

A RETROSPECTIVE COHORT STUDY

BACKGROUND

Surgical management of miscarriage (SMM) is a well established choice for patients, yet there is sparse up-to-date data on technique, outcomes and complication rates, with many studies cited by RCOG Consent Advice No.10 being over 10years old (1-5).

METHODS

- Retrospective, single-centre, cohort study
- 9 month period in 2024 (n=229)
- Uptake, experiences & outcomes up to 42days post-operatively
- Inclusion criteria: 1st trimester miscarriage/termination
- Exclusion criteria: MVA, CRL 75+mm (13 weeks)

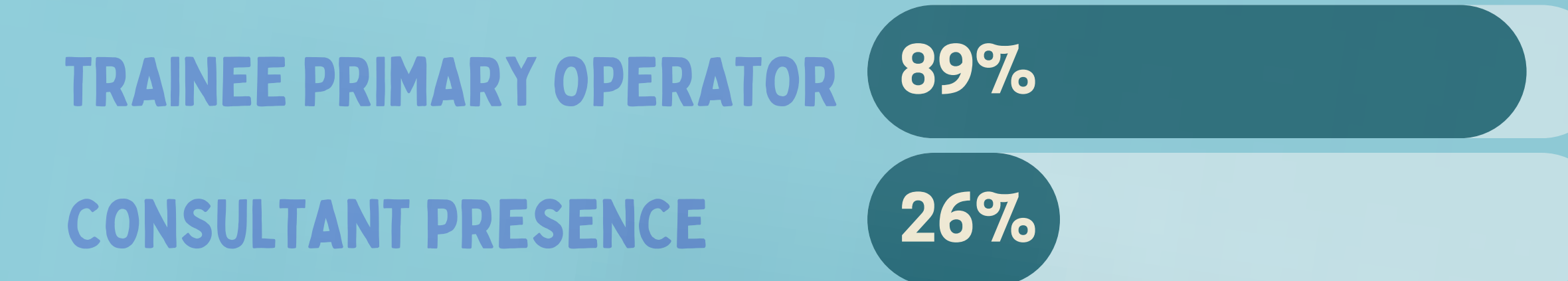
RESULTS

AVERAGE WAIT TIMES



Delays driven by NICE diagnostic criteria, early GA at 1st contact, failed primary Mx, and scan or theatre availability.

A TRAINEE-LED SERVICE



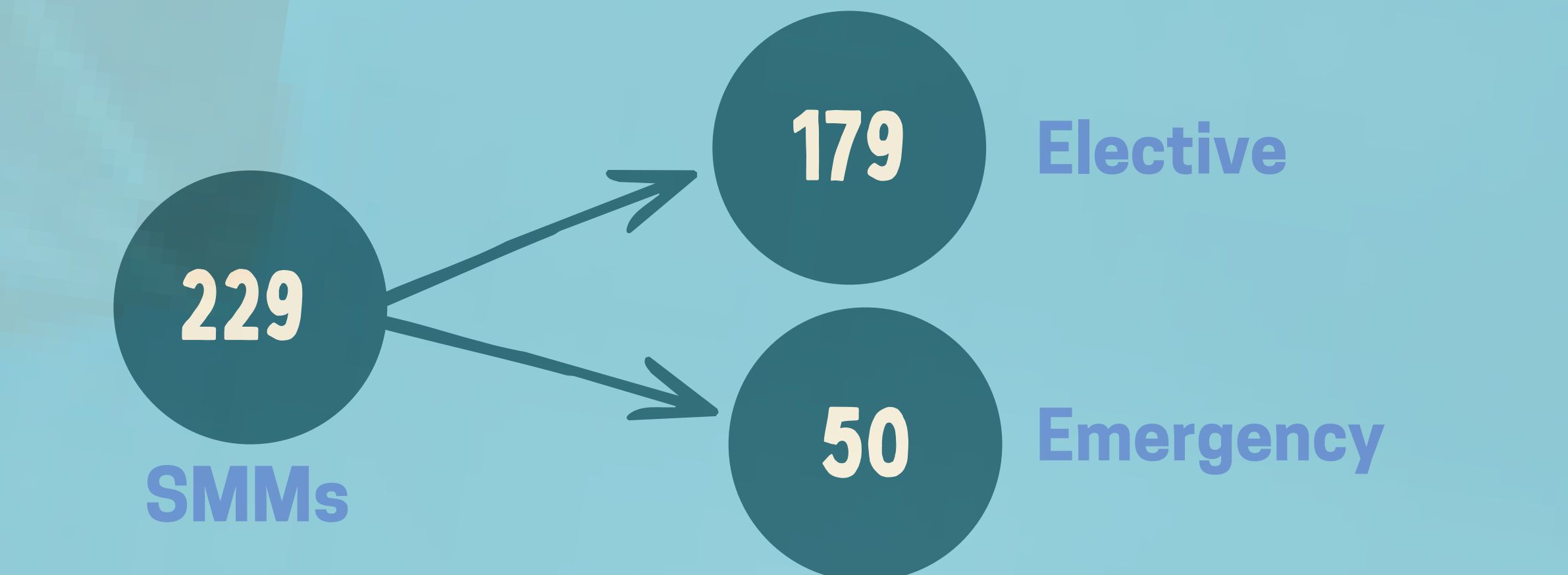
SURGICAL MANAGEMENT OF MISCARRIAGE

UPTAKE, OUTCOMES & PATIENT EXPERIENCES AT A UK DISTRICT GENERAL HOSPITAL

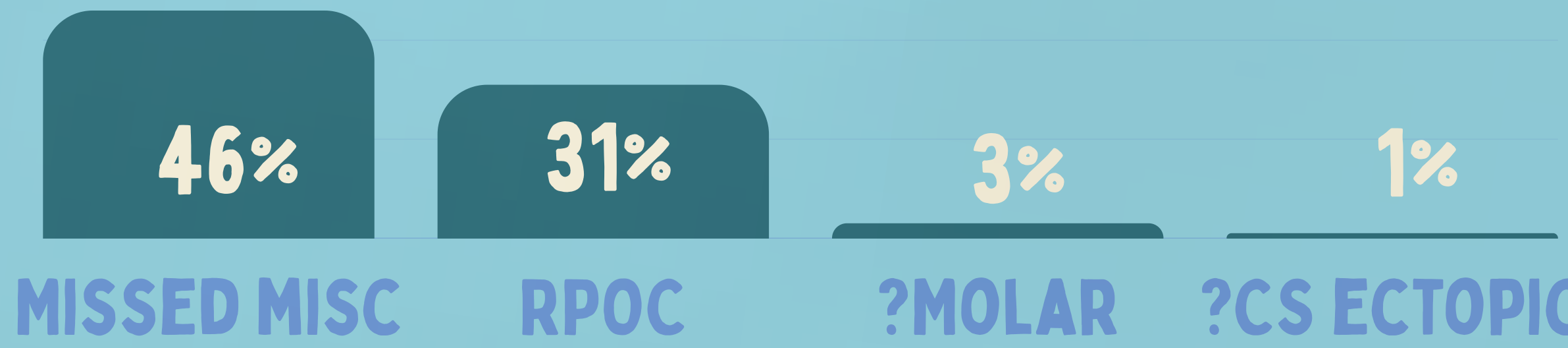
Dr Sarah Adams, Dr Sara Hassan, Miss Nirmala Murugandoss



INDICATION FOR SMM

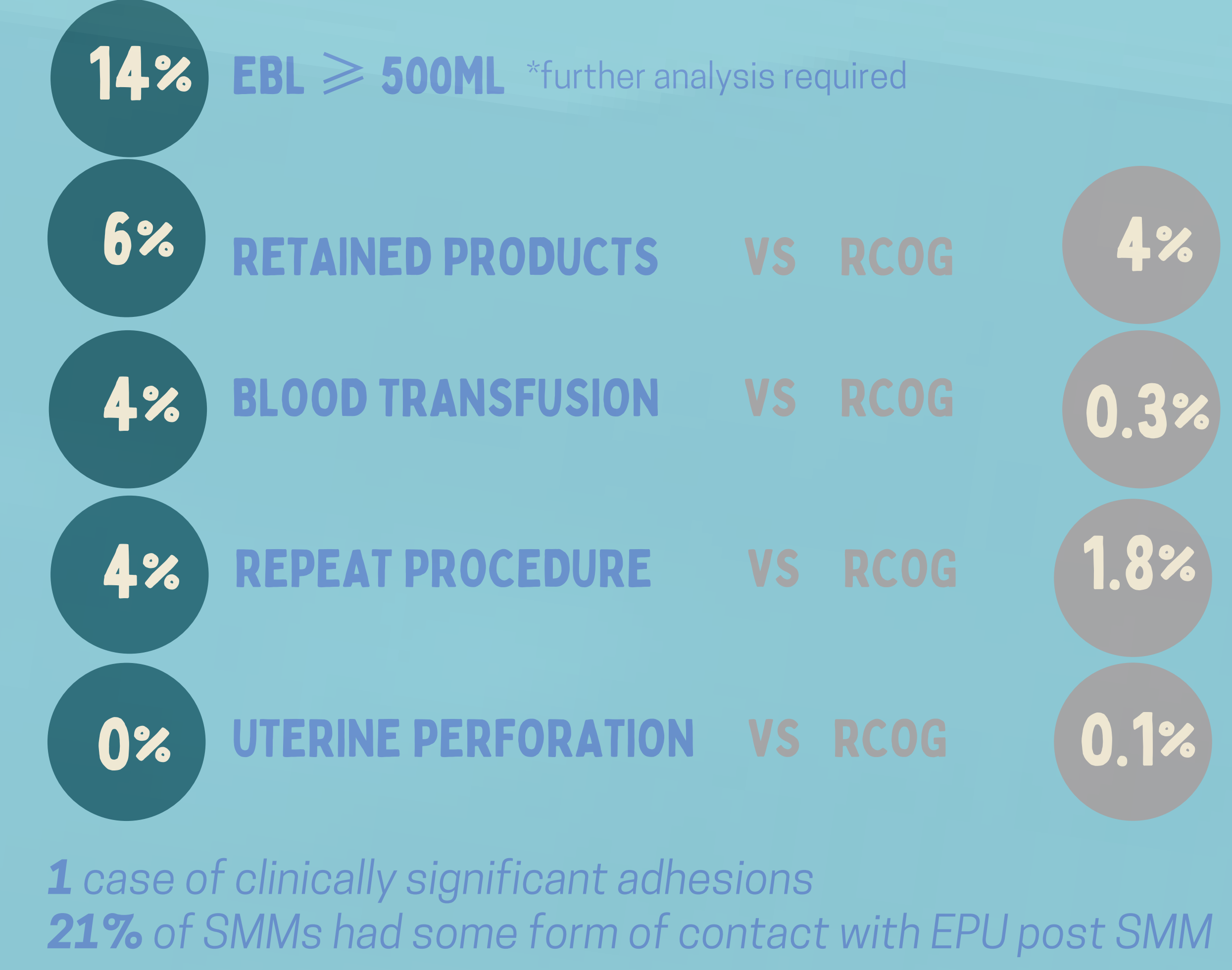


22% of SMMs were emergencies- for acute bleeding, pain or infection.



Previous failed medical management (MMM/ mTOP) (p=0.0097) and CRL 22+ mm (9weeks) (p=0.0019) were more likely to have an **emergency** Vs elective **SMM**.

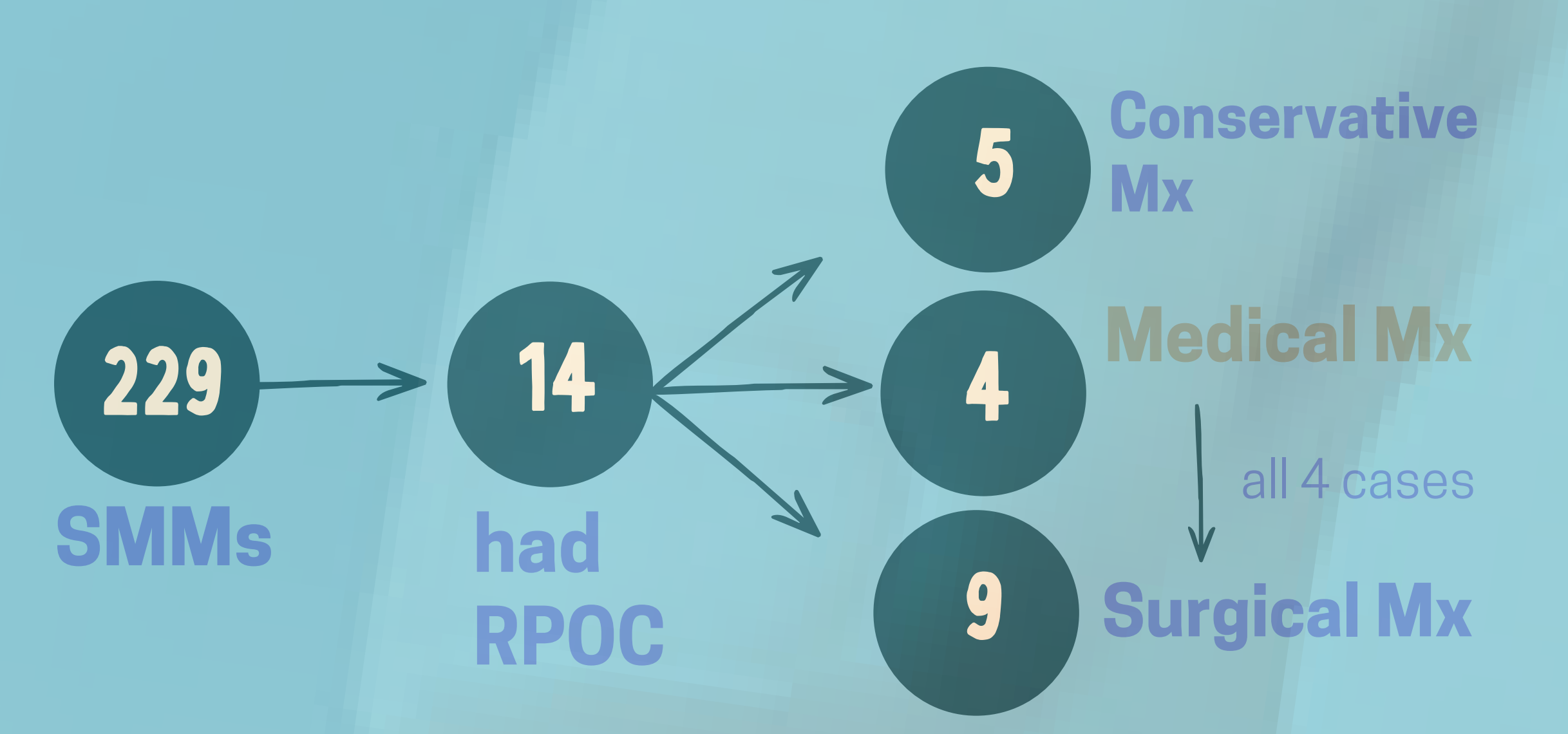
OUTCOMES



REFERENCES

- 1.RCOG, 2018. Consent Advice No. 10 - Surgical Management of Miscarriage.
- 2.Al-Ma'ani, W. et al. 2014. Expectant versus surgical management of first-trimester miscarriage: a randomised controlled study. Arch. Gynecol. Obstet. 289
- 3.Nadarajah, R. et al. 2014. A randomised controlled trial of expectant management versus surgical evacuation of early pregnancy loss. Eur. J. Obstet. Gynecol. Repro. Biol. 178, 35-41.
- 4.Shelley, J.M. et al. 2005. A randomised trial of surgical, medical and expectant management of first trimester spontaneous miscarriage. Aust. N. Z. J. Obstet. Gynaecol. 45, 122-127.
- 5.Trinder, J. et al. 2006. Management of miscarriage: expectant, medical, or surgical? Results of randomised controlled trial (miscarriage treatment (MIST) trial). BMJ 332, 1235-1240.

RPOC POST SMM



Incidence of RPOC did not reduce with:

- Larger suction catheter (10+mm) (p=0.4684)
- Intra-operative transabdominal ultrasound (p=0.8139)

CONCLUSIONS

1. **Improve scans & theatre access** to shorten 15-day elective wait.
2. **Prioritise** previous failed MMM/ mTOP or CRL 22+mm for theatre.
3. **Don't rely on intra-op TAUSS or larger catheter** to prevent RPOC.
4. **Medical management has no role in RPOC Mx** post SMM.
5. **Further testing** - *analysis of EBL rate and multivariate analysis needed in multiple centres.