



MISCARRIAGE
ASSOCIATION

The knowledge to help

Management of Miscarriage:

surgical, medical,
conservative

Introduction

If you're reading this leaflet, you are probably in the process of dealing with a miscarriage – or perhaps supporting someone else in this situation. You may be facing difficult choices at a difficult and distressing time, or perhaps you're trying to find out more about what has happened so far. Whatever your circumstances, we hope that you find this leaflet helpful.

Background

In some miscarriages the womb (uterus)¹ empties itself completely. In some cases, though, an ultrasound scan shows that the baby has died or not developed but has not been physically miscarried. This leaflet explains some of the medical terms that are used in this situation and describes the different ways in which the miscarriage process can be managed in these circumstances.

Medical terminology

There are several ways that doctors might describe a miscarriage where the womb does not empty itself completely. Unfortunately, not everyone uses the same terminology, so it can be difficult to understand what they mean. We explain the main terms below:

Missed miscarriage (also called delayed or silent miscarriage)

This is where the baby has died or failed to develop but your body has not physically miscarried the pregnancy. There may have been little or no sign that anything was wrong and this may have been diagnosed at a routine scan. You may still feel pregnant, though your symptoms may be weaker than before and a pregnancy test may still show positive.

Blighted ovum

Now more often called missed or delayed miscarriage, this term is still sometimes used when an ultrasound scan shows a pregnancy sac with nothing inside. This may be because the fertilised egg does not divide and develop as it should and although the pregnancy sac develops, the baby does not. Alternatively, it may be that the baby stops developing at such an early stage that it is absorbed back into the surrounding tissue. You may still feel pregnant, as with a missed miscarriage.

¹ We use the word "womb" rather than "uterus" in this leaflet. You'll probably find that doctors, nurses and midwives tend to use the word "uterus".

Incomplete miscarriage

Sometimes when a miscarriage occurs, not all the pregnancy tissue in the womb comes away. Although the pregnancy is over, symptoms of pain and heavy bleeding continue.

Methods of management

In all of these situations, the pregnancy will fully miscarry in time, but the miscarriage may also be managed surgically or medically. You will usually be offered a choice, or the doctor might make a recommendation. In most cases, you should be able to have time to think about which method to choose. This can be difficult – not least because you would almost certainly prefer not to have to consider any of these options at all.

It may help to know that a large research study¹ comparing surgical, medical and expectant (natural) methods came to three very important conclusions:

- the risks of infection or other harm are very small with all three methods
- your chances of having a healthy pregnancy in the future are just as good whichever method you choose
- women interviewed for the research study generally coped better when they were given clear information, good support and were able to choose the management method that they felt they could best cope with.

We hope that the following information might help you in making a decision and/or in understanding more about the process.

I was told I had a missed miscarriage and was then sent home to think about the various options. I went to see my GP who was very helpful and explained that the choice was mine and all options were right.

Surgical management: ERPC

This is an operation to remove the remains of your pregnancy and it is usually done under general anaesthetic (you are asleep). ERPC is an abbreviation for Evacuation of Retained Products of Conception, which means the removal of the remains of the pregnancy and surrounding tissue. Some people call it a D & C, which means dilatation and curettage, but this is a slightly different procedure, usually carried out for women with period problems.

What happens?

The cervix² (neck of the womb) is dilated (opened) gradually, and a narrow suction tube is inserted into the womb to remove the remaining pregnancy tissue. This procedure takes about 5 to 10 minutes. A sample of the tissue is usually sent to the pathology department to check that it is normal pregnancy tissue (though not all hospitals do this). It is not usually tested for anything else unless you are having investigations after recurrent miscarriage.

Does it hurt?

The ERPC is usually carried out under a general anaesthetic (though in some cases it may be done with local anaesthetic). It is done vaginally and you will have no cuts or stitches. You may have some abdominal cramps (like strong period pain) when you wake up and for a few days afterwards. You are likely to have vaginal bleeding for up to two or even three weeks. Bleeding may stop and start but should gradually tail off during that time. If bleeding continues to be heavy or gets heavier than a period, it is best to contact your GP or the hospital where you were treated.

I only bled for a short time after the ERPC (about 4-5 days like a period). I only had mild aching and soreness the next morning.

Are there any risks?

There is a small risk of infection or injury with any surgical operation and, more rarely, a risk from having a general anaesthetic.

The risk of infection after ERPC is low (about 2 to 3 cases per 100). There is a very small risk (less than 1 in 200) of uterine perforation (making a small hole in the wall of the womb), and in rare cases, damage to the bowel or other internal organs. The risks of haemorrhage (extremely heavy bleeding), or of scarring (adhesions) on the lining of the womb are also very low (less than 1 in 200 cases).

Very occasionally, there is still pregnancy tissue remaining in the womb and a second ERPC may be needed.

What if I get an infection? Will I know?

Signs of infection are a raised temperature and flu-like symptoms, a vaginal discharge that looks or smells offensive and/or abdominal pain

² The cervix is a cone-shaped passageway, about an inch long, that connects the vagina and the womb. It is normally closed, but dilates (opens) during labour. It may also dilate naturally during miscarriage.

that gets worse rather than better. Treatment is with antibiotics. In some cases, you may need a second ERPC.

Some hospitals give a course of antibiotics routinely after ERPC to prevent infection. You will probably also be advised to use pads rather than tampons for the bleeding and not to have sexual intercourse until the bleeding has stopped.

What are the benefits of an ERPC?

For many women, the main benefit is that their miscarriage is “over and done with” and they feel they can move on more easily. They may be shocked to find out that their baby has died and may not be able to tolerate “carrying a dead baby” once they find out. With surgical management they know when the miscarriage will happen and can plan around that. Some women prefer not to be aware of the process of miscarrying.

When I was told I had lost the baby I just wanted it to be all over as soon as possible. I was booked in immediately and had the op the following day. I was treated with great kindness and informed all the way along of what would be happening. I recovered physically within a couple of weeks.

And the disadvantages?

Some women are frightened of having an anaesthetic, surgery or a hospital stay or of something going wrong during the operation. Some prefer to let nature take its course and to be aware of the whole process. Some women worry that the diagnosis might be wrong and refuse surgery in case there is a chance that their baby is still alive. Don't be afraid to ask for another scan if you need to be sure before making a decision.

Medical management

This is treatment with pills and/or vaginal tablets or pessaries to start or speed up the process of a delayed or missed miscarriage. They can also be used to help empty the womb after an incomplete miscarriage. Not all hospitals offer this option, however and it isn't suitable for women with certain health problems.

What happens?

This depends both on the kind of miscarriage and on your particular hospital, as treatment methods can differ slightly. In most cases, you will be given a tablet to take by mouth. This contains medication that blocks the action of the hormone progesterone and causes the lining of the

womb to break down. You will usually go home within a few hours of taking the tablet and be asked to return to the hospital two days later. A small number of women miscarry before their second appointment.

At the second visit, you will have pessaries (tablets) inserted inside your vagina. These work by making your womb contract and push out the pregnancy tissue. You may need more than one treatment with pessaries before the miscarriage happens. Most women will stay in hospital for the day so that staff can check their progress and offer pain relief if it is needed. Bleeding may continue for up to 3 weeks after treatment.

If you have had an incomplete miscarriage, you will not usually need the first tablet and will start treatment with the pessaries straight away.

Does it hurt?

Once the miscarriage starts, most women have quite strong period-like pain and cramps and some find the process very painful, especially as the pregnancy tissue is expelled. This is because the womb is contracting and pushing (imagine tightly clenching and then relaxing your fist a few times), rather like the contractions of labour. You are also likely to have heavy bleeding and pass blood clots. You may see the pregnancy sac and it may be larger than you expect. You might see an intact fetus, which may look like a tiny baby, especially if you are miscarrying after 10 weeks. The hospital should give you some guidance as to what to expect and provide or recommend pain-relief.

I was told it would be like a heavy period with cramps and may go on longer than usual. Because I had never had a miscarriage before, I did not know what to expect. I was unable to cope with the pain and needed strong pain-killers.

Some women react to the medication with nausea and/or diarrhoea.

Are there any risks?

The risk of infection after medical management is low, at around 1 in 100. Signs of infection are a raised temperature and flu-like symptoms, a vaginal discharge that looks or smells offensive and/or abdominal pain that gets worse rather than better. Treatment is with antibiotics. In some cases, you may be advised to have an ERPC. Some hospitals give a course of antibiotics routinely to prevent infection. You will probably also be advised to use pads rather than tampons for the bleeding and not to have sexual intercourse until the bleeding has stopped.

There is a small risk of haemorrhage; a recent studyⁱⁱ reported that 1 in 100 women had bleeding severe enough to need a blood transfusion. If

you have very heavy bleeding or severe pain and/or feel unwell, or if you just find it hard to manage, you may wish to contact the hospital where you were treated – most units will provide a 24-hour contact number.

Medical management is effective in approximately 80 to 90% of cases. Where it is not, women may be advised to have surgical management – an ERPC.

What are the benefits of medical management?

The main benefit is in avoiding an operation and general anaesthetic. Some women prefer to be fully aware of the process of miscarriage and may want to see the pregnancy tissue and perhaps the fetus. Some women feel this helps them say goodbye, though they may want guidance on what to do with the remains of their baby (see *After the miscarriage* on page 10).

Some women see medical management as a more natural process than having an operation, but more manageable than waiting for nature to take its course. It may be helpful to know that if the treatment doesn't work, you may be able to opt for an ERPC.

I felt I needed to go through the process to get closure. I was lucky not to experience too much pain although I was regularly offered pain relief. The hospital gave me a side room and my husband stayed with me throughout.

And the disadvantages?

Some women find the process painful and frightening, though good information about what to expect can help. Some women are anxious how they might cope with pain and bleeding, especially if they are not in hospital at the time. Some fear seeing the fetus. Bleeding can continue for up to three weeks after the treatment and women may have to have several follow-up scans to monitor progress. This can be upsetting. Some women will end up having an ERPC as well as medical treatment.

Natural management (also called expectant or conservative management): letting nature take its course

Some women prefer to wait and let the miscarriage happen naturally – and hospitals may recommend this too, especially in the first 8 or 9 weeks of pregnancy. Doctors tend to call this expectant or conservative management, though they may also call it a “wait and see” approach.

What happens?

The process of a natural miscarriage will vary depending on the size of the pregnancy and the findings of the ultrasound scan. There is wide variation and it may take days or several weeks before the miscarriage begins. Once it does, you are likely to experience abdominal cramps, and bleeding can continue for two or three weeks. It can be very difficult to predict what will happen and when. In some women, the small sac in the womb will re-absorb without much bleeding at all.

The hospital is likely to invite you back for another scan or scans over the next few weeks to monitor progress and ensure that the womb has emptied.

I decided to wait for things to happen naturally as I wanted to keep control of what was happening to me, as much as you can.

Does it hurt?

It varies, but most women will experience abdominal cramps, possibly quite severe and painful, especially as the pregnancy tissue is expelled. As with medical management, this is because the womb is contracting and pushing (imagine tightly clenching and then relaxing your fist a few times), rather like the contractions of labour. You are also likely to have heavy bleeding and pass blood clots. You may see the pregnancy sac and it may be larger (or smaller) than you expect. You might see an intact fetus, which may look like a tiny baby, especially if you are miscarrying after 10 weeks. The hospital should give you some guidance as to what to expect and provide or recommend pain-relief.

I had small cramps, which I had been having for some time and then severe period cramps. The pain was uncomfortable but in my experience you soon forget that and in the scheme of what has happened to you, it is not the worst thing.

Are there any risks?

The risk of infection with expectant management is low, at around 1 in 100. Signs of infection are a raised temperature and flu-like symptoms, a vaginal discharge that looks or smells offensive and/or abdominal pain that gets worse rather than better. Treatment is with antibiotics. In some cases, you may be advised to have an ERPC. Some hospitals give a course of antibiotics routinely to prevent infection. You will probably also be advised to use pads rather than tampons for the bleeding and not to have sexual intercourse until the bleeding has stopped.

There is a small risk of haemorrhage (extremely heavy bleeding); a recent studyⁱⁱⁱ reported that 2 in 100 women had bleeding severe enough to need a blood transfusion and some women will need an emergency ERPC. If you have very heavy bleeding or severe pain and/or feel faint or unwell, or if you just find it hard to manage, you may wish to contact the hospital where you were treated – most units will provide a 24-hour contact number.

In rare cases, pregnancy tissue may become stuck in the cervix and will need removing during a vaginal examination: this can be painful and distressing. If there is still pregnancy tissue remaining in the womb after several weeks, you may be advised to have an ERPC.

What are the benefits?

The main benefit is in avoiding hospital treatment – medication or an operation and general anaesthetic. Some women feel strongly that they want their miscarriage to be as natural a process as possible. They prefer to be fully aware of the process of miscarriage and may want to see the pregnancy tissue and perhaps the fetus. Some feel this helps them to say goodbye, though they may want guidance on what to do with the remains of their baby (see *After the miscarriage* on page 10).

It may be helpful to know that if you reach a point where you no longer want to wait, you can request an ERPC.

After my second missed miscarriage I opted to let nature take its course. It took two weeks until I had a miscarriage and although those weeks were very difficult, I found that I managed to accept the situation much quicker than previously. I also found my body got back to normal in a much shorter period of time.

And the disadvantages?

Some women find it very difficult not knowing when – and therefore where – the miscarriage might start. Sometimes it can take several weeks before the womb empties itself. Women may worry about starting to bleed heavily when they are least prepared and perhaps in public (though carrying or wearing sanitary pads can help). Some women are anxious about how they might cope with pain and bleeding, especially if they are not within easy reach of a hospital. Some fear seeing the fetus.

For some women, waiting can become intolerable after a time, though they may have mixed feelings about having follow-up scans to monitor progress. They may decide to request an ERPC. Others will need an ERPC because of heavy bleeding or infection.

After the miscarriage

In hospital

When a baby dies in pregnancy before 24 weeks, there is no legal requirement to have a burial or cremation. Even so, many hospitals have a policy of sensitive disposal of pregnancy remains and they may offer burial or cremation, perhaps along with the remains of other pregnancy losses. Other hospitals may treat the remains of an early loss as clinical waste (sent for incineration).

If you want to find out about the arrangements at your hospital, ask a nurse or midwife on the ward or unit where you are or were cared for, the hospital chaplain, the PALS (Patient Advice and Liaison) officer, or the hospital bereavement service.

Even if you miscarry in hospital, you may want to make your own arrangements for burying or cremating the remains of your baby, whether you use a funeral director or choose to bury the remains at home. There are some things to think about and you may want to contact The Miscarriage Association for further information.

At home

If you miscarry at home or somewhere other than a hospital, you are most likely to pass the remains of the pregnancy into the toilet (this could happen in hospital too). You may look to see what has come away and you might see a pregnancy sac and/or the fetus, or perhaps something that you think might be the fetus. You may decide simply to flush the toilet – many people do that automatically – or perhaps to remove the sac or fetus for a closer look. That's also a very natural thing to do.

Whether or not you see a recognisable fetus, however tiny, you may wonder what to do with it. Flushing it down the toilet may seem right or it may not:

It wasn't what I'd intended, but a friend said "Just think about your baby being swept through the system and then floating out to sea, bobbing about under the stars.." I found that really comforting.

You might decide to bury the remains at home, in the garden or in a planter with flowers or a shrub. Or you may want to see if they can be buried in a local cemetery. You may want to put the remains into a container and take them to your GP or the hospital. Do be aware that they probably won't be able to do any tests on the fetus or tissue, though they may be able to confirm that you have passed pregnancy tissue.

You are welcome to contact The Miscarriage Association if you have any questions about what to do.

Summary

There are several ways of managing a miscarriage. All have advantages and disadvantages but risks of infection or other harm are low and the chances of having a healthy pregnancy in the future are just as good whichever method you choose.

The processes are different and personal experience varies, so if you are given options, you may find it hard to decide between them. We understand that you would almost certainly prefer not to be making these choices at all.

The one thing all these methods have in common is that they are all unhappy experiences to go through. But if you feel informed with the correct information then at least you have some control of a situation where you feel horribly out of control.”

We hope that this leaflet provides the information to help you make decisions at what may be a difficult and distressing time.

Acknowledgements

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Useful resources

The Miscarriage Association

c/o Clayton Hospital, Northgate, Wakefield WF1 3JS

Tel: 01924 200799; e-mail: info@miscarriageassociation.org.uk;

www.miscarriageassociation.org.uk

Association of Early Pregnancy Units www.earlypregnancy.org.uk

Information on EPU's around the UK, common questions and guidelines for health professionals

Royal College of Obstetricians & Gynaecologists www.rcog.org.uk

Information for patients and clinical “green-top” guidelines for health professionals.

ⁱ J Trinder et al: Management of miscarriage: expectant, medical or surgical? Results of a randomised controlled trial (miscarriage treatment (MIST) trial). *BMJ* 2006;332:1235-1240 (27 May)

ⁱⁱ Trinder, J et al: As above

ⁱⁱⁱ As above

^{iv} Association of Early Pregnancy Units: AEPU Guidelines, 2007



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