Brighton and Sussex University Hospitals NHS Trust

Management of Miscarriage

Maternity Protocol: GP001

Date agreed: January 2017

Guideline Reviewer:	Tasneem Singhal
Version:	1
Approval Committee:	Women's Services Safety and Quality Committee
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Contents

Key Principles

These guidelines and algorithms are aimed to assist in decision making. They are not designed to be prescriptive and you are not expected to use them in exclusion of discussions with senior colleagues.

Evidence used to inform these guidelines had been drawn from national/RCOG guidelines. Where applicable other references are quoted.

These guidelines have been reviewed by all clinicians involved in early pregnancy care, including consultants, trainees and specialist and senior nursing staff.

A protocol is a set of measurable, objective standards to determine a course of action. Professional judgement may be used in the application of a protocol.

Scope

These guidelines apply to women who have a confirmed diagnosis of miscarriage.

Responsibilities

Nurses, Midwives & Gynaecologists & Obstetricians:

- To access, read, understand and follow this guidance
- To use their professional judgement in application of this guidance

Management Team

- To ensure the protocol is reviewed as required in line with Trust and National recommendations
- To ensure the protocol is accessible to all relevant staff
- To ensure protocols are available to service users on request

1 Introduction:

Miscarriage is the spontaneous loss of a pregnancy before viability, ie before 22 weeks gestation

Common symptoms are bleeding PV and pelvic pain. This guideline is for the management of women up to 14 weeks of gestation.

IMPORTANT

- **If a woman comes in with bleeding PV**
- **with or without abdominal pain**
- **and then has an ultrasound scan, which shows no intrauterine pregnancy**
- **In the absence of a previous scan in this pregnancy which has seen an intrauterine pregnancy**
- **A diagnosis of a miscarriage CANNOT be made.**

This is to be treated as a PUL.

2 Threatened Miscarriage

2.1 If the bleeding gets worse or persists beyond 14 days, she should return for further assessment and an ultrasound scan

2.2 If the bleeding stops, she should start or continue antenatal care.

3 Using Ultrasound for Diagnosis

3.1 Offer women a trans-vaginal ultrasound scan to identify the location of the pregnancy and whether there is a fetal pole and heartbeat.

3.2 Consider a trans-abdominal ultrasound for women with an enlarged uterus or other pelvic pathology, such as fibroids or an ovarian cyst.

3.3 If a trans-vaginal ultrasound scan is unacceptable to the women, offer a trans-abdominal ultrasound scan and explain the limitations of this method of scanning.

3.4 If the crown-rump length is less than 7.0 mm with a trans-vaginal ultrasound scan and there is no visible heartbeat, perform a second scan a minimum of 7 days after the first before making a diagnosis. Further scans may be needed before diagnosis can be made.

3.5 If the crown-rump length is 7.0 mm or more with a trans-vaginal ultrasound scan and there is no visible heartbeat:

3.5.1 Seek a second opinion on the viability of the pregnancy and/or

3.5.2 Perform a second scan a minimum of 7 days after the first before making a diagnosis

3.6 If there is no visible heartbeat when the crown-rump length is measured using a trans-abdominal ultrasound scan:

3.6.1 Record the size of the crown-rump length and

3.6.2 Perform a second scan a minimum of 14 days after the first before making a diagnosis

3.7 If the mean gestational sac diameter is less than 2.50mm with a trans-vaginal ultrasound scan and there is no visible fetal pole, perform a second scan a minimum of 7 days after the first before making a diagnosis. Further scans may be needed before a diagnosis can be made.

3.8 If the mean gestational sac diameter is 25.0mm or more using trans-vaginal ultrasound scan and there is no visible fetal pole:

3.8.1 Seek a second opinion on the viability of the pregnancy and/or

3.8.2 Perform a second scan a minimum of 7 days after the first before making a diagnosis.

3.9 If there is no visible fetal pole and the mean gestational sac diameter is measured using a trans-abdominal ultrasound scan

3.9.1 Record the size of the mean gestational sac diameter and

3.9.2 Perform a second scan a minimum of 14days after the first before making a diagnosis

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

3.11 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.

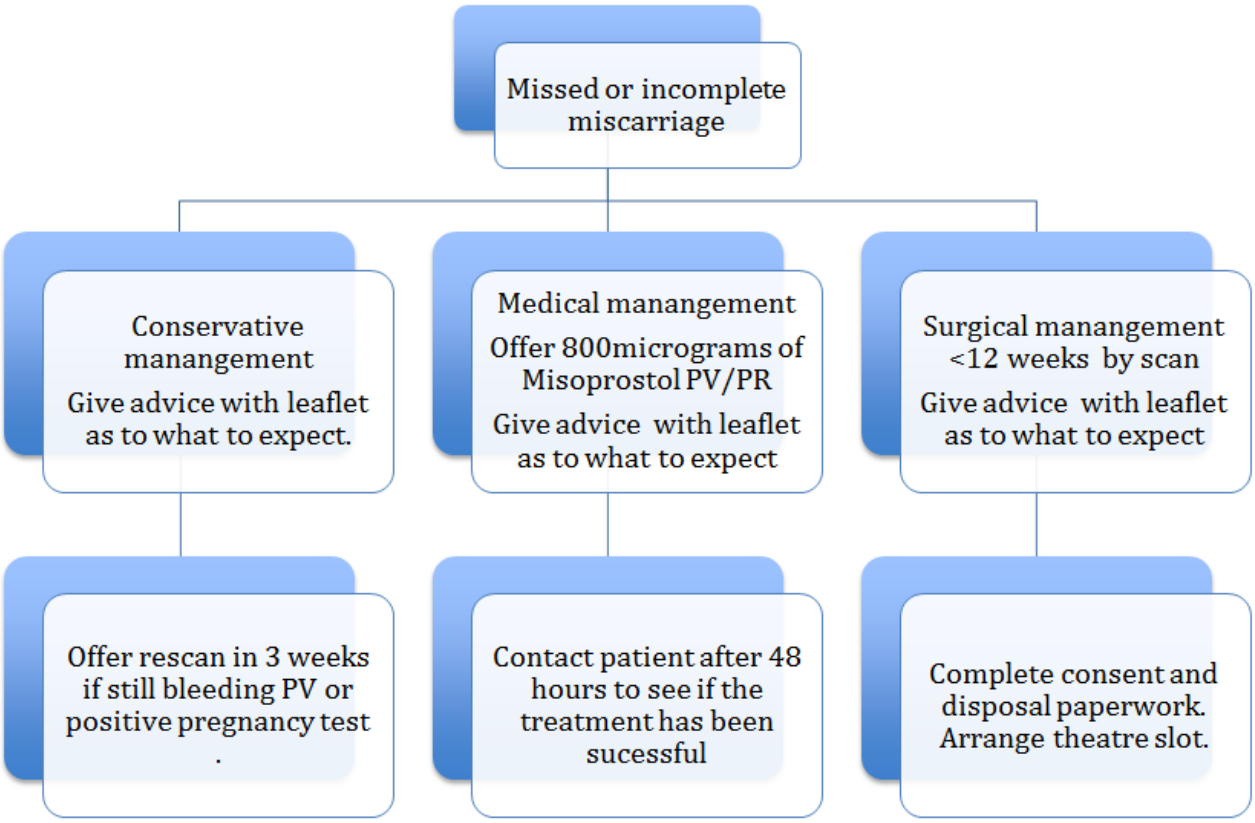
3.12 Inform women what to expect while waiting for a repeat scan and that waiting for a repeat scan has no detrimental effects on the outcome of the pregnancy.

3.13 Provide women with a contact telephone number for the EPU.

4 Management of a confirmed miscarriage pregnancy

4.1 Verbal and written information needs to be given to patients with a miscarriage

4.2 Send bloods: FBC and Group & Save



5 Conservative Management

5.1 Offered to women as a first line option in early first trimester miscarriage

5.2 Offer written and verbal information about what to expect, where and when to get help in an emergency.

5.3 Offer rescan in 3 weeks to confirm complete miscarriage if continues to bleed or pregnancy test is positive.

5.4 If the rescan shows retained products, discuss individualised care depending on the size of the products and clinical signs and symptoms.

5.5 This is usually successful in up to 60% of women.

5.6 10-15% of Women may need to come in to hospital for heavy PV bleeding and may need surgical evacuation.

5.7 Offer all women receiving expectant management of miscarriage pain relief and anti-emetics as needed

6 Medical Management

6.1 Offer medical management to women when conservative management is not appropriate, nor suitable (i.e late first trimester, bleeding disorders) or not acceptable, and to all women with missed miscarriage after 12 weeks gestation by ultrasound.

6.2 Offer written and verbal information about what to expect, where and when to get help in an emergency.

6.3 Offer vaginal or oral misoprostol for the medical treatment of missed or incomplete miscarriage.

6.4 Use a single dose of 800 micrograms of misoprostol upto 12 weeks of gestation.

6.5 Advise the woman that if bleeding has not started 24 -48 hours after treatment, she should contact the EPU to determine on going individualised care

6.6 A second dose of 800micrograms of misoprostol may be repeated after 48hours if the sac has not been passed.

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

6.8 Advise women to take a urine pregnancy test 3 weeks after medical management of miscarriage unless they experience worsening symptoms, in which case advise them to return to the EPU for providing their medical management.

6.9 Advise women with a positive urine pregnancy test after 3 weeks to return for a review in the EPU.

6.10 Be aware of the possibility of molar or ectopic pregnancy.

6.11 Women with a CRL>17mm or a gestational sac diameter of 30mm or more or twin pregnancy should be offered in-patient management in view of increased risk of bleeding.

6.12 For women with missed miscarriage 12-14 weeks gestation by dates – admit on gynaecology ward, send FBC and group and save, and administer 200mcg of Vaginal Misoprostol every 6 hours for a total of 4 doses.[2]

7 Surgical Management

7.1 Provide verbal and written information to all women undergoing surgical management of miscarriage about the treatment options available and what to expect during and after the procedure

7.2 Complete stage one consent and the fetal cremation form P1/P2 (Appendix B/C)

7.3 Inform the women that the tissue is sent to the lab to confirm that this is pregnancy tissue. - It does not test for the cause of the miscarriage (except those having a Fetal karyotype after the 3rd miscarriage).

7.4 If sending tissue for Fetal Karyotyping divide the tissue and send some to histology and some to karyotyping.

8 Anti-D rhesus prophylaxis

8.1 Offer anti-D rhesus prophylaxis at a dose of 250 IU (50 micrograms) to all rhesus negative women who have a surgical procedure to manage an ectopic pregnancy or a miscarriage

8.2 Do not offer anti-D rhesus prophylaxis to women who have a gestation of less than 12 weeks and

- receive solely medical management for an ectopic pregnancy or miscarriage

or

- have a threatened miscarriage or
- have a complete miscarriage or
- have a pregnancy of unknown location

8.3 Offer all women Anti D rhesus prophylaxis to women who have a gestation of more than 12 weeks.

8.4 Do not use a Kleihauer test for quantifying fetal–maternal haemorrhage.

9 Follow up

9.1 For women with their third - first trimester miscarriage offer surgical management of miscarriage so that the products can be sent for fetal karyotype

9.2 Offer a follow- up appointment in gynae clinic to all women after their 1st second trimester miscarriage or 3rd first trimester miscarriage. Women at PRH to be referred to Miss T Singhal and Women at RSCH to be referred to Mr T Ajala / Mr T Kelly

10 Terminology

The clinical term “fetal remains” is used for a pregnancy loss if there is no recognisable body, this term should not be used in discussion with parents. For most parents it is better to use a phrase such as “the remains of your baby”. However, a few parents may not want to think of their loss as a baby and may prefer the term fetus. The parents may wish to take the remains of their baby themselves. If they do not, the hospital should ensure sensitive disposal.

11 Paperwork to be completed

11.1 Form P1 Pregnancy Losses under 12 weeks Gestation (Appendix B)

- If fully completed this form will be accepted by histopathology and the crematorium. Doctors ONLY must complete the final section. Nurses and midwives can complete the first section.
- The top copy of the form (blue) must be sent with the products of conception to the Histopathology laboratory as it contains the original signatures.
- The second copy (white) to go to the Bereavement Office, the third copy (yellow) handed to the parents and the fourth copy (pink) placed in the patient's notes.
- The forms are available in A&E and at RSCH and on Level 11 Gynaecology Ward, and at PRH on Horsted Keynes Ward.
- Ensure that the *Your Baby – under 12* weeks leaflet is given to the parents.
- If parents request removing from the hospital products of conception below 12 weeks which at no time have shown signs of independent viability use appendix ##.
- Recommend all products of conception under 12 weeks gestation should be sent to histopathology following which the pathology department will arrange for the products to be sent for communal cremation at Woodvale Crematorium via the contracted funeral directors.
- In the case of parents consenting to histopathology but wanting to arrange disposal themselves, this should be handwritten on the form and the specimen sent to the histopathology with the top copy (blue). The second copy (white) must also be sent to the Bereavement Office. It is important to point out that they have 30 days in which to make arrangements to collect the specimen after that date the hospital will arrange a cremation without a service and that there will be no ashes. The parents need to make arrangements with an undertaker of their choosing.
- In the case of parents declining histopathology and want to make their own arrangements in regard to disposal, this should be handwritten on the form, and the specimen sent to the mortuary with the top copy (blue). The second copy (white) must also be sent to the Bereavement Office. It is important to point out that they have 30 days in which to make arrangements to collect the specimen after that date the hospital will arrange a cremation without a service and that there will be no ashes.
- A label must be completed containing the following information:

The baby of: [complete mother's details and add father's details where possible]
Mother's Trust ID number:
Was delivered on: [date of delivery]
On: [ward/department]
The label must be fixed securely to the outside of the container.

11.2 Pregnancy Losses 12 – 14 weeks (Appendix C)

- As above, but use **P2 form** (Appendix C)
- Ensure that the 'Your Baby 12 - 23 weeks' leaflet is given to the parents (Appendix A)
- Use "Release and Return of Baby's Body" letter stating parents have taken baby's body home (Appendix D)

12 Appendix A - Patient Information Leaflet 'Your Baby' 12-23 weeks

Brighton and Sussex University Hospitals NHS Trust

Your Baby

A leaflet for you if you have lost your baby during 12 to 23 weeks of pregnancy

Losing a baby can be one of the hardest of lifes experiences. Please accept our sympathy. Parents often tell us they feel a sense of disbielf, anger and hurt, as well as a mixture of so many other feelings. You may have many questions at this time: this leaflet aims to answer some of them.

How can we remember our baby?

Book of Rememberance

You may like to have your baby's name written in the Book of Rememberance. There is one in the chapel at both the Royal Sussex County Hospital and Princess Royal Hospital. Please ask a member of staff about how to make an entry, or contact the chaplaincy office at the hospital. There is no charge for making an entry.

Annual Memorial Service

There is also a memorial service held every year for families to remember their babys who have died. You will be sent information about this nearer the time, unless you ask us not to do this.

Can we arrange a funeral?

You will need to arrange a funeral with a Funeral Director of your choice. The Bereavement office will have a list of local funeral directors to help you if you wish. The funeral can take the form of a cremation or of a burial. The funeral director you approach will be able to help you with all the arrangements. Most funeral directors will not charge for a funeral, if you decide on a cremation, you will need to check before you go ahead. However if you are wanting a buriel and headstone you will need to discuss this with the funeral director.
The funeral does not need to be a religious service – you can say goodbye in whatever way feels best for you. There may be certain pieces of music, poems or other readings that are special to you. The funeral director will be able to help. You may also find it helpful to talk to the hospital chaplain or to a minister you know.

If you or your funeral director have not cotacted the bereavement office /mortuary within 30 days of signing the P2 form the hospital will arrange a cremation.
What will happen if we do not wish to organise a private funeral?

The hospital will arrange a cremation of your baby but there will be no service for you or others to attend and no ashes to collect.

Contact Numbers:

Brighton and Sussex University Hospitals NHS Trust:

Mortuary Department:

Royal Sussex County Hospital	01273 696955 Ext 4144
Princess Royal Hospital	01444 441881 Ext 8449

Bereavement office:

Royal Sussex County Hospital	01273 696955 Ext 4611
Princess Royal Hospital	01444 441881 Ext 8101

Chaplaincy Department:

Royal Sussex County Hospital	01273 696955 Ext 4122
Princess Royal Hospital	01444 441881 Ext 8232

Counsellor for Maternity and Neonatal Services:

Royal Sussex County Hospital	01273 696955 Ext 7928

MAPS – Midwives and Parents Support Group	01444 441881 Ext 8484/5
Just Friends Support Group	01273 696955 Ext 4373/4

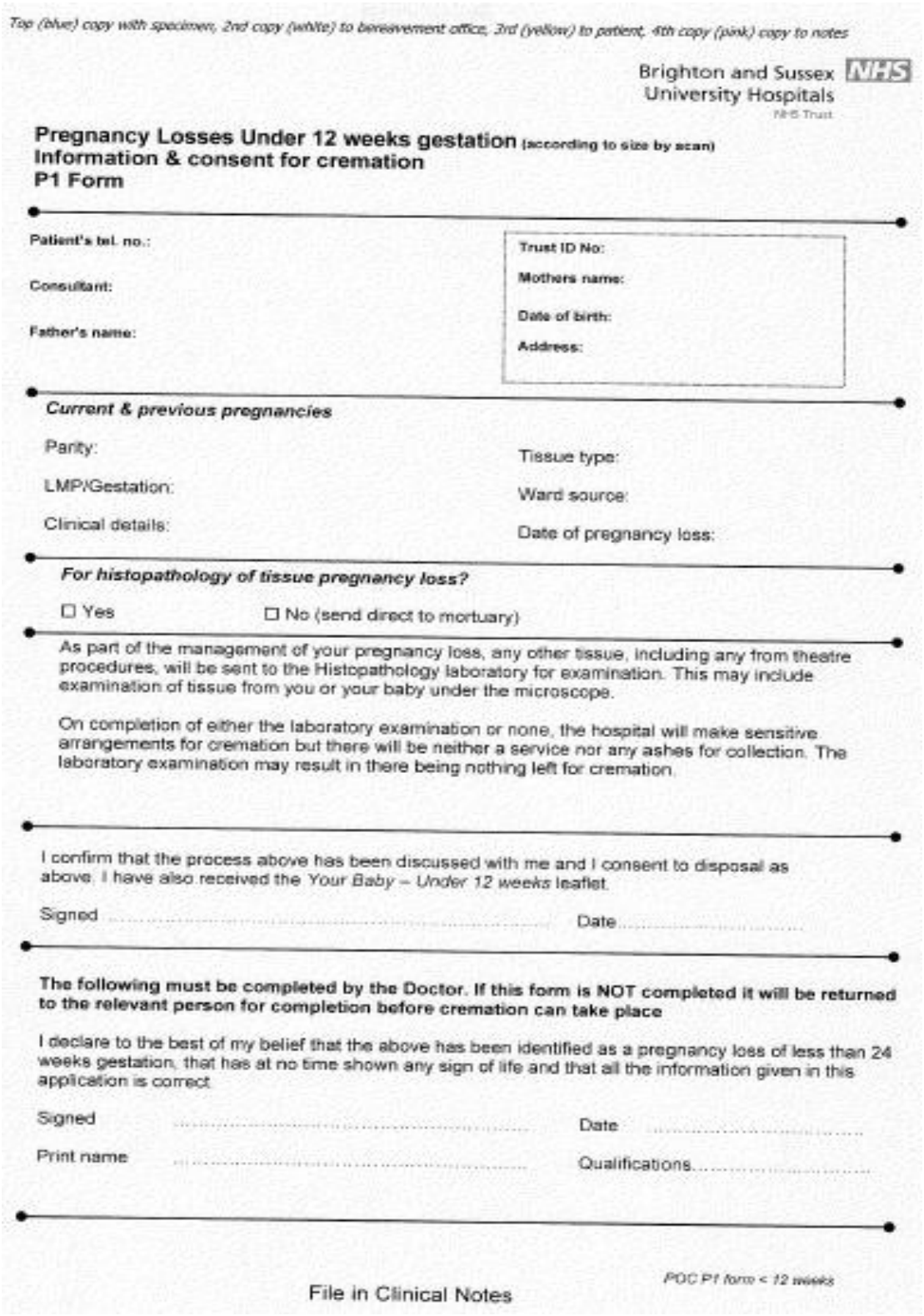
Local and National Support:

ARC – Antenatal Results and Choices Helpline	0207 6310285
Counsellor – Morley Street	01273 242091
Miscarriage Association	01924 200799

SANDS - Stillbirth and Neonatal Death Society

National number	0207 4365881
SANDS Local Befriender service	07799031645

13 Appendix B - P1 Form



Top (blue) copy with specimen, 2nd copy (white) to bereavement office, 3rd (yellow) to patient, 4th copy (pink) copy to notes

Brighton and Sussex University Hospitals NHS
NHS Trust

Pregnancy Losses Under 12 weeks gestation (according to size by scan)
Information & consent for cremation
P1 Form

Patient's tel. no.:

Consultant:

Father's name:

Trust ID No:

Mothers name:

Date of birth:

Address:

Current & previous pregnancies

Parity:

LMP/Gestation:

Clinical details:

Tissue type:

Ward source:

Date of pregnancy loss:

For histopathology of tissue pregnancy loss?

☐ Yes ☐ No (send direct to mortuary)

As part of the management of your pregnancy loss, any other tissue, including any from theatre procedures, will be sent to the Histopathology laboratory for examination. This may include examination of tissue from you or your baby under the microscope.

On completion of either the laboratory examination or none, the hospital will make sensitive arrangements for cremation but there will be neither a service nor any ashes for collection. The laboratory examination may result in there being nothing left for cremation.

I confirm that the process above has been discussed with me and I consent to disposal as above. I have also received the *Your Baby – Under 12 weeks* leaflet.

Signed ..... Date .....

The following must be completed by the Doctor. If this form is NOT completed it will be returned to the relevant person for completion before cremation can take place

I declare to the best of my belief that the above has been identified as a pregnancy loss of less than 24 weeks gestation, that has at no time shown any sign of life and that all the information given in this application is correct.

Signed ..... Date .....

Print name ..... Qualifications.....

File in Clinical Notes

POC P1 form < 12 weeks

14 Appendix C - P2 Form

Top (blue) copy with baby, 2nd copy (white) to bereavement office, 3rd (yellow) to patient, 4th copy (pink) copy to notes

Brighton and Sussex University Hospitals NHS Trust

Pregnancy Losses 12 – 23 weeks gestation (according to size by scan)
P2 Form

Patient's tel. no.:	Trust ID No:
	Mothers name:
Consultant:	Date of birth:
	Address:
Father's name:	

Current & previous pregnancies

Parity:	Tissue type:
LMP/Gestation:	Ward source:
Clinical details:	Date of pregnancy loss:

Post mortem verbally agreed? (Ensure additional consent booklet is completed by staff and parents)

☐ Yes ☐ No (send direct to mortuary) ☐ No (home with parents)

Where post mortem is not desired, any tissue from you or your baby, including any from theatre procedures, may be sent to the histopathology laboratory for examination which may include examination under a microscope.

We encourage parents to make their own private funeral arrangements for their baby. It may be too soon to decide now but, if you do decide to make your own arrangements, you must contact the Bereavement Office (PRH 01444 441881 Ext: 8101 or RSCH 01273 696955 Ext: 4611) **within 30 days** of the date on this form, otherwise the hospital will arrange a simple cremation but there will be no service for you to attend nor ashes to collect.

Confirmation by mother: I confirm that the process above has been discussed with me and I confirm I have also received the *Your Baby – 12 to 23 weeks* leaflet.

Signed …….. Date……

The following must be completed by the Doctor. If this form is NOT completed it will be returned to the relevant person for completion before cremation can take place

I declare to the best of my belief that the above has been identified as a pregnancy loss of less than 24 weeks gestation, that has at no time shown any sign of life and that all the information given in this application is correct.

Signed	……	Date	……
Print name	……	Qualifications	……

POC P2 form 12 to 23 weeks

File in Clinical Notes

15 Appendix D - Release of baby's body to parents

Brighton & Sussex *NHS*
University Hospitals
NHS Trust

The Royal Sussex County Hospital
Eastern Road
Brighton
BN2 5BE

Tel: 01273 696955

Extension Number: .....

To: The Mortuary

Release of baby's body to parents

Baby's name:				
Mother's name:				
Hospital Number:		Ward:		
Address:				
Telephone Number:				
Is baby to be returned to the Hospital	YES		NO	
If yes, approximately when:				
Signature of Parent:				
Print Name:				

16 References

1. National Institute for Health and Clinical Excellence (2012) *Ectopic pregnancy and miscarriage: diagnosis and initial management*. Clinical guideline 154. London. NICE.
2. Saraswat L, Ashok PW, Mathur M. Medical management of miscarriage. The Obstetrician & Gynaecologist 2014;16:79–85.