STANDARD OPERATING PROCEDURE

Miscarriage

Special Region (1)

Union of Myanmar

Version: (1)

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Approved by: Internal Medicine Unit

Miscarriage

- 15-20% up to 40% of all conceptions
- The expulsion of a pregnancy, embryo or fetus at a stage of pregnancy when it is

incapable of independent survival:

- Includes all pregnancy losses before 24wks
- The vast majority are before 12wks

Classification of miscarriage Clinical USG findings 1.Threatened miscarriage PVB ± pain Intrauterine gestation sac Closed cervix Fetal pole Fetal Ht (+) 2.Complete Bleeding and pain cease Empty uterus Closed cervix ET < 15mm 3.Incomplete Bleeding ± pain Heterogeneous t/s + gestation sac Possible open cervix Any ET 4.Missed miscarriage/ Bleeding ±pain ±loss of Fetal pole >7mm with no fetal heart early fetal demise pregnancy symptoms Closed cervix MSD >25mm with no fetal pole or yolk sac 5.Inevitable Bleeding ± pain Intrauterine gestation sac± fetal pole ± fetal heart activity Open cervix 6.Pregnancy of uncertain ±Bleeding ± pain intrauterine gestation sac < 25 mm viability with no fetal pole or yolk sac Closed cervix Fetal echo with CRL <7mm with no fetal heart 7.Pregnancy of unknown ±bleeding ±pain +ve pregnancy test location (PUL) Empty uterus Closed cervix No sign of extrauterine pregnancy Clinical presentation Common symptoms include:

- Vaginal bleeding
- Lower abdominal pain or cramping
- Passage of products of conception
- Back pain
- Fever (suggests infection)

History taking

- Amount and duration of bleeding
- Passage of tissue
- Associated with pain or not
- Last menstrual period
- Other relevant history

Physical examination

- Assess vital signs
- Abdominal and pelvic examination

Investigation

- Ultrasound (abdomen and pelvic)
- UCG
- Blood for CP, group and Rh typing
- HVS for C & S if infection is suspected

Management

- Informed consent should be obtained whatever treatment option is desired
- Prophylactic antibiotics are recommended for uterine vacuum aspiration
- Women who present for uterine evacuation, medical or vacuum aspiration, should be
- ffered all pain management options and provided these services without delay

Treatment option Threatened miscarriage/abortion

- Reassurance
- Expectant management
- If continued bleeding, further clinical assessment

Incomplete miscarriage/abortion

- Depending on the clinical condition and the women’s preference, she may be offered

expectant, surgical (vacuum aspiration) or medical management

- Antibiotics if indicated and pain control

Missed miscarriage/abortion

- Depending on the clinical condition and the women’s preference, she may be offered

expectant, surgical (vacuum aspiration) or medical management Complete miscarriage/abortion

- Expectant management
- Antibiotics if indicated and pain control

Surgical and medical management For uterine size up to 12 weeks gestation Medical management

- Incomplete miscarriage/abortion: Misoprostol 600 mcg orally or 400 mcg sublingually in

a single dose (FIGO 2023)

- Missed miscarriage/abortion: Misoprostol 800 mcg sublingually/vaginally every 3hours

until expulsion (FIGO 2023) Uterine aspiration

- Vacuum aspiration using a manual or electric aspirator
- Where vacuum aspiration is not available, dilatation and curettage (D & C) or evacuation

and curettage (E & C) have to be used with care. It should be replaced with vacuum aspiration, to improve safety. Advantages of MVA over D & C include decreased blood loss, less pain and shorter duration of the procedure For uterine size greater than 12 weeks gestation Medical management Under the supervision of Obstetrician and Gynecologist

- Incomplete miscarriage: Misoprostol 400 mcg sublingually/buccal every 3 hours (FIGO

2023)

- Missed miscarriage: Misoprostol 400 mcg sublingually/vaginally/buccal every 3hours

until expulsion (FIGO 2023) Dilatation & Evacuation Under the supervision of Obstetrician and Gynecologist

- Dilatation and evacuation (D&E/RPOC is a uterine evacuation method that utilizes a

combination of vacuum aspiration (MVA) with 12-16 mm diameter cannulas and specialized forceps if available

- Specialized training, experience, and equipment are necessary to use this method safely

Septic abortion Septicemic shock with complications such as peritonitis, DIC, acute renal failure. Emergency management

- Rapid initial assessment and resuscitate if shock present
- Parenteral broad-spectrum antibiotics should be given initially before referral
- Give the first dose of a combination of antibiotics before transfer to hospital
- IV ceftriaxone 1 g stat or IV ampicillin 2 g PLUS
- IV metronidazole 500 mg
- IV gentamycin 80 mg stat if there is urine output
- Give tetanus toxoid or tetanus immunoglobulin
- IV C pen 20 L stat and 10 L 6 hrly if clostridium infection is suspected

Care in hospital

- Rapid initial assessment and resuscitation
- Continue monitoring
- Control of infection
- HVS for culture and sensitivity, blood culture
- Continue IV antibiotics and then changed according to C & S results

- Change to oral antibiotics if the patient responded
- Parenteral antibiotics for at least 24 hours after temperature touch normally
- Give anti-D prophylaxis if maternal blood group is Anti-D negative
- Control of bleeding
- Determine the source of bleeding by doing an abdominal examination, speculum and

bimanual examination to check for the tissue at os

- Remove tissue at os if present
- Empty the uterus as soon as possible
- Evacuation of uterus
- Removal of septic foci by surgical method MVA or Evacuation of RPOC
- Posterior colpotomy for a pelvic abscess
- Laparotomy and drainage of intraabdominal abscesses and a pelvic abscess may

be necessary and refer to higher-level care if facilities are not available

- it should be deferred until reasonable tissue level of antibiotics have been

achieved (i.e., about 12-24 hours) Anti-D prophylaxis Anti-D should be given to all non-sensitized Rh negative patients in the following circumstances:

- <12wks
- Uterine evacuation (medical and surgical)
- 250IU IM
- >12wks:
- All women with bleeding
- 250IU IM before 20wks and 500IU IM after20wks

Counseling and follow-up

- Explain cause if known
- Provide emotional support
- Advise family planning
- Discuss future pregnancy planning
- Follow-up visit in 1-2 weeks

Documentation Record:

- History
- Examination findings

- Investigations
- Treatment given
- Patient condition
- Counseling provided

References

1. Kumar S, Padubidri VG, Daftary SN (2018). Ectopic Gestation, In: Shaw's Textbook of Gynaeco-logy, 17th edition, Elsevier India, 234241.

2. NICE Clinical Guideline 126 (2019). Ectopic pregnancy and miscarriage: diagnosis and initial management.

3. 3.FIGO Misoprostol only dosing chart redommended reggimens (2023).