Hello. I'm Dr. Charles Hall, a Clinical Editor at BMJ Learning. In this module we discuss the management of miscarriage in primary care. Here to talk to us is Dr. Nicola Davis, a GP in Luton, Medical Trainer, and a trustee of The Miscarriage Association. Hello Nicola. Thanks for joining us.


Charles: So, if we start with the definition of miscarriage. What is a miscarriage, and how common is it?

Nicola: Miscarriage is defined as any spontaneous loss of pregnancy before 24 weeks gestation. There are some people who have late losses,
from about 22 weeks, who actually class their loss as a stillbirth. So I think between about 22 and 24 weeks it can be a mixed picture, but actually, legally, up to 24 weeks is defined as a miscarriage.

It’s fairly common. We think about one in four pregnancies will end in miscarriage, or pregnancy loss, and that also includes ectopic pregnancies, and molar pregnancies, which are much less common.

In addition to that, 11 in 1000 pregnancies, so about 1 in 100, will end in ectopic pregnancy, and about 1 in 1200 will be a molar pregnancy.

Charles: What about recurrent miscarriages?

Nicola: Recurrent miscarriages are much less common. About 1% of all miscarriages are recurrent, and that’s defined as three or more losses in a row.

Charles: Are there different types of miscarriages? Can you split things up into different types?

Nicola: There are different types. There’s the most commonly expected type, which is where a woman starts bleeding. That may be defined as a threatened miscarriage until it’s clear whether or not the pregnancy will continue.

There’s also a complete or incomplete miscarriage, and that’s usually defined according to whether the uterus is empty or not.

There’s also a missed or silent miscarriage, also called a blighted ovum sometimes, which is where a lady has no signs or symptoms that anything is wrong with the pregnancy, goes along for her first scan, and actually finds that the foetus is not viable.
Okay, so let's hear from two real patients who had miscarriages, and their experience with their GP. Let's hear from patient one.

When I had my first miscarriage, it was at six and a half weeks. My surgery was shut on the Saturday, so I had to go to an alternative emergency GP.

I don’t say I didn’t think she was bothered, because that's a bit mean, but I really didn’t think she was that bothered.

I know it’s very early. She said, “It’s very early, anything can happen, and you’ll know if you're having a miscarriage.” But to me, I was pregnant, and when you're trying you're waiting for a positive result straight away. I never even imagined I’d lose the baby. So I was a bit...

She sent me home as well. I was a bit lost for the rest of the weekend really. She just dealt with it in a very clinical way, yes. It was just this whole idea about it being early, and I know it’s early, but not to me.

The second miscarriage, when I went to see another GP, he was better because A) it was more about the baby, and the loss of the baby, and B) he made it about me. I actually really thought that he was genuinely concerned about it, rather than it being very clinical. So that was better for me. It was a longer process, but he helped me through it.

Now let’s hear from patient two.

I miscarried at probably about eight and a half weeks, and the pregnancy hadn’t developed beyond five and a half weeks. It was a very straightforward process, and I miscarried naturally at home, and
didn't need any interventions.

So it wasn't until the week following the miscarriage that I actually went to my GP. She empathised right from the start, and she made it clear that she was concerned for my welfare, that she wasn't just interested in the physical aspect of what had happened. That I think really helped me come to terms with what had happened.

She said very quickly that what I was going through was bereavement. I think that really helped, to have that acknowledgment that I was actually going through a grieving process, and that this wasn’t something trivial because physically I didn't seem too unwell.

Charles: Nicola, any comments before we move on?

Nicola: I think it’s just really clear to see that actually GPs can make a huge difference to a woman’s experience.

There isn’t much that as a GP we can do in terms of changing the outcome of the pregnancy. But, actually, just by being sympathetic, taking some time, listening to the lady, and really appreciating that this may well be a very significant loss in her life, and not just a routine pregnant woman who happens to be bleeding a little bit, we can really make a big difference to her.

Charles: Let’s consider some case scenarios that further illustrate what we’ve covered, but also address some new situations a GP may encounter.

Here’s case scenario one. Miss. G. is seeking your opinion as to why she has had a miscarriage. She has a few theories: it could be because she had sex during the pregnancy; that she had two previous abortions; had a good few drinks at a party before she knew that she was pregnant; or that she is allergic to her partner’s sperm.
What do you think about this?

Nicola: I think the first thing to do is really reassure the woman that probably none of those things made any difference to her pregnancy outcome whatsoever.

It’s very common for women and their partners to blame themselves after a pregnancy loss, and the first thing as a GP is to be reassuring that that’s really not the case.

Certainly there’s some evidence that a previous termination may affect the chance of miscarriage, but obviously you would play that down a little, and as I say, be as reassuring as possible. There’s nothing she can do in terms of further pregnancies.

In terms of alcohol, caffeine, stress, and allergic to her partner’s sperm, there’s certainly no evidence that any of those make any difference to the outcome of the miscarriage.

You may then go on further to give her a few tips about what she should do to make the next pregnancy as healthy as possible, and those may include things like minimising alcohol, caffeine, stopping smoking, or smoking as little as possible.

Charles: Okay, so what about the biological causes behind miscarriage?

Nicola: We know that we don’t know enough about miscarriage is the first thing to say, and in most cases we don’t know what the problem is. But we know that most people who miscarry do go on to have a normal pregnancy afterwards.

In most cases there’s probably a random genetic problem with the fertilisation of the egg, and that there’s a random abnormality, genetically, in either the sperm or in the ova, and that’s probably what
causes a pregnancy that can’t continue, that is not viable.

There are some other causes which are less common, including Antiphospholipid Syndrome, also known as Hughes Syndrome. GPs will be familiar with the ‘sticky blood syndrome’. Sometimes aspirin and heparin can help in those situations, if it’s proven.

That wouldn’t be a test that would be routinely carried out until after a third early miscarriage, or after one late miscarriage, so a second trimester miscarriage.

Also there’s some evidence that people with polycystic ovaries may have a higher chance of miscarriage. Also in the case of uncontrolled diabetes, and untreated thyroid abnormalities, then there is a higher risk of miscarriage.

Other diagnoses, as well, such as Hyperprolactinaemia, but they’re very rare indeed compared to the number of miscarriages.

There has been some association with Bacterial Vaginosis, but probably with second trimester miscarriages rather than first trimester.

Occasionally an anatomical problem is picked up, such as a bicornuate uterus, or what’s termed cervical incompetence, although of course women hate that phrase.

Charles: Any tips on how to explain these to your patient?

Nicola: Well, I think the first thing, after the first miscarriage, is really to say that it’s probably unfortunately just one of those things that can’t be prevented, that can’t be helped, and that hopefully won't happen in the next pregnancy.

Her chances of having a normal pregnancy for the second pregnancy are the same as in the first. So the risk of miscarriage is still the same, one in four, as it would be in any case, and to be very reassuring
about that.

Of course after a second miscarriage, although we can’t start doing tests, the risks probably aren’t that much greater of having a third miscarriage. Although we know that after a third miscarriage, actually the risk of going on to have subsequent miscarriages is much higher, which is why investigations start at that point.

Charles: You’ve already mentioned some of the environmental factors that might have a small influence on miscarriage. Are there any other factors, such as BMI/substance misuse?

Nicola: Yes, BMI is a very interesting one because we know that a high BMI, so over 30, is associated with reduced fertility, and also associated with an increased risk of miscarriage. But, in fact, actually probably a BMI under 18 is also associated with an increased risk of miscarriage.

In terms of smoking/alcohol/caffeine, it makes sense to tell the woman to minimise their use, but actually the data is inconclusive, and actually there’s not great data about these.

Being over 35 is also a risk factor, which of course we’re seeing as people start their families later.

A previous miscarriage, although, as I say, not the first or the second, but after the third.

We mentioned before that if someone’s had a previous termination of pregnancy, not from a foetal abnormality, then that’s also associated with an increased risk.

There’s an association with infertility/assisted conception, although actually the association is probably with the amount of time it takes to conceive. So the longer it takes for a woman to conceive, the higher the chance of a miscarriage.
That's probably something we don't fully understand, but is to do with the factor that stopped her getting pregnant for so long in the first place.

A new partner is also associated with an increased risk of miscarriage, as is a paternal age over 45, and sustained stress, particularly at work, interestingly. But that stress does have to be sustained.

Also multiple pregnancies are associated with an increased risk of miscarriage.

Charles: Okay. So in terms of symptoms, and signs, is there a typical presentation that a GP might see?

Nicola: I think that most GPs will see a lady that's had a positive pregnancy test, maybe she's six or seven weeks pregnant, maybe a little later, and she starts to have some pain or some spotting.

Of course the first thing that the GP needs to be sure of is that this is not an ectopic pregnancy, and that that woman does not need to be admitted urgently.

As long as they're stable, and not in severe pain, just having slight pain, and the examination is fairly normal, then the GP can go on to refer to the local gynaecologist or early pregnancy unit for further investigation.

The GP should be wary that actually in early pregnancy, so under about six and a half weeks, scans are actually often inconclusive, because the foetus would be so small, even if it's a viable pregnancy.

So it's very important to allow your patients to have reasonable expectations of what might happen, because actually it may be two or three weeks before they know whether their pregnancy is viable or not.
Charles: If your patient does go to A&E, or goes to the early pregnancy unit, what kinds of things might happen to them?

Nicola: You should advise them that they may have an ultrasound scan. The gold standard is a trans-vaginal scan. You need to explain that to them, because actually it is an internal scan, which lots of women will find very invasive and be quite shocked that you're going to examine them vaginally.

If that doesn't show a miscarriage one way or the other, or the location of the pregnancy is not obvious, then they may also have some blood tests, and that would be to check their Beta HCG. There's no diagnosis that could be made on a single Beta HCG, and therefore they may need a second one a couple of days later, and a repeat scan, either at that point, or actually more likely a week or two later.

It can be a very prolonged time of uncertainty, and I think the woman needs to really be warned about that, that she isn't going to get the answer necessarily on the same day.

Charles: Case scenario two: Mrs. D. has miscarried at home at around 11 weeks, and brings in the pregnancy tissue in a small plastic container. She hopes that you might be able to get the tissue analysed to find the reason for her miscarriage, but if not, she's not sure what to do with it. She couldn't bring herself to flush it down the toilet.

What's your response, and what should you do in this instance?

Nicola: I think, as a GP, you have to be very careful about your response to this lady. Everyone's first reaction would be “Eek, what do I do?”
think you have to be very aware that your look of shock will indeed be a surprise to her, and be very, very sensitive. That’s the first thing.

Then I think you have to have a conversation. Usually, if this was a first miscarriage, no chromosomal analysis would be done on the foetus. Therefore it’s really a practical issue about what you do with the tissue.

There are different options. She is legally able to take that tissue home, and she may wish to bury it. Of course, to her it’s her baby, and you need to be very aware about what terminology you use about the tissue.

I would mirror the terms that she uses. If she calls it her baby, then I would call it a baby. If she calls it a foetus, then I would call it a foetus, and likewise with tissue.

So she could go home and bury it, and there are practical issues around that. Some people will bury it in their garden, under a tree. But you may just want to remind them that actually, if they move house, then that may be very difficult for them, and actually some people prefer to put it perhaps in a plant container that they could take with them.

It’s not something you normally think about, at all, but actually may be very important to the woman in the future. So she needs to know that she has permission to do that, and that she’s not going to have police knocking on her door for burying a baby.

The other option, of course, is that you send it off to the hospital, and most hospitals would incinerate it. So you have to let her know that that’s what would happen to the small container.

You’d have that discussion with her, and be very sensitive about how you speak to her, and the significance of the plastic container to her, because actually it’s her baby, and we’re talking about its burial.
Charles: So, in terms of missed or incomplete miscarriages, what are the management options that are available?

Nicola: The first option available to everyone is expectant management, also called watchful waiting. This means that the lady is sent home, with information hopefully, in order to allow the spontaneous passage of products of conception. So the expectation is that she would miscarry at home, with some painkillers, and information about what might happen.

Of course she needs to be told that if she bleeds very heavily, and becomes unwell, then she needs to go back to medical services. Her partner needs to be told that as well.

The advantage of this is that it's a natural option. It stops people having to go into hospital. It avoids any surgery. Many women are scared of surgery. It leads to a very natural process, which lots of women desire.

The disadvantage, of course, is the uncertainty. We don't know how long it will take, particularly in a missed miscarriage, for the foetus to pass. So a woman might have to put her life on hold, really, for two or three weeks, until the miscarriage may happen naturally, which can be a very difficult time for her.

Also there is a risk of heavy bleeding and prolonged bleeding. It may go on for weeks. If the lady is working, then that might lead to time off work. As I say, there's no definite end to it, and no-one knows quite what to expect.

But lots of women will opt for expectant management, because, as I say, it avoids any surgery, and hospital stays hopefully.

There's also medical management. That's given with some anti-progesterone with a prostaglandin analogue. That causes the cervix to soften, and open, and therefore causes probably a quicker passage of the products of conception.
It gives women more control, so they know that it’s going to happen sooner rather than later. They don’t have to wait for weeks. It gives them more privacy. They can have the treatment, and then go home in order to miscarry. So, again, it may avoid a hospital stay.

But the problems include pain, bleeding, visits, in terms of repeat scans to make sure that all the products are passed. There’s a possibility that she may have to have a transfusion, which happens in about 1 in 100 cases.

It may be a very difficult time, and she may feel that the support isn’t there if she’s at home. Again, it just depends on different people, their circumstances, their support at home, and their personalities really.

Then there’s surgical management, which at the moment is called evacuation of retained products of conception, but there’s a move for that to change to being called surgical management, to fit in with medical management and expectant management. Women really don’t like the term retained products of conception. They find it very insensitive.

That’s where a woman would have an operation, under a general anaesthetic, to empty the womb. That’s a very controlled procedure. She knows when she’s having it. The bleeding usually stops within a few days, and she gets the control back over her life really.

The advantages are of time, as long as she can be fitted in. The bleeding is over very quickly.

But the disadvantages are, of course, that she has to go into hospital. There’s the small risk of a general anaesthetic. There’s the possibility of perforation, that it’s incomplete, and that she might have to have another operation. There’s also a very small risk of infection.

There is a type of surgical management called manual vacuum aspiration, which isn’t done in many centres, but may be done increasingly, which is actually performed under a local anaesthetic, and may be done in an outpatient setting. It’s a similar procedure to the ERPC, but can be done under a local anaesthetic, which obviously
has its advantages.

Charles: How can you help your patient decide which treatment is best for them?

Nicola: A lot of the time the early pregnancy units will push women towards having expectant management. But of course women need choice, and as I say, there are pros and cons of all management. It really needs to include the women in that decision based on her own personal circumstances.

Charles: Here’s case scenario three: Miss. A. tells you she is pregnant. Her last menstrual period was six weeks ago, and she had a positive home pregnancy test. She’s very anxious to be referred for an early scan. She has no pain, or bleeding, but she had a silent miscarriage six months earlier, diagnosed at fourteen weeks at the routine booking-in scan. She was told the baby had died at around seven weeks.

What can we say about this lady?

Nicola: Of course you have to understand her anxiety, and you have to be very sensitive and sympathetic to that anxiety. She obviously wants an early scan because she wants to know that this baby is fine, and that it will be fine, and that she’s going to make it through the whole pregnancy. So you have to be open to her and listen to her. I think that’s very important.

Now, the problem of course is that she’s only six weeks. As we mentioned earlier, actually a scan at six weeks can be very inconclusive, and actually may heighten her anxiety.

Also, it's a difficult situation of some early pregnancy units would scan
a lady that’s had a previous missed miscarriage, and others actually won’t, because of the workload that that might make in terms of extra scans just for reassurance. So it’s useful to know what your local early pregnancy unit or gynaecology department’s thoughts on it are.

So you need to share that with her, really, and explain that actually a scan at six weeks might not be normal, and there probably won’t be a foetal heart seen at that gestation, and given that she’s had no pain, and bleeding, there are no signs that there is anything wrong.

Of course, however, that’s what she thought last time. She waited until 14 weeks, and obviously got very excited for 14 weeks, and then found that actually the foetus had already died.

So I think I would share my thoughts with her, and possibly arrange for her to have a scan maybe in a week or two, when actually it will be more useful. Because at seven or eight weeks they would know for sure whether there was a foetal heart there, and hopefully be able to reassure her that everything is okay.

She needs to know that you’re supporting her, and she needs to know that obviously if she did start to have any pain, or bleeding, that she could see you again, and you could bring that scan forward.

We have an expression at The Miscarriage Association which is that sans are reassuring until you get to the car park. So you need to discuss with her that actually seeing the baby is okay, even at seven or eight weeks, doesn’t promise that the pregnancy will continue until term. There are no guarantees. Therefore, again, that can increase anxiety actually rather than lessening it.

So I think it’s very important, really, to discuss the pros and cons, and not to refer too early. Because actually most early pregnancy units would really struggle with someone at six weeks, to whom they can’t give an answer either way as to whether this is a viable foetus or not.

If she was bleeding, of course, you may want to refer her a little bit earlier. But, again, at six weeks it’s going to be difficult to give her a definite diagnosis as to the foetal viability. If she had any pain, and of
course if you were suspicious of an ectopic pregnancy, then you would want to refer her earlier.

Charles: So, in terms of recurrent miscarriage, what’s the risk in a future pregnancy?

Nicola: After one miscarriage, one early first trimester miscarriage, the risk is low, and is deemed to be the same as the general population, so one in four to one in five pregnancies.

After two, there’s probably a slight increase, although not significant, so again it’s quoted to be the same.

But actually, after a history of recurrent first trimester miscarriage, therefore they’ve had three recurrent miscarriages, it really depends on their previous obstetric history.

If they’ve had a previous live birth then the risk is said to be 25 to 30% of a further miscarriage. But if they have never had a live birth, so they have no children, then it may be as high as 50% in those women.

The overall prognosis, however, is good, whether or not there is an explanation for their recurrent miscarriage. About 60 to 70% of these women will go on to have a successful pregnancy.

Charles: So, in terms of referring women for investigations for the risk of recurrent miscarriage, what are the issues involved in this?

Nicola: The issues are that unfortunately women have to have three consecutive miscarriages, which can be extremely distressing, before they start investigations.

Now, of course we know the statistics, and we understand why that is,
but for a woman who has had two miscarriages, and wants to know why, and doesn't want to have a third miscarriage, that can be very distressing indeed. It needs to be clearly explained to her.

Now, if she were a little bit older, so if she was over the age of 35, or she’d had a particularly stressful time for any reason, then, as a GP, you may want to start some investigations slightly earlier than waiting for her third miscarriage.

If she’s had a second trimester, then actually, because that’s only 1% of all miscarriages, you would refer for investigations straight away.

Charles: Okay. On to case scenario four: Miss. B. complains of difficulty sleeping. She’s tired, can’t seem to concentrate at work, and she’s got no appetite. Could you prescribe something to help her sleep? You see from her notes that she had a miscarriage six weeks ago, and when you mention it she bursts into tears.

What are the points here?

Nicola: Well, firstly you’ve obviously opened a can of worms, as such, and this is going to be a difficult consultation. But, actually, most women would be grateful to you for mentioning it.

That’s obviously the reason she’s come. I’m sure both her tiredness and her lack of concentration at work are likely to be related to her miscarriage.

It may be, as is often the case, that she has felt that she just has to get on with life, regardless, and hasn’t been given the opportunity to talk about it. So listening would be extremely important in this case. You’re very unlikely to have made matters worse by asking about it.

Of course there could be a reason for her symptoms. She could be tired because she’s anaemic, if she’s bled a lot. So it may be worth checking her full blood count.
It’s obviously worth asking her about symptoms of depression. However, it’s only been six weeks, and actually most women and doctors would deem this as a normal reaction.

It’s very important to realise that women, and their partners, often experience common bereavement reactions, including sadness, anger, and guilt, that we would expect with any other bereavement.

The bereavement process with miscarriage is often made more difficult because there’s no foetus to bury and mourn, and actually society as a whole is very poor at giving women the time and the support that they need. It’s an area little talked about.

After 24 weeks a woman would get a certificate to show that she’s had a baby, and that it’s been a stillbirth, whereas there’s no such paperwork. As I say, there may be nothing to bury, so there may be nothing to grieve over.

Lots of women on forums will talk about when they should go back to work and what’s normal. Of course everyone is different. Some women will be quite happy going back to work soon, but for others they have a more severe bereavement reaction and actually need some more time.

So I think you need to be very open. You need to listen to her. Counselling may be helpful. Encouraging her to have more time off work may be helpful.

She may need something to help her sleep, although probably that’s not the case. Probably a kind word will be enough. She needs reassurance that miscarriage is common, that her reaction to it is common.

Just to be careful what is said really, and not to imply that she should get up and get on with it. Most women will need some time to recover from a miscarriage, both physically and psychologically.
Charles: Is there anything else to say about the psychological aspects of miscarriage?

Nicola: Really just to say that 30 to 50% of women will have symptoms of depression within the first six months following a miscarriage, and it’s important to be aware of that, but actually most will have resolved within a year.

So it’s also important to reassure the lady that it’s normal, but that it is very likely to improve, and her emotional state is very likely to improve.

There can be lots of stresses on a relationship, as well, and often the partner who is trying to support the woman feels like he can’t grieve himself. So just to be very aware of the effect it may have on her partner as well.

Open and empathetic listening, really, between partners, and also between you and your patient, providing support, both by yourself, and also signposting to organisations, can really help to support these couples through a difficult time.

Charles: What else can a GP do to help women who have had a miscarriage?

Nicola: I think the first thing to do is really to assume nothing. Don’t assume that because they were only five weeks pregnant that it’s going to be an insignificant event. Likewise, don’t assume that because they were twelve weeks pregnant that that’s going to make it more significant.

It is more likely to be significant if they’ve been trying to conceive for a long time. It’s more likely to be significant if there were other difficulties involved. So I think it’s very important to be aware of the situation.

Also, if it was an unplanned pregnancy, it may be that the lady is
actually relieved to have had a miscarriage. But, likewise, it may be that she feels very guilty that her thoughts about that pregnancy made her have a miscarriage. There may be lots of thoughts around that. So really assume nothing.

It’s very important not to tell her to pick herself up and get on with life, but to appreciate that actually this may be a major event in her life.

It’s very important to provide information – she may not want it now, but she may want it in the future – and to signpost to sources of support and information.

She may feel she’s fine just after the miscarriage, but actually in a few weeks time it may suddenly hit home, and it may be then that she needs the support. Offer counselling, because it can be very helpful.

Also just think about the next pregnancy, and maybe be a bit more sympathetic, and a bit more supportive, in the next pregnancy. Obviously anxieties are going to be higher, perhaps, than in this pregnancy at the beginning.

Charles: So any final comments?

Nicola: Miscarriage is very important, and can be seen as a natural part of any pregnancy history, particularly to us as doctors. But it can cause really significant distress.

Just acknowledging the distress can be helpful in itself, and offering or just signposting to support. So even if you feel that you’re not the person who can provide the support yourself, actually knowing where they can go for it.

So there’s your local counselling service, or, again, organisations such as The Miscarriage Association. Relate can be helpful for relationship problems. The Samaritans, if that’s necessary. There are many other charitable organisations.
Charles: Many thanks to Dr. Nicola Davis. For further reading, and useful resources, follow the links on the next page.

Male: Thank you for listening to this audio module from BMJ Learning.

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