Early Pregnancy Assessment Unit Guidelines
### Policy Title:
**EARLY PREGNANCY ASSESSMENT UNIT GUIDELINE**  
(Care of a Woman with Pain and Bleeding in Early Pregnancy)

### Executive Summary:
The early pregnancy service offers sensitive and timely care to women with early pregnancy complications. Within its remit is diagnosis and treatment along with the offering of support and information to women who suffer an early pregnancy loss, taking into account their individual circumstances and emotional response. Early pregnancy is a pregnancy in the first trimester – that is up to 13 completed weeks of pregnancy.

### Supersedes:
Previous Individual EPAU Guidelines

### Description of Amendment(s):
Updated to reflect National Institute for Health and Clinical Excellence (NICE) (2012) Pain & Bleeding in Early Pregnancy


### Financial Implications:
Non Known

### Policy Area:
Maternity Services

### Version Number:
1.0

### Effective Date:
May 2015

### Issued By:
Women and Children’s Business Unit

### Review Date:
May 2018

### Authors:
Dr S Dean
MW A stone

### Impact Assessment Date:
May 2015

### APPROVAL RECORD

<table>
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<th>Committees / Group</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultation Phase:</td>
<td>December 2014-April 2015</td>
</tr>
<tr>
<td>Obstetric Lead</td>
<td>May 2015</td>
</tr>
<tr>
<td>Head of Midwifery</td>
<td>May 2015</td>
</tr>
<tr>
<td>IT Dept &amp; Legal Services</td>
<td>June 2015</td>
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</tbody>
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EPAU Guidelines  
Dr S Dean & MW A Stone  
Version 1 May 2015
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EPAU Guidelines
Dr S Dean & MW A Stone
Version 1 May 2015
1.0 Policy Statement

This guideline offers best practice advice on the care of women with pain and bleeding in early pregnancy

1.1 Background

The National Institute of Clinical Excellence (NICE) have issued guidance on the management of Pain and Bleeding in Early Pregnancy and this guideline aims to reflect their guidance on best practice.

Pain and bleeding in early pregnancy has an adverse effect on the quality of life of many women. Approximately 20% of pregnancies miscarry, and miscarriages can cause considerable distress. Early pregnancy loss accounts for over 50,000 admissions in the UK annually. The rate of ectopic pregnancy is 11 per 1000 pregnancies, with a maternal mortality of 0.2 per 1000 estimated ectopic pregnancies.

About two thirds of these deaths are associated with substandard care. Women who do not access medical help readily (such as women who are recent migrants, asylum seekers, refugees, or women who have difficulty reading or speaking English) are particularly vulnerable.

Improvement in the diagnosis and management of early pregnancy loss is thus of vital importance, in order to reduce the incidence of the associated psychological morbidity and avoid the unnecessary deaths of women with ectopic pregnancies.

1.2 Organisational Responsibilities

Chief Executive

Has ultimate responsibility for the implementation and monitoring of the policies in use in the Trust. This responsibility may be delegated to an appropriate colleague.

Clinical Leads/Head of Midwifery

Where Clinical Leads/Head of Midwifery are asked to ratify this guideline they are responsible for the review of the guideline and the final ratification prior to the guideline actually being implemented. This ratification process will take place following the consultation and approval process.

Trust Committees

As a group are responsible for the consultation and approval process required during the development of guidelines for the Trust. The committees are responsible for the review of guidelines submitted to them to ensure that guidelines are appropriate, workable and follow the principles of best practice.
All Staff

It is incumbent on relevant staff, when asked, to provide comments and feedback on the content and practicality of guidelines that are being developed and reviewed. It is the duty of all staff when asked, to provide assistance during the development and review stages of guideline formulation.

Stakeholders

Are those people with an interest in a guideline who contribute, comment and agree to the content of the guideline. They include specific committees, groups or forums, individual colleagues, whole departments, service users and their families.

1.3 Planning and Implementation

The objectives of this guideline are to ensure the appropriate care of the woman who experience an early pregnancy complications (up to 13 weeks completed weeks of gestation).

Newly ratified guidelines are included on the maternity newsletter. Relevant staff have the responsibility to ensure awareness of the contents of the guideline and to inform their Line Manager of any training needs which may affect their ability to follow this guideline.

1.4 Measuring Performance and Audit

The Trust will measure performance of this guideline against specified audit criteria.

1.5 Review

This guideline will be reviewed every three years or sooner following findings from audit, changes to national guidance, or in response to clinical practice. The responsibility for the review of guidelines lies with the Practice Development Midwife who will report to the overarching maternity clinical governance committee.
EARLY PREGNANCY ASSESSMENT UNIT GUIDELINE

2.0 Referral Criteria

Positive pregnancy test up to 13 completed weeks gestation

AND at least one of the following

- Abdominal pain / pain suggestive of an ectopic pregnancy
- Active bleeding at greater than 6 weeks of pregnancy
- Previous ectopic or molar pregnancy (self-referral from this group is acceptable)
- Recurrent miscarriage (more than 2 confirmed miscarriages)
- Pre-existing medical condition known to increase the risk of miscarriage

NB Women less than 6 weeks pregnant with PV bleeding but no pain or other symptoms should NOT be referred to EPAU. They should be advised to continue with expectant management and to perform a urine pregnancy test after a week and return if it is positive. A negative test means that the pregnancy has miscarried. Also advise woman to seek medical advice if her symptoms continue or worsen.
3.0 Assessment

History taking

All women attending the EPAU for the first time this pregnancy should have a comprehensive history taken by a midwife/doctor and recorded on the EPAU history and assessment sheet.

History should include details of last menstrual period, cycle length, date of a positive pregnancy test and estimated gestation. Any relevant medical history, medications, obstetric history and allergies should also be recorded. The woman should be asked about her smoking status, alcohol intake and any drug misuse.

Do not use gestational age from the last menstrual period (LMP) alone to determine whether a fetal heartbeat should be visible. Women should be informed that the date of their LMP may not give an accurate representation of gestational age because of variability in the menstrual cycle.

Information and Advice

- Clear, concise documentation should be filed in the appropriate place in the medical records.
- Women should be informed what to expect whilst waiting for a repeat scan and should be given 24 hour telephone contact numbers so advice can be sought when needed.
- Up to date, appropriate written information should be given to the woman.
- If a miscarriage is diagnosed the woman should be informed regarding the listening and support service available and/or counselling via her own GP.

Investigations

A Chlamydia test should be offered to all women who attend EPAU under the age of 25 years, in line with current screening policy.
In addition all women who have a pregnancy loss should be offered Chlamydia screening.
# 3.1 Ultrasound Scan Diagnostic Criteria

**NB: ALL SCANS MUST BE TRANSVAGINAL (unless unacceptable to the woman)**

- All ultrasound scans should be performed and reviewed by someone with training in, and experience of, diagnosing ectopic pregnancies
- Verbal consent should be obtained by the person performing the scan
- If a TV scan is declined by the woman it should be documented on the report and a transabdominal (TA) scan should be performed. The limitations of such should be clearly explained to the woman.
- TA scans should also be considered when women have an enlarged uterus or other pelvic pathology such as fibroids or an ovarian cyst
- Inform women that the diagnosis of miscarriage using one ultrasound scan cannot be guaranteed to be 100% accurate and there is a small chance that the diagnosis may be incorrect, particularly at very early gestational ages
- An attempt to identify a fetal heartbeat should be made. If there is no visible heartbeat but there is a visible fetal pole, the crown-rump length (CRL) should be measured. Only measure the mean gestational sac diameter if the fetal pole is not visible

- When diagnosing complete miscarriage on scan, in the absence of a previous scan confirming an intrauterine pregnancy, always be aware of the possibility of an ectopic pregnancy
- In all cases where a decision is being made on whether a pregnancy is non-viable, the scan must be checked by a second sonographer AND/OR a second scan should be performed a minimum of 7 days after the first before making a diagnosis

<table>
<thead>
<tr>
<th>TYPE OF SCAN</th>
<th>FETAL POLE CROWN RUMP LENGTH (CRL) For Determining Viability</th>
<th>MEAN GESTATION SAC MEASUREMENT For Determining Viability</th>
</tr>
</thead>
<tbody>
<tr>
<td>TRANSVAGINAL*</td>
<td>Greater than or equal to 7mm</td>
<td>Greater than or equal to 25mm</td>
</tr>
<tr>
<td>Or TRANSABDOMINAL**</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* On **TRANSVAGINAL scan**, if the CRL is less than 7mm and there is no visible fetal heartbeat, or if the MGSD is less than 25mm and there is no visible fetal pole, perform a second scan a **minimum of 7 days** after the first before making a diagnosis

** On **TRANSABDOMINAL scan** if the CRL is 7mm or greater and there is no visible heartbeat or if the MGSD is 25mm or greater and there is no visible fetal pole, record the size of the CRL or MGSD respectively and perform a second scan a **minimum of 14 days** after the first before making a diagnosis
**3.2 ASSESSMENT OF PAIN AND / OR BLEEDING IN PREGNANCY**

**ADDRESSOGRAPH**

**DATE**

**PLEASE CIRCLE A, B, C, D, E, F OR G AND FOLLOW APPROPRIATE PATHWAY**

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**TRANSVAGINAL SCAN**

(Women with positive pregnancy test plus bleeding and / or pain at 6 - 13 completed weeks)

ONLY FOLLOW PATHWAY IF CLINICALLY STABLE – IF NOT SEEK URGENT MEDICAL RVW

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**VIABLE PREGNANCY**

**NO INTRAUTERINE PREGNANCY**

**INTRAUTERINE PREGNANCY**

Non-Viable OR Uncertain Viability

---

**A**

**B**

**C**

**D**

**E**

**F**

**G**

EXIT PATHWAY

Retained Products of conception

CRL < 7mm No Fetal Heart

CRL ≥ 7mm No Fetal Heart Beat

MGSD <25mm No Fetal Pole

MGSD ≥25mm No Fetal Pole

Follow Ectopic Pregnancy OR Pregnancy of Unknown Location Protocol (depending upon scan findings and clinical assessment)

Check βHCG and if >1500iu needs consultant to review

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Name ....................................... Signature ........................................ Date .....................

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**REVIEW VISIT**

PLEASE CIRCLE ONE BOX AND FOLLOW APPROPRIATE PATHWAY

**NAME** ....................................... **SIGNATURE** ........................................ **DATE** .....................

---

**Viable intrauterine pregnancy**

**Non-viable intrauterine pregnancy but CRL or MGSD has increased since previous scan**

**Non-viable intrauterine pregnancy with no increase in CRL or MGSD**

**Non-viable intrauterine pregnancy with CRL ≥ 7mm OR MSD ≥ 25mm & no fetal pole**

**EXIT Pathway Referral to maternity services**

Senior Clinical Review – may need βHCG and if increasing, repeat scan in 7 days

Transfer to miscarriage pathway

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Name ....................................... Signature ........................................ Date .....................
3.3 PREGNANCY OF UNKNOWN LOCATION

TWO SERUM ΒHCG MEASUREMENTS 48 HOURS APART
NB. Always place more importance on signs and symptoms and clinical examination than βHCG and review woman condition if any of her symptoms change.

A
βHCG INCREASE > 63%
(likely to be viable intrauterine, BUT Ectopic cannot be excluded)

B
βHCG CHANGE BETWEEN
50% DECREASE AND 63% INCREASE
(Ectopic likely)

C
βHCG DECREASE > 50%
(likely to be failing pregnancy)

If symptoms remain unchanged, repeat scan in:
☐ 7-10 days (βHCG <1500)
☐ 4-7 days (βHCG ≥1500)
(Please tick appropriate box)

? ECTOPIC
Urgent Senior clinical review
AND must be discussed with consultant

Give written info and ask her to perform a urine pregnancy test in 14 days. Put in EPAU diary for telephone follow-up

REVIEW VISIT
PLEASE CIRCLE ONE BOX AND FOLLOW APPROPRIATE PATHWAY

Viable intrauterine pregnancy
EXIT Pathway, referral to maternity services

Non-viable intrauterine pregnancy
Transfer to ‘Bleeding in Pregnancy’ pathway

No intrauterine pregnancy
? ECTOPIC
Urgent Senior clinical review AND must be discussed with consultant

Positive
? ECTOPIC
Urgent Senior clinical review AND must be discussed with consultant

Negative
EXIT Pathway

Name …………………………..… Signature …………………………………   Date  ……….………

Addressograph

Date

Please circle A, B or C and follow appropriate pathway
3.4 MANAGEMENT OF CONFIRMED MISCARRIAGE

MANAGEMENT OF CONFIRMED MISCARRIAGE

A

EXPECTANT MANAGEMENT
1st Line Management for 14 days
(if no contraindications*)
Review after 10-14 days (EPAU diary for telephone follow-up)

Resolution of pain / bleeding

Pain / bleeding persists

C

MEDICAL MANAGEMENT
If expectant management not acceptable or is contra-indicated

NO pain/ bleeding as yet

Refer to Medical Management of Miscarriage protocol

SURGICAL MANAGEMENT
If expectant / medical management not appropriate

Refer to Surgical Management of Miscarriage protocol

*Contraindications to Expectant Management:
- Late first trimester (inc risk haemorrhage)
- Previous adverse / traumatic experience with pregnancy
- Coagulopathies
- Jehovah’s Witness
- Infection

Name …………………………..… Signature …………………………………   Date …………..

REVIEW VISIT

OUTCOME OF REPEAT SCAN AND MANAGEMENT PLAN (if opts for continued expectant management review after another 14 days provided condition remains stable):

Name …………………………..… Signature …………………………………   Date …………..
3.5 Medical Management of Miscarriage

All women should be offered expectant management as a first line treatment for missed/incomplete miscarriage unless this is contraindicated (NICE 2012 Ectopic Pregnancy & Miscarriage).

For women undergoing medical management the use of mifepristone is no longer recommended (NICE 2012 Ectopic Pregnancy & Miscarriage)

Aim for Medical management of Miscarriage as out-patient provided there are no contra-indications and the following criteria are met:

Criteria for out-patient medical management

- Must not have any contra-indications (see below)
- Ultrasound diagnosis MUST be Transvaginal
- Haemodynamically stable and not bleeding heavily
- Singleton pregnancy
- Gestation up to 13 completed weeks confirmed on scan
- In cases of incomplete miscarriage retained products of conception (RPC) must be ≤ 50mm diameter
- Patient understands the procedure and need for compliance with follow-up arrangements
- Continuous support at home from an adult for at least 24-48 hours
- Must not be geographically isolated
- Must have access to transport in case admission to hospital is required

Contra-indications to medical management

- Pyrexia
- Infection
- Anaemia (Hb < 95g/l)
- Haemoglobinopathies
- Anticoagulant therapy
- Long term steroid therapy
- Adrenal insufficiency
- Porphyria
- Jehovah’s Witness
- Allergy to Misoprostol or other prostaglandins
- Heavy smoker over 35 years of age

This list is not exhaustive - discuss any concerns with senior colleague.
### 3.6 MEDICAL MANAGEMENT OF MISCARRIAGE

**MEDICAL MANAGEMENT OF CONFIRMED MISCARRIAGE**
(MISSED OR INCOMPLETE)

(PLEASE TICK ALL BOXES)

- Ensure patient meets ALL criteria for outpatient medical management
- Ensure there are no contraindications to outpatient medical management
- Ensure patient has been counselled
- Obtain written Consent
- Check baseline OBS are normal and document
  - Pulse ………………
  - BP ………………
  - Temp ………………
- Take blood FBC, G&S – if low Hb contact patient & admit for inpatient management
- Prescribe & administer single ORAL dose of MISOPROSTOL 800 micrograms
- Prescribe a further dose of MISOPROSTOL 800 micrograms for 24 hrs later if needed
- Prescribe analgesia and anti-emetics to take home (advise avoidance of NSAID’s)
- Prescribe and administer Anti-D if required
- Observe for 30 mins and if stable allow home with written information & contact numbers
- Check advice given re: disposal of any fetal tissue

#### Resolution of pain and bleeding

Advise woman to do a urine pregnancy test in 3 weeks. If positive contact EPAU to arrange repeat scan & review

#### Pain / bleeding worsening

Contact EPAU / Women's Unit to arrange URGENT review

#### Pain / bleeding persists beyond 3 weeks

Contact EPAU Repeat scan & review

#### NO pain / bleeding after 24 hours

Contact EPAU to arrange review. Either repeat misoprostol or continue expectant. If neither acceptable review by Consultant

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**REVIEW VISIT**

OUTCOME OF REPEAT SCAN AND MANAGEMENT PLAN:

Name …………………………. Signature ………………………………. Date ……………..
3.7 SURGICAL MANAGEMENT OF MISCARRIAGE

SURGICAL MANAGEMENT OF MISCARRIAGE (MISSED OR INCOMPLETE)
(PLEASE TICK ALL BOXES)

- Ensure there are no contraindications to surgical management and the woman is ≤ 13 completed weeks gestation
- Ensure woman has been counselled and provide written information
- Middle grade or Consultant to obtain written consent
- Obtain histology & tissue disposal consent
- Check baseline OBS are normal and document Pulse ..................... BP................. Temp .....................
- Take blood for FBC, G&S
- Prescribe Misoprostol 400μg and Azithromycin 1g both orally 2 hours pre-operative
- Prescribe Anti-D if required – refer to Anti D flowchart
- SHO or Middle Grade to book woman onto the theatre list (NECPOD list if appropriate)
- Contact inpatient flow coordinator on extension 3326/3713
- Inform Bed Manager
- Inform anaesthetist
- Advise patient re: fasting and admission arrangements
- Allow patient to go home if appropriate with written information and contact numbers
- Track notes to place of admission

Name .................................. Signature .................................. Date ..................
3.8 EXAMINATION & DISPOSAL OF PRODUCTS OF CONCEPTION

Products of conception (POC’s) up to 13 completed weeks of gestation

- Send to the pathology department in a pot with formalin.
- Label pot with the woman’s details
- Attach a completed yellow histology form
- A completed consent form must also be sent with the specimen – see appendix. ( a separate form for each sample sent)
- The person taking consent for histological assessment must be aware of and able to explain to the woman the implications of not giving consent. (A life threatening condition or treatable cancer or an Arias Stella reaction may be missed if the sample is not analysed). A senior obstetrician must be informed who may wish to further discuss the implications of this. All discussions between staff and the woman and her partner must be documented in the woman's records.
- If there is an obviously recognisable fetus the parents must be asked if they would like photographs to be taken.
- All outstanding appointments must be cancelled by completing the template letter informing the antenatal clinic of the pregnancy loss.

NB: Women who pass products of conception at home should be advised to dispose of them by flushing them down the toilet. If however they wish for the tissue / small fetus to be disposed of by the hospital this can be arranged.
3.9 MANAGEMENT OF ECTOPIC PREGNANCY

PATIENT WITH CONFIRMED ECTOPIC OR HIGHLY SUSPICIOUS OF ECTOPIC PREGNANCY

HAEMODYNAMICALLY UNSTABLE

URGENT SURGICAL MANAGEMENT
- 2x large bore cannulae (16G)
- Take blood FBC, U&E, Clotting
- Cross match 4 units of blood
- Inform middle grade/consultant
- Inform anaesthetist
- Consent for surgery and Histology & disposal of tissue
- VTE form
- Transfer to theatre for laparotomy immediately
- Salpingectomy operation of choice (salpingostomy if necessary). Aim for Laparoscopic surgery if appropriate
- Ensure surgical management proforma completed

HAEMODYNAMICALLY STABLE

MEDICAL MANAGEMENT
- All of the following criteria must be met:
  - No significant pain
  - Unruptured ectopic with adnexal mass <35mm and NO visible heart beat
  - βHCG <5000iu/l
  - NO intrauterine pregnancy on TVS scan
  - Able to return for follow-up
  - Acceptable to woman
  - No contra-indications to methotrexate (pre-existing liver, renal, GI or blood disease)

SURGICAL MANAGEMENT
- Recommended for women with:
  - Significant pain
  - Ruptured ectopic
  - Adnexal mass ≥35mm and/or visible heart beat
  - βHCG ≥5000iu/l
  - Unable to return for follow-up
  - Medical management contra-indicated or NOT acceptable to woman

Refer to Medical Management of Ectopic Protocol
Refer to Surgical Management of Ectopic Protocol

PLEASE CIRCLE A B OR C AND FOLLOW APPROPRIATE PATHWAY

ADDRESSOGRAPH

DATE

Name .................................. Signature ........................................... Date .................
3.10 MEDICAL MANAGEMENT OF ECTOPIC PREGNANCY

(PLEASE TICK ALL BOXES)

- Ensure patient meets ALL criteria for medical management (see pathway)
- Ensure patient has been counselled
- Obtain written Consent
- Check baseline OBS are normal and document
- Pulse ………………  BP ………………  Temp ………………
- Take blood for FBC, U&E’s, LFT’s, Creatinine, G&S
- Weigh patient and measure height
- Prescribe METHOTREXATE (pharmacist will calculate dosage according to patients’ body surface area in m², calculated from height and weight) – see appendix
- Review blood results and Administer METHOTREXATE if bloods normal
- Prescribe analgesia to take home
- Allow home after 2-4 hours with written information & contact numbers
- Advise to avoid intercourse & future pregnancy for at least 3 months
- Arrange follow-up appointment in EPAU on day 4 after treatment

REVIEW VISIT ON DAY 4

- Assess Medical Condition & if any concerns obtain Medical Review
- Take blood for ßHCG and record level on results sheet
- Arrange to review on day 7

REVIEW VISIT ON DAY 7

- Assess Medical Condition & if any concerns obtain Medical Review
- Take blood for ßHCG, FBC, U&E, Creatinine, LFT’S and record levels on result sheet

If ßHCG has increased or fallen by <15% discuss with consultant and reassess the woman’s condition for further treatment.

If ßHCG has fallen by > 15% and the woman is clinically stable, continue to repeat weekly until ßHCG < 20iu.

Senior medical review if < 15% fall in ßHCG at any time.

Name …………………………..  Signature  …………………………………  Date  ……….……..

Name …………………………..  Signature  …………………………………  Date  ……….……..

Name …………………………..  Signature  …………………………………  Date  ……….……..
APPENDIX

Methotrexate dose is 50mg/m², dose banded according to tablet below:

<table>
<thead>
<tr>
<th>Body Surface Area (m²)</th>
<th>Dose (mg)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.5 -1.7</td>
<td>80mg</td>
</tr>
<tr>
<td>&gt;1.7 and &lt;1.9</td>
<td>90mg</td>
</tr>
<tr>
<td>1.9 and above</td>
<td>100mg</td>
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</tbody>
</table>
## 3.11 MEDICAL MANAGEMENT OF ECTOPIC PREGNANCY

### BLOOD RESULTS

<table>
<thead>
<tr>
<th>Date</th>
<th>(\beta HCG) (IU/l)</th>
<th>FBC</th>
<th>U&amp;E’S</th>
<th>CREATININE</th>
<th>LFT’S</th>
<th>G&amp;S</th>
<th>Name &amp; Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Administration of Methotrexate</strong> (Day 0)</td>
<td></td>
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<tr>
<td>Day 4</td>
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<tr>
<td>Day 7</td>
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<td>Day 14</td>
<td></td>
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<tr>
<td>Day 21</td>
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<tr>
<td>Day 28</td>
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<td>Day 42</td>
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</tbody>
</table>
3.12 SURGICAL MANAGEMENT OF ECTOPIC PREGNANCY

(PLEASE TICK ALL BOXES)

- Is the patient STABLE …………………… UNSTABLE …………………..

- Insert a wide bore cannula (If UNSTABLE insert two wide bore cannulae)
- Take blood for FBC, G&S +/- Cross Match (+ U&E if appropriate)
- If UNSTABLE Cross Match at least 4 units of blood
- Inform Senior Medical staff (Immediately if Unstable)
- Inform Anaesthetist
- If UNSTABLE speak to theatre co-ordinator arrange transfer to theatre Urgently
- If STABLE SHO to book patient onto the theatre list (NCEPOD list if appropriate)
- If STABLE Contact inpatient flow coordinator on ext’n 3326/3713
- Contact Bed Manager

- Ensure patient has been counselled and provide written information
- Obtain written consent (Registrar or Consultant)
- Obtain histology & disposal of tissue consent.
- Prescribe Anti-D if required – refer to Anti D flowchart
- Advise patient re fasting and admission arrangements
- Track notes to place of admission

ADDRESSOGRAPH
DATE

All surgical managements of miscarriage are performed under general anaesthetic

Name ………………………….. Signature ………………………………… Date
3.13 ANTI D ADMINISTRATION

Up to and including 13 weeks gestation (by scan) with PV Bleeding

- Viable Pregnancy
- Complete Miscarriage
- Expectant Management of Miscarriage
- Medical management of Miscarriage
- Medical Management of Ectopic

Anti D NOT required

Check Blood Group

Rh Positive
Anti D NOT required

Rh Negative
Offer 250 i/u Anti D

More than 13 weeks gestation (by scan) with PV Bleeding (regardless of outcome)

- Surgically managed miscarriage
- Surgically managed Ectopic Pregnancy

ALL cases

Check Blood Group

Rh Positive
Anti D NOT required

Rh Negative
Offer 250 i/u Anti D

Name .................................. Signature .................................. Date .................
3.14 EPAU – FIRST VISIT HISTORY & ASSESSMENT SHEET

Addressograph

Date ....................  Time ....................

Patient Tel No(s)  ....................  ....................

GP Details  ........................................

Consultant  ........................................

LMP  Cycle  Gestation

Positive Pregnancy Test Date  Past Obs History

Medication  Allergies

Presenting Complaint

Relevant Medical History

Smoker  Yes/No  No per day .................  Alcohol  Yes/No  Units per week .................

Chlamydia Screen indicated  Yes/No  Taken  Yes/No

OBSERVATIONS  Pulse  BP  Temp

BLOODS TAKEN  FBC  G&S Ab’s  BHCG

Name ..............  Signature  .....................  Job Title ..............  Date ..............
3.15 EPAU – RESULTS AND MANAGEMENT SHEET

Addressograph

Date .......................  Time .....................

Patient Tel No(s) .................  .....................

GP Details ..............................................................

Consultant ..............................................................

SCAN FINDINGS

EXAM’N
(IF PERFORMED)
NB: ALL WOMEN WITH PUL SHOULD BE EXAMINED

MEDICAL REVIEW & MANAGEMENT PLAN

BLOOD GROUP
(if performed)

HB  βHCG

ANTI –D  Yes / No  GIVEN BY

Name .........................  Signature  .........................  Job Title .............  Date..............
## EPAU CONTINUATION SHEET

<table>
<thead>
<tr>
<th>Addressograph</th>
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Discharge Date ......................  Time ..............

Patient Tel No(s) ................. ......................

GP Details  ..................................................

Consultant  .................................................
Addressograph

Discharge Date ...........................  Time ...............  
Patient Tel No(s) ..........................  ........................  
GP Details ..........................................................  
Consultant ..........................................................

REASON FOR REFERRAL

DIAGNOSIS

MANAGEMENT

BLOOD RESULTS

FOLLOW-UP ARRANGEMENTS

DRUGS PRESCRIBED

Any Additional Information

Anti D Given  YES/NO  Leaflets Provided  YES/NO 
All future Antenatal / Ultrasound appointments cancelled  YES/NO

Name ......................  Signature ........................................ Job Title .................  Date..................

3.16 EPAU OUTCOME FINAL SUMMARY / DISCHARGE SHEET
4.0 Audit /Monitoring Compliance of this Guideline

This Guideline will be reviewed within three years.

Coordination of audit

Any audits undertaken will be the responsibility of the Practice Development Midwives

Reporting arrangements

The Practice Development Midwives will report the results of audit to the overarching Maternity and Women’s Service Clinical Governance Committee Any action plans will be tabled at the overarching Maternity and Women’s Service Clinical Governance Committee by the Practice Development Midwives

Acting on recommendations

The audit recommendations and subsequent action plan will be discussed and agreed by the overarching Maternity and Women’s Service Clinical Governance Committee.

The Maternity and Women’s Service Clinical Governance Committee will agree which individual will be responsible for action(s) within a specified timeframe. This will be documented on the action plan and within the minutes from the Maternity and Women’s Service Clinical Governance Committee.

Changes in practice and lessons to be shared

Any required system or organisational change to practice will be discussed and agreed by the overarching Maternity and Women’s Service Clinical Governance Committee. Changes to practice will be identified and actioned within a specified time frame.

A lead member of the team will be identified to take each change forward. This will be documented on the agreed action plan and monitored at the Maternity and Women’s Service Clinical Governance Committee on a monthly basis until completion.

Lessons will be shared with the relevant stakeholders

5.0 References
