WEBVTT

1
00:00:03.820 --> 00:00:05.550
- In this module, we will review

2
00:00:05.550 --> 00:00:08.560
a patient-centered approach
to miscarriage management.

3
00:00:08.560 --> 00:00:12.260
There are four relatively
effective and safe options

4
00:00:12.260 --> 00:00:16.570
for early pregnancy loss in
the clinically stable patient.

5
00:00:16.570 --> 00:00:20.950
Expecting care allows a
pregnancy to pass naturally.

6
00:00:20.950 --> 00:00:23.850
Medication management uses pharmacotherapy

7
00:00:23.850 --> 00:00:26.170
to induce the miscarriage process.

8
00:00:26.170 --> 00:00:29.560
And uterine aspiration
can be offered safely

9
00:00:29.560 --> 00:00:34.560
with local anesthesia only
or moderate to deep sedation

10
00:00:34.790 --> 00:00:36.870
depending on the setting, resources,

11
00:00:36.870 --> 00:00:39.570

and patient considerations.

12
00:00:39.570 --> 00:00:42.580
Choosing management is a
preference-sensitive decision,

13
00:00:42.580 --> 00:00:44.720
and a counseling approach
to guide patients

14
00:00:44.720 --> 00:00:46.800
through a shared decision-making process

15
00:00:46.800 --> 00:00:49.340
is reviewed in a separate module.

16
00:00:49.340 --> 00:00:52.500
Honoring preferences can be
done by both primary care

17
00:00:52.500 --> 00:00:54.320
and generalist providers.

18
00:00:54.320 --> 00:00:57.520
In fact, a comprehensive set
of options can be offered

19
00:00:57.520 --> 00:01:00.130
in a typical outpatient setting.

20
00:01:00.130 --> 00:01:02.390
Details about practice
integration can be found

21
00:01:02.390 --> 00:01:06.550
in a separate module and
through our online resources.

22
00:01:06.550 --> 00:01:08.010

For both providers and patients,

23
00:01:08.010 --> 00:01:10.480
having the big picture in
mind about success rates

24
00:01:10.480 --> 00:01:14.160
may be helpful in considering
choices for management.

25
00:01:14.160 --> 00:01:16.100
Ranges are presented here

26
00:01:16.100 --> 00:01:18.270
because of the variability in study design

27
00:01:18.270 --> 00:01:20.170
among EPL treatment trials

28
00:01:20.170 --> 00:01:23.470
and the differences between
different types of EPL.

29
00:01:23.470 --> 00:01:26.410
With expecting care,
incomplete miscarriages,

30
00:01:26.410 --> 00:01:29.630
or those with some bleeding
or passage of pregnancy tissue

31
00:01:29.630 --> 00:01:31.550
at the time of diagnosis

32
00:01:31.550 --> 00:01:33.910
are most likely to reach completion

33
00:01:33.910 --> 00:01:38.513
at rates of 75% to 85%

over one to two weeks.

34
00:01:39.570 --> 00:01:42.640
Anembryonic gestations
and demise are less likely

35
00:01:42.640 --> 00:01:44.090
to spontaneously pass,

36
00:01:44.090 --> 00:01:48.390
with success ranging from
30% to 60% at two weeks.

37
00:01:48.390 --> 00:01:50.840
Medication management
improves completion rates

38
00:01:50.840 --> 00:01:52.940
over expecting care alone.

39
00:01:52.940 --> 00:01:55.240
Incomplete miscarriages
pass with misoprostol

40
00:01:55.240 --> 00:01:57.850
nearly 96% of the time.

41
00:01:57.850 --> 00:02:00.610
In one of the most recent
well-designed studies,

42
00:02:00.610 --> 00:02:03.980
the PreFaiR Trial,
mifepristone pre-treatment

43
00:02:03.980 --> 00:02:08.120
plus misoprostol had a
high success rate of 88%

44

00:02:08.120 --> 00:02:10.620
at the one week follow-up.

45
00:02:10.620 --> 00:02:14.640
Finally, uterine aspiration
is the most definitive option

46
00:02:14.640 --> 00:02:18.290
with a near 100% success rate.

47
00:02:18.290 --> 00:02:21.170
Expecting care is often
called watchful waiting

48
00:02:21.170 --> 00:02:23.180
as it is allowing time

49
00:02:23.180 --> 00:02:26.210
for a natural miscarriage
process to occur.

50
00:02:26.210 --> 00:02:28.410
Large observational
studies have shown waiting

51
00:02:28.410 --> 00:02:32.120
up to eight weeks has the
same low risk of infection

52
00:02:32.120 --> 00:02:34.340
as with other treatment options.

53
00:02:34.340 --> 00:02:37.000
The type of EPL can affect success rates,

54
00:02:37.000 --> 00:02:39.610
but overall this is a
very acceptable option

55

00:02:39.610 --> 00:02:43.220
for patients when they are
given realistic expectations

56
00:02:43.220 --> 00:02:45.460
about the duration of bleeding,

57
00:02:45.460 --> 00:02:47.830
associated uterine discomfort,

58
00:02:47.830 --> 00:02:52.020
and the possibility of needing
a D&C or a uterine aspiration

59
00:02:52.020 --> 00:02:56.130
should a spontaneous
miscarriage not occur.

60
00:02:56.130 --> 00:02:59.390
In our research on patient
experiences with counseling

61
00:02:59.390 --> 00:03:02.450
for EPL management, one
participant we interviewed

62
00:03:02.450 --> 00:03:05.250
praised her provider, as many did,

63
00:03:05.250 --> 00:03:08.770
for providing a candid
account of what to expect

64
00:03:08.770 --> 00:03:11.080
as she felt adequately prepared

65
00:03:11.080 --> 00:03:14.560
when the physical symptoms of
miscarriage began suddenly.

66
00:03:14.560 --> 00:03:17.580
She told us, the doctor said
that a natural miscarriage

67
00:03:17.580 --> 00:03:20.590
will come when you least
expect it, at the wrong place,

68
00:03:20.590 --> 00:03:21.950
and at the wrong time

69
00:03:21.950 --> 00:03:24.090
and that's exactly what happened to me.

70
00:03:24.090 --> 00:03:26.220
She told me things that an actual person

71
00:03:26.220 --> 00:03:28.670
that went through it would tell you.

72
00:03:28.670 --> 00:03:30.600
Patients who choose expectant management

73
00:03:30.600 --> 00:03:33.370
often prefer to let nature take its course

74
00:03:33.370 --> 00:03:37.290
and avoid an invasive
procedure and associated risks.

75
00:03:37.290 --> 00:03:40.810
However, disadvantages
include an unpredictable time

76
00:03:40.810 --> 00:03:43.600
to completion and symptoms
of bleeding and cramping

77

00:03:43.600 --> 00:03:46.150
can be prolonged over days to weeks.

78
00:03:46.150 --> 00:03:48.860
And of course, despite
waiting, a uterine aspiration

79
00:03:48.860 --> 00:03:51.450
may still be needed to
complete the process.

80
00:03:51.450 --> 00:03:53.650
Use of medications for EPL management

81
00:03:53.650 --> 00:03:56.240
actively induces the miscarriage process.

82
00:03:56.240 --> 00:04:00.300
The most effective regimen
established by the PreFaiR study,

83
00:04:00.300 --> 00:04:04.100
a multi-site randomized control
trial includes pretreatment

84
00:04:04.100 --> 00:04:07.940
with mifepristone followed
by use of misoprostol.

85
00:04:07.940 --> 00:04:11.170
This combination was shown
to be safe and more effective

86
00:04:11.170 --> 00:04:13.690
than use of misoprostol alone in achieving

87
00:04:13.690 --> 00:04:17.770
more timely completion and
avoiding an aspiration procedure.

88
00:04:17.770 --> 00:04:21.440
With a higher success rate, it
is also highly cost effective

89
00:04:21.440 --> 00:04:24.260
to use mifepristone pretreatment.

90
00:04:24.260 --> 00:04:27.840
Misoprostol is the prostaglandin
analogue most commonly used

91
00:04:27.840 --> 00:04:29.570
for treatment of miscarriage.

92
00:04:29.570 --> 00:04:32.700
It stimulates uterine contractions
and softens the cervix

93
00:04:32.700 --> 00:04:34.600
for expulsion of the pregnancy tissue.

94
00:04:35.530 --> 00:04:38.580
Misoprostol is more readily
available in many settings

95
00:04:38.580 --> 00:04:41.850
than mifepristone and can be
used alone for EPL treatment

96
00:04:41.850 --> 00:04:44.300
when mifepristone is not accessible.

97
00:04:44.300 --> 00:04:46.820
Mifepristone primes the
myometrium and cervix

98
00:04:46.820 --> 00:04:49.640
for prostaglandin activity,
making the misoprostol

99
00:04:49.640 --> 00:04:53.120
more effective at expulsion
of the pregnancy tissue.

100
00:04:53.120 --> 00:04:55.170
Details about medication dosing,

101
00:04:55.170 --> 00:04:58.320
key anticipatory guidance,
and follow up evaluation

102
00:04:58.320 --> 00:05:00.670
for patients choosing
medication management

103
00:05:00.670 --> 00:05:04.030
or expecting care can be
found in our separate modules

104
00:05:04.030 --> 00:05:07.610
on at home and medication
management of EPL.

105
00:05:07.610 --> 00:05:10.740
People with miscarriage who
choose medication management

106
00:05:10.740 --> 00:05:13.100
often prefer the increased predictability

107
00:05:13.100 --> 00:05:14.830
over expecting care alone,

108
00:05:14.830 --> 00:05:18.630
but still with a private at
home miscarriage experience

109
00:05:18.630 --> 00:05:21.560

with its higher success rates,
patients can avoid the need

110
00:05:21.560 --> 00:05:24.100
for multiple follow-up
visits that sometimes occur

111
00:05:24.100 --> 00:05:27.790
during a prolonged period
of watchful waiting.

112
00:05:27.790 --> 00:05:31.030
Disadvantages include an
increased need for analgesics

113
00:05:31.030 --> 00:05:32.430
to alleviate cramps

114
00:05:32.430 --> 00:05:34.490
that are often stronger with misoprostol

115
00:05:34.490 --> 00:05:36.530
and other medications
for drug side effects

116
00:05:36.530 --> 00:05:38.750
particularly GI upset.

117
00:05:38.750 --> 00:05:41.520
Uterine evacuation for
EPL was historically done

118
00:05:41.520 --> 00:05:44.730
in an operating room out of
concern for complications

119
00:05:44.730 --> 00:05:47.130
frequently seen when abortion was illegal

120

00:05:47.130 --> 00:05:49.860
and clandestine abortion
attempts were more common.

121
00:05:49.860 --> 00:05:53.080
However, now the majority
of patients in the US

122
00:05:53.080 --> 00:05:57.000
present with EPM non-emergently
and in stable condition

123
00:05:57.000 --> 00:05:59.990
making it safe to perform
in outpatient settings.

124
00:05:59.990 --> 00:06:03.000
You may hear a variety
of terms used to describe

125
00:06:03.000 --> 00:06:07.080
the same procedure, D&C
or dilation and curettage

126
00:06:07.080 --> 00:06:09.980
is still widely used
despite the diminishing use

127
00:06:09.980 --> 00:06:11.100
of sharp curates.

128
00:06:11.100 --> 00:06:14.680
Instead, most providers are
performing a cervical dilation

129
00:06:14.680 --> 00:06:19.320
and suction curettage with
either a manual uterine aspirator

130
00:06:19.320 --> 00:06:20.700

shown here on the left

131
00:06:20.700 --> 00:06:24.460
or an electric vacuum
aspirator shown on the right.

132
00:06:24.460 --> 00:06:27.130
There are some advantages
to performing an aspiration

133
00:06:27.130 --> 00:06:28.880
in the operating room.

134
00:06:28.880 --> 00:06:31.820
Primarily when it is the
patient's preference to be asleep

135
00:06:31.820 --> 00:06:33.560
or have deep sedation.

136
00:06:33.560 --> 00:06:35.370
The other advantages in the operating room

137
00:06:35.370 --> 00:06:37.800
are true of aspiration in any setting

138
00:06:37.800 --> 00:06:41.760
as it provides a predictable
and rapid resolution to EPL

139
00:06:41.760 --> 00:06:44.050
with minimal post-procedure bleeding

140
00:06:44.050 --> 00:06:47.460
or need for further
treatment or intervention.

141
00:06:47.460 --> 00:06:51.500
However, there are disadvantages

to relegating the simple,

142
00:06:51.500 --> 00:06:53.980
five-minute procedure
to the operating room.

143
00:06:53.980 --> 00:06:56.360
The cost is significantly higher.

144
00:06:56.360 --> 00:06:58.690
There are additional but infrequent risks

145
00:06:58.690 --> 00:07:01.630
associated with general
anesthesia or deep sedation.

146
00:07:01.630 --> 00:07:04.600
And in most cases, patients
will spend more time

147
00:07:04.600 --> 00:07:07.340
in the hospital than
for procedures performed

148
00:07:07.340 --> 00:07:09.090
in an office setting.

149
00:07:09.090 --> 00:07:11.440
Advantages of an office-based aspiration

150
00:07:11.440 --> 00:07:13.470
over that in an operating room include

151
00:07:13.470 --> 00:07:15.880
these resource and cost savings.

152
00:07:15.880 --> 00:07:19.190
Additionally, when procedures
can be performed in a setting

153
00:07:19.190 --> 00:07:22.220
familiar to the patient and
do not have to be worked

154
00:07:22.220 --> 00:07:24.450
into a busy operating room schedule,

155
00:07:24.450 --> 00:07:26.770
there can be improved patient access

156
00:07:26.770 --> 00:07:28.890
and continuity of care as well.

157
00:07:28.890 --> 00:07:31.610
Aspiration can be offered
safely and comfortably

158
00:07:31.610 --> 00:07:36.340
with local anesthesia plus
either oral or IV analgesia

159
00:07:36.340 --> 00:07:39.770
or sedation, which honors the
preference of many patients

160
00:07:39.770 --> 00:07:43.960
to avoid the risks and side
effects of general anesthesia.

161
00:07:43.960 --> 00:07:47.440
There are four distinct
management options for EPL

162
00:07:47.440 --> 00:07:50.830
that are safe and acceptable to patients.

163
00:07:50.830 --> 00:07:54.260
Choosing treatment is a

preference-sensitive decision

164
00:07:54.260 --> 00:07:58.730
and patients have strong and
widely divergent preferences.

165
00:07:58.730 --> 00:08:03.020
A comprehensive and
patient-centered model for EPL care,

166
00:08:03.020 --> 00:08:05.420
makes aspiration, medication,

167
00:08:05.420 --> 00:08:08.893
and expected management available
in the outpatient setting.