

WOMEN'S HEALTH PARTNERS, LLC

DIPLOMATES AMERICAN BOARD OF OBSTETRICS & GYNECOLOGY

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PROCEDURE EDUCATION LITERATURE

We recommend that you read this handout carefully in order to prepare yourself or family members for the proposed procedure. In doing so, you will benefit both the outcome and safety of the procedure. *If you still have any questions or concerns, we strongly encourage you to contact our office prior to your procedure so that we may clarify any pertinent issues. "An educated patient is the best patient."*

MISCARRIAGE

Definition

Miscarriage = a pregnancy that ends before 20 weeks of pregnancy and before the fetus can survive outside the uterus (womb); often referred to as *spontaneous abortion*

Fetus = an unborn, growing baby

Dilation = to dilate, as in the cervix

Curettage = to gently scrape, as in the lining of the uterus

Miscarriage can suddenly turn what has been a very happily anticipated event into a devastating experience. Many women feel an intense sense of loss and guilt when a miscarriage occurs. It is important to know that a miscarriage very rarely happens because of something under your control. Approximately 15 to 20% of all *recognized* (known) pregnancies, and as many as 50% of all pregnancies, will end in miscarriage.

Many women who have had a miscarriage worry if they will have a successful pregnancy or if a miscarriage will happen again. More than 85% of women who have had one miscarriage and 75% of women who have had two or three miscarriages will have a healthy baby in the next pregnancy.

The most common cause of miscarriage in the first trimester of pregnancy is a chromosomal abnormality. Many times, miscarriage is a consequence of abnormal development of the growing fetus and nothing can be done to prevent the end of the pregnancy. In some cases, infection, alcohol use, cigarette smoking and illicit drug use will increase a woman's chance of having a miscarriage. Normal activities of work and exercise do not typically contribute to the risk of having a miscarriage.

Symptoms of a miscarriage may include:

-) Vaginal bleeding that is heavier than a normal period or which soaks a thick menstrual pad in an hour or less
-) Vaginal bleeding with passing large blood clots
-) Abdominal/pelvic cramping
-) Foul-smelling vaginal discharge
-) Weight loss and a sense that you are no longer pregnant

Miscarriage is managed with a variety of methods depending on your specific symptoms, the gestational age of the pregnancy and you and your doctor's preferences. Some women will have passed most or all of the pregnancy tissue from the uterus and may require only medication to help the uterus contract to its non-pregnant size. Others will have no symptoms of pregnancy loss and will need a surgical procedure to empty the uterus.

Surgical management of miscarriage includes dilation with curettage or evacuation. Dilation and curettage (D&C) is performed before 14 weeks of pregnancy; between 14 and 20 weeks of gestation the procedure is called a dilation and evacuation (D&E). Both of these procedures involve dilating the cervix (opening to the uterus) and removal of the pregnancy tissue. These operations are usually done in a procedure room of an outpatient center or clinic equipped to handle this type of procedure.

Medication for miscarriage

In some cases, it is not necessary to have a surgical procedure and you will be asked to take a medication to cause the uterus to contract (squeeze) and push out any remaining pregnancy tissue. With this method you are able to be at home, where you are comfortable and have support. Many women prefer to complete miscarriage in this manner and avoid an operation.

Preparation for surgical management

The diagnosis of a miscarriage often involves an ultrasound and laboratory blood work. With this information your doctor can determine if the fetus is no longer living, if any of the pregnancy tissue has already been expelled from the uterus and how much blood you might have

lost. Your doctor may also do a speculum exam to see if your cervix is already dilating. He or she will do an exam and determine the position of the uterus in the pelvis.

Your doctor may place dilators or medicine inside your cervix prior to the procedure (overnight or early in the morning of the procedure). These dilators will help dilate your cervix before coming to the procedure room. A common name for these dilators is laminaria. Also, your doctor may place a prostaglandin tablet in your vagina or give it to you by mouth. This tablet will help to soften the cervix prior to the procedure and will make it easier to dilate the cervix. Both of these methods will reduce the risk of lacerating the cervix while dilating it in the operating room.

You may be given medication by mouth to help you relax and to ease the pain prior to the operation.

Procedure

You will be placed on the operating table in a position similar to the one that you are in when you get a Pap smear. Once adequately positioned, your doctor will do an exam. Most often this procedure is done with anesthesia to make you "asleep".

Your doctor will place a sterile speculum into your vagina so that he or she may see the cervix and the cervix and vagina cleaned with an antiseptic solution. Your doctor may give you anesthesia by injecting the area around your cervix with local anesthesia. Once adequately visualized, your doctor will slowly dilate the cervix with cervical dilators. Your doctor may place an instrument onto the cervix to stabilize it during the procedure. After the cervix is adequately dilated, a suction tube will be inserted through the cervix and into the uterus. The suction tube is attached to a machine that provides suction and will remove the products of conception. The products of conception (fetal parts and placenta) may need to be removed with a grasping instrument called forceps.

After this is done, your doctor will place a curette into your uterus and gently scrape any remaining products of conception, making sure that all of it is removed. An ultrasound may be done to see that all the products of conception are removed from your uterus. Your doctor will also examine the products of conception visually.

Your doctor will remove the instruments and make sure that there is no bleeding from the cervix. Once satisfied, your doctor will remove the speculum and you will be transferred to the recovery room.

Expectations of Outcomes

This procedure should remove products of conception from the uterus. You should expect to have some cramping and bleeding after the procedure, but it should be only a small amount. You should anticipate the return of your period and with it a chance to become pregnant. Your ability to have children in the future should not be affected by having a miscarriage.

It is often recommended that tests be done to determine the cause of the miscarriage *before you become pregnant again*. In any case, you should not try to become pregnant before you are emotionally prepared to do so. It is safe to become pregnant again after one menstrual period.

Most women (75 to 85%) who have had a miscarriage will have a healthy baby in the next pregnancy.

Post Procedure

After this procedure, you will recover in the recovery room to make sure that you tolerated the procedure well. Once this is accomplished, you may be allowed to go home and rest. Your doctor may tell you to take it easy for the next several days. You are instructed to refrain from sexual intercourse (sex), tampon use and douching until after returning to your doctor's office for a follow up appointment (a week or more after the procedure).

It is normal to have some bloody discharge from the vagina for several days. If you have significant bleeding or are soaking menstrual pads, please contact the office immediately. You may shower after surgery, but no bathing or swimming (unless otherwise instructed).

We encourage you to take one or two days off from work and perhaps more if your occupation requires strenuous activity or heavy lifting. Some patients have almost no discomfort while others are somewhat uncomfortable for a few days to weeks. Severe pain is unlikely but possible. Your doctor will give you pain medicine to control the cramping pain that you may have while your uterus returns to its normal pre-pregnancy size.

Your doctor may do blood work periodically to make sure that the pregnancy hormone, BHCG, is decreasing as it should.

If you have been given antibiotics, be sure to take them as prescribed until finished. Contact our office if you have any reaction to the medication.

Your menstrual period should return four to six weeks after the procedure. You will be able to get pregnant soon after the procedure, so be careful to use birth control after the procedure.

Possible Complications of the Procedure

All procedures, regardless of complexity or time, can be associated with unforeseen problems. They may be immediate or delayed in presentation. While we have discussed these and possibly others in your visit, we would like you to have a list so that you may ask questions if you are still concerned. These complications include, but are not limited to:

Complications of both Medical and Surgical Management:

- J Retained Products of Conception: There is a small risk that not all of the products of conception will be removed. Your doctor may need to perform a dilatation and curettage to remove what remains in the uterus.
- J Bleeding: Bleeding may result from the uterus failing to contract down after the products of conception are removed. The bleeding may result in your doctor having to give you a blood transfusion.
- J Infection: There is a risk of infection in your uterus after the procedure. This infection rarely becomes serious enough that you would need to be re-admitted to the hospital for IV antibiotics. If this is the case and you do not respond to IV antibiotics, then this may lead to a hysterectomy (removing the uterus surgically).

Complications of Surgical Management:

- J Complications of local anesthesia: Since your doctor may inject some local anesthesia around your cervix, you may have a reaction to the anesthesia used. This could be anything from a mild allergic reaction to cardiorespiratory arrest. The risk of this occurring is remote.
- J Vasovagal syncope: There is a risk that by dilating your cervix and manipulating the uterus that a nerve (called the vagus nerve) will be stimulated. This can lead to a variety of symptoms. Most often this causes nausea and lightheadedness and, rarely, slow pulse and seizure activity. This risk is small, and the seizure usually stops by itself without medication.
- J Perforation of the uterus: Since this procedure is done by inserting instruments into the uterus, there is a chance of perforation. This risk may be close to one of every 100 procedures. If this occurs, your doctor may need to further evaluate this to determine the size of the perforation.
- J Injury to bowel and bladder: Since the bladder sits on top of the cervix, there is a chance of injury to the bladder during a D&C. Also, if a perforation is done and not recognized, damage to the bowel may occur by either the suction cannula or the curette. If this is suspected, then an incision in your abdomen may have to be done to repair the bowel.
- J Cervical laceration: Since the cervix is being dilated, there is a risk of lacerating or tearing the cervix. This risk may be lowered by placing a dilator into your cervix prior to the procedure.

Patient Signature

Date

Account #

Patient Name (Print)

Physician

Date

Witness

Date

The information contained in this Medical Informed Consent Form (“Consent Form”) is intended to solely inform and educate and should not be used as a substitute for medical evaluation, advice, diagnosis or treatment by a physician or other healthcare professional. Please call your doctor if you have any questions.