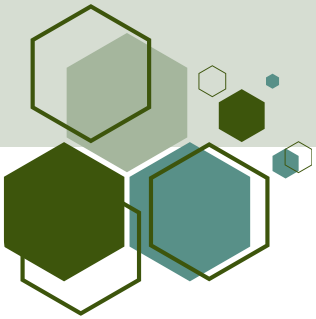
Miscarriage

In the first 12 weeks of pregnancy

Pregnancy Loss Research Group

National Women & Infants Health Programme



Contents

> “I suppose I knew that things could go wrong, but I suppose I didn’t necessarily expect it to go wrong for myself.”

Introduction

Miscarriage is, unfortunately, the most common complication of pregnancy. However, despite almost 1 in 4 pregnancies ending in miscarriage, it is not always clear why a miscarriage has happened. The loss of a pregnancy can be a very distressing life event, regardless of how early this loss has occurred. Every person responds differently, psychologically and emotionally, and that is okay.

Miscarriage is the loss of a pregnancy before 24 weeks. However, miscarriage can happen in the first or second trimester of pregnancy. In this booklet, we focus on first trimester miscarriage, which means the loss of a pregnancy in the first 12 weeks.

Please keep in mind that, while this booklet offers valuable information, it is not a substitute for personalised medical advice. We encourage you to consult with a healthcare professional for any specific concerns or questions you may have.

For more information about recurrent miscarriage, which is the loss of 2 or more pregnancies in a row in the first trimester, please find the 'Recurrent Miscarriage' booklet on the Pregnancy and Infant Loss Ireland website: pregnancyandinfantloss.ie.

This booklet was developed through research conducted by the Pregnancy Loss Research Group, with the input of knowledge users, including people with lived experience of recurrent miscarriage, and healthcare professionals (learn more about the research group at the end of this booklet). Throughout the booklet, you will find direct quotes from people who took part in this research.

People who experience miscarriage have different ways of describing pregnancy, pregnancy loss, or miscarriage. Throughout the booklet we use terms such as fetus, pregnancy tissue, and fetal tissue, in an effort to be as inclusive and accurate as we can, as there is no one term that everyone agrees on. It is important that healthcare professionals be guided by you and use the language that you prefer.

Types of miscarriage

What are the types of miscarriage?

Miscarriage can be divided into:

- Threatened
- Inevitable
- Incomplete
- Complete
- Missed miscarriage.

The following information can be difficult to look at, but these are terms that the medical staff use on scans and reports, so it is useful to know what they mean.

Threatened miscarriage
The term threatened miscarriage is used when vaginal bleeding occurs, but an examination has confirmed that the neck of the uterus (womb) is closed, and an ultrasound has shown an ongoing pregnancy. If you are experiencing a threatened miscarriage, you will be advised to return if bleeding happens again. You should always contact the hospital if you have further bleeding.

Although bed rest was routinely advised in the past for threatened miscarriage, it has been shown not to make any difference to the outcome of the pregnancy. However, it is a very worrying time, and if you have concerns, you may need to rest and take time off work until the bleeding resolves.

Inevitable miscarriage
Inevitable miscarriage occurs when there is vaginal bleeding and, sometimes, period-like cramps, and an examination shows that the neck of the uterus is open. However, even though an ultrasound scan may show an ongoing pregnancy and/or no pregnancy tissue has passed from the uterus, miscarriage will definitely happen.

Complete miscarriage
A miscarriage is diagnosed as complete when an ultrasound scan shows that there is no pregnancy tissue remaining in the uterus.

Incomplete miscarriage
Sometimes, despite heavy bleeding, an ultrasound scan may show that pregnancy tissue remains in the uterus; this is called an incomplete miscarriage. If this happens, you may still be experiencing vaginal bleeding and pain and may go on to have a complete miscarriage. Or, the bleeding may have stopped, and further treatment may be required.

Missed miscarriage
A missed miscarriage is also known as a silent miscarriage because the common symptoms of miscarriage i.e., bleeding and pain, do not occur. The pregnancy stops developing, but the signs of pregnancy continue, giving no reason to suspect a miscarriage. Often it is not until a routine ultrasound scan is performed that the miscarriage is diagnosed, which can be a shocking and upsetting experience.

An ultrasound examination can also show a pregnancy of uncertain viability
Pregnancy of uncertain viability describes when the ultrasound scan shows a pregnancy in the uterus but cannot confirm if the pregnancy will develop normally, or if it will miscarry. An embryo may not be seen, or it may be too small to expect to see a heartbeat. It will not be possible to tell you if the pregnancy will continue to be successful based on a single scan. In cases of pregnancies of uncertain viability, a repeat ultrasound scan will be necessary.

> “You just have a scan. You have a heartbeat the first time. Go back the next time. No heartbeat the second time.”

> “You know so it was very traumatic physically and emotionally but like I think where the services could improve would be definitely don’t play things down. Empower women to have knowledge of their own bodies and don’t hide from them the stuff that could go wrong with their bodies.”

> We were actually very excited because it was the following week that we were going to get our scan and picture and we were gonna tell our families and everyone. Instead of that, we hadn't anything.

Having a miscarriage

Bleeding and pain are the most common symptoms of a miscarriage; however, the symptoms differ from person to person and can occur at any time after a missed period. The amount of pain and bleeding varies and is more likely to increase when the pregnancy is further along (in number of weeks). In some cases, for example, in missed miscarriage, there are no symptoms of miscarriage; it may only be discovered that a pregnancy has ended during a routine ultrasound examination.

Bleeding

Bleeding is often noticed when going to the toilet as a staining of pink, brown, or red blood loss on the toilet paper. The bleeding can range from brown vaginal discharge or light pink spotting, to bright red and heavy bleeding with or without clots. Some people experience very heavy bleeding, a situation that may require hospitalisation.

At home, there may be times when you notice increased bleeding. This may occur when you stand up or go to the toilet. This is due to the pooling of blood in the vagina from lying down, which then becomes noticeable upon standing due to gravity.

If the bleeding is very heavy, i.e., you need to change a sanitary towel (pad) that has filled with blood clots every 15 minutes for over an hour (or 4 soaked pads in the course of 1 hour), you need to go to the Emergency Room (or Emergency Department) of your local maternity unit/hospital.

Pain

Some will experience pain associated with their miscarriage. The level of pain can vary, ranging from a dull ache to strong abdominal cramping. Many women describe it as a strong period pain, but others experience much more severe pain. This pain may or may not be associated with vaginal bleeding. You might also experience dizziness due to this pain and/or the level of bleeding.

If the pain is very severe and not responding to over-the-counter pain relief, such as paracetamol or ibuprofen, you may need to go to the Emergency Room of your local maternity unit/hospital.

> A lot of both women and men have said to me that, especially for the first miscarriage, that you don't expect the seriousness of it, you know, the blood, what actually is happening, that it can be quite frightening.

> The bleeding can be so heavy and the pain can be so intense.

> I just didn't know what to do you know. And no that was just very scary. I kind of knew it would be a lot [of blood] but I didn't think it would be as much.

What are the causes of vaginal bleeding in early pregnancy?

Vaginal bleeding in early pregnancy is very common, affecting 20-40% of pregnancies. It is not always possible to give an explanation as to why bleeding occurs in early pregnancy. If an ultrasound scan of the pregnancy shows a heartbeat between 7 to 8 weeks, there is an 85-97% chance of the pregnancy continuing as normal.

The most likely causes of bleeding in early pregnancy are:

1. **The implantation site:** As the pregnancy itself attaches to the uterus (womb), it may cause some blood vessels of the uterus to bleed.
2. **The cervix (neck of the uterus):** During pregnancy, tissues become rich in blood supply and soften. Any slight trauma to the cervix can provoke bleeding. Sometimes an unusual area of tissue on the cervix can also cause bleeding.
3. **The vagina:** Thrush or infection can cause the vagina to become inflamed, and bleeding may occur in the form of spotting.
4. **Miscarriage:** This can be a threatened miscarriage, an incomplete miscarriage, or a complete miscarriage.

What should I do if I think I am having a miscarriage?

If you are concerned, you should go to your GP (General Practitioner). However, know that it is not always possible to get a conclusive diagnosis right away. The GP might first ask you some detailed questions about your menstrual cycle and timing of your first positive pregnancy test, and they might do a blood test. This may be followed by a physical examination.

Depending on your symptoms and on how far along (how many weeks) in the pregnancy you are, the GP may not be able to make a diagnosis and may refer you to an Early Pregnancy Unit (EPU) or the Emergency Room of your local maternity unit/hospital. This referral may take days or weeks.

It is possible that your GP might not be available to see you. In this situation, another option is to contact your local maternity unit/hospital Emergency Room for advice.

You should go immediately to the Emergency Room of your local maternity unit/hospital if:

- Your pain is severe
- Your bleeding is especially heavy - i.e., you need to change a sanitary towel (pad) that has filled with blood clots every 15 minutes for over an hour (or 4 soaked pads in the course of 1 hour)
- You are feeling weak or dizzy
- You have severe abdominal pain that is not relieved by painkillers
- You have a high temperature
- You feel very unwell.

It is advisable to bring someone with you to the hospital.

What is an Early Pregnancy Unit (EPU)?

The Early Pregnancy Unit is a specialised unit in the maternity unit/hospital where trained sonographers provide early pregnancy scans. This unit is appointment-based, and your GP or the Emergency Room will organise the scan appointment for you. It is only open on certain days and times and is not a 24/7 service.

In some maternity units/hospitals, an EPU may be called an Early Pregnancy Assessment Unit (EPAU) or Early Pregnancy Clinic (EPC).

Blood tests

Blood tests will sometimes be used to give doctors more information about your pregnancy. The pregnancy hormone hCG (human chorionic gonadotropin) can be measured using serum Beta-hCG (β-hCG), a blood test that can be done in early pregnancy. This test may be done by your GP or in the Emergency Room.

This is usually done when:

- An ultrasound scan is inconclusive
- The gestation (number of weeks) of a pregnancy is unknown
- There is a query that the pregnancy is not in the right location (for example, a suspected ectopic pregnancy, where the pregnancy develops outside of the correct position inside the uterus).

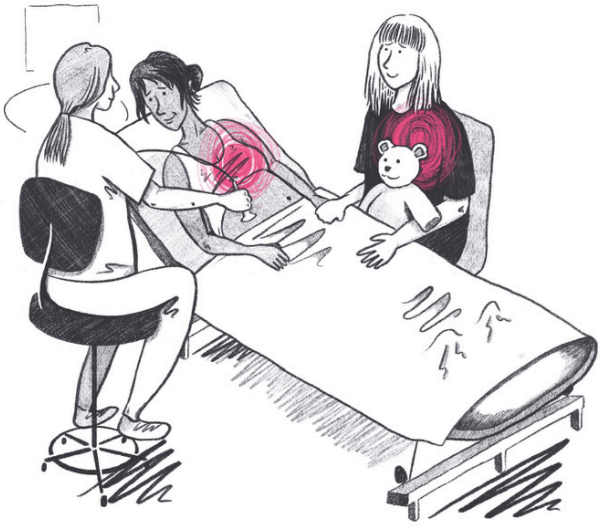
Two or more results are needed, usually 48 hours apart, to interpret the test accurately. If the β-hCG level increases by more than 66% in 48 hours, this is reassuring and is likely to be associated with a healthy viable pregnancy. If the β-hCG level decreases by more than 15%, this suggests a likely miscarriage. It is important that blood results are interpreted along with your detailed history, a clinical examination, and, if medically indicated, an ultrasound scan.

Ultrasound

To identify a pregnancy that is less than 8 weeks along, a transvaginal or a transabdominal ultrasound scan may be necessary. A transvaginal ultrasound scan involves placing a probe gently inside your vagina; a transabdominal ultrasound scan involves gently rubbing the probe on your stomach.

It is possible that you may not be given a definite diagnosis of miscarriage after one scan. It is important that a diagnosis of miscarriage is made only when certain measurements of the pregnancy on scan are reached.

In some cases, it may be hard to detect if you have miscarried, for example, in a pregnancy of uncertain viability, as described in the section 'Types of miscarriage'. A repeat ultrasound scan may be necessary approximately 7 to 10 days after the first scan to see if the pregnancy develops.



How can a miscarriage be confirmed?

If you are in the early stages of pregnancy, specifically, within the first 6 weeks, and you experience pain or bleeding, a blood test will be conducted. This will happen either at your GP's office or at the hospital, to assess the level of pregnancy hormone in your body. This blood test will be repeated after 48 hours. If you have a clear understanding of your pregnancy timeline and are beyond 6 weeks along, you will have the option to undergo an ultrasound scan at the hospital's Early Pregnancy Unit (EPU). This unit is appointment-based, and your GP or the Emergency Room will organise the scan appointment for you.

Ultrasound scans in early pregnancy are best performed within a designated early pregnancy clinic by a trained sonographer. This is a person trained to performed this scan, a doctor or a midwife.

As noted in the previous section, it is possible that you may not be given a definite diagnosis of miscarriage after one scan, and a repeat ultrasound scan may be necessary 7 to 10 days after the first scan.

If I miscarry at home or outside the hospital, what should I do with the pregnancy tissue?

During the early stages of pregnancy, it can be very hard to tell the difference between pregnancy tissue and large blood clots. If you pass any pregnancy tissue at home during a miscarriage, you can call the EPU or your local maternity unit/hospital to get guidance on how to collect it and take it with you to the hospital.

You do not have to collect it if you don't wish to. However, if you collect it, the medical team will examine the tissue to determine if the miscarriage appears to be complete. This is to rule out the possibility of a molar pregnancy (a particular type of pregnancy loss caused by over-development of the placenta). With your permission, they will send the pregnancy tissue to a laboratory for testing.

If you have recurrent miscarriage, you may be advised to collect the pregnancy tissue and have it sent for genetic testing. This will be discussed with you. Additionally, the staff will provide further guidance, for example, for the burial of the pregnancy tissue, and other options. Please also see the section 'What happens to the pregnancy tissue' for more information on this.

Management of miscarriage

What ways are there to manage miscarriage?

Once a miscarriage has been diagnosed, and the type of miscarriage is identified, there are options for how to manage the miscarriage. You should be provided with verbal and written information regarding treatment options and advised of the risks and benefits associated with each approach.

You could be offered conservative, medical, or surgical management, based on a combination of your symptoms, ultrasound scan findings, how far along you are in the pregnancy, if you have recurrent miscarriage, and other factors, such as your medical history, where you live, and supports available to you.

You should take your time when making this decision. It is important to remember that it is your decision, and the doctors and midwives are there to offer you support and information.

Conservative management

Conservative management involves waiting for the miscarriage to happen by itself, without doing anything medically to cause it to happen. With this option you may experience some bleeding and discomfort over the next few days.

What happens during conservative management?

Conservative management is an appropriate method for you if you:

- Have no signs of infection
- Do not have excessive bleeding
- Do not have a high temperature
- Have no or mild abdominal pain
- Are at an early number of weeks in the pregnancy
- Do not live too far from your maternity unit/hospital
- Have sufficient supports regarding childcare/transport.

After the ultrasound scan confirms a miscarriage, you will return home to allow the natural process of miscarriage to occur. You will be offered an ultrasound in around 2 weeks, if you have no bleeding within that time, to see if you want to continue with conservative management, or if you want to change to medical or surgical management.

You are likely to experience vaginal bleeding and abdominal pain over the next few days. It may not occur immediately and may take up to 3 weeks to start, especially if it is a missed miscarriage. There will be heavy bleeding for a few hours as the pregnancy passes, then lighter bleeding (somewhat like a normal period) for up to 2 weeks after this.

During the early stages of pregnancy, it can be challenging to tell the difference between pregnancy tissue and large blood clots. That is why it is important to stick to the hospital's recommended follow-up plan to make sure all the pregnancy tissue has passed, and to rule out the possibility of a molar pregnancy.

You may be asked to come back to the EPU in 2 weeks for a blood test or ultrasound scan to ensure that the miscarriage process is complete. You will need to take a home pregnancy test 3 weeks after the bleeding stops, and you will need to contact the EPU if the test result is positive.

Are there any risks with conservative management?

All managements of miscarriage carry some risks. The risks associated with conservative management of miscarriage are low, but they can happen, including:

Feeling faint	1-2 in 100 people
Heavy bleeding	1 in 100 people
Heavy bleeding requiring a blood transfusion	1 in 1000 people
Incomplete emptying of the uterus (womb) / retained pregnancy tissue, requiring further treatment	3-10 in 100 people (an estimate, depends on the type of miscarriage)
Infection	1-3 in 100 people

More people now opt for conservative management, which has been proven to be a safe option. Importantly, there is no conclusive evidence to suggest that conservative management increases the risk of infection. The risk of infection is relatively the same whether one chooses conservative, medical, or surgical management.

When should I go to the hospital during conservative management?

You may feel large clots passing. If you have any concerns, contact your GP or the Emergency Room of your local maternity unit/hospital. If the bleeding is very heavy i.e., you need to change a sanitary towel (pad) that has filled with blood clots every 15 minutes for over an hour (or 4 soaked pads in the course of 1 hour), you need to go the Emergency Room.

You should also go to the hospital if you:

- Develop severe abdominal pain that is not relieved by painkillers
- Have a high temperature
- Feel very unwell.

If the pain and bleeding do not settle after you go to the hospital, there is a small possibility that you may require treatment with antibiotics, or an emergency operation.

You may be asked to come back to the EPU for a blood test or ultrasound scan to ensure that the miscarriage process is complete. You will need to take a home pregnancy test 3 weeks after the bleeding stops, and you will need to contact the EPU if the test result is positive.

You should contact the EPU for re-assessment if you:

- Have bleeding that lasts longer than 2 weeks, or
- Have no bleeding at all after 2 weeks.

In cases where a letter for work is needed, the EPU will be able to provide one. Please see the section ‘Aftercare at home following miscarriage’ for more information.

Medical management

What happens during medical management?

The most common method for inducing miscarriage is through medications that speed up the process of passing the pregnancy tissue. About 80-90% of women will have a complete miscarriage with the use of these medications.

Medical management uses 2 medications: mifepristone and misoprostol. Mifepristone is taken by mouth first, in the presence of a doctor. It may cause nausea, for which anti-sickness medicine is available. If you vomit within 1 hour after taking mifepristone, you must contact the hospital for a new dose.

It is uncommon that miscarriage starts after mifepristone alone. Even if it does start, you must take misoprostol to complete the miscarriage process.

Misoprostol works by softening the neck of the uterus (womb), and it is taken at least 24 hours – but no more than 48 hours – after mifepristone, ideally at around 36 hours.

Misoprostol tablets generally work best if taken by buccal administration. This means the tablets are placed between the gums and the inner lining of the cheek and left to dissolve for 30 minutes, without eating, drinking, smoking, or chewing gum during this time. You then rinse your mouth and swallow. Vaginal administration is also possible. Pain medication (a non-steroidal anti-inflammatory drug) is advised, to be taken 1 hour before the misoprostol tablets. If no bleeding occurs 24 hours after taking the misoprostol tablets, you should contact the EPU.

Depending on the size of the pregnancy and how far you are from the hospital, healthcare providers may recommend a hospital stay during the process.

Complete miscarriage is confirmed either through a home pregnancy test or an ultrasound scan in the EPU after 3 weeks. If the home pregnancy test is positive, you should contact the EPU.

Are there any risks with medical management?

Using medication to treat early pregnancy miscarriage is a safe and effective option. Many studies report that this treatment is successful in completing miscarriage in about 80 - 90% of cases.

Risks of medical management of miscarriage include:

Feeling faint	1-2 in 100 people
Heavy bleeding	1 in 100 people
Heavy bleeding requiring a blood transfusion	1 in 1000 people
Incomplete emptying of the uterus (womb) / retained pregnancy tissue, requiring further treatment	1-10 in 100 people (an estimate, depends on the type of miscarriage)
Infection	1-3 in 100 people

Does the medication have any side effects?

Side effects of the medication can include nausea, vomiting, cramping, diarrhoea, or hot flushes. After taking the medication, you may experience lower abdominal pain and vaginal bleeding. The bleeding is heavier than a period and can last up to 7 to 10 days. You may feel large clots passing.

It is advisable to use sanitary towels (pads) rather than tampons to reduce the likelihood of infection. The abdominal pain is typically worse than period pain, and regular pain relief should be taken.

About 80-90% of women will experience a complete miscarriage within a week of using misoprostol tablets.

Are there any alternatives to having medical management at home?

You can discuss inpatient management with your medical team, who may advise you to remain in hospital throughout the duration of the medical management process when:

- The pregnancy is advanced (over 10 weeks)
- You live far away from the hospital
- You have another medical condition
- You have limited support at home
- You express a definite preference for in-patient medical management.

When should I go to the hospital during medical management?

During miscarriage, you may feel large blood clots passing. If you have any concerns, contact your GP or the Emergency Room or EPU. If the bleeding is very heavy i.e., you need to change a sanitary towel (pad) that has filled with blood clots every 15 minutes for over an hour (or 4 soaked pads in the course of 1 hour), you need to go to the Emergency Room.

You should also go to the hospital if you:

- Develop severe abdominal pain that is not relieved by painkillers
- Have a high temperature
- Feel very unwell.

You will be given the choice of a home pregnancy test or a follow up ultrasound scan in the EPU within 3 weeks of the first administration of the misoprostol tablets. This is to confirm that a complete miscarriage has taken place. If the home pregnancy test is positive, you should contact the EPU.

You should also contact the EPU if bleeding persists longer than 2 weeks, as this may indicate retained pregnancy tissue or infection.

Going to the hospital or Early Pregnancy Unit may be upsetting, as people in the waiting area will be there for any number of reasons.

Surgical management

An operation may be offered to you, depending on the how far along you may be in the pregnancy.

Surgical management means vacuum aspiration of the uterus (womb). There are 2 procedures:

- Evacuation of Retained Products of Conception (ERPC), or
- Manual Vacuum Aspiration (MVA).

You may hear people refer to surgical management of miscarriage as a D&C (Dilation and Curettage), but this is not the correct term for operations performed in the case of miscarriage.

What happens during an Evacuation of Retained Products of Conception (ERPC) Procedure?

The ERPC procedure is performed in the operating theatre, under a general anaesthetic. It involves gently widening the neck of the uterus and removing the pregnancy tissue, and it takes approximately half an hour. You will be given information about where to go, which may be to a day ward, gynaecology ward, or a different hospital.

Your medical team should meet you before your procedure. Before admission for your surgical management, you might be asked not to eat or drink from midnight the night before. This includes avoiding chewing gum, sweets, and water.

If you have been given tablets (misoprostol) to take before your operation, you will be advised what time to swallow these with a small sip of water on the day of the operation. You may also take them by buccal administration (between your gum and your cheek) or sublingually (under your tongue) 1 hour before the operation**;** they work faster when taken buccally or sublingually. These tablets soften the neck of the uterus and make the surgical management procedure easier to perform. They may upset your stomach, and you may experience some pain or vaginal bleeding.

What happens during a Manual Vacuum Aspiration (MVA) Procedure?

MVA is a medical procedure used to remove pregnancy-related tissue from the uterus (womb). Before the procedure begins, you will receive an injection to numb the neck of the uterus, which the doctor will gently open just enough to pass a small suction tube into it to remove the contents. Sometimes, an ultrasound scan machine might be used during the procedure to make sure the uterus is completely empty. During this part, you may feel some period-like pain, which can be uncomfortable.

It is important to note that MVA is an outpatient procedure done while you are awake. The procedure takes about a half an hour, and you can usually return home shortly afterwards.

Who might be offered a MVA procedure?

MVA is suitable for those who are less than 12 weeks pregnant, and who prefer this method over taking medication or having surgery with a general anaesthetic.

Potential advantages:

- There is no need for general anaesthesia, so it may be possible to return to ordinary activities on the same day, if you wish to do so.
- Because the procedure empties the uterus quickly, your body can recover and return to a regular menstrual cycle.
- You won't have to wait for hours for medication to take effect.
- You won't have to wait for a hospital surgery appointment.

Potential disadvantages:

- You will be awake and aware during the procedure.
- You may experience some discomfort during the procedure, similar to period pain.
- For some people, the procedure may not be completed because it may be too challenging, due to pain or discomfort.

Are there any risks with surgical procedures?

All surgical procedures carry risks. The risks associated with surgical management of miscarriage are low, but they can happen. You will be made aware of these when you sign written consent for the operation.

The risks include:

Anaesthesia-related complications	<1 in 1000 people
Asherman Syndrome / uterine adhesions*	1 in 100 people
Cervical tear/injury	1 in 100 people
Feeling faint**	1-2 in 100 people (only if awake during surgery, otherwise not applicable)
Heavy bleeding	1 in 100 people
Heavy bleeding requiring a blood transfusion	1 in 1000 people
Incomplete emptying of the uterus (womb) / retained pregnancy tissue, requiring further treatment	1-3 in 100 people
Infection	1-3 in 100 people
Injury to uterus / need for further surgery	1-4 in 1000 people

* Sticky scar tissue may form inside the uterus, potentially causing menstrual and fertility problems due to the walls of the uterus sticking together.

** Pain and fainting after an outpatient procedure could signal complications and hinder recovery, with prompt medical attention needed to ensure well-being and recovery.

In the rare event that the medical team suspect injury to the uterus or to the internal organs during surgical management, additional surgery or treatment may be needed. Your medical team will discuss this with you.

It is a common misunderstanding that surgical management increases infection or bleeding risk. In fact, infection rates stay very low regardless of which management method is chosen.

Take any regular daily medications with a small amount of water on the morning of the operation. For blood thinners like aspirin or heparin, you may need to stop these before surgery - check with your medical team or GP if unsure about any medications.

What is the physical recovery time after surgical management of miscarriage?

The physical recovery time after surgical management of miscarriage is short. You will usually be allowed home within 2 to 4 hours, and it may be possible to go back to work after a few days, if you wish to do so. If you experience complications, your medical team can offer treatment; for example, if the complication is an infection, they can offer antibiotics.

If your blood group is Rhesus negative, you will require an anti-D injection. This is done because there is a possibility that small quantities of fetal cells will enter your bloodstream during the surgical procedure.

Please arrange for an adult to pick you up and stay with you the night after surgical management, as you are advised not to drive for at least 48 hours.

You may feel some cramps and pain similar to what you experience during your period. If you need something to help with the pain, you can take ibuprofen or paracetamol. You can take both of these medicines together for better pain relief.

You will also have bleeding that is a lot like your period, and it will last for about 7 to 10 days. During this time, it is best to use sanitary towels (pads), not tampons. And it's important to avoid having sex until the bleeding has stopped.

After surgical management of miscarriage, there is usually no need for routine follow up to the hospital or EPU. However, it is recommended you contact your GP if you have heavy vaginal bleeding, vaginal discharge with a bad smell, abdominal pain, or if you have a positive pregnancy test 2 weeks after you have stopped bleeding.

Why might I have one form of management over another?

Your doctor or midwife might recommend one form of management over another. For example, if this is your second (or more) miscarriage, they may recommend surgical management so that pregnancy tissue can be collected for genetic testing.

Surgical management may also be more appropriate if you are further along in your pregnancy, for several reasons:

- As the pregnancy progresses, the size of the pregnancy tissue gets bigger, and it becomes more difficult for the body to remove it naturally.
- If a miscarriage happens later in the pregnancy, there is a higher chance of heavy bleeding or infection. The controlled surgical environment is better able to manage these issues.
- When the person is already unwell, e.g. bleeding very heavily from a miscarriage that is already happening.
- Sometimes there is a need to examine the pregnancy tissue or do genetic testing. Surgery provides a controlled and precise way to collect the tissue, which allows for more accurate analysis and diagnosis.
- It might be your preference to have surgical management.

It is important to talk to your healthcare providers to figure out the best way to manage a miscarriage in your personal situation. For example, conservative or outpatient medical management may not be recommended if you are living a distance from the hospital, or if you do not have childcare supports or transport.

What happens to the pregnancy tissue?

What happens to the pregnancy tissue after miscarriage management?

Following surgical management, pregnancy tissue will be sent for examination, with or without genetic testing. In conservative or medical management, if the miscarriage happens at home, pregnancy tissue may also be collected and brought to the maternity unit/hospital for examination.

For example, if you have experienced 2 or more miscarriages, you may be advised to undergo genetic testing on the pregnancy tissue. It is advised to call your local maternity unit/hospital and/or EPU when heavy bleeding begins, so that they can advise you how to collect and transport it.

Sometimes fetal tissue is identified within the pregnancy tissue. It is not identified in the majority of cases, as it is too small to see. Should fetal tissue (or cells) be separately identified, you may consent to a hospital burial or may make your own arrangements in a private burial plot.

If you chose to have a hospital burial, you will sign a consent form. The pregnancy tissue will always be treated with respect and dignity. The location of the burial will be documented in the cemetery records. These options will be discussed with you by the healthcare professionals in the Emergency Room or EPU, and when you are deciding on the miscarriage management option.

Aftercare at home following miscarriage

Why do I feel tired, and how long should I rest, after having a miscarriage?

You may experience fatigue or exhaustion during and after a miscarriage. It is not unusual to feel tired and emotional for a few weeks afterward, or for any pre-existing anxiety, or other mental health challenges to increase for a time. It is advisable to rest for a couple of days immediately following a miscarriage and to seek support, if needed. Resources listed at the end of this booklet may be of help.

Returning to work depends on many factors, including how you are feeling. For some people, taking time off work or normal activities to recover is beneficial. Others may seek familiar people, environment, and routine at work, or may be constrained by financial need to be in work. Circumstances differ for everyone and will depend on the physical, mental, and emotional state of the person experiencing the miscarriage, as well as on the demands and culture of their workplace.

If your tiredness persists and does not improve, please consult your GP. In cases where a letter for work is needed, the EPU will be able to provide one.

> I did take time off work after this miscarriage because it did knock me again.

> Everybody tells you 'oh miscarriage is so common', and you're almost expected to just get up and get on with it.

When should my period return?

It is normal to experience light bleeding for 7 to 10 days following a miscarriage. During this time, you should avoid sex, baths, swimming, and the use of tampons, to prevent infection.

Your period should return 3 to 6 weeks after the bleeding has stopped; however, this may vary from person to person. If you have any concerns, for example, if your period does not return within 3 months, and you have persistent positive pregnancy tests, contact your GP.

Are there any possible complications following a miscarriage?

Normally, you should not need any routine follow up with the hospital or EPU following a miscarriage. However, if you experience any of the following, contact your GP, Out of Hours GP Service, Emergency Room or the EPU:

- Positive pregnancy test 2 weeks after you have stopped bleeding
- Bleeding for more than 2 weeks following miscarriage
- Heavy bleeding i.e., you need to change a sanitary towel (pad) that has filled with blood clots every 15 minutes for over an hour (or 4 soaked pads in the course of 1 hour)
- Severe abdominal pain
- Discharge from your vagina that is green or yellow and with a bad smell.

Why miscarriage happens

Understanding miscarriage

Miscarriage is a common and a regular event in pregnancy. It is estimated that miscarriage occurs in approximately 1 in 4 pregnancies, and for some people, it occurs more than once. However, despite how common it is, having a miscarriage can be a deeply emotional and complicated journey, and people can experience it in many different ways.

Pregnancy loss is not talked about as openly as it could be, for any number of reasons, i.e., that it feels very personal, that there is often a level of discomfort around grief and loss, and that it may feel awkward, in general, to talk about bodies. While the causes of early pregnancy loss vary, understanding the factors involved can provide clarity and support. With more open conversation around pregnancy loss, the people who experience it may begin to feel less isolated.

Why does miscarriage happen?

Miscarriages occur due to various factors, with some cases having identifiable causes, and others remaining uncertain. Understanding the knowable underlying causes and risk factors associated with miscarriage can help people gain insight into their own situation (see the table below).

Genetic causes	• Chromosomal anomalies in the fetus, such as the number of chromosomes, such as trisomies (three copies of a chromosome), or changes in the structure of a chromosome, such as a translocation • Inherited genetic disorders that affect fetal development
Hormonal causes	• Imbalances in hormone levels, such as low progesterone • Thyroid disorders affecting hormone regulation
Specific medical conditions	• Autoimmune disorders, such as antiphospholipid syndrome • Uncontrolled diabetes
Anatomical problems	• Uterine anomalies, including septate uterus or fibroids • Cervical insufficiency, where the cervix weakens or opens prematurely
Risk factors	• Older maternal age (if you are over 35) • Behavioural risk factors, including smoking, excessive alcohol consumption, or drug use • Obesity or being significantly underweight.

Recurrent miscarriage

What is recurrent miscarriage?

Recurrent miscarriage is the loss of 2 or more pregnancies in a row within the first trimester. These include pregnancies confirmed by pregnancy test or ultrasound, as well as molar pregnancies (a particular type of pregnancy loss caused by over-development of the placenta).

For more guidance related to recurrent miscarriage, see the 'Recurrent Miscarriage' booklet, available on the Pregnancy and Infant Loss Ireland website pregnancyandinfantloss.ie.

Emotional and psychological impact

Are my feelings normal?

Everyone experiences miscarriage differently. Some people will not feel or express the emotions they might expect, or that others might expect them to feel or express, and that is okay. Feelings may be numbed, delayed, or even be contradictory. There is no one way, or right way, to respond. What is most important is to try to allow space, acceptance, and compassion for whatever feelings arise.

And while the above is true, people who miscarry often experience the same cycle of emotions as those who have lost a close relative or friend; denial, anger, guilt, sadness, anxiety, depression, feelings of emptiness and longing are all part of the normal grieving process. A pregnancy loss may leave you feeling isolated. You may also feel disappointed and think that your body has let you down. Your emotions can change daily. There is no set pattern, and, depending on what else is going on in your life, some days will be easier than others.

It is important to remember that miscarriage is not your fault.

Getting your first period after a miscarriage can be a particularly hard experience, as the bleeding can remind you of your miscarriage and the loss of a baby you may have really wished for. With time, support, and giving yourself a chance to recover physically, you should gradually start to feel better.

If, after giving yourself time to grieve and heal, you have continued trouble coping with daily life (i.e. loss of appetite, inability to sleep or focus at work, becoming isolated from family and friends), or if you have ongoing feelings of anxiety (an even more common symptom following miscarriage than depression), your GP can provide support and refer you for professional counselling if required.

> “I just found getting my period again and seeing the blood over and over and over again really hard, really hard and I wasn’t really expecting that either.”

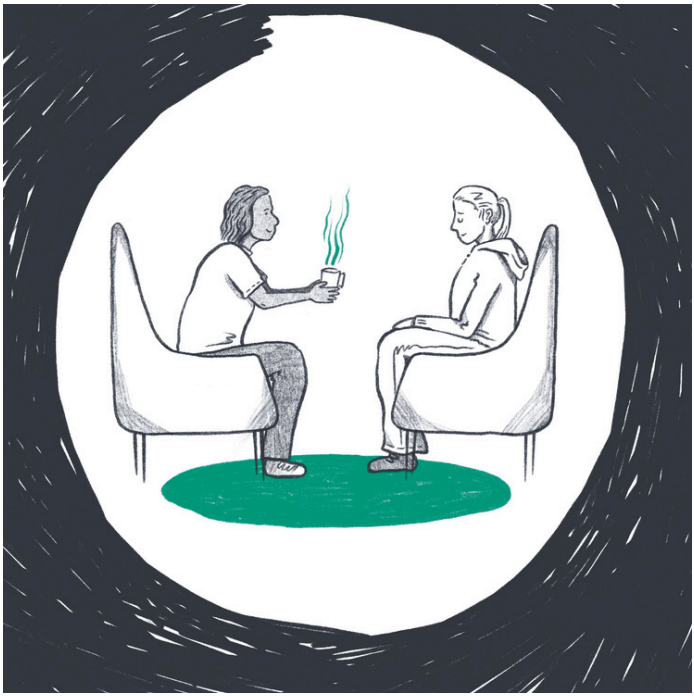
> “When you’ve had a miscarriage the way to address it isn’t saying oh that’s very common. Just because its common doesn’t make it okay.”

Seeking support

While this booklet provides valuable information, it is important to remember that each situation is unique, and everyone's experience is very personal. If you have experienced recurrent miscarriages, or are struggling emotionally, seeking professional support is crucial. Your healthcare provider may offer guidance, discuss potential treatment options, and provide emotional support.

Additionally, connecting with support groups, online communities, or counselling services specialised in pregnancy loss, can provide invaluable comfort and understanding during this difficult time. Remember, you are not alone, and support is available.

See the resources at the end of this booklet for further information on supports that are available.



How can I acknowledge the loss of my pregnancy?

Miscarriage in the first trimester differs from later pregnancy losses, as there is often no funeral or burial to acknowledge and mark the loss. However, many people have found that acknowledging their pregnancy loss with memorial rituals, such as planting a tree, lighting a candle, or perhaps taking some time away, can be helpful. You decide what's best for you.

You may feel sad on what should have been your due date, or on the anniversary of your miscarriage. You might find it helpful to do something special at these times. You can mark your loss in whatever way is appropriate for you.

Pregnancy loss remembrance service

All maternity units/hospitals and support organisations in Ireland hold remembrance services each year. For many, this service is an opportunity to acknowledge the loss of their pregnancy, and to remember, in a supported space with others who have experienced pregnancy loss.

When to try again

When can I try for another baby?

Unless there is a medical reason that has been discussed with you by your doctor following your miscarriage, i.e., molar pregnancy, ectopic pregnancy or personal illness, there is no right answer as to when the best time to try to conceive again may be. You don't have to wait a particular amount of time.

There are many factors to consider in deciding the timing of another pregnancy, your own feelings, your partner's feelings, and perhaps family or social circumstances. It is a very personal and individual decision.

Medical staff advise to have at least one period before trying for another baby. This is because the first cycle after a miscarriage varies, and it may be difficult to calculate how far along you are in your pregnancy when you have the positive pregnancy test. However, if you conceive during the first cycle, this does not make you more likely to miscarry.

.

> "I'm kind of torn between afraid that I might never have another baby but afraid of having another positive test."

> "I was so traumatised after the first miscarriage. It was about a year before I was okay to start trying again."

What are my chances of having another miscarriage?

Miscarriage is usually a one-time occurrence. Most women who miscarry go on to have healthy pregnancies after a miscarriage. A small number will have repeated miscarriage. We generally do not carry out investigations until you have had at least 2 miscarriages in a row.

Though the risk of another miscarriage increases after 3 consecutive miscarriages, the odds are still in your favour of having a healthy pregnancy outcome.

As you get older, particularly over 40 years of age, the risk of miscarriage is higher.

Number of previous miscarriages	Likelihood of having another miscarriage
2 or 3	28 in 100 people
4	40 in 100 people
5	47 in 100 people
≥6	64 in 100 people

Is there anything I can do to prevent miscarriage from happening again?

Miscarriage is common, and sometimes the cause will not be known. The following information is intended to guide you to be as healthy as possible, and to prepare you for a healthy pregnancy.

Most miscarriages cannot be prevented and are often attributed to issues with chromosomal anomalies in the fetus, leading to improper development of the pregnancy.

There are certain measures you can take to lower the risk of miscarriage:

- Avoid consuming alcohol and drugs such as cannabis, heroin, crack, and cocaine during pregnancy
- Refrain from smoking, or exposure to second-hand smoking, during pregnancy
- Achieve a healthy weight prior to becoming pregnant
- Take precautions to prevent infections
- Maintain a healthy and balanced diet
- Take folic acid, starting at least three months before you become pregnant: the recommended dose is 400 micrograms every day. Some women may be at a higher risk of having a baby with a neural tube defect (such as spina bifida) and a higher supplement of folic acid (5 mg) may be recommended
- Take a vitamin D supplement.

For more information about these measures, please visit www2.hse.ie/my-child/.

Once you have decided to try to become pregnant again, you should consult with your doctor before taking any supplements to ensure you receive the correct dosage. You should also discuss any prescription or non-prescription medications that you are taking with your GP to ensure that they are safe to take when you are trying to conceive, or during your pregnancy.

It is normal to feel anxious about another pregnancy after a miscarriage, so taking steps to improve your mental health is also important. Good support and care can improve your pregnancy outcome. Finding someone you trust to share how you feel, be it your partner, family, friends, or a therapist or counsellor, can be helpful. You may also find it beneficial to talk to others who have experienced a pregnancy loss and became pregnant again. Additionally, the resources on the next page may be of help.

More information and support

In addition to services available within your hospital, which you can discuss with your healthcare providers, the following may be helpful sources of information and support:

Pregnancy and Infant Loss Ireland a directory of support services and knowledge for both people who experience pregnancy loss and healthcare professionals.

- pregnancyandinfantloss.ie

Cork Miscarriage Website a resource for anyone who needs information and support around early miscarriage, from pregnancy to pregnancy after miscarriage.

- corkmiscarriage.com

Miscarriage Association of Ireland provide support, help, and information to women and men who experience miscarriage.

- miscarriage.ie

National Women and Infants Health Programme, Health Service Executive and **Institute of Obstetricians and Gynaecologists of the Royal College of Physicians of Ireland** produce clinical practice guidelines to guide clinician and patient decision-making, with the aim of improving care quality and patient outcomes.

- hse.ie/eng/about/who/acute-hospitals-division/woman-infants/clinical-guidelines/
- rcpi.ie/Faculties-Institutes/Institute-of-Obstetricians-and-Gynaecologists/National-Clinical-Guidelines-in-Obstetrics-and-Gynaecology

Getting involved in research on pregnancy loss:
This booklet was developed with the input of knowledge users, including people with lived experience of recurrent miscarriage, and healthcare professionals. To get information on the research conducted by the Pregnancy Loss Research Group, including how you might get involved in the research, go to:

- ucc.ie/pregnancyloss.

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Pregnancy Loss
Research Group

National
Women & Infants
Health Programme