

Miscarriage

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Miscarriage

edited by
Roy G Farquharson



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Introduction

There are events in the womb of time as yet, undeliver'd.

William Shakespeare, *Othello*, i. iii. 369

Understanding miscarriage is as perplexing now, as it has been, since Malpas wrote his seminal paper in 1938 on 'A study of abortion sequences' from Liverpool Women's Hospital. There are many adverse events in the womb during pregnancy for which an explanation remains 'undelivered'. This lack of insight reflects our meagre understanding of normal early pregnancy development, let alone the occurrence of miscarriage, an event with untold consequences for individuals and couples alike.

The mystery of miscarriage continues to deepen when trying to explain to couples why all the maternal signals may be right yet an ultrasound scan shows a complete absence of a developing fetus when there have been no abnormal symptoms. The so-called afetal sac or embryo loss remains a virtually inexplicable paradox to the mother who rightly thinks that the absence of fetal development should automatically mean immediate miscarriage and expulsion of a non-viable process. This is one enigma among many that reveals more about the complexity of early pregnancy formation than explanation. The interaction between endometrial receptivity, genomic transmission and fetal development requires careful elucidation before any reasonable explanation can be formed about incomplete or incorrect processes that may cause miscarriage. A single over-arching and all encompassing explanation is no longer tenable.

Coping with miscarriage has been significantly improved by the supportive efforts of the Miscarriage Association who have done much to bring help to sufferers and spread the word of women's needs at a vulnerable time.

This book has been largely based on our experience at the Miscarriage Clinic. More importantly, it reflects the enormous influence that others have brought into this burgeoning area of frontline investigation and clinical need, that could be termed a Cinderella area for funded research. What started out as an enthusiastic group dealing with the commonest pregnancy complication has spread

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out over many areas to adopt a multidisciplinary approach, as well as overseas to colleagues with the same interest and focus. To pay adequate tribute to these friends and colleagues would be impossible. Their excellent contributions reflect the genuine interest and tremendous commitment that they have shown towards the appearance of this text.

Finally, this book may show evidence of repetition but this is strength of consensus in an area of controversy, rather than a weakness of content. All authors agree that if classification of pregnancy loss were adopted by clinicians world-wide then this book will have served good purpose.

Roy G Farquharson
Liverpool Women's Hospital
October, 2001

**Section I:
Women-centred approach**

I

Miscarriage and ectopic pregnancy: patients' experiences, professional help

Ruth Bender Atik

Miscarriage¹ is a common occurrence. It is estimated that one in four pregnancies ends in miscarriage (Smith, 1988), but from a clinical point of view it is generally regarded as a minor medical event. It is not usually life threatening and requires only brief medical or surgical intervention, if any. From the woman's perspective, and from that of her partner, it is rarely an insignificant event. At the very least it is a crisis, physically unpleasant and disruptive. For many, it is the loss of a much-wanted baby.

Women often perceive their miscarriage differently from the people around them. For example, comments made to women by family, friends and professionals include:

*It's nature's way
You're young — you can always have another one
At least it happened early on
It was only a bunch of cells
It wasn't really a baby yet
You should try to forget you were ever pregnant*

Women talking about their experience may say:

*To my husband and me it was a baby and it was going to be
our son or daughter
This was my first baby, I wanted it so badly
It seems like all my dreams and hopes have been shattered*

Despite improvements in medical care and an increase in public and media recognition of the misery which miscarriage can cause, there is still resistance on the part of both health professionals and the public to accept the emotional dimension of miscarriage. Clinicians may refer to implantation failure, anembryonic pregnancy, or

1 The term miscarriage can be taken generally to include ectopic and molar pregnancy, unless these conditions are specified in the text. The generic term 'pregnancy loss' is also used occasionally

embryonic or fetal demise. The professional support or even acknowledgement routinely provided for miscarrying women is limited. Family, friends and colleagues may attempt to minimise distress with comments which deny the reality of the pregnancy. Some couples will find this helpful and reassuring. For others such comments, however well meant, will only exacerbate their distress.

Individuality of response

There is no single emotional response to the experience of miscarriage and it is difficult to predict how women will respond or for how long. Some will be devastated, their distress persisting for some months, others will adapt to the miscarriage quite quickly and carry on with their lives. Contrary to conventional wisdom, the degree of distress is not necessarily proportionate to the length of gestation nor the length of time a woman has known of her pregnancy. A miscarriage at eight weeks may be as distressing to one woman as a sixteen-week loss is to another, however different the physical experience. A woman with an ectopic pregnancy may find out that she is pregnant only at diagnosis, yet still experience intense feelings of grief.

Studies show that miscarriage can have a significant impact on many women's lives (Slade, 1994; Robinson *et al*, 1994) and that for a minority the consequences may be severe and prolonged (Cordle and Prettyman, 1994). Many factors have been suggested in the research literature as determining women's reactions to a miscarriage, although no firm conclusions can be drawn (Friedman and Gath, 1989; Lasker and Toedter, 1991; Slade 1994).

As with any illness or medical condition, patients with an identical diagnosis will display different reactions (Moulder, 1998, 2001). Each pregnancy has a meaning and physical process of its own which will influence the way the miscarriage is experienced. Women who miscarry more than once may react differently to each loss. A miscarriage is unique to that particular woman at that particular time.

Women's accounts of their experiences suggest that feelings about the pregnancy, reproductive history, personal circumstances, personality, culture and personal style are some of the factors to take into account in considering how they react to a miscarriage.

Pregnancy history: Previous pregnancy loss may make miscarriage harder to bear, particularly if some form of treatment had been tried

on this occasion. A history of recurrent miscarriage will rarely make the experience easier to cope with, even if it means that the miscarriage is half expected. Similarly, if a miscarriage occurred at a later gestation than a previous loss, raised hopes that this pregnancy was going to be successful will have been shattered. Feelings, long buried, about a previous termination of pregnancy may resurface when a woman miscarries. Whatever the reason for the termination, women may feel guilt and self-blame when miscarriage occurs.

Fertility problems: Difficulties in conceiving can make miscarriage extremely distressing. Women's feelings about the miscarriage may be affected by whether the pregnancy was achieved naturally or by assisted conception. The swing from the elation of a confirmed pregnancy to the shock of its loss is likely to be felt keenly. Barriers to trying again, emotional and/or financial, can exacerbate the problem. For some women, this may have been their last chance of a pregnancy.

Current pregnancy: A long period of uncertainty as to the viability of the pregnancy, with continuing symptoms and inconclusive scans, may mean that the final diagnosis that the pregnancy has ended brings elements of relief. There may also be a sense of relief if the pregnancy was unwanted and especially if the woman had contemplated termination. Equally, however, it may cause feelings of guilt and a belief that negative thoughts caused the miscarriage.

Ectopic and molar pregnancy: Ectopic pregnancy is likely to compromise future fertility, whether because of a decreased chance of pregnancy or because of a higher risk of another ectopic pregnancy, or both. A woman may feel that she has lost not only her baby, but also some of the hope of ever having a baby. Women with the diagnosis of molar pregnancy may have an even more complex reaction. Not only are they warned not to conceive until completion of several months' follow-up, but they also have to deal with real anxieties about their future health.

Social and personal factors: Older women are likely to be concerned about the chances of conception and the increasing risk of miscarriage or fetal abnormalities. Women whose social, cultural or religious background holds childbearing as being of great importance may be devastated by the experience of miscarriage, and particularly by recurrent loss. Miscarriage may come as a considerable blow if the birth of a baby was crucial to the relationship. Personality and personal style are very likely to affect the way in which women and their partners react to miscarriage. While some may take the view