What are the symptoms of miscarriage?

The symptoms of a miscarriage can be quite varied. One of the more common symptoms is that of vaginal spotting (ie bleeding during early pregnancy). It may signify that the pregnancy is not stable and there is the possibility of a miscarriage. At that point, the patient should seek medical attention and an ultrasound may be necessary to confirm the status of the ongoing pregnancy. At other times this might progress to a full miscarriage, with acute symptoms of severe abdominal cramps, heavy bleeding, even giddiness and fainting and the contractions of the womb might actually push out the pregnancy. Patients with such symptoms must seek medical attention immediately, as there is the danger of excessive blood loss.

Occasionally there may be no symptoms at all, and a miscarriage is detected only on an ultrasound scan when it is seen that the pregnancy (fetus) has stopped growing with an absent heart beat.

Should women who do not show the general signs of pregnancy, ie morning sickness, bloating, nausea, be concerned that they might be at higher risk of miscarriage?

Most women do have some of the general symptoms of pregnancy such as nausea, vomiting, bloatedness, acid reflux and indigestion etc. These symptoms tend to be more obvious during the first 3 months, subsequently slowly abate as the pregnancy progresses. These changes are due to a rapid rise in some of the hormones produced by the placenta. However, there are some very lucky women who do not experience such symptoms at all. This does not mean that their pregnancy is not progressing well.

However, if patients have experienced such pregnancy symptoms and then find a rapid reduction in such symptoms within the first 3 months, it may signify that the placenta function is deteriorating and that a miscarriage may have occurred. An assessment at the clinic is advised.

What happens after a miscarriage? What procedures does a patient have to go through after suffering from one?

If a patient does not know that she has suffered a miscarriage (ie not diagnosed before she comes into the hospital), she may bleed suddenly and experience severe cramps. This is usually due to womb contractions that are pushing the failed pregnancy out. This may result in heavy bleeding and usually the miscarriage is not completely emptied out of the womb at this point. The patient must seek medical attention and upon admission to the hospital, a procedure to clear out the remaining parts of the failed pregnancy (called an evacuation of the uterus) is usually arranged so that the bleeding is controlled.

If a patient has been assessed by a gynaecologist and has been informed that she has a miscarriage, then usually the procedure of evacuation of the womb is offered so that this can be arranged at a convenient timing for the patient. Sometimes while waiting in the few days before the procedure, actual bleeding may take place. The procedure may then have to be expedited and performed that day.

Sometimes for an early pregnancy failure, spontaneous expulsion takes place at home and by the time the patient is seen and assessed at the clinic, bleeding has already stopped. If the ultrasound scan then shows the womb lining is thin and this implies that the contents has been emptied, an evacuation of the womb may not be necessary and monitoring is required.

Can couples do anything to minimise the possibility of occurence, and how long after suffering a miscarriage can couples try to conceive again?

When a miscarriage occurs, it is usually not due to what the couple did, or did not do. This is because a large portion of miscarriages are due to chromosomal abnormalities, which can happen at the time of formation of sperm and egg, and also during fertilization itself when the sperm fuses with the egg. Genetic material may be lost or duplicated, thus not producing the right coding for information when it is required during development of the fetus.

Couples often ask: is it due to food/diet/activity? The answer is no, if you have been previously healthy and have been leading a normal lifestyle. For most couples, it is not due to exercise or sex or even travel!

So does that mean that there is nothing the couple can do? Not really - for one, preconception folate supplementation is important for all couples, even for those who do not have a history of miscarriages. Adequate rest, a healthy lifestyle and reduction of stress levels might help, although this has not been scientifically proven. An early booking to the gynaecologist is usually advised, for assessment and follow-up. The use of progestogens such as dydrogesterone as prescribed by the gynaecologist up to 12-14 weeks of pregnancy may be helpful especially for those with recurrent miscarriages.

Most doctors will advise couples to wait for 1-2 months before trying again. In addition to allowing enough time for the couple to recover emotionally and physically, many doctors also feel that it gives time for the womb lining to regenerate healthily and be receptive to embryo implantation.

Should couples trying to conceive be worried if they suffer from one failed pregnancy?

One must realise that even after a miscarriage, the chance that the couple will have a normal pregnancy is still very high. Two European studies done in 1988 (UK) and 1991 (Denmark) respectively, have shown that:

Couple without any history of miscarriage having successful pregnancy: 85-90%

Couple with 1 miscarriage having next successful pregnancy: 80%

Couple with 2 miscarriages having next successful pregnancy: 70-75%

Couple with 3 miscarriages having next successful pregnancy: 60-70%

Thus couples should not be unduly anxious about their chances of the subsequent pregnancies after a miscarriage. Many patients go onto having 2 or 3 babies despite having suffered a miscarriage earlier.

When couples suffer from repeated miscarriages, are there diagnostic tests to find out the cause of the problem?

Recurrent miscarriage loss occurs when a woman loses 3 or more consecutive pregnancies. Usually, the doctor will initiate diagnostic tests at this stage, or earlier if it is indicated.

Some of the tests done will include blood tests such as to test for anti-phospholipid syndrome and other auto-immune disorders, clotting disorders and also the parents' chromosomes. Routine screening for

infection is less useful as doctors believe that these infections do not reside and cause repeated miscarriages (mother would have mounted an immune response to these infections).

An ultrasound of the pelvis is also useful to check for any uterine abnormalities such as any septum, fibroids or large polyps within the uterine cavity.

The presence of some of these clotting disorders will probably warrant treatment from the start of the pregnancy until the baby is mature to prevent complications from setting in. In some instances, the Rheumatologist (specialist in auto-immune disorders) or Haematologist (specialist in blood disorders) will come into the picture and provide valuable advice on the joint management of such patients.

Structural abnormalities of the uterus or womb should be dealt with as far as possible as it has been shown to improve pregnancy rates after correction. A hysteroscopic route should be planned and open surgery avoided as far as possible as this might lead to adhesions and impair fertility in the future.

Does age have any correlation to a higher risk of miscarriage?

Yes, it has been shown that there is a positive correlation between age and miscarriage, that is, as age increases, so does the risk of miscarriage. This risk of fetal loss increases sharply after the age of 35, coinciding also with a drop in fertility.