

Early miscarriage: information for you



Royal College of
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What is early miscarriage?

Early miscarriage is when a woman loses her pregnancy in the first three months and may be accompanied by vaginal bleeding and pain (see RCOG Patient Information [Bleeding and pain in early pregnancy: information for you](#)).

Many early miscarriages occur before a woman has missed her first period or before her pregnancy has been confirmed. Once you have had a positive pregnancy test, there is around a one in five (20%) risk of having a miscarriage in the first three months. Most miscarriages occur as a 'one-off' (sporadic) event and there is a good chance of having a successful pregnancy in the future.

Why does early miscarriage occur?

Much is still unknown about why early miscarriages occur. The most common cause is chromosome problems. Chromosomes are tiny thread-like structures found in all the cells of the body. In order to grow and develop normally a baby needs a precise number of chromosomes. If there are too few or too many chromosomes, the pregnancy may end in a miscarriage.

What is the risk of having a miscarriage?

The risk of miscarriage is increased by:

- a woman's age - the risk of early miscarriage increases with age. At the age of 30, the risk of miscarriage is one in five (20%). At the age of 42, the risk of miscarriage is one in two (50%).
- health problems - as an example, poorly controlled diabetes can increase the risk of an early miscarriage.
- lifestyle factors - smoking and heavy drinking are linked with miscarriage.

There is no scientific evidence to show that stress causes a miscarriage.

Sex during pregnancy is not harmful and is not associated with early miscarriage.

There is no treatment to prevent a miscarriage.

What happens if it is a miscarriage?

If the miscarriage has completed, you will not need any further treatment.

If the miscarriage has not completed, there is a range of options available.

What are my choices?

You may choose to have an operation, or you may prefer to let nature take its course or take tablets to start the process.

Letting nature take its course (expectant management)

Expectant management is successful in 50 out of 100 women (50%). It can take time before bleeding starts and it is normal for the bleeding to continue for up to three weeks. Bleeding may be heavier than normal and you may experience cramping pain. Very occasionally emergency admission for heavy bleeding or severe pain is necessary. If bleeding does not start or the miscarriage has not completed, you will be offered the option of taking tablets or having an operation.

Taking tablets (medical treatment)

You will either be given tablets to swallow or pessaries to insert into the vagina, which allows the entrance of the womb (cervix) to open and pass the pregnancy. This usually takes a few hours and there is some pain with bleeding or clotting (like a heavy period). You can take pain-relieving drugs. After the treatment you may bleed for up to three weeks. If treatment does not work, or the miscarriage has not completed, you will be given the option of having an operation.

Medical treatment is successful in 85 out of 100 women (85%) and avoids a general anaesthetic. You will often only need to be in hospital for a few hours and can then go home. However, there is a risk of heavy bleeding and the need for an emergency admission to hospital. Whether this is an option for you will depend on your hospital.

Having an operation (surgical treatment)

The operation is usually carried out under general anaesthetic, but it can also be carried out under local anaesthetic. Surgery is usually arranged as a planned operation, usually within a few days. Surgical treatment is successful in 95 out of 100 women (95%).

You may be advised to have surgery immediately if:

- you are bleeding heavily and continuously
- the miscarriage is infected
- expectant or medical management are unsuccessful.

The cervix is gently opened and the pregnancy tissue removed by use of a suction device. You may be given tablets to swallow or vaginal pessaries before the operation to soften the cervix and make the operation easier and safer. This operation is called an evacuation (emptying) of the womb (uterus). You may hear this described as 'evacuation of retained products of conception' (ERPC). This operation is similar to a D&C (dilatation and curettage).

The operation (evacuation) is safe, but there is a small risk of complications. These complications do not happen very often. They can include heavy bleeding (haemorrhage), infection, a repeat operation if not all the pregnancy tissue is removed and, less commonly, perforation (tear) of the womb that may need repair.

The risk of infection is the same if you choose medical or surgical treatment.

When should I phone for help?

You should be given a 24-hour telephone number to use if you:

- are worried about the amount of bleeding
- are worried about the amount of pain you are in and the pain-relieving drugs are not helping
- have a smelly vaginal discharge
- get shivers or flu-like symptoms
- are feeling faint
- have pain in your shoulders.

Are there any tests?

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

You may miscarry at home. In this situation, some women choose to bring any tissue to the hospital so that it can be analysed.

Further tests are not routine unless you have had three miscarriages in a row (see RCOG Patient Information [Couples with recurrent miscarriage: what the RCOG guideline means for you](#)).

I would like to have a memorial

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

What happens next?

To reduce the chance of infection, sanitary towels are advised rather than tampons until the bleeding has stopped. You may also be advised to wait until you have stopped bleeding before you have sex.

When you leave hospital, a letter (known as a discharge letter) with details of your treatment will be sent to your general practitioner. You can ask for a copy of this letter.

Your next period will be in four to six weeks time. Ovulation occurs before this, so you are fertile in the first month after a miscarriage. If you do not want to become pregnant, you should use contraception.

Making sense of what has happened can take time. You and your partner should be offered a follow-up appointment with a member of the healthcare team. Many couples find talking helps and you may be given information about other sources of support and counselling.

When can I return to work?

This will vary for each woman. You should be able to go back to work after a week or so. It can take longer than this to come to terms with your loss.

When can we try for another baby?

The best time to try again is when you and your partner feel physically and emotionally ready.

How will I feel?

Losing a pregnancy is a deeply personal experience that affects everyone differently. It can affect the woman, her partner and others in the family.

Many women grieve, but come to terms with their loss. Other women feel overwhelmed and find it difficult to cope. Physical symptoms such as fatigue, loss of appetite, difficulty concentrating and trouble sleeping can be signs of emotional distress. Some women feel fine initially and only later do they experience difficulties. Many men feel similar distress.

Many women experience a profound sense of loss and disappointment. They describe a feeling of numbness and emptiness. Many women grieve as they would do for a close friend or relative. They experience feelings of shock and sadness and anger and can find it difficult to accept their loss. Other women experience a sense of relief. These emotions are common and will pass with time and good support.

Other women experience feelings of guilt, blaming themselves for what they did or did not do. Some women find it hard to move on without knowing the exact cause of their miscarriage. Others are consoled by the fact that their miscarriage was a chance event and once the process had started, nothing could have been done to prevent it.

Some women want to talk about their experience. Others find this too painful.

You should be given all the time you need to grieve. Talking about how you feel with your healthcare professional can help. If you feel you need further assistance in coming to terms with your miscarriage, ask for a referral for support or counselling.

Is there anything else I should know?

- There are over 200 Early Pregnancy Assessment Units (EPAUs) across the UK. Details of the unit nearest to you can be found at: www.earlypregnancy.org.uk/FindUs1.asp
- If you are planning a pregnancy, you should have 400 micrograms daily of folic acid when you first start trying until 12 weeks of pregnancy. This reduces the risk of your baby being born with a neural tube defect (spina bifida).
- For information about recurrent miscarriage (which means three early pregnancy losses in a row) see RCOG Patient Information [Couples with recurrent miscarriage: what the RCOG guideline means for you](#).
- You should get as healthy as you can before as well as during your next pregnancy. You should eat a healthy balanced diet, and not smoke.
- It is advisable to stay within the maximum recommended units of alcohol (see RCOG Patient Information [Alcohol and pregnancy: information for you](#)) and take regular exercise (see RCOG Patient Information [Recreational Exercise and Pregnancy: information for you](#)).