Medical Management of Mid-Trimester Abortion

Linda Hunt RN RM
Nurse Specialist
NHS Lothian
Lisbon 2016

Mid-trimester Abortions

Royal Infirmary Edinburgh

- 2000 abortions/year
- 120 mid-trimesters/year
- 50% abort within 7 hours
- 97% abort within 24hours
- 5% evac
- Nurse led unit

On admission

- Gestations 12-20 weeks
- Mifepristone 200mg 36-48hrs prior to admission
- 800mcg Misoprostol pv/sl
- Prophylactic analgesia: paracetamol, ibuprofen
- Antibiotic prophylaxis
- Blood group and Hb check prior to treatment

In the ward

- Single room en-suite (ideally)
- Eat and drink as normal and wear own clothes
- Encourage mobilisation
- No need to get into bed yet
- Take baseline T, P, BP and repeat 3 hourly.

Nursing management

- 3 hourly Misoprostol (400mcg) SL or PV
- Anti-emetic, if required
- Routine pain scores 3 hourly (0-10)
- Dihydrocodeine and Tramadol as required for severe breakthrough pain (rarely require opiates)
- Bed rest if required
- Observe for membrane rupture
- **VE not required**
- Check for fetus: toilet in bathroom, push when feel pressure

Management after fetus delivered

- Relax and recover for 1 hour (**fasting from now on**)
- Give oxytocics: Syntometrine (ergometrine maleate 500mcg, Oxytocin 5unit/ml IM)
- **But,**
- Immediate Oxytocin if heavy bleeding following fetus delivery
- Advice: vaginal pressure, heavy bleeding
- 15 minute checks of blood loss
- **No VE required**
- Delivery of placenta after 1 hour

Management post fetus delivery

- **Fasting from fetus delivery**
- Control of pain: ibuprofen, tramadol
- Pain scores 3 hourly
- Rest = better maternal effort
- **VE?** Only if retained placenta and medical help sought
- IV access now

Management of placenta

- No placenta following fetus at delivery, cut cord
- No traction at this stage
- Do not cut cord too close to vagina
- Lengthening cord ~ placental separation
- Be patient, do not force placental delivery
- Encourage micturition

Examination of placenta

- Check for completeness
- Identify discrepancies
- An incomplete or ragged placenta:
  - Antibiotics: Co-Amoxiclav 625mg 7 days
  - Advise re signs of infection, haemorrhage
  - Emergency contact numbers

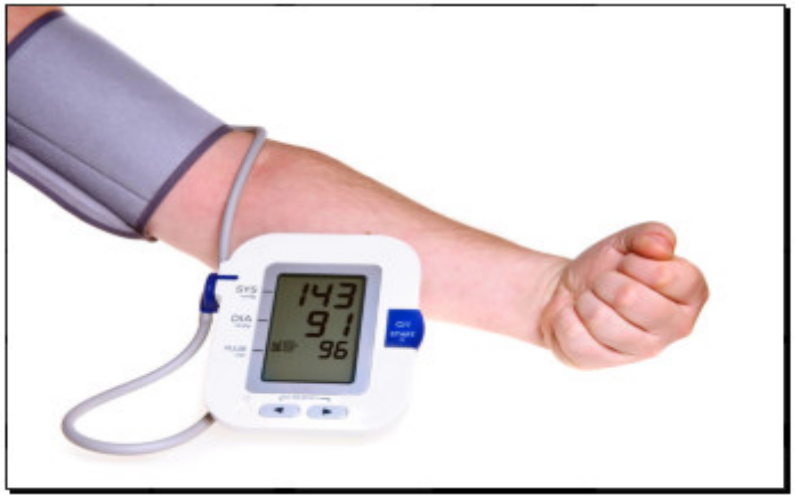
Complications: retained placenta

- Medical review if no placenta after 1 hour
- Risk of major haemorrhage
- Speculum exam
- If placenta visible in os, remove using sterile sponge holders
- If no placenta visible, prepare for theatre

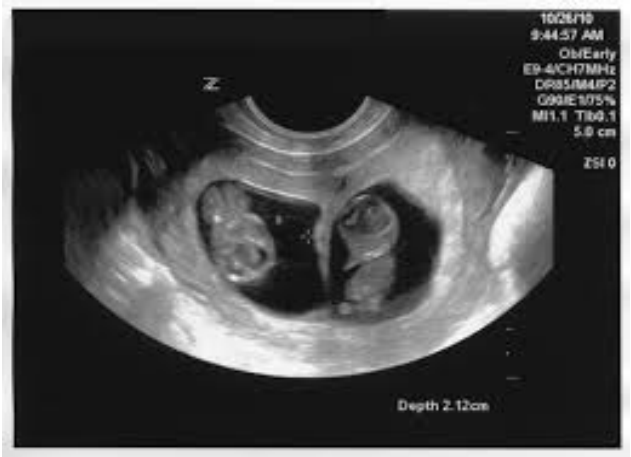
Common concerns (1)

Multiple caesarean sections:

- Be aware of risk of uterine rupture(1:1000)
- Monitor for signs: abdominal tenderness
- Shock: ↓BP ↑pulse, pain



Common concerns (2)



Twin Pregnancy:

- Same management, but:
  - Bleeding may be heavier
  - Maybe give oxytocic sooner following fetal delivery, if required
  - If patient stable, wait

Common concerns (3)

Previous Post Partum Haemorrhage:

monitor blood loss

Low lying placenta: monitor blood loss

Placenta accreta suspected on ultrasound:

- Manage in labour ward with full medical and radiology support

Helpful hints

- Empty bladder
- Sitting position: gravity helps
- Assistance where appropriate
- Minimal interference is important
- Medical intervention only when necessary

Outcome

- Women cared for professionally and safely

Thank you.

Any questions?