Early Pregnancy Disorders Referral Pathway

Type: Clinical Guideline	**HDSS Certification Standard:**
Issued by: Maternity Audit Group	**Version:** 1.0
Applicable to: Gynaecology, Primary Care, Acute Services, Outpatients, Maternity	**Document Owner:** Alex Williamson – Maternity Clinical Quality Facilitator

Purpose

- To provide a Wairarapa DHB-specific pathway for General Practitioners, Lead Maternity Carer (LMC) Midwives, Acute Services staff and other providers to triage patients with miscarriage and associated disorders.
- To ensure timely, standardised, evidence-based management with efficient use of resources while recognising and providing women's choice.

Scope

Applies to all LMC midwives, medical, midwifery and nursing staff that provide care to women requiring referral for cases of miscarriage or ectopic pregnancy.

Roles and Responsibilities

The **Primary Care Provider** will:

1. Use the 3D Health Pathways (3d.healthpathways.org.nz) for initial assessment and management.
2. Contact the Triage Midwife on 0275720283, Monday-Friday 0900-1600.
3. At other times institute initial management and contact the Triage Midwife when available.
4. Provide relevant documentation/investigations (email ClinicMidwife@wairarapa.dhb.org.nz or fax to: 069469848)
   4.1 Referral letter
   4.2 Ultrasound scans
   4.3 Blood tests.
5. If there is high suspicion of ectopic pregnancy, uncontrollable vaginal bleeding or serious clinical concern transfer directly to the Emergency Department (ED). On admission to ED manage as appropriate and complete Early Pregnancy Follow up Form (Appendix 2).

The **Triage Midwife** will:

1. Provide advice for further primary care management referring to Appendix 1 and the guideline content.
2. Request and process relevant documentation/investigations.
3. Arrange elective secondary care management
   3.1. Process relevant documentation/investigations
   3.2. Arrange urgent clinic appointment via the booking clerk (on 069469833).
4. Discuss semi-urgent cases with the on-call Gynaecologist.
5. If there is high suspicion of ectopic pregnancy, uncontrollable vaginal bleeding or serious clinical concern recommend transfer directly to ED.

Summary of findings and triage recommendation

	Bleeding	IU Sac	POC	Fetal pole (CRL)	FHR	Adnexal mass	Free fluid	Serial BhCG	Triage
Threatened	Any	Present	-	Present	Present	¶	Absent	Rising	Primary
Uncertain	Any	<25mm	-	<7mm	Absent	¶	Absent	Any	Primary
Complete	Heavy	Absent	Absent	Absent	-	¶	Absent	Falling	Primary
Incomplete	Heavy	Any	Present	Any	Absent	¶	Absent	Falling	Primary/S
Anembryonic	Nil	>25mm	-	Absent	-	¶	Absent	Static	Primary/S
Missed	Nil	Any	-	Present	Absent	¶	Absent	Static	Primary/S
PUL	Minor	Absent*	-	Absent	Absent	¶	Absent	Any	Primary/S
Ectopic	Minor	Absent*	-	Absent	Any**	Present	Present	Any	S/ED
Mole	Any	Absent	Plentiful	Absent	Absent	¶	Maybe	High	S/ED

* Small, irregular pseudo sac might be seen

** FHR sometimes seen outside the uterine cavity

¶Corpus luteal cyst possible with any pregnancy

Most cases can be referred electively via the Triage Midwife.

Guideline

Women should be offered evidence based information and support to enable them to make informed decisions about the management of their pregnancy. Women's views and concerns are an integral component of the decision making process. Women may choose expectant, medical or surgical management this choice may be influenced by the clinical presentation and accessibility to services.

Initial Assessment

- Clinical assessment should be undertaken including medical history and baseline investigations.
- Check Rhesus status and anti-D requirement in all women.
- Exclude significant anaemia.
- Share information regarding choice of management options, women should be involved in choosing their preferred option.

Consider

- Non-obstetric causes of vaginal bleeding and pain.
- Pregnancy supplements: Iron, folate and iodine.
- Emotional and social support, share information regarding Crisis Pregnancy Support Wairarapa.
- Discuss future pregnancy plans, if desires another pregnancy can attempt to conceive when she feels ready.
- If not planning another pregnancy, discuss contraception and prescribe as necessary.

Threatened miscarriage

- Bleeding can be heavy but compatible with a viable pregnancy. Cramping and an open cervix suggest inevitable miscarriage.
- Slowly rising or falling hCG predicts non-viable pregnancy.
- Institute expectant management.
- Counsel regarding blood loss assessment.
- Reduce daily activities (mainly of psychological value).
- Repeat TV-USS for viability (7-10 days if persistent bleeding, selectively if asymptomatic).

Uncertain

Early viable pregnancy, early failed pregnancy or ectopic.

- Slowly rising or falling hCG predicts non-viable pregnancy.
- Repeat TV-USS when sac should be >25mm (grows 1mm per day).
- Counsel regarding symptoms/signs of ectopic.

Complete miscarriage

Expect vaginal bleeding to steadily decline over 10-14 days.

- Repeat TV-USS if bleeding increases or is prolonged.

Incomplete miscarriage

Anembryonic pregnancy ('Blighted ovum')

Missed miscarriage

- Discuss and determine management plan.
- Ensure formal review if expectant management and repeat TV-USS if prolonged.
- Counsel regarding symptoms/signs of infection.
- Refer to secondary care for medical or surgical treatment.

Pregnancy of Unknown Location (PUL)

Expectant management with planned review,

- Counsel regarding symptoms/signs of ectopic.
- Measure serial hCG levels.
- If hCG level increasing repeat TV-USS.

Ectopic pregnancy

Trophoblastic disease (e.g. Hydatidiform mole)

- Refer directly to secondary care for expectant, medical or surgical treatment.

Implementation and monitoring compliance with/effectiveness of document

Data captured for acute presentation in the Emergency Department will continue to measure the effect of the introduction of internal referral systems on a quarterly basis.

Monitoring of complaints regarding miscarriage management within the DHB will continue with a vision that these will significantly reduce.

Workload for the Antenatal Clinic midwife will be monitored as the triage component is an introduction to this role.

Definitions

Early Pregnancy: gestation up to 12 weeks and 6 days. (For pregnancy loss at ≥12+6/40 gestation see mifepristone protocol).

Miscarriage: The recommended medical term for pregnancy loss under 20 weeks is 'miscarriage' in both professional and woman contexts. The term 'abortion' should not be used.

Threatened miscarriage: a viable pregnancy is confirmed by ultrasound, but there has been an episode of PV bleeding.

Missed miscarriage: a non-viable intrauterine pregnancy. No fetal heart activity is seen, the gestational sac is intact, the cervix is closed and no POC have been passed.

Incomplete miscarriage: some pregnancy tissue has been passed but there is a clinical or ultrasound evidence of retained tissue.

Complete miscarriage: all the pregnancy tissue has been passed and the uterus is empty.

Anembryonic pregnancy (blighted ovum): the gestational sac has developed but the embryo hasn't.

References

- Horne. A.W and Alexander. C. Recurrent miscarriage, *BMJ Sexual & Reproductive Health*. 2005, 31 (2), pp 103-107.

- https://www.midwife.org.nz/women/for-women/pregnant/miscarriage/

- Prager. S, Mase. M, Dalton. V.K and Schreiber, C. A. Pregnancy Loss (miscarriage): Risk factors, etiology, clinical manifestations and diagnostic evaluation. Up-to-date.com, https://www.uptodate.com/contents/pregnancy-loss-miscarriage-risk-factors-etiology-clinical-manifestations-and-diagnostic-evaluation

- Regan, L. Epidemiology and the medical causes of miscarriage, *Best Practice & Research Clinical Obstetrics & Gynaecology*. 2000, 14 (5), pp 839-854.

Related Documents

WrDHB Early Pregnancy Follow up Form (available as standalone document on SharePoint Forms and Templates)

Keywords for searching

- Miscarriage
- Early pregnancy
- Ectopic pregnancy

Appendices

1. hCG and Ultrasound Parameters
2. Early Pregnancy Bleeding Follow Up

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Approval Authority Signature

Name:	Michelle Thomas ……..
Role:	MQSP Coordinator……
Signature:	
Date:	08/05/19 ……

Appendix 1 - hCG and Ultrasound Parameters

From LMP (weeks)	Normal hCG levels (mIU/ml)	hCG doubling time	IU Sac	CRL	Yolk sac	FHR
Non-pregnant	<5.0					
3	5 - 50	31-72 hours (longer with advancing gestation)		N/A		
4	5 - 426					
5	18 - 7,340		10 mm		2-3 mm	
6	1,080 - 56,500		14-16 mm	2-4 mm	3.5 mm	
7-8	7, 650 - 229,000		20-28 mm	8-15 mm	3.8-4.3 mm	Visible
9-12	25,700 - 288,000	hCG levels off	38+ mm	26+ mm	4.8-5.1 mm	
13-16	13,300 - 254,000			N/A		
17-24	4,060 - 165,400	hCG levels fall				
25 - 40	3,640 - 117,000					
Postmenopausal	<9.5					

Appendix 2 – Early Pregnancy Follow up Form

Wairarapa DHB
Wairarapa District Health Board
Te Poari Hauora a-rohe o Wairarapa

Early Pregnancy Follow up Form

Follow up via ANC MW (Mon-Fri 9am-4pm excl. public holidays)
Ph: 027 572 0283 (NB: texts or non-urgent calls)
ALL URGENT CONCERNS RE EARLY BLEEDING OR SEVERE PAIN COME IN FOR EMERGENCY DEPARTMENT ASSESSMEMT
Questions or follow up can be by email: res-clinicmidwife@wairarapa.dhb.org.nz

Name: DOB: / / Address: NHI: NB: Please use sticker if have one	**Best contact number:** (NB: name of owner / relationship to client for phone if different from client) **Email:**

Source of referral: ED LMC GP **Date of referral:** ___/___/___
Relevant Medical History: **Gravida:** **Parity:** **LMP:** (last menstrual period) ___/___/___
Allergies: _____

Actual diagnosis: (circle one) a) Suspected/confirmed ectopic? b) Threatened miscarriage
c) Missed miscarriage d) Complete miscarriage

On call Gynaecology doctor informed? Y N
How was initial diagnosis determined?
Scan? If **yes** circle where and what date? Circle; WAISCAN WAIDHB SCAN OTHER: _____

General Practice: (name of GP if sees one specifically) _____
LMC: (if involved in care) _____
Blood Group: _____ **ANTI D Required:** Y N **Consent:** Y N **Date given:** ___/___/___

ANC Clinic Midwife follow up

Date	Serial HCG Levels	Repeat Scans (state where & diagnosis)	Misoprostol Doses (Prescribed by Dr)	Date of D & C (if required)

Follow Up / Information given: Miscarriage pamphlet given? Y N
Crisis Pregnancy Support information given: (if applicable) Ph: 0800 006 277 Website: crisispregnancysupport.org.nz
Number of ANC MW follow up calls _____ **Number of ANC Clinic MW clinic consults** _____
Date discharged back to GP: ___/___/___

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