MANUAL VACUUM ASPIRATION (MVA) FOR TREATMENT MISCARRIAGE AND RETAINED PREGNANCY TISSUE – CLINICAL GUIDELINE

1. Aim/Purpose of this Guideline

   All clinical staff working in the Division of women, children & sexual health to provide evidence based guidance in the management of MVA for Miscarriage and Retained Pregnancy Tissue

2. The Guidance

   Provide information leaflet on MVA

   The procedure, risks and alternatives should be explained to the patient and all questions answered.

   Pain control during the procedure should be discussed:

   The woman may be advised to take an analgesic 1 hour prior to her appointment at the clinic/unit. Suitable options include:

   Paracetamol 1g AND Ibuprofen 400mg, or Cocodamol 8mg/500mg (1-2 Tablets)

   Alternatively oral Ibuprofen can be provided at the treatment unit

   Entonox will be available to the patient throughout the procedure

   Para-cervical local anaesthetic will be provided unless patient has an allergy or declines

   The woman should be advised that a health professional will be at her side during the procedure providing reassurance and support

   Informed consent must be obtained. * On pre-printed approved consent form (Appendix 3) to include disposal consent for sensitive disposal of pregnancy tissue.

   Prescribe Misoprostol 400mg to be taken (orally / vaginally) 2 hours prior to the procedure

   Medical history, physical examination and Laboratory evaluation

   Complete proforma

   Any patient with a complex medical history, where suitability is not clear, should have her case reviewed by a consultant

   Pre-procedure blood testing is typically undertaken prior to MVA.
• **Haemoglobin** should be obtained for any patient where there is a significant history of anaemia or concern about anaemia based on clinical signs and symptoms.

• **Rhesus status** must be obtained and if Rhesus negative, **Anti-D Immunoglobulin provided on the day of treatment.**

**Treatment**

**2.1 Patient Preparation**

• Before the treatment begins, the woman should be introduced to the nurse/assistant and doctor, the procedure should be reviewed with her, including the use and benefits of entonox and any questions she has should be answered.
• The treatment doctor should review the woman’s medical history, gestational age dating (i.e. ultrasound).
• An initial set of observations (pulse and blood pressure) should be taken and recorded in the case notes.
• The woman should be asked to void shortly before the procedure; urinary bladder catheterisation is not recommended.
• The woman should be allowed some privacy to remove her underwear, undress from the ‘waist down’ or be provided with a gown, whichever is her preference.
• The woman should be assisted onto the treatment couch and her legs put into the supports. The hips should be flexed to about 45° and care should be taken in maintaining symmetry of leg positions.
• The woman should be kept covered until the doctor is ready to proceed.
• An entonox mask or mouthpiece should be offered to the woman and instructions on its use provided.

**2.2 Uterine evacuation**

• A bimanual pelvic examination should be performed to assess the uterine size and position or the USS reviewed to gain this information.
• In cases of known uterine anomaly, large fibroids, or an ante-retroflexed uterus, the use of continuous transabdominal ultrasound guidance during the procedure may be helpful.
• After introduction of a vaginal speculum, the vagina and cervix should be cleaned with a non spirit based preparation.
• A tenaculum should be placed on the cervix to stabilise and align the cervical canal and uterine cavity during the procedure. Injection of 1% Prilocaine at the site where the tenaculum will be placed can reduce discomfort from applying the instrument.
• Intra or para cervical infiltration of 1% Prilocaine (Citanest) or equivalent is recommended: instillation of intra-cervical Lidocaine gel is an option.
• The appropriate cannula and aspirator should be chosen.
MVA cannulas are made of rigid plastic and come in a range of sizes up to 12mm in diameter. Typically, the size of the cannula used would match the gestational age in weeks. However, practitioners are often able to successfully and completely evacuate the uterus with cannula of smaller diameter: this may avoid the need for cervical dilation and may be more comfortable for the woman.

- If dilatation is necessary, the cervix should be dilated to the minimum necessary to insert a cannula of the appropriate size.
- Insert the cannula gently through the cervix into the uterine cavity, just passed the internal os; rotating the cannula with gentle pressure often helps ease insertion.
- Attach the charged 60ml self locking syringe to the cannula. Make sure that the cannula does not move forward into the uterus as you attach the syringe. Alternatively, treatment doctors may attach the charged syringe to the cannula before inserting the cannula into the cervical os.
- Never grasp the syringe by the plunger arms after the syringe has been charged.
- Advance the cannula until it gently touches the fundus and then withdraw it slightly.
- Open the valve(s) so that the vacuum is applied to the uterine cavity.
- Move the cannula gently back and forth from the fundus to the internal cervical os while rotating it to aspirate all sections of the uterus.
- Withdrawing the cannula apertures beyond the cervical os will cause the vacuum to be lost. If the cannula becomes clogged and must be removed or if it passes the os accidentally, the aspirator must be emptied and ‘recharged’. It is sometimes more efficient to have more than one ‘charged’ aspirator available for use, particularly at higher gestations.
- The aspiration process is complete when no further tissue is seen passing through the cannula. Other signs of complete aspiration are when pinkish foam is seen passing through the cannula, a gritty sensation is felt as the cannula passes over the surface of the evacuated uterus, and the uterus contracts around the cannula.
- Typically, the vaginal speculum will be removed prior to examination of the aspirate. If there is any concern regarding completion of the aspiration, the woman should remain in the treatment room until the products have been examined.
- A transabdominal or transvaginal scan should now be performed and documentation of endometrial appearance and thickness made. To be deemed a success, the absence of a gestation sac (if previously seen) and endometrial thickness of <15mm would be expected.

2.3 Tissue Examination

- The evacuated tissue must be examined
- Empty the contents of the evacuation into an appropriate container by removing the cannula, releasing the buttons if not depressed, and gently pushing the plunger completely into the cylinder. Do not push aspirated contents through the cannula.
- Tissue may only be viewed directly in the container into which it was
emptied.
- If the sac is not identified, perform a vaginal ultrasound. If no sac is seen in the uterus, send tissue for histology and refer client immediately for evaluation of possible ectopic pregnancy. If a sac is seen, reaspirate. Consider continuous ultrasound guidance throughout aspiration.
- If MVA has been performed for retained products of conception or haemotometra, a gestational sac may not be seen. Documentation of what was visualised should occur. Post-procedure ultrasound may also be helpful to document that the aspiration was complete.
- All tissue is sent for histological evaluation (unless woman declines) and MUST be accompanied by a signed cremation form. (Appendix 4)

2.4 Post-procedure care

- When the treatment doctor confirms that the treatment is complete, the woman is assisted from the couch, allowed to rest and taken from to a recliner chair to recover.
- As a minimum, one set of post-procedure observations should be recorded in the case notes.
- Refreshment is offered to the woman at an appropriate time.
- Check woman’s Rhesus status and if non-sensitised Rhesus negative, administer Anti D
- When the patient is fully recovered, she can be discharged by the nurse.

Duration of stay in the clinic/unit

- Procedure duration is typically 10-15 minutes and recovery time 30-45 minutes.

Anti-biotic prophylaxis

- Anti-biotic prophylaxis should be provided to all clients prior to MVA. 1g oral azithromycin and 400mg oral metronidazole

Aftercare

- A routine follow up appointment is not necessary after an uncomplicated procedure. A pregnancy test at 3 weeks is not recommended after MVA.

Persistent bleeding following discharge

- Persistent bleeding and/or cramping post-procedure may be a sign of retained products of conception or another complication. The patient should return for evaluation.
3. Monitoring compliance and effectiveness

<table>
<thead>
<tr>
<th>Element to be monitored</th>
<th>Audit of outcome and patient experience feedback</th>
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</thead>
<tbody>
<tr>
<td>Lead</td>
<td>Miss Lisa Verity, Consultant O&amp;G</td>
</tr>
<tr>
<td>Tool</td>
<td>EGU &amp; miscarriage databases and patient questionnaire</td>
</tr>
<tr>
<td>Frequency</td>
<td>Annually EGU &amp; EPU MDT</td>
</tr>
<tr>
<td>Reporting arrangements</td>
<td>EGU / EPU MDT</td>
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<td></td>
<td>Dashboard</td>
</tr>
<tr>
<td></td>
<td>Women’s &amp; Newborn Audit meeting</td>
</tr>
<tr>
<td>Acting on recommendations and Lead(s)</td>
<td>EGU &amp; EPU MDT</td>
</tr>
<tr>
<td>Change in practice and lessons to be shared</td>
<td>Required changes to practice will be identified and actioned within 3 months. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders</td>
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4. Equality and Diversity

a. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the 'Equality, Diversity & Human Rights Policy' or the Equality and Diversity website.

b. Equality Impact Assessment

The Initial Equality Impact Assessment Screening Form is at Appendix 2.
### Appendix 1. Governance Information

<table>
<thead>
<tr>
<th>Document Title</th>
<th>Protocol For Manual Vacuum Aspiration (MVA) For Treatment Miscarriage And Retained Pregnancy Tissue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date Issued/Approved:</td>
<td>11/04/2017</td>
</tr>
<tr>
<td>Date Valid From:</td>
<td>08/06/2017</td>
</tr>
<tr>
<td>Date Valid To:</td>
<td>08/06/2020</td>
</tr>
</tbody>
</table>
| Directorate / Department responsible (author/owner): | Miss Lisa Verity  
Consultant O&G |
| Contact details: | 01872 252685 |
| Brief summary of contents | All clinical staff working in the Division of women, children & sexual health to provide evidence based guidance in the management of Manual Vacuum Aspiration (MVA) |
| Suggested Keywords: | Manual Vacuum Aspiration MVA  
Miscarriage |
| Target Audience | RCHT  
PCH  
CFT  
KCCG |
| Executive Director responsible for Policy: | Medical Director |
| Date revised: | 11/04/2017 |
| This document replaces (exact title of previous version): | Protocol For Manual Vacuum Aspiration (MVA) For Treatment Miscarriage And Retained Pregnancy Tissue |
| Approval route (names of committees)/consultation: | Obstetric & Gynaecology Directorate meeting |
| Divisional Manager confirming approval processes | Miss Karen Watkins |
| Name and Post Title of additional signatories | Not Required |
| Signature of Executive Director giving approval | {Original Copy Signed} |
| Publication Location (refer to Policy on Policies – Approvals and Ratification): | Internet & Intranet |
| Document Library Folder/Sub Folder | Clinical / Gynaecology |
| Links to key external standards | Ectopic pregnancy & miscarriage: Diagnosis and initial management in early pregnancy of
ectopic pregnancy & miscarriage. NICE clinical guideline 154. Dec 2012

Related Documents: List other guidelines & hyperlink guidelines in document library

Training Need Identified? No

### Version Control Table

<table>
<thead>
<tr>
<th>Date</th>
<th>Version No</th>
<th>Summary of Changes</th>
<th>Changes Made by (Name and Job Title)</th>
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<tr>
<td>11 Jun 14</td>
<td>V1.0</td>
<td>Initial Issue</td>
<td>Lee Azancot</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Data Administrator</td>
</tr>
<tr>
<td>2 Mar 17</td>
<td>V1.1</td>
<td>Addition of Appendices 3 + 4</td>
<td>Lisa Verity</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Consultant</td>
</tr>
</tbody>
</table>

All or part of this document can be released under the Freedom of Information Act 2000

This document is to be retained for 10 years from the date of expiry.

This document is only valid on the day of printing

**Controlled Document**

This document has been created following the Royal Cornwall Hospitals NHS Trust Policy on Document Production. It should not be altered in any way without the express permission of the author or their Line Manager.
## Appendix 2. Initial Equality Impact Assessment Form

| Name of the strategy / policy / proposal / service function to be assessed (hereafter referred to as *policy*) (Provide brief description): MANUAL VACUUM ASPIRATION (MVA) FOR TREATMENT MISCARRIAGE AND RETAINED PREGNANCY TISSUE – CLINICAL GUIDELINE |
| Directrorate and service area: Gynaecology | Is this a new or existing Policy? Existing |
| Name of individual completing assessment: Miss Lisa Verity | Telephone: 01872 252685 |

1. Policy Aim*  
Who is the strategy / policy / proposal / service function aimed at?  
All clinical staff working in the Division of women, children & sexual health to provide evidence based guidance in the management of Manual Vacuum Aspiration (MVA)

2. Policy Objectives*  
As above

3. Policy – intended Outcomes*  
As above

4. *How will you measure the outcome?  
See section 3

5. Who is intended to benefit from the policy?  
All obs & gynae patients

6a) Is consultation required with the workforce, equality groups, local interest groups etc. around this policy?  
No

b) If yes, have these *groups been consulted?  

C). Please list any groups who have been consulted about this procedure.

### 7. The Impact
Please complete the following table.

Are there concerns that the policy **could** have differential impact on:

<table>
<thead>
<tr>
<th>Equality Strands:</th>
<th>Yes</th>
<th>No</th>
<th>Rationale for Assessment / Existing Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>X</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Clinical Guideline Template
|Sex (male, female, transgender / gender reassignment) | X |
|Race / Ethnic communities / groups | X |
|Disability - learning disability, physical disability, sensory impairment and mental health problems | X |
|Religion / other beliefs | X |
|Marriage and civil partnership | X |
|Pregnancy and maternity | X |
|Sexual Orientation, Bisexual, Gay, heterosexual, Lesbian | X |

You will need to continue to a full Equality Impact Assessment if the following have been highlighted:
- You have ticked “Yes” in any column above and
- No consultation or evidence of there being consultation- this excludes any policies which have been identified as not requiring consultation. or
- Major service redesign or development

8. Please indicate if a full equality analysis is recommended. Yes No

9. If you are not recommending a Full Impact assessment please explain why.

Signature of policy developer / lead manager / director

Date of completion and submission

Names and signatures of members carrying out the Screening Assessment
1. Miss Lisa Verity
2. 

Keep one copy and send a copy to the Human Rights, Equality and Inclusion Lead, c/o Royal Cornwall Hospitals NHS Trust, Human Resources Department, Knowledge Spa, Truro, Cornwall, TR1 3HD

A summary of the results will be published on the Trust’s web site.

Signed ____________________

Date ____________________
APPENDIX 3

CONSENT FORM 1 (Patient copy)  
Procedure Specific Patient Agreement

Manual Vacuum Aspiration 'MVA'
operation to remove pregnancy tissue from within the womb, under local anaesthetic

STATEMENT OF HEALTH PROFESSIONAL (to be filled in by health professional with appropriate knowledge of proposed procedure, as specified in consent policy)

I have explained the procedure to the patient. In particular, I have explained the intended benefits and summarised the risks, as below:
• To treat miscarriage

Significant, unavoidable or frequently occurring risks:
• infection (may require antibiotics 3 in 100 women)
Bleeding (usually a little heavier and more prolonged than a period would be, heavy bleeding uncommon 1-2 in 1000 women)
Repeat operation (if all the pregnancy tissue not removed 5 in 100 women)
Feeling faint

Uncommon but more serious risks:
• reaction to local anaesthetic
surgical complications (e.g. perforation of womb up to 5 in 1000 which may very rarely lead to damage of internal organs), trauma to cervix

Any extra procedures which may become necessary during the procedure:
• Blood transfusion rarely required - only if particularly heavy bleeding
• Other procedure (please specify): Rarely during the operation a hole can be made in the womb. If this happened, a laparoscopy (keyhole surgery) or laparotomy (open operation) may be required to repair any injury.

I have also discussed what the procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment) and any particular concerns of this patient.

I have given and discussed the Trust's approved patient information leaflet for this procedure, reference number CHA1249, along with a copy of this consent

I am satisfied that this patient has the capacity to consent to the procedure.

This procedure will involve:
General and/or regional anaesthesia □ Local anaesthesia ☒ Sedation □

Health Professional signature: ____________________________________________________________ Date: ______________________

Name (PRINT): ___________________________ Job title: ___________________________

STATEMENT OF INTERPRETER (where appropriate)
I have interpreted the information above to the patient to the best of my ability and in a way in which I believe he/she can understand.

Interpreter signature: ___________________________ Name (PRINT): ___________________________ Date: ______________________
Manual Vacuum Aspiration 'MVA'

STATEMENT OF PATIENT

Please read this form carefully. If your treatment has been planned in advance, you should already have your own copy of page one which describes the benefits and risks of the proposed treatment. If not, you will be offered a copy now. If you have any further questions, do ask – we are here to help you. You have the right to change your mind at any time, including after you have signed this form.

I agree to the procedure or course of treatment describe on this form.

I understand that you cannot give me a guarantee that a particular person will perform the procedure. The person will, however, have appropriate experience.

I understand that I will have the opportunity to discuss the details of anaesthesia with an anaesthetist before the procedure, unless the urgency of my situation prevents this. (This only applies to patients having general or regional anaesthesia).

I understand that any procedure in addition to those described on this form will only be carried out if it is necessary to save my life or to prevent serious harm to my health.

I understand tissue samples may be taken for analysis and kept as part of my patient record. Any sample arising from a pregnancy will be treated with dignity and respect. The hospital will arrange for collective cremation of the products of conception (unless otherwise indicated here that a separate consent has been taken

☐ I have been told about additional procedures which may become necessary during my treatment.

I have listed below any procedures which I do not wish to be carried out without further discussion.

I have received a copy of the Consent Form and Patient Information leaflet CHA1249 which forms part of this document.

Patient signature: Name (PRINT): Date:

A witness should sign below if this patient is unable to sign but has indicated his or her consent. Young people/children may also like a parent to sign here (see guidance notes).

Witness signature: Name (PRINT): Date:

CONFIRMATION OF CONSENT (to be completed by health professional when the patient is admitted for the procedure, if the patient has signed the form in advance).

On behalf of the team treating the patient, I have confirmed with the patient that they have no further questions and wish the procedure to go ahead.

Health Professional signature: Date:

Name (PRINT): Job title:

Important notes (tick if applicable - ask patient to sign/date here):

☐ See advance decision to refuse treatment  ☐ Patient has withdrawn consent

Patient signature: Name (PRINT): Date
Manual Vacuum Aspiration 'MVA'

operation to remove pregnancy tissue from within the womb, under local anaesthetic

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- Repeat operation (if all the pregnancy tissue not removed 5 in 100 women)
- Feeling faint

Uncommon but more serious risks:

- Reaction to local anaesthetic
- Surgical complications (e.g., perforation of womb up to 5 in 1000 which may very rarely lead to damage of internal organs), trauma to cervix

Any extra procedures which may become necessary during the procedure:

- Blood transfusion rarely required - only if particularly heavy bleeding
- Other procedure (please specify): Rarely during the operation a hole can be made in the womb. If this happened, a laparoscopy (keyhole surgery) or laparotomy (open operation) may be required to repair any injury.

I have also discussed what the procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment) and any particular concerns of this patient.

I have given and discussed the Trust’s approved patient information leaflet for this procedure, reference number CHA1249, along with a copy of this consent.

I am satisfied that this patient has the capacity to consent to the procedure.

This procedure will involve:

General and/or regional anaesthesia [ ] Local anaesthesia [X] Sedation [ ]

Health Professional signature: ___________________________ Date: ___________________________

Name (PRINT): ___________________________ Job title: ___________________________

STATEMENT OF INTERPRETER (where appropriate)

I have interpreted the information above to the patient to the best of my ability and in a way in which I believe he/she can understand.

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I agree to the procedure or course of treatment describe on this form.

I understand that you cannot give me a guarantee that a particular person will perform the procedure. The person will, however, have appropriate experience.

I understand that I will have the opportunity to discuss the details of anaesthesia with an anaesthetist before the procedure, unless the urgency of my situation prevents this. (This only applies to patients having general or regional anaesthesia).

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I understand tissue samples may be taken for analysis and kept as part of my patient record. Any sample arising from a pregnancy will be treated with dignity and respect. The hospital will arrange for collective cremation of the products of conception (unless otherwise indicated here that a separate consent has been taken)

I have been told about additional procedures which may become necessary during my treatment. I have listed below any procedures which I do not wish to be carried out without further discussion.

I have received a copy of the Consent Form and Patient Information leaflet CHA1249 which forms part of this document.

Patient signature: __________________________ Name (PRINT): __________________________ Date: __________

A witness should sign below if this patient is unable to sign but has indicated his or her consent. Young people/children may also like a parent to sign here (see guidance notes).

Witness signature: __________________________ Name (PRINT): __________________________ Date: __________

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On behalf of the team treating the patient, I have confirmed with the patient that they have no further questions and wish the procedure to go ahead.

Health Professional signature: __________________________ Date: __________

Name (PRINT): __________________________ Job title: __________________________

Important notes (tick if applicable - ask patient to sign/date here):
□ See advance decision to refuse treatment  □ Patient has withdrawn consent

Patient signature: __________________________ Name (PRINT): __________________________ Date: __________
Appendix 5. Certificate of Medical Practitioner or Midwife in Respect of Fetal Remains

Clini

Certifi
ti

Collecti

Crematory

Cornwall Council
PENMOUNT CREMATORY, TRURO
Tel 01872 272871

CERTIFICATE OF MEDICAL PRACTITIONER OR MIDWIFE IN RESPECT OF FETAL REMAINS

(The products of conception expelled from the uterus before 24 weeks gestation which showed no visible signs of life)

I hereby certify that I have examined the fetal remains whose details are shown below:

Delivered on: ...........................................(Date) at ............................................ am/pm of ............................................ weeks gestation and which at no time showed any visible signs of life. Place of delivery ............................................

I have no reason to suspect that the duration of pregnancy was shortened by violence, poison or any unlawful act and I know of no reason why any further examination or enquiry should be made.

Tick one box

I confirm that informed written consent for collective cremation has been obtained. (Complete sections A & B)  ☐

I confirm that informed written consent for a private funeral has been obtained. The mother/parents understand that they may contact the Hospital Bereavement Office to discuss the options available and/or any financial concerns they may have. (Complete sections A & C)  ☐

A) Doctor/Midwife details

Print Name............................................................ Signature............................................................

Registered qualifications ............................................................ Date ............................................................

Workplace ............................................................ Tel. ............................................................

(Mother’s details to be removed by bereavement office if remains are for collective cremation)

Funeral Arrangements

As explained these are the options available to you, please indicate your preference below:

B) The mother/parents would like the hospital to arrange collective cremation by means of a monthly collective cremation together with other tissue of conception only.  ☐

C) The mother/parents would like to make private funeral arrangements. They will instruct a funeral director and advise the bereavement office accordingly within one month.  ☐

Affix Patient Label

Procedure for the sensitive disposal of pre-24 week fetal tissue

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