NHS
The Leeds Teaching Hospitals
NHS Trust

Miscarriage

Information for patients

Leeds Centre for Women's Health

This booklet explains the options for the management of miscarriage. This is probably a very difficult and distressing time for you. Our staff are here to help and support you.

How to contact us:

Please see page 19 for urgent and non-urgent contact details.

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Introduction

Unfortunately you have been told that you have had a miscarriage. This is probably a very difficult and distressing time for you. Our staff are here to help and support you.

The aim of this leaflet is:

- To explain what a miscarriage is.
- To give you advice on what the possible treatment options are and which ones would be best suited to you.
- To give you contact details of counselling services that you may wish to use to help you deal with what has happened to you.
- To give you information on when you may want to seek further advice.

What is a miscarriage?

A miscarriage is when you lose your baby any time up to 24 weeks of pregnancy.

How common is it to have a miscarriage?

Miscarriages are very common. More than one in every five pregnancies ends in miscarriage.

Why did you have a miscarriage?

In most cases the miscarriage is not caused by something you did or didn't do. There is often no cause found and your next pregnancy (if you choose to try again) is most likely to result in a healthy baby.

About half of all early miscarriages before nine weeks of pregnancy are caused by 'one-off' genetic faults in the mother's egg or father's sperm or in how the fertilised egg develops.

There are less common causes of miscarriage. These are usually discovered in women who experience recurrent miscarriages (three or more miscarriages in a row with the same partner).

If this has happened to you, you will be offered investigations to look into these causes.

What are the risk factors for having a miscarriage?

Having a miscarriage is more likely in these circumstances:

- **Older age** - The risk of early miscarriage increases with the age of the woman. At the age of thirty years the risk of a miscarriage is one in five pregnancies (20%). At the age of 42 years the risk of miscarriage is one in two (50%).
- **Health problems:** There are certain health conditions that may increase your risk of miscarriage such as poorly controlled thyroid disease or diabetes.
- **Lifestyle factors:** Smoking, heavy drinking and being overweight are associated with miscarriage.

What happens after a miscarriage has been diagnosed?

You will be seen by a doctor or a nurse who will explain the diagnosis to you and answer any questions you might have. They will then talk you through the treatment options available to you. If you are ready to make a decision at this point, then your chosen treatment can be arranged.

Please be aware that you may need to wait for up to three days before having medical or surgical treatment.

You may not feel ready to make a decision straight away. It is alright to take your time.

If you would like some more time you can go home and ring the Gynaecology Acute treatment unit (GATU) at St James's University Hospital.

If you have been counselled at St James's University Hospital, you should call 0113 206 5724 (GATU).

What are the management options for miscarriage?

There are three options for management of miscarriage:

- **Expectant management:** also known as 'wait and see' or 'natural' method.
- **Medical management:** with tablets.
- **Surgical management:** evacuation (emptying) of the womb under general or local anaesthetic.

The risk of developing infection is similar regardless of the method of management.

Expectant management - 'wait and see'

What is expectant management of miscarriage?

With this treatment you do not need to take any medication or undergo surgery.

The aim is to wait until your body naturally passes the pregnancy.

What does expectant management involve?

You will have between 7 and 14 days to see whether your body naturally passes the pregnancy. Before you go home you will be given advice on what to expect regarding your bleeding or discomfort. You will also be given a pregnancy test kit.

If your pregnancy was very early you may have little or no bleeding or pain because the body re-absorbs the pregnancy. However, usually you will experience abdominal cramps and heavier bleeding (with or without clots) when the pregnancy is coming away. Paracetamol, ibuprofen and codeine may be taken for pain relief.

You should contact the hospital if you are concerned about the amount of pain or bleeding you are experiencing **(See page 19)**.

Once the bleeding has stopped, you should perform a pregnancy test after three weeks and contact GATU at St James' University Hospital **(see page 19)** with the result.

Who can be offered expectant management 'wait and see'?

This treatment is recommended if you are experiencing ongoing vaginal bleeding or if you would prefer to let nature take its course.

Most women in this situation will pass the pregnancy naturally without the need for further treatment.

Is there anyone who can't have this treatment?

Expectant management is not offered as a first option of treatment in the following situations:

- Women who are at increased risk of bleeding heavily.

- Women who have had a difficult time in a previous pregnancy (for example a still birth) if they do not want to 'wait and see'.
- Women who have signs of infection in the womb.

Advantages of expectant management:

- It is a natural process. Some women feel it is part of the healing process.
- There are no risks from drugs or anaesthetics.
- There are no risks from an operation including the risk of injury to the womb.

Disadvantages of expectant management:

- You will not be able to predict when the bleeding will start or how heavy or painful it might be.
- Bleeding heavily enough to need a blood transfusion is rare (less than 1 in 200 women).
- It may not work (this is more likely if you have not yet started bleeding).
- Pregnancy tissue may become stuck in the cervix - this is unusual and is normally quickly sorted by removing the pregnancy tissue during a vaginal examination.

Medical management

What is medical management of miscarriage?

Medical management involves taking tablets by mouth (or occasionally in the vagina) which should make your womb (uterus) contract and the neck of your womb (cervix) dilate in order to expel the pregnancy. The name of the medication is Misoprostol.

What does medical management involve?

You can receive this treatment in the Leeds Centre for Women's Health. Most women are able to go home after taking the medication (outpatient management) but some women may need to be admitted to the gynaecology ward (inpatient treatment) for monitoring.

A doctor or nurse will explain the treatment to you and take your written consent to proceed with the management. You will also be advised whether it is safe for you to go home soon after having your medication (outpatient management) or whether you ought to be admitted to hospital for observation during your treatment (inpatient management).

The tablets should be allowed to dissolve under your tongue. This method acts quicker than if you swallow them and it is less likely to cause side effects of nausea, diarrhoea and stomach upset. Unless you are an inpatient, you will be asked to stay in hospital for half an hour before going home to make sure you do not have any reactions to the tablets.

It is best if you do not drive yourself home.

Who can be offered medical managment?

This could be your first option or your second choice if expectant management has not worked.

Is there anyone who can't have this treatment?

You can't take it if you have uncontrolled high blood pressure, heart problems or a stroke in the past.

What can you expect when you get home?

If you have had no symptoms before taking the tablets, you should expect bleeding to start within 48 hours of taking the tablets. If you are already bleeding then it should continue to increase over this period. You may also experience some abdominal (stomach) pain. Once the pregnancy has passed your symptoms should settle rapidly although you may have light bleeding for up to two weeks. Paracetamol and codeine should be strong enough to manage the pain.

You should AVOID aspirin and ibuprofen for the first 48 hours because they counteract the effects of the treatment.

If you have severe pain or you are concerned about your bleeding, contact the Gynaecology Acute treatment unit **(0113 206 5724)**. **In an emergency, you may go to A&E at St James's University Hospital.**

- You may bathe and shower as normal.
- You should take two days off work, or as long as you need for heavy bleeding to settle.

What follow-up can you expect?

If you have not started to bleed after 48 hours, you should call the Team who started your treatment **(see page 19)**:

- **Gynaecology Acute treatment Unit (GATU): 0113 206 5724**

You will be invited to attend for assessment. You may be offered a further dose of treatment as well as expectant or surgical management.

If the treatment seems to be working, you should perform a pregnancy test after three weeks and contact the hospital **(see Page 19)** with the result whether positive or negative.

Advantages of medical management:

- It avoids the risks associated with surgery.
- It avoids the need for a general anaesthetic.
- It avoids the need to stay in hospital for most women.

Disadvantages of medical management:

- It may take longer for bleeding to settle compared to a surgical procedure.
- It may not work for 5 out of 100 women.
- You may get side effects from the medication including nausea, mild diarrhoea, abdominal pain, headache, heartburn, rash.

Surgical management

What is surgical management of miscarriage?

Surgical management of miscarriage is a short procedure which involves gently opening the neck of the womb (cervix) and removing the pregnancy tissue from the womb. It can offered under local anaesthetic or under general anaesthetic.

What does surgical management involve?

We usually recommend surgical treatment under local anaesthetic, which can be completed on the gynaecology ward. If you have been booked for the procedure under a general anaesthetic you will be given a date to come to the gynaecology ward by the doctor or nurse seeing you.

You will be admitted to the ward (usually within 3 days) to await your procedure.

Manual vacuum aspiration (surgical treatment) under local anaesthetic (MVA)

Manual vacuum aspiration is the recommended treatment for most women requesting surgery to treat miscarriage. During the procedure you are less likely to bleed, or experience a perforation (damage to the womb) when compared to surgery under general anaesthetic. You are also in hospital for a shorter amount of time, recover quicker and, if required, can drive yourself home. Most women who have had the procedure in our unit have found that it was an acceptable alternative to surgery under general anaesthetic. Please ask your doctor or nurse for more information about this procedure.

Surgical management under general anaesthetic

Our aim is to perform your surgery as soon as possible on the day of your admission. Unfortunately we are not able to give you a definite time that your operation will take place. There may be delays due to other patients requiring emergency surgery before you. We will do our best to keep you informed of a likely time for your operation while you are waiting. These procedures are not performed during the night unless it is an emergency.

The following will be done before your procedure:

- Blood tests.
- Vaginal swab tests.
- MRSA (super bug) screening swab test.
- Written consent will be taken for the procedure.

- You will have an opportunity to discuss with your doctor or nurse whether you would like the pregnancy tissue to be examined in more detail by our pathology department. Your written consent will be obtained if you do.
- You will also be able to discuss the options available for sensitive disposal of the pregnancy tissue (please see page 15 for further details).
- Misoprostol tablets will be given by mouth or inserted into your vagina about one hour before your procedure to encourage your cervix (neck of your womb) to open and make surgery safer.

Who may be offered surgical management?

This is a treatment option if:

- Expectant or medical management of your miscarriage hasn't worked.
- You have chosen this method.

Is there anyone who can't have this treatment?

Surgical treatment is not offered as the first choice to women in the following situations because it is associated with increased risks:

- If the pregnancy is very small it may be left behind.
- If the pregnancy is further on than 12 weeks / 3 months there is a risk of heavy bleeding and some pregnancy tissue remaining. The risk of injury or damage to the womb is higher.
- If the womb is heart-shaped (bicornuate) the pregnancy may be missed during the operation.

- Some other medical problems can increase the risks of surgery or general anaesthetic. Your doctor or nurse will discuss these with you if relevant.

What can you expect after the procedure?

- You will experience some cramping abdominal pain after the operation and bleeding which tends to settle over a few days.
- You will have a drip line in your arm if you have had your procedure under general anaesthetic.
- If your doctor is concerned that you may have an infection in the womb or vagina, you will be prescribed a course of antibiotics.
- You are normally able to go home the same day or a day later.
- You will be asked to perform a pregnancy test after three weeks. You should call the Gynaecology Acute Treatment unit **(see Page 19)** if the test is still positive.

Advantages of surgical management:

- It is a quick procedure. However the time spent in hospital is longer than for expectant or medical management.
- Surgical management under general anaesthetic may be preferred by some women who want to be unaware during the procedure.

Risks of the procedure:

- Bleeding for up to 2 weeks. 1-2 women in every 1000 will need a blood transfusion.
- Incomplete removal of all the pregnancy tissue from the womb and the need to repeat the surgery for up to 5 in 100 women.

- Infection in the lining of the womb happens in 3 out of 100 women.
- Damage to the body of the womb by perforation (a hole) is rare (5 cases in every 1000).
- Damage to the neck of the womb (cervix) such as scarring is rare.
- Damage to the lining of the womb by scarring which can cause infertility in the longer term is rare.
- The risk of dying from a general anaesthetic is 1 in a million anaesthetics.

What if I have had a complete miscarriage?

What is this?

This is when the pregnancy completely comes away from your womb without the need for medication or surgery.

What happens next?

Normally you are able to go home after being checked over by a nurse or doctor. Your bleeding should settle quickly over the next two weeks. You may need to take some pain relief for a few days. You should perform a pregnancy test in three weeks' time (the testing kit will be given to you). If it is positive you should contact the Gynaecology Acute Treatment unit (GATU) for advice. **(See page 19).**

What happens to the pregnancy tissue afterwards?

Whether you have had medical or surgical management, your pregnancy tissue could be sent to the pathology department with your consent for examination by a specialist pathologist. Examination of your pregnancy tissue may provide valuable information that might help in the management of your future pregnancies.

Pregnancy tissue (at the time of miscarriage) is made up of placental tissue, blood clots and parts of the lining of the womb. In about 10% of cases, an embryo (very early baby), is seen. In the remaining 90% of cases an embryo is not identified in the pregnancy tissue even though it was seen on an ultrasound scan. This is because it may be too small to be visible to the naked eye. If you would like examination of the pregnancy tissue by the pathology department (where they look at the tissue both with the naked eye and under a microscope) you will be able to discuss this in more detail with the doctor or nurse taking your written consent for the examination.

If you miscarry somewhere other than in hospital you are most likely to pass the pregnancy into the toilet. Every woman is different in what they chose to do next. You may decide to flush it away - many people do. If you would like your pregnancy tissue to be examined, you may bring it to the Gynaecology Acute Treatment unit. Please call the ward first so that they know to expect you or if you need advice. **(See page 19)**. You have the following choices for the sensitive disposal of the pregnancy tissue whether you choose to have it examined or not:

- A group cremation at a crematorium in Leeds organised by Leeds Teaching Hospitals. You will not be able to attend and the ashes will be scattered in the crematorium baby garden.

- A respectful incineration organised by Leeds Teaching Hospitals NHS Trust.
- You may make your own arrangements for a private individual cremation or burial at your expense, within 4 weeks of signing the consent form to have the tissue examined. If you have not done so by 4 weeks Leeds Teaching Hospitals NHS Trust will proceed to group cremation as above.
- You may choose to take your pregnancy tissue home to bury yourself. There is some specific advice to follow if you do this. Separate information will be provided.

If any part of the consent statement is incomplete or not signed by yourself and your witness within 4 weeks, the Leeds Teaching Hospitals NHS Trust will arrange the sensitive disposal of your pregnancy tissue by group cremation at a Leeds crematorium.

Where can I get emotional support?

This can be a very difficult time to go through in your life. We aim to give you as much time as you need to talk about what you are going through and the treatment options available to you. However, you may feel that you need to speak to someone after your miscarriage to help you cope with what you are going through. If so please contact your GP or one of the support groups listed on page 18 for counselling and emotional support. You may also contact the Gynaecology Acute Treatment unit for telephone advice **(See page 19).**

Periods after miscarriage and contraception

Most women will get a period between four and six weeks after their miscarriage, and it may be heavier and longer than usual. It can take a while for periods to get back to a fairly regular pattern.

Ovulation (release of an egg that can get fertilised) can occur from two weeks after a negative pregnancy test. You may wish to consider what contraception you may want to use. You can discuss this with the your doctor or nurse.

Useful resources

Association of Early Pregnancy Units

- **www.earlypregnancy.org.uk**

  Early miscarriage leaflet.

Charlies Angel Centre Foundation

- **www.charlies-angel-centre.org.uk**
- **Email: charliesangelcentre@hotmail.com**

  Telephone: 0113 808 1507

  This organisation supports bereaved parents and families with free telephone, online and face-to-face counselling.

Fertility Network UK

- **www.fertilitynetworkuk.org**

  The national charity, here for anyone who has ever experienced fertility problems.

Leeds Pregnancy Crisis Centre

- **www.leedspcc.co.uk**

  This organisation offers emotional support and bereavement counselling

Royal College of Obstetricians and Gynaecologists

- **www.rcog.org.uk**

  Information for patients.

The Miscarriage Association

- **www.miscarriageassociation.org.uk**

Contact us

Gynaecology Acute Treatment Unit (GATU) - St James's University Hospital

- **Telephone: 0113 206 5724**

What did you think of your care?

Scan the QR code or visit **bit.ly/nhsleedsfft**

Your views matter

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