MISCARRIAGE ASSOCIATION

The knowledge to help

Caring for patients with pregnancy loss

Miscarriage ● Ectopic pregnancy ● Molar pregnancy

Additional information for ambulance crews

Miscarriage

- **Miscarriage** is defined as the spontaneous end of a pregnancy before 24 weeks' gestation. A pregnancy that ends after 24 weeks is called a stillbirth.

- The **incidence** is estimated to be 20% to 25% of pregnancies.

- Most miscarriages occur before 14 weeks of pregnancy and most of these in the first 8 weeks, but it can take days or weeks after the embryo/fetus/baby dies before the physical miscarriage process starts.

- Miscarriages where the baby dies after 14 weeks are much less common: about 2% of pregnancies end this way.

- Around 1% of women trying for a baby will have three or more consecutive miscarriages - the former definition of recurrent miscarriage. A larger number will have three or more non-consecutive miscarriages.

Miscarriage can happen to any woman of fertile age who is sexually active, but the risk increases:

- with maternal age (and especially after 39)
- with the number of previous miscarriages (especially three or more consecutive miscarriages)
- with Black or Asian ethnicity
- if there were fertility problems, whether or not the pregnancy was the result of assisted conception
- with a twin or multiple pregnancy (where one or more babies die/s but one or more may survive)
- with certain medical conditions, including blood clotting problems.

Miscarriage may be:

- **threatened:** bleeding or spotting, possibly on and off over a period of days or weeks. Around half of these pregnancies continue, but there's some evidence of increased risk of pre-term labour.
- **Complete:** the uterus empties itself naturally and completely.
- **Incomplete:** bleeding and evidence of fetal death, but ultrasound shows pregnancy tissue in the uterus.
- **missed or silent:** usually diagnosed at the 12 week booking-in visit, the scan shows fetal death, often some time earlier, but the process of miscarriage has not started. Pregnancy hormone levels are often normal and most women have no signs or symptoms that anything is wrong.

Useful references:

M.A. leaflets: *Your miscarriage*
Why me?
Second trimester loss (Late miscarriage)

Ectopic pregnancy

- **Ectopic pregnancy** is a potentially life-threatening condition in which a fertilised egg implants outside the uterine cavity

- The **incidence** is estimated to be 1 in 80 pregnancies.

- The pregnancy is usually in one of the fallopian tubes, but may be elsewhere, including in the scar from a C-section.

- Ectopic pregnancy can be difficult to diagnose and may be confused with appendicitis or irritable bowel syndrome.

- Symptoms can include

    - abdominal pain, often one-sided
    - watery brown vaginal discharge
    - shoulder-tip pain
    - pain on moving the bowels
    - pallor, faintness and/or collapse
    - – or none of these.

- A pregnancy test may or may not be positive and serial blood tests are more informative.

- Ectopic pregnancy may be managed:

    - Surgically (laparoscopy or abdominal); the tube may or may not be removed
    - Medically (methotrexate)
    - Conservatively (watch and wait)

- Ectopic pregnancy and its management can be very frightening and traumatic for the patient and her partner. At the very least, it reduces future fertility and increases the risk of another ectopic pregnancy.

Ectopic pregnancy can happen to any woman of fertile age who is sexually active, but the risk increases if:

- the woman has had a previous ectopic pregnancy/ies
- she has had previous abdominal surgery, including a C-section
- she has/had Chlamydia or a history of PID
- she has an IUCD *in situ*
- she has problems conceiving or has been sterilised
- she is under 20
- she smokes cigarettes

Useful references:

Miscarriage Association leaflet:	Ectopic pregnancy
Miscarriage Association web pages:	Ectopic pregnancy
RCOG Green-top guideline no.21	Diagnosis and management of ectopic pregnancy

Molar pregnancy

- In **Molar pregnancy**, an abnormal fertilised egg implants and trophoblast tissue grows rapidly to fill the uterus. It is also known as trophoblastic disease.

- The incidence of molar pregnancy is around 1 in 600 pregnancies.

- Molar pregnancy is usually diagnosed in histological examination after surgical management of miscarriage. It may be suspected during pregnancy, on ultrasound or by serial blood tests.

- Symptoms include pronounced pregnancy symptoms, especially nausea and vomiting, reflecting abnormally high pregnancy hormone (hCG) levels.

- The hydatidiform mole may be **partial** or **complete**. It may become **invasive**.

- The diagnosis and follow-up of molar pregnancy can be very confusing and frightening for the patient and her partner, especially the association with cancer. Clear information is crucial.

A molar pregnancy can happen to any woman of fertile age who is sexually active, but the risk increases if:

- the woman has had a previous molar pregnancy/ies
- she is over 40

Follow-up is essential to monitor hCG levels. Patients with a molar pregnancy are referred to one of three UK specialist follow-up services:

- Charing Cross, London
- Weston Park, Sheffield
- Ninewells, Dundee.

Follow-up is for different periods of time, depending on the type of molar pregnancy (partial or complete) and the length of time it takes for hormone levels to drop to normal. Women are advised not to become pregnant until hCG levels are normal. They may need advice on contraception.

If hCG levels do not fall adequately and/or women develop choriocarcinoma, they are likely to be treated with chemotherapy. The success rate for treatment of choriocarcinoma is close to 100%.

Useful references:

Miscarriage Association leaflet: Molar pregnancy
Miscarriage Association web pages: Molar pregnancy
RCOG Green-top Guideline no.38: Gestational Trophoblastic disease

Miscarriage: the physical process

The physical process of miscarriage varies considerably. There is almost always some pain and bleeding but it varies in:

- **Timing:** spotting or bleeding may be intermittent and last for days or weeks. If miscarriage is diagnosed by ultrasound scan, it may take some days or weeks before the physical miscarriage happens, especially if the woman decides to wait for nature to take its course (see below).

- **Intensity:** during the miscarriage itself, pain may be very intense, with severe cramps akin to contractions. Bleeding may be copious and very heavy, with large clots. If there is an infection or the miscarriage is incomplete, pain and bleeding may diminish and then intensify again.

- **Duration:** the worst of the pain and bleeding is usually a matter of days, but it can last longer, especially with expectant management (letting nature take its course).

- **Gestation:** second trimester loss (after 14 weeks) usually means going through labour and delivery. This may be induced if the miscarriage does not start naturally.

Management of miscarriage

If missed/silent or incomplete miscarriage is diagnosed, women may be offered options of:

- surgical management (SMM): under general or local anaesthetic (MVA)
- medical management: medication to "kick-start" the miscarriage process
- expectant management: waiting for nature to take its course

While NICE guidance recommends particular pathways, the M.A. supports patient choice, subject to clinical indications and available options. In all cases, women need clear and accurate information about options, risks and the physical experience.

Useful references:

Miscarriage Association leaflet: Management of miscarriage
Miscarriage Association web pages: Management of miscarriage

After the loss

Women may be advised about and asked for their consent for:

- Histology: determining if this is normal pregnancy tissue – i.e. neither molar nor maternal only
- Karyotyping: fetal or parental
- Postmortem (autopsy): more likely after mid trimester (or later) loss
- Disposal of pregnancy remains; hospital or private (see below)

Useful references:
Guidance from: Human Tissue Authority in England & Wales; the Scottish Government and the Royal College of Nursing
Miscarriage Association guidance: Talking to patients about the disposal of pregnancy remains

Causes of miscarriage

Most women never know why they miscarry. Investigations are usually done only after three (or more) miscarriages and even then, a problem is identified in fewer than 50% of cases. Sometimes, there may be a combination of factors. The main causes, in order of incidence, are:

- **Genetic**
  - usually a chance (random) chromosome abnormality (more than half of all miscarriages)
  - in some cases a parental chromosome anomaly
- **endocrine:** sometimes associated with problems conceiving and including polycystic ovarian syndrome (PCOS)
- **immunological:** often related to blood-clotting problems, e.g. antiphospholipid syndrome
- **infection:** some infections are more likely to cause late miscarriage
- **anatomical**
  - problems with the shape of the uterus or strength of the cervix or
  - a structural abnormality in the fetus

A poor diet, smoking, alcohol consumption and sustained stress, especially at work, are also associated with increased miscarriage risk, though research reports can be contradictory.

Treatment/prevention of miscarriage

There is very little proven medical treatment to prevent miscarriage, though doctors can increase the chances of a healthy pregnancy in some cases, e.g. treatment with aspirin and heparin for women with some blood-clotting conditions.

Research published in 2015 concluded that progesterone supplements during pregnancy in women with previously unexplained recurrent miscarriage do **not** improve outcomes. Research published in 2019 found that progesterone treatment of bleeding in the first trimester reduced miscarriage rates in women with previous recurrent miscarriage. Other research continues.

Useful references:

Miscarriage Association leaflets:	Why me?
	Recurrent miscarriage
	Second trimester loss
RCOG Green-top Guideline no.17:	Recurrent miscarriage

The impact of miscarriage, ectopic and molar pregnancy varies with:

- **This particular woman (or man or couple)**:
    - personality and personal style, how they cope with adversity
    - the relationship (if there is a partner: some relationships break down after miscarriage)
    - other relationships (other support or lack of it)
    - culture/religion/social group (norms & expectations, though not everyone conforms to type)
- **This pregnancy/ this loss**:
    - what it means to her/him/them
    - previous pregnancy history
    - gestation (but don't make assumptions)
    - implications of this loss on future fertility/pregnancies (recurrent miscarriage, ectopic or molar pregnancy)
    - special pregnancy (after infertility, in a new relationship)
    - hopes, expectations, anxieties (hopeful after treatment, anxious because of history or age)
    - physical experience (symptoms or not, pain, bleeding, labour and delivery)

Feelings associated with pregnancy loss

For some people:

- Relief
- Acceptance
- Moving on

For many, if not most people:

- Shock
- Embarrassment
- Anxiety and fear
- Confusion
- Powerlessness
- Loss, grief, emptiness
- Seeking reasons
- Guilt and self-blame
- Isolation
- Anger
- Jealousy
- Loss of confidence, feeling unable to cope
- Symptoms of depression
- And for some, clinical depression, anxiety or PTSD

Patients' wants and needs

The tough ones:

- Stop the miscarriage
- Tell me why it happened
- Prevent it ever happening again
- Promise special care in the next pregnancy

The manageable ones:

- Good listening
- Acknowledgement of feelings
- Clear information
- Sensitive language and terminology
- Joined-up communication
- Written and on-line information
- Support during/after the loss and in the next pregnancy

Your needs

- Information – and knowing where to find it
- Training, conferences, refresher courses
    - The Miscarriage Association e-learning
    - ROCG
    - Association of Early Pregnancy Units
    - Ectopic Pregnancy Trust
- Support for yourself, especially in
    - dealing with patients' uncertainty and distress
    - understanding your own personal experiences and values

The Miscarriage Association

A registered UK charity, with four main areas of work:

- **Support**
  - *Support rather than counselling*
- **Information**
  - *Information rather than advice*
- **Raising public awareness**
  - *Of the facts and feelings of pregnancy loss*
- **Promoting good practice in caring for women with pregnancy loss**

Support

- Staffed helpline (calls, email, live chat)
- Volunteer support network
- Private online forum

Listening; Acknowledging feelings; Reducing isolation; Reassurance re range of emotional responses

Information

- Staffed helpline
- Leaflets
- Website

Explaining and clarifying; Reducing anxiety & guilt; Enabling some decision-making; Restoring some control & self-confidence

Awareness & Good Practice

- Media
- Advice & consultancy
- Collaborative working
- Representation on planning and research groups

We will always try to help

www.miscarriageassociation.org.uk