Options for Management of Miscarriage

Gynaecology

Introduction

We are very sorry for your loss. We understand this may be a very distressing time and we fully appreciate that it can be difficult to take in all the facts when you are anxious especially in the hospital environment. This leaflet aims to help you understand more about reasons why miscarriage happens and the treatment we will offer you. It also explains some of the medical language you might hear or read.

What is a miscarriage?

A miscarriage is the spontaneous loss of a pregnancy between conception and 24 weeks into pregnancy. Many early miscarriages occur before a woman has missed her first period or before her pregnancy has been confirmed. Once you have had a positive pregnancy test, there is around a one in five (20%) risk of having a miscarriage in the first three months. In general, the risk of miscarriage decreases as the pregnancy progresses further. Most miscarriages occur as a 'one-off' (sporadic) event and there is a good chance of having a successful pregnancy in the future.

What are the types of miscarriage?

Doctors have different ways of describing miscarriages where the uterus does not empty itself completely. The main terms used are:

Missed miscarriage (also called 'delayed' or 'silent' miscarriage)

This is where the baby has died or failed to develop but is still in your uterus. You might have had no idea that anything was wrong until a routine scan. You may still feel pregnant and have a positive pregnancy test.

Blighted ovum (also called an 'anembryonic pregnancy' or 'missed' or 'delayed' miscarriage).

This is where an ultrasound scan shows a pregnancy sac with nothing inside. This is usually because the fertilized egg has not developed normally so the pregnancy sac grows, but the baby does not. Sometimes, the baby stops developing at such an early stage that it is absorbed back into the surrounding tissue. As with a missed miscarriage, you may still feel pregnant.

Incomplete miscarriage

This is where some, but not all, of the pregnancy tissue is miscarried. You may still have pain and heavy bleeding.

The prevention of infection is a major priority in all healthcare and everyone has a part to play.

- **Wash your hands with soap and warm water and dry thoroughly. Use hand gel, if provided, in care facilities.**
- **If you have symptoms of diarrhoea and vomiting stay at home and do not visit relatives that are vulnerable in hospital or in residential care. You will spread the illness.**
- **Keep the environment clean and safe. Let's work together to keep it that way. Prevention is better than cure.**

Complete miscarriage

All of the pregnancy has been passed and the uterus is empty.

What are the symptoms of miscarriage?

Symptoms of miscarriage vary from one woman to another. The most common symptom is vaginal bleeding. Period-like pains usually accompany this. Some women will have no bleeding or pain and the only symptoms they experience are the loss of pregnancy symptoms such as nausea or breast tenderness. Some women may not experience any symptoms at all, and may be diagnosed as having a miscarriage at a routine ultrasound scan. Bleeding and pain are not always associated with a miscarriage as many women with normal pregnancies may also experience these symptoms.

Why do miscarriages happen?

Most miscarriages happen because the embryo (tiny baby) has abnormal chromosomes and is not developing normally. This is not preventable and it is not caused by anything you have done during your pregnancy. The risk of faults occurring on chromosomes increases with the mother's age, so miscarriage is more likely to occur in older women. The risk of miscarriage increases from about 10% for a 20 year old woman to approximately 40% at the age of 40.

Very rarely, a miscarriage can happen because the uterus (womb) is not the normal shape or because the mother's immune system rejects the pregnancy. Because these problems are so rare, we would normally only search for them in women who have experienced three or more miscarriages in a row. There is no evidence that early miscarriages are caused by any infections.

How is a miscarriage diagnosed?

The most accurate way of finding out if you are miscarrying is to have an internal ultrasound scan. This can help us to see whether you have a normal pregnancy or you are miscarrying. We are not always able to diagnose a miscarriage at the first scan, so you may need to have another one a week or two later.

How are miscarriages managed?

There are four ways in which miscarriages are managed. They are: expectant management, medical management, surgical management and vacuum aspiration. Each of these treatments will be explained in further detail along with their respective risks and benefits.

Consent

We must seek your consent for any procedures or treatment beforehand. Your doctor or specialist nurse will explain the risks, benefits and alternatives where relevant before they ask for your consent. If you are unsure about any aspect of the proposed procedure or treatment, please do not hesitate to ask for more information.

Expectant management of miscarriage

This means waiting for the miscarriage to happen naturally, without any intervention. You will be monitored by the hospital over the next few weeks and attend a follow up appointment instead of having immediate treatment. It may also be known as 'conservative' management. Doctors often recommend this especially in the first eight or nine weeks of pregnancy or in women with incomplete miscarriage. It is successful in more than 80% of women with an incomplete miscarriage and success rates are lower with missed miscarriage. National (NICE) guidance also states that natural management should be the first method to consider. However, your choice will be important in deciding the best option for you.

What should I expect?

When you start to miscarry you will bleed and get crampy lower abdominal pains; this can last up to 2-3 weeks. Some women experience severe cramping pains with heavy bleeding and pass clots for 4-5 hours. This may last for a few hours. Take pain killers if you need them, such as codeine, paracetamol or ibuprofen. Please use sanitary towels rather than tampons for the bleeding. Try to rest at home, preferably with a companion.

If at any point you feel that you cannot cope (for example, if you are feeling faint, dizzy, or have unbearable pain or bleeding), please feel free to contact either:

The Early Pregnancy Assessment Unit (EPAU)
Monday to Friday, 8.00am – 4.30pm
Saturday, 8.00am – 1.00pm
Outside of these hours you can call NHS 111 for advice.

Should the situation become an emergency, please go directly to the Emergency Department or dial 999. During this time, you should watch for signs of infection such as temperature, malaise, sickness and offensive smelling discharge. Should you have any of these symptoms, please seek further advice from your GP as antibiotics may be required.

What are the benefits of expectant management?

- You do not have to stay in hospital
- Avoids medication or surgery with a general anaesthetic and the possible associated risks and side effects of both
- It is seen as a more 'natural' process, which some women prefer

What are the risks of expectant management?

- It can take a few weeks before the uterus (womb) empties itself
- You may find it difficult not knowing when the miscarriage might start
- You might be anxious about coping with pain and bleeding and not knowing when the miscarriage is complete
- You may be concerned about the possibility of seeing the pregnancy tissue, in particular, the fetus
- Further visits to the hospital may be required which may include blood tests or scans
- Medical or surgical management may be required if the miscarriage does not occur after 3 weeks, or you experience persistent heavy bleeding and/or pain

Medical management of miscarriage

This involves using a medicine called Misoprostol to allow the pregnancy tissue to pass. You may also require a medicine called Mifepristone depending on the size and gestation of your pregnancy. You may be able to continue your treatment at home once you have been commenced on the medication.

Before treatment can take place, you will need to complete a consent form for treatment to make sure you understand and agree to the treatment. Misoprostol is unlicensed for treatment of miscarriage. However, it has been used safely to manage miscarriage for many years nationally and internationally. Before starting treatment, we will also take a blood test which will check your full blood count. This is to ensure you are not anaemic.

The doctor or nurse will administer your medication. Misoprostol is inserted into your vagina, Mifepristone is taken by mouth. These medications help the uterus to contract. This is likely to give you some strong lower tummy cramps or pains and some moderate to heavy vaginal bleeding.

Please ask for pain relief if needed. Once you have been given the Misoprostol you will be asked to use bedpans every time you pass urine. This allows the nurses to check your blood loss and to see if any pregnancy tissue has been passed. Tissue passed may be sent to the laboratory for testing. You will be given a form to sign your consent for this. Once pregnancy tissue is passed, you will be allowed home, as long as you are not bleeding heavily.

If you pass the pregnancy at home and you wish for the hospital to examine the pregnancy, then you can contact EPAU and they can arrange this for you.

What are the benefits of Medical Management?

- You are more in control of your treatment
- If successful, medical management avoids surgery and general anaesthetic
- Medical management is successful in 80 - 90% of cases

What are the risks of Medical Management?

Medical management is usually very safe. The possible complications, although uncommon, are as follows:

- Heavy bleeding
- Infection
- Reaction to the drugs used
- Failure – drug treatment may not work, and the pregnancy tissue may remain inside the womb

If any of the above occurs you may be required to have further treatment such as:

- Blood transfusion
- Course of antibiotics
- Repeated drug treatment; if you have not passed any pregnancy tissue or had minimal bleeding in the first 24 hours, you may need another dose of Misoprostol
- Surgery to remove remaining pregnancy tissue

The drug treatment may also cause side effects such as sickness, diarrhoea, headache, dizziness and hot flushes or sweats.

What advice should I follow on discharge?

Bleeding, following medical management of miscarriage, may last for 2-3 weeks. Once you are discharged we will ask you to repeat a home pregnancy test in 3 weeks time. This will ensure that it is negative so that you can be reassured that the process has been successful and a scan is not necessary. It is essential that if it is still positive, you contact the EPAU for further advice or review.

Manual vacuum aspiration for management of miscarriage.

Manual vacuum aspiration (MVA) is a short outpatient procedure done under local anaesthetic to empty the womb of any remaining tissue. The retained tissue can only be of a specific size to undergo this procedure. If you are deemed a suitable candidate you will be offered this as an option and be given a separate information leaflet for this procedure, explaining the procedure and associated risks and benefits, briefly described below.

This procedure is done whilst you are awake to help remove the risks from general anaesthetic and help you recover quicker. Prior to the procedure you will be given analgesia (pain relief) and medication to soften the cervix (neck of the womb).

Shortly after this, you will be escorted to the treatment room where using a speculum, we locate the cervix. Local anaesthetic will be applied to the cervix to block the nerves there and reduce your discomfort.

Following this, the cervix is dilated (opened) and a small tube passed through into the womb. The womb is then emptied of any tissue remaining. You will hear some noises of the suction during this time and feel some crampy period-type pain.

What are the benefits of this procedure?

- Success rate: This procedure is successful in removing all the pregnancy tissue in 94-98% of patients
- Less invasive procedure: Previous management involving surgery has required general anaesthetic and a longer procedure. The MVA approach is associated with less pain after the procedure. It carries a lower risk of uterine perforation and avoids risks associated with general anaesthetics
- Less bleeding: As with other surgical methods of treating miscarriage, such as ERPC, it is expected that MVA will cause less bleeding than is commonly seen with conservative or medical treatment approaches
- Quicker recovery: Opting for MVA will require less recovery time in hospital, (in most cases, you will not need to be admitted overnight) and less time at home before returning to work

What are the disadvantages?

- Pain: Despite local anaesthetic, some pain is to be expected both during and after the procedure. In most cases, it is described as similar to period like cramps
- Being conscious for your treatment: A general anaesthetic is not required to receive MVA but some patients may find it uncomfortable to be awake for the procedure
- Post-procedure complications: MVA is rarely ineffective at treating miscarriage and may have to be done a second time. There is also a small risk of infection and uterine perforation.

What are the risks of this procedure?

In addition to the disadvantages the specific risks of the procedure are:

- Bleeding – some bleeding is expected after the procedure but, bleeding that is heavy and needs further treatment happens in 2 in 100 women
- Infection – this occurs in up to 6 in 100 women and is usually treated with oral antibiotics
- Pain – although you are given local anaesthetic and pain relief, around 8 in 1000 women are unable to tolerate this procedure
- Retained pregnancy tissue – the procedure is largely effective but tissue can be left behind in up to 6 in 100 women
- Uterine perforation – during the procedure it is possible to make a small hole in the womb. This may require a further operation to check for damage in the abdomen. This happens around 4 in 1000 times

Surgical management of miscarriage

Surgical management of miscarriage involves using a gentle suction device to remove the remaining pregnancy tissue from inside of the womb. If you are considered a suitable candidate for this procedure, you will be offered it as an option. It is normally performed under a general anaesthetic. This operation is usually arranged as a day case and you can go home the same evening. In some cases, we may suggest you have the operation done as an emergency and in these cases, or if complications arise during or after surgery, you should be prepared to stay the night.

We must, by law, obtain your written consent to any operation and some other procedures beforehand. Staff will explain all the risks, benefits and alternatives before they ask you to sign a consent form. If you are unsure about any aspect of the treatment proposed, please do not hesitate to ask to speak with a senior member of staff again.

What are the benefits of surgical management?

- Essentially it is a relatively safe procedure which may reduce the amount of bleeding after a miscarriage.
- It is usually a planned admission. This means it will give you time to plan family and work commitments as necessary.
- You will have a general anaesthetic which means you are asleep whilst the procedure is done.

What are the risks of this procedure?

- **Bleeding** - If you bleed very heavily during the operation, you may need a blood transfusion. This is rare and would only happen if the doctors felt it is absolutely necessary. If you object to receiving blood products please tell us before you sign a consent form. After the operation you are likely to have some light vaginal bleeding for 14 - 21 days
- **Infection** - All surgical procedures carry a risk of infection. If you develop fever, unusual vaginal discharge or persistent abdominal pain, please visit your GP or contact Early Pregnancy Unit as soon as possible. If this happens, we will take vaginal swabs and give you a course of antibiotics.
- **Uterine perforation** - This is a very rare complication. During the operation it is possible for the surgeon to accidentally make a small hole in the uterus. In this situation, he or she may need to make a small cut on the abdomen and insert a telescope (laparoscopy) in order to check whether there is bleeding, and if necessary, repair the hole. In exceptional circumstances, it might be necessary to proceed to an open operation (laparotomy).
- **Incomplete removal of pregnancy tissue** - Occasionally, small amounts of pregnancy tissue can be left inside the uterus after the procedure. If tissue is left behind, it may sometimes be necessary to repeat the procedure.

These problems are rare but they will be discussed in more detail when the operation is explained to you.

What happens to the pregnancy tissue that is taken out?

We send it to the laboratory for routine tests to confirm that it is placental tissue. We also test it to make sure it is not an unusual type of miscarriage called a molar pregnancy. We then dispose of the tissue respectfully.

Will I receive any follow up after my miscarriage?

During the first two weeks following a miscarriage, you should avoid having sex or using tampons to reduce the risk of infection. If you continue to bleed heavily with clots, or experience pain for more than a week, you should go back to your GP as it may be a sign of infection or retained pregnancy tissue. It can take up to three weeks following a miscarriage for your pregnancy hormones to clear, during which time a pregnancy test can still read positive.

What happens if I have a rhesus negative blood group and have a miscarriage?

If your blood group is rhesus negative and you miscarried after 12 weeks, or you had surgical management of miscarriage, we recommend that you have an anti-D injection. Being rhesus negative means you can develop antibodies that attack the blood cells of your next baby and cause late miscarriage, stillbirth, or severe anaemia and jaundice after birth. The anti-D injection helps with this.

When will my normal periods start again?

After a miscarriage, your body will still contain some pregnancy hormone and a pregnancy test may stay positive for up to 2-3 weeks. Once the pregnancy hormone has fallen to a level which is not detected from a urine pregnancy test, your body will start the next menstrual cycle. You should expect your period within 4 to 6 weeks following miscarriage but this does vary with each person. If your periods have not resumed after 3 months (and you are not pregnant) you should consult your GP.

When can I go back to work?

Going back to work is an individual decision and varies from person to person, as some prefer to be among colleagues whilst others may need to take time off work. You may feel physically low for a week or so and need to take it easy during this time.

Is it normal to feel depressed after the miscarriage?

The loss of a baby is very sad and what you are feeling is normal. Everyone reacts differently following a miscarriage. Some women find that they can get through quickly with little emotional support. Others find the feeling of grief and bereavement last much longer. Some people never forget the loss of a baby but the pain will get easier over time. Some of the feelings associated with loss are difficult to talk about. You may feel shocked or angry, or you may feel empty. Some women feel really tired and lose interest in everyday life. Talking with your partner can be very helpful. Your family doctor can also be contacted for help and advice.

When can I try for another pregnancy?

If you would like to try for another pregnancy we advise that you wait for your next normal period. This makes it easier to find out the due date of the pregnancy. If you get pregnant before the first period, this should not increase the risk of miscarriage. Some women may need a little more time to recover emotionally and physically from the miscarriage. The best time to start again is when you and your partner feel ready to do so. There are several things you can do to increase your chance of having a healthy pregnancy

- Take folic acid supplements
- Reduce alcohol and caffeine intake
- Stop smoking
- Eat a healthy, balanced diet

Contact us

Early Pregnancy Assessment Unit
01902 694606
(Monday to Friday 8.30 am - 4.30 pm or
Saturday 8.30 am - 13.00 pm)

Early Pregnancy Bereavement Nurse
07917 398313 please leave a message if she is unable to take the call.

Further help:

The Miscarriage Association
Helpline: 01924 200799
Website: www.miscarriageassociation.org.uk

SANDS
(Stillbirth, miscarriage and neonatal death support)
Telephone: 020 7436 5881

Babyloss (website for miscarriage)
www.Babyloss.com

There are also books which can be helpful:

Miscarriage: Women’s experiences and needs by Christine Moulder published by Pandora Press.

English

If you need information in another way like easy read or a different language please let us know.

If you need an interpreter or assistance please let us know.

Lithuanian

Jeigu norėtumėte, kad informacija jums būtų pateikta kitu būdu, pavyzdžiui, supaprastinta forma ar kita kalba, prašome mums apie tai pranešti.

Jeigu jums reikia vertėjo ar kitos pagalbos, prašome mums apie tai pranešti.

Polish

Jeżeli chcieliby Państwo otrzymać te informacje w innej postaci, na przykład w wersji łatwej do czytania lub w innym języku, prosimy powiedzieć nam o tym.

Prosimy poinformować nas również, jeżeli potrzebowaliby Państwo usługi tłumaczenia ustnego lub innej pomocy.

Punjabi

ਜੇ ਤੁਹਾਨੂੰ ਇਹ ਜਾਣਕਾਰੀ ਕਿਸੇ ਹੋਰ ਰੂਪ ਵਿਚ, ਜਿਵੇਂ ਪੜ੍ਹਨ ਵਿਚ ਆਸਾਨ ਰੂਪ ਜਾਂ ਕਿਸੇ ਦੂਜੀ ਭਾਸ਼ਾ ਵਿਚ, ਚਾਹੀਦੀ ਹੈ ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ ਸਾਨੂੰ ਦੱਸੋ।

ਜੇ ਤੁਹਾਨੂੰ ਦੁਭਾਸ਼ੀਏ ਦੀ ਜਾਂ ਸਹਾਇਤਾ ਦੀ ਲੋੜ ਹੈ ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ ਸਾਨੂੰ ਦੱਸੋ।

Romanian

Dacă aveți nevoie de informații în alt format, ca de exemplu caractere ușor de citit sau altă limbă, vă rugăm să ne informați.

Dacă aveți nevoie de un interpret sau de asistență, vă rugăm să ne informați.

Traditional Chinese

如果您需要以其他方式了解信息，如易读或其他语种，请告诉我们。

如果您需要口译人员或帮助，请告诉我们。

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