Wrightington, Wigan and Leigh Teaching Hospitals
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Management of a Miscarriage

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Patient Information

Obstetrics and Gynaecology Services

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Introduction

Miscarriage is the most common kind of pregnancy loss, affecting around one in four pregnancies. If you are 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 are 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) empties itself completely. In other cases, an ultrasound scan shows that the baby has died, or not developed as expected, but has not been physically miscarried. This leaflet explains some of the medical terms that are used in these situations and describes the different ways in which the miscarriage process can be managed in these circumstances.

It is important to know that your miscarriage is very unlikely to have happened because of anything you did or didn’t do.

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. There may have been little or no sign that anything was wrong, so the miscarriage 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.

Early embryo loss

(Also called ‘anembryonic pregnancy’ or ‘blighted ovum’)

Now more often called missed or delayed miscarriage, the term Blighted Ovum is still sometimes used when 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 reabsorbed. The pregnancy sac, where the baby should develop continues to grow. You may still feel pregnant, as with a missed miscarriage.

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.

Chemical Pregnancy

(Sometimes called a biochemical pregnancy)

This is a very early loss that occurs usually just before 5 weeks (around implantation of the embryo). Pregnancy tests have become more sensitive, so that it is possible to detect pregnancy hormones up to 3 days before a period is due. As a result, more women are finding out about these very early losses. There may be no other symptoms apart from a positive pregnancy test. Unfortunately, a scan would not be able to detect the pregnancy, as it happens at such an early stage.

Methods of management

If you have a missed or incomplete miscarriage, doctors will need to make sure the miscarriage is complete and there is no remaining tissue in your womb. This is called management of miscarriage.

In all the situations described above, a miscarriage will happen naturally in time (expectant management). However, you may choose to speed up the process by opting for medical treatment (drugs) or surgery (an operation).

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 decide 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 a large research study comparing surgical, medical and expectant (natural) methods came to three very important conclusions:

- The risk of infection or other harm is 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 deciding and in understanding more about the process.

Natural or Expectant Management

Some women prefer to wait and let the miscarriage happen naturally – 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.

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 and safest option for you.

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. 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.

You will be invited to attend for another scan or scans over the next few weeks to monitor progress and ensure that the womb has emptied. At this point you may be offered medical or surgical treatment if the expectant management fails.

If you decide to manage the miscarriage naturally, being prepared with sanitary pads, painkillers 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.

Does it hurt?

It varies, but most women will experience abdominal cramps, possibly quite severe and painful, especially as the pregnancy tissue is pushed out. 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 foetus, which may look like a tiny baby, especially if you are miscarrying after 10 weeks. The nurse will give you some guidance as to what to expect and provide or recommend pain relief.

Are there any risks?

The risk of infection with expectant (natural) 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 (Evacuation of Retained Products of Conception – see page 7). You will 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 study 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 Ward 2 at Leigh Infirmary **01942 264252 or 01942 264857**; out of hours - Swinley Ward, Royal Albert Edward infirmary on **01942 822072**.

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, such as 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 foetus. Some feel this helps them to say goodbye, though they may want guidance on what to do with the remains of their baby.

It may be helpful to know that if you reach a point where you no longer want to wait, you can change your mind at any stage and ask to have medical or surgical management.

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 foetus.

For some women, waiting can become intolerable after a time, and 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.

Medical Management

This is treatment with oral and vaginal medication to start or speed up the process of a delayed or missed miscarriage. This treatment can also be used to help empty the womb after an incomplete miscarriage

Can anyone have medical management of miscarriage?

Medical management is not suitable for all women, but you will be assessed to ensure it is

safe for you.

You may not be offered medical management for any of the following reasons:

- You have asthma
- You have a drug allergy/sensitivity to Misoprostol or similar drugs
- You have a blood clotting problem
- You have active liver or kidney disease
- You have severe anaemia
- You have acute inflammatory bowel disease
- We have a suspicion or diagnosis of a complete molar pregnancy. A molar pregnancy is where a foetus doesn't form properly in the womb and the baby doesn't develop. A mass of abnormal cells grows in the womb instead of a foetus.
- We suspect an ectopic pregnancy. An ectopic pregnancy is when the baby starts to develop outside the uterus (womb), most commonly in a Fallopian tube.
- You are unwell with your miscarriage
- You have signs of pelvic infection and/or sepsis
- You have heavy active bleeding
- Your pregnancy has grown beyond a certain size

What happens?

Medical management involves a single visit to the hospital. The treatment consists of taking a tablet by mouth, which will be followed by four tablets of a drug called Misoprostol, which will be self-administered at home 48 hours later. These tablets are put into the vagina, near the cervix (neck of the womb); you may take the tablets by mouth if you are having vaginal bleeding. Please discuss this with the nurse on the day. These work by making your womb contract and push out the pregnancy tissue. Bleeding may continue for up to 3 weeks after treatment.

You will be offered a follow-up scan appointment 3 weeks afterwards, to check if the tablets have worked. After your bleeding from the miscarriage has stopped, you should usually expect to receive your next period in 4-6 weeks' time. Your first period after the miscarriage may be heavier than usual.

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 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. You may see the pregnancy sac, which might look different from what you expected. You may see an intact foetus that looks like a tiny baby, especially if you are miscarrying after 10 weeks. You may take Paracetamol or Co-codamol for pain relief, but you should not take Aspirin or Ibuprofen, as they may make the treatment less effective.

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.

You will 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 study 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 ring Ward 2, Leigh Infirmary **01942 264252 or 01942 264857**; out of hours - Swinley Ward, Royal Albert Edward Infirmary on **01942 822072**.

Medical management is effective in approximately 80% to 90% 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 of medical management?

The main benefit is in avoiding an operation and general anaesthetic.

Some women see medical management as a more natural process rather 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 Manual Vacuum Aspiration (MVA) (see page 9) or ERPC.

Disadvantages?

Some women find the process painful and frightening, though good information about what to expect can help. Some women are anxious as to how they might cope with the pain and bleeding, especially if they are not in hospital at the time. Some fear the possibility of seeing the baby.

The tablets may cause some unpleasant, but temporary, side effects i.e. flu-like symptoms, nausea and/or diarrhoea. In about 5% to 10% of cases, the miscarriage is incomplete and must be completed by an operation under general anaesthetic or Manual Vacuum Aspiration (MVA).

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.

Surgical Management: ERPC

This is an operation to remove the pregnancy tissue, 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 Dilation and Curettage, but this is a slightly different procedure, usually carried out for women with period problems.

What happens?

The cervix (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. The tissue will then be sent for histology (analysis), and following completion, you can decide if you would like the hospital to arrange a cremation service or you can arrange your own private cremation, or you may choose a burial at home. (You will be asked for consent to this before the operation).

Does it hurt?

The ERPC is usually carried out under a general 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.

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).

If there is still pregnancy tissue remaining in the womb, a second ERPC may be needed (up to five in 100 women).

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, which is surgical removal of the uterus; this would only be if there is uncontrollable bleeding or severe damage to the uterus. You will be given full information about this before the procedure.

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

You will 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 they feel they can move on more easily. 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.

Disadvantages of ERPC

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.

Surgical management under local anaesthetic (MVA):

This is also called MVA, which stands for Manual Vacuum Aspiration. A small hand-held device is used to empty out the contents of the uterus after some local anaesthetic has been applied to the cervix (neck of the womb).

This procedure offers an additional choice to women who want surgical management of miscarriage but want to avoid having a general anaesthetic.

What happens?

If you decide to have the MVA, you will be given an appointment. You can eat and drink normally before you attend. You may be given tablets or vaginal pessaries before the procedure to soften the cervix, along with pain relief. The doctor or nurse will meet you and go through any questions that you may have. You will be asked to sign a consent form. A nurse or a health care assistant will stay with you throughout the procedure. They will assist the doctor and provide reassurance and support. A local anaesthetic is injected into the cervix, and/or the cervix may be numbed with a gel. The cervix is then dilated (stretched) gradually. A narrow suction tube is then inserted into the uterus to remove the pregnancy tissue. At this stage, you will experience a period-like pain. The whole procedure will take about 10 to 15 minutes.

After the procedure

You can rest in a recovery area with refreshments until you feel able to go home (usually you are fine to leave within an hour, but you may need to stay longer).

You may experience some period-like pains after the procedure. Pain killers are available if you need them.

Does it hurt?

If you are given tablets or vaginal pessaries before the operation, you might feel discomfort as the cervix opens. Most women have period-type pain during the procedure. You will be given painkillers and offered Entonox during the procedure; the discomfort probably won't last long. You may have some light vaginal bleeding afterwards. If it becomes heavy, you

need to contact us (you will be given contact numbers prior to discharge).

Are there any risks?

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

What are the benefits?

MVA has been shown to be:

- 99.5% effective
- Associated with less blood loss
- No risks of general anaesthetic
- Shorter length of stay in hospital than general anaesthetic
- You are offered a scan after the procedure to ensure the uterus has been emptied

What are the disadvantages?

Some women prefer not to be aware of the procedure. You may worry about coping with pain or anxiety.

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. However, if you choose to, we will offer to arrange for your baby to be cremated. The service will take place at Wigan crematorium, and you will be offered the opportunity to attend this service. The nurse will explain these details to you.

Private Burial/Cremation

You can arrange a private burial or cremation. You will need to contact a funeral director of your choice to arrange this; most funeral directors do not charge for this service.

At Home

There is no legal prohibition to a woman taking foetal remains home, so you are allowed to, if you wish.

Arrangements can be made for burial outside a cemetery, but the following should be taken into consideration:

- The burial should not take place near to water supplies or a water course.
- There must be no chance of bodily fluids leaking into or onto adjoining land.
- The foetal tissue must be buried at a depth of at least 18 inches (45 centimetres).

- Permission must be obtained from the landowner if the woman does not own the land.
- Careful thought must be given when considering burial in a garden, taking into account what would happen if the parents moved house, or the land is used for new purposes in the future, and therefore you may choose to bury in a planter with flowers or a shrub

Miscarriage at home

If you miscarry at home and would like the hospital to arrange a cremation for you, you may want to put the remains into a container, and take them to Ward 2, Leigh Infirmary, Monday to Friday, or Swinley Ward, Royal Albert Edward Infirmary at weekends and on Bank Holidays. Do be aware that they probably won't be able to do any tests on the foetus or tissue, though they may be able to confirm that you have passed pregnancy tissue.

You are welcome to contact us if you have any questions about what to do.

Baby Loss Certificates

Any parents who have lost a baby before the 24th week of pregnancy are eligible to apply for a Baby Loss Certificate. It is not a legal certificate, but a formal acknowledgement of the loss, offered to provide recognition, comfort and validation for grieving families. These certificates cover every type of loss that occurs before 24 weeks. This includes early, late, or missed miscarriages and ectopic pregnancies. Certificates can be applied for by visiting the government website.

Counselling Services

Ward 2 Counselling Service was set up in August 1977. It is based at Leigh Infirmary and provides a confidential service Appointments can be made by ringing **01942 264308** Monday to Friday 8:00am to 5:00pm,

What does it offer?

It doesn't offer advice, but it was set up to help you in the following ways:

- To provide emotional support.
- To help you become aware of your emotions and to come to terms with them.
- To reduce the stress, you are experiencing about your situation.

Who do we help?

We help Obstetrics and Gynaecology patients attending either as an outpatient, or an inpatient. You can be seen individually or as a couple.

The service is run by a qualified counsellor and has additional trainee counsellors on placement. If you have any questions or worries, you can call them on **01942 264308**. If they are unavailable, there is a confidential answering machine, and if you leave your name and telephone number, they will call you back.

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.

We hope that this leaflet provides the information to help you make decisions at what may be a difficult and distressing time, and remember a miscarriage is not your fault and you are not alone. Many women go on to have healthy pregnancies after a miscarriage. Please let us know of any concerns or questions you may have.

Useful resources

The Miscarriage Association

Clayton Hospital, Northgate, Wakefield WF1 3J. Telephone: 01924 200799.

email: info@miscarriageassociation.org.uk

email: info@miscarriageassociation.org.uk

Association of Early Pregnancy Units:

www.earlypregnancy.org.uk

Royal College of Obstetricians & Gynaecologists:

www.rcog.org.uk

NICE GUIDELINE- NG126, UPDATED NOV 2021: Ectopic pregnancy and miscarriage: diagnosis and initial management. (www.nice.org.uk)



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