

DIAGNOSIS AND MANAGEMENT OF EARLY PREGNANCY MISCARRIAGE

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1. PURPOSE

- To encourage the use of desired terminology in such sensitive circumstances.
- To provide guidance on management of early pregnancy complications, such as pain and bleeding, before 13 completed weeks of pregnancy ($\leq 13+6$ weeks).
- To provide guidance on ultrasound scan interpretation in early pregnancy.
- To provide guidance on the management options of miscarriage.
- To provide guidance on ways to support patients and limit the psychological impact of their loss.

2. SCOPE

- Applies to all healthcare providers including medical, nursing, midwifery and sonographers working within the health board who come in contact/ provide care for women in their early pregnancy.

3. ABBREVIATIONS

- **CRL:** Crown Rump Length
- **D&C:** Dilatation and curettage.
- **EGU:** Emergency Gynaecology Unit
- **EPU:** Early Pregnancy Unit
- **ERPOC:** Evacuation of Retained Products of Conception
- **ET:** Endometrial Thickness
- **hCG:** Human chorionic gonadotrophin.
- **IUCD:** Intrauterine Contraceptive Device
- **IUP:** Intra Uterine Pregnancy
- **Live Pregnancy:** pregnancy with cardiac activity (preferred term to viable)
- **LMP:** Last Menstrual Period
- **MMM:** Medical management of miscarriage.
- **MSD:** Mean Gestational Sac Diameter
- **RPOC:** Retained Products of Conception
- **SMM:** Surgical management of miscarriage. (preferred term to D&C and ERPOC)
- **STI:** Sexually transmitted Infections
- **TAS:** Transabdominal Ultrasound Scan
- **TVS:** Transvaginal Ultrasound Scan
- **USS:** Ultrasound Scan

4. TYPES OF MISCARRIAGES

Table 1: Definitions / types of miscarriage

S. No	DEFINITION	SIGNS	SYMPTOMS
1	Threatened miscarriage	-Intrauterine gestational sac, fetal pole with visible fetal heartbeat. -Intra-uterine pregnancy of uncertain viability	Vaginal bleeding and/or abdominal pain.
2	Missed miscarriage	-Fetal pole of 7mm or more with no visible fetal heartbeat, or -Mean Gestation Sac diameter of 25 mm or more with no fetal pole.	Usually Asymptomatic, Can have very mild bleeding or pain.
3	Incomplete Miscarriage	Retained products of conception. <i>Significant if the thickness* is more than 25mm on USS.</i>	Passage of some of the conception tissue with bleeding and/or abdominal pain
4	Septic Miscarriage	Any of the above with signs of sepsis related to the pregnancy	Fever, vaginal discharge, bleeding, abdominal pain
5	Complete Miscarriage	Passed all pregnancy products.	Subsiding vaginal bleeding and/or pain

**Refers to the antero-posterior measurement of the suspected retained product, not to be confused with the length (in sagittal views) or the width (transverse views measurement).*

5. INITIAL ASSESSMENT

- All patients must be referred to EPU in order to be triaged (via telephone), allowing the nurses within EPU to provide advice to patients and appoint accordingly.
- Once triaged, women who require further assessment should be evaluated in a dedicated early pregnancy assessment unit (EPU) with trained and competent staff to deal with early pregnancy complications, adequate facilities to perform early pregnancy ultrasound scans, measurements of serum human chorionic gonadotropin (hCG) levels and checking rhesus status.
- Currently, EPU runs a weekday service, it closes on weekends and public holidays.
- EPU hours: Clinic runs 8:30am-11:30am, 10 scan slots. Phone line open 8:30am-4:00pm
- Internal Contact number for EPU and EGC: ext. 35895. Use 37648 for The nurse in charge. External 01792 286868.
- Urgent patients can be assessed on the gynaecology ward if out of hours. If patient's condition does not require immediate attendance, the registrar on call will write down the patient's details and a brief history on a referral form that will be passed on to EPU the next working day.
- Full history should be obtained including current symptoms and risk factors of ectopic pregnancy (previous ectopic, IUCD, previous STIs, etc.)
- First date of the last menstrual period (LMP) and date of a positive pregnancy test should be noted.
- Assess general well-being and record observations. Perform pelvic examination where indicated.
- When indicated, arrange an ultrasound scan in the next available appointment (ideally in next 24 hours) and advise the patient about the need of Transvaginal Ultrasound Scan (TVS), its tolerability and safety.
- Serum hCG should be performed after the scan if required for assessment of pregnancy of unknown location/ectopic pregnancy/molar pregnancy.
- When there is an intra-uterine pregnancy, avoid using HCG to diagnose or predict miscarriages, the ultrasound scan findings are the only accepted confirmative diagnosis of missed miscarriage.
- Do not use progesterone for diagnosis or management of early pregnancy complications.

6. ULTRASOUND SCAN

- The request form for an USS should include all relevant clinical details.
- A Transvaginal Ultrasound Scan (TVS) should be initially offered for all women with early pregnancy problems to identify the location of pregnancy and whether the fetal pole and a heartbeat can be determined.
- In practice, the USS will be performed abdominally if the gestation is presumed to be >9 weeks by LMP and transvaginally for <9 weeks. TVS may still become necessary after the abdominal scan (see below).

- A Transabdominal scan when the heartbeat is visible (cardiac activity present) is sufficient to diagnose a live pregnancy regardless of gestation.
- However, if the scan views aren't adequate or there is doubt, a TVS must be performed unless declined by the patient. A patient's decline should be recorded in the notes/scan report when applicable.
- When a woman declines a TVS. The limitation of TAS should be explained and longer interval between scans to make the diagnosis (see below).
- **A transvaginal USS is essential to make the diagnoses of a missed miscarriage.** Based on our local departmental capacity, a transabdominal scan is accepted to diagnose a missed miscarriage in certain cases only: The views obtained are clear, there are no doubts about the findings and the CRL $\geq 32\text{mm}$ = 10+0 weeks with no cardiac activity (no visible heartbeat).
- If an USS is performed out of hours by the oncall doctors and an intrauterine live pregnancy is confirmed, the patient can be reassured. A departmental USS after that is **unnecessary** and should not be routinely booked.

Table 2: Ultrasound findings and diagnosis of miscarriage

**please note departmental capacity for repeat scan for confirmation as explained in article 7.*

USS with Intra-uterine Pregnancy							
TVS				TAS			
Visible fetal heartbeat	Fetal pole seen, No visible fetal heartbeat		GS, No fetal pole visible		Visible fetal heartbeat	No visible fetal heartbeat	
	CRL <7mm	CRL ≥ 7 mm	MSD < 25mm	MSD $\geq 25\text{mm}$			
Reassure - ongoing intrauterine pregnancy					Reassure - ongoing intrauterine pregnancy	CRL < 32mm (10+0 weeks)	CRL $\geq 32\text{mm}$ (10+0 weeks)
Return for further assessment if worse or bleeding >14 days	Rescan in 7 days	Diagnose Missed Miscarriage*	Rescan in 7 days	Diagnose Missed Miscarriage*	Return for further assessment if worse or bleeding >14 days	Perform TVS or rescan 2 weeks before making diagnosis	Diagnose Missed Miscarriage*

7. DIAGNOSIS OF MISCARRAIGE

- Advise women that LMP may not give accurate representation of gestational age, therefore do not use LMP alone to determine the gestation age and diagnose a miscarriage.
- If the fetal heartbeat is not visible and the crown–rump length (CRL) is less than 7.0 mm on **TVS**, perform a second scan after a minimum of 7 days from the first scan before making a diagnosis of a missed miscarriage.
- If the CRL is 7.0 mm or more on **TVS** and there is no visible heartbeat:
 - i. The current USS department capacity and recommendation is that the sonographer can make the diagnosis based on one scan and to request further scans only if they deem it necessary.
 - ii. A second scan can be considered if the patient requests one.
- If a **TAS** is used to measure the CRL, the patient declines **TVS** and no fetal heartbeat is visible, perform a second scan after a minimum of 14 days before making a diagnosis of a missed miscarriage.
- One exception for TAS is when the CRL is ≥ 32 mm (10+0 weeks) where the USS gained adequate views and the scanner had no doubt about the findings.
 - i. The current USS department capacity and recommendation is that the sonographer can make the diagnosis based on one scan and to request further scans only if they deem it necessary.
 - ii. A second scan can be considered if the patient requests one.
- Measure mean gestational sac diameter (**MSD**) **only if no fetal pole is visible**.
- If the MSD is less than 25 mm on **TVS** with no visible fetal pole, repeat TVS in a minimum of 7 days before making a diagnosis of a missed miscarriage. The interval will be adjusted depending on the size (7 -14 days).
- If the MSD is 25 mm or more on **TVS** with no visible fetal pole;
 - i. The current USS department capacity and recommendation is that the sonographer can make the diagnosis based on one scan and to request further scans only if they deem it necessary.
 - ii. A second scan can be considered if the patient requests one.
- If a **TAS** is used to measure the mean gestational sac diameter, the patient declines **TVS** and a fetal pole is not visible, perform a second scan after a minimum of 14 days before making a diagnosis of a missed miscarriage..
- Inform women what to expect while waiting for a repeat scan and that waiting for a repeat scan has no detrimental effects on the outcome of the pregnancy. Provide a 24 hour emergency contact number.
- Subsequent repeat scans should be interpreted in the context of previous scans and if the diagnosis is unclear seek advice from a senior Gynaecology registrar or consultant.
- Non-urgent unclear cases where there has been different conflicting senior input can be kept aside for detailed review on Thursday Clinic when available.
- **Those cut off are for patients who have not had a scan confirming a live intrauterine pregnancy before.** If the patient has had a scan confirming a live pregnancy and the current scan does not show a cardiac activity, then a diagnosis of missed miscarriage can be made regardless of measurements. However the

TVS/TAS cut off still apply (32mm). Senior advice in such cases may become essential.

- For previous scans that were performed privately, see a separate document available at EPU.

8. THREATENED MISCARRIAGE

- Advise women with confirmed intrauterine live pregnancy (fetal cardiac activity present) who present with vaginal bleeding, but have no history of previous miscarriage, that:
 - i. If bleeding gets worse, or persists beyond 14 days, she should return for further assessment
 - ii. If the bleeding stops, she should start or continue routine antenatal care.
- Offer vaginal micronized progesterone 400 mg (Cyclogest®) twice daily to women with an USS confirmed intrauterine pregnancy, if they have vaginal bleeding and have previously had a miscarriage.
- If a fetal cardiac activity is confirmed, continue progesterone until 16 completed weeks of pregnancy.

9. MANAGEMENT OF DIAGNOSED MISSED MISCARRIAGE

- Women should be given adequate information for management options, let to choose their own option, and offered the necessary bereavement counselling.
- Provide verbal and written information about what to expect, the options for pain relief, and the red flag signs along with an emergency contact number.

9.1. EXPECTANT MANAGEMENT

- i. Offer expectant management for 7 to 21 days as a first line management for cases of confirmed missed miscarriage.
- ii. Discusses the risk and benefits- Lower morbidity, avoids surgery, similar rate of infection. Most women may not need any further treatment.
- iii. Explore other options other than expectant if

- a. Women at an increased risk of haemorrhage. [known coagulopathy (VWD, Haemophilia, etc.), anticoagulation therapy]
 - b. At increased risk from the effect of haemorrhage; (refusing blood products, HB<100g/L, anticoagulation therapy)
 - c. Signs of infection related directly to the miscarriage (septic miscarriage like pyrexia, foul smelling vaginal etc.)
 - d. Previous traumatic experience (still birth, APH, PPH) where expectant management is unacceptable to the women
- iv. Provide a container in which the patient can place any pregnancy tissue if she wishes for the hospital to manage disposal or if further testing is required.
 - v. If the patient passes the products and her bleeding and pain settles in those 21 days, advise her to do a home pregnancy test in 3 weeks and to contact EPU if positive for an individualized plan (serum HCG and TVS)
 - vi. If the patient does not pass any products by the end of those 21 days, they should be reviewed. If the miscarriage process has not started, then discuss the options of either further 7-14 days of expectant management or switch to medical or surgical options.
 - vii. Any woman wishing to continue expectant management after 28 days or the length agreed on, should be reviewed by the registrar/consultant and an individualised plan of care made.
 - viii. Women can change their choice of treatment after starting expectant management, requests for medical or surgical management should be arranged.

9.2. MEDICAL MANAGEMENT

- i. Obtain a written consent, after discussing the risks and benefits. The woman should be counselled that medical management may fail, there may be heavy bleeding or infection and when to contact EPU/Ward with concerning symptoms. See appendix i
- ii. Review patients with the following conditions with extra caution and discuss the management option.
 - a. Women with high risk of haemorrhage (e.g. coagulopathy, anticoagulant therapy, declines blood products, anaemic with Hb below 100g/l etc.) - Surgical management may be preferable. Discuss with registrar/consultant.
 - b. Signs of infection related directly to the miscarriage (septic miscarriage- pyrexia, foul smelling vaginal etc.). Surgical management is preferable
 - c. Known allergy to prostaglandin

- d. Mifepristone: contraindicated in severe uncontrolled asthma.
- e. Misoprostol: caution with cerebrovascular or cardiovascular disease where hypotension may precipitate severe complications.
- f. Avoid breastfeeding for 12 hours after last dose of misoprostol.

9.2.a HOME MANAGEMENT

- a) Offer home management if gestational age is below 9 weeks and they are suitable.

See [appendix iii](#)

- b) Inform women undergoing medical management of miscarriage about what to expect throughout the process, including the length and extent of bleeding and the potential side effects of treatment including pain, bleeding, nausea, vomiting and the red flag signs to contact EPU.
- c) The woman should be counselled that it may fail, there may be heavy bleeding, infection and that they may require surgical intervention.
- d) First part: Use 200 mg Mifepristone PO as a single dose for the management of missed miscarriage. Women should take the medication in presence of a staff prior to going home. If she has an episode of vomiting within the hour, then consider repeating the mifepristone dose. Keep in EPU for 30 minutes after the medication for observation.
- e) Second part: Use 800mcg of misoprostol as a single dose 36-48 hours after Mifepristone for the management of missed miscarriage. Women will have misoprostol to take at home.
- f) Provide a container in which the patient can place any pregnancy tissue if the patient wishes for the hospital to manage such tissue or if further testing is required.
- g) Offer pain relief, Co-Codamol (30/500mg) 8 tablets, to alleviate pain, and anti-emetics like Cyclizine 50mg tds for 24h period.
- h) If bleeding has not commenced within the agreed timeframe (2-7 days), women should contact EPU to determine ongoing individualized plan.
- i) Advise women to do home pregnancy test in 3 weeks. If positive or patient continues to have bleeding and pain, advice women to contact EPU (01792 286868) for review.
- j) Ensure Anti-D is administered if appropriate prior to discharge.

9.2.b INPATIENT MANAGEMENT

- a) Consider inpatient management if gestational age is above 9 week (9+1 till 13+6 weeks) and if not suitable for home management for other medical conditions or patient's choice.
- b) The woman should be counselled that it may fail, there may be heavy bleeding or infection, and that they may require surgical intervention.
- c) First part: Use 200 mg Mifepristone PO as a single dose for the management of missed miscarriage. Women should take the medication in presence of a staff prior to going home. If she has an episode of vomiting within the hour, then consider repeating the mifepristone dose. Keep in EPU for 30 minutes after the medication for observation.
- d) Patient needs to be admitted for the second part of the treatment.
- e) Second part: Use 800mcg of Misoprostol as a single dose after 36-48 hours after Mifepristone.
- f) If bleeding has not commenced or the products have only partially passed (incomplete miscarriage), then consider repeating Misoprostol 800 mcg pv after 24 hours. If patient chooses to go home and await onset of bleeding for up to one week, then they can do so. (exception; very high risk list)
- g) Advise women to do home pregnancy test in 3 weeks. If positive or patient continues to have bleeding and pain, advice women to contact EPU (01792 286868) for review.
- h) Ensure Anti-D is administered if appropriate prior to discharge.

9.2.c INCOMPLETE MISCARRIAGE

- a) If visually the product doesn't look complete, or if there is evidence of retained products of conception (RPOC) on scan.
- b) Use the anterior posterior diameter for the measurement of thickness of RPOC. If <25mm, then surgical option should be kept as last resort.
- c) Consider surgical management if the patient is haemodynamically unstable or having heavy vaginal bleeding.
- d) If the patient is stable, consider expectant or medical management: misoprostol 600mcg vaginally.
- e) Allow 1-2 weeks before rescanning to assess the RPOC if managed expectantly or medically and there are still concerns.

- f) Advise women to do home pregnancy test in 3 weeks. If positive or patient continues to have bleeding and pain, advice women to contact EPU (01792 286868) for review.
- g) Ensure Anti-D is administered if appropriate prior to discharge.

9.3 SURGICAL MANAGEMENT

- i. Do not offer surgical management in gestations $\geq 12+6$ weeks confirmed by USS, unless other methods have failed.
- ii. Surgical management should be planned on CEPOD.
- iii. Indications include infection, where expectant/medical management is not suitable, unsuccessful, and unacceptable to the woman and if trophoblastic disease is suspected.
- iv. Risks include:
 - a. Infection 2-3%
 - b. Retained products of conception, need for repeat treatment
 - c. Haemorrhage
 - d. Uterine perforation 1% and potential intra-abdominal trauma
 - e. Damage to cervix
 - f. Intra-uterine adhesions /Asherman syndrome
 - g. Anaesthesia risks
- v. Explain and provide written information about what surgical management of miscarriage involves, including the admission process. (EIDO information)
- vi. Obtain written consent. See appendix ii
- vii. When possible consider PV Misoprostol 400 micrograms, 2 hours before the operation in cases of missed miscarriage. This is to reduce the risk of trauma to the cervix and uterus during the procedure. (Misoprostol, caution with cerebrovascular or cardiovascular disease where hypotension may precipitate severe complications.)
- viii. Consider antibiotic prophylaxis for STI if swabs are unavailable. Azithromycin 1g orally stat, and Metronidazole 1g PR stat dose at time of procedure. Consider doxycycline 100mg bd for 10 days if allergic to azithromycin.
- ix. Using an appropriately sized suction curette, visually check the tissue obtained appears to be pregnancy tissue and in proportion to the size on the scan and the gestation age. Send for histology as routine.
- x. Send histology request as USC if molar pregnancy is suspected and copy the request to Mr Paul Flynn or Miss Charity Knight. (Please refer to the Management of Molar pregnancy guideline for further advise)

- xi. Remove IUCD if present.
- xii. Advise women to do home pregnancy test in 3 weeks. If positive or patient continues to have bleeding and pain, advise women to contact EPU (01792 286868) for review.
- xiii. Ensure Anti-D is administered if appropriate prior to discharge.
- xiv. Outpatient follow-up is rarely required unless operative complications occurred or investigations for recurrent miscarriage have been initiated.
- xv. Inform women of the histology result. If there is evidence of trophoblastic disease then appropriate referral needs to be arranged.

10. ANTI-D IMMUNOGLOBULIN PROPHYLAXIS*

- Offer anti-D immunoglobulin prophylaxis at a dose of 250 IU (50 micrograms) to all previously non-sensitized D negative women who have had medical or surgical procedure to manage the miscarriage, regardless of the gestational age.
- Anti-D should be given within 72 hours of the sensitizing event. (The event will be the surgical management or the painful bleeding after the medical management)
- Test for feto-maternal haemorrhage is not required.
- Do not offer Anti D in case of spontaneous complete miscarriage before 12 weeks of gestation with mild bleeding as the risk of feto-maternal haemorrhage is minimal.

**This guidance was made based on the British Blood Transfusion Society guideline 2014, which has noted at the time the recent NICE Guideline NG126 2012 "Ectopic pregnancy and miscarriage" that had recommendations against Anti-D without clear evidence, The NICE used the same evidence included in the RCOG GTG 2011 which used to advise on Anti-D for any intervention to treat miscarriage. The NICE updated versions since has not addressed this issue further and kept the old 2012 article unchanged. This has a potential to cause confusion resulting from inconsistency with the established current practice based upon RCOG green top and BCSH guidelines and introduces complexity into decision making without strong evidence to support such changes.*

Table 3: Management options of Miscarriage

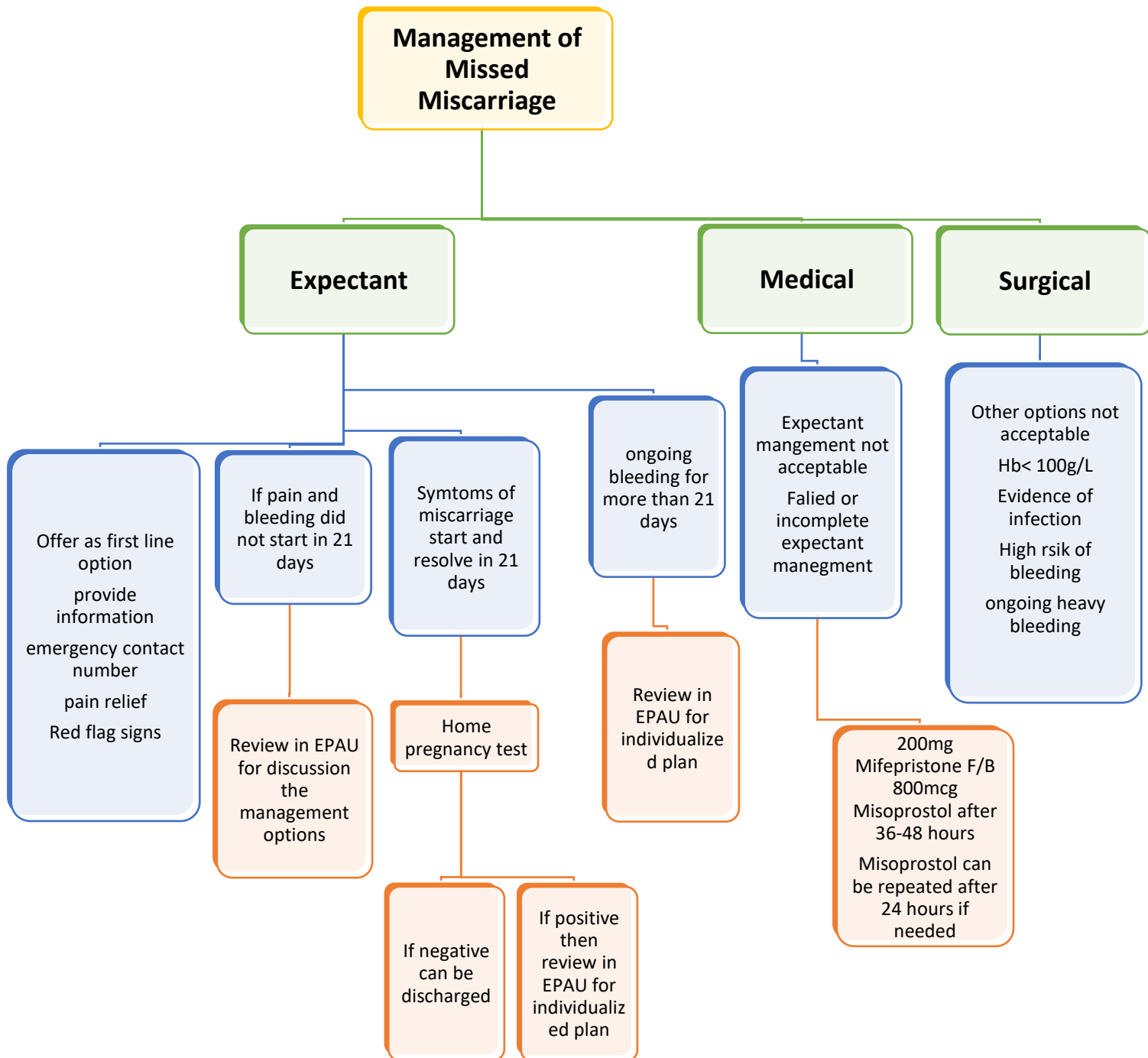


Table 4: Treatment doses for medical management of miscarriage

Gestation	Place	Mifepristone	Misoprostol	Further management
<9 weeks	Home or Hospital Gynae ward	200mg oral Mifepristone 36-48hr before Misoprostol	800mcg Misoprostol pv	Can have a repeat course of Misoprostol 24hrs (speculum examination may be needed)
9-12+6 weeks	Hospital Gynae ward	200mg oral Mifepristone 36-48hr before Misoprostol	800mcg Misoprostol pv	Can have a repeat course of Misoprostol 24hrs (speculum examination may be needed)
13-17+6 weeks	Hospital, Gynae ward	200mg oral Mifepristone 36-48hr before Misoprostol	200mcg Misoprostol pv, 6 hourly. 4 doses. Double the dose if not effective, max 1600mcg per 24hr	Can have a repeat course of Misoprostol or treat as incomplete miscarriage if fetus passed but placenta not passed (speculum examination may be needed)
18-24 weeks	Hospital Gynae ward or Labour ward* <i>*if felt more appropriate</i>	200mg oral Mifepristone 36-48hr before Misoprostol	100mcg Misoprostol pv, 6 hourly. 4 doses. Double the dose if not effective, max 800mcg per 24hrs	Can have a repeat course of Misoprostol or treat as incomplete miscarriage if fetus passed but placenta not passed (speculum examination may be needed)
Incomplete miscarriage	Hospital Gynae ward	None needed	600mcg Misoprostol pv	Can be repeated 24hrs

Appendix i: Sample of consent form for medical management

Consent Form 1: Patient agreement to examination or treatment

This form is to be used for people aged 16 years and over with mental capacity and people under 16 years of age who are Gillick competent

Please press hard and ensure all three copies are legible

Patient details (or pre-printed label)

Patient's surname/family name
 Patient's first names
 Date of birth
 Male Female
 NHS Number (or other identifier)

Special requirements

(e.g. other language/other communication method)

 (Please press hard to ensure all 3 copies are legible)

Name of proposed procedure or course of treatment (include brief explanation if medical term not clear)

MEDICAL MANAGEMENT OF MISSED MISCARRIAGE

Anaesthetic This procedure will involve:

General and/or regional anaesthesia Local anaesthesia Sedation None

Any extra procedures which may become necessary during the procedure

None expected Blood transfusion
 Other procedure (please specify) SURGICAL INTERVENTION

Statement of health professional (health professional must have appropriate knowledge of proposed procedure)

People aged 16 years and over (are presumed to have capacity to consent to treatment). Please tick ONE box:

In my opinion there are no reasons to doubt the patient's capacity to make this decision; **OR**
 The patient's mental capacity to consent to/refuse this treatment has been assessed and the patient has the mental capacity to make this decision. A note of the assessment has been placed on the patient's record.

People under 16 years of age

After a full explanation of the procedure and its risks and benefits, I believe that the child has sufficient maturity and intelligence to be capable of understanding fully the treatment proposed and making a decision based on the information provided. I therefore believe that the patient is **Gillick competent** to make this decision.
 The child has **agreed** / **declined** to involve someone with parental responsibility in this decision.

Advance decisions (for patients aged 18 years and over only)

The patient has made a valid and applicable advance decision refusing this treatment/procedure **or** a treatment or procedure which may become necessary during the treatment/procedure in question.
 (Ensure the patient completes full details in the Advance decisions section on the opposite page.)

Information about the procedure/treatment

I have explained the procedure to the patient. In particular, I have explained:

Intended benefits: MEDICAL MANAGEMENT TO REMOVE PREGNANCY REMAINS

Significant, unavoidable or frequently occurring risks, including any risks of particular significance to this patient:

BLEEDING, INFECTION, RETAINED FETAL TISSUE, NEEDING SURGICAL INTERVENTION

I have also discussed:

What the procedure is likely to involve.
 Any particular concerns of the patient.
 The benefits and risks of any available alternative treatments (including no treatment).

Please include details:

I have provided the following leaflet cd / dvd / weblink (please specify title of the leaflet and date of issue; title of the cd/dvd or "version" if it has been amended).

Signed SAMPLE Date 23-08-23

Name (PLEASE PRINT) X.Y.Z Job title REGISTRAR

Professional registration number (e.g. GMC, NMC, GDC, HCPC etc.) 123

Contact details (if patient wishes to discuss options later)

Appendix ii: Sample consent for Surgical Management of Miscarriage

Consent Form 1: Patient agreement to examination or treatment

This form is to be used for people aged 16 years and over with mental capacity and people under 16 years of age who are Gillick competent

Please press hard and ensure all three copies are legible

Patient details (or pre-printed label)

Patient's surname/family name

Patient's first names

Date of birth

Male Female

NHS Number (or other identifier)

Special requirements

(e.g. other language/other communication method)

.....

.....

.....

(Please press hard to ensure all 3 copies are legible)

Name of proposed procedure or course of treatment (include brief explanation if medical term not clear)

SURGICAL MANAGEMENT OF MISCARRIAGE

Anaesthetic This procedure will involve:

General and/or regional anaesthesia Local anaesthesia Sedation None

Any extra procedures which may become necessary during the procedure

None expected Blood transfusion
 Other procedure (please specify) LAPAROSCOPY +/- LAPAROTOMY +/- REPAIR OF INJURY

Statement of health professional (health professional must have appropriate knowledge of proposed procedure)

People aged 16 years and over (are presumed to have capacity to consent to treatment). Please tick ONE box:

- In my opinion there are no reasons to doubt the patient's capacity to make this decision; **OR**
 The patient's mental capacity to consent to/refuse this treatment has been assessed and the patient has the mental capacity to make this decision. A note of the assessment has been placed on the patient's record.

People under 16 years of age

- After a full explanation of the procedure and its risks and benefits, I believe that the child has sufficient maturity and intelligence to be capable of understanding fully the treatment proposed and making a decision based on the information provided. I therefore believe that the patient is **Gillick competent** to make this decision.
 The child has agreed / declined to involve someone with parental responsibility in this decision.

Advance decisions (for patients aged 18 years and over only)

- The patient has made a valid and applicable advance decision refusing this treatment/procedure or a treatment or procedure which may become necessary during the treatment/procedure in question.
 (Ensure the patient completes full details in the Advance decisions section on the opposite page.)

Information about the procedure/treatment

I have explained the procedure to the patient. In particular, I have explained:

Intended benefits: SURGICAL MANAGEMENT TO REMOVE THE PREGNANCY REMAINS

Significant, unavoidable or frequently occurring risks, including any risks of particular significance to this patient:

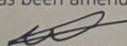
BLEEDING, INFECTION, RETAINED FETAL TISSUE OR PLACENTA, PERFORATION
 CERVICAL TRAUMA, INTRA-UTERINE ADHESIONS

I have also discussed:

- What the procedure is likely to involve.
 Any particular concerns of the patient.
 The benefits and risks of any available alternative treatments (including no treatment).

Please include details:

- I have provided the following (leaflet) / cd / dvd / weblink (please specify title of the leaflet and date of issue; title of the cd/dvd and "version" if it has been amended).

Signed  (SAMPLE) Date 23-08-23

Name (PLEASE PRINT) XYZ Job title REGISTRAR

Professional registration number (e.g. GMC, NMC, GDC, HCPC etc.) 123

Contact details (if patient wishes to discuss options later)

Appendix iii: Home management



HOME TREATMENT FOR MEDICAL MANAGEMENT OF MISCARRIAGE <9/40

Has the patient chosen home management? Yes/No

Does she have any of the following?

Known bleeding/other haematological disorder	Yes/No	
Cardiovascular disorder	Yes/No	
Known allergies to drugs used	Yes/No	
Previous PPH	Yes/No/N/A	
Hb <100	Yes/No	
Liver/adrenal disorder	Yes/No	Specify
Severe asthma	Yes/No	
Regular medication	Yes/No	Specify

NB. Home management contraindicated if taking corticosteroids, ketoconazole, uraconazole, erythromycin, rifampicin, phenytoin, phenobarbital, carbamazepine, St John's Wort, turmeric supplements

If yes to any of the above will need inpatient management

Does she have

A responsible adult at home in case of emergency	Yes/No
Transport to return if necessary	Yes/No
Access to telephone in case of emergency	Yes/No
FBC/G&S	Yes/No

Version 1.0 Approved January 2018

Author Dr F Hodge

Review Date 2021

Discuss

Simple analgesia

Hot water bottle

To use pads not tampons

Bleeding post procedure

When to contact – nil passed/heavy bleeding/ongoing bleeding/infection

Referral to GOPD if 3rd consecutive miscarriage

Need for urine pregnancy test in 3 weeks and to contact department if remains positive

Miscarriage association contact details

After discussion does the patient still wish to proceed with home management? Yes/No

Written consent form completed? Yes/No

Patient information leaflet provided? Yes/No

Signature of doctor

Signature of patient

Version 1.0 Approved January 2018

Author Dr F Hodge

Review Date 2021

11. REFERENCES

- NICE Clinical Guideline 154: Ectopic Pregnancy and Miscarriage
guidance.nice.org.uk/cg154
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