**EM Basic- First Trimester Vaginal Bleeding**

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**History**

Look at triage note, take note of Gs and Ps

Gs- number of pregnancies Ps- Number of living children

 Quantify how much bleeding- spotting vs pads

 History of spontaneous or elective abortions, pre-term birth

**PEARL-** Pregnancy does not mean your patient can’t have an appy or a chole or something else- don’t turn your brain off and ignore everything else!

**Associated signs and symptoms**

Abdominal pain, nausea/vomiting, discharge

 Chest pain, SOB, dizziness, near syncope or syncope

**Exam**

Standard physical exam- HEENT, heart/lungs, back

 Good abdominal exam

 Pay attention to rebound, guarding, perotinits

 Miscarriages can have abdominal pain and tenderness, usually diffuse

**PEARL-** If a pregnant patient is unstable or has a concerning abdominal exam, they need an immediate OB/GYN consultation and the OR.

**PEARL-** Some women with ruptured ectopics will have bradycardia instead of tachycardia (blood irritates peritoneum and causes vagal response). Don’t let a lack of tachycardia sway you or your consultant away from the diagnosis.

**Differential Diagnosis**

Ectopic pregnancy

Spontaneous abortion (miscarriage)

Threatened abortion

Abnormal pregnancy

Normal early pregnancy

**Workup**

**UA** (check for UTI)

**Quantitative HCG** (quantify how far along the pregnancy is and for trending)

**CBC** (not absolutely necessary unless you think severe blood loss)

**Type and Rh or Type and screen** (if the patient is Rh negative, they need Rhogam, type and screen gets you an antibody match that is one step closer to crossmatched blood)

**Pelvic setup**

**GC/Chlamydia**

**Wet Prep/KOH-** (may be overkill to get on all patients but asymptomatic pregnant patients with BV should be treated, you are doing the pelvic exam anyway so there isn’t any harm in checking this box)

**Transvaginal ultrasound** (done by yourself or radiology)

**Pelvic exam**

Quantify the amount of bleeding during the exam- scant amount vs. active bleeding

Look for any tissue and have a ring forceps available to remove any products of conception that you may see (and send to pathology)

Check to see whether the os is open or closed

Perform a bimanual exam and check the ovaries

**Transvaginal ultrasound**

Answer one clinical question- is there an IUP or not?

 All in context of quantitative HCG

 1,500- HCG cutoff for seeing an IUP

 5,000- HCG cutoff for cardiac activity

 Progression of US findings

 Double decidual sign (two rings)

 Early gestational sac (large empty sac of fluid)

 Yolk sac (little round ring inside of sac)

 Fetal pole (little body attached to yolk sac)

**If you find a mass outside the uterus or free fluid in the cul de sac- get a formal TVUS from radiology**

**PEARL**- Ectopic pregnancies can give a psuedogestational sac inside the uterus while there is an ectopic pregnancy elsewhere

**PEARL-** If the quant is below 1500 and the radiologist says “there’s no point in doing an US- we won’t see anything” tell them you are looking for evidence of an ectopic or a large amount of free fluid.

**Disposition**

**Quant below 1,500**- could be early ectopic vs. early normal pregnancy- OB-GYN followup in 2-3 days for repeat quant and TVUS

**Quant above 1,500 and evidence of an IUP-** if stable and non-concerning abdominal exam, discharge with OB/GYN followup in 2-3 days for repeat quant and TVUS

**Ectopic pregnancy** **management**

Don’t forget the ABCs, resuscitate as appropriate

 Usually taken to the OR by OB/GYN

 Methotrexate is an option in consultation with OB/GYN

**PEARL:** Don’t give methotrexate without having OB/GYN look at ultrasound scans and having examined and consented the patient themselves and arranged for close followup

**Other concerns**

**UTIs**- be aggressive about treating UTI in pregnancy. Even the slightest hint of a UTI like small or moderate leukocyte esterase should get treated

**PEARL**- send a urine culture if you decide to treat for UTI

 Macrobid 100mg PO BID for 7 days

 Keflex 500mg PO TID for 7 days

**Bacterial Vaginosis**

Flagyl 500mg PO BID for 7 days

**Vaginal Candiadiasis**

Fluconazole 150mg PO x1 dose

**PEARL-** Don’t treat asymptomatic trichomonas in pregnancy

**PID-** rare in pregnancy but should be admitted for IV antibiotics

**Rh negative patient**- give rhogram in consultation with OB/GYN to prevent alloimmunization

**Talking with patients about miscarriages**

**During the initial H and P**

Let the patient know up front that you may not know for sure whether or not this is a miscarriage. This helps keep expectations reasonable. Let them know that no matter what happens, they will need to followup with their OB/GYN doctor in 2-3 days to see how the pregnancy is progressing. Make sure they know that you may not have all the answers today.

**Discharging a patient with a threatened abortion (miscarriage)**

Every patient with 1st trimester vaginal bleeding gets this diagnosis regardless of their workup. Stress the importance of followup in 2-3 days. Classically, discharge instructions advise pelvic rest (no sex or anything in the vagina) until seen by OB/GYN. However, studies have not shown and increased rate of miscarriages in patients who have sex in these situations. That being said, I tell my patients about this but I also tell them that it may be better for them psychologically in case they do miscarry. That way they don’t blame themselves and wonder “what if” down the road. Tell the patient that “threatened abortion” is the medical term for a possible miscarriage because the word “abortion” can have negative connotations.

**Breaking bad news**

You will have to tell some women that they are having a miscarriage. Some women know or are strongly suspecting it. This can be devastating news especially if the patient has tried for a long time to get pregnant. Make sure to sit down next to the patient on their level. In a calm voice explain that you’ve got the test results back and you are sorry to say that they are having a miscarriage. Let the patient react to the news. Have tissues handy. Once they have collected themselves a little bit, let them know that nothing they did or didn’t do that caused the miscarriage. Let them know that that most miscarriages have abnormalities that could not have resulted in the birth of a child. Let them know that this wasn’t their fault and that it doesn’t affect chances of future fertility.

**Miscarriage management options**

**Expectant-** discharge the patient with an OB/GYN followup in 2-3 days. Let them know that they will continue to pass tissue. Prescribe vicodin or Percocet and encourage round the clock motrin for cramping. Good return precautions for increased pain, persistent vomiting, or passing out

**Cytotec**- cervical ripening medication- to be done in consultation with OB/GYN only

**D and C**- some women prefer this go this route to take care of everything at one time. Talk with your OB/GYN consultant- will most likely be discharging these patients with close followup and outpatient surgery.

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