



Case: Early Pregnancy PV Bleeding

Candidate brief

You are a F2 in a GP surgery

Please take a focused history from Louisa Alcott, a 28-year-old female who had a positive pregnancy test two weeks ago and started to bleed yesterday.

9 mins	<ol style="list-style-type: none">1. Please take a gynaecological history2. Explain the differential diagnosis to Louisa3. Recommend investigations and ongoing management to Louisa
10 mins	<ol style="list-style-type: none">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: Louisa Alcott

DOB: 03/12/1992 (28 years old)

Job: Primary School Teacher

Opening statement: "I thought I should come in as I had a positive pregnancy test 2 weeks ago and I started bleeding yesterday"

HPC:

Put the HPC here

- Had positive pregnancy test 2 weeks ago.
- **PV Bleeding** – started yesterday afternoon, when out on a run, has passed some bright red fresh coloured blood, some clots (50p coin in size) , no 'tissue'.
- Changing Pads every 6 hours since yesterday afternoon.
- **Cramping Pain**- rated 6/10, lower abdominal pain.

Associated symptoms

- Have Pain- cramping, lower abdominal pain, like a bad period
- No shoulder tip pain radiation, or signs of infection (temperature, breathlessness, headaches, cough, fever etc). Otherwise feeling well.

Obs Hx

- 1 pregnancy 3 years ago, resulted in Ventouse delivery at 39 weeks. Medical conditions in pregnancy: uncomplicated, delivery initially midwife-led.
- Had no bleeding in previous pregnancy.

Gynae Hx

Period: Last menstrual period: 7 weeks ago-

- Normal cycle is 5/29 (bleeding for 5 days every 29 days)
- Periods have been regular since menarche at age 1
- Periods have never been particularly heavy

Smears: Up to date with smears. Last smear this year. Never had an abnormal smear.

STIs: Had Chlamydia age 18 - which was treated, no PID. Same sexual partner (her husband) for last 10 years. Last STI check - 10 years ago.

Contraception: Was using COCP - had stopped 5 months ago with the intention to get pregnant

PMHx – Never had a miscarriage before.

Had chlamydia when she was 18. Not aware of having PID



Same sexual partner over the last 10 years
Never had abdominal/pelvic surgery
Has asthma (well controlled) but no other medical conditions

DHx – NKDA, Folic Acid, Pregnacare vitamins , Salbutamol and Beclomethasone (Asthma)

FHx – Sister and sister in law have had 2 miscarriages

SHx – Does not smoke, BMI 22, does not drink ETOH. Never used recreational drugs. Quite active, runs regularly. Works full time as a primary school teacher (Year 4) – enjoys her job and does not find it particularly stressful.

Other information:

- Other systems review - normal

Ideas: Thinks she has had a miscarriage.

Concerns: Concerned about the implications of the miscarriage, and is worried it is her fault. Concerned she will have another and that she will be unable to get pregnant again. Has always wanted a large family and worried this could mean that she will not be able to.

Expectations: Patient would like to know why this has happened. Would like to know if she would have to have surgery?



INVESTIGATIONS:

BMI – 22kg/m²

OBSERVATIONS AT THE TIME OF ASSESSMENT:

Unremarkable – NEWS0 (BP 127/82, HR 64, O2 sats 99% on RA, temp 36.8C, RR 16)



Examiner Brief

Candidate Brief:

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Please take a focused history from Louisa Alcott, a 28-year-old female who had a positive pregnancy test two weeks ago and started to bleed yesterday.GP.

9 mins	<ol style="list-style-type: none"> 1. Please take a gynaecological history 2. Explain the differential diagnosis to Louisa 3. Recommend investigations and ongoing management to Louisa
10 mins	<ol style="list-style-type: none"> 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

Positive descriptors	Marks
History/Clinical skills (18)	
Appropriate introduction, elicit patient details and invite consultation	2
Bleeding: Onset, Volume, Colour and Progression	2
Presence of clots, dysuria, dyspareunia or discharge	2
Pain – with SOCRATES as appropriate – include screening for shoulder tip pain	2
Menstrual history – age at time of menarche, LMP, regularity of periods and characteristics	2
Gynaecological history – contraception , menopause, STIs, cervical screening, history of PID	2
Obstetric history – Gravity, Parity, outcome of pregnancies and bleeding in pregnancy	2
Enquire about risk factors: Ask about PID, IVF, FHx miscarriages, previous miscarriage	2
Past medical (surgical) history; drug history, family history , social history	1
Formulation of clinical issue (5)	
Summary and interpretation of clinical findings accurately	2
Differentials diagnoses explained to the patient.	1
Viva	2
Discussion of management (4)	
Build patient concerns into plan and Justify choice of investigations	2

Disclaimer: All contents are contributed by medical students and/or junior doctors on behalf of BUSOG, although every effort has been made to ensure the information is correct and robust; however, authors accept no liability for errors.



Discuss same-day referral to Early Pregnancy Clinic and what to expect at the clinic		1
Viva (Management)		1
Professionalism and patient centered approach (3)		
Able to elicit patient ideas, concerns, expectations		1
Use empathic behaviour and language		1
Explain accurately, uses everyday language and check for understanding		
Professional communication to examiner as colleague		1

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: **Ectopic pregnancy and miscarriage: diagnosis and initial management**

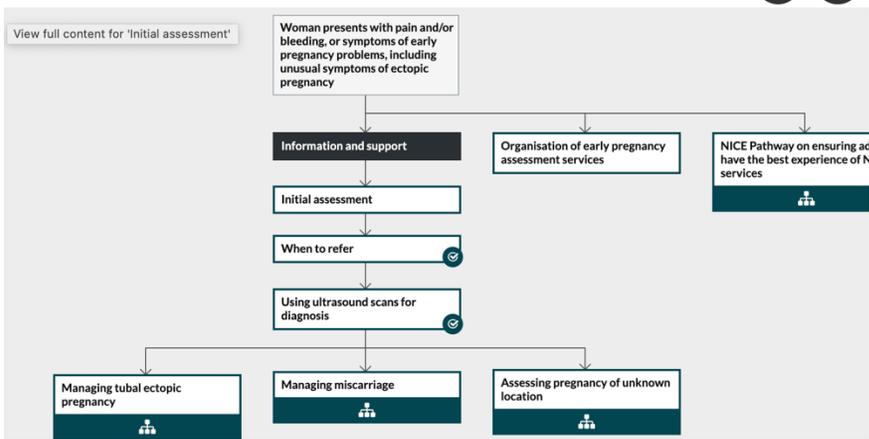
NICE guideline [NG126]

1. Differential diagnosis	Ectopic Pregnancy Miscarriage PV bleeding due to a cause unrelated to the positive pregnancy test – e.g. cervical ectropion, reproductive tract malignancy, PID endocrine abnormalities.
2. How would you differentiate between the two most likely diagnoses?	Serial beta hCG hormone in blood serum sample- if serum hCG falling by >50% in 48h, more likely a non-viable pregnancy. Speculum exam, to look for evidence of miscarriage, pregnancy tissue or clots Transvaginal Ultrasound, looking for fetal pole and heartbeat.
3. How would you manage a patient with a miscarriage	Medical- 600mg Vaginal Misoprostol and Pain Relief Surgical- Evacuation of Retained Products of Conception (ERPC)
4. How should this patient be followed up?	take a urine pregnancy test 3 weeks after medical management of miscarriage unless they experience worsening symptoms, in which case advise them to seek medical advise. Advise women with a positive urine pregnancy test after 3 weeks to return for a review by a healthcare professional to ensure that there is no molar or ectopic pregnancy.



Algorithm for management of Suspected Miscarriage (NICE)

Ectopic pregnancy and miscarriage overview



Information and support

Treat all women with **early pregnancy** complications with dignity and respect. Be aware that women will react to complications or the loss of a pregnancy in different ways. Provide all women with information and support in a sensitive manner, taking into account their individual circumstances and emotional response. For more guidance about providing information, see [the NICE Pathway on patient experience in adult NHS services](#).

Healthcare professionals providing care for women with early pregnancy complications in any setting should be aware that early pregnancy complications can cause significant distress for some women and their partners. Healthcare professionals providing care for these women should be given training in how to communicate sensitively and breaking bad news. Non-clinical staff such as receptionists working in settings where early pregnancy care is provided should

Initial assessment

During clinical assessment of women of reproductive age, be aware that:

- they may be pregnant, and think about offering a pregnancy test even when symptoms are non-specific and
- the symptoms and signs of ectopic pregnancy can resemble the common symptoms and signs of other conditions – for example, gastrointestinal conditions or urinary tract infection.

Exclude the possibility of ectopic pregnancy, even in the absence of risk factors (such as previous ectopic pregnancy), because about a third of women with an ectopic pregnancy will have no known risk factors.

Use **expectant management** for women with a pregnancy of less than 6 weeks gestation who are bleeding but not in pain, and who have no risk factors, such as a

Refer to an early pregnancy assessment service

Refer immediately to an early pregnancy assessment service (or out-of-hours gynaecology service if the early pregnancy assessment service is not available) for further assessment of women with a positive pregnancy test and the following on examination:

- pain and abdominal tenderness or
- pelvic tenderness or
- cervical motion tenderness.

Refer to an early pregnancy assessment service (or out-of-hours gynaecology service if the early pregnancy assessment service is not available) women with bleeding or other symptoms and signs of early pregnancy complications who have:

- pain or
- a pregnancy of 6 weeks gestation or more or
- a pregnancy of uncertain gestation.

The urgency of this referral depends on the clinical situation.

Refer women who return with worsening symptoms and signs that could suggest an ectopic pregnancy to an early pregnancy assessment service (or out-of-hours gynaecology service if the early pregnancy assessment service is not available) for further assessment. The decision about whether she should be seen immediately or within 24 hours will depend on the clinical situation.

Using ultrasound scans for diagnosis

Offer women who attend an early pregnancy assessment service (or out-of-hours gynaecology service if the early pregnancy assessment service is not available) a transvaginal ultrasound scan to identify the location of the pregnancy and whether there is a fetal pole and heartbeat.

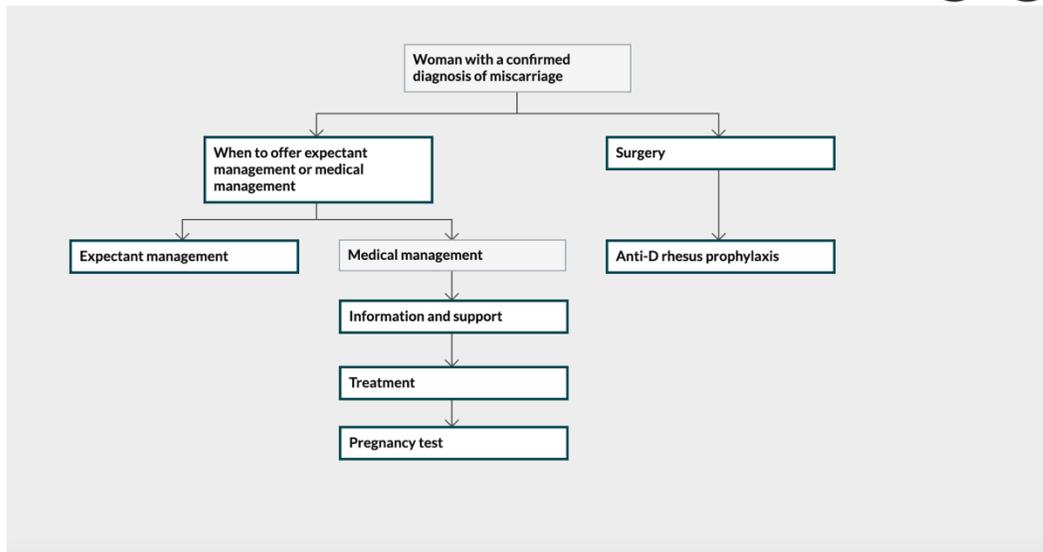
Consider a transabdominal ultrasound scan for women with an enlarged uterus or other pelvic pathology, such as fibroids or an ovarian cyst.

If a transvaginal ultrasound scan is unacceptable to the woman, offer a transabdominal ultrasound scan and explain the limitations of this method of scanning.

All ultrasound scans should be performed or directly supervised and reviewed by appropriately qualified healthcare professionals, with training in, and experience



Managing miscarriage



Treatment

Offer all women receiving medical management of miscarriage pain relief and anti-emetics as needed.

Offer vaginal misoprostol¹ for the medical treatment of missed or incomplete miscarriage. Oral administration is an acceptable alternative if this is the woman's preference.

For women with an incomplete miscarriage, use a single dose of 600 micrograms misoprostol.¹ (800 micrograms can be used as an alternative to allow alignment of treatment protocols for both missed and incomplete miscarriage.)

For women with a missed miscarriage, use a single dose of 800 micrograms of misoprostol¹.

Do not offer mifepristone as a treatment for missed or incomplete miscarriage.

Surgery

Provide oral and written information to all women undergoing surgical management of miscarriage about the treatment options available and what to expect during and after the procedure. (See also [information and support](#) for details of further information that should be provided.)

Where clinically appropriate, offer women undergoing a miscarriage a choice of:

- manual vacuum aspiration under local anaesthetic in an outpatient or clinic setting **or**
- surgical management in a theatre under general anaesthetic.

Pregnancy test

Advise women to take a urine pregnancy test 3 weeks after medical management of miscarriage unless they experience worsening symptoms, in which case advise them to return to the healthcare professional responsible for providing their medical management.

Advise women with a positive urine pregnancy test after 3 weeks to return for a review by a healthcare professional to ensure that there is no molar or ectopic pregnancy.

For more information on diagnosing an ectopic pregnancy, see [using ultrasound scans for diagnosis](#).