

The Miscarriage Association



Acknowledging Pregnancy Loss

Preparing for another pregnancy

A brief guide to pre-pregnancy care after miscarriage

If you would like information, support or simply to talk to someone who has had a miscarriage and can understand, please contact:

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Planning together

After a miscarriage*, many women will blame themselves and their lifestyles for the loss of their baby. Although this feeling is understandable, it is important to know that miscarriage is rarely caused by anything you did or didn't do. Nevertheless, couples often want to do something positive to try to ensure that their next pregnancy has the best possible chance of success.

There is no magical formula for success, but the emotional and physical health of both parents in the months before pregnancy can affect the woman's ability to become pregnant, and may also affect the health of the baby in the crucial early weeks when the major organs are developing.

Making sure that you are both in good health physically and emotionally will help to give your baby the best possible start. It may also help you to feel more confident and relaxed as your pregnancy progresses.

This leaflet suggests some of the things you and your partner can do to prepare for your next pregnancy. Please bear in mind that these are only suggestions – the most important thing is to decide together how you feel about becoming pregnant again, and to prepare in whichever way feels right for you.

Timing

Couples' feelings vary after the experience of a miscarriage. You may feel that you want to get pregnant again as quickly as possible, or you may feel apprehensive and anxious at the thought of another pregnancy.

It is important to give yourselves the chance to recover physically and emotionally and not to feel pressurised by family and friends. Only you and your partner will know when the time is right. You may both need time to grieve for the loss of your baby and come to terms with what has happened. A new pregnancy means looking to the future, but for many women especially it can also be a time of intense anxiety, overshadowed by the past experience of miscarriage.

You and your partner may each have difficult feelings about the prospect of another pregnancy. You may both have mixed feelings – hope, fear, excitement, apprehension. All these are normal, but it often helps if you can talk about and share your hopes and misgivings with each other. Sharing your feelings, whether with your partner or with others, is a way of helping the healing process. For both of you, emotional wellbeing is just as important as physical health.

*To make this leaflet easier to read, we generally use the word 'miscarriage' for all forms of pregnancy loss, including ectopic and molar pregnancy. Whatever your circumstances, we hope this leaflet will be helpful.

Most doctors advise waiting until you have had at least one period after your miscarriage before trying to conceive again, since this makes it easier to date a subsequent pregnancy. There is no evidence, however, to show that when you conceive makes any difference to the risk of miscarriage in the next pregnancy. In most cases, you and your partner are the best judges of when to try again. There are some circumstances, however, such as after hydatidiform mole or ectopic pregnancy, when you will be advised to wait longer. In addition, if you have suffered from repeated losses, you may wish to obtain advice from your GP or specialist before trying to conceive.

Health

The physical health of both partners in the three months before conception will influence the quality of both the sperm and the egg which will eventually join to make an embryo. Sperm are being produced constantly and take 12 weeks to become mature. The immature sperm are affected by smoking, alcohol, heat and stress in the male. These factors can therefore affect the chances of becoming pregnant. It is therefore worth ensuring that you and your partner are both in good health before conceiving again.

Drugs and medicines

In general it is best not to take any drugs or medicines unless you have checked with your doctor that they are safe to take during pregnancy or when you are trying to conceive. This is true for both prescribed or over-the-counter medicines, including herbal remedies.

If you or your partner are taking medication for an illness or long-term condition, ask your GP or consultant whether it might affect the pregnancy. If there is a risk to the pregnancy, you might want to ask whether the medication could be changed, reduced or even stopped. On the other hand, you may need to balance the risks to your pregnancy with the risks to your health without the medication.

Common drugs such as alcohol, tobacco, caffeine and tranquillisers all affect the body's chemistry. We still do not fully understand the effects of most of these drugs on pregnancy (see also pages 6 and 7).

Drugs such as cannabis, heroin, crack and cocaine are likely to affect fertility, increase the risk of premature or low-weight babies and may cause damage to the developing baby. The safest course of action is to avoid using any of these drugs before and during pregnancy. Talk to your doctor if you need help with this.

Infections

Certain infections may increase the risk of miscarriage or damage to the baby during pregnancy.

Rubella (German Measles) can seriously damage your baby if contracted in the first months of pregnancy. Before trying to conceive, ask your doctor for a blood test to check your immunity, even if you have been vaccinated or have had the illness before. If you are vaccinated against rubella, you will need to wait three months after the injection before getting pregnant.

Some infections are particularly harmful in pregnancy, e.g. toxoplasmosis, parvovirus, cytomegalovirus and listeria (from soft cheeses, pâté etc. – see also *Diet* on pages 5 and 6). Some infections can be contracted through cattle and sheep and for this reason it may be advisable to avoid contact with farm animals, especially during lambing, in early pregnancy.

Sexually transmitted diseases, including chlamydia, can cause infertility, ectopic pregnancy or miscarriage, or may infect the baby at birth. If you think there is a chance that you or your partner might have been infected, both of you should seek investigation and treatment if necessary before you become pregnant. Consult your GP, or visit a GUM (Genito-Urinary Medicine) clinic where treatment is confidential.

Health at work

Most research has shown that work in itself is not harmful in pregnancy. However, work which is particularly stressful may be linked to increased problems in pregnancy, although it's not clear exactly how. Perhaps you can consider ways of reducing the load but if not, it may be especially important to find other ways of getting support (see page 7).

Exposure to certain hazards in the workplace can affect fertility or a developing pregnancy. Chemicals, X-rays, radiation and lead are some of the substances which can be harmful.

You and your partner should find out about any potential hazards in your job or workplace, and what precautions, if any, should be taken. Your trade union Health and Safety representative, your Occupational Health Department or the local Health and Safety Executive can provide information. You may want to visit the National Health and Safety Executives website: www.hse.gov.uk.

Diet

A well-balanced diet is the basis of good health, and good health will influence your and your partner's fertility and your ability to become and stay pregnant. A healthy diet before and during pregnancy helps to protect against toxins, such as high levels of lead and other damaging minerals.

A good diet will help to provide the best possible conditions for a baby to grow. Try to eat from each of these four groups every day:

Fruit and vegetables

Fresh fruit, vegetables and salads are very important and appear to reduce the risk of miscarriage⁴: try to eat **5 portions** a day. Leafy green vegetables are good choices as are yellow and red vegetables (such as peppers, tomatoes and carrots). Frozen and tinned vegetables are usually as nutritious as fresh ones.

It is best to choose fresh, frozen or dried fruit rather than tinned fruit, which usually contains added sugar. Do make sure that fruit and salad vegetables are washed thoroughly before eating.

Meat, fish, pulses, eggs and meat-alternatives

These are all excellent sources of protein and you should try to eat **2 portions** a day. Ensure that all meat is cooked thoroughly and that you store cooked and raw meats separately. Liver should not be eaten more than once a week and it is best to avoid meat patés altogether.

The Food Standards Agency* also recommends eating only a limited amount of tuna and avoiding swordfish, marlin and shark. This is because of reported high mercury levels which can damage a baby's developing nervous system.

Eggs should be cooked thoroughly, and it is best to avoid freshly made mousses, mayonnaise or other foods which contain raw eggs.

Beans (including tinned baked beans), chickpeas, lentils, nuts and seeds are all good sources of protein and particularly important in a vegetarian or vegan diet. So too are soya products and other meat alternatives, such as tofu, Quorn™ and textured vegetable protein (TVP).

Cereals and bread

Try to eat **4 portions** of bread and cereals a day, including pasta and rice or barley dishes. Unrefined varieties (such as wholemeal bread and brown rice) are particularly healthy choices. Breakfast cereals are often fortified with extra vitamins and minerals, including iron.

*See *Helpful publications* on page 10

Milk, cheese or vegan alternatives

Try to eat **3 to 4 portions** a day of dairy products or plant-based alternatives before and during pregnancy. It is important to avoid unpasteurised dairy products, such as raw (untreated) milk, and soft or mould-ripened cheeses such as Brie, Camembert and blue cheeses. Cream cheese and cottage cheese are safe to eat.

Caffeine

Caffeine is found in coffee, tea, some soft drinks and “energy” drinks and, to a lesser extent, in chocolate. There is some evidence that drinking or eating large amounts of caffeine is linked to an increased risk of miscarriage, so it is generally recommended to limit caffeine consumption in pregnancy¹. It is interesting that many women find that they go off coffee and tea in early pregnancy anyway, especially if they are feeling sick, so cutting down may not be a problem for you.

Supplements

Folic acid supplements are recommended by the Department of Health, as they reduce the risk of neural tube defects such as spina bifida – an abnormality in the development of the baby’s spinal cord. These should be taken pre-conceptually and up to 12 weeks of pregnancy and will be prescribed free of charge once you are pregnant. Speak to your doctor or pharmacist for further information.

There is still uncertainty about whether women with a well-balanced diet need supplements in or when preparing for pregnancy. Equally, we still don’t fully understand how a lack of vitamins and minerals in the diet, or food allergies, or high levels of toxic metals (e.g. lead or aluminium) in the blood may affect pregnancy. Vitamin or mineral supplements may help to protect against some of these problems. High doses of certain vitamins and minerals can be harmful, however, so you should seek advice from your doctor or pharmacist.

Weight

If you are very underweight or very overweight, you may have difficulty conceiving. There is some evidence to suggest a higher risk of miscarriage in women who are underweight (with a Body Mass Index, or BMI, of less than 18.5)⁴. If you are concerned about your weight, ask your doctor to refer you to a dietician, who is the best person to give you advice about gaining or losing weight safely if you are hoping to conceive. Drastic dieting in the months before or during pregnancy could deprive your baby of essential foods.

Smoking

Smoking can make a man less fertile by reducing the quality and quantity of his sperm. The chances of having a miscarriage are higher for women who smoke heavily. In addition, smoking during pregnancy affects the baby's growth, and a small baby is more likely to have health problems in the weeks after birth. If your partner smokes but you don't, you are still affected by the smoky air you breathe in. If you both smoke, try to stop together. Giving up is hard, but your doctor may be able to give you advice or help – some GPs run stop-smoking clinics. If you find it impossible to stop, try to cut down as much as you can.

Alcohol

Heavy drinking can reduce the quantity and quality of a man's sperm and can affect a woman's fertility. Heavy drinking in pregnancy has been linked to miscarriage as well as causing problems to the developing baby. While an occasional drink is unlikely to be harmful, it is best for both of you to cut out or cut down on alcohol during the period you are trying to conceive as well as during pregnancy.

Exercise, rest and relaxation

Moderate exercise before conception and during pregnancy will help to give your baby a good start. This doesn't mean you have to become an athlete; walking and swimming are two healthy options.

If you don't get much time to relax, or you find it difficult to unwind or get to sleep, think about building a routine for relaxing into your day. Allow yourself some time during the day to 'switch off' and relax. You may find it helpful to read, watch TV, listen to the radio, or do something like yoga or meditation.

Support during your next pregnancy

Studies^{2,3,4} have shown that women who have previously miscarried are more likely to have a healthy pregnancy if they minimise stress and feel well cared for and supported before and during that pregnancy. This is a good time to think about what support and care you would like during your next pregnancy.

If you can, share your feelings with your partner and talk about how you can support each other before and throughout your pregnancy.

Talk to your family, friends and perhaps to children too, if you have them, about what they can do to help. In addition, The Miscarriage Association can offer support through our UK network of telephone contacts and support groups.

Talk to your doctor about your plans to become pregnant and about any anxieties or questions you may have. This is also an opportunity to ask if you can have additional care during your next pregnancy, if you would like this – perhaps an extra ultrasound scan or scans at critical times. You may be able to arrange this directly with a specialist early pregnancy clinic, although most will require a GP's referral.

Having an early scan in your next pregnancy is particularly important if you have had an ectopic pregnancy, since this can confirm that the baby is growing in the uterus, or allow early treatment if not. However, if you have had a missed miscarriage, you may also want to ask for an earlier scan in your next pregnancy, perhaps around the stage at which your baby died. If all is well and a heartbeat is detected, this can help reassure you that the pregnancy is developing as it should.

Having additional scans may not be the right thing for you, however. Some people find that this can increase anxiety, rather than reduce it, especially if a heartbeat cannot be detected and you face a period of anxiety before you are scanned again.

It may be that you were disappointed by a lack of sympathy or support from your GP around your miscarriage. If you wish to consider changing to a different GP, ask friends or neighbours whom they find sympathetic. Alternatively you can get a list of doctors in your area from one of the following sources:

In England and Wales:	NHS Direct	0845 46 47
In Scotland:	NHS 24	08454 24 24 24
In Northern Ireland:	Your local Health Board	

Finally

It is normal and understandable to feel anxious about pregnancy after miscarriage. You may be worried about trying to conceive, or about what will happen if you do conceive. You may feel particularly anxious when you reach the stage at which you previously miscarried, or you may sail through until you get closer to your due date and then begin to worry if your baby will be born safe and well.

We hope that the contents of this leaflet and the sources of information and support which follow will go some way to increasing your confidence, and wish you well for the future.

Source of information and support

The Miscarriage Association

A staffed helpline and a network of volunteers provide support and information following pregnancy loss, when you are considering another pregnancy and during the next pregnancy.

The Centre for Pregnancy Nutrition

University of Sheffield

Tel: 0845 130 3646

www.sheffield.ac.uk/pregnancy_nutrition

Provides information for women on healthy eating and food safety before and during pregnancy.

NHS pre-conception care clinics

Some hospitals and health centres run special pre-conception care clinics. Your GP or hospital staff should be able to tell you if there is one in your area. If you have a long-term medical condition (e.g. diabetes), you may also be referred for specialist pre-conception care.

Well-Woman clinics

These can be a useful source of advice, especially if you want to see a woman doctor. They sometimes provide a pre-conception check-up.

Helpful publications

Although there is no guaranteed method for ensuring a healthy pregnancy, you may find the following publications useful for general guidance. Please note that The Miscarriage Association is not able to endorse all that is in these publications and therefore does not accept responsibility for their contents.

Thinking of having a baby

Ref: FSA/0452/0105

Eating while you are pregnant

Ref: FSA/0451/0806

Short information booklets produced by the Food Standards Agency.
Available on line or by post, free of charge from:

Food Standards Agency

POB 369, Hayes, Middlesex UB3 1UT

Tel: 0845 606 0667

www.food.gov.uk

Planning a baby? A complete guide to pre-conceptual care

by Dr Sarah Brewer

Published by Vermillion (2004)

ISBN: 009189848X

References

1. The Food Standards Agency – *Eating while you are pregnant* (see above).
2. Stray-Pederson & Stray-Pederson. *Aetiologic factors and subsequent reproductive performance in 195 couples with a prior history of habitual abortion*. American Journal of Obstetrics & Gynaecology. 1984; **148**: **2**: 140-146.
3. Liddle, Pattinson & Zanderigo. *Recurrent miscarriage – outcome after supportive care in early pregnancy*. Australian Journal of Obstetrics & Gynaecology. 1991; **31**: **4**: 320-322.
4. N Maconochie, P Doyle, S Prior, R Simmons. *Risk factors for first trimester miscarriage: results from a UK-population-based case-control study*. BJOG
Published article online: 5-Dec-2006 doi: 10.1111/j.1471-0528.2006.01193.x

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