Case: Complex communication miscarriage station

Candidate brief

You are a 4th year medical student in the early pregnancy clinic.

Please take a focused history from Kate Wallis, a 25-year-old female who presented with vaginal bleeding.

15 mins	1. Please take a full history (7 mins) 2. Counsel her with an appropriate management plan (4 mins) 3. Viva with the examiner afterwards (4 mins)
10 mins	1. Please take a full history (7 mins) 2. Viva with the examiner afterwards (3 mins)

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Patient Brief

(Do not volunteer information unless asked)

Name: Katie Wallis
DOB: 16/07/1995 (25 years old)
Job: primary school teacher
Opening statement: "I came here to the early pregnancy unit following some vaginal bleeding that began yesterday"

HPC:

- **8 weeks pregnant**
- **Some vaginal bleeding that suddenly started yesterday morning**
- Bleeding worsened today and now has **lower abdominal cramps**
- Passed clots and bits of red-looking tissue
- Used sanitary pads to control bleeding

Associated symptoms

- Have **lower abdominal cramps**, nauseous
- No collapse or feeling faint, no fever feel, no other vaginal discharge other than blood

Obs Hx

- Never been pregnant before

Gynae Hx
Period: Last menstrual period: 9/01/2020 (two months ago)

- Regular periods
- 28-day cycle
- Not heavy
- No clots

Smears: not had a smear yet since she is 25 years old
STIs: no history of STIs
Contraception: none

PMHx – hay fever, blood group is B rhesus positive

DHx – NKDA – only anti-histamines during spring and summer, folic acid for the past 4 months, no allergies

FHx – nil

SHx – lives with her boyfriend and has a stable relationship with him. Partner was supportive of pregnancy and did not attend today as he works offshore. No problems at home and manages well. Works as a primary school teacher. Non-smoker, does not drink.

Other information:

- Other systems review - normal

Ideas: worried about miscarriage and whether she needs to be in the hospital or stay home

Concerns: if she will be able to become pregnant again

Expectations: that she needs to undergo tests to investigate why she had a miscarriage

Investigations findings (Provide it after history talking or to enquire candidate about differential diagnosis)

INVESTIGATIONS:

- BMI – 32kg/m^2
- Rhesus blood group: Rhesus -ve mother needs anti-immunoglobulin D
- Speculum examination: Cervical os is open with some fetal tissue seen at cervical os.
- TVUS: Gestational sac >25mm with no visible yolk sac or fetal pole. No fetal heartbeat is detected
- Serum beta HCG titres can aid diagnosis (fall of >50% in 48 hours suggests a failing pregnancy)
- If suspicious of STD, will require vaginal swab
- Repeated miscarriage: consider parental karyotype for genetic abnormalities

Findings are consistent with an incomplete miscarriage

Examiner Brief

Candidate Brief:
You are 4th year medical student in the early pregnancy clinic.
Please take a focused history from Kate Wallis, a 25-year-old female who is 8 weeks pregnant and presented with vaginal bleed.

15 mins	1. Please take a full history (7 mins) 2. Counsel her with an appropriate management plan (4 mins) 3. Viva with the examiner afterwards (4 mins)
10 mins	1. Please take a full history (7 mins) 2. Viva with the examiner afterwards (3 mins)

- **Please do not** provide **any verbal or non-verbal feedback** for the candidate. This includes nodding to correct answers and shaking head to wrong answers - particularly during the viva.
- **Please provide positive and negative feedback** (both verbal and written) at the end of the session once the examination is complete.
- The questions below are provided as a guide for discussion only. For viva, please ask questions surrounding the case and challenge the candidate where appropriate

Examiners will grade the performance across four domains: **(15 minute station)**

1. Clinical skills
2. Formulation of clinical issues
3. Discussion of management
4. Professional behaviours and patient centred approach

	0	1	2	3

History
Presenting complaint and History of presenting complaint
- Clarifies history (duration, onset, presence of clots)
- Associated symptoms
  ○ Suprapubic pain
  ○ Vaginal bleeding with or without clots
  ○ Lower back pain
  ○ Fever, vaginal discharge (septic miscarriage/infection)
  ○ Nausea, collapse
  ○ History of trauma
 	
Past Medical History
- Diabetes, hypertension, clotting disorders?
- Blood group (need for Anti-D?)
 	
Drug history and allergies
 	
Past Obstetric history
- Asks how she knew she was pregnant and how many weeks she is
- Ascertains if this was a wanted pregnancy
- Previous pregnancies/first pregnancy?				

Past Gynaecological history - Clarifies the LMP - Length of cycle, nature of periods Social history - Smoking status, alcohol consumption - Living arrangements/partner and support system - Asks if there's anyone who the patient can rely on for support or help Suggests appropriate investigations – Transvaginal ultrasound Invites questions from patient and addresses ideas, concerns and expectations				
Breaking bad news (can use SPIKES framework or any other appropriate format) Situation Perception – explores patient's understanding and expectation Information – Gives an appropriate warning shot Knowledge – explains results of the scan sensitively Empathy – shows empathy in an appropriate, professional manner Summarise and offer support (leaflets and telephone numbers)				
Patient's ideas, concerns and expectations - Addresses these and signposts to appropriate services Management plan: - In the case of incomplete miscarriage with fetal tissue seen in cervical os, manual evacuation is required - Describes next steps/management options (offer watch and wait/conservative management [first line] or offer misoprostol only NOT mifepristone) - Explains that 1 in 5 pregnancies end in a miscarriage and reassures patient that there is no need to investigate cause as this is only offered after 3 consecutive miscarriages - Explains that the cause of majority of miscarriages is unknown - Advises bleeding should gradually reduce over the next few days. (safety mark) - Advises to come back if notices bleeding continues or discharge becomes foul smelling or doesn't stop within a few days. - Explain may still have abdominal cramps and can take paracetamol or other analgesics to manage this.				

- Advises to wait for at least 1 menstrual cycle before trying to conceive again and to continue taking folic acid - Considers need for anti-D (safety mark) but reassures patient does not need this injection - Suggests patient takes time off work if appropriate				

ASSESS criteria					
Accuracy	1	2	3	4	5
Skilfulness	1	2	3	4	5
Supportiveness	1	2	3	4	5
Efficiency	1	2	3	4	5
Safety	1	2	3	4	5
Structure	1	2	3	4	5

Viva Questions: (Please ask questions surrounding the case and challenge the candidate where appropriate); **The questions below are provided as a guide for discussion only.**

Resource: miscarriage patient UK; BMJ best practice

1. Differential diagnosis	● Ectopic pregnancy (Red flags: pain, hypotension, tachycardia, anaemia) ● Hydatidiform mole ● Cystitis ● Pregnancy coexisting with bleeding cervical polyp/ large ectropion
2. What are the risk factors of a miscarriage	● Age >30 years old ● Uterine malformation ● Bacterial vaginosis ● Thrombophilias (antiphospholipid syndrome >3 miscarriages warrant investigation- lupus anticoagulant/ anticardiolipin antibodies)
3. How would you manage a patient with a miscarriage	● Rhesus blood group- Rh-negative need anti-D immunoglobulin ● Threatened miscarriage- conservative with analgesics and counselling ● If early pregnancy tissue seen in cervical os- manual evacuation + analgesics + misoprostol + anti-D immunoglobulin ● Incomplete/ inevitable/ missed miscarriage ○ Conservative management (analgesia, anti-emetics) unless there is profuse, heavy, persistent bleeding; Repeat HCG and US follow up in 2 weeks ○ Medical management with vaginal misoprostol ○ Surgical management (suction evacuation under local anaesthetic in outpatient clinic/ general anaesthetic in a theatre) suitable for patient with heavy menstrual bleeding and intrauterine bleeding

	● Complete miscarriage ○ Analgesics counselling + anti-D immunoglobuli ● Recurrent miscarriage ○ Counselling ○ Genetic testing ○ Antiphospholipid testing ○ Uterine abnormalities (fibroid, adhesion, congenital) ○ Endocrine causes (DM poorly controlled, thyroid, PCOS)
4. What are the prognostic factors	● Risk of subsequent preterm delivery ● Increased risk of further miscarriages (after 3, expect recurrent spontaneous miscarriage) ● Women with antiphospholipid syndrome have increased risk of thrombosis and poor uteroplacental circulation. Treat with aspirin and LMWH until 34 weeks pregnancy in future pregnancy.

Diagnostic approach (UptoDate guideline)