Medical management in the community as an option for first trimester miscarriage

Women may prefer to receive treatment for miscarriage at home rather than in hospital. A pilot study assessed the effectiveness of community based management

A study by Hemminki (1998) found that 74% of women who attended their doctor with a possible miscarriage were admitted to hospital and, of those, 84-88% underwent uterine evacuation.

In 1993, Henshaw et al published the results of a study looking at medical management of inevitable or incomplete miscarriage with prostaglandin analogues. Of 43 patients studied, the treatment was found to have been successful in 41 and it was concluded that this approach was a suitable alternative to surgical management.

Medical management of miscarriage was extended to include women with missed miscarriage and anembryonic pregnancy, and a study by Wagaarachchi et al (2001), of mifepristone and misoprostol, showed a success rate of 84%.

This approach to treatment subsequently became an important management option offered to women found to have a non-continuing first trimester pregnancy.

However, it still required inpatient care with obvious resource implications and was unpopular with many patients.

OUTPATIENT CARE

At the Royal Infirmary of Edinburgh, inpatient medical management was only possible at weekends due to pressure on beds in the gynaecology unit during the week.

This situation limited the number of women who were able to have the treatment and led to lengthy waits during which many miscarried naturally or decided to have surgical management which requires day case admission to hospital.

In 2006, a retrospective study carried out at the Royal Infirmary of women who had planned to have inpatient medical management in the hospital found that 22% miscarried naturally at home due to delay in admission. An additional 8% changed their mind and opted for surgical management, usually because of the long wait for admission. This meant that 30% of the women were not receiving the management they would have preferred (Fig 1).

INTRODUCTION

Management of first trimester miscarriage has undergone a number of changes in the past 20 years.

In the main, these changes can be attributed to the use of ultrasound, which has enabled an accurate diagnosis of the gestation of the pregnancy and the introduction of several management options.

This article discusses how community based medical management has become a viable option for women living through this experience.

MANAGEMENT OF MISCARRIAGE

Before the availability of ultrasound, it was difficult to determine the cause of pain or bleeding in the first trimester of pregnancy, and women were usually admitted to hospital and placed on bed rest.

Under observation, it generally became clear if the symptoms of pain and/or bleeding were due to early foetal demise.

Because it was often difficult to know if the miscarriage was complete, many women underwent dilatation and curettage in the belief that this would reduce the risk of infection (Trinder et al, 2006).

Once ultrasound became established as a diagnostic tool in the management of early pregnancy problems, surgical evacuation of the uterus became the preferred treatment.

A study by Hemminki (1998) found that 74% of women who attended their doctor with a possible miscarriage were admitted to hospital and, of those, 84-88% underwent uterine evacuation.

Outpatient medical management of miscarriage improves access to this treatment.

Patients prefer outpatient management and would have it again if necessary.