MISCARRIAGE INFORMATION

One in two fertilised eggs will miscarry and most of the time you will be unaware of this. Approximately one in five pregnancies end in early miscarriage which is recognisable by bleeding, pain or a non viable pregnancy seen on ultrasound scanning. In other words, miscarriage is a common event. By far the most common reason for miscarriage is a problem with the actual pregnancy itself. This could take the form of a chromosomal abnormality, embryo malformation or even absence of a developing embryo itself. In fact, very few babies are born with severe abnormalities (less than one or two percent). In a sense, one can view miscarriage as "nature's way" of only allowing normal pregnancies to proceed to term. It is important to realise that this does not mean that you are more likely to have a baby with a chromosomal abnormality or severe malformation next time.

Essentially there are two main ways of managing a miscarriage. The first is to allow nature to take its course i.e. no operation. This may be suitable for you if the pregnancy is very early and bleeding or pain are either not present or very mild. However, once the pregnancy is relatively advanced and especially if there is pain or bleeding, then an operation may well be appropriate. The operation is performed under a general anaesthetic. The name of the operation is a "D&C" i.e. dilatation of the cervix (neck of womb) and curettage of the uterus (womb). The cervix is gently dilated and then a suction scraping device is used to remove any remaining pregnancy material. The procedure itself takes about five minutes. I will generally send the pregnancy material off for general pathology analysis. In addition, I usually send the material for chromosomal analysis. The whole procedure is usually performed as a day case and discharge is usually two hours after the operation.

One other option in early pregnancy is vaginal medication so as to induce a miscarriage medically. This results in miscarriage at home and requires follow up and repeat ultrasound scanning. This maybe indicated if you are at high risk for surgery.

As with any operation there is always a small risk of complications. The combined risk of the complications below is about one percent. In other words these complications are rare.

The risks are:

1. Infection requiring antibiotics or surgical drainage.

2. Bleeding requiring iron tablets or a blood transfusion.

3. Residual products left behind often requiring a "re-do" D&C.

4. Very occasionally a perforation or hole may be made in the top of your womb. This mostly requires only antibiotic treatment but occasionally may require an additional operation if there is a suspicion of other damage. This may involve either "key-hole" surgery or a formal incision in the abdomen.

5. Scarring of the womb leading to problems with fertility (Asherman's syndrome) is also a very rare outcome.

It must be stressed that many of these outcomes are extremely rare. These risks need to be weighed up against the alternative of not having a "D&C". Not having a "D&C" may be associated with incomplete emptying of the uterus, bleeding, infection and also problems with fertility.

One other form of treatment involves vaginal misoprostol tablets to medically induce the miscarriage. It has an 80% success rate in early pregnancy. If you prefer medical treatment I would refer you to KEMH as this treatment requires close medical supervision over days or occasionally weeks.

From a medical point of view, there is no reason why you can't start trying to become pregnant again soon. Some women will prefer to have a "break". If you have had a "D&C", you should wait for two periods. This shows that there have been no problems from the surgery and also is associated with a lower subsequent miscarriage rate.

In addition, some women will experience a severe grief reaction from an early pregnancy loss. It is important that if this happens to you that you seek appropriate counselling from others such as health professionals eg Raphael Centre or myself.

If you have a "D&C" I will generally see you again at the six week mark to go over many of the above issues and also review the pathology results.

DR ADAM GUBBAY (Reviewed May 2014)