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Royal College of Obstetricians & Gynaecologists

# Information for you

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# Early miscarriage

## About this information

This information is for you if you want to know more about miscarriage in the first 3 months of pregnancy. It may also be helpful if you are a relative or friend of someone who has had an early miscarriage.

This leaflet explains the care you will receive after an early miscarriage has been confirmed. For more information on bleeding and pain in early pregnancy, see the RCOG patient information *Bleeding and/or pain in early pregnancy* (**www.rcog.org.uk/en/patients/patient-leaflets/bleeding-and-pain-in-early-pregnancy**).

Losing a baby is a deeply personal experience that affects people differently. It can be very distressing and you may need a great deal of support afterwards. You can find further information and support from the Miscarriage Association at: **www.miscarriageassociation.org.uk** and from NHS Choices at: **www.nhs.uk/conditions/miscarriage**.

# What is an early miscarriage?

If you lose your baby in the first 3 months of pregnancy, it is called an early miscarriage. Most women experience vaginal bleeding but occasionally there may be no symptoms. If this is the case, the miscarriage may be diagnosed by an ultrasound scan.

# Why do early miscarriages happen?

In most cases, it is not possible to give a reason for an early miscarriage. The most common cause is thought to be a problem with the baby's chromosomes (the genetic structures within the body's cells that we inherit from our parents). If a baby does not have the right number of chromosomes, it will not develop properly and the pregnancy can end in a miscarriage.

# What are my chances of having a miscarriage?

Sadly, early miscarriages are very common. Many early miscarriages occur before a woman has missed her first period or before her pregnancy has been confirmed. In the first 3 months, one in five women will have a miscarriage, for no apparent reason, following a positive pregnancy test.

The risk of miscarriage is increased by:

- your age – at the age of 30, the risk of miscarriage is one in five (20%); over the age of 40, the risk of miscarriage is one in two (50%)
- medical problems such as poorly controlled diabetes
- lifestyle factors such as smoking, being overweight or heavy drinking.

There is no evidence that stress can cause a miscarriage. Sex during pregnancy is not associated with early miscarriage.

# What should I do if I have bleeding and/or pain in the first 3 months?

Vaginal bleeding and/or cramping pain in the early stages of pregnancy are common and do not always mean that there is a problem. However, bleeding and/or pain can be a sign of a miscarriage.

If you have any bleeding and/or pain, you can get medical help and advice from:

- your GP or midwife
- your nearest Early Pregnancy Assessment Service: details of the unit nearest to you can be found at: **www.earlypregnancy.org.uk**
- NHS 111: call 111 when you need medical help fast but it's not a 999 emergency; NHS 111 is available 24 hours a day, 365 days a year, and calls are free from landlines and from mobile phones
- the A&E department at your local hospital, particularly if you are bleeding heavily, have severe pain or feel very unwell.

# How is an early miscarriage diagnosed?

An early miscarriage is usually diagnosed by an ultrasound scan. You may be advised to have either a transvaginal scan (where a probe is gently inserted in your vagina) or a transabdominal scan (where the probe is placed on your abdomen) or occasionally both. A transvaginal scan may be recommended as it gives a clearer image. Neither scan increases your risk of having a miscarriage.

You may be offered blood tests that could include checking the level of your pregnancy hormone (βhCG).

If you are bleeding or have pain, a vaginal examination may be carried out. You should be offered a chaperone (someone to accompany you) for a vaginal examination or a transvaginal scan. You may also wish to bring someone to support you during your examination or scan.

Some women will miscarry quite quickly but for others the diagnosis and ongoing management may take several weeks.

# What are my choices if a miscarriage is confirmed?

If your ultrasound scan shows that you have miscarried and nothing remains in your womb, you may not need any further treatment.

If the miscarriage is confirmed but some or all of the pregnancy is still inside your womb, your healthcare professional will talk to you about the best options for you. You may choose to wait and let nature take its course, or to use medicines or to have an operation.

## Letting nature take its course (expectant management of a miscarriage)

This is successful in about 50 out of 100 women who choose this option. It can take some time before the bleeding starts and this may continue for up to 3 weeks. It may be heavy and you may experience cramping pain. If you have severe pain or very heavy bleeding, you may need to be admitted to hospital.

You should be given a follow-up appointment about 2 weeks later:

- If the bleeding and pain has settled by then, it is likely that all the pregnancy has come away. You will be advised to do a urine pregnancy test 1 week after this. If it is still positive, you should contact your local Early Pregnancy Assessment Service.
- If bleeding fails to start within 7–14 days or is persisting or getting heavier, you will be offered a further ultrasound scan. The options of continuing expectant management, medical treatment or having an operation will then be discussed with you.

## Taking medication (medical management of a miscarriage)

This is successful in 85 out of 100 women and avoids an anaesthetic.

You will be given medication called misoprostol, usually as vaginal pessaries although tablets to swallow may be taken if you prefer. The

medication helps the neck of the womb (cervix) to open and lets the remaining pregnancy come away. It will take a few hours and there will be some pain with bleeding or clotting (like a heavy period). You will be offered pain relief and anti-sickness medication. Some women may experience diarrhoea and vomiting.

If bleeding has not started 24 hours after treatment, you should contact your Early Pregnancy Assessment Service or hospital.

After the treatment, you may bleed for up to 3 weeks. If the bleeding is heavy, you should contact your local hospital.

You will be advised to do a pregnancy test 3 weeks later. If this is positive, you should contact your Early Pregnancy Assessment Service to arrange a follow-up appointment. If the treatment has not worked, you will be given the option of having an operation.

## Having an operation (surgical management of a miscarriage)

The operation may be carried out under general or local anaesthetic. It is successful in 95 out of 100 women.

The pregnancy is removed through the cervix. You may be given tablets to swallow or vaginal pessaries before the operation to soften your cervix.

Surgery will usually take place within a few days of your miscarriage but you may be advised to have surgery immediately if:

- you are bleeding heavily and continuously
- there are signs of infection
- medical treatment to remove the pregnancy has been unsuccessful.

The operation is safe but there is a small risk of complications including heavy bleeding, infection or damage to the womb. A repeat operation is sometimes required. The risk of infection is the same if you choose medical or surgical treatment.

For information on recovering after your operation, see the RCOG patient information *Recovering from surgical management of a miscarriage* (**www.rcog.org.uk/en/patients/patient-leaflets/recovering-from-surgical-management-of-a-miscarriage**).

# What happens to the pregnancy remains?

Some tissue removed at the time of surgery may be sent for testing in the laboratory. The results can confirm that the pregnancy was inside the womb and not an ectopic pregnancy (when the pregnancy is growing outside the womb). It also tests for any abnormal changes in the placenta (molar pregnancy).

Some women who miscarry at home choose to bring pregnancy remains to the hospital so that they can be tested.

Options for disposal of the remains will be discussed with you and your partner.

# I would like to have a memorial for my baby. How do I organise that?

Depending on your unit and your own individual circumstances, you may choose burial or cremation. Many hospitals have a book of remembrance. If you would like further information, talk to your doctor or nurse about the options at your hospital.

# What happens next?

## Vaginal bleeding

You can expect to have some vaginal bleeding for 1–2 weeks after your miscarriage. This is like a heavy period for the first day or so. This should lessen and may become brown in colour. You should use sanitary towels rather than tampons, as using tampons could increase the risk of infection.

If you normally have regular periods, your next period will usually be in 4–6 weeks' time. Ovulation occurs before this, so you may be fertile in the first month after a miscarriage. Therefore, if you do not want to become pregnant, you will need to use contraception.

## Discomfort

You can expect some cramps (like strong period pains) in your lower abdomen on the day of your miscarriage. You may get milder cramps or an ache for a day or so afterwards. If the discomfort is not relieved by simple painkillers from the pharmacy and you experience the following symptoms, you should seek medical advice from your GP, Early Pregnancy Assessment Service or the hospital where you had your care, or call NHS 111:

- **Heavy or prolonged vaginal bleeding, smelly vaginal discharge and abdominal pain:** If you also have a raised temperature (fever) and flu-like symptoms, you may have an infection of the lining of the womb (uterus). This occurs in two to three out of 100 women. It can be treated with antibiotics. These symptoms can also indicate that some tissue remains from the pregnancy (see above).
- **Increasing abdominal pain and you feel unwell:** If you also have a temperature (fever), have lost your appetite and are vomiting, this may be due to damage to your uterus. You may need to be admitted to hospital.

## Emotional recovery

A miscarriage affects every woman differently and can be devastating for her partner too. Some women come to terms with what has happened within weeks; for others, it takes longer. Many women feel tearful and emotional for a short time afterwards. Some women experience intense grief over a longer time.

Your family and friends may be able to help. Talk to your GP if you feel you are not coping. You can find further information and support from

the Miscarriage Association at: **www.miscarriageassociation.org.uk**, from NHS Choices at: **www.nhs.uk/conditions/miscarriage** and from Sands at: **www.uk-sands.org**.

### Returning to work

When you return to work depends on you and how you feel. It is advisable to rest for a few days before starting your routine activities but returning to work within a day or two will not cause you harm if you feel well enough. Most women will return to work in a week, but you may need longer to recover emotionally. If so, it may be helpful to talk with your GP or occupational health adviser.

### Having sex

You can have sex as soon as you both feel ready. It is important that you are feeling well and that any pain and bleeding has significantly reduced.

## When can we try for another baby?

You can try for a baby as soon as you and your partner feel physically and emotionally ready.

## Am I at higher risk of a miscarriage next time?

You are not at higher risk of another miscarriage if you have had one or two early miscarriages. Most miscarriages occur as a one-off event and there is a good chance of having a successful pregnancy in the future.

A very small number of women have a condition that makes them more likely to miscarry. If this is the case, medication may help. For further information, see the RCOG patient information *Recurrent and late miscarriage* (**www.rcog.org.uk/en/patients/patient-leaflets/recurrent-and-late-miscarriage**).

# Is there anything else I should know?

Like anyone else planning to have a baby, you should:

- take 400 micrograms of folic acid every day from when you start trying until 12 weeks of pregnancy to reduce the risk of your baby being born with a neural tube defect (spina bifida)
- be as healthy as you can – eat a balanced diet and stop smoking
- not drink alcohol as this may increase your chance of miscarriage (see the *UK Chief Medical Officers' Low Risk Drinking Guidelines*, which is available at: **www.gov.uk/government/publications/alcohol-consumption-advice-on-low-risk-drinking**).

# Key points

- Early miscarriages are very common and one in five women have a miscarriage for no apparent reason.
- Bleeding and/or pain in early pregnancy can be a warning sign of miscarriage and you should seek medical advice if you are in this situation.
- You may be offered tests including an ultrasound scan to check your pregnancy.
- Once a miscarriage is diagnosed, your healthcare professional will tell you about your options, which include expectant, medical or surgical treatment.
- Most miscarriages are a one-off event and there is a good chance of a successful pregnancy in future.

# Further information

Association of Early Pregnancy Units (AEPU): **www.earlypregnancy.org.uk**

Human Tissue Authority (HTA): **www.hta.gov.uk/faqs/disposal-pregnancy-remains-faqs**

Miscarriage Association: **www.miscarriageassociation.org.uk**

National Institute for Health and Care Excellence (NICE): *Ectopic Pregnancy and Miscarriage*: **www.nice.org.uk/guidance/cg154/ifp/chapter/About-this-information**

NHS 111 service: **www.nhs.uk/NHSEngland/AboutNHSservices/Emergencyandurgentcareservices/Pages/NHS-111.aspx**

Royal College of Nursing: *Managing the Disposal of Pregnancy Remains*: **www.rcn.org.uk/professional-development/publications/pub-005347**

Sands: **www.uk-sands.org**

# Making a choice

## Shared Decision Making

If you are asked to make a choice, you may have lots of questions that you want to ask. You may also want to talk over your options with your family or friends. It can help to write a list of the questions you want answered and take it to your appointment.

### Ask 3 Questions

**To begin with, try to make sure you get the answers to three key questions if you are asked to make a choice about your healthcare.**

1. What are my options?
2. What are the pros and cons of each option for me?
3. How do I get support to help me make a decision that is right for me?

* Ask 3 Questions is based on Shepherd HL, et al. Three questions that patients can ask to improve the quality of information physicians give about treatment options: A cross-over trial. Patient Education and Counselling, 2011;84: 379-85

AQuA Advancing Quality Alliance

Right Care Shared Decision Making Programme

NHS

https://www.aquanw.nhs.uk/SDM

## Sources and acknowledgements

This information has been developed by the RCOG Patient Information Committee. It is based on the NICE Guideline *Ectopic Pregnancy and Miscarriage: Diagnosis and Initial Management*, which you can find online at: **www.nice.org.uk/guidance/CG154**.

This leaflet was reviewed before publication by women attending clinics in Liverpool, Chester, Prescot and Wrexham, by the RCOG Women's Network and by the RCOG Women's Voices Involvement Panel.

The RCOG produces guidelines as an educational aid to good clinical practice. They present recognised methods and techniques of clinical practice, based on published evidence, for consideration by obstetricians and gynaecologists and other relevant health professionals. This means that RCOG guidelines are unlike protocols or guidelines issued by employers, as they are not intended to be prescriptive directions defining a single course of management.

A glossary of all medical terms is available on the RCOG website at: **www.rcog.org.uk/en/patients/medical-terms**.

**A final note**

The Royal College of Obstetricians and Gynaecologists produces patient information for the public. The ultimate judgement regarding a particular clinical procedure or treatment plan must be made by the doctor or other attendant in the light of the clinical data presented and the diagnostic and treatment options available. Departure from the local prescriptive protocols or guidelines should be fully documented in the patient's case notes at the time the relevant decision is taken.

All RCOG guidelines are subject to review and both minor and major amendments on an ongoing basis. Please always visit www.rcog.org.uk for the most up-to-date version of this guideline.