MANAGEMENT OF A WOMAN WITH VAGINAL BLEEDING AND A VIABLE INTRAUTERINE PREGNANCY

BACKGROUND

Threatened miscarriage is defined as vaginal bleeding with or without abdominal pain, while the cervix is closed and the fetus is viable, inside the uterine cavity\(^1\). Threatened miscarriage is the most common complication of early pregnancy occurring in 20% of women before 20 weeks gestation\(^2\). 17% of these women will continue to have further complications in pregnancy and are 2.6 times more likely to experience miscarriage at a later stage in the pregnancy\(^2\).

Threatened miscarriage is associated with adverse maternal and perinatal outcomes\(^3\). An increased risk of antepartum haemorrhage, pre-labour rupture of membranes, preterm delivery and intrauterine growth restriction has been documented\(^1\). A UK study reports an association with malpresentation, manual removal of placenta and elective caesarean section\(^4\).

Ultrasound has improved management by rapid confirmation of viability.\(^1\) Transvaginal scanning has a positive predictive value of 98% in confirming diagnosis of complete miscarriage and should be used in assessment. The presence of a fetal heart has the most powerful association with pregnancy outcome. Studies have varied from indicating that at 3 - 5.3mm crown rump length (CRL) a viable fetus can be visualised\(^5\). 100% success rate has been found with a crown rump length of 6mm or more in diagnosing a viable pregnancy\(^5\). Fetal bradycardia was a sign present in 1 in 3 pregnancies that were subsequently lost, whilst 7% of pregnancies that continued had bradycardia found on ultrasound\(^6\).

KEY POINTS

- Manage all women with early pregnancy complications with respect and dignity, as this can cause significant distress\(^5\). Provide comprehensive information throughout.

- Non-sensitised rhesus negative women should receive anti-D immunoglobulin for threatened miscarriages\(^2\).

- In the case where a heartbeat is absent with a CRL of less than 7.0 mm or a mean gestational sac diameter of less than 25.0 mm measured on a single ultrasound, a repeat scan is recommended in 7 days if using transvaginal ultrasound or 14 days when transabdominal ultrasound is used\(^5\).

PROCEDURE

1. Inform the woman of the assessment findings and diagnosis and provide reassurance.

2. Give the woman the information sheet “Bleeding in Early Pregnancy”.

3. Check the woman’s blood group and provide anti D immunoglobulin if rhesus negative.

4. Advise the woman that if vaginal bleeding gets worse or persists beyond 14 days, she should return for further assessment. If bleeding stops to continue with routine antenatal care\(^5\).
5. Follow up may be required in the following situations:
   i. Significant vaginal bleeding and patient refusing to be admitted.
   ii. A haematoma is noted.
   iii. Fetal bradycardia.
   iv. After IUCD removal.
   v. For reassurance at woman’s request because of previous recurrent miscarriages (3 or more).

6. Discharge to the care of her GP with a formal discharge letter for referral to the antenatal clinic.

For further information on diagnosis and management refer to Clinical Guideline C.9.2.1 Early Pregnancy Bleeding/Pain Algorithm.

REFERENCES