The Shrewsbury and Telford Hospital NHS
NHS Trust

Diagnosis and Management of Miscarriage

Version 7.1

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Comments	:	References to SaTH Guidelines in the text pertain to the latest version of the Guideline on the intranet. Printed copies may not be the most up to date version.

For Triennial Review

Version	Implementation Date	History	Ratified By	Full Review Date
1	Feb 2005		Gynae Clinical Governance	Feb 2007
2	24th June 2011			June 2014
3	10th May 2012			May 2015
4	4th February 2014	Review following updates to NICE guidance	Gynae Governance	February 2017
5	22nd August 2017	Fetus <8mm change and other minor changes	Gynae Governance	August 2020
6	10th November 2020	Full Re-write	Gynae Governance	10/11/2023
7	15/12/2022	Addition of Medical Management of Miscarriage detail and mental health support	Gynae Governance	15/12/2025

		Updates following Datix to include management of haemorrhage, miscarriage at the dating scan and advice on cervical priming		
7.1		Appendix 1 – Auditable standards added		15/12/2025

Contents:

1.0 Introduction

1.1 More than 1 in 5 pregnancies end in miscarriage. The experience of miscarriage is unique to each person and requires a sensitive and caring environment for the client and their partners.

1.2 It is recommended that all units should provide an early pregnancy assessment service to provide this care. (RCOG, 2006).

1.3 The indications and process of referral to the Early Pregnancy services are detailed in guideline “EPAS – Referrals and appointments”.

2.0 Aims

2.1 The aim of this guideline is to ensure that the optimum care is given and to provide a framework for appropriate management.

2.2 To provide clients with advice regarding choice of management and associated risk factors.

2.3 To ensure safety of the clients at all times.

2.4 To provide psychological support.

3.0 Glossary of Terms

EPAS	Early Pregnancy Assessment Services
GATU	Gynaecology Assessment and Treatment Service
MSD	Mean Sac Diameter
IUP	Intrauterine Pregnancy
EUP	Extrauterine Pregnancy
HCG	Human Chorionic Gonadotrophin

4.0 Definitions

4.1 Viable Pregnancy

- intrauterine gestational sac containing an embryo with a heartbeat

4.2 Gestational Sac

- Intrauterine sac like structure with clearly defined yolk sac +/- fetal pole

4.3 Probable Early Gestational Sac/Cystic Space

- round hypoechoic structure with an echogenic rim, eccentrically situated within the decidua, usually at or near the uterine fundus that is likely to represent an IUP but not certain.

4.4 Pregnancy of uncertain Viability

- an intrauterine gestational sac seen with a Mean Sac Diameter of less than 25mm without a visible yolk sac or embryonic pole
- an intrauterine gestational sac with MSD of less than 25 mm with a yolk sac seen without a visible embryonic pole
- an intrauterine gestational sac with an embryo with a CRL measuring less than 8 mm with no visible heartbeat.

4.5 Non-Viable Pregnancy or Miscarriage

- On transvaginal ultrasound:
  - Gestational sac (no yolk sac or fetal pole) on transvaginal scan >25mm
  - Fetus 8mm and above with no fetal heart

4.5 Complete miscarriage

- A diagnosis of complete miscarriage should not be made on the basis of a single ultrasound scan. By definition, if a pregnancy has not been visualised in the uterus on the current scan and there is no previous scan to confirm an intrauterine pregnancy with a positive urinary pregnancy test or a raised BHCG, the pregnancy should be classified as a pregnancy of unknown location.

4.6 Incomplete Miscarriage

- Collection of mixed echoes within the endometrial cavity following an episode of bleeding and a previously confirmed intrauterine pregnancy.
- The diagnosis of an incomplete miscarriage without a previous scan is difficult – refer to main text for advice.

4.7 Pregnancy of Unknown Location

- Used where the exact location of the pregnancy cannot be confirmed and would include:
  - Small intrauterine sac or Uncertain sac with no yolk sac
  - No IUP or EUP seen
  - No IUP with suspicious adnexal lesion

4.8 Uncertain Sac

- Intrauterine cystic structure that does not clearly exhibit enough features to be classified as a gestational sac and may represent:
  - Intrauterine pregnancy (viable or non-viable)
  - Pseudosac

4.9 Pseudosac

- a collection of fluid within the uterine cavity that does not exhibit features consistent with an intrauterine pregnancy
  - Fluid usually echogenic
  - Centrally located in cavity rather than eccentric
  - Beaking at one or both ends in the longitudinal plane
  - Absence of yolk sac

4.10 Inconclusive Scan (Inconclusive Intrauterine Findings)

- Ultrasound diagnosis where a sac like structure without a yolk sac is identified in uterine cavity that the sonographer is unable to define. May include both a regular cystic space or uncertain sac. More likely to represent an intrauterine pregnancy than not.

5.0 Diagnosis and Management of Miscarriage

5.1 Diagnosis of intrauterine pregnancy

5.1.1 Offer women who attend EPAS a transvaginal ultrasound scan to identify the location of the pregnancy and whether there is a fetal pole and heartbeat. A transabdominal scan alone may be sufficient from 8 weeks size (CRL 17mm) however the sonographer must be clear on pregnancy location.

5.1.2 Consider a transabdominal ultrasound scan for women with an enlarged uterus or other pelvic pathology, such as fibroids or an ovarian cyst.

5.1.3 If a transvaginal ultrasound scan is unacceptable to the woman, offer a transabdominal ultrasound scan and explain the reduced ability of this scan to make a diagnosis.

5.1.4 A systematic approach to the scan should be adopted with labelled images printed/stored including:

- Full view of uterus and cervix including pregnancy sac in longitudinal plane
- Transverse uterine view
- Right ovary/adnexum
- Left ovary/adnexum
- Any other pertinent findings

5.1.5 Identify the presence or absence of gestational sac as defined above

5.1.6 Identify and document the presence or absence of yolk sac. If no yolk sac then measure the gestational sac in three dimensions to obtain mean sac diameter (MSD)

5.1.7 Identify and document the presence or absence of the fetal pole, identified as a linear structure adjacent to the yolk sac. Exercise caution in diagnosing a small fetal pole without a yolk sac unless a previous scan has clearly confirmed an intrauterine pregnancy as a clot within a pseudosac can be confused with a fetal pole.

5.1.8 Where a scan shows a “Cystic Space” fitting the above definition, this is more likely than not to represent an early intrauterine pregnancy and would normally be defined as Inconclusive Intrauterine findings or probable early intrauterine preganncy. 48 hour HCG should be arranged and the case

highlighted for review by the EPAS lead consultant to plan further management within one week.

5.1.9 For scans where an intrauterine fluid collection is seen without a yolk sac or fetal pole, that cannot be described as an early gestational sac or cystic space as above, the report should describe a “fluid filled area in the uterus”. This will be categorised as an “Uncertain” Sac in the drop down list. ALL cases will need to have one HCG taken as a baseline and the images/report put for the EPAS Lead consultant to review and determine further management. When away or unavailable this responsibility will fall to the on call Gynaecology Consultant.

5.2 Using ultrasound scans for diagnosis of viability of an intrauterine pregnancy

5.2.1 Inform women that the diagnosis of miscarriage using 1 ultrasound scan cannot be guaranteed to be 100% accurate and there is a small chance that the diagnosis may be incorrect, particularly at very early gestational ages.

5.2.2 When performing an ultrasound scan to determine the viability of an intrauterine pregnancy, first look to identify a fetal heartbeat. If there is no visible heartbeat but there is a visible fetal pole, measure the crown–rump length. Only measure the mean gestational sac diameter if the fetal pole is not visible.

5.2.3 If the crown–rump length is less than 7.0 mm with a transvaginal ultrasound scan and there is no visible heartbeat the scan conclusion would be “Intrauterine Pregnancy of Uncertain Viability”. Perform a second scan a minimum of 7 days after the first before making a diagnosis. A more definitive diagnosis can USUALLY be made after an interval of 14 days however further scans may be needed before a diagnosis can be made.

5.2.4 If the crown–rump length is 7.0 mm or more with a transvaginal ultrasound scan and there is no visible heartbeat:

- Repeat the scan that day by a different operator (scan to be performed by second operator rather than just observing and/or
- Perform a second scan a minimum of 7 days after the first before making a diagnosis if a second operator is not available.
- It would be reasonable to repeat the scan sooner if a different operator can be guaranteed at the next appointment.

- If the second person is present throughout the entire scan it would be acceptable to diagnose a miscarriage without having to fully repeat the scan.

5.2.5 If there is no visible heartbeat when the crown–rump length is measured using a transabdominal ultrasound scan (and TV scan declined):

- Make a diagnosis of “Intrauterine Pregnancy of Uncertain Viability”.
- record the size of the crown–rump length and
- perform a second scan a minimum of 14 days after the first before making a diagnosis.
- It would be acceptable to diagnose a miscarriage on a single transabdominal scan at a gestation of 11 weeks or over (CRL 44mm).

5.2.6 If the mean gestational sac diameter is less than 25.0 mm with a transvaginal ultrasound scan and there is no visible fetal pole, the scan conclusion would be “Intrauterine Pregnancy of Uncertain Viability”. Perform a second scan a minimum of 7 days after the first before making a diagnosis. The patient should in informed that further scans may be needed before a diagnosis can be made.

5.2.7 If the mean gestational sac diameter is 25.0 mm or more using a transvaginal ultrasound scan and there is no yolk sac or fetal pole:

- Repeat the scan with a second operator (scan to be performed by second operator rather than just observing) and/or
- perform a second scan a minimum of 7 days after the first before making a diagnosis if a second operator is unavailable.
- It would be reasonable to repeat the scan sooner if a different operator can be guaranteed at the next appointment.
- If the second person is present throughout the entire scan it would be acceptable to diagnose a miscarriage without having to fully repeat the scan.

5.2.8 If there is no visible fetal pole and the mean gestational sac diameter is measured using a transabdominal ultrasound scan (and a TV scan declined):

- record the size of the mean gestational sac diameter and
- perform a second scan a minimum of 14 days after the first before making a diagnosis.

- A diagnosis of blighted ovum should not be diagnosed on a single transabdominal scan.

5.2.9 Do not use gestational age from the last menstrual period alone to determine whether a fetal heartbeat should be visible.

5.2.10 Women should be advised that these safeguards are in place to avoid accidental termination of a potentially viable pregnancy as a single scan by a single operator will never be 100% accurate

5.2.11 Inform women that the date of their last menstrual period may not give an accurate representation of gestational age because of variability in the menstrual cycle.

5.2.12 Inform women what to expect while waiting for a repeat scan, including the risk of very heavy vaginal bleeding, as detailed in the patient information leaflet entitled “Inconclusive Scans”, and that waiting for a repeat scan has no detrimental effects on the outcome of the pregnancy.

5.2.13 Women are given a card with the telephone numbers of the Early Pregnancy Assessment service on both sites, as well as the gynaecology ward to be used out of hours.

5.2.14 A complete miscarriage should not be diagnosed unless a previous scan has diagnosed an intrauterine pregnancy. Advise these women to return for follow-up (for example, hCG levels, ultrasound scans) until a definitive diagnosis is obtained.

5.2.15 Where no yolk sac or fetal pole is present, take additional care to differentiate the intrauterine sac from the intracavity fluid associated with an ectopic pregnancy (sometimes referred to as a pseudo sac). If unclear the woman should be referred to the early pregnancy lead consultant. When away or unavailable this responsibility will fall to the on call Gynaecology Consultant, however the Lead consultant usually can be contacted for advice in complex cases.

5.3 Initial Management of Miscarriage

5.3.1 Threatened miscarriage

Advise a woman with vaginal bleeding and a confirmed intrauterine pregnancy **with** a fetal heartbeat that:

- if her bleeding gets worse, or persists beyond 14 days, she should return for further assessment

- if the bleeding stops, she should start or continue routine antenatal care.
- The use of Utrogestan at a dose of 400mg twice daily (per vagina) can be offered for women with early pregnancy bleeding and a history of 1 or more miscarriages (refer to Guideline Management of Threatened Miscarriage).

5.3.2 Confirmed Miscarriage:

- Following their ultrasound scan, patients are often too upset/unsure to make a decision regarding management of miscarriage. In this case the client will given leaflets on all management options and then go home to consider their options.
- Direct access numbers are given to patient for advice.
- Patient is advised to contact EPAS when she knows what management she wants.
- If patient has not contacted EPAS within 72 hours – EPAS to contact patient.
- Patient added to Miscarriage Notification List to ensure unnecessary maternity appointments are cancelled.

5.3.3 Women identified to have miscarriage at the dating scan

- This will usually be a significant shock as women will often have had no symptoms
- Criteria for diagnosing a miscarriage is the same as that used in EPAS
- Women should be counselled in a sensitive manner initially by the midwife sonographer
- They should be given the appropriate information leaflets on miscarriage or pregnancy of uncertain viability depending on the diagnosis an allowed to go home, as well as the contact details and opening hours for EPAS.
- Instruct the woman to contact EPAS at a time they are ready the next day (working hours), and they will be contacted after 48 hours if they have not called.
- Where the woman goes home they must be advised about the risk of very heavy bleeding (women will often be in the late first trimester and therefore higher risk) and to consider how she would access care in an emergency (eg childcare plans/ambulance)
- Patient details must be telephoned through to EPAS, including an up to date telephone number.
- If the woman is too distressed to go home then refer to EPAS / GATU for immediate review.

5.4 Expectant management miscarriage

5.4.1 Use expectant management for 7 to 14 days as the first-line management strategy for most women with a confirmed diagnosis of miscarriage. Explore management options other than expectant management if:

- the woman is at increased risk of haemorrhage (for example, she is in the late first trimester [CRL > 44mm, Sac size >50mm], has significant fibroids, RPOC >50mm) or
- she has previous adverse and/or traumatic experience associated with pregnancy (for example, stillbirth, miscarriage or antepartum haemorrhage) or
- she is at increased risk from the effects of haemorrhage (for example, if she has coagulopathies or is unable to have a blood transfusion) or
- there is evidence of infection or
- Conservative management is unacceptable to the woman

5.4.2 Explain what expectant management involves and that most women will need no further treatment. Also provide women with oral and written information about further treatment options if not already done so. Information should include:

- Further advice given to patient regarding bleeding/pain. Explain to patient that bleeding may become very heavy with clots. In some cases it may be necessary to call an ambulance.
- Advice given to patient that if an offensive discharge develops, to contact EPAS for review.

5.4.3 Give all women undergoing expectant management of miscarriage oral and written information about what to expect throughout the process, advice on pain relief and where and when to get help in an emergency. This is detailed in the “Conservative Management Following a Miscarriage” Patient Information Leaflet.

5.4.4 Women should be contacted by telephone at the end of the pre-defined time period of 7-14 days and a remote review conducted. This should be documented on the patients electronic record as a telephone contact.

5.4.5 If the **occurrence and resolution of bleeding and pain suggest that the miscarriage has completed** during 7 to 14 days of expectant management, advise the woman to take a urine pregnancy test after 3 weeks

from when the bleeding stopped, and to contact EPAS for individualised care if it is positive.

5.4.6 Offer a repeat scan if after the period of expectant management of 7-14 days, the bleeding and pain:

- have not started (suggesting that the process of miscarriage has not begun or that the diagnosis may be incorrect) or
- are persisting and/or increasing (suggesting incomplete miscarriage).

Where the miscarriage has not begun or is incomplete:

- Send FBC to direct further treatment options
- Discuss all treatment options (further 14 days of expectant management, medical management and surgical management) with the woman to allow her to make an informed choice.

5.4.7 If after 4 weeks of conservative management the miscarriage is incomplete based on clinical and/or ultrasound findings, and ongoing expectant management is being considered, invite the patient in for review by the on call gynaecologist for an individualised management plan. The risk of infection and heavy bleeding will increase after 4 weeks.

5.5 Medical Management of 1st trimester Miscarriage

- Offer medical management to women with a confirmed diagnosis of miscarriage if expectant management is not acceptable to the woman, and the patient fits the criteria.
- Consider suitability inpatient management where:
    - the woman is at increased risk of haemorrhage (for example, she is in the late first trimester [CRL > 44mm, Sac size >50mm], has significant fibroids, RPOC >50mm)
    - she has previous adverse and/or traumatic experience associated with pregnancy (for example, stillbirth, miscarriage or antepartum haemorrhage)
    - she is at increased risk from the effects of haemorrhage (for example, if she has coagulopathies or is unable to have a blood transfusion)
    - Patient lives in remote areas with minimal support available
    - Patient prefers inpatient management

- Contraindications include:
    - Allergy to prostaglandins
    - History of cardiovascular disease or cerebrovascular disease
    - Inflammatory bowel disease (for oral dose)
    - Anaemia <95g/L
- Written consent should be obtained using standardised consent form for Medical Management of Miscarriage using sensitive terminology.
- Offer vaginal misoprostol at a dose of 800mcg (prescribed by the on call gynaecology team) for the medical treatment of missed or incomplete miscarriage. Oral administration is an acceptable alternative if this is the woman's preference.
- Advise the woman that if bleeding has not started 24 hours after treatment, she should contact her EPAS to determine ongoing individualised care.
    - If bleeding has not commenced then discuss the option of further misoprostol in a further 48 hours and make an appointment
    - If patient declines further misoprostol and wishes surgical management this can be arranged a further 48-72 hours later as some women will go on to miscarry during that time and avoid the need for surgery.
- Offer all women receiving medical management of miscarriage pain relief and anti-emetics as needed.
- 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, diarrhoea and vomiting. Ensure the woman is aware that bleeding is likely to be very heavy for a short time.
- Give clear advice both verbal and written of where and when to attend for medical review
- For women who live in remote areas or do not have good support available consider inpatient management.
- Provide women with a urine pregnancy test to carry out at home 3 weeks after medical management of miscarriage unless they experience worsening symptoms, in which case advise them to contact EPAS during clinical hours (0800hours to 1600 hours), or to attend via A&E where the woman should be referred to the gynaecology on call team.
- If women do not contact with pregnancy test result they should be telephoned by 4 weeks to ensure they are well and to offer ongoing support.
- Advise women with a positive urine pregnancy test after 3 weeks to return for a review in EPAS to ensure that there is no molar or ectopic pregnancy.
    - Follow up may include repeat ultrasound.

5.6 Surgical Management of Miscarriage

5.6.1 Where clinically appropriate, offer women undergoing a miscarriage a choice of:

- manual vacuum aspiration under local anaesthetic in GATU (arranged by EPAS nurses) Refer to guideline for MVA.
- surgical management in a theatre under general anaesthetic (see below).

Surgical Management under General Anaesthetic

At the time of decision for surgery (usually done by phone)

- If patient is currently bleeding heavily arrange admission to GATU for management by the oncall gynaecology team.
- If patient is not bleeding significantly EPAS nurses to arrange planned admission and provide the date to the woman along with contact numbers if not already done so.
- Patient triaged to admission on GATU or Inpatient depending on medical risk factors.
- Patient given NBM instructions by EPAS nurses.
    - Patient copies of consent form should have already been provided.
- Ensure leaflets on surgical management of miscarriage have been provided.
- Patient details written on correct TCI date in GATU communication diary.
- Tier 1 Doctor to add patient details to NCEPOD list the day before planned admission.

Day of admission

- Patient to attend EPAS at 07:30 on day the day of planned surgery. EPAS nurses will admit the woman and ensure parental wishes and cremation forms are completed.
- stockings/Tinzaparin appropriately.
- Bloods tests including FBC and G&S to be taken and documented on admission sheet.
- MRSA swabs taken and sent.
- Patient to be admitted to GATU trolleys under the care of GATU staff. Verbal handover given the Nurse in charge on GATU.
- Patient admitted on SEMA by GATU staff.
- Tier 1 doctor to put patient on NCEPOD list if not already done so.

- Tier 1 doctor to complete VTE risk assessment and prescribe any necessary medications, including misoprostol if meets criteria below.
- Gynaecology on call consultant informed of admission
- Operating surgeon to ensure that consent is taken/completed by an appropriate person (Operating surgeon or delegated to another doctor who is trained to take the consent), and that parental wishes forms are completed.
- GATU nursing staff to complete theatre checklist.

Cervical Priming

- There is very little direct evidence on the use of cervical priming for management of miscarriage.
- Guidance for women undergoing surgical termination of pregnancy (NICE 2019) advise that the use of misoprostol 1-3 hours (depending on route of administration) prior to the procedure can reduce the force needed to dilate the cervix and therefore potentially reduce the risk of perforation as well as reduce the risk of incomplete abortion.
- There is no data to support the use of misoprostol in a woman already bleeding – in this case the cervix is usually softened already. Use of cervical priming in this situation may increase the risk of miscarriage on the ward before the procedure is conducted causing distress for the patient.

- Clinicians should consider the use of 400mcg misoprostol pre-operatively in nulliparous asymptomatic women or any woman in the late third trimester (past 10 weeks size) with minimal symptoms.
    - In this situation the use of misoprostol will be discussed with women by the nursing staff, obtaining verbal consent including:
        - Benefits – shorter operation and safer to dilate the cervix
        - Risks: Allergy, Bleeding or Cramps, Miscarriage on the ward if surgical delays
    - She should be advised that misoprostol is being used off license but is commonly used in this situation.
    - Misoprostol should be prescribed on the drug chart by medical staff once they are happy that the above information has been given, to be administered by the nursing staff 1 hour prior to the procedure (given between 7:30 and 8am)
    - An alternative option would be to give 200mg Mifepristone 24-48h prior to the procedure with the same risks
  - If cervical priming is used outside the above criteria it should be discussed with the woman by the consultant in charge of the procedure, and theatres organised accordingly.

Processing of products of conception

- Procedure completed as per standard process
- Plastic Casing carefully opened by operating surgeon by releasing the two clamps
- If recurrent miscarriage and Cytogenetics are required transfer a portion of RPOC to dry pot – Liaise with EPAS nurses about appropriate preparation of samples for cytogenetics.
- Contents of Plastic Sieve otherwise transferred to suitably sized formalin container to ensure representative sample sent.
- Lid of plastic trap replaced
- Both trap and formalin pot sent to Mortuary with Histology Form, Parental Wishes form, Cremation form and Disposal of POC form

Post Procedure

- Patient admitted to GATU from recovery
- Blood group checked and confirmed by Nursing staff and anti-D requested if patient is Rhesus negative
    - Anti-D 1500units prescribed by medical team or EPAS nurse if not already done so.
    - Anti-D administered prior to discharge
- Patient to be reviewed by medical team prior to discharge.
- Final discharge summary to be completed by medical team prior to discharge.

5.7 Management of Haemorrhage during medical or expectant management

- Any woman presenting to the emergency department with a positive pregnancy test and heavy vaginal bleeding should be urgently escalated to the gynaecology team on call.
- Any woman with evidence of haemodynamic instability should be admitted to ED Resus, cross match for 4 units RBC sent, and fluids commenced.
- Fast bleep the gynaecology tier 2 (Bleep 328 from 09:00 to 19:00 Mon- Sat, Bleep 331 from 19:00 – 09:00)
- Simultaneously contact the Gynaecology Consultant on call
- A gynaecology “grab bag” is stored on GATU (contents list in appendix 1) that should be taken to any emergency in an outlying area.
- The woman should be examined by the tier 2/consultant to assess and remove (as tolerated) any pregnancy tissue in the cervix.
- The primary treatment for haemorrhage secondary to miscarriage is emergency surgical evacuation.
- Whilst this is being organised medical treatment of the haemorrhage can be instituted:
    - Tranexamic Acid 1g IV
    - Ergometrine 500mg IM (if no contraindications)
    - Syntometrine 5/500mg IM

- Misoprostol 1000mg may sometimes be used however be aware that the onset of action is over 1 hour and therefore shorter acting medications should be used first line.

- Medical treatment in this setting should not delay any plans for surgical management
- In the setting of heavy bleeding, a positive pregnancy test and an open cervical OS an ultrasound scan would not be required and could delay life saving treatment.
- Sensitive disposal forms do NOT need to be completed before going to theatre in the emergency setting, and women will not be in a position to make an informed choice. Best practice would be to send the appropriate labelled histology samples to the mortuary, and for the sensitive disposal forms to completed at an appropriate time post operatively when the woman has recovered.
- Please ensure mortuary are aware that forms are to follow, by documenting on the histology form. Forms must be completed prior to discharge, seek advice from EPAS when unsure.

6.0 Anti-D

- All women with miscarriage over 12 weeks, or anyone under 12 weeks undergoing surgical management should have rhesus status checked and Anti-D prescribed for rhesus negative women in accordance with the Anti-D guideline.

7.0 Symptomatic women with a negative pregnancy test

- Following a miscarriage it is possible for women to have retained products of conception with a negative pregnancy test.
- Conservative management would usually be encouraged as any remaining tissue or clots may come away with the next period.
- Women with persistent or severe symptoms should be referred to the EPAS consultant clinic where a scan may be performed, or the on call gynaecologist depending on the individual circumstance and clinical need.
- In the absence of the EPAS consultant a scan may be requested in the main radiology department at the request of the on call consultant.

8.0 Private Scans

- Explain to women that we are unable to accept private scans as evidence of pregnancy history as we are not always able to guarantee the reliability of previous scans.
- Where a woman has been referred from a private scan they should have an urgent appointment made to repeat the scan.
- Where a previous private scan has shown a viable intrauterine pregnancy and a scan in EPAS has shown a CRL <7mm with no fetal heart, a follow up scan should be arranged after 7 days rather than 14 days to minimise distress to the woman as this is still likely to confirm the miscarriage.

9.0 Early Scans in asymptomatic women and Reassurance Scans

- Women with a history of miscarriage can be offered a reassurance scan at 8 weeks in the maternity unit.
- Women with a history of ectopic pregnancy can be offered a pregnancy location check at 6 weeks in EPAS, ideally on a consultant list wherever possible.
- Women with a history of recurrent miscarriage or other medical conditions that require an early viability in order to commence urgent treatments (eg LMWH, Aspirin) should be discussed with the Early Pregnancy consultant and a scan offered in EPAS depending on the circumstance.

10.0 Support of wellbeing during and following Pregnancy Loss

- The loss of pregnancy at any stage (including ectopic or miscarriage) can be a significant life changing event for some families and it's importance should not be understated.
- Women seen through EPAS diagnosed with pregnancy loss will be offered support for mental wellbeing including the option of telephone or face to face follow up
- Women will be signposted to the relevant online support networks (Miscarriage association and Ectopic Trust as relevant) and given the EPAS support card "Talk about pregnancy loss"
- For women who are managed in other areas (Gynaecology ward/GATU/Outlying wards):
    - Ensure sensitive language is used at all times
    - A letter or discharge summary should be provided that recognises the patient has undergone a pregnancy loss and its significance

- Prior to discharge ensure women are signposted to the Miscarriage Association (www.miscarriage.org.uk) or Ectopic Trust (https://ectopic.org.uk)
- Patient should be given EPAS support card: “Talk about Pregnancy Loss”
- Ward/GATU staff to complete miscarriage notification form and taken to EPAS on daily basis.
- Copy of discharge summary to be taken to EPAS to ensure suitable follow up is offered.

11.0 Patient Involvement and communication

- Options regarding surgical or medical management discussed and advantages and disadvantages of each approach following diagnosis of miscarriage. Patient to fully participate in management plan.
- Conservative management to be encouraged as first line management
- Leaflets given as appropriate eg. Miscarriage, ERPC, conservative and medical management of miscarriage.
- Miscarriage notification to be completed on a daily basis and the ward clerk will input onto computer system. Appointments for antenatal care to be cancelled on sema by ward clerk
- Adequate time to be given in a caring and sensitive manner to provide both physical and emotional support for each individual.
- Mental Health should be discussed with all women during follow up and ongoing support offered as needed.

12.0 Training

9.1 All staff have a responsibility to read any new or updated guidelines

9.2 All staff employed by SATH will be informed how to access guidelines on the intranet at induction

9.3 Information regarding new and updated guidelines is circulated by email/memo to medical and nursing staff

9.4 Guideline updates will be presented at Governance Feedback Meetings

9.5 A paper copy is placed in the Gynaecology Guideline Folder on Ward 14 and file in EPAS with a notice posted to alert staff to be aware of new and updated guidelines

9.6 Staff working with women with early pregnancy complications will be expected to undertake training on Bereavement care provided by the e-LFH website.

9.7 Staff working with women with early pregnancy loss are encouraged to complete the e-learning programme offered by the Miscarriage Association.

13.0 References

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NICE Guideline [NG126]: Ectopic pregnancy and miscarriage: diagnosis and initial management

NICE Guideline NG140: Abortion care (September 2019)

Royal Shrewsbury Hospital (2003). Anti D Protocol.

Appendix 1

Diagnosis and Management of Miscarriage Version 7 – Auditable Standards

5.0 Diagnosis and Management of Miscarriage

5.1 Diagnosis of intrauterine pregnancy

5.1.1 Offer women who attend EPAS a transvaginal ultrasound scan to identify the location of the pregnancy and whether there is a fetal pole and heartbeat.

5.1.2 Consider a transabdominal ultrasound scan for women with an enlarged uterus or other pelvic pathology, such as fibroids or an ovarian cyst.

5.1.3 If a transvaginal ultrasound scan is unacceptable to the woman, offer a transabdominal ultrasound scan and explain the reduced ability of this scan to make a diagnosis.

5.1.4 A systematic approach to the scan should be adopted with labelled images printed/stored including:

- Full view of uterus and cervix including pregnancy sac in longitudinal plane
- Transverse uterine view
- Right ovary/adnexum
- Left ovary/adnexum
- Any other pertinent findings

5.1.5 Identify the presence or absence of gestational sac as defined above

5.1.6 Identify and document the presence or absence of yolk sac. If no yolk sac then measure the gestational sac in three dimensions to obtain mean sac diameter (MSD)

5.1.7 Identify and document the presence or absence of the fetal pole, identified as a linear structure adjacent to the yolk sac.

5.1.8 Where a scan shows a "Cystic Space" fitting the above definition, this is more likely than not to represent an early intrauterine pregnancy and would normally be defined as Inconclusive Intrauterine findings or probable early intrauterine pregnancy. 48-hour HCG should be arranged and the case highlighted for review by the EPAS lead consultant to plan further management within one week.

5.1.9 For scans where an intrauterine fluid collection is seen without a yolk sac or fetal pole, that cannot be described as an early gestational sac or cystic space as above, the report should describe a "fluid filled area in the uterus". This will be categorised as an "Uncertain" Sac in the drop down list. ALL cases will need to have one HCG taken as a baseline and the images/report put for the EPAS Lead consultant to review and determine further management. When away or unavailable this responsibility will fall to the on call Gynaecology Consultant.

5.2 Using ultrasound scans for diagnosis of viability of an intrauterine pregnancy

5.2.1 Inform women that the diagnosis of miscarriage using 1 ultrasound scan cannot be guaranteed to be 100% accurate and there is a small chance that the diagnosis may be incorrect, particularly at very early gestational ages.

5.2.2 When performing an ultrasound scan to determine the viability of an intrauterine pregnancy, first look to identify a fetal heartbeat. If there is no visible heartbeat but there is a visible fetal pole, measure the crown–rump length. Only measure the mean gestational sac diameter if the fetal pole is not visible.
5.2.3 If the crown–rump length is less than 7.0 mm with a transvaginal ultrasound scan and there is no visible heartbeat the scan conclusion would be "Intrauterine Pregnancy of Uncertain Viability". Perform a second scan a minimum of 7 days after the first before making a diagnosis. A more definitive diagnosis can USUALLY be made after an interval of 14 days however further scans may be needed before a diagnosis can be made.
5.2.4 If the crown–rump length is 7.0 mm or more with a transvaginal ultrasound scan and there is no visible heartbeat:

- Repeat the scan that day by a different operator (scan to be performed by second operator rather than just observing and/or
- Perform a second scan a minimum of 7 days after the first before making a diagnosis if a second operator is not available.
- It would be reasonable to repeat the scan sooner if a different operator can be guaranteed at the next appointment.
- If the second person is present throughout the entire scan it would be acceptable to diagnose a miscarriage without having to fully repeat the scan.

5.2.5 If there is no visible heartbeat when the crown–rump length is measured using a transabdominal ultrasound scan (and TV scan declined):

- Make a diagnosis of "Intrauterine Pregnancy of Uncertain Viability".
- record the size of the crown–rump length and
- perform a second scan a minimum of 14 days after the first before making a diagnosis.
- It would be acceptable to diagnose a miscarriage on a single transabdominal scan at a gestation of 11 weeks or over (CRL 44mm).

5.2.6 If the mean gestational sac diameter is less than 25.0 mm with a transvaginal ultrasound scan and there is no visible fetal pole, the scan conclusion would be "Intrauterine Pregnancy of Uncertain Viability". Perform a second scan a minimum of 7 days after the first before making a diagnosis. The patient should in informed that further scans may be needed before a diagnosis can be made.
5.2.7 If the mean gestational sac diameter is 25.0 mm or more using a transvaginal ultrasound scan and there is no yolk sac or fetal pole:

- Repeat the scan with a second operator (scan to be performed by second operator rather than just observing) and/or
- perform a second scan a minimum of 7 days after the first before making a diagnosis if a second operator is unavailable.
- It would be reasonable to repeat the scan sooner if a different operator can be guaranteed at the next appointment.
- If the second person is present throughout the entire scan it would be acceptable to diagnose a miscarriage without having to fully repeat the scan.

5.2.8 If there is no visible fetal pole and the mean gestational sac diameter is measured using a transabdominal ultrasound scan (and a TV scan declined):

- record the size of the mean gestational sac diameter and
- perform a second scan a minimum of 14 days after the first before making a diagnosis.
- A diagnosis of blighted ovum should not be diagnosed on a single transabdominal scan.

5.2.10 Women should be advised that these safeguards are in place to avoid accidental termination of a potentially viable pregnancy as a single scan by a single operator will never be 100% accurate
5.2.11 Inform women that the date of their last menstrual period may not give an accurate representation of

gestational age because of variability in the menstrual cycle.
5.2.12 Inform women what to expect while waiting for a repeat scan, including the risk of very heavy vaginal bleeding, as detailed in the patient information leaflet entitled “Inconclusive Scans”, and that waiting for a repeat scan has no detrimental effects on the outcome of the pregnancy.
5.2.14 A complete miscarriage should not be diagnosed unless a previous scan has diagnosed an intrauterine pregnancy. Advise these women to return for follow-up (for example, hCG levels, ultrasound scans) until a definitive diagnosis is obtained.
5.2.15 Where no yolk sac or fetal pole is present, take additional care to differentiate the intrauterine sac from the intracavity fluid associated with an ectopic pregnancy (sometimes referred to as a pseudo sac). If unclear the woman should be referred to the early pregnancy lead consultant. When away or unavailable this responsibility will fall to the on-call Gynaecology Consultant, however the Lead consultant usually can be contacted for advice in complex cases.

5.3 Initial Management of Miscarriage

5.3.1 Threatened miscarriage

Advise a woman with vaginal bleeding and a confirmed intrauterine pregnancy with a fetal heartbeat that:

- if her bleeding gets worse, or persists beyond 14 days, she should return for further assessment
- if the bleeding stops, she should start or continue routine antenatal care.
- The use of Utrogestan at a dose of 400mg twice daily (per vagina) can be offered for women with early pregnancy bleeding and a history of 1 or more miscarriages

5.3.2 Confirmed Miscarriage:

- Following their ultrasound scan, patients are often too upset/unsure to make a decision regarding management of miscarriage. In this case give leaflets on all management options and to take home to consider their options.
- Direct access numbers are given to patient for advice.
- Patient is advised to contact EPAS when she knows what management she wants.
- If patient has not contacted EPAS within 72 hours – EPAS to contact patient.
- Patient added to Miscarriage Notification List to ensure unnecessary maternity appointments are cancelled.

5.3.3 Women identified to have miscarriage at the dating scan

- Women should be counselled in a sensitive manner initially by the midwife sonographer
- They should be given the appropriate information leaflets on miscarriage or pregnancy of uncertain viability depending on the diagnosis an allowed to go home, as well as the contact details and opening hours for EPAS.
- Instruct the woman to contact EPAS at a time they are ready the next day (working hours), and they will be contacted after 48 hours if they have not called.
- Where the woman goes home they must be advised about the risk of very heavy bleeding (women will often be in the late first trimester and therefore higher risk) and to consider how she would access care in an emergency (eg childcare plans/ambulance)
- Patient details must be telephoned through to EPAS, including an up to date telephone number.
- If the woman is too distressed to go home then refer to EPAS / GATU for immediate review

5.4 Expectant management miscarriage

5.4.1 Use expectant management for 7 to 14 days as the first-line management strategy for most

women with a confirmed diagnosis of miscarriage. Explore management options other than expectant management if:

- the woman is at increased risk of haemorrhage (for example, she is in the late first trimester [CRL > 44mm, Sac size >50mm], has significant fibroids, RPOC >50mm) or
- she has previous adverse and/or traumatic experience associated with pregnancy (for example, stillbirth, miscarriage or antepartum haemorrhage) or
- she is at increased risk from the effects of haemorrhage (for example, if she has coagulopathies or is unable to have a blood transfusion) or
- there is evidence of infection or
- Conservative management is unacceptable to the woman

5.4.2 Explain what expectant management involves and that most women will need no further treatment. Also provide women with oral and written information about further treatment options if not already done so. Information should include:

- Further advice given to patient regarding bleeding/pain. Explain to patient that bleeding may become very heavy with clots. In some cases it may be necessary to call an ambulance.
- Advice given to patient that if an offensive discharge develops, to contact EPAS for review.

5.4.3 Give all women undergoing expectant management of miscarriage oral and written information about what to expect throughout the process, advice on pain relief and where and when to get help in an emergency. This is detailed in the "Conservative Management Following a Miscarriage" Patient Information Leaflet.

5.4.4 Women should be contacted by telephone at the end of the pre-defined time period of 7-14 days and a remote review conducted. This should be documented on the patient's electronic record as a telephone contact.

5.4.5 If the occurrence and resolution of bleeding and pain suggest that the miscarriage has completed during 7 to 14 days of expectant management, advise the woman to take a urine pregnancy test after 3 weeks from when the bleeding stopped, and to contact EPAS for individualised care if it is positive.

5.4.6 Offer a repeat scan if after the period of expectant management of 7-14 days, the bleeding and pain:

- have not started (suggesting that the process of miscarriage has not begun or that the diagnosis may be incorrect) or
- are persisting and/or increasing (suggesting incomplete miscarriage). Where the miscarriage has not begun or is incomplete:
- Send FBC to direct further treatment options
- Discuss all treatment options (further 14 days of expectant management, medical management and surgical management) with the woman to allow her to make an informed choice.

5.4.7 If after 4 weeks of conservative management the miscarriage is incomplete based on clinical and/or ultrasound findings, and ongoing expectant management is being considered, invite the patient in for review by the on call gynaecologist for an individualised management plan. The risk of infection and heavy bleeding will increase after 4 weeks.

5.5 Medical Management of 1st trimester Miscarriage

- Offer medical management to women with a confirmed diagnosis of miscarriage if expectant management is not acceptable to the woman, and the patient fits the criteria.
- Consider suitability inpatient management where:
    - the woman is at increased risk of haemorrhage (for example, she is in the late first trimester [CRL > 44mm, Sac size >50mm], has significant fibroids, RPOC >50mm)

- she has previous adverse and/or traumatic experience associated with pregnancy (for example, stillbirth, miscarriage or antepartum haemorrhage)
- she is at increased risk from the effects of haemorrhage (for example, if she has coagulopathies or is unable to have a blood transfusion)
- Patient lives in remote areas with minimal support available
- Patient prefers inpatient management

- Written consent should be obtained using standardised consent form for Medical Management of Miscarriage using sensitive terminology.
- Offer vaginal misoprostol at a dose of 800mcg (prescribed by the on call gynaecology team) for the medical treatment of missed or incomplete miscarriage. Oral administration is an acceptable alternative if this is the woman's preference.
- Advise the woman that if bleeding has not started 24 hours after treatment, she should contact her EPAS to determine ongoing individualised care.
  - o If bleeding has not commenced then discuss the option of further misoprostol in a further 48 hours and make an appointment
  - o If patient declines further misoprostol and wishes surgical management this can be arranged a further 48-72 hours later as some women will go on to miscarry during that time and avoid the need for surgery.

Offer all women receiving medical management of miscarriage pain relief and anti-emetics as needed.

- 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, diarrhoea and vomiting. Ensure the woman is aware that bleeding is likely to be very heavy for a short time.
- Give clear advice both verbal and written of where and when to attend for medical review
- For women who live in remote areas or do not have good support available consider inpatient management.
- Provide women with a urine pregnancy test to carry out at home 3 weeks after medical management of miscarriage unless they experience worsening symptoms, in which case advise them to contact EPAS during clinical hours (0800hours to 1600 hours), or to attend via A&E where the woman should be referred to the gynaecology on call team.
- If women do not contact with pregnancy test result they should be telephoned by 4 weeks to ensure they are well and to offer ongoing support.
- Advise women with a positive urine pregnancy test after 3 weeks to return for a review in EPAS to ensure that there is no molar or ectopic pregnancy. o Follow up may include repeat ultrasound.

5.6 Surgical Management of Miscarriage

5.6.1 Where clinically appropriate, offer women undergoing a miscarriage a choice of:

- manual vacuum aspiration under local anaesthetic in GATU (arranged by EPAS nurses) Refer to guideline for MVA.
- surgical management in a theatre under general anaesthetic (see below).

Surgical Management under General Anaesthetic At the time of decision for surgery (usually done by phone)

- o If patient is currently bleeding heavily arrange admission to GATU for management by the on-call gynaecology team.

- o If patient is not bleeding significantly EPAS nurses to arrange planned admission and provide the date to the woman along with contact numbers if not already done so.

o Patient triaged to admission on GATU or Inpatient depending on medical risk factors.

o Patient given NBM instructions by EPAS nurses.

o Patient copies of consent form should have already been provided.

o Ensure leaflets on surgical management of miscarriage have been provided.

o Patient details written on correct TCI date in GATU communication diary.

o Tier 1 Doctor to add patient details to NCEPOD list the day before planned admission.

Day of admission

o Patient to attend EPAS at 07:30 on day the day of planned surgery. EPAS nurses will admit the woman and ensure parental wishes and cremation forms are completed.

o stockings/Tinzaparin appropriately.

o Bloods tests including FBC and G&S to be taken and documented on admission sheet.

o MRSA swabs taken and sent.

o Patient to be admitted to GATU trolleys under the care of GATU staff. Verbal handover given the Nurse in charge on GATU.

o Patient admitted on SEMA by GATU staff.

o Tier 1 doctor to put patient on NCEPOD list if not already done so

Tier 1 doctor to complete VTE risk assessment and prescribe any necessary medications, including misoprostol if meets criteria below.

o Gynaecology on call consultant informed of admission

o Operating surgeon to ensure that consent is taken/completed by an appropriate person (Operating surgeon or delegated to another doctor who is trained to take the consent), and that parental wishes forms are completed.

o GATU nursing staff to complete theatre checklist

Cervical Priming

- Guidance for women undergoing surgical termination of pregnancy (NICE 2019) advise that the use of misoprostol 1-3 hours (depending on route of administration) prior to the procedure can reduce the force needed to dilate the cervix and therefore potentially reduce the risk of perforation as well as reduce the risk of incomplete abortion.
- There is no data to support the use of misoprostol in a woman already bleeding – in this case the cervix is usually softened already. Use of cervical priming in this situation may increase the risk of miscarriage on the ward before the procedure is conducted causing distress for the patient.

Clinicians should consider the use of 400mcg misoprostol pre-operatively in nulliparous asymptomatic women or any woman in the late third trimester (past 10 weeks size) with minimal symptoms.

o In this situation the use of misoprostol will be discussed with women by the nursing staff, obtaining verbal consent including:

o Benefits – shorter operation and safer to dilate the cervix

o Risks: Allergy, Bleeding or Cramps, Miscarriage on the ward if surgical delays

o She should be advised that misoprostol is being used off license but is commonly used in this situation.
o Misoprostol should be prescribed on the drug chart by medical staff once they are happy that the above information has been given, to be administered by the nursing staff 1 hour prior to the procedure (given between 7:30 and 8am)
o An alternative option would be to give 200mg Mifepristone 24-48h prior to the procedure with the same risks
o If cervical priming is used outside the above criteria it should be discussed with the woman by the consultant in charge of the procedure, and theatres organised accordingly.

Post Procedure

- Patient admitted to GATU from recovery
- Blood group checked and confirmed by Nursing staff and anti-D requested if patient is Rhesus negative

  o Anti-D 1500units prescribed by medical team or EPAS nurse if not already done so.
  o Anti-D administered prior to discharge
- Patient to be reviewed by medical team prior to discharge.
- Final discharge summary to be completed by medical team prior to discharge.

5.7 Management of Haemorrhage during medical or expectant management

- Any woman presenting to the emergency department with a positive pregnancy test and heavy vaginal bleeding should be urgently escalated to the gynaecology team on call.
- Any woman with evidence of haemodynamic instability should be admitted to ED Resus, cross match for 4 units RBC sent, and fluids commenced.
- Fast bleep the gynaecology tier 2 (Bleep 328 from 09:00 to 19:00 Mon- Sat, Bleep 331 from 19:00 – 09:00)
- The primary treatment for haemorrhage secondary to miscarriage is emergency surgical evacuation.
- Whilst this is being organised medical treatment of the haemorrhage can be instituted:

  o Tranexamic Acid 1g IV
  o Ergometrine 500mg IM (if no contraindications)
  o Syntometrine 5/500mg IM
  o Misoprostol 1000mg may sometimes be used however be aware that the onset of action is over 1 hour and therefore shorter acting medications should be used first line.
- Medical treatment in this setting should not delay any plans for surgical management
- In the setting of heavy bleeding, a positive pregnancy test and an open cervical OS an ultrasound scan would not be required and could delay lifesaving treatment.
- Sensitive disposal forms do NOT need to be completed before going to theatre in the emergency setting, and women will not be able to make an informed choice. Best practice would be to send the appropriate labelled histology samples to the mortuary, and for the sensitive disposal forms to completed at an appropriate time post operatively when the woman has recovered.
- Please ensure mortuary are aware that forms are to follow, by documenting on the histology form. Forms must be completed prior to discharge, seek advice from EPAS when unsure.

6.0 Anti-D

- All women with miscarriage over 12 weeks, or anyone under 12 weeks undergoing surgical management should have rhesus status checked and AntiD prescribed for rhesus negative women in accordance with the Anti-D guideline.

7.0 Symptomatic women with a negative pregnancy test

- Following a miscarriage, it is possible for women to have retained products of conception with a negative pregnancy test.
- Conservative management would usually be encouraged as any remaining tissue or clots may come away with the next period.
- Women with persistent or severe symptoms should be referred to the EPAS consultant clinic where a scan may be performed, or the on-call gynaecologist depending on the individual circumstance and clinical need.
- In the absence of the EPAS consultant a scan may be requested in the main radiology department at the request of the on-call consultant

8.0 Private Scans

- Explain to women that we are unable to accept private scans as evidence of pregnancy history as we are not always able to guarantee the reliability of previous scans.
- Where a woman has been referred from a private scan they should have an urgent appointment made to repeat the scan.
- Where a previous private scan has shown a viable intrauterine pregnancy and a scan in EPAS has shown a CRL <7mm with no fetal heart, a follow up scan should be arranged after 7 days rather than 14 days to minimise distress to the woman as this is still likely to confirm the miscarriage

9.0 Early Scans in asymptomatic women and Reassurance Scans

- Women with a history of miscarriage can be offered a reassurance scan at 8 weeks in the maternity unit.
- Women with a history of ectopic pregnancy can be offered a pregnancy location check at 6 weeks in EPAS, ideally on a consultant list wherever possible.
- Women with a history of recurrent miscarriage or other medical conditions that require an early viability in order to commence urgent treatments (eg LMWH, Aspirin) should be discussed with the Early Pregnancy consultant and a scan offered in EPAS depending on the circumstance

10.0 Support of wellbeing during and following Pregnancy Loss

- The loss of pregnancy at any stage (including ectopic or miscarriage) can be a significant life changing event for some families and its importance should not be understated.
- Women seen through EPAS diagnosed with pregnancy loss will be offered support for mental wellbeing including the option of telephone or face to face follow up
- Women will be signposted to the relevant online support networks (Miscarriage association and Ectopic Trust as relevant) and given the EPAS support card “Talk about pregnancy loss”
- For women who are managed in other areas (Gynaecology ward/GATU/Outlying wards):

  o Prior to discharge ensure women are signposted to the Miscarriage Association (www.miscarriage.org.uk) or Ectopic Trust (https://ectopic.org.uk)
  o Patient should be given EPAS support card: “Talk about Pregnancy Loss”
  o Ward/GATU staff to complete miscarriage notification form and taken to EPAS on daily basis.
  o Copy of discharge summary to be taken to EPAS to ensure suitable follow up is offered.

11.0 Patient Involvement and communication

- Options regarding surgical or medical management discussed and advantages and disadvantages of each approach following diagnosis of miscarriage. Patient to fully participate in management plan.

- Conservative management to be encouraged as first line management
- Leaflets given as appropriate eg. Miscarriage, ERPC, conservative and medical management of miscarriage.
- Miscarriage notification to be completed on a daily basis and the ward clerk will input onto computer system. Appointments for antenatal care to be cancelled on sema by ward clerk