# FIRST TRIMESTER ABORTION

<table>
<thead>
<tr>
<th>DEFINITION</th>
<th>Approximately 10-15% of all clinically diagnosed pregnancies end in spontaneous abortion. In the first trimester, women who present with bleeding and cramping must have ectopic pregnancy ruled out and the type/stage of abortion must be assessed to determine the appropriate therapy. Women with incomplete, septic and missed abortions (early intrauterine demise) and blighted ova need to be referred to ER/MD for management. This protocol defines the different types of abortions and describes the therapy for women with a threatened abortion. See Table 1 for definitions of different types of abortions.</th>
</tr>
</thead>
</table>
| SUBJECTIVE | Must include:  
1. Pregnancy in first trimester.  
2. Complaints of vaginal bleeding and uterine cramping.  

Must exclude:  
1. Any passage of products of conception or rupture of membranes.  
2. Fevers or chills.  
3. Foul smelling discharge.  
4. Dizziness or lightheadedness.  
5. History of previous ectopic pregnancy with similar symptoms.  

May include:  
1. Nausea, vomiting.  
2. Breast tenderness.  
3. History of previous losses. |
| OBJECTIVE | Must include  
1. Stable vital signs.  
2. Cervical os closed.  
3. Soft, globular uterus <13 cm in size.  

Must exclude:  
1. T > 100.4°F or pulse > 100 beats per minute.  
2. Uterine or adnexal tenderness.  
4. Heavy vaginal bleeding.  

May include:  
1. Fetal heart tones.  
2. Shortened cervix. |
| LABORATORY | 1. Positive pregnancy test, if not previously documented.  
2. Hemoglobin for baseline.  
3. Rh and antibody status. |
| ASSESSMENT | Possible threatened first trimester abortion. |
| PLAN | 1. If hemoglobin <8 mg/dL, active excessive bleeding from os, CMT, unstable vital signs or gestational age >13 weeks, consult MD and arrange transport to ER.  
2. Rule out ectopic pregnancy with ultrasound. If not possible, counsel patient about signs and symptoms of ectopic pregnancy and advise her to go to ER if severe, unilateral abdominopelvic pain, lightheadedness or shoulder pain (see Ectopic Pregnancy protocol).  
3. If pregnancy not desired and unable to rule out ectopic pregnancy, consult MD about possible referral to ER for D&C to rule out ectopic pregnancy.  
4. If patient stable, afebrile with only moderate bleeding, offer expectant management. Advise |
| **Threatened Abortion PLAN** (Continued) | patient:  
a. Pelvic rest.  
b. Go to ER if:  
   1) Increase in cramping.  
   2) Bleeding heavy (changing pad more frequently than every 2 hours).  
   3) Passage of products of conception.  
   4) Dizziness or lightheadedness.  
   c. Avoid heavy lifting.  
   5. If Rh- with negative antibody screen, consult MD about RhIG use. |  
| **PATIENT EDUCATION**  
1. Reassure patient (and her partner) that there is nothing that either of them did that caused this problem.  
2. Advise her that bed rest has not been shown to avert a miscarriage.  
3. Advise patient that about 20-50% of threatened abortion result in complete abortion. Women with heavy bleeding are more likely to lose the pregnancy. Women with spotting face only a 10% risk of spontaneous abortion.  
4. Reinforce need to have transportation available to bring her to ER promptly should she develop symptoms of more advanced abortion (heavy bleeding, increased cramping, passage of tissue) or complications (fever, chills).  
5. Tell patient that pregnancies that continue after an episode of threatened abortion are not at higher risk for congenital anomalies. However, pregnancies that continue after an episode of vaginal bleeding are at higher relative risk (but still low absolute risk) for preterm delivery, preterm premature rupture of membranes, maternal hemorrhage or low birth weight babies. They are also at a slightly higher risk for complications in future pregnancies.  
6. Reinforce need to keep all prenatal appointments. She may need special obstetrical care.  
7. Recommend she continue her prenatal vitamins.  
8. Counsel patient that many therapies have been tried to treat threatened abortion (acupuncture, progesterone therapy, hCG therapy), but none has been shown to reduce the chance of pregnancy loss.  
9. If she asks about other tests that may predict whether this pregnancy will continue, tell her that none of the many tests (3-D ultrasound, progesterone levels, β hCG levels, etc.) has been shown to be clinically helpful.  
10. Women who desire pregnancy but lose current pregnancy should be advised that there is no need to wait to conceive next pregnancy. Outcomes are best if the interval between the lost pregnancy and the subsequent one is less than 6 months. |  
| **REFER TO MD/ER**  
1. Any woman with passage of products of conception.  
2. Women with fever, uterine tenderness, symptoms of anemia.  
3. Women with possible ectopic pregnancy. |  
| **REFERENCES**  
8. Hanita O, Hanisah AH. Potential use of single measurement of serum progesterone in detecting
<table>
<thead>
<tr>
<th>Abortion Classification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Threatened Abortion</td>
</tr>
<tr>
<td>Bleeding and cramping</td>
</tr>
<tr>
<td>Internal os closed</td>
</tr>
<tr>
<td>No passage of POCs (Products of conception)</td>
</tr>
</tbody>
</table>