RCOG Consent Advice No. 10
Peer review draft – December 2025

Surgical Management of First Trimester Miscarriage including Manual Vacuum Aspiration

1. When to use this guidance

This is the third edition of this guidance, first published in 2010 under the title *Surgical Evacuation of the Uterus for Early Pregnancy Loss*, and updated in 2018 under the title *Surgical Management of Miscarriage [and Removal of Persistent Placental or Fetal Remains]*.

This guidance is for healthcare professionals who care for women, non-binary and trans people considering whether to have their miscarriage managed surgically, in order to aid the provision of appropriate and balanced information about the potential benefits, risks and alternatives to a surgical procedure. Expectant management and medical management are other methods for managing miscarriage, but these options will depend on the clinical circumstances.

This guidance is relevant to those aged 16 years and over with mental capacity, and those under 16 years of age who are considered competent*,[1–3] to help make the decisions that are appropriate for them.

Within this document we use the terms woman and women's health. However, it is important to acknowledge that it is not only women for whom it is necessary to access women's health and reproductive services in order to maintain their gynaecological health and reproductive wellbeing. Gynaecological and obstetric services and delivery of care must therefore be appropriate, inclusive and sensitive to the needs of those individuals whose gender identity does not align with the sex they were assigned at birth.

2. How to use this guidance

This guidance should be used by healthcare professionals to support personal informed choices, with reference to the General Medical Council's guidance on *Decision making and consent*[4] and *Intimate examinations and chaperones*,[5] and the following resources on management of miscarriage:

- RCOG patient information on Early miscarriage and Recovering from surgical management of a miscarriage (www.rcog.org.uk/for-the-public/browse-our-patient-information/).
- NHS website (www.nhs.uk/conditions/miscarriage/what-happens/).
- Miscarriage Association: Management of miscarriage (www.miscarriageassociation.org.uk/leaflet/management-of-miscarriage/).
- Tommy's: Surgical management of miscarriage (www.tommys.org/baby-loss-support/miscarriage-information-and-support/your-options-and-decisions/surgical-management).

* If a child (under 16) has sufficient maturity and understanding to make informed decisions about their treatment, they would be considered to meet the requirements of 'Gillick' competency as recognised in England, Wales and Northern Ireland; and described in the Age of Legal Capacity (Scotland) Act 1991. Under these circumstances, the child can consent to their own medical treatment without the need for parental knowledge or expressed permission.

- RCOG Green-top Guideline No. 17 Recurrent Miscarriage (Fourth Edition).[6]
- National Institute for Health and Care Excellence (NICE). Ectopic pregnancy and miscarriage: diagnosis and initial management [NG126]. Information for the public. (www.nice.org.uk/guidance/ng126/informationforpublic).

3. How to provide information

Information about surgical management of miscarriage, including manual vacuum aspiration (MVA), should be provided during the consultation and ideally well in advance of hospital admission to allow the woman enough time to consider the implications and ask any questions.

Information should be made available in commonly used languages, and large print/Braille versions should be made available for those with impaired vision. Healthcare professionals must make all reasonable efforts to make translators or translation services available for those unable to read and/or understand the information. For non-English speaking users, consent should be obtained with the use of an interpreter or language line. Healthcare professionals should not rely on family members or friends as interpreters.

Healthcare professionals are encouraged to consider using visual or other explanatory aids to signpost to available resources to support the woman's understanding of the risks, taking into account their clinical and personal circumstances, compared with population level risk. Benefits of the proposed option and reasonable alternatives including expectant management should be discussed.[1] Information from local audits, including that of Local Safety Standards for Invasive Procedures (LocSSIPs), should also be shared when discussing the risks of the procedure.

After provision and discussion of all available information, women should be offered time and opportunity to clarify any concerns they may have, before seeking their written consent. B.R.A.I.N. can be a helpful tool to share with the person considering whether or not to have any procedure, in order to make sure informed consent is authentically obtained, that is:

- **B**enefits – What are the benefits of making this decision?
- **R**isks – What are the risks associated with this decision?
- **A**lternatives – Are there any alternatives?
- **I**ntuition – How do I feel? What does my 'gut' tell me?
- **N**othing – What if I decide to wait and see? What happens next?

4. Documentation of informed consent

Using the information in the attached consent form, healthcare professionals should explain that the potential risks of surgical management of miscarriage, as stated, are summary estimates only,[6–9] mainly based on available evidence from RCOG Green-top Guideline No. 17 *Recurrent Miscarriage*[6] and NICE guideline [NG126] *Ectopic pregnancy and miscarriage: diagnosis and initial management*.[7] Women should be informed that there were some limitations with the quality of evidence, and not all of the evidence compared surgical management of miscarriage with medical and expectant management.

Women should be informed that some of these figures indicate the additional risks related to the procedure over the background risk of miscarriage itself (e.g. excessive bleeding) and some are primarily because of the procedure itself.

Women must be given contact details for the team who will organise appointments. They should also be advised about recommendations for activity and work, any pain relief (if required), when to seek help, and whom to contact for advice if they have any symptoms suggestive of complications following the procedure, including for support and counselling.

References

1. House of Lords in Gillick v West Norfolk and Wisbech Area Health Authority, 1985.
2. The Northern Ireland Executive Department of Health. Consent guides for healthcare professionals. Seeking consent: Working with children [www.health-ni.gov.uk/publications/consent-guides-healthcare-professionals].
3. Age of Legal Capacity (Scotland) Act 1991, section 2 [www.legislation.gov.uk/ukpga/1991/50/section/2].
4. General Medical Council. *Decision making and consent* [gmc-uk.org/professional-standards/professional-standards-for-doctors/decision-making-and-consent].
5. General Medical Council. *Intimate examinations and chaperones* [gmc-uk.org/professional-standards/professional-standards-for-doctors/intimate-examinations-and-chaperones].
6. Regan L, Rai R, Saravelos S, Li T-C, on behalf of the Royal College of Obstetricians and Gynaecologists. *Recurrent Miscarriage*: Green-top Guideline No. 17. *BJOG*. 2023;130(12):e9–e39.
7. National Institute for Health and Care Excellence. Ectopic pregnancy and miscarriage: diagnosis and initial management. NICE guideline [NG126], 2019 (Updated 2023) [www.nice.org.uk/guidance/ng126].
8. Trinder J, Brocklehurst P, Porter R, Read M, Vyas S, Smith L. Management of miscarriage: expectant, medical, or surgical? Results of randomised controlled trial (miscarriage treatment (MIST) trial) BMJ 2006;332:1235.
9. Hooker AB, Lemmers M, Thurkow AL, Heymans MW, Opmeer BC, Brölmann HA, et al. Systematic review and meta-analysis of intrauterine adhesions after miscarriage: prevalence, risk factors and long-term reproductive outcome. *Hum Reprod Update* 2014;20:262–78.

Consent form for surgical management of first trimester miscarriage including manual vacuum aspiration

Patient identifier:

Name of proposed procedure: Surgical management of miscarriage

Anaesthesia:

Surgical management of miscarriage will require the use of anaesthesia.

This will be discussed further with you by the healthcare professional who will perform the anaesthetic.

Statement of healthcare professional (to be filled in by healthcare professional with appropriate knowledge of the procedure):

I have explained the above procedure, specifically, I have explained that:

- This procedure involves surgically removing pregnancy tissues from your uterus (womb) under general anaesthesia, local anaesthesia or sedation.
- Your cervix may need to be dilated and tissue will be gently removed from your uterus (womb) using either suction or a surgical instrument.
- You will be offered analgesia (pain relief) before, during and after the procedure.
- Manual vacuum aspiration is considered a safe alternative choice to surgical management of miscarriage, usually carried out using local anaesthesia or sedation.

Below is a table showing the chance of experiencing certain complications when surgical management of miscarriage including manual vacuum aspiration is performed by an appropriately trained healthcare professional, compared with medical and expectant management. **These numbers are estimates only and the chance of experiencing a complication will also depend on the individual situation.**

		Frequency/occurrence			
		Surgical management	**Manual vacuum aspiration**	**Expectant management**	**Medical management**
Chance of procedure-related complications	**Infection**	2–5 in 100	2–5 in 100	2–3 in 100	< 3 in 100
	Excessive bleeding	1–2 in 100	< 1 in 1000	1–2 in 100	1–2 in 100
	Prolonged bleeding	Unlikely/Rare[†]	Rare[†]	2–4 in 10	4 in 10
	Uterine perforation (potentially resulting in further procedures [laparoscopy/laparotomy/ hysterectomy])	1–4 in 1000	1 in 6000	N/A	N/A
	Intrauterine adhesions	19 in 100	19 in 100	Rare[†]	Rare[†]

[†] Rare is defined as affecting between 1 in 1000 and 1 in 10 000.

	Incomplete procedure requiring further treatment which can be medical or surgical	1–2 in 100	1 in 1500	1–4 in 10	1–2 in 10
	Others	**Post procedure pain not controlled by simple analgesia:** Rare†	**Post procedure pain not controlled by simple analgesia:** Rare†	**Post procedure pain not controlled by simple analgesia:** Rare†	**Gastrointestinal effects:** • Nausea 2–4 in 10 • Vomiting 1–2 in 10 • Diarrhoea 10–15 in 100

I have discussed the chance of complications taking into account their personal circumstances, and plans for the future (specify details): ☐

I have discussed the following alternatives (medical management and expectant management of miscarriage): ☐

I have discussed the procedures that may become necessary during the surgery (tick as appropriate if agreed by the patient):

- Blood transfusion ☐
- Laparoscopy ☐
- Laparotomy ☐
- Repair of any damage to bowel, bladder or blood vessels ☐
- Emergency hysterectomy (when necessary, as a life-saving procedure) ☐

The following resources have been provided (specify details):

RCOG patient information on Early miscarriage and Recovering from surgical management of a miscarriage
Miscarriage Association: Management of miscarriage

I confirm that ..... has been offered time and opportunity to ask further questions about the information provided.

Healthcare professional:

Signed ..... Date.....

Name (PRINT) .....Job title .....

Statement of interpreter (where appropriate)

I have interpreted the information above to the patient to the best of my ability and in a way in which I believe they can understand.

Signed .....Date.....

Name (PRINT) .....Contact details……

Patient:

I agree to the procedure, examination or treatment described, including the procedures, treatments or examinations which may become necessary.

I do / do not agree* that students may be present during the procedure.

I do / do not agree* that students may examine me during the procedure.

Signed .....Date.....

Name (PRINT) .....

*please delete as appropriate

Confirmation of consent (to be completed by a healthcare professional and the patient on the day of the procedure/treatment)

Healthcare professional:

Signed .....Date.....

Name (PRINT) .....

GMC/NMC number……..

Job title .....

Patient:
I confirm that I still want the procedure/treatment to go ahead.

Signed .....Date.....

Name (PRINT) .....

This Consent Advice was produced on behalf of the Royal College of Obstetricians and Gynaecologists by the Patient Safety Committee.

The following individuals and organisations submitted comments at peer review:
[Guidance Editorial Manager to add post consultation].

The Chair of the Patient Safety Committee was: Dr CJ Calderwood FRCOG, Clydebank; and the Vice Chair was: Dr J Elson FRCOG, Nottingham.

The final version is the responsibility of the Patient Safety Committee of the RCOG.

The review process will commence in XXXX, unless otherwise indicated.