Miscarriage….What are my options?

Miscarriage occurs in about 15-20% of all pregnancies. The cause will probably never be known. Often, this is nature's way of ending a pregnancy in which the embryo was not growing normally and could not survive. Do not blame yourself for the pregnancy loss. It is not likely that it could have been prevented, and does not mean anything is wrong with you. We realize this is a very difficult time, and offer our sympathy as well as health information. We confirm a non-viable pregnancy by either or both: ultrasound showing no heart rate and no normal growth and/or, Beta HCG levels that fall, or do not rise normally. Once it is known that the pregnancy is not viable, there are several options.

Option 1: Expectant Management.(Do nothing and wait). Most pregnancies under 8 weeks gestation will miscarry spontaneously within one month of diagnosis. In an early pregnancy, it should involve bleeding like a very heavy menses, with some cramping. Many midwife patients prefer this option because there are no medications or surgery involved. It is somewhat unpredictable, however, when or how much, bleeding will occur. During this time, the midwives would like to keep in close contact with you. We may order weekly for blood testing of your Beta HCG level to help monitor the trend toward completing the miscarriage. Please call us when you start to bleed or if you have any questions during this difficult time. After a significant bleeding episode has occurred, and tapered off, one more HCG level should be drawn. Then we recommend you begin taking weekly home pregnancy tests. Within 5 weeks of a miscarriage, a home pregnancy test should be negative and normal menses should return. If **both** of these do not occur, it is important to call the midwife office. At any time, you may change your mind and move on to options 2 or 3.

Option 2: Medical Management. We can prescribe a medication (Ctyotec/misoprostol) that will initiate a miscarriage. This method is most effective with pregnancies less than 8 weeks gestation. Some women prefer this method as they can control the timing of the event. Very occasionally it does not work completely and further intervention (such as D&C, see #3) could be needed. It is best to start in the early morning to be as rested as possible. Moisten 4- 200mcg pills of cytotec, with tap water and insert them high into the vagina. The medicine absorbs through the vaginal lining. 75% of women will begin cramping and bleeding (more than a normal period) within 6 hours. Heavier bleeding, often with clots, usually lasts 2-6 hours, until ultimately the contents of the uterus are expelled. Then cramping and bleeding should taper down. Do not take any NSAIDs (aspirin, aleve and ibuprofen) within 24 hours of using cytotec. You will be given a prescription for Tylenol #3 (with codeine) for pain. Some women will experience initial discomfort with the miscarriage and then again 2-3 days later when the lining of the uterus is shed. Light bleeding/spotting may persist up to 4 weeks. Please call us the following morning to let us know if you have completed your miscarriage. If you do not have results with the first dose, you may repeat the Cytotec dose again after 24 hours. Page the midwife on call if you have questions, or are bleeding more than a pad/hour x 2-3hours in a row, or have pain that is not controlled by the medication.

Option 3: Surgical Management. A D&C (dilation and curettage) procedure can be arranged with one of our physician colleagues. This is done in the hospital as a same-day, outpatient, procedure, using anesthesia or IV sedation. The cervix is dilated manually and the uterine contents are cleaned out using surgical instruments and suction. Risks are minimal, but may include bleeding, infection, and possible damage to any organs in the area of the operation. D&C is the most predictable and scheduled way to know that the miscarriage is completed. Pregnancies greater than over 8 weeks gestation are more likely to need a D and C, due to the amount of tissue in the uterus. The doctor meets with you beforehand to discuss the risks and benefits and to answer any questions. Most women require minimal pain medication, such as ibuprofen 600mg every 6 hours, for a day or so afterward. A follow up appointment 1-2 weeks post-procedure is generally scheduled.

Miscarriage Follow-up Instructions: Do not put anything (i.e. tampons, douching or intercourse) in the vagina for two weeks following the miscarriage to allow your body a chance to heal and to reduce risk of infection. You might ovulate as early as two weeks following the miscarriage, but we recommend waiting a few cycles before another pregnancy. If you do not wish to become pregnant again at this time, we can discuss birth control options with you.