key points

SELECTED BY

Dr Phillip Bland
Former GP, Dalton-in-Furness, UK

First trimester miscarriage is common affecting up to one in four pregnancies. While some women will experience bleeding and pain, others have no symptoms and are given the diagnosis at their 12-13 week booking scan. In 50-85% of cases the cause is due to a spontaneous chromosomal abnormality, most commonly trisomy.

Vaginal bleeding in early pregnancy is common, non-specific and does not always signify pregnancy loss. Nevertheless, it is the most common sign of miscarriage and therefore a cause for concern, more so when bleeding is heavier than a normal period, lasts for more than 24 hours and is accompanied by cramping abdominal pain. Clinical history and physical examination should be undertaken to rule out other causes of vaginal bleeding and to determine the urgency of referral.

NICE recommends expectant management in the primary care setting for women at less than six weeks' gestation who have painless bleeding and no risk factors for an ectopic pregnancy. Any pregnant woman with heavy vaginal bleeding and signs of shock such as pallor, tachycardia or hypotension should be transferred immediately to the nearest emergency department.

It is important to ascertain if an ultrasound has already been performed and an ectopic pregnancy has been excluded. If not, an urgent referral to an early pregnancy unit should be made. However, if the woman has significant pain, there is evidence of infection or the early pregnancy unit is closed, a referral to the gynaecology on call team should be considered.

Women should be offered a choice of expectant, medical or surgical management. NICE recommends expectant management for 7-14 days first line for all women, but also advises that other options should be explored for women with: an increased risk of haemorrhage or its effects; evidence of infection; a previous adverse and/or traumatic experience associated with pregnancy or expectant management is unacceptable to the woman. Medical management involves administration of misoprostol, as a single dose vaginally or sublingually. Women should be advised to seek medical attention if heavy bleeding persists, significant pain is not relieved with simple analgesia, or they feel unwell with dizziness, fever or have any other reasons for concern.

Many women suffer from psychological sequelae including PTSD, anxiety and depression following pregnancy loss. GPs should offer a follow-up appointment to all women who have had a miscarriage to: discuss any questions the woman has regarding her miscarriage; assess the woman's psychological wellbeing and offer counselling if appropriate; ensure that all Rhesus-negative women who have had a surgical procedure have received anti-D immunoglobulin. If the woman has had three or more miscarriages, a referral to the recurrent miscarriage clinic should be made.