MISCARRIAGE ASSOCIATION

The knowledge to help

Management of miscarriage: your options

If you're reading this leaflet, you are probably dealing with a miscarriage right now – or supporting someone else through the process. You may be facing difficult choices at a distressing time; or you may be trying to find out more about what has happened already.

Whatever your situation, we hope you will find this leaflet helpful.

We have separate leaflets on the management of second trimester loss (late miscarriage), ectopic pregnancy and molar pregnancy *(see page 15)*.

What this leaflet is about

In some miscarriages the uterus (womb) empties itself completely. But in others an ultrasound scan shows that the baby has died or not developed but has not been miscarried.

This leaflet describes the different ways these kinds of miscarriage can be managed. It also explains some of the medical language you might hear or read.

Understanding the medical language

Doctors have different ways of describing miscarriages where the uterus does not empty itself completely.

We share the main terms in the next column.

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.

Early embryo loss (also called 'anembryonic pregnancy' or 'blighted ovum')

This is where an ultrasound scan shows a pregnancy sac with nothing inside. This is usually because the cells that should become the baby stop developing early on, and the tiny embryo is re-absorbed. However, the pregnancy sac, where the baby should develop, continues to grow. 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.

Methods of management

In all the situations described on page 3, a full miscarriage will happen naturally in time and some women[1] choose this option. But the process can be aided or 'managed' by medical treatment (drugs) or surgery (an operation).

We describe all these options in this leaflet.

Ideally you should be able to choose what treatment to have and be given information to guide your decision. You may find it easy or difficult to make a decision depending on your situation. Unless you need emergency treatment, you should be given time to choose the right way forward for you.

It may help to know that research[i] comparing natural, medical and surgical management found that:

- the risks of infection or other harm are very small with all three methods;
- your chances of having a healthy pregnancy next time are equally good whichever method you choose;
- women[1] cope better when given clear information, good support and a choice of management methods.

We hope the information that follows will help you to understand the different options better and make it easier to decide.

"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."

[1] We often use the words 'woman' or 'women' in this leaflet, but we recognise that the person who has the physical loss may not identify as such.

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

Some women prefer to wait and let the miscarriage happen naturally. Doctors often recommend this, especially in the first eight or nine weeks of pregnancy. National (NICE) guidance[ii] also states that natural management should be the first method to consider. However, your choice will be important in deciding the best and safest option for you.

What happens?

This can vary a lot depending on the size of the pregnancy and the findings of the ultrasound scan. It can take anything from days to weeks before the miscarriage begins. Once it does, you are likely to have strong cramps and bleeding. The bleeding may go on for 2-3 weeks; or the small pregnancy sac in the womb may be reabsorbed without much bleeding at all. It can be very difficult to predict exactly what will happen and when.

You will probably be asked to visit or contact the hospital over the next few weeks. You may be offered a scan to check whether the uterus 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..."**

Or you may be asked to do a pregnancy test at home and come back if it is still positive after 2-3 weeks. At this point you may be offered medical or surgical management.

Does it hurt?

Most women have cramps that can be extremely painful, especially when the pregnancy tissue is being pushed out. This is because the uterus is tightly squeezing to push its contents out, much like it does in labour.

You are also likely to bleed very heavily and pass clots. These can be as big as the palm of your hand. You may see the pregnancy sac, which might look different from what you expected. You may – especially after 10 weeks – see an intact fetus. The hospital team should prepare you for what to expect and provide or advise you about 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."**

What are the risks?

Infection

This affects about 1 in 100 women, so some hospitals give antibiotics routinely to prevent it. Signs include:

- a raised temperature and flu-like symptoms
- vaginal discharge that is a different colour, thickness or smell to usual
- abdominal pain that gets worse rather than better
- bleeding that gets heavier rather than lighter.

Treatment is with antibiotics. You may need an operation to remove any remaining pregnancy tissue.

It is usually advised to use pads rather than tampons for the bleeding and not to have sex until it has stopped.

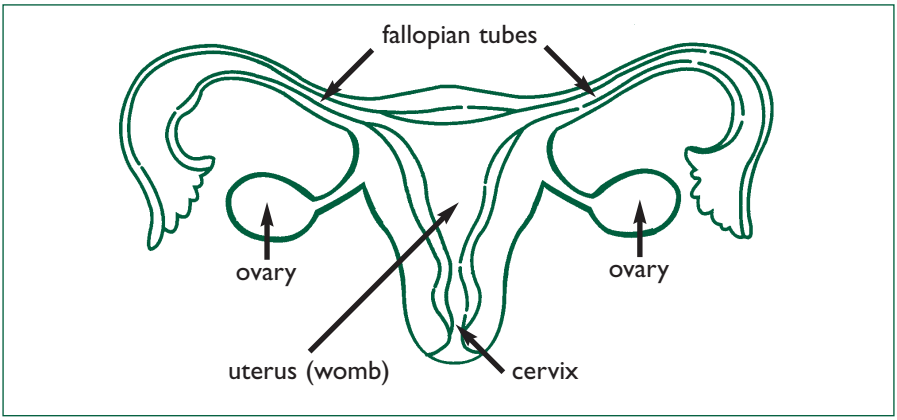
Haemorrhage (extremely heavy bleeding)

About 2 in 100 women have bleeding bad enough to need a blood transfusion. Some of them need emergency surgery to stop the bleeding. If you are bleeding very heavily – or feel otherwise unwell or unable to cope – it is best to contact the hospital where you were treated or your nearest Accident & Emergency Department.

Retained tissue

Sometimes a natural miscarriage doesn't complete itself properly – even after a few weeks – and some pregnancy tissue remains in the uterus. You may need an operation to remove it.

In rare cases, pregnancy tissue gets stuck in the cervix (neck of the uterus[2]) and needs to be removed during a vaginal examination. This can be very painful and distressing.



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

What are the benefits?

The main benefit is avoiding invasive treatment. You may want your miscarriage to be as natural as possible and to be fully aware of what is happening. You may also find it easier to say goodbye to the pregnancy if you see the tissue and maybe the fetus as it passes. You may still want advice, though, on what to do with the remains of your baby (see *After the miscarriage* on page 14).

If you choose natural management, it may help to know that you can change your mind at any stage and ask to have medical or surgical management.

> **"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?

- You may find it difficult not knowing when or where the miscarriage might happen. This can take anything from days to weeks. You may worry about starting to bleed heavily in public when you are least prepared – although wearing sanitary pads as a precaution can help;
- You may be anxious about how you will cope with pain and bleeding, especially if you are not within easy reach of a hospital;
- You may be frightened about seeing the remains of your baby;
- You may find it upsetting or difficult to have follow-up calls or appointments to check on progress – although some women find this reassuring;
- You might be too upset to wait for the miscarriage to happen naturally once you know your baby has died.

Be prepared

Being prepared with sanitary pads, pain-killers and emergency contact numbers can help you cope with what happens. You may want to make sure you have people on hand to support you.

Medical management

This means treatment with pills and/or vaginal tablets (pessaries) to start or speed up the process of a missed or incomplete miscarriage. However, it isn't suitable for women with some health conditions.

What happens?

The exact treatment your hospital offers will depend on current practice and individual patient assessment. You might have some or all of your treatment in hospital, or you might be given some or all of the medication to use at home.

If you have a missed or delayed miscarriage or an anembryonic pregnancy, you are likely to be given tablets to help break down the lining of the uterus. You will be asked to return two days later for the next stage of treatment, unless you have already miscarried.

The next stage means having tablets or pessaries to make your uterus contract and push out the pregnancy tissue.[3] If you have had an incomplete miscarriage, you will start with this second stage treatment.

You may need more than one dose of the medication before the miscarriage happens.

The medication may make you feel sick and can cause diarrhoea and flu-like symptoms. The hospital team should provide you with anti-sickness tablets.

Does it hurt?

Most women have cramps that can be extremely painful, especially when the pregnancy tissue is being pushed out. This is because the uterus is tightly squeezing to push its contents out, much like it does in labour. You are also likely to bleed very heavily – more than with a normal period – and pass clots. These can be as big as the palm of your hand. You may need to use extra-absorbent pads, possibly even more than one at a time.

You may see the pregnancy sac, which might look different from what you expected. You may – especially after 10 weeks – see an intact fetus.

The hospital team should prepare you for what to expect. They should provide you with strong pain-killers or advise what you can use and should also give you emergency contact numbers in case you need help or advice.

You will be advised to take a pregnancy test three weeks after your treatment. If it is still positive, you will be asked to return to the hospital for further assessment.

[3] This means the remains of your baby, or fetus or embryo, the pregnancy sac and the lining of the uterus.

What are the risks?

Infection affects about 1-4 women in every 100. Haemorrhage affects about 2 in 100 – the same as for natural miscarriage *(see page 6)*.

Medical management is effective in 80-90 per cent of cases. If it is not, or if you have an infection, you may be advised to have surgical management to complete the miscarriage.

What are the benefits?

The main benefit is avoiding an operation and the anaesthetic (general or local) that goes with it.

Some women see medical management as more natural than having an operation, but more controllable than waiting for nature to take its course.

As with natural management, you may prefer to be fully aware of what is happening, to see the pregnancy tissue and maybe the fetus.

"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?

- You may find the process painful and frightening, although good information about what to expect can help;
- You may be anxious about how you will cope with pain and bleeding, especially if you are not in hospital at the time;
- You may be frightened about seeing the remains of your baby;
- Bleeding can continue for up to three weeks after the treatment and you may need several follow-up scans to check on progress;
- Some women end up having an operation anyway.

"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."

Surgical management of miscarriage: SMM

This is an operation to remove the pregnancy tissue. It may be done under general anaesthetic, so you are asleep, or under local anaesthetic, when you stay awake.

SMM under general anaesthetic

This used to be called called ERPC or ERPoC, which stands for Evacuation of Retained Products of Conception. You might hear it called it a D & C, but that is a slightly different procedure, usually carried out for women with period problems. Both of these terms are still used occasionally.

What happens?

The cervix (neck of the uterus) is dilated (stretched) gradually. This is usually done under anaesthetic but you might be given pills or vaginal pessaries before the operation to soften the cervix. A narrow suction tube is then inserted into the uterus to remove the remaining pregnancy tissue. This takes about 5-10 minutes.

A sample of the tissue removed is usually sent to the pathology department to check that it is normal pregnancy tissue. It is not usually tested further unless you are having investigations after recurrent miscarriage.

Does it hurt?

If you are given tablets or vaginal pessaries before the operation, you may have cramping pain and perhaps some bleeding as the cervix opens. Having a general anaesthetic means you will not feel anything during the operation itself; and there are 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 may bleed for up to 2-3 weeks after the operation. Bleeding may stop and start but should gradually tail off. If it stays heavy, gets heavier than a period or makes you worried, it is best to contact your GP or the hospital.

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

What are the risks?

- About 2-3 women in every hundred get an infection. For signs of infection and treatment, see under 'natural miscarriage', on page 6;
- Rarely – less than 1 in 200 cases – the operation can perforate (tear) the uterus; damage to other organs is rarer still;
- Haemorrhage (extremely heavy bleeding) and scarring (adhesions) on the lining of the uterus are also rare – less than 1 in 200;
- Very occasionally some pregnancy tissue remains in the uterus and a second operation is needed to remove it;
- Very rarely, the general anaesthetic can cause a severe allergic reaction (about 1 in 10,000 cases) or even death (fewer than 1 in 100,000 cases);
- Very rarely (less than 1 in 30,000 cases) it can result in a hysterectomy; this would only be if there is uncontrollable bleeding or severe damage to the uterus.

What are the benefits?

With surgical management you know when the miscarriage will happen and can plan around that. With a general anaesthetic you won't be aware of what's going on.

It may be a relief when the miscarriage is 'over and done with' and you can begin to move on.

And the disadvantages?

Some women are frightened of anaesthetics, surgery and staying in hospital. Some prefer to let nature take its course and to remain aware of the miscarriage process.

The anaesthetic might make you feel groggy or unwell for a few days.

Some women refuse surgery because they worry that the diagnosis might be wrong and their baby is still alive. If this is your concern, don't be afraid to ask for another scan just to be sure.

"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."

SMM under local anaesthetic

This is also sometimes called MVA, which stands for Manual Vacuum Aspiration. It may be carried out in a hospital ward, a day surgery unit or an out-patient clinic.

What happens?

You may be given tablets or vaginal pessaries before the operation to soften the cervix, along with pain relief. A local anaesthetic is injected into your cervix, or the cervix may be numbed with a gel and the cervix is then dilated (stretched) gradually. A narrow suction tube is then inserted into the uterus to remove the remaining pregnancy tissue. You will be offered further pain relief during the procedure and may have a scan afterwards.

This usually takes about ten minutes. Afterwards you will probably be advised to wait for an hour or two to make sure you are well enough to go home.

As with SMM under general anaesthetic, a sample of the tissue removed may be tested afterwards to check that it is normal pregnancy tissue.

Does it hurt?

Most women feel some pain during the procedure, which can range from mild discomfort to a very intense cramping pain. The injection of local anaesthetic into your cervix might feel uncomfortable, but it only lasts for a few seconds. It's likely you'll then feel some pain or cramping as the tissue is removed and the uterus contracts. You can be given additional pain relief, such as nitrous oxide (gas and air).

We recommend you speak to your healthcare professional before the procedure to discuss how they will help you manage any pain, and what your options are if you find it too uncomfortable. Know that you can ask for the procedure to be stopped if you need to.

You will usually have the option of then having the procedure under general anaesthetic, but often you may have to wait some time for this, depending on when you last ate, and what else is happening in your hospital.

You should expect some light vaginal bleeding and cramping afterwards. You may be given painkillers to take home or be advised to take some over-the-counter medication. If the bleeding becomes heavy, it is best to contact the team that treated you.

> **"I had the surgery done under local anaesthetic (just with gas and air). It was painful, but very quick. The actual removal took less than 5 minutes. Within an hour I walked home with my husband, bleeding only a little bit and in no pain."**

Are there any risks?

These are mostly the same as for SMM under general anaesthetic. There is a very small risk of having a reaction to the local anaesthetic.

What are the benefits?

As with SMM with general anaesthetic, you will know when the miscarriage will happen and may then feel you can begin to move on. The procedure is quick and you will recover more quickly than from a general anaesthetic.

You may actually prefer to be awake and aware of what is happening.

And the disadvantages?

Some women prefer not to be aware of the process of miscarrying. And you may worry about coping with pain or anxiety.

"I was worried about whether the MVA would be painful, but the consultant talked to me all the way through, which was very reassuring. It only hurt for a few minutes and I felt in control of the pain and what was going on. The pain and bleeding stopped very quickly afterwards and the next morning I felt fine."

After the miscarriage

In hospital

When a baby dies before 24 weeks of pregnancy, there is no legal requirement to have a burial or cremation. Even so, most hospitals will offer to arrange for your baby to be buried or cremated, perhaps along with the remains of other miscarried babies. This is always the case in Scotland. Some hospitals treat the remains of an early loss as clinical waste, which is sent for incineration, but this is changing.

If you want to find out about what happens at your hospital, you could ask a nurse or midwife on the ward or unit where you are or were cared for. The hospital chaplain, the hospital bereavement service or the PALS (Patient Advice and Liaison) officer may be able to provide further information or advice.

Even if you miscarry in hospital, you may want to make your own arrangements for burying or cremating the remains of your baby. You can do this through a funeral director or carry out your own burial at home.

There are a few 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 else outside a hospital, you are most likely to pass the remains of the pregnancy into the toilet. Actually this can happen in hospital too. You may look at what has come away and see a pregnancy sac and/or, the fetus – or something you think might be the fetus. You may want to simply flush the toilet – many people do that automatically – or you may prefer to remove the remains for a closer look. That's natural too.

You may decide to bury the remains at home, in the garden or in a planter with flowers or a shrub. Or you may prefer to arrange burial in a local cemetery. You may want your GP or hospital to look at the remains. Be aware, though, that while they may be able to confirm you have passed pregnancy tissue, they probably won't be able to carry out any tests on it.

If you have any questions about what to do or would just like to talk it through, you are welcome to contact us at the Miscarriage Association.

"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."

Summary

There are several ways of managing a miscarriage. Each has its pros and cons. But the good news is that the risks associated with all of them are low; and your chances of having a healthy pregnancy in future are equally good whichever you choose.

Each method is different and affects people differently. This can make it hard to choose between them – especially when you wish you didn't have to choose at all.

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

> **"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."**

Help and support

The Miscarriage Association offers support and information through a staffed helpline: phone, live chat, email and direct messaging; online and in-person support groups, an online forum and private Facebook groups. See: www.miscarriageassociation.org.uk/how-we-help.

Useful reading

Miscarriage Association leaflets, including:

Second trimester loss (late miscarriage)

Ectopic pregnancy

Molar pregnancy.

All our leaflets are available at www.miscarriageassociation.org.uk/leaflets.

Patient information from the National Institute of Health and Clinical Care (NICE), available online at https://www.nice.org.uk/guidance/ng126

References

[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] NICE guidelines [NG126] Ectopic pregnancy and miscarriage: Diagnosis and initial management (April 2023,) https://www.nice.org.uk/guidance/NG126

Need to talk to someone who understands?

Call our support line on 01924 200799. Mon, Tues, Thurs 9am to 4pm, Weds and Fri 9am to 8pm.

Chat with us online at www.miscarriageassociation.org.uk.

Or email info@miscarriageassociation.org.uk

MISCARRIAGE
ASSOCIATION

The knowledge to help

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