine is injected superficially into the cervix at four or more points.

Using a vulsellum or tenaculum the cervix is dilated with different size plastic cannulas. The previously loaded MVA pump (IPAS) is connected to the cannula in the cervix and the vacuum released. When the MVA syringe is full, it should be emptied, re-charged and re-attached. Several pre-charged syringes may be used simultaneously. The procedure is complete when the 'grittiness' of the uterine wall can be detected. When the vulsellum is removed, the cervix should be inspected for bleeding. An intra-uterine contraceptive device may be inserted at the end if the patient wishes.

Anti-D can be administered into the (anaesthetised) cervix (=smooth muscle) at the end of treatment if required.

Complete evacuation can be confirmed by ultrasound and/or by inspecting the evacuated tissue to identify the gestational sac.

The patient is escorted to the recovery area where she can relax. One final set of post-procedure observations should be recorded during this time. The patient will be offered a drink and snack, and is discharged once she feels well, which may be as soon as 15 minutes after the treatment. She does not require an escort. The patient will be provided with a discharge summary letter and can be delivered to the GP by the patient.

Post Procedure

The patient should be advised that she may experience some mild abdominal pain and period like vaginal bleeding for the next few days which should gradually settle. However if she is concerned about the amount of pain or bleeding she is experiencing, she is to contact EPAU/C1 Gynaecology for advice.

Advise not to use tampons, avoid swimming and intercourse until vaginal bleeding is minimal/period like loss.

FOLLOW-UP

- Routine follow-up is not required but patients are reminded how to get in touch in case of concerns over the next few days.
- Advise to repeat a pregnancy test 3/52 post procedure and if positive to contact EPAU for further advice.
- A follow up appointment will be made in GOPD if genetic testing has been undertaken.

All MVA treatments should be recorded in an electronic procedure diary on the S-drive.

COMPLICATIONS

Primary (during treatment)

Minor complications:

- Vaso-vagal attack during procedure, but no loss of consciousness
- Patient unable to cope with discomfort
- Difficult cervical dilation
- Heavy bleeding during treatment

Major complications

- Loss of consciousness / ‘seizure’ during treatment
- Major haemorrhage
- Uterine perforation

SECONDARY (AFTER DISCHARGE)

Minor complications:

- Retained pregnancy tissue

- Prolonged bleeding
- Endometritis
- Prolonged depression / sadness

Major complications

- Failed procedure
- High fever, shivers, tachycardia, purulent discharge, severe abdominal pain.

Management of complications

The doctor in the treatment room manages complications and refers to the on-call team if appropriate.

Patients who suffer complications should be offered a follow-up appointment in the EPAU Consultant clinic. Such complications may have arisen on the day of treatment or after discharge. In all cases: if urgent attention is required, patient must be seen by the on-call Gynaecology team.

All patients requiring admission after miscarriage treatment are cared for by the on-call team and their on-call Consultant Gynaecologist.