WEBVTT

1
00:00:00.320 --> 00:00:03.860
- This module in our series
on early pregnancy loss,

2
00:00:03.860 --> 00:00:07.480
will review essential
principles and considerations

3
00:00:07.480 --> 00:00:09.600
for providing management support

4
00:00:09.600 --> 00:00:12.230
for miscarriage completion at home,

5
00:00:12.230 --> 00:00:15.030
and guidelines for follow-up care.

6
00:00:15.030 --> 00:00:17.930
There are four options
for miscarriage management

7
00:00:17.930 --> 00:00:20.470
available to the clinically stable patient

8
00:00:20.470 --> 00:00:22.330
in the first trimester,

9
00:00:22.330 --> 00:00:27.300
defined as up through 12
completed weeks gestational age.

10
00:00:27.300 --> 00:00:28.960
All four are comparable

11
00:00:28.960 --> 00:00:32.010
in safety and acceptability to patients,

12
00:00:32.010 --> 00:00:35.970
making it a preference sensitive decision.

13
00:00:35.970 --> 00:00:39.330
Use of a shared decision-making
model to choose treatment,

14
00:00:39.330 --> 00:00:41.330
and an overview of all options

15
00:00:41.330 --> 00:00:44.740
are discussed in detail
in a separate module.

16
00:00:44.740 --> 00:00:48.940
Here, we will review principles
for safe at-home management

17
00:00:48.940 --> 00:00:52.850
of early pregnancy loss,
either with expecting care,

18
00:00:52.850 --> 00:00:57.190
or the use of medications
to complete a miscarriage.

19
00:00:57.190 --> 00:01:00.640
Patients who choose at-home
care often prioritize

20
00:01:00.640 --> 00:01:04.460
having privacy or a natural
miscarriage experience,

21
00:01:04.460 --> 00:01:07.130
and avoiding an aspiration procedure

22
00:01:07.130 --> 00:01:10.470
with its associated or perceived risks.

23
00:01:10.470 --> 00:01:13.950
When an aspiration requires
a referral to a new provider,

24
00:01:13.950 --> 00:01:17.530
or delay in treatment due
to scheduling constraints,

25
00:01:17.530 --> 00:01:20.310
these barriers may lead patients to choose

26
00:01:20.310 --> 00:01:23.310
at-home management as
they balance priorities

27
00:01:23.310 --> 00:01:26.240
such as work schedules or
childcare availability,

28
00:01:26.240 --> 00:01:28.770
with their preferences for treatment.

29
00:01:28.770 --> 00:01:31.790
Studies have shown that
with clear and accurate

30
00:01:31.790 --> 00:01:34.520
anticipatory guidance, folks experiencing

31
00:01:34.520 --> 00:01:38.000
at-home miscarriages can
have high satisfaction

32
00:01:38.000 --> 00:01:40.190
with their management choice.

33
00:01:40.190 --> 00:01:42.620
The majority of people

experiencing miscarriage

34
00:01:42.620 --> 00:01:45.500
can be safely cared for as an outpatient,

35
00:01:45.500 --> 00:01:49.150
as long as certain management
principles are met,

36
00:01:49.150 --> 00:01:51.190
there is a clear diagnosis of

37
00:01:51.190 --> 00:01:55.030
intrauterine pregnancy loss
in the first trimester,

38
00:01:55.030 --> 00:01:58.540
the patient is hemodynamically stable,

39
00:01:58.540 --> 00:02:02.170
they have access to
phone in emergency care,

40
00:02:02.170 --> 00:02:04.470
they are aware of and comfortable

41
00:02:04.470 --> 00:02:07.760
with available pain control options.

42
00:02:07.760 --> 00:02:10.130
They are also aware of and comfortable

43
00:02:10.130 --> 00:02:13.200
with expectations for bleeding, cramping,

44
00:02:13.200 --> 00:02:16.440
and reasons to return urgently for care,

45

00:02:16.440 --> 00:02:18.270
and they have reliable followup

46
00:02:18.270 --> 00:02:21.770
to confirm completion
of their miscarriage.

47
00:02:21.770 --> 00:02:24.050
From a practice integration perspective,

48
00:02:24.050 --> 00:02:25.870
it is ideal for patients to have

49
00:02:25.870 --> 00:02:28.660
a 24 hour on-call service to reach,

50
00:02:28.660 --> 00:02:31.690
should questions arise during the process.

51
00:02:31.690 --> 00:02:34.270
The triage service may not be experts

52
00:02:34.270 --> 00:02:37.110
in miscarriage management,
but capable of identifying

53
00:02:37.110 --> 00:02:40.690
signs and symptoms
requiring emergency care.

54
00:02:40.690 --> 00:02:44.140
Some notable contraindications
to at-home management

55
00:02:44.140 --> 00:02:46.900
include conditions that may
require tissue collection

56
00:02:46.900 --> 00:02:51.360

for evaluation, such as
suspected molar pregnancy.

57
00:02:51.360 --> 00:02:53.570
Other rare contraindications include

58
00:02:53.570 --> 00:02:56.720
patients who are on anticoagulant therapy

59
00:02:56.720 --> 00:02:59.010
and specific to mifepristone use,

60
00:02:59.010 --> 00:03:03.720
patients with porphyrias or
on chronic steroid therapy.

61
00:03:03.720 --> 00:03:06.390
Generally, aspiration is also preferable

62
00:03:06.390 --> 00:03:08.460
for patients with significant anemia,

63
00:03:08.460 --> 00:03:12.180
or who are experiencing
unexpected severe pain,

64
00:03:12.180 --> 00:03:14.580
bleeding, or signs of infection,

65
00:03:14.580 --> 00:03:18.870
in order to complete the
miscarriage more expeditiously.

66
00:03:18.870 --> 00:03:21.300
Clear and realistic anticipatory guidance,

67
00:03:21.300 --> 00:03:23.920
about the natural history
of pregnancy loss,

68
00:03:23.920 --> 00:03:26.440
and the associated symptoms, is essential

69
00:03:26.440 --> 00:03:29.650
for patient acceptance
of at-home management.

70
00:03:29.650 --> 00:03:32.860
The hallmark of expecting
care is that when bleeding

71
00:03:32.860 --> 00:03:36.140
and cramping will begin is unpredictable.

72
00:03:36.140 --> 00:03:39.070
Medication management gives
the patient more control

73
00:03:39.070 --> 00:03:41.920
over when the miscarriage process begins,

74
00:03:41.920 --> 00:03:45.870
usually within four to six
hours of taking misoprostol.

75
00:03:45.870 --> 00:03:49.940
However, in either case when
a pregnancy is expelled,

76
00:03:49.940 --> 00:03:53.570
symptoms generally follow
a decrescendo pattern,

77
00:03:53.570 --> 00:03:55.550
with the heaviest bleeding coinciding

78
00:03:55.550 --> 00:03:58.240
with the greatest amount

of uterine cramping,

79
00:03:58.240 --> 00:04:00.700
and passage of the pregnancy tissue.

80
00:04:00.700 --> 00:04:03.800
Lighter bleeding may
persist for several days,

81
00:04:03.800 --> 00:04:07.870
or weeks, or until the
next menstrual cycle.

82
00:04:07.870 --> 00:04:09.030
The typical parameter

83
00:04:09.030 --> 00:04:11.230
for what constitutes too much bleeding,

84
00:04:11.230 --> 00:04:14.290
is heavy bleeding that leads
to dizziness or syncope,

85
00:04:14.290 --> 00:04:17.060
or bleeding that soaks
through two thick maxi pads

86
00:04:17.060 --> 00:04:21.390
in an hour for two consecutive
hours without improvement.

87
00:04:21.390 --> 00:04:24.210
Patients should call or
seek care immediately

88
00:04:24.210 --> 00:04:26.670
in these rare scenarios.

89
00:04:26.670 --> 00:04:28.540

The majority of miscarriages occur

90
00:04:28.540 --> 00:04:30.850
at less than eight weeks gestation,

91
00:04:30.850 --> 00:04:32.330
and the pregnancy tissue itself

92
00:04:32.330 --> 00:04:34.420
may not be noticeable when it passes,

93
00:04:34.420 --> 00:04:37.550
but rather obscured by larger blood clots.

94
00:04:37.550 --> 00:04:40.530
However, it is also important to recognize

95
00:04:40.530 --> 00:04:42.760
that the tissue will appear differently,

96
00:04:42.760 --> 00:04:44.390
depending on how far along

97
00:04:44.390 --> 00:04:47.610
development continued before the loss.

98
00:04:47.610 --> 00:04:51.500
Fetal demise over nine weeks
gestation can be visible

99
00:04:51.500 --> 00:04:55.223
to patients as recognizable
fetal tissue when it passes.

100
00:04:56.090 --> 00:04:57.650
Some patients may choose

101
00:04:57.650 --> 00:05:00.890

against at-home management
for this reason.

102
00:05:00.890 --> 00:05:04.290
So it is recommended to
include this when counseling

103
00:05:04.290 --> 00:05:07.830
about management options and expectations.

104
00:05:07.830 --> 00:05:10.010
It is also recommended to make a plan

105
00:05:10.010 --> 00:05:12.340
with the patient about use of analgesics

106
00:05:12.340 --> 00:05:16.463
and other medications or
possible side effects in advance.

107
00:05:17.390 --> 00:05:21.340
NSAIDs are considered by most
as first-line pain control.

108
00:05:21.340 --> 00:05:22.830
Patients can be directed to use

109
00:05:22.830 --> 00:05:24.790
over-the-counter formulations,

110
00:05:24.790 --> 00:05:26.890
or prescribed a higher dose option

111
00:05:26.890 --> 00:05:30.350
like 800 milligram tablets of ibuprofen.

112
00:05:30.350 --> 00:05:33.030
Stronger pain medications like hydrocodone

113
00:05:33.030 --> 00:05:35.550
are infrequently required,

114
00:05:35.550 --> 00:05:38.550
but may be considered at
the provider's discretion.

115
00:05:38.550 --> 00:05:41.960
Misoprostol side effects can
include nausea, vomiting,

116
00:05:41.960 --> 00:05:45.560
diarrhea, low grade fevers,
body aches and chills,

117
00:05:45.560 --> 00:05:48.250
but are generally mild
and should be self limited

118
00:05:48.250 --> 00:05:52.580
to the first two to six
hours after administration.

119
00:05:52.580 --> 00:05:55.190
Any fever beyond the day
of taking misoprostol

120
00:05:55.190 --> 00:05:58.140
should prompt the patient to call you.

121
00:05:58.140 --> 00:06:02.100
As many pregnant people are
already experiencing nausea

122
00:06:02.100 --> 00:06:04.960
and vomiting, prescription
of an anti-emetic

123
00:06:04.960 --> 00:06:08.610

is common with medication
management of EPL,

124
00:06:08.610 --> 00:06:10.560
and patients can be directed to take it

125
00:06:10.560 --> 00:06:14.560
prior to misoprostol and
NSAID use or as needed.

126
00:06:14.560 --> 00:06:16.850
For patients using misoprostol only,

127
00:06:16.850 --> 00:06:20.900
a phone call at 24 to 48 hours after use,

128
00:06:20.900 --> 00:06:24.910
is a good time to assess the
success of that first dose,

129
00:06:24.910 --> 00:06:29.650
and the need of a second
dose if not already taken.

130
00:06:29.650 --> 00:06:34.010
For most patients, an
in-person or tele-health visit

131
00:06:34.010 --> 00:06:37.450
one to two weeks after
initiating a management plan,

132
00:06:37.450 --> 00:06:39.750
is an appropriate time to reassess

133
00:06:39.750 --> 00:06:41.580
for miscarriage completion,

134
00:06:41.580 --> 00:06:44.420

or to discuss alternate treatment options,

135
00:06:44.420 --> 00:06:47.280
should the miscarriage be incomplete.

136
00:06:47.280 --> 00:06:49.140
Those choosing expectant care,

137
00:06:49.140 --> 00:06:52.690
can be offered medication
management at any time,

138
00:06:52.690 --> 00:06:54.840
and some may want to have a prescription

139
00:06:54.840 --> 00:06:58.580
or pills on hand to use in
case they tire of waiting,

140
00:06:58.580 --> 00:07:02.170
without need to return
to your office to do so.

141
00:07:02.170 --> 00:07:04.440
Others will ultimately choose aspiration,

142
00:07:04.440 --> 00:07:06.510
after days or weeks have passed

143
00:07:06.510 --> 00:07:10.080
without successful completion
of the process at home.

144
00:07:10.080 --> 00:07:13.170
We can evaluate for completion
with use of ultrasound

145
00:07:13.170 --> 00:07:15.910
to confirm the absence

of a previously seen

146
00:07:15.910 --> 00:07:20.410
intrauterine pregnancy or
inappropriate hCG decline

147
00:07:20.410 --> 00:07:23.530
documented by serum or urine testing.

148
00:07:23.530 --> 00:07:25.540
When those criteria are met,

149
00:07:25.540 --> 00:07:27.420
as long as bleeding has decreased,

150
00:07:27.420 --> 00:07:29.160
the patient is without pain,

151
00:07:29.160 --> 00:07:32.210
and feels as though they
successfully pass tissue,

152
00:07:32.210 --> 00:07:34.360
the process is complete.

153
00:07:34.360 --> 00:07:36.370
The appearance of the uterine cavity

154
00:07:36.370 --> 00:07:39.970
after successful miscarriage
can be highly variable,

155
00:07:39.970 --> 00:07:43.460
and a thicker stripe is
not cause for concern,

156
00:07:43.460 --> 00:07:46.640
if the patient appears and feels well.

157
00:07:46.640 --> 00:07:49.430
Rather, we use a combination of history

158
00:07:49.430 --> 00:07:51.660
and exam for confirmation.

159
00:07:51.660 --> 00:07:56.160
We treat the whole patient,
not just the ultrasound.

160
00:07:56.160 --> 00:07:58.620
Follow-up visits are
also an important time

161
00:07:58.620 --> 00:08:00.700
to address their future pregnancy goals

162
00:08:00.700 --> 00:08:02.700
and current needs if any,

163
00:08:02.700 --> 00:08:06.990
whether it be for contraception
or preconception care.

164
00:08:06.990 --> 00:08:10.770
Recent studies affirm that
stated pregnancy intention

165
00:08:10.770 --> 00:08:14.830
at the time of miscarriage
diagnosis does not uniformly

166
00:08:14.830 --> 00:08:18.500
predict patients' preferences
for use of contraception

167
00:08:18.500 --> 00:08:20.870
after miscarriage completion.

168
00:08:20.870 --> 00:08:23.970
These researchers concluded
that contraception counseling

169
00:08:23.970 --> 00:08:27.090
and access should be
offered to all patients,

170
00:08:27.090 --> 00:08:29.250
with the understanding that some patients

171
00:08:29.250 --> 00:08:32.800
will choose to defer these conversations.

172
00:08:32.800 --> 00:08:36.350
Importantly, increasing
attention is being given

173
00:08:36.350 --> 00:08:38.130
to the problematic nature

174
00:08:38.130 --> 00:08:43.130
of using the terms planned
or unplanned pregnancies,

175
00:08:43.150 --> 00:08:46.340
and acknowledging that
nuances of intention exist

176
00:08:46.340 --> 00:08:50.510
on a spectrum that includes
ambivalence or incongruence

177
00:08:50.510 --> 00:08:53.780
between stated goals and behaviors.

178
00:08:53.780 --> 00:08:56.530
There is no evidence
supporting a waiting period

179
00:08:56.530 --> 00:08:59.520
before trying to conceive
after miscarriage.

180
00:08:59.520 --> 00:09:04.200
In fact, research shows a
shorter inter-pregnancy interval,

181
00:09:04.200 --> 00:09:07.250
is protective against repeat miscarriage.

182
00:09:07.250 --> 00:09:09.620
Therefore attempts at immediate conception

183
00:09:09.620 --> 00:09:12.000
should not be discouraged.

184
00:09:12.000 --> 00:09:15.260
Encouraging patients to
consider their own emotional

185
00:09:15.260 --> 00:09:18.150
or mental health needs after a miscarriage

186
00:09:18.150 --> 00:09:22.220
in the context of trying to
conceive again may be helpful.

187
00:09:22.220 --> 00:09:24.990
It is also important to
know your local resources

188
00:09:24.990 --> 00:09:27.850
for grief counseling or support groups,

189
00:09:27.850 --> 00:09:30.213
and make referrals as needed.