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Uterine aspiration: From OR to office

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Author and Disclosure Information

OBG MANAGEMENT

Compared with uterine aspiration in the OR, an office-based procedure is as safe, less expensive, and more patient centered—all reasons to make it the standard for surgical management of early pregnancy failure

CASE Patient with early pregnancy failure opts for surgical management

A 36-year-old woman (G3P2) at 9 weeks from her last menstrual period presents for an initial obstetric examination. On transvaginal ultrasound, her ObGyn notes an embryo measuring 9 weeks without cardiac activity. The ObGyn informs her of the early pregnancy failure diagnosis and offers bereavement support, and then reviews the available options: expectant management with follow-up in 2 weeks, medical management with mifepristone and misoprostol, and surgical management with a dilation and curettage (D&C). The patient is interested in expedited treatment and thus selects D&C, and the staff books the next available operating room (OR) slot for her the subsequent week. Over the weekend, the patient calls to report heavy bleeding and

passage of clots, and the ObGyn's practice partner takes her to the OR for a D&C for incomplete abortion.

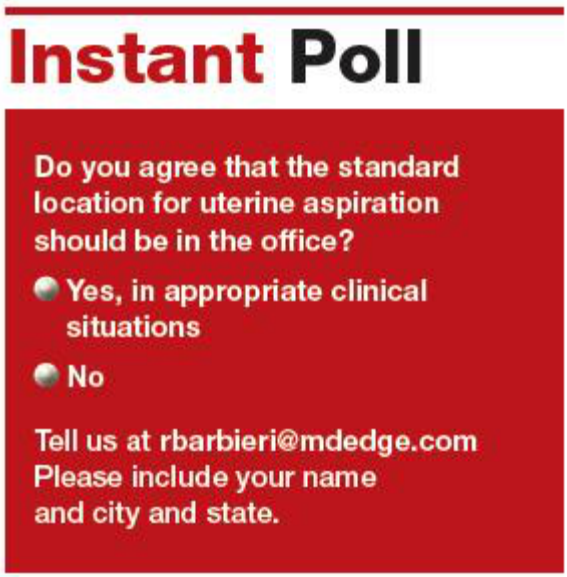
Early pregnancy failure occurs in about 1 in 5 pregnancies. Treatment options include expectant, medical, or surgical management. Surgical management is classically offered in the OR via D&C. With the advent of manual vacuum aspiration (MVA) using a 60-mL handheld syringe aspirator, office-based treatment of pregnancy failure has become more widely available.

In this article we make the case for why, in appropriate clinical situations, office-based uterine aspiration, compared with uterine aspiration in the OR, should be the standard for surgical management of early pregnancy failure, for these reasons:

1. equivalent safety profile

2. reduced costs, and

3. patient-centered characteristics.



1 Office-based procedures are safe

Suction curettage is one of the most common surgical procedures for a woman to undergo during her lifetime, and it has an excellent safety profile. Authors of a recent systematic review found that major surgical complications, including transfusion and uterine perforation requiring repair, occurred in less than 0.1% of all uterine aspiration procedures.[1] Importantly, this complication rate did not differ by inpatient or outpatient site of procedure.

Anesthesia-related complications at the time of aspiration also are extremely rare, and they are less likely to occur in the office setting than in surgical centers or hospital-based clinics (<0.2% and <0.5%, respectively).[1] This may be a result of the types of anesthesia offered at varying locations, given that local analgesia or moderate sedation is likely used in office-based procedures while deep sedation or general anesthesia may be employed at other practice locations.

Studies specifically designed to determine the safety of suction aspiration by practice location have yielded similar results. Researchers who conducted a systematic review comparing the safety of procedures done at ambulatory surgical centers with office-based procedures found no difference in safety between procedures performed in these 2 settings.[2] These findings were confirmed by results from a large retrospective cohort study that reviewed more than 50,000 aspiration procedures performed in ambulatory surgical centers versus private offices.[3] In that study, only 0.32% of women had any major adverse event, and there were no statistically significant differences in complication rates between settings.[3]

Complication rates based on procedure type are similar for MVA and electric suction aspiration. Early studies revealed no difference in the need for reaspiration or other complications for MVA compared with electric suction.[4] This was later confirmed by a systematic review that found no significant differences in safety by type of suction overall, and a possible trend toward fewer uterine perforations with MVA.[5] When procedures were assessed by gestational age, additional trends toward the safety of MVA emerged. For example, in procedures performed at less than 50 days' gestational age, estimated blood loss and severe pain occurred less commonly during procedures performed using MVA.[5]

Continue to: 2 Office-based procedures are less expensive

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