EARLY PREGNANCY CARE

EARLY PREGNANCY FAILURE - MANAGEMENT OF MISCARRIAGE

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MEDICAL MANAGEMENT

BACKGROUND

Early pregnancy loss is defined as a loss within the first 12 completed weeks of pregnancy. Early pregnancy loss is defined as a loss within the first 12 completed weeks of pregnancy. Miscarriage occurs in 10-20% of clinical pregnancies and accounts for 55,000 couples experiencing early pregnancy loss in Australia each year. While the rate of miscarriage has remained relatively stable, improvements in diagnostic and therapeutic interventions have changed standard treatments, with medical outpatient management becoming more common as an effective alternative option in place of surgical evacuation.

Missed miscarriage could be an anembryonic pregnancy or an early fetal demise. Diagnosis of anembryonic pregnancy is made when there is presence of a gestational sac larger than 25mm without evidence of embryonic tissues (yolk sac or embryo); and embryonic demise is when an embryo larger than 7mm is seen with no cardiac activity.

Most first trimester miscarriages occur completely and spontaneously without any intervention. Although dilatation and curettage has historically been the treatment of choice, several recent trials confirm that expectant management or medical management with Misoprostol can be as effective and safer, while offering the woman more control over her care.

Women treated expectantly have more outpatient visits than those treated medically and those treated medically have more visits than surgically treated women. Women treated medically have more bleeding but less pain than those treated surgically. To avoid unnecessary anxiety, women should be advised that bleeding may continue for up to three weeks after medical uterine evacuation. There is no real difference in the risk of infection between these two options (2-3%). Satisfaction rates are comparable if women are given the choice.

Significant psychological effects of miscarriage on the woman and her partner have been reported and appropriate support should be offered.

Misoprostol, a prostaglandin E1 analogue, is the most commonly used agent for medical management of miscarriage. Its safety and efficacy has been proven in multiple trials and it has many advantages over other drugs, such as low incidence of side effects with vaginal administration, ready availability and low cost.

KEY POINTS

1. With appropriate counselling regarding expected blood loss and adequate analgesia, outpatient management should be appropriate in most cases.
2. Medical management of missed miscarriage should be offered as a treatment option to all women presenting to KEMH Emergency centre for management of an early pregnancy loss (miscarriage).
3. Consent is required for this procedure. The consent form must be signed by the woman and the treating medical officer following a full and frank discussion of the risks and alternative treatments.

4. All woman shall be provided with information pamphlets and offered a token of remembrance ('heart') available in the Emergency centre.

5. All health care professionals should be aware of the psychological sequelae associated with pregnancy loss and should provide support, follow up and access to formal counselling when necessary. Appropriate support can result in significant psychological gain.

MISOPROSTOL USE ELIGIBILITY CRITERIA

- All women presenting to KEMH Emergency centre with a confirmed ultrasound diagnosis of Missed Miscarriage. Refer to Clinical Guideline Early Pregnancy Bleeding Algorithm.

- All women presenting with an Incomplete miscarriage or inevitable miscarriage.

CONTRAINDICATIONS TO MEDICAL MANAGEMENT

- Suspicion of ectopic pregnancy
- Heavy bleeding with soaking of pads every 1-2 hours
- Complete miscarriage
- Molar pregnancy
- Temperature > 37.5
- Contraindications to the use of Misoprostol – see below

CONTRAINDICATIONS TO MISPROSTOL

- Severe asthma
- Hypertension
- Glaucoma
- Mitral stenosis
- Sickle cell anaemia.

SIDE EFFECTS

- Gastro-intestinal – nausea, vomiting, diarrhoea
- Pyrexia

ANALGESIA

- Paracetamol +/- Codeine or Tramadol should be provided for the woman to take home.
- Morphine (if no allergies) may be required for inpatients.
### Day 1
800mcg Misoprostol given vaginally
Use only water as lubricant

### Day 7
USS
Uterus empty → discharge
POC still in situ → 800mcg Misoprostol given vaginally.
Use only water as the lubricant

### Day 14
USS
Uterus empty → discharge
POC still in situ → arrange surgical evacuation (D&C)

#### DISCHARGE INFORMATION
- Provide the woman with a copy of ‘Patient Information Regarding Medical Management of Miscarriage’ pamphlet.
- Any care expected of the woman’s GP during medical management should be negotiated with the stakeholders prior to discharge.
- The woman shall be informed of the side effects, and advised to return if the pain is not controlled with the analgesia provided or the bleeding is very heavy. NB: ‘very heavy’ needs to be quantified with the woman i.e. soaked pad every 1-2 hours.
- Admission to hospital should be offered to any woman who returns with:
  - excessive bleeding or
  - pain uncontrolled by prescribed analgesia.

#### HISTOPATHOLOGY EXAMINATION
Any tissue passed vaginally should be collected and sent for histological examination.

#### REFERENCES