# Managing your miscarriage

A miscarriage is almost always a sad event. We are aware that this could be a difficult time for you, and therefore acknowledge your loss and whatever that may mean for you and your family.

A miscarriage is a pregnancy that has ended spontaneously before 20 weeks and may have occurred unnoticed or some bleeding and abdominal discomfort may have happened.

## Are all miscarriages the same?

Some women have their miscarriage diagnosed on a routine scan and they have had very little or no bleeding or pain. This is called an early pregnancy loss. Other names for this are missed miscarriage, non-viable pregnancy or blighted ovum.

Some women seek medical attention because of bleeding and/or pain in pregnancy. Some may have already passed some pregnancy tissue. If this happens it is called an incomplete miscarriage.

A complete miscarriage is when all the pregnancy tissue has been passed. In this situation no further treatment is necessary.

## What happens after a miscarriage is confirmed?

Unfortunately, nothing can be done to save the pregnancy. It will either be lost naturally through the vagina, or will need some intervention to help the emptying process of the uterus.

# Treatment options

Treatment options for miscarriage can be conservative, medical or surgical.

## Conservative, also known as Expectant Management

A 'Wait & See" approach. In an early pregnancy loss, if the pregnancy tissue were left, we would expect the uterus to empty itself naturally within a few weeks. However, it is hard to say when exactly this will happen. Up to two-thirds (2/3) of women have an empty uterus by the end of 4 weeks, but the other one third (1/3) will need medical intervention (1).

If you choose this option, your pregnancy hormone (BHCG) will be monitored weekly and a scan arranged for two weeks' time if needed. You can call the clinic to change your option at any time.

## Medical Management

This treatment option would involve using medications called Mifepristone & Misoprostol (MifeMiso), which is given to help the natural passing of the pregnancy tissue (4).

Mifepristone (Mifegyne) can be used for induction of labour. It blocks the action of progesterone. This hormone makes the lining of the uterus (womb) keep the pregnancy. It will prepare the uterus for delivery by causing the lining to break down.

Misoprostol is a medicine in the same group as prostaglandin, which is used to induce labour. It is licensed world-wide as a medication used in the treatment of stomach complaints. Misoprostol has, however, been widely used in gynaecology for several years as it causes the cervix (neck of the uterus) to soften, and the uterus to contract.

The most common side effects of Misoprostol are moderate to severe abdominal pain and heavy vaginal bleeding. Less commonly, women may experience diarrhoea or nausea, and very rarely vomiting.

**Day 1**: Medication will be provided by the EPAU Nurse. The Mifepristone is given orally in EPAU on Day 1. Alternatively, you may take this to have at home at a time that suits you and your support person.

**Day 2:** On Day 2, you will take the Misoprostol at home - no earlier than 24 hours after the Mifepristone. Misoprostol reduces the risk of side effects when taken buccaly (dissolved in the cheeks/mouth) and acts more quickly on the cervix and uterus. You need to have a support person with you at home on this day.

**Day 3:** You will receive a call from the nurse. They will ask about your bleeding and pain after taking Misoprostol. A follow-up dose may be needed the next day and a blood test will be arranged for one week later.

## What can I expect if I choose Conservative or Medical Management?

### Bleeding

When the miscarriage is about to happen, you can expect very heavy bleeding for a short time. It will last at least a couple of hours, with some pregnancy tissue and clots being passed. This should settle to moderate bleeding within a few hours, similar to the heaviest day of your monthly menstrual period. After that you should expect light bleeding which should slowly settle over several days. The amount of time before the bleeding stops varies from person to person.

The total amount of blood lost during expectant or medical management of a miscarriage is the same as if you had a surgical evacuation (D&C). With a D&C, most of the blood is lost during the surgery, and therefore settles down more quickly. Without surgery the bleeding is more spread out, lasting longer.

Sometimes you may see the foetus in the pregnancy tissue that is passed. Some women find this upsetting and others find it helpful to see what has happened. We will provide you with a small container for the pregnancy tissue so that you

can bring it into the hospital (within three days) so that it can be sent to the laboratory if you wish. The laboratory will confirm whether it is pregnancy tissue.

## Pain

The emptying process of the uterus can be painful, but the pain should only last for a few hours. We advise you to take tablets for pain relief such as Paracetamol, Ibuprofen or other prescription pain relief. We will provide you with a prescription for these medications. Heat packs are also very helpful as a pain relief method.

# How to take care of yourself

- Stay at home (or the equivalent of ‘home’) while you are miscarrying.
- Let someone at home, or close to home, know what is happening to you and that you may need some help.
- Take regular pain relief as prescribed
- Use sanitary towels or pads, NOT tampons
- Have showers NOT baths
- Ring the hospital for help if you feel concerned or out of control of your pain or bleeding. (307 4949 x25900)

## Do go to hospital Emergency Department if you have:

- Heavy bleeding that is not settling down (i.e. you are soaking your pad half-hourly and have done for the past 2 to 3 hours)
- Pain that isn’t relieved by regular pain relief
- Hot & cold “flu like” symptoms
- A fever (high temperature)

## For as long as you are bleeding:

- Don’t go swimming in swimming pools, the sea or spa pools
- Don’t have intercourse or put anything into your vagina
- Don’t use tampons – just use pads

There are some situations when it is not advisable to use expectant or medical management of miscarriage.

### In the following situations, surgical evacuation is the best option:

- Very heavy bleeding with low blood pressure or low blood count
- Signs of infection
- Molar pregnancy – your doctor or nurse can explain this more fully.
- Intra Uterine Contraceptive Device (IUCD) in the uterus
- Recurrent miscarriage (3 or more)
- History of severe illness
- If the pregnancy is more than 12 weeks in size, it is recommended to have a D&C.

## Surgical Management

Having an operation following a miscarriage (called either a D&C or an Evacuation) is a relatively safe procedure, but there is still a small risk of complications such as anaesthetic-related problems or damage to the uterus and internal organs. These will be discussed with you further. Recent studies have shown chances of having a complication has decreased greatly (1).

Some women prefer the pregnancy tissue to be removed rather than wait for it to be expelled naturally.

If you choose this option, you will need to complete paperwork and return for your surgical appointment which can usually be booked within one week.

## What to expect after a miscarriage

It is normal to bleed for 1-2 weeks following a miscarriage. Some women can also continue with light spotting for longer than this.

Please allow at least 10 days or until the bleeding has stopped before having intercourse again.

Expect your next period in 4—8 weeks after the miscarriage. It is common for this period to be heavier than usual.

Please wait until after your first or second period before trying to conceive again.

If you experience heavy bleeding (soaking 2 pads in 1 hour), pain that is unrelieved by basic analgesia (paracetamol and ibuprofen), light headedness/dizziness or you feel unsafe and overwhelmed, please go to your local hospitals emergency department or call 111.

# Care of your pregnancy tissue

It is *tikanga*- customary practice in Aotearoa New Zealand, that pregnancy tissue is buried in a significant place. In doing so, this reinforces the relationship between *Ira Tangata* -tissue of human origin and the land.

This is a very personal decision. You may choose to test your pregnancy tissue- *Ira tangata.* We are here to support you if you wish to test. It is your choice to choose to test your pregnancy tissue- *Ira tangata* or not.

Testing will confirm you have passed pregnancy tissue. It can identify gestational Trophoblastic disease (molar pregnancy).

If you have chosen surgery to manage your miscarriage, your pregnancy tissue – *Ira tangata*, will be sent for testing. Please let the staff know if you do not want the testing to proceed and if you wish to have your pregnancy tissue – *Ira tangata*, returned to you.

You may wish to bury it. If you do not have access to private land, some *whanau* select a special pot plant to use.

We cremate all tissue left at the hospital, and the ashes are placed at the Mangere Gardens Cemetery. We are happy to provide you with a map. If you wish to arrange private cremation, we can provide a form to assist in this process.

Please ask us any questions and we will do our best to help.

# Kupu hou- new words

*Whakatahe* – Pregnancy Tissue

*Ira Tangata* – of human origin

*Tikanga* – to act in accordance with tikanga is to behave in a way that is culturally proper or appropriate

*Whanau* - family

# Contact

## Early Pregnancy Assessment Unit (EPAU)

If you have any questions, concerns or problems please contact the EPAU.

09 307 4949 ext. 27230 or 021 537 795

7.30am – 3 30pm, Monday to Friday

## Afterhours: Women's Assessment Unit (WAU)

If you are phoning outside of these hours, please ring WAU at Auckland City Hospital, and ask to speak to the Gynecology nurse.

Phone 307 4949 ext. 25900.

# References

1) Luise et al "Outcome of expectant management of spontaneous first trimester miscarriage: observational study"; British Medical Journal 13 April 2002 pp 873 - 875

2) Nielsen and Hahlin "Expectant management of first-trimester spontaneous abortion"; Lancet 1995; 345: 84 – 86

3) Chung et al "Spontaneous abortion: a randomized, controlled trial comparing surgical management with conservative management using misoprostol"; Fertility and Sterility 1999; 71: 1054 – 9

4) Murchison A and Duff P "Misoprostol for uterine evacuation in patients with early pregnancy failures" Am. J. Obstet.Gynaecol. 2004:190:1445-6

Te Whatu Ora
Health New Zealand
Te Toka Tumai Auckland

Classification number: WH137 (Reviewed: July 2024)