Suction evacuation of the Uterus (Womb)

What is suction evacuation of the Uterus?

This is the surgical operation that enables the remaining contents of a miscarriage within the womb to be removed. It is sometimes also referred to as “evacuation of retained products of conception” (ERPC).

Before the procedure, the woman is usually given a tablet (“misoprostol”) to be inserted into the vagina; this helps to soften the cervix (neck of the womb), enabling the procedure to be performed more smoothly. Under general anaesthesia, the woman is placed in a position with the legs in stirrups. She is then examined internally to assess the womb. The cervix is then grasped and the opening gently stretched. This will allow the passage of instruments into the inside cavity of the womb.

A suction tube is then passed into the cavity of the womb. When suction is applied, the contents of the womb are then gently removed. When most or all of the contents have been removed, the tube is taken out, and the cavity of the womb gently checked with a metal scrape. This ensures that the womb is completely emptied.

The procedure usually takes 10 to 15 minutes to complete. Antibiotics are given during the procedure.

What are the alternatives?

Depending on the type of miscarriage, the following alternative options may be available:

- Natural miscarriage or expectant management: when nature is allowed to take its course. The pregnancy will eventually miscarry, but it is hard to predict when this is going to happen. For most women, it happens within two weeks, but occasionally it can take longer.
- Medical management of miscarriage: this involves the use of medication to help to pass the pregnancy tissues. High dose misoprostol is usually used. The purposes of the drug are to tell the body it is no longer pregnant, and to promote contractions (cramps) of the womb to pass the pregnancy.

What are the potential risks and side effects?

This procedure is associated with the following potential risks and complications:

- **Heavy vaginal bleeding**: bleeding is inevitable following any form of treatment for miscarriage. It is usually light and stops within one or two weeks. However, heavy bleeding may occur rarely, at a rate of about 1.5/1,000 procedures (that is, out of 2,000 procedures, three women may suffer very heavy bleeding). If heavy bleeding occurs, blood transfusion and additional procedures may be required to stop the bleeding.
- **Pelvic infection following suction evacuation of the uterus** may occur to varying degrees of severity. In order to reduce this risk, women are given a course of antibiotics during and after the procedure. It is of paramount importance that the course of antibiotics is complete, otherwise infection may develop and future fertility may be compromised.
- **Trauma to the cervix (neck of the womb):** special instruments are applied to the cervix during surgical treatment of miscarriage. During the procedure, damage may occur when the cervix is being dilated. This complication occurs at no greater than 1% of the time. This risk is reduced if “misoprostol” tablets are used before the procedure.

- **Incomplete emptying of the womb**: Occasionally the womb does not get emptied completely and part of the pregnancy tissues is left behind. This may lead to heavy bleeding or an infection. An additional procedure may be required.
- **Perforation of the womb**: making a hole through the wall of the womb occurs rarely, at a risk of 1 - 4 per 1,000 procedures. When perforation of the womb happens, bowel and bladder are at risk of being damaged. If uterine perforation is suspected, an additional procedure called laparoscopy (commonly known as 'key-hole surgery') is required to assess the extent of the damage. If there is excessive bleeding from the perforation site on the womb, or if there is suspected bowel or bladder injury, an open operation into the abdomen will be required to deal with the damage. These additional procedures will be associated with their own levels of risks.
- **Anaesthetic complications***:* General anaesthesia is usually very safe. Problems however may arise very rarely as a result of anaesthesia. Your anaesthetist will see you before the operation to discuss your anaesthetic and to answer any questions you may have. This is also your opportunity to discuss the best way to control any pain or discomfort you may have after your operation. Please also refer to other leaflets you will have been given, produced by The Royal College of Anaesthetists: Anaesthesia Explained, and You and Your Anaesthetic for further details*.*

Although you will sign a consent form for this treatment, you may at any time after that withdraw such consent. Please discuss this with your medical team.

What are the expected benefits of treatment?

By undergoing this procedure, you are fairly certain that it will be over and done with, unlike the uncertainty of not knowing when things may happen if one lets nature takes its course. The bleeding will be significantly less than and shorter than the other choices of treatment.

What should I do before I come into hospital?

You will be asked **not** to have any food or drink for at least six hours before the operation. This is a rule that should be strictly observed. If the stomach is not empty before an operation, there is high risk of serious complications from both the anaesthesia and the operation. If it is known that the patient has had food within six hours of the procedure, the operation will be delayed or cancelled and rescheduled on another day.

Will I have an anaesthetic?

General anaesthesia is usually required for this procedure.

How will I feel afterwards?

Most women will have some lower tummy discomfort immediately following the procedure; this usually settles within a few days. You will be given some pain killers for this discomfort. There will also be bleeding as explained above.

How long will I be in hospital?

Most women recover quickly from the procedure and may be allowed to go home after four to six hours. If the procedure is carried out late in the evening or at night, then it is usually advisable to remain in hospital overnight to ensure a safe recovery.

What should I do when I go home?

You should be resting for at least a couple of days. To reduce the chance of infection, the course of antibiotics should be completed, and sanitary towels are advised rather than tampons

until the bleeding has stopped. It would be advisable to wait until you have stopped bleeding before you have sexual intercourse.

Your next period will be in about four to six weeks' time. Ovulation occurs before this, so you are fertile in the first month after a miscarriage. If you do not want to become pregnant, you should use some form of contraception.

Will I have to come back to hospital?

If this is your first miscarriage, no follow-up is usually necessary, unless you specifically request it. For women with repeated miscarriages (three or more), particularly for those who have no children, arrangement can be made for attendance at the clinic to carry out some tests.

When can I return to work?

This will vary for each woman. You should be able to go back to work after three to five days, but some women takes longer to fully recover, especially to come to terms with the loss.

Sources of information

Early Pregnancy Assessment Unit
Tel: (01424 757047) EXT 2725 generic phone number that serves both women for Eastbourne and Hastings.

Molar Pregnancy Web - www.hmole-chorio.org.uk

Miscarriage Association
Clayton Hospital
Northgate
Wakefield
West Yorkshire WF1 3JS
Helpline 01924 299799
Web: www.miscarriageassociation.org.uk

Early Pregnancy Information Centre - www.earlypregnancy.org.uk

Important information

The information in this leaflet is for guidance purposes only and is not provided to replace professional clinical advice from a qualified practitioner.

Your comments

We are always interested to hear your views about our leaflets. If you have any comments, please contact the Patient Experience Team – Tel: (01323) 417400 Ext: 5860 or by email at: esh-tr.patientexperience@nhs.net

Hand hygiene

The Trust is committed to maintaining a clean, safe environment. Hand hygiene is very important in controlling infection. Alcohol gel is widely available at the patient bedside for staff use and at the entrance of each clinical area for visitors to clean their hands before and after entering.

Other formats

If you require any of the Trust leaflets in alternative formats, such as large print or alternative languages, please contact the Equality and Human Rights Department.

Tel: 01424 755255 Ext: 2620

After reading this information are there any questions you would like to ask? Please list below and ask your nurse or doctor.

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Reference

The following clinicians have been consulted and agreed this patient information:
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The directorate group that have agreed this patient information leaflet:
Guideline Implementation Group

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Responsible clinician/author: Mr David Chui, Consultant Obstetrician and Gynaecologist