Clinical Practice Guidelines: Obstetrics/Miscarriage

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<th>Date</th>
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<tr>
<td>Purpose</td>
<td>To ensure consistent management of a Miscarriage.</td>
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<td>Scope</td>
<td>Applies to all QAS clinical staff.</td>
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</tbody>
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In Australia miscarriage is defined as the spontaneous loss of pregnancy before 20 weeks of gestation (or < 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 paramedics 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

**Clinical presentation includes:**

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

**Clinical features**

**Clinical features (cont.)**

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**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.[5,6]

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 foetus (the mother may or may not wish to hold the foetus.)
- acknowledge the foetus as the mother's baby, provide psychological cares

Some foetuses < 20 weeks will show signs of life (movement/gasp). If the foetus is less than 20 weeks, then resuscitation is futile.[6] 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 < 23 weeks and/or birthweight < 400 g.[7]

Additional information
- A Recognition of Life Extinct (ROLE) form must be completed for all delivered foetus deaths ≥ 20 weeks gestation.

Note: Officers are only to perform procedures for which they have received specific training and authorisation by the QAS.