Current issues in management of miscarriage and early pregnancy bleeding

Miscarriage is the most common complication of pregnancy. Up to 50% of all conceptions fail (Kline et al, 1989), most before the woman is aware that she is pregnant, and between 13% (Saraiya et al, 1999) and 22% (French and Bierman, 1962) of known pregnancies miscarry. Despite this frequency of incidence, miscarriage remains poorly managed and understood by many health-care professionals and women alike.

The presenting signs and symptoms of pain and bleeding are well known but do not provide the complete picture. Bleeding in the first trimester is common, occurring in up to 30% of all pregnancies (Walker and Shillito, 1997). With the increasing use of home pregnancy testing kits, more women are aware that they are pregnant early in gestation when bleeding is more common. This increases the number of women who present with early bleeding and look for reassurance even though most of these pregnancies are viable. This has produced a new demand on pregnancy services.

EARLY PREGNANCY UNITS

Early pregnancy units (EPU) evolved as an efficient way of organizing the services required to manage early pregnancy complications (Bigrigg and Read, 1991). Initially, they were designed as 'fast tracking' diagnostic and evacuation services for those with miscarriage, but more recently they have developed into full early pregnancy care facilities (Walker and Shillito, 1997). Patients will be seen during normal working hours by dedicated staff who have access to ultrasound examination and serum testing as required. This is an efficient use of resources (Wren and Craven, 1999), reducing the demands made on the acute gynaecology team and the need for inpatient beds. It also appears attractive to patients, providing information and reassurance to those using the clinics (Bradley and Hamilton-Fairley, 1998).

Ultrasound has revolutionized the management of early pregnancy bleeding and virtually removed the term 'threatened' miscarriage from use. In a woman with no other complications, if a viable intrauterine pregnancy is confirmed by ultrasound, the 'take home baby rate' is over 95%. There is no need to admit or confine the woman to bed, although bleeding may continue for a few days.

In those pregnancies in which a miscarriage or ectopic pregnancy is confirmed, the patient can now be offered more than one management opportunity. Surgery is not the only option. Both medical (El-Rafaey el al, 1992) and conservative management (Nielsen et al, 1996) are available after appropriate discussion. Both of these require a high level of counselling, understanding and support. All this care and management can be offered safely within the EPU. This provides continuity – the patient sees the same person during diagnosis, which might take several days if a repeat ultrasound or β-human chorionic gonadotrophin tracking is required, counselling of management options and the treatment itself.

EPUs can take on a day-care role for the management of miscarriage and ectopic pregnancy with the administration of drugs and the support of the women electing for medical management and for the perioperative care of women electing for surgery. When the clinical picture falls outside the guidance of the protocol, senior medical staff with an interest in early pregnancy complications are then involved.

Emergency surgery is only necessary in cases of cardiovascular compromise, so most women opting for surgery can be offered this on day-care lists. This reduces disruption to the woman and her family and removes the need for inpatient admission and then a wait for a space on the acute list. It allows surgery to be carried out within working hours and increases training opportunities for juniors, particularly in the laparoscopic management of extrauterine pregnancy.

Once an EPU has been set up, referral numbers increase dramatically over time. The majority of women who attend do not have a medically significant pregnancy problem, so who should be the gatekeeper to this service? Should GPs screen out those who do not require these services and refer only those who have complications? Or, is it better to accept that the first trimester can be complicated by the woman's anxiety as well as bleeding or pain?

The philosophy of many units is to provide a relative open door to make sure that all those that require support are seen. Woman who self-refer can be screened on the telephone to reduce demands on GP's time and to minimize delays for women with potentially life-threatening complications, e.g. ectopic pregnancy. This needs to be matched against the greater demands on those providing the ultrasound service. If this is provided by another department, conflict can occur if the philosophies of care differ. This means that appropriate guidelines and training must be in place for all staff involved.

INFORMING WOMEN

Along with improving access to the services for women, there should be an increase in the access to information. Women need to know what to expect in early pregnancy, what is normal and abnormal and also how to seek help when they are concerned. Vaginal bleeding in the first trimester can be a frightening experience, even if a viable

pregnancy is subsequently found. If she has carried out a pregnancy test, she knows that she is pregnant and is frightened that she will lose her baby. If women can self-refer to EPUs, they will receive immediate advice and support as well as access to clinical and ultrasound assessment. Information about EPUs should be available in the community, and all pregnant women should have access to the facilities if required.

There are many instances where staff discover social complications. In some cases, the woman may not wish to continue with the pregnancy. This can be very difficult for EPU staff, who work closely with wanted pregnancies that fail. However, these women need empathy and access to the appropriate counselling – usually outwith the EPU itself. There is increasing awareness of the problems of domestic violence in all areas of women's health. Presentation to a pregnancy care service is a common refuge for women seeking help. There should be information leaflets available and access to the appropriate counselling and support for all women suspected of being a victim of this.

Management of the complications of early pregnancy does not end with the removal of a non-viable pregnancy. Women's emotional needs need to be met as well (Turner et al, 1991). Many women will have concerns about the disposal of the products of conception. It is important to discuss clearly what a miscarriage is and the fact that there may be little tissue passed if any. In early miscarriage, it is unlikely that any recognizable fetal tissue will be seen. As much information that is available about the cause of the miscarriage as possible should be given to the woman, and it is important that she knows that the full reasons are usually never known.

A full explanation of what may have occurred and what support is available in a subsequent pregnancy helps a woman come to terms with her loss and prepare for the future, although this can take a varying amount of time. It is important to make sure that she does not blame herself in any way. It is rare for any action or inaction by the woman herself to influence the outcome.

Care also should be taken over the terms used. Abortion, although medically correct, is no longer acceptable to women as they associate it with termination of pregnancy. Miscarriage should be used instead. Similarly 'blighted ovum', as well as being a medical misnomer, is unpleasant, and the term early pregnancy loss is more acceptable and medically more accurate.

Most women will recover quite quickly from an early pregnancy loss, and the support they need can be adequately provided by the EPU staff they already know, their GP and family and friends. Support for their partners should not be forgotten. Some women will need much more support, especially those who have had more than one loss or experienced an ectopic pregnancy. While such women can be referred to external agencies, e.g. the Miscarriage Association and the Ectopic Pregnancy Trust, some will need more formal counselling, and EPUs should have access to such services. Many units have specialized recurrent miscarriage clinics.

CONCLUSIONS

It is no longer enough simply to diagnose early pregnancy failure. EPUs must provide a far wider range of services for both those women with ongoing pregnancies and those who miscarry. This requires a change of attitude that early pregnancy problems are not a minor gynaecological inconvenience but a large specialist role which, if done well, can have a huge impact on a large number of women and their families. HM

Judith Moore/T Jayne Shillito/James J Walker
Locum Lecturer/Lecturer/Professor
Academic Unit of Paediatrics, Obstetrics and Gynaecology
St James University Hospital
Leeds LS9 7TF

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KEY POINTS

- Around 30% of women experience bleeding in the first trimester.
- The majority of women that present with early pregnancy bleeding have viable pregnancies.
- An ultrasound scan is the definitive investigation.
- If a miscarriage is diagnosed, there are various treatment options available.
- There is a significant psychological effect following miscarriage that often carries forward into the subsequent pregnancy.