key points

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Miscarriage is defined as a pregnancy failure occurring before the completion of 24 weeks of gestation. It has been estimated that 10 to 15% of all pregnancies end in early spontaneous first trimester miscarriage. Advancing maternal and paternal age is known to be associated with increasing chance of miscarriage. Environmental risk factors include being underweight or overweight, smoking and high alcohol consumption.

Vaginal bleeding can range from scanty pink discharge to active heavy blood loss with the passage of large clots. Unilateral pain with or without vaginal bleeding should raise suspicion of ectopic pregnancy. Pregnancy tissue passing through the cervix may cause a vasovagal response, referred to as cervical shock, which manifests as bradycardia and collapse. If intrauterine infection develops then initial presentation may be with lower abdominal pain, pyrexia and an offensive vaginal discharge. Prompt recognition, investigation and treatment are essential to prevent serious morbidity and mortality.

Traditional practice classified miscarriage according to the history and findings on speculum examination but transvaginal ultrasound scan should now be considered the standard test to assess viability of the pregnancy. Assessment of the amount of vaginal bleeding experienced is best made in the context of time taken to saturate a sanitary pad. Changing a pad soaked with blood and clots more than once an hour is an indication of heavy bleeding that requires immediate referral.

Following confirmation of a viable intrauterine pregnancy, symptoms may resolve. However, if the symptoms worsen, or persist beyond 14 days, a repeat referral should be made to the early pregnancy unit for further assessment. If a pregnancy is at 12 weeks' gestation or beyond and the woman is rhesus negative, she will require anti-D prophylaxis if there are symptoms of bleeding.

Expectant management is the first-line approach, and is encouraged for 7-14 days after diagnosis of miscarriage. Most women will miscarry spontaneously during this time and will need no further treatment. It is not appropriate if there are risk factors for haemorrhage, or if the woman is at increased risk from the effects of haemorrhage. Medical management of miscarriage can be offered using misoprostol. It is given vaginally or orally and will usually provoke the onset of miscarriage within 24 hours of its administration. Surgical management may be chosen by a woman if she has had a previous adverse or traumatic experience associated with pregnancy.