SURGICAL EVACUATION OF THE UTERUS FOR EARLY PREGNANCY LOSS

This is the first edition of this guidance. This paper provides advice for clinicians in obtaining consent of women undergoing surgical evacuation of the uterus for early pregnancy loss.

This paper is intended to be appropriate for a number of procedures and combinations and the consent form should be carefully edited under the heading ‘Name of proposed procedure or course of treatment’ to accurately describe the exact procedure to be performed, after discussion with the woman. The paper follows the structure of Consent Form 1 of the Department of Health, England/Welsh Assembly Government/Scottish Government/Department of Health, Social Services and Public Safety, Northern Ireland. It should be used in conjunction with RCOG Clinical Governance Advice No. 6 Obtaining Valid Consent. Please also refer to RCOG Green-top Guideline No. 25: The Management of Early Pregnancy Loss.

The aim of this advice is to ensure that all women are given consistent and adequate information for consent; it is intended to be used together with dedicated patient information. After discharge women should have clear direction to obtaining help if there are unforeseen problems.

Clinicians should be prepared to discuss with the women any of the points listed on the following pages.

<table>
<thead>
<tr>
<th>Term</th>
<th>Equivalent numerical ratio</th>
<th>Colloquial equivalent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very common</td>
<td>1/1 to 1/10</td>
<td>A person in family</td>
</tr>
<tr>
<td>Common</td>
<td>1/10 to 1/100</td>
<td>A person in street</td>
</tr>
<tr>
<td>Uncommon</td>
<td>1/100 to 1/1000</td>
<td>A person in village</td>
</tr>
<tr>
<td>Rare</td>
<td>1/1000 to 1/10000</td>
<td>A person in small town</td>
</tr>
<tr>
<td>Very rare</td>
<td>Less than 1/10 000</td>
<td>A person in large town</td>
</tr>
</tbody>
</table>

The above descriptors are based on the RCOG Clinical Governance Advice, Presenting Information on Risk. They are used throughout this document.

To assist clinicians at a local level, we have included at the end of this document a fully printable page 2 of the Department of Health, England/Welsh Assembly Government/Scottish Government/Department of Health, Social Services and Public Safety, Northern Ireland, Consent Form 1. This page can be incorporated into local trust documents, subject to local trust governance approval.
CONSENT FORM

1. Name of proposed procedure or course of treatment
Surgical evacuation of the uterus for early pregnancy loss.

2. The proposed procedure
Describe the nature of the procedure: removal of early pregnancy tissue from the uterus, usually with suction curettage. Explain the procedure as described in the RCOG or locally produced information leaflets/tapes. Note: if other procedures are anticipated, such as diagnostic laparoscopy to exclude ectopic pregnancy if there is no pregnancy tissue in the uterus, then these must be discussed and a separate consent obtained.

3. Intended benefits
The aim of the procedure is to treat an incomplete or missed miscarriage, or retained placental tissue, when the woman prefers surgical as opposed to medical or expectant treatment, or if there is a medical indication for surgery such as sepsis, heavy bleeding or haemodynamic instability, or where other treatments have failed, or there is a suspicion of gestational trophoblastic disease.

4. Serious and frequently occurring risks
It is recommended that clinicians make every effort to separate serious from frequently occurring risks.

Women who are obese, who have significant pathology, have had previous surgery or who have pre-existing medical conditions must understand that the quoted risks for serious or frequent complications will be increased.

4.1 Serious risks
Serious risks include:
- uterine perforation, up to five in 1000 women (uncommon)
- significant trauma to the cervix (rare)
- there is no substantiated evidence in the literature of any impact on future fertility.

4.2 Frequent risks
Frequent risks include:
- bleeding that lasts for up to 2 weeks is very common but blood transfusion is uncommon (1–2 in 1000 women)
- need for repeat surgical evacuation, up to five in 100 women (common)
- localised pelvic infection, three in 100 women (common).

5. Any extra procedures which may become necessary during the procedure
- Laparoscopy or laparotomy to diagnose and/or repair organ injury or uterine perforation.

6. What the procedure is likely to involve, the benefits and risks of any available alternative treatments, including no treatment
The cervix may need to be dilated to allow emptying of the uterine contents. If tissue is sent for histology, the reasons (to exclude ectopic or molar pregnancy) should be explained.

The alternatives are:
- medical management (with mifepristone, prostaglandins)
- expectant management, particularly for women without an intact sac.

Non-surgical methods are associated with longer and/or heavier bleeding and a 15–50% possibility of eventually needing surgical evacuation for clinical need or the woman’s preference. However, non-surgical methods are also associated with a lower risk of infection compared with surgery.
7. Statement of patient: procedures which should not be carried out without further discussion

Other procedures, which may be appropriate but not essential at the time, should be discussed and the woman’s wishes recorded.

8. Preoperative Information

A record should be made of any sources of information (such as RCOG or locally produced information leaflets/tapes) given to the woman prior to surgery. Please refer to the RCOG Patient Information: Early Miscarriage: Information for You.¹.

9. Anaesthesia

General or local anaesthesia can be used. Where possible, the woman must be aware of the form of anaesthesia planned and be given an opportunity to discuss this in detail with the anaesthetist before surgery. It should be noted that, with obesity, there are increased risks, both surgical and anaesthetic.

References


This Consent Advice was produced by Mr D Siassakos MRCOG, Bristol, with the support of the Consent Group of the Royal College of Obstetricians and Gynaecologists.

It was peer reviewed by:

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The final version is the responsibility of the Consent Group of the RCOG.

The Consent Advice review process will commence in 2013 unless otherwise indicated
Surgical evacuation of the uterus (womb): operation to remove pregnancy tissue from within the womb when a miscarriage has not completed.

The intended benefits: To remove any pregnancy tissue from within the womb.

Serious risks:
- Significant tear of the neck of the womb (rare).
- Perforation of the womb, up to 5 in 1000 women (uncommon).

Frequent risks:
- Bleeding that lasts for up to 2 weeks is very common but heavy bleeding is uncommon (1–2 in 1000 women).
- Need for repeat procedure if all the pregnancy tissue is not removed, up to 5 in 100 women (common).
- Pelvic infection, 3 in 100 women (common).

Any extra procedures which may become necessary during the procedure:
- ☐ laparoscopy (keyhole surgery) to investigate for any suspected injury, if there is perforation of the womb
- ☐ laparotomy (open surgery) to repair any injury
- ☐ other procedure (please specify)

I have also discussed what the procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment) and any particular concerns of this patient.

The following leaflet/tape has been provided: Please see RCOG Patient Information: Early Miscarriage: Information for You

This procedure will involve:
- ☐ general and/or regional anaesthesia
- ☐ local anaesthesia
- ☐ sedation

Signed ................................................................. Date .................................................................
Name (PRINT).......................................................... Job title..........................................................

Statement of interpreter (where appropriate)
I have interpreted the information above to the patient to the best of my ability and in a way in which I believe s/he can understand

Signed ................................................................. Date .................................................................
Name (PRINT).................................................................................................................................

Top copy accepted by patient: yes/no (please ring)