Management of Complications Following Termination of Pregnancy GL1082

Approval

<table>
<thead>
<tr>
<th>Approval Group</th>
<th>Job Title, Chair of Committee</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gynaecology Clinical Governance Committee</td>
<td>Alex Swanton Consultant Gynaecologist</td>
<td>10th May 2019</td>
</tr>
</tbody>
</table>

Change History

<table>
<thead>
<tr>
<th>Version</th>
<th>Date</th>
<th>Author, job title</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>January 2017</td>
<td>W Kuteesa Consultant Gynaecologist</td>
<td>Emergency Gynae requirement</td>
</tr>
<tr>
<td>2</td>
<td>January 2019</td>
<td>W Kuteesa Consultant Gynaecologist</td>
<td>Reviewed, minor changes throughout to reflect current practice</td>
</tr>
</tbody>
</table>
Contents

1.0 Scope .................................................................................................................. 3
2.0 Introduction ........................................................................................................ 3
3.0 Complications following termination of pregnancy ........................................ 3
  3.1 Management of post-TOP haemorrhage ......................................................... 3
  3.2 Management of post-TOP infection/endometritis ........................................... 4
  3.3 Incomplete evacuation following TOP ............................................................. 5
  3.4 Uterine perforation (+/- visceral injury) during STOP ..................................... 5
  3.4 STOP, MTOP failure ........................................................................................ 6
4.0 Management of products of conception (POC) / histology ............................. 6
  4.1 General Post-TOP management/advice .......................................................... 7
  4.2 Discharge advice from 602 Emergency Gynaecology Clinic .......................... 7
5.0 Consultation Undertaken .................................................................................. 7
6.0 Dissemination/Circulation/Archiving ................................................................. 7
7.0 Implementation .................................................................................................. 8
8.0 Training ................................................................................................................ 8
9.0 Monitoring of Compliance ................................................................................ 8
10.0 Supporting Documentation and References .................................................... 8

Other relevant corporate or procedural documents:

This document should be read in conjunction with:

- Medical Management of Miscarriage Protocol (CG621)
- Management of First Trimester Miscarriage Protocol (CG565)
- Medical Management of Ectopic Pregnancy (CG623)
- Diagnosis and Management of Ectopic Pregnancy Green-top Guideline No. 21
  RCOG/AEPU Joint Guideline | November 2016
1.0 Scope
Emergency Gynaecology Clinic Staff
Gynaecology Theatre staff

2.0 Introduction
Termination of pregnancy is common in the UK: over 200,000 procedures are performed annually\textsuperscript{(1)}. These include surgical TOP (STOP) and Medical TOP (MTOP).

The vast majority of terminations are performed by outside agencies (BPAS), some patients with co-morbidities or fetal abnormalities will undergo terminations within in the Trust. Emergency gynaecology will manage most complications associated with termination of pregnancy. These are rare but increase with increasing gestation.

3.0 Complications following termination of pregnancy
- Haemorrhage. Less than 1 in 1000 <20/40 are severe enough for transfusion.
- Infection in up to 10% of cases
- Incomplete evacuation following TOP <5%.
- Uterine perforation (+/- visceral injury) during STOP 1–4 in 1000
- STOP and MTOP failing to end the pregnancy (< 1 in 100), necessitating another procedure.
- Uterine rupture has been reported in association with medical termination of pregnancy
- (MTOP) at late gestations. The risk is less than 1 in 1000.
- Termination performed on an empty uterus (misdiagnosed ectopic pregnancy).

3.1 Management of post-TOP haemorrhage.
Less than 1 in 1000 TOPs (in those <20/40) are severe enough for transfusion. This risk is increased with greater gestations.

Causes:
- Incomplete evacuation, most common for early haemorrhage
- Cervical trauma
- Perforation,
- Infection (late haemorrhage)

Investigations (Ix.)
- FBC, Group & Save/ Cross match
- Pelvic ultrasound scan (USS)

**Treatment (Tx)**
- Resuscitate, large bore IV access,
- Treat cause

Examine for signs of infection, perforation, retained products of conception (RPOC).

Often EUA and repeat evacuation after IV antibiotics if infection is also suspected

- Intravenous Oxytocin 5IU – 10IU
- Oral or intravenous Tranexamic acid 1G
- +/- Oral or PR Misoprostol 500-1000µg 2
- Transfuse as indicated.

**3.2 Management of post-TOP infection/endometritis.**

- MTOP and STOP infection rates are roughly equal.
- Severity varies and may lead to sepsis.
- Often associated with pre-existing infection.
- Prophylactic antibiotics and bacterial screening for lower genital tract infection at the time of termination reduces infection risk.
- RPOC may accompany infection

Presenting symptoms:
- Most common cause of PV bleeding post TOP (classically delayed/persistent/increasing).
- Low abdominal pain
- Discharge – malodourous
- +/- Fever
- Dyspareunia

**Signs:**
- Pyrexia
- Abdo/pelvic tenderness (bimanual)
- Closed cervical os on palpation (if no RPOC).

**Ix.**
- FBC, CRP.
- Vaginal swabs
- Blood cultures (as indicated)
- USS – may find RPOC in addition to infection

**Tx.**
- Antibiotics – usually IV Augmentin for 24-48h.
- Also start Oral Doxycycline 100mg BD 14/7
- And Metronidazole 500mg BD 5-14/7

### 3.3 Incomplete evacuation following TOP.

STOP - approx. 1% require surgical evacuation of RPOC.
MTOP – approx. 5% require surgical evacuation of RPOC.
Rates are greater after MTOP in gestations >13/40

**Presenting symptoms:**
- Persistent bleeding (>2 weeks)
- Increasing severity of bleeding.
- Haemorrhage
- Infection (Endometritis) may accompany RPOC.

**Examination findings:**
- Bulky uterus
- Classically, open cervical os.

**Ix:**
- FBC, Group & Save
- Ultrasound findings: Intrauterine tissue diameter >15 mm indicates likely RPOC.

**Rx:** dependent on symptoms, volume of RPOC and patient preference.
- Expectant Mx.
- Surgical evacuation of retained products of conception (ERPC).
If infected RPOC are suspected, proceed to ERPC after 6-24h of IV antibiotics.
Send RPOC for histology (confirm diagnosis/exclude molar pregnancy)

### 3.4 Uterine perforation (+/- visceral injury) during STOP.

Increased risk with greater gestation.

**Presenting symptoms:**
- May be asymptomatic
- Abdominal/pelvic pain
- +/- PV bleeding
- Symptoms/signs associated with intra-abdominal bleeding
- Symptoms/signs associated with bladder or bowel perforation (often delayed fever, distension, no motion/wind, absent bowel sounds, tachycardia, pyrexia)

Ix:
- FBC, CRP, U&E
- USS – pelvic fluid/collection
- Abdo X-ray/Erect Chest X-ray
- Consider CT

Rx:
- IV access
- Discuss with Consultant Gynaecologist.
- Conservative +/- Antibiotics
- Diagnostic laparoscopy

3.4 STOP, MTOP failure.
STOP - Greater risk at less than 6/40 gestations.
MTOP - Greater risk with advancing gestations.

Ix:
- USS
- Serial serum ßHCG assessment
  o A fall in ßHCG of >50% in 48 hours usually confirms completion of procedure.
  o A rise in ßHCG or a fall of <50% (over 48 hours) indicates possible failed TOP or undiagnosed ectopic pregnancy.

4.0 Management of products of conception (POC) / histology.
- Document if POC are seen during evacuation/on the ward.
- Send an adequate sample to histology for confirmation.
- At ERPC, if unsure, or if minimal sample is obtained, the surgeon should empty the suction trap and send the entire sample.
- It is the surgeon’s responsibility to chase the histology result of all POC samples.
4.1 General Post-TOP management/advice.
- Confirm that Anti-D IgG was administered in non-sensitised RhD negative women.
- All appropriate methods of contraception should be discussed if patient is unclear of options.

4.2 Discharge advice from 602 Emergency Gynaecology Clinic.
- Advise patients to call the 602 Emergency Gynaecology Clinic number +/- return to the clinic if:
  - Bleeding very heavily (Clots the size of their palm or soaking sanitary pads every 20 minutes)
  - Bleeding persists for more than 14 days
  - Pyrexia
  - Pain not controlled with simple analgesia
  - Concerned/worried
- Complete the electronic discharge letter.
- GP should provide routine follow-up care.

5.0 Consultation Undertaken
- Emergency Gynaecology and Sonning Ward Sisters
- Gynaecology Clinical Governance Committee – This includes: a patient representative, Gynaecology Operations Managers, Gynaecology consultants, Junior and middle grade medical staff.
- A copy of the protocol was circulated to all stakeholders for amendments prior to a scheduled clinical governance meeting.

6.0 Dissemination/Circulation/Archiving
- A hard copy will be kept in the Emergency Gynaecology clinic and on Sonning Ward.
- A hard copy will be given to all junior medical staff at induction.
- Copy will be e-mailed all medical staff.
- The Guideline will be available on the Trust intranet Policy Hub (Gynaecology guideline section)
- The Trust Secretary will be responsible for archiving old versions of this document.
7.0 Implementation
Medical and nursing staff will be reminded of protocol by the Emergency Gynaecology Sister and the Gynaecology Consultants.

8.0 Training
There is no mandatory training associated with this procedure. If staff have queries about its operation, they should contact their line manager in the first instance.

9.0 Monitoring of Compliance

<table>
<thead>
<tr>
<th>Aspect of compliance or effectiveness being monitored</th>
<th>Monitoring method</th>
<th>Individual or dept. responsible for the monitoring</th>
<th>Frequency of the monitoring activity</th>
<th>Group/committee which will receive the findings/monitoring report</th>
<th>Committee/individual responsible for ensuring that the actions are completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Departmental audit of numbers and management of complications of TOP.</td>
<td>Audit</td>
<td>Emergency Gynaecology</td>
<td>Every 2 Years</td>
<td>Gynaecology MDT/Governance</td>
<td>/ J Waite</td>
</tr>
</tbody>
</table>

The Trust reserves the right to amend its monitoring requirements in order to meet the changing needs of the organisation.

10.0 Supporting Documentation and References