Manual Vacuum Aspiration (MVA) for Treatment of Miscarriage and Retained Pregnancy Tissue Clinical Guideline

V3.0

August 2023
1. **Aim/Purpose of this Guideline**

1.1. All clinical staff working in the Women and Children Care Group to provide evidence based guidance in the management of MVA for Miscarriage and Retained Pregnancy Tissue.

1.2. This version supersedes any previous versions of this document.

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### Data Protection Act 2018 (General Data Protection Regulation – GDPR) Legislation

The Trust has a duty under the Data Protection Act 2018 and General Data Protection Regulations 2016/679 to ensure that there is a valid legal basis to process personal and sensitive data. The legal basis for processing must be identified and documented before the processing begins. In many cases we may need consent; this must be explicit, informed, and documented. We cannot rely on opt out, it must be opt in.

Data Protection Act 2018 and General Data Protection Regulations 2016/679 is applicable to all staff; this includes those working as contractors and providers of services.

For more information about your obligations under the Data Protection Act 2018 and General Data Protection Regulations 2016/679 please see the Information Use Framework Policy or contact the Information Governance Team

Royal Cornwall Hospital Trust  
rch-tr.infogov@nhs.net

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2. **The Guidance**

2.1. Provide information leaflet titled ‘Surgical Management of your miscarriage under local anaesthetic’ RCHT1249.

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

2.3. 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 or Penthrox will be available to the patient throughout the procedure.
- Para-cervical local anaesthetic will be provided unless patient has an allergy or declines.

2.4. The woman should be advised that a health professional will be at her side during the procedure providing reassurance and support.
2.5. Informed consent must be obtained on pre-printed approved consent form (Appendix 3) to include disposal consent for sensitive disposal of pregnancy tissue.

2.6. Prescribe Misoprostol 400 micrograms to be taken vaginally 3 hours before the procedure of buccally / sublingually one hour prior to procedure.

2.7. Medical history, physical examination and Laboratory evaluation

2.7.1. Complete EGU proforma.

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

2.7.3. Pre-procedure blood testing is NOT typically undertaken prior to MVA unless:

- There is a significant history of anaemia or concern about anaemia based on clinical signs and symptoms.
- Rhesus status is unknown.

2.8. Treatment

2.8.1. Patient Preparation

2.8.1.1. Before the treatment begins, the woman should be introduced to the staff, the procedure should be reviewed with her, including the use and benefits of entonox or penthrox and any questions she has should be answered.

2.8.1.2. The treatment practitioner should review the woman’s medical history, gestational age dating (i.e., ultrasound) and confirm consent.

2.8.1.3. The woman should be asked to void shortly before the procedure; urinary bladder catheterisation is not recommended.

2.8.1.4. 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.

2.8.1.5. 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.

2.8.1.6. The woman should be kept covered until the practitioner is ready to proceed.

2.8.1.7. An Entonox or penthrox mouthpiece should be offered to the woman and instructions on its use provided.
2.8.2. **Uterine Evacuation**

2.8.2.1. A bimanual pelvic examination can be performed to assess the uterine size and position, or the USS reviewed to gain this information.

2.8.2.2. 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.

2.8.2.3. After introduction of a vaginal speculum, the vagina and cervix should be cleaned with a non-spirit based preparation.

2.8.2.4. A tenaculum may 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.

2.8.2.5. A deep para-cervical block (see training slides in EGU) of 1% Prilocaine (Citanest) or equivalent is recommended: instillation of intra-uterine Lidocaine gel is recommended.

2.8.2.6. 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.

2.8.2.7. If dilatation is necessary, the cervix should be dilated to the minimum necessary to insert a cannula of the appropriate size.

2.8.2.8. 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.

2.8.2.9. 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, the cannula could be attached to the charged syringe before inserting the cannula into the cervical os.

2.8.2.10. Never grasp the syringe by the plunger arms after the syringe has been charged.

2.8.2.11. Advance the cannula until it gently touches the fundus and then withdraw it slightly.
2.8.2.12. Open the valve(s) so that the vacuum is applied to the uterine cavity.

2.8.2.13. 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.

2.8.2.14. 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’.

2.8.2.15. 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.

2.8.2.16. 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.

2.8.2.17. 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.

2.8.3. **Tissue Examination**

2.8.3.1. The evacuated tissue must be examined.

2.8.3.2. 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.

2.8.3.3. Tissue may only be viewed directly in the container into which it was emptied.

2.8.3.4. All tissue is sent for histological evaluation (unless woman declines) and MUST be accompanied by a signed cremation form, unless she is postnatal – in which case this needs to be clearly stated on the histology request. (Appendix 4).

2.8.4. **Post-procedure Care**

2.8.4.1. As a minimum, one set of post-procedure observations should be recorded in the case notes.
2.8.4.2. Refreshment is offered to the woman at an appropriate time.

2.8.4.3. Check woman’s Rhesus status and if non-sensitised Rhesus negative, administer Anti D.

2.8.4.4. When the patient is fully recovered, she can be discharged by the nurse.

2.9. **Duration of Stay in the Clinic/Unit**

Procedure duration is typically 10-15 minutes and recovery time 15-20 minutes.

2.10. **Anti-biotic Prophylaxis**

Anti-biotic prophylaxis should be provided to all clients undergoing MVA. 400mg oral metronidazole or 1g rectal metronidazole or three days of oral doxycycline 100mg bd (prescribe on an outpatient prescription)

2.11. **Aftercare**

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

2.12. **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>Information Category</th>
<th>Detail of process and methodology for monitoring compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Element to be monitored</td>
<td>Audit of outcome and patient experience feedback.</td>
</tr>
<tr>
<td>Lead</td>
<td>Sarah Eddy; Advanced Nurse Practitioner, Emergency Gynaecology Unit / Early Pregnancy Unit</td>
</tr>
<tr>
<td>Tool</td>
<td>EGU and miscarriage databases and patient questionnaire.</td>
</tr>
<tr>
<td>Frequency</td>
<td>Annually EGU and EPU MDT.</td>
</tr>
<tr>
<td>Reporting arrangements</td>
<td>EGU / EPU MDT.</td>
</tr>
<tr>
<td></td>
<td>Dashboard.</td>
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<tr>
<td></td>
<td>Women’s and Newborn Audit meeting.</td>
</tr>
</tbody>
</table>
### Acting on recommendations and Lead(s)

- EGU and EPU MDT.

### Change in practice and lessons to be shared

- 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.

### 4. Equality and Diversity

4.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the [Equality Diversity And Inclusion Policy](#) or the [Equality and Diversity website](#).

4.2. Equality Impact Assessment

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

<table>
<thead>
<tr>
<th>Information Category</th>
<th>Detailed Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Document Title:</strong></td>
<td>Manual Vacuum Aspiration (MVA) for Treatment of Miscarriage and Retained Pregnancy Tissue Clinical Guideline V3.0</td>
</tr>
<tr>
<td><strong>This document replaces (exact title of previous version):</strong></td>
<td>Manual Vacuum Aspiration (MVA) for Treatment of Miscarriage and Retained Pregnancy Tissue Clinical Guideline V2.0</td>
</tr>
<tr>
<td><strong>Date Issued/Approved:</strong></td>
<td>August 2023</td>
</tr>
<tr>
<td><strong>Date Valid From:</strong></td>
<td>August 2023</td>
</tr>
<tr>
<td><strong>Date Valid To:</strong></td>
<td>August 2026</td>
</tr>
<tr>
<td><strong>Directorate / Department responsible (author/owner):</strong></td>
<td>Sarah Eddy; Advanced Nurse Practitioner, Emergency Gynaecology Unit / Early Pregnancy Unit</td>
</tr>
<tr>
<td><strong>Contact details:</strong></td>
<td>01872 252 685</td>
</tr>
<tr>
<td><strong>Brief summary of contents:</strong></td>
<td>All clinical staff working in the Women and Children Care Group to provide evidence based guidance in the management of MVA for miscarriage and retained pregnancy tissue</td>
</tr>
<tr>
<td><strong>Suggested Keywords:</strong></td>
<td>MVA, Miscarriage, retained pregnancy tissue</td>
</tr>
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</table>
| **Target Audience:**                             | **RCHT:** Yes  
**CFT:** No  
**CIOS ICB:** No                                                                                                                                  |
| **Executive Director responsible for Policy:**   | Chief Medical Officer                                                                                                                                   |
| **Approval route for consultation and ratification:** | Gynaecology Specialty Meeting                                                                                                                            |
| **Manager confirming approval processes:**       | Caroline Chappell                                                                                                                                     |
| **Name of Governance Lead confirming consultation and ratification:** | Caroline Amukusana                                                                                                                                    |
| **Links to key external standards:**             | Ectopic pregnancy and miscarriage: Diagnosis and initial management                                                                                 |
**Information Category** | **Detailed Information**
--- | ---
Manual Vacuum Aspiration (MVA) for Treatment of Miscarriage and Retained Pregnancy Tissue Clinical Guideline | NICE clinical guideline 126. April 2019

**Related Documents:**
As above

**Training Need Identified?**
No

**Publication Location:**
Internet and Intranet

**Document Library Folder/Sub Folder:**
Clinical/ Gynaecology

### Version Control Table

<table>
<thead>
<tr>
<th>Date</th>
<th>Version Number</th>
<th>Summary of Changes</th>
<th>Changes Made by</th>
</tr>
</thead>
<tbody>
<tr>
<td>11 Jun 14</td>
<td>V1.0</td>
<td>Initial Issue</td>
<td>Lee Azancot; Data Administrator</td>
</tr>
<tr>
<td>2 Mar 17</td>
<td>V1.1</td>
<td>Addition of Appendices 3 + 4</td>
<td>Lisa Verity Consultant</td>
</tr>
<tr>
<td>08 July 2020</td>
<td>V2.0</td>
<td>Full review. Formatting updated. Medication details updated in section 2.3, 2.6, 2.8 and 2.10.</td>
<td>Miss Lisa Verity Consultant O&amp;G</td>
</tr>
<tr>
<td>August 2023</td>
<td>V3.0</td>
<td>Full review, no amendment required. Update to new Trust formatting. Link to MVA consent now included in appendix.</td>
<td>Sarah Eddy; Advanced Nurse Practitioner, Emergency Gynaecology Unit / Early Pregnancy Unit</td>
</tr>
</tbody>
</table>

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

All Policies, Strategies and Operating Procedures, including Business Plans, are to be kept for the lifetime of the organisation plus 6 years.

This document is only valid on the day of printing.
Controlled Document.

This document has been created following the Royal Cornwall Hospitals NHS Trust The Policy on Policies (Development and Management of Knowledge Procedural and Web Documents Policy). It should not be altered in any way without the express permission of the author or their Line Manager.
Appendix 2. Equality Impact Assessment

Section 1: Equality Impact Assessment (EIA) Form

The EIA process allows the Trust to identify where a policy or service may have a negative impact on an individual or particular group of people.

For guidance please refer to the Equality Impact Assessment Policy (available from the document library) or contact the Equality, Diversity, and Inclusion Team
rcht.inclusion@nhs.net

<table>
<thead>
<tr>
<th>Information Category</th>
<th>Detailed Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Name of the strategy / policy / proposal / service function to be assessed:</strong></td>
<td>Manual Vacuum Aspiration (MVA) For Treatment of Miscarriage And Retained Pregnancy Tissue Clinical Guideline V3.0</td>
</tr>
<tr>
<td><strong>Directorate and service area:</strong></td>
<td>Gynaecology</td>
</tr>
<tr>
<td><strong>Is this a new or existing Policy?</strong></td>
<td>Existing</td>
</tr>
<tr>
<td><strong>Name of individual completing EIA</strong> (Should be completed by an individual with a good understanding of the Service/Policy):</td>
<td>Sarah Eddy; Advanced Nurse Practitioner, Emergency Gynaecology Unit / Early Pregnancy Unit</td>
</tr>
<tr>
<td><strong>Contact details:</strong></td>
<td>01872 252685</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Information Category</th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Policy Aim - Who is the Policy aimed at?</strong> (The Policy is the Strategy, Policy, Proposal or Service Change to be assessed)</td>
<td>All clinical staff working in the Care Group of women, children and HIV to provide evidence based guidance in the management of Manual Vacuum Aspiration (MVA).</td>
</tr>
<tr>
<td><strong>2. Policy Objectives</strong></td>
<td>As above</td>
</tr>
<tr>
<td><strong>3. Policy Intended Outcomes</strong></td>
<td>As above</td>
</tr>
<tr>
<td><strong>4. How will you measure each outcome?</strong></td>
<td>See section 3</td>
</tr>
<tr>
<td><strong>5. Who is intended to benefit from the policy?</strong></td>
<td>All obstetrics and gynaecology patients</td>
</tr>
<tr>
<td>Information Category</td>
<td>Detailed Information</td>
</tr>
<tr>
<td>----------------------</td>
<td>----------------------</td>
</tr>
</tbody>
</table>
| 6a. Who did you consult with? (Please select Yes or No for each category) | - Workforce: Yes  
- Patients/ visitors: No  
- Local groups/ system partners: No  
- External organisations: No  
- Other: No |
| 6b. Please list the individuals/groups who have been consulted about this policy | Please record specific names of individuals/ groups: Gynaecology Specialty meeting |
| 6c. What was the outcome of the consultation? | Approved 18 August 2023 |
| 6d. Have you used any of the following to assist your assessment? | National or local statistics, audits, activity reports, process maps, complaints, staff, or patient surveys: No |

### 7. The Impact

Following consultation with key groups, has a negative impact been identified for any protected characteristic? Please note that a rationale is required for each one.

Where a negative impact is identified without rationale, the key groups will need to be consulted again.

<table>
<thead>
<tr>
<th>Protected Characteristic</th>
<th>(Yes or No)</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Sex (male or female)</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Gender reassignment (Transgender, non-binary, gender fluid etc.)</td>
<td>No</td>
<td>Any information provided should be in an accessible format for the patient’s need- i.e., available in different languages if required/access to an interpreter if required</td>
</tr>
<tr>
<td>Race</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>
### Protected Characteristic

<table>
<thead>
<tr>
<th>Protected Characteristic</th>
<th>(Yes or No)</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Disability</strong> (e.g. physical or cognitive impairment, mental health, long term conditions etc.)</td>
<td>No</td>
<td>Those patients with any identified additional needs will be referred for additional support as appropriate - i.e., to the Liaison team or for specialised equipment. Written information will be provided in a format to meet the family’s needs e.g., easy read, audio etc.</td>
</tr>
<tr>
<td><strong>Religion or belief</strong></td>
<td>No</td>
<td>All staff should be aware of any beliefs that may impact on treatment</td>
</tr>
<tr>
<td><strong>Marriage and civil partnership</strong></td>
<td>No</td>
<td></td>
</tr>
<tr>
<td><strong>Pregnancy and maternity</strong></td>
<td>No</td>
<td></td>
</tr>
<tr>
<td><strong>Sexual orientation</strong> (e.g. gay, straight, bisexual, lesbian etc.)</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

A robust rationale must be in place for all protected characteristics. If a negative impact has been identified, please complete section 2. If no negative impact has been identified and if this is not a major service change, you can end the assessment here.

I am confident that section 2 of this EIA does not need completing as there are no highlighted risks of negative impact occurring because of this policy.

Name of person confirming result of initial impact assessment: Miss Lisa Verity

If a negative impact has been identified above OR this is a major service change, you will need to complete section 2 of the EIA form available here:

*Section 2. Full Equality Analysis*
APPENDIX 3. Consent Form 1- Manual Vacuum Aspiration

APPENDIX 4. Certificate of Medical Practitioner or Midwife in Respect of Foetal Remains

Cornwall Council
PENMOUNT CREMATORIUM, 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 knew 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 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