Appendix 3: How to perform dilatation and evacuation

Procedure step by step

- Perform safety and equipment check.
- Have the woman empty her bladder before entering the procedure room.
- Initiate any intravenous pain and/or antianxiolytics. Any oral medications should be given in advance of the procedure in order to perform the D&E at the time of their maximal effect.
- Perform bimanual exam to check uterine size and position as well as adequacy of cervical dilation. Remove and account for all osmotic dilators previously placed. If the cervix is not adequately prepared, give an additional dose of misoprostol and/or place another set of dilators.
- Place speculum.
- Clean cervix with an antiseptic solution, such as providone-iodine (Betadine).
- Perform paracervical block and place tenaculum.
- Place traction on the tenaculum to bring cervix down the vagina.
  - Ring/Foerster/sponge-holding/vulsellum forceps can be used in place of a tenaculum for later gestations, if desired.
- Recheck adequacy of dilation by attempting to pass the largest diameter dilator without using force.
- Mechanically dilate cervix, as needed, to achieve desired/necessary amount.
  - Dilators need to reach the internal os, without going higher into the uterus. Touching the fundus with the dilator is painful for the woman and increases the risk of perforation.
- Perform uterine aspiration with largest cannula available (12-16 mm) and aspirate the amniotic fluid (see Figure 1). Either electric or manual vacuum aspiration can be used.
  - Perform the suction as is done during a first-trimester aspiration abortion, rotating the cannula during suction. If using MVA, empty the aspirator when it is full and repeat as necessary. When nothing more can be suctioned, remove cannula from uterus.
  - For gestations up to 15 weeks, it may be possible to complete the abortion using aspiration only.
- Maintaining gentle traction on the tenaculum to straighten the cervical canal, pass the closed forceps through the cervix in a vertical direction (the jaw of the Bierer or Sopher forceps should open in an up-down direction, not horizontally) (see Figure 2).

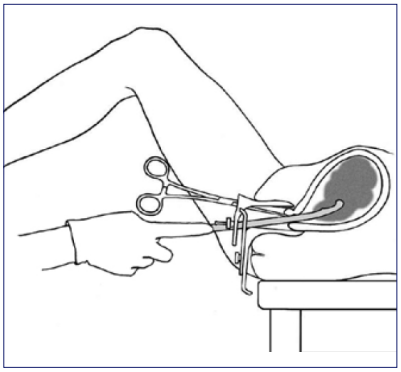

Figure 1. Aspirate the amniotic fluid.

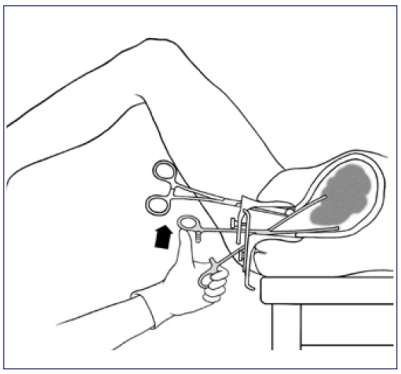

Figure 2. Open the forceps.

- As soon as the forceps pass through the internal os, gently open it as wide as possible. While opening the forceps, drop your hand and forceps in the direction of the floor to angle the jaws of the forceps into the anterior lower-uterine segment (see Figure 3).
  - A mid-trimester gravid uterus is usually positioned anteriorly, toward the anterior abdominal wall.
- To evacuate the tissue, close the forceps around the fetal tissue and rotate it 90 degrees to assist with disarticulation before withdrawing.
  - Be careful not to grasp the myometrium with the forceps.
  - Keep forceps within the lower to mid-uterine segment. There is usually no need to use the forceps near the fundus, which increases the risk of perforation (see Figure 4).
- Repeat until fetal removal is completed as is the majority or all of the placenta.
  - Attempt to remove tissue with each pass of the forceps.
    - If you cannot locate and move the fetus/fetal parts within 5-7 minutes, consider using ultrasound to visualize and direct the movement of the forceps.
    - If the tissue has moved upwards to the fundus from the lower segment of the uterus, use suction to bring the tissue down within grasp of the forceps or consider removing the speculum and tenaculum and massaging the uterus. If dilated sufficiently to allow passage of part of the provider's hand, the pregnancy can be repositioned internally. In the unlikely event that these maneuvers do not bring the tissue within reach of the forceps, administer misoprostol 400mcg (buccal) or high-dose oxytocin (200 units in 500mL normal saline or lactated ringers and run at 50mL/hour IV). The D&E procedure should be re-attempted in 30 minutes to 3 hours. The woman should be observed during this time.
- When all fetal tissue is removed, perform suction aspiration to ensure no tissue is remaining.
- Examine the fetal tissue to ensure that evacuation is complete:
  - Identify fetal parts (thorax, spine, calvarium, all 4 extremities and placenta, for all procedures 14 weeks and greater).
  - If it is unclear whether the evacuation is complete, an ultrasound or a digital exam of the uterine cavity may be used for confirmation.

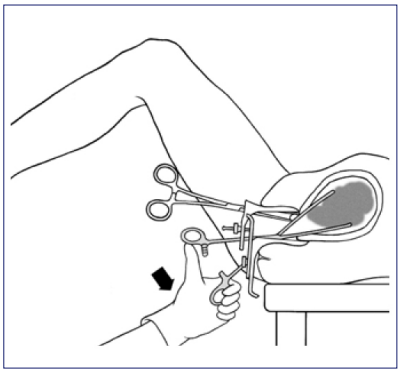

Figure 3. Pull the forceps handle down so graspers are in the anterior lower-uterine segment.

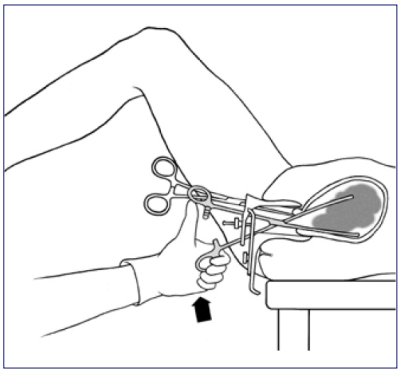

Figure 4. Evacuate from the lowest section of the uterine cavity.

Source: Reproduced with permission from Ipas. Edelman A, Kapp N. Dilatation & Evacuation (D&E) Reference Guide: Induced abortion and postabortion care at or after 13 weeks gestation ('second trimester'). Chapel Hill, NC: Ipas; 2018. Available at: https://www.ipas.org/resource/dilatation-evacuation-de-reference-guide-induced-abortion-and-postabortion-care-at-or-after-13-weeks-gestation-second-trim\ester/