

WEBVTT

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00:00:09.230 --> 00:00:12.100

<v Instructor>Dilation and evacuation, or D&E,

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00:00:12.100 --> 00:00:14.520

is the most frequently used method of abortion

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00:00:14.520 --> 00:00:17.400

in the second trimester in many countries.

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00:00:17.400 --> 00:00:19.430

This animation will show the steps

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00:00:19.430 --> 00:00:22.930

for performing a dilation and evacuation procedure.

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00:00:22.930 --> 00:00:26.180

A D&E is characterized by cervical preparation

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00:00:26.180 --> 00:00:31.180

with medications, osmotic dilators, and/or a Foley balloon

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00:00:31.610 --> 00:00:34.430

followed by removal of the fetus and placenta

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00:00:34.430 --> 00:00:37.200

with strong, elongated forceps.

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00:00:37.200 --> 00:00:39.540

A well prepared cervix is essential

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00:00:39.540 --> 00:00:41.890

for providing a safe D&E.

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00:00:41.890 --> 00:00:45.900

Adequate dilation decreases the risk of complications.

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00:00:45.900 --> 00:00:48.410

The amount of cervical expansion needed

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00:00:48.410 --> 00:00:51.950

depends on gestational age, provider skill,

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00:00:51.950 --> 00:00:54.670

and the instruments being used.

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00:00:54.670 --> 00:00:58.170

As a rule, dilation should be sufficient to insert

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00:00:58.170 --> 00:01:01.840

and remove the extraction forceps without resistance.

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00:01:01.840 --> 00:01:05.570

For more information about placement of osmotic dilators

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00:01:05.570 --> 00:01:09.990

for cervical dilation, please see our companion video.

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00:01:09.990 --> 00:01:12.100

Before beginning the procedure,

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00:01:12.100 --> 00:01:15.730

complete a pre-procedure evaluation of the patient

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00:01:15.730 --> 00:01:18.233

and obtain informed consent.

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00:01:19.260 --> 00:01:22.050

Once you are ready to start the procedure,

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00:01:22.050 --> 00:01:25.270

assist the patient onto an examination table

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00:01:25.270 --> 00:01:27.643

and into the lithotomy position.

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00:01:28.750 --> 00:01:31.960

Operators should employ a no-touch technique,

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00:01:31.960 --> 00:01:33.830

in which the parts of the instruments

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00:01:33.830 --> 00:01:36.483

that enter the uterus are not handled.

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00:01:37.500 --> 00:01:41.100

Careful and gentle instrumentation avoids injury

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00:01:41.100 --> 00:01:45.170

to the cervix or uterus, and good communication is needed

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00:01:45.170 --> 00:01:47.860

between the operator, the client,

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00:01:47.860 --> 00:01:51.200

if they are awake or only mildly sedated,

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00:01:51.200 --> 00:01:54.580

and other members of the surgical team.

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00:01:54.580 --> 00:01:59.240

After administration of sedation and/or anesthesia,

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00:01:59.240 --> 00:02:01.590

if the client has osmotic dilators

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00:02:01.590 --> 00:02:03.750

or a Foley balloon in place,

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00:02:03.750 --> 00:02:06.250

remove them either before or after

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00:02:06.250 --> 00:02:10.453

inserting a vaginal speculum or vaginal retractor.

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00:02:11.660 --> 00:02:14.700

If the patient has osmotic dilators in place,

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00:02:14.700 --> 00:02:19.190

remove them digitally or use a ring forcep to gently pull

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00:02:19.190 --> 00:02:23.443

on the strings of laminaria or handles of Dilapan-S.

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00:02:24.420 --> 00:02:27.080

The dilator should be inspected and counted

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00:02:27.080 --> 00:02:29.110

to ensure the number removed

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00:02:29.110 --> 00:02:32.100

is the same as the number placed.

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00:02:32.100 --> 00:02:35.873

Gently clean the cervix with an antiseptic solution.

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00:02:36.880 --> 00:02:40.240

A paracervical block is used when performing a D&E

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00:02:40.240 --> 00:02:42.940

under minimal or moderate sedation

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00:02:42.940 --> 00:02:45.490

and is sometimes used when doing a D&E

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00:02:45.490 --> 00:02:48.480

under deep sedation or general anesthesia.

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00:02:48.480 --> 00:02:50.820

Some clinics use dilute vasopressin

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00:02:50.820 --> 00:02:53.750

in the paracervical block to decrease blood loss

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00:02:53.750 --> 00:02:57.070

regardless of the type of sedation or anesthesia.

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00:02:57.070 --> 00:03:01.110

An example of the dose used is four units of vasopressin

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00:03:01.110 --> 00:03:05.810

diluted in 20 milliliters of a local anesthetic.

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00:03:05.810 --> 00:03:08.513

There are many ways to do a paracervical block.

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00:03:10.040 --> 00:03:13.450

In this animation, we show placement of a small amount

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00:03:13.450 --> 00:03:17.490

of local anesthetic at 12 o'clock before placing a tenaculum

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00:03:17.490 --> 00:03:21.350

on the anterior lip of the cervix and then injection

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00:03:21.350 --> 00:03:23.840

of a safe amount of local anesthetic,

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00:03:23.840 --> 00:03:25.610

based on the patient's weight,

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00:03:25.610 --> 00:03:29.010

to a depth of three centimeters at three o'clock

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00:03:29.010 --> 00:03:31.113

and nine o'clock on the cervix.

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00:03:32.320 --> 00:03:35.210

We recommend that you become familiar with the options

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00:03:35.210 --> 00:03:39.350

for paracervical block in your clinical environment.

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00:03:39.350 --> 00:03:43.320

Once the anesthetic block is placed, check the dilation

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00:03:43.320 --> 00:03:47.310

of the cervix by passing the forceps through the cervix.

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00:03:47.310 --> 00:03:50.740

Additional mechanical dilation may be necessary

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00:03:50.740 --> 00:03:53.503

if insufficient to pass the forceps.

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00:03:54.370 --> 00:03:57.500

Drain the amniotic fluid either passively,

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00:03:57.500 --> 00:04:00.240

by rupturing membranes and retracting the cervix

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00:04:00.240 --> 00:04:04.780

with a ring forcep, or actively, with vacuum aspiration.

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00:04:04.780 --> 00:04:08.080

This reduces the risk of amniotic fluid embolism

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00:04:08.080 --> 00:04:11.610

and facilitates extraction from the lower uterine segment,

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00:04:11.610 --> 00:04:14.260

which lessens the risk of perforation.

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00:04:14.260 --> 00:04:18.150

Continuous procedural ultrasound is generally recommended

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00:04:18.150 --> 00:04:22.890

to guide instrumentation, especially in training settings,

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00:04:22.890 --> 00:04:26.580

however, some experienced providers may not always use

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00:04:26.580 --> 00:04:29.210

ultrasound guidance during the procedure.

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00:04:29.210 --> 00:04:31.800

While maintaining steady traction on the cervix

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00:04:31.800 --> 00:04:35.630

with an atraumatic tenaculum, or similar instrument,

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00:04:35.630 --> 00:04:40.020

the forceps are inserted usually with the blades oriented

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00:04:40.020 --> 00:04:42.883

in the anterior-posterior plane.

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00:04:44.110 --> 00:04:46.660

Once the internal os is traversed

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00:04:46.660 --> 00:04:48.630

and remaining in the lower uterus

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00:04:48.630 --> 00:04:51.370

the jaws of the forceps are opened widely

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00:04:51.370 --> 00:04:54.140

to grasp the presenting fetal part

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00:04:54.140 --> 00:04:57.780

and then withdrawn with steady outward traction

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00:04:57.780 --> 00:04:59.283

while gently rotating.

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00:05:00.180 --> 00:05:04.163

Multiple passes are used to remove the fetus and placenta.

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00:05:05.780 --> 00:05:08.390

This can be a challenging procedure to do

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00:05:08.390 --> 00:05:11.770

and requires training to become competent.

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00:05:11.770 --> 00:05:15.070

During training, operators will learn many techniques

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00:05:15.070 --> 00:05:17.383

to evacuate the uterus safely.

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00:05:18.270 --> 00:05:22.340

For example, as gestational age increases,

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00:05:22.340 --> 00:05:24.880

the passes may become more difficult,

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00:05:24.880 --> 00:05:26.610

and attention needs to be paid

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00:05:26.610 --> 00:05:29.400

to reducing the size of the parts removed.

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00:05:29.400 --> 00:05:33.080

Operators will also learn how much pressure to apply

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00:05:33.080 --> 00:05:35.850

to remove parts safely.

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00:05:35.850 --> 00:05:38.360

The fetal parts in the placenta should be noted

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00:05:38.360 --> 00:05:40.430

as they are removed and inspected

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00:05:40.430 --> 00:05:43.260

afterwards for completeness.

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00:05:43.260 --> 00:05:46.580

A final uterine aspiration is then performed

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00:05:46.580 --> 00:05:49.160

with a manual or electric device

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00:05:49.160 --> 00:05:51.850

to remove any remaining blood or tissue.

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00:05:51.850 --> 00:05:56.163

A sharp curettage may also be done to ensure completeness.

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00:05:57.090 --> 00:05:59.850

The amount of bleeding is then assessed,

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00:05:59.850 --> 00:06:03.710

the cervix inspected for any potential lacerations,

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00:06:03.710 --> 00:06:05.580

and the instruments are removed

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00:06:05.580 --> 00:06:07.980

when haemostasis is confirmed.

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00:06:07.980 --> 00:06:10.370

To decrease risk of infection,

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00:06:10.370 --> 00:06:14.620

we recommend administration of periprocedure antibiotics

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00:06:14.620 --> 00:06:16.690

per your clinic protocol.

114

00:06:16.690 --> 00:06:18.870

After the patient has recovered,

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00:06:18.870 --> 00:06:21.840

detailed instructions should be reviewed with the patient

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00:06:21.840 --> 00:06:25.980

prior to discharge about warning signs and symptoms

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00:06:25.980 --> 00:06:29.270

that should warrant calling the clinic for advice.

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00:06:29.270 --> 00:06:32.960

This concludes our video about performing a safe D&E.

119

00:06:34.010 --> 00:06:36.250

Please see our companion video

120

00:06:36.250 --> 00:06:39.453

of Techniques for Placing Osmotic Dilators.