Recurrent miscarriages

You are directed to this leaflet by your doctor is because you either suffered from recurrent miscarriages or want more information on it.

If you are suffering from recurrent miscarriages, we are sorry to hear that you have had a recurrent pregnancy loss. As a result of your history, we are now suggesting that we do some additional investigations to see if there is an underlying reason for the miscarriages you have suffered. It is important to realise that in most cases, there is often no underlying cause found and the outlook is still very good.

This information is for couples who have had three or more miscarriages in a row. It is based on the Royal College of Obstetrics and Gynaecology guidelines (RCOG) 'The management of recurrent miscarriage.'

Why me?

Unfortunately, miscarriage is very common. Around one in five pregnancies end this way. Often, in spite of careful investigations, the reason for your miscarriages cannot be found. However, if you and your partner keep trying, you still have a good chance of a successful birth in the future.

There are a number of factors which may play a part in recurrent miscarriages, it is complicated and more research is needed.

Your age and past pregnancies

The older you are, the greater the risk of miscarriage. For example, a woman aged 25 with a history of 3 previous miscarriages (and normal investigations) has over an 85% chance of a successful pregnancy next time. By comparison, a 40-year-old woman with the same history and results has a 65% chance of a successful pregnancy. However, the outlook in both cases is still very good.

Genetic factors

For around 3-5 in every 100 women who have recurrent miscarriage, they or their partner have an abnormality on one of their chromosomes. If appropriate, we can analyse your pregnancy tissue for chromosome abnormalities (further information later in this leaflet). Genetic abnormalities can lead to a higher rate of pregnancy loss, but even when these abnormalities are present you can still achieve a successful pregnancy.

Autoimmune factors

Around 15 in every 100 women who have recurrent miscarriage have particular antibodies called anticardiolipin antibodies. These antibodies relate to a condition called antiphospholipid or Hughes syndrome. If untreated, this can lead to miscarriage in 8-9 times of out of ten. With treatment, the risk of miscarriage drops down to the same as the rest of the population.

Blood clotting conditions

Some women carry abnormalities in the way their blood clots. This leads to them form blood clots more easily than unaffected women. These conditions called thrombophilia are more commonly found in women who have recurrent miscarriage. Although the evidence behind treatment is not strong, we are currently suggesting that women who are known to have one or more of these conditions take treatment throughout their pregnancy to try and improve the chances of a live birth.

There are a range of other conditions that have been associated with recurrent miscarriage, many of these have not been proven and in most cases more research is needed to understand this further. As a result, we only investigate and treat conditions where we feel there is a real benefit to you.

What will happen now?

When you are seen in the clinic, we will go through your history, investigations so far and perform a transvaginal scan to check the pelvic organs and then decide the management and future care with you.

We would suggest performing a series of investigations, including blood tests over the coming weeks.

It can take up to eight weeks to get a result and about half of all the tests don't give clear answers.
Once we have the results of these blood tests, we will then invite you to come and discuss what happens next with Mr Borase (or the consultant you had been referred to), who is a specialist in looking after couples with recurrent miscarriage.

In the meantime, if you are pregnant, please ring the Early Pregnancy Unit for an early scan around 6 – 7 weeks. Following that, we will also offer you another scan at 10 -11 weeks before your dating scan.

If you experience any bleeding in your subsequent pregnancy, we would advise you to contact the EPU or the gynaecology ward. You are unlikely to have another recurrent miscarriage (only 28% of couples do). However, if you have vaginal bleeding and a pregnancy has been confirmed on scan, we can give a vaginal progesterone hormonal pessary to insert in your vagina to prevent a miscarriage from happening. This treatment can only be used before 16 weeks of pregnancy if you have had one or more previous miscarriages.

What investigations are needed?

1. **Abnormal chromosomes.**

We will aim to perform genetic tests (karyotype) on the tissue from your miscarriage. This is to check for underlying genetic problems. In general, we find that pregnancy loss is due to an underlying genetic problem with the pregnancy, but most of the time this is not an abnormality that will recur. What we are looking for when we send this tissue off for analysis is the presence of a specific type of abnormality that may happen each time you are pregnant. If tests on the miscarriage tissue show chromosomal abnormalities, that usually means that this is a 'one-off' problem and you have a good chance that you will have a healthy pregnancy next time.

2. **Antiphospholipid syndrome (APS).**

Patients with this condition make abnormal antibodies that attack fats called phospholipids in their blood. This makes the blood more 'sticky' and likely to clot, which is why APS is sometimes called 'sticky blood syndrome'. APS is a treatable cause of recurrent miscarriage. We screen women for antiphospholipid syndrome with a blood test. However, this cannot be done until six weeks after the pregnancy loss, and if the first test is positive, then it needs repeating again after a further six weeks. Both tests need to be positive to give a diagnosis.

3. **Other blood clotting problems.**

Some inherited blood clotting disorders can cause recurrent miscarriage, particularly after 14 weeks. These include factor V Leiden, factor II (prothrombin) gene mutation and protein S deficiency.

4. **Cervical weakness** (also known as 'incompetent cervix')

Some women – probably less than 1 in a 100 – have a weakness in the cervix that allows it to dilate too early. This is a known cause of late (second trimester) miscarriage. If we think this could be cause, you will be referred to the Preterm clinic when you are pregnant the next time.

5. **Other blood tests**

There are other blood tests looking at the hormonal levels that can sometimes cause miscarriages. These are done if you are symptomatic. Therefore, your doctor will ask a few questions about your general health before deciding if it is important to perform them.

How to collect your pregnancy tissue

The pregnancy tissue will be sent if it is your 3rd miscarriage or more.

If you are having surgical management of your miscarriage then we will send your pregnancy tissue for chromosome analysis. If you choose to have medical or conservative management then please speak to the early pregnancy nurse who will discuss with you in further detail what to do next. This system can occasionally fail to produce useful results and in these situations, we may suggest some alternative blood tests on you and your partner.

If you chose medical or conservative management then we need to ensure that the laboratory receives your pregnancy tissue as soon as possible so you should bring your pregnancy tissue to the gynaecology ward within 24 hours of your miscarriage. You will be asked to collect your tissue in a clean container which then needs to be kept in the fridge until you bring it up to the ward. (Further information will be given to you by the Early Pregnancy Unit nurse).

Are there other tests I need?

You may have read about a number of other tests that you feel may be relevant, but we focus on the most important factors and any other tests that may become necessary will be discussed with you when you are seen in clinic.

We are keen to give you as much information as possible at this difficult time but the implications and actual results of your tests will be discussed with you in person at your appointment. Women who have supportive care from the beginning of a pregnancy have a better chance of a successful birth, there is some evidence that attending an early pregnancy clinic for reassurance scans can reduce the risk of further miscarriage.

Hence, even if we do not find an underlying cause for your miscarriages, we will offer you reassurance scans from six weeks. These are normally offered twice leading up to your routine scan at twelve weeks of pregnancy.

However, if at any point between your scans, you feel the need to be seen in the Early Pregnancy Unit (pain, bleeding, feeling unwell, or just for reassurance), please do not hesitate to contact us.

More information

We are working on provision of the counselling for the NHS patients but it might take a while so we would recommend that if you need a counsellor, you can find one and get in touch with them directly

The Miscarriage Association

The Miscarriage Association provides support and information to anyone affected by miscarriage, ectopic pregnancy and molar pregnancy. Their contact details are: www.miscarriageassociation.org.uk

If you have bleeding and /or pain you can get medical help and advice from:

- Your GP or midwife who may advise you to go to hospital
- Watford General Hospital EPAU can be contacted on 01923 217831
- NHS CHOICES 111 when you need medical help fast but it's not a 999 emergency. The service is available 24 hours a day, 365 days a year. Calls are free from landlines and mobile phones.
- Royal College of Obstetricians and Gynaecologists: **www.rcog.co.uk**
- National Institute for Heath and Clinical Excellence, Clinical Guidelines: Nice Pathways **www.nice.org.uk**

Special thanks to Ms Bee Chen from Barnsley Hospital, Barnsley for her help in designing the leaflet

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