South Eastern Health and Social Care Trust

WACH Maternity/Gynae PRO (31) 2016

SOUTH EASTERN TRUST

Title:	**Elective Surgical Management of Miscarriage**			
Author(s)	**Sharon Watt**			
Ownership:	**Woman and Acute Child Health Directorate (WACH), SEHSCT**			
Approval by:	**Consensus from Nursing staff, Midwifery Staff and Medical Staff within WACH**		**Approval date:**	**July 2016**
Operational Date:	**July 2016**		**Next Review:**	**July 2019**
Version No.	**1.1**	**Supercedes**		
Links to other policies	**To be read in conjunction with: Guideline: Use of Mifepristone and Misoprostol in Obstetrics and Gynaecology. Policy for the Transfer of Patients Internal and External to the South Eastern Trust. Policy for Consent to Examination, Treatment or Care: UCHT/CI/PtCare (27) 2004**			

1.0 INTRODUCTION / PURPOSE OF PROTOCOL

1.1 Introduction

Surgical Management of miscarriage is being offered to selected women. This protocol has been written to give direction to staff, working within WACH, on the surgical management of miscarriage in women (CRL<12 weeks).

1.2 Purpose

This protocol gives direction to staff who are involved in the care of such women.

2.0 DEFINITIONS/SCOPE OF THE PROTOCOL

This protocol applies to all staff, working within WACH, who may be involved in the care of women undergoing surgical management of miscarriage (CRL<12 weeks).

3.0 ROLES/RESPONSIBILITIES

It is the responsibility of managers and supervisors to ensure that this protocol has been brought to the attention of all staff, within WACH, who have contact with women undergoing surgical management of miscarriage (CRL<12 weeks); and the responsibility of those staff to read and adhere to the contents of this protocol.

4.0 KEY PROTOCOL PRINCIPLES

4.1 Diagnosis of miscarriage

4.1.1 Ultrasound diagnosis of miscarriage should only be considered with a mean gestation sac diameter >/= 25mm (with no obvious yolk sac), or with a fetal pole with crown rump length >/=7mm (the latter without evidence of fetal heart activity)

4.1.2 A transvaginal ultrasound scan should be performed in all cases

4.1.3 Where there is any doubt about the diagnosis and/or a woman requests a repeat scan, this should be performed at an interval of at least one week from the initial scan before medical or surgical measures are undertaken for uterine evacuation.

4.1.4 No growth in gestation sac size or CRL is strongly suggestive of a non-viable pregnancy in the absence of embryonic structures.
To ensure correct diagnosis a repeat ultrasound scan should be arranged for 7-14 days following initial consultation. Confirmation of diagnosis is required from a second, appropriately qualified practitioner prior to any intervention.

Treatment options to be fully explained by diagnosing Healthcare Professional.

4.2. Exclusion Criteria

- Crown Rump Length greater than 12 weeks gestation

4.2.1. Unsuitable for Day Procedure Unit

- Suspicion of molar pregnancy
- BMI greater than 35
- Predisposing medical conditions

4.3. Procedure on Admission

4.3.1 Patient to attend fasting at 0800hrs on pre-arranged day

4.3.2 Ultrasound scan, if applicable, to ensure still need for procedure

4.3.3 Commence care pathway

4.3.4 Informed, written consent obtained

4.3.5 Administer misoprostol 400 micrograms sublingually (3 hours prior to procedure)

4.3.6 Confirmation of blood group/ sample obtained for same

4.3.7 Histopathology consent obtained

4.3.8 Transfer to and from theatre as per Trust Policy

4.4. Follow-up

4.4.1 Confirm blood group and administer anti-D if required

4.4.2 Complete care pathway and discharge checklist

4.4.3 Patients will not routinely have a review appointment at the hospital, except for recurrent miscarriage.

5.0. IMPLEMENTATION OF PROTOCOL

5.1. Dissemination

This protocol will be disseminated to all staff, working within WACH, who have contact with women undergoing surgical management of miscarriage.

5.2. Exceptions

This protocol applies to staff working within WACH across the Trust.

6.0 MONITORING

This protocol will be audited, to check the appropriateness of the women assigned to surgical management and the success of the treatment. This protocol will be reviewed every 3 years.

7.0. EVIDENCE BASE / REFERENCES

7.0.1 Association of Early Pregnancy Units: AEPU Guidelines, 2007

7.0.2 Department of Health, Social Services and Public Safety: Good practice in consent and the care of the bereaved, a consultation document (January 2004), chapter 6: Care plan for women who experience a miscarriage, stillbirth or neonatal death.

http://www.dhsspsni.gov.uk/postmortem.pdf

7.0.3 National Institute for Health and Clinical Excellence: NICE clinical guideline 154 (2012): Ectopic pregnancy and miscarriage.

http://guidance.nice.org.uk/CG154/Guidance

7.0.4 Royal College of Obstetricians and Gynaecologists: Green-top Guideline No.25 (2006): The Management of Early Pregnancy Loss.

http://www.rcog.org.uk/womens-health/clinical-guidance/management-early-pregnancy-loss-green-top-25

7.0.5 Royal College of Obstetricians and Gynaecologists: Addendum to Green-top Guideline No.25 (2006): The Management of Early Pregnancy Loss.

http://www.rcog.org.uk/news/statement-interim-guidance-gtg-no-25-management-early-pregnancy-loss

8.0 CONSULTATION PROCESS

The nursing, midwifery and medical staff, working within WACH, were consulted in the writing of this protocol.

9.0 EQUALITY STATEMENT

In line with duties under the equality legislation (Section 75 of the Northern Ireland Act 1998), Targeting Social Need Initiative, Disability discrimination and the Human Rights Act 1998, an initial screening exercise to ascertain if this policy should be subject to a full impact assessment has been carried out.

The outcome of the Equality screening for this policy is:

No impact

SIGNATORIES:

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