Clinical Practice Guidelines: Obstetrics/Miscarriage

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Date	February, 2021
Purpose	To ensure consistent management of a miscarriage.
Scope	Applies to Queensland Ambulance Service (QAS) clinical staff.
Health care setting	Pre-hospital assessment and treatment.
Population	Applies to all ages unless stated otherwise.
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Miscarriage

February, 2021

In Australia **miscarriage** is defined as the spontaneous loss of pregnancy before 20 weeks of gestation (or less than 400 grams),[1] the aetiology for the majority of cases being unknown.[2] Approximately 20% of pregnancies will end in first trimester miscarriage, with the majority being in the first 8 weeks.

Although vaginal bleeding and abdominal pain are characteristics of a miscarriage, about 25% of pregnancies are associated with bleeding in the first 12 weeks.[3] With this in mind, it is important for clinicians to not make comments that could be interpreted as a diagnosis.

Miscarriage has been associated with significant psychological consequences and patients have been shown to benefit from appropriate counselling and support. This should be initiated in the pre-hospital setting.[4]

Miscarriage is the leading cause of ante-partum haemorrhage. The most significant complications include:

- haemorrhagic shock
- uterine sepsis

First trimester pregnancy termination by medical abortion refers to the termination of a pregnancy using medications to induce a process similar to miscarriage, and is available to women up to nine weeks gestation. Treatment is normally provided in an outpatient setting, undertaken in consultation with a GP or accredited clinic, and is managed in two stages: Administration of mifepristone taken at the GP or clinic, followed by administration of misoprostol, generally self-administered with 48 hours at home.[5] Women are provided advice concerning expected pain, blood loss and/or blood clots, however, there is a possibility of abnormal significant abdominal cramping, fever and heavy blood loss to occur in some cases. Patients experiencing these symptoms should be managed symptomatically and transported to a suitable medical facility for assessment and ongoing management.

Clinical features

Clinical presentation includes:

- lower abdominal discomfort
- vaginal bleeding
- hypotension
- tachycardia
- postural symptoms

Signs suggestive of intrauterine infection include:

- severe pelvic pain and/or rigidity and/or guarding
- purulent discharge
- fever

Risk assessment

Pre-hospital diagnosis of miscarriage can be difficult to determine, particularly where the products of conception (POC) are not obvious.

Definitive diagnosis of miscarriage is based on confirmed passage of POC or ultrasound findings consistent with a miscarriage diagnosis at the receiving facility.[6,7]

Therefore, differential diagnosis of antepartum/per vaginal (PV) bleeding must include:

- normal early pregnancy implantation bleed
- ectopic pregnancy
- sexual assault/non accidental-injury

Risk assessment

If possible, all tissue and large clots should be retained and transported to the receiving facility.
If miscarriage occurs after the first trimester or later gestation, a foetus may be passed out of the vagina. Often the placenta will not separate.

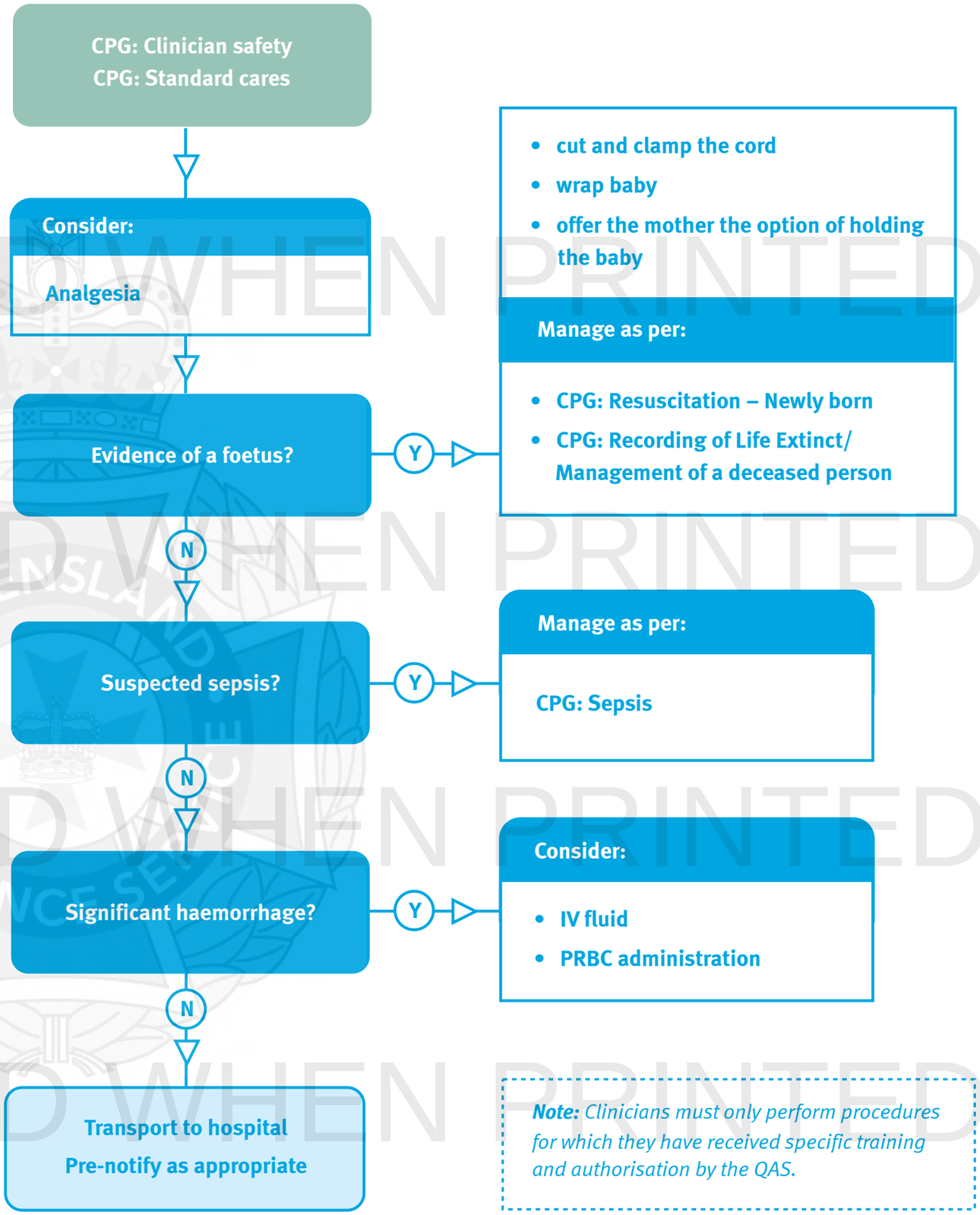
If this occurs:

- cut and clamp the cord
- wrap the pre-term infant (the mother may or may not wish to hold the baby.)
- acknowledge the pre-term infant as the mother's baby, provide psychological cares

Some pre-term infants less than 20 weeks will show signs of life (movement/gasp). If the baby is less than 20 weeks, then resuscitation is futile.[7] European resuscitation guidelines inform that it is feasible to identify conditions associated with high mortality where withholding resuscitation may be considered reasonable. These include gestational age less than 23 weeks and/or birthweight less than 400 g.[7]

Additional information

- A Recognition of Life Extinct (ROLE) form must be completed for all delivered pre-term infant death equal to or greater than 20 weeks gestation.



Note: *Clinicians must only perform procedures for which they have received specific training and authorisation by the QAS.*