Medical Management of Mid-Trimester Abortion

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Mid-trimester Abortions

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- 2000 abortions/year
- 120 mid-trimesters/year
- 50% abort within 7 hours
- 97% abort within 24 hours
- 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?