Patient information and consent to surgical management of miscarriage (SMM)

Key messages for patients

- Please read your admission letter carefully. It is important to follow the instructions we give you about not eating or drinking or we may have to postpone or cancel your operation.

- Please read this information carefully, you and your health professional will sign it to document your consent.

- It is important that you bring the consent form with you when you are admitted for surgery. You will have an opportunity to ask any questions from the surgeon or anaesthetist when you are admitted. You may sign the consent form either before you come or when you are admitted.

- Please bring with you all of your medications and its packaging (including inhalers, injections, creams, eye drops, patches, insulin and herbal remedies), a current repeat prescription from your GP, any cards about your treatment and any information that you have been given relevant to your care in hospital, such as x rays or test results.

- Painkillers may be required after your hospital stay; please ensure you have appropriate supplies at home.

- Take your medications as normal on the day of the procedure unless you have been specifically told not to take a drug or drugs before or on the day by a member of your medical team. If you have diabetes please ask for specific individual advice to be given on your medication.

- Please call the staff in Clinic 24 (The Early Pregnancy Unit) on telephone number 01223 217636 if you have any questions or concerns about this procedure or your appointment.

After the procedure we will scan the consent form into your electronic medical notes and you may take this information leaflet home with you.

Important things you need to know

Patient choice is an important part of your care. You have the right to change your mind at any time, even after you have given consent and the procedure has started (as long as it is safe and practical to do so). If you are having an anaesthetic you will have the opportunity to discuss this with the anaesthetist, unless the urgency of your treatment prevents this.

We will only carry out the procedure on your consent form unless, in the opinion of the health professional responsible for your care, a further procedure is needed in order to save your life or prevent serious harm to your health. However, there may be procedures you do not wish us to carry out and these can be recorded on the consent form.

We are unable to guarantee that a particular person will perform the procedure. However the person undertaking the procedure will have the relevant experience.

All information we hold about you is stored according to the Data Protection Act 1998.

Surgical Management if Miscarriage, CF463, Version number 2, October 2016
About surgical management of miscarriage (SMM)

Sadly your pregnancy has resulted in a miscarriage. We are very sorry that this has happened.

Miscarriage in early pregnancy is very common, with as many as one in four confirmed pregnancies ending this way.

Your miscarriage has left some pregnancy tissue that has not developed and/or blood clot in the uterus (womb) which has not come away and we need to help you to consider what happens next.

There are four ways in which to proceed. Dependent upon certain criteria, the staff in Clinic 24 will discuss which of the following methods are suitable for you:

- The tissue and/or blood clot may pass naturally (Expectant management)
- You can have medication to empty the uterus (Medical management)
- We can perform a procedure under local anaesthetic (Manual vacuum aspiration)
- We can perform an operation under general anaesthetic (Surgical management)

You have chosen Surgical Management.

The procedure is performed under a general anaesthetic (this will be explained later in this leaflet). Generally, you will be admitted onto the Day Surgery Unit (DSU) for this at a planned time and date (Elective admission). The DSU is located on level 2 of Addenbrookes’ Treatment Centre (ATC). Occasionally it is necessary for you to have this done sooner and you may stay on Clinic 24 or Daphne Ward (the Inpatient Gynaecology Ward) which is on level 2 of the Rosie.

Intended benefits

- To remove any remaining tissue and/or blood clot in the uterus after a miscarriage. Many women find surgery a benefit as the miscarriage can be “over and done with” and they can plan around this (Miscarriage Association 2010)

- In addition, this procedure is advised for the following clinical indications:
  - to treat sepsis (infection)
  - to alleviate heavy bleeding
  - to ensure completion of miscarriage if suspicion of gestational trophoblastic disease (a rare and serious condition of early pregnancy)

Disadvantages of the procedure

- Requires an operation and general anaesthetic, which has associated risk (please see later)
- Must not drive for 24 hours following an anaesthetic
Who will perform my procedure?

This procedure will be performed by:
- A Consultant Gynaecologist
- A Junior Doctor who has been trained or is training under the supervision of a Consultant Gynaecologist.

Before your procedure

Most patients are seen in Clinic 24, when you will meet the nursing and medical staff. At this time we will ask for details of your medical history and carry out any necessary clinical examinations and investigations. Please ask us any questions about the procedure, and feel free to discuss any concerns you might have at any time.

We will ask if you take any tablets or use any other types of medication either prescribed by a doctor or bought over the counter in a pharmacy. Please bring all your medications and any packaging (if available) with you. Please tell the staff about all of the medicines you use. If you wish to take your medication yourself (self-medicate), please ask your nurse. Pharmacists visit the wards regularly and can help with any medicine queries.

It is important that you tell the nurse or doctor looking after you about any previous or current health problems you have.

You will need to starve for at least six hours prior to your procedure. The staff will advise you at what time to do this.

This procedure is a day case procedure and most women are able to go home a few hours after the operation. Sometimes we can predict whether you will need to stay longer than usual – your doctor/nurse will discuss this with you before you decide to have the procedure.

Sometimes you may be given medication called misoprostol to help the opening up of the cervix, if this has not already happened. Generally, this is given as a vaginal pessary an hour before your operation.

What do I need to bring in with me?

- Bring some basic toiletries with you, such as a toothbrush and some sanitary towels.
- Bring a dressing gown and some slippers.
- Wear only a minimal amount of jewellery. Only small rings, which will be taped, are allowed into the theatre suite and the Trust cannot take responsibility for valuables.
- Do not wear makeup, and ensure any nail polish is removed from your finger and toe nails.
- If you wear contact lenses, they will need to be removed prior to your going into theatre, so ensure you bring a pair of glasses with you.
May I bring someone with me?

Yes. Your partner, friend or family member is welcome to stay with you for the day. However, there are no facilities to care for children on the unit, therefore if you have other children, please make your own arrangements for childcare before attending the hospital.

During surgical management of miscarriage

- Before your procedure, you will be given the necessary general anaesthetic - see below for details of this and the role of the anaesthetist in your care.
- Once you are asleep with the general anaesthetic, the gynaecologist inserts a speculum into your vagina so that the cervix (the opening of the uterus) can be seen. We then gently stretch open the cervix using some dilators, and pass a hollow tube through it. We then use some suction to remove the retained tissue and any blood clot.
- After emptying the uterus by suction, it is usually explored with other instruments which can remove any tissue that may remain or confirm the uterus is empty. These instruments include one called a curette which many women have heard about as it is often described as having a scrape. The procedure takes less than 15 minutes.
- If you have consented to further treatments such as the insertion of an intrauterine device (IUCD/coil) this will then be undertaken.

During surgery, you may lose blood. If you lose a considerable amount of blood your doctor may want to replace the loss with a blood transfusion as significant blood loss can cause you harm. The blood transfusion can involve giving you other blood components such as plasma and platelets which are necessary for blood clotting. Your doctor will only give you a transfusion of blood or blood components during surgery, or recommend for you to have a transfusion after surgery, if you need it.

Compared to other everyday risks the likelihood of getting a serious side effect from a transfusion of blood or blood component is very low. Your doctor can explain to you the benefits and risks from a blood transfusion. Your doctor can also give you information about whether there are suitable alternatives to blood transfusion for your treatment. There is a patient information leaflet for blood transfusion available for you to read. Your questions about blood transfusion answered.

After surgical management of miscarriage

Once your surgery is completed you will usually be transferred to the recovery ward where you will be looked after by specially trained nurses, under the direction of your anaesthetist. The nurses will monitor you closely until the effects of any general anaesthetic have adequately worn off and you are conscious. They will monitor your heart rate, blood pressure, oxygen levels and will regularly check to see if you have had excessive vaginal bleeding. You may be given oxygen via a facemask, fluids via your drip and appropriate pain relief until you are comfortable enough to return to your ward.
Sometimes, people feel sick after an operation, especially after a general anaesthetic, and might vomit. If you feel sick, please tell a nurse and you will be offered medicine to make you more comfortable.

If there is not a bed in the necessary unit on the day of your operation, your operation may be postponed as it is important that you have the correct level of care after surgery.

Eating and drinking.
After this procedure, you should not have anything to eat or drink until your medical team considers it to be safe - this is usually as soon as you are awake enough. We also recommend you avoid any alcohol for the first 24 hours following the procedure as any effects will be enhanced by the anaesthetic.

Getting about immediately after the procedure.
After this procedure, we will try to get you mobile (up and about) as soon as we can to help prevent complications from lying in bed. Typically, you will be able to get up when you feel awake enough.

Leaving hospital.
Most women are able to go home a minimum of four hours after the operation, on the same day. The actual time that you stay in hospital will depend on your general health, how quickly you recover from the procedure and your doctor’s opinion. You must have had something to eat and drink, been able to pass urine, have minimal pain and vaginal bleeding and have someone to take you home and be with you overnight.

Resuming normal activities including work.
Most women prefer to take the following day off work, both for their emotional and physical recovery. You must not drive for 24 hours following general anaesthetic as the drugs may still be in your system. You may feel very tired while your body is healing and you may want to have a rest or nap during the day in the first few days after your operation. If you have (an)other child(ren) at home, we suggest you have another adult around to assist you. Some women can take up to a week off work – you are able to self-certificate for five working days. If you do manual work or have to stand for long periods, you might need more time off than if you are sitting at a desk. You should not feel pressurised by family, friends or your employer to return to work before you feel ready. You do not need ours or your GP’s permission to go back to work. The decision is yours.

It is important to get back to full activity soon, as this will help with your recovery and help you feel better in yourself. Keeping active can help you cope with your feelings and emotions, and it may also be helpful to do activities with a friend. Build up slowly at your own pace. If you want to exercise, this will not do you any harm. Listen to your body.
If the exercise you are doing is causing you pain, stop and try something less active for a few days. If you are not experiencing any problems, you can soon increase the number and distance of your daily walks. Doing this will help to keep you fit.

**Special measures after the procedure:**
Women whose blood group is rhesus negative will be given an injection of anti-D before discharge to protect future pregnancies from being affected by rhesus incompatibility.

**Pain:** You may have period-like pains for a few days; this is normal. Simple painkillers that you can buy over the counter such as paracetamol and ibuprofen should help this. If your pain is not relieved by this medication, please contact us on the numbers below.

**Vaginal bleeding:** You may have some vaginal bleeding for up to three weeks following the procedure and we advise you to use sanitary towels, not tampons. Avoid sexual intercourse or swimming until the bleeding has stopped. This is to help prevent any infection. The bleeding is like a heavy period for the few days but this will lessen over time and you may even have a brown discharge before it stops completely. We suggest that you avoid long soaks in the bath and shower instead; ensure someone is around in case you feel faint/dizzy. Should you have concerns that your bleeding is not settling or you have a fever and ‘flu-like’ symptoms then contact your GP or contact us on the numbers below.

**Next period and future pregnancies:** Your next period may happen in four to six weeks after the procedure. Prior to this you will have ovulated and therefore will be able to become pregnant again. You can have intercourse as soon as you both feel ready. You may therefore wish to consider some form of contraception. Please see your GP for this. You are able to try for another pregnancy whenever you feel ready; there are no rules as to when you can do this. If you have any concerns about this, then please speak to a member of staff.

**Emotional impact:**
Losing a pregnancy is a deeply personal experience that affects people differently. It can be a very distressing experience and you are likely to need considerable support afterwards. Women react in different ways to a miscarriage; some women come to terms with what has happened within a few weeks, others can take much longer. It is normal to feel tearful and sad, angry or even guilty. Some women experience intense grief over a longer time. Losing a baby can be a very painful experience for partners too, and sometimes their grief is unacknowledged.

**Check-ups and results:**
Unless you are otherwise told, you will not be contacted following the procedure. However, if you have any concerns or questions you can telephone Clinic 24 on the number listed below.
If this is not your first miscarriage and you meet certain criteria, you may be referred to a recurrent miscarriage clinic. For this, you and your partner may need additional tests. The staff on Clinic 24 will have discussed this with you.

**Do I need to inform anyone about my miscarriage?**
No. We will have written to your GP and community midwife. Any antenatal scans or appointments will have been cancelled, so you do not need to worry about doing this.

**Significant, unavoidable or frequently occurring risks of this procedure**
If you have a pre-existing medical condition, smoke, are obese or have had previous surgery, the quoted risks for serious or frequent complications will be increased.

The table below is designed to help you understand the risks associated with this type of surgery (based on the RCOG Clinical Governance Advice, Presenting Information on Risk).

<table>
<thead>
<tr>
<th>Term</th>
<th>Equivalent numerical ratio</th>
<th>Colloquial equivalent</th>
</tr>
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<tbody>
<tr>
<td>Very common</td>
<td>1/1 to 1/10</td>
<td>A person in family</td>
</tr>
<tr>
<td>Common</td>
<td>1/10 to 1/100</td>
<td>A person in street</td>
</tr>
<tr>
<td>Uncommon</td>
<td>1/100 to 1/1000</td>
<td>A person in village</td>
</tr>
<tr>
<td>Rare</td>
<td>1/1000 to 1/10 000</td>
<td>A person in small town</td>
</tr>
<tr>
<td>Very rare</td>
<td>Less than 1/10 000</td>
<td>A person in large town</td>
</tr>
</tbody>
</table>

Surgical management of miscarriage is a very safe operation, however, like all surgical procedures there are potential risks involved. Your Gynaecologist and nurse will ensure that the appropriate measures are taken to reduce the risk of complications. The main risks of the procedure are:

**Serious risks**
- Tear in the cervix. (Rare).
- Uterine perforation, this means a hole is made in the uterus. (Uncommon – up to 5 in 1000 women). This is a risk because the wall of the recently pregnant uterus is very soft. This can cause trauma to other abdominal organs. If this happens it might be necessary to check that there is no internal bleeding using a laparoscopy. This is a procedure in which a laparoscope (telescope) is passed through a small cut below the umblicius (belly button). If there is internal bleeding, we might be able to control this using this ‘key hole’ surgery or you might need a larger ‘open operation’, which will take longer to recover from.
- Deep vein thrombosis, DVT (blood clot in the leg). (Rare)
- Death (very rare – 0.5 in every 100 000).

**Frequent risks**
- Bleeding that lasts for up to two weeks is very common but blood transfusion is uncommon (1-2 in 1000 women)
Patient Information

- Infection of the lining of the uterus. (Common – 3 in 100 women)
- Intrauterine adhesions (stickiness inside the uterus) (Uncommon – 1 in every 200 women)
- There is a chance that we will miss some of the retained tissue and that you will require a further management to remove it. (Common - up to 5 in 100 women)

**Alternative procedures that are available**

Surgical management of miscarriage is not recommended if your pregnancy is less than seven weeks gestation due to the increased risks involved at this stage. We would therefore recommend you undertake one of the following three pathways listed below.

- If the bleeding is not excessive, and you prefer not to have an operation, you might wish to wait and allow the uterus to pass the remaining tissue without assistance (**expectant management**).
- You might choose to have **medical management**, when you will be given some medication to cause the uterus to contract and empty itself. The success rate of a medical evacuation in emptying the uterus can, in some cases, be slightly less than the surgical approach although this is to be balanced against the risks of surgery.
- You might choose to have **manual vacuum aspiration** (MVA), when you have a procedure under local anaesthetic to empty the uterus.

**What happens to any tissue or the fetus?**

Any tissue or fetal parts are sent to the histopathology laboratory to confirm the miscarriage.

No other investigations are usually carried out into the cause of the miscarriage at this time, unless specifically discussed with you.

There are standard procedures in place for the sensitive disposal of fetal remains following miscarriage; interment (buried) in a local woodland burial site. Further information concerning this is available in the leaflet: [Barton Glebe woodland burial site](#). Please ask a member of staff to discuss this with you or to give you a copy of the leaflet.

For further information, please contact the Chaplaincy Team on 01223 217769.

**What if I think I have miscarried before I come in for the operation?**

This does sometimes happen, so it is advisable to have some sanitary towels and mild analgesia (pain relief) such as paracetamol or ibuprofen at home, just in case.

The bleeding may be very heavy, and you may pass blood clots, tissue or even a recognisable fetus.
If you are concerned that the bleeding is excessive (requiring you to change a sanitary pad every half an hour) please telephone us on the numbers listed later in this information leaflet or attend the Emergency Department (ED).

We understand that bleeding heavily at home can be frightening - please do not hesitate to contact us if you are unsure what to do.

If you think you have miscarried, an operation may not be necessary, provided you are well and the bleeding has lessened. We would still like for you to attend so that staff can discuss this with you and together you can make an informed decision.

If clinically indicated it may be possible to arrange an ultrasound prior to the procedure. However, generally at this time it is not beneficial, as it would normally show blood in the uterus anyway.

Please telephone Clinic 24 to discuss the situation with nursing staff.

If you miscarry over the weekend, but are well, please telephone Clinic 24 before 08:30 on Monday morning or attend the Day surgery unit as planned and discuss the situation with medical staff.

When to seek help post-surgery

As with any operation, complications can occur after an operation for a miscarriage. You should seek medical advice from your GP, Clinic 24 or Daphne ward on the numbers listed below for:

- Heavy or prolonged vaginal bleeding, smelly vaginal discharge and abdominal pain: If you also have a raised temperature (fever) and 'flu-like symptoms, this may be due to an infection of the lining of the uterus.

- Increasing abdominal pain and you feel unwell: If you also have a temperature, have lost your appetite and are vomiting, this may be due to damage to your uterus. You will be readmitted to hospital.

- Burning and stinging when you pass urine or pass urine frequently: This may be due to a urine infection.

- Painful, red, swollen, hot leg or difficulty bearing weight on your legs: This may be due to a DVT. If you have shortness of breath or chest pain or cough up blood, this could be a sign that a blood clot has travelled to the lungs (pulmonary embolism). If you have any of these symptoms, you should seek medical help immediately.

Information and support

You might be given some additional patient information before or after the procedure, for example: leaflets that explain what to do after the procedure and what problems to look out for.
If you have any questions or concerns, please feel free to contact us:

- Clinic 24 (The Early Pregnancy Unit, Emergency Gynaecology Unit)
  01223 217636
  Open 08:00 – 20:00 Monday to Friday
  08:30 – 14:00 at weekends
  Closed Bank holidays

- Daphne Ward (Inpatient Gynaecology ward)
  01223 257206
  At all other times

Other useful sources of support:

- The Miscarriage Association
  01924 200799
  (Monday-Friday 09:00 – 16:00)
  www.miscarriageassociation.org.uk

  Recovering Well Information about recovering from Surgical management of a miscarriage. London

- Petals
  Charity who provide specialist counselling for individuals and couples affected by loss during pregnancy
  0300 688 0068
  Counselling@petalscharity.org

Anaesthesia

Anaesthesia means ‘loss of sensation’. There are three types of anaesthesia: general, regional and local. The type of anaesthesia chosen by your anaesthetist depends on the nature of your surgery as well as your health and fitness. Sometimes different types of anaesthesia are used together.

Before your operation

Before your operation you will meet an anaesthetist who will discuss with you the most appropriate type of anaesthetic for your operation, and pain relief after your surgery. To inform this decision, he/she will need to know about:

- your general health, including previous and current health problems
- whether you or anyone in your family has had problems with anaesthetics
- any medicines or drugs you use
- whether you smoke
- whether you have had any abnormal reactions to any drugs or have any other allergies
- your teeth, whether you wear dentures, or have caps or crowns.
Your anaesthetist may need to listen to your heart and lungs, ask you to open your mouth and move your neck and will review your test results.

**Pre-medication**
You may be prescribed a ‘premed’ prior to your operation. This is a drug or combination of drugs which may be used to make you sleepy and relaxed before surgery, provide pain relief, reduce the risk of you being sick, or have effects specific for the procedure that you are going to have or for any medical conditions that you may have. *Not all patients will be given a premed or will require one and the anaesthetist will often use drugs in the operating theatre to produce the same effects.*

**Moving to the operating room or theatre**
You will usually change into a gown before your operation and we will take you to the operating suite. When you arrive in the theatre or anaesthetic room and **before starting your anaesthesia, the medical team will perform a check of your name, personal details and confirm the operation you are expecting.**

Once that is complete, monitoring devices may be attached to you, such as a blood pressure cuff, heart monitor (ECG) and a monitor to check your oxygen levels (a pulse oximeter). An intravenous line (drip) may be inserted. If a regional anaesthetic is going to be performed, this may be performed at this stage. If you are to have a general anaesthetic, you may be asked to breathe oxygen through a face mask.

**General anaesthesia**
During general anaesthesia you are put into a state of unconsciousness and you will be unaware of anything during the time of your operation. Your anaesthetist achieves this by giving you a combination of drugs.

While you are unconscious and unaware your anaesthetist remains with you at all times. He or she monitors your condition and administers the right amount of anaesthetic drugs to maintain you at the correct level of unconsciousness for the period of the surgery. Your anaesthetist will be monitoring such factors as heart rate, blood pressure, heart rhythm, body temperature and breathing. He or she will also constantly watch your need for fluid or blood replacement.

**Regional anaesthesia**
Regional anaesthesia includes epidurals, spinals, caudals or local anaesthetic blocks of the nerves to the limbs or other areas of the body. Local anaesthetic is injected near to nerves, numbing the relevant area and possibly making the affected part of the body difficult or impossible to move for a period of time. Regional anaesthesia may be performed as the sole anaesthetic for your operation, with or without sedation, or with a general anaesthetic. Regional anaesthesia may also be used to provide pain relief after your surgery for hours or even days. Your anaesthetist will discuss the procedure, benefits and risks with you and, if you are to have a general anaesthetic as well, whether the regional anaesthesia will be performed before you are given the general anaesthetic.
Local anaesthesia

In local anaesthesia the local anaesthetic drug is injected into the skin and tissues at the site of the operation. The area of numbness will be restricted. Some sensation of pressure may be present, but there should be no pain. Local anaesthesia is used for minor operations such as stitching a cut, but may also be injected around the surgical site to help with pain relief. Usually a local anaesthetic will be given by the doctor doing the operation.

Sedation

Sedation is the use of small amounts of anaesthetic or similar drugs to produce a ‘sleepy-like’ state. Sedation may be used as well as a local or regional anaesthetic. The anaesthesia prevents you from feeling pain and the sedation makes you drowsy. Sedation also makes you physically and mentally relaxed during an investigation or procedure which may be unpleasant or painful (such as an endoscopy) but where your co-operation is needed. You may remember a little about what happened but often you will remember nothing. Sedation may be used by other professionals as well as anaesthetists.

What will I feel like afterwards?

How you will feel will depend on the type of anaesthetic and operation you have had, how much pain relieving medicine you need and your general health.

Most people will feel fine after their operation. Some people may feel dizzy, sick or have general aches and pains. Others may experience some blurred vision, drowsiness, a sore throat, headache or breathing difficulties.

You may have fewer of these effects after local or regional anaesthesia although when the effects of the anaesthesia wear off you may need pain relieving medicines.

What are the risks of anaesthesia?

In modern anaesthesia, serious problems are uncommon. Risks cannot be removed completely, but modern equipment, training and drugs have made it a much safer procedure in recent years. The risk to you as an individual will depend on whether you have any other illness, personal factors (such as smoking or being overweight) or surgery which is complicated, long or performed in an emergency.

Very common (1 in 10 people) and common side effects (1 in 100 people)

Feeling sick and vomiting after surgery
Sore throat
Dizziness, blurred vision
Headache
Bladder problems
Damage to lips or tongue (usually minor)
Itching
Aches, pains and backache
Pain during injection of drugs
Bruising and soreness
Confusion or memory loss

**Uncommon side effects and complications (1 in 1000 people)**
- Chest infection
- Muscle pains
- Slow breathing (depressed respiration)
- Damage to teeth
- An existing medical condition getting worse
- Awareness (becoming conscious during your operation)

**Rare (1 in 10,000 people) and very rare (1 in 100,000 people) complications**
- Damage to the eyes
- Heart attack or stroke
- Serious allergy to drugs
- Nerve damage
- Death
- Equipment failure

Deaths caused by anaesthesia are very rare. There are probably about five deaths for every million anaesthetics in the UK.

For more information about anaesthesia, please visit the Royal College of Anaesthetists’ website: [www.rcoa.ac.uk](http://www.rcoa.ac.uk)
Information about important questions on the consent form

1 Creutzfeldt Jakob Disease ('CJD')

We must take special measures with hospital instruments if there is a possibility you have been at risk of CJD or variant CJD disease. We therefore ask all patients undergoing any surgical procedure if they have been told that they are at increased risk of either of these forms of CJD. This helps prevent the spread of CJD to the wider public. A positive answer will not stop your procedure taking place, but enables us to plan your operation to minimise any risk of transmission to other patients.

2 Photography, Audio or Visual Recordings

As a leading teaching hospital we take great pride in our research and staff training. We ask for your permission to use images and recordings for your diagnosis and treatment; they will form part of your medical record. We also ask for your permission to use these images for audit and in training medical and other healthcare staff and UK medical students; you do not have to agree and if you prefer not to, this will not affect the care and treatment we provide. We will ask for your separate written permission to use any images or recordings in publications or research.

3 Students in training

Training doctors and other health professionals is essential to the NHS. Your treatment may provide an important opportunity for such training, where necessary under the careful supervision of a registered professional. You may, however, prefer not to take part in the formal training of medical and other students without this affecting your care and treatment.

4 Use of Tissue

As a leading biomedical research centre and teaching hospital, we may be able to use tissue not needed for your treatment or diagnosis to carry out research, for quality control or to train medical staff for the future. Any such research, or storage or disposal of tissue, will be carried out in accordance with ethical, legal and professional standards. In order to carry out such research we need your consent. Any research will only be carried out if it has received ethical approval from a Research Ethics Committee. You do not have to agree and if you prefer not to, this will not in any way affect the care and treatment we provide. The leaflet ‘Donating tissue or cells for research’ gives more detailed information. Please ask for a copy.

If you wish to withdraw your consent on the use of tissue (including blood) for research, please contact our Patient Advice and Liaison Service (PALS), on 01223 216756.
Privacy & dignity

Same sex bays and bathrooms are offered in all wards except critical care and theatre recovery areas where the use of high-tech equipment and/or specialist one to one care is required.

We are now a smoke-free site: smoking will not be allowed anywhere on the hospital site. For advice and support in quitting, contact your GP or the free NHS stop smoking helpline on 0800 169 0 169.

Other formats:

If you would like this information in another language, large print or audio, please ask the department where you are being treated, to contact the patient information team: patient.information@addenbrookes.nhs.uk.

Please note: We do not currently hold many leaflets in other languages; written translation requests are funded and agreed by the department who has authored the leaflet.

Document history

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Contact number
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Publish/Review date
October 2016/October 2019

File name
Surgical management of miscarriage consent

Version number/Ref
Version 2/CF463

Surgical Management if Miscarriage, CF463, Version number 2, October 2016
Surgical Management of Miscarriage

To remove any remaining tissue and/or blood clot in the uterus after a miscarriage.
To treat sepsis (infection)
To alleviate heavy bleeding
To ensure completion of miscarriage if suspicion of gestational trophoblastic disease (a rare and serious condition of early pregnancy)

Tear in the cervix. (Rare).
Uterine perforation (Uncommon – up to 5 in 1000 women).
Deep vein thrombosis (blood clot in the leg). Death (very rare – 0.5 in every 100 000).
Bleeding that lasts for up to two weeks is very common but blood transfusion is uncommon (1-2 in 1000 women). Infection of the lining of the womb. (Common – 3 in 100 women). Intrauterine adhesions (Uncommon – 1 in every 200 women). Failed procedure (Common - up to 5 in 100 women)

Patient safety – at the heart of all we do
Consent Form

Surgical Management of miscarriage

1. The following information leaflet has been provided:
   Name of leaflet(s) Surgical management of miscarriage

   Version, reference and date: Version 2, ref CF463, October 2016

   or I have offered the patient information about the procedure but this has been declined.

2. This procedure will involve:
   □ General and/or regional anaesthesia □ Local anaesthesia □ Sedation □ None

   Signed (Health professional): ___________________________ Date: D D / M M / Y Y Y Y

   Name (PRINT): __________________________________________ Time (24hr): ____________

   Designation: __________________________________________ Contact/bleep no: ____________

C Consent of patient / person with parental responsibility

   I confirm that the risks, benefits and alternatives of this procedure have been discussed
   with me and that my questions have been answered to my satisfaction and understanding.
   Important: please read the patient information about this procedure and then put a
   tick in the relevant boxes for the following questions:

1. Creutzfeldt Jakob disease (CJD)
   Have you ever been notified that you are at risk of CJD or variant CJD
   for public health purposes? If yes, please inform your health professional.
   □ Yes □ No

2. Photography, Audio or Visual Recording
   a) I agree to the use of any of the above type of recordings for the purpose
      of diagnosis and treatment.
   b) I agree to unidentified versions of any of the above recordings being used
      for audit and medical teaching in a healthcare setting.
   □ Yes □ No

3. Students in training
   I agree to the involvement of medical and other students as part
   of their formal training.
   □ Yes □ No

For staff use only:
Hospital number:
Surname:
First names:
Date of birth:
NHS no: __ _ / _ _ _ / _ _ _
Use hospital identification label
Use of Tissue

a) I agree that tissue (including blood) not needed for my own diagnosis or treatment can be used and stored for ethically approved research which may include ethically approved genetic research.

b) Where additional clinical information is needed for the purposes of ethically approved research, I agree that relevant sections of my medical record may be looked at by researchers or by relevant regulatory authorities. I give permission for these individuals to have access to my records.

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

I have read and understood the Patient Information about this procedure and the above additional information. I agree to the procedure or treatment.

Signed (Patient): .......................................................... Date:   D.D./M.M./Y.Y.Y.Y.
Name of patient (PRINT): ..........................................................

If signing for a child or young person; delete if not applicable.
I confirm I am a person with parental responsibility for the patient named on this form.
Signed: .......................................................... Date:   D.D./M.M./Y.Y.Y.Y.
Relationship to patient: ..........................................................

If the patient is unable to sign but has indicated his/her consent, a witness should sign below.
Signed (Witness): .......................................................... Date:   D.D./M.M./Y.Y.Y.Y.
Name of witness (PRINT): ..........................................................
Address: ..........................................................
Confirmation of consent

Confirmation of consent (where the treatment/procedure has been discussed in advance)
On behalf of the team treating the patient, I have confirmed with the patient that she/he has no further questions and wishes the treatment/procedure to go ahead.

Signed (Health professional): .......................................................... Date: ....D. D. / M. M. / Y. Y. Y. Y.
Name (PRINT): .......................................................... Job title: ..........................................................

Please initial to confirm all sections have been completed: ..........................................................

Interpreter’s statement (if appropriate)

I have interpreted the information to the best of my ability, and in a way in which I believe the patient can understand:

Signed (Interpreter): .......................................................... Date: ....D. D. / M. M. / Y. Y. Y. Y.
Name (PRINT): ..........................................................

Or, please note the language line reference ID number: ..........................................................

Withdrawal of patient consent

☐ The patient has withdrawn consent (ask patient to sign and date here)

Signed (Patient): .......................................................... Date: ....D. D. / M. M. / Y. Y. Y. Y.
Signed (Health professional): .......................................................... Date: ....D. D. / M. M. / Y. Y. Y. Y.
Name (PRINT): .......................................................... Job title: ..........................................................