

# Miscarriage

Each mother reacts differently following a miscarriage. You may be devastated, angry, depressed, feel guilt, or may feel that it is simply an experience that you just have to live through.

You may grieve for the lost dreams of a future with an anticipated child.

Some people do not develop a closeness with the baby until the birth seems more of a reality.

Other people think of a baby from the moment of conception.

All of these reactions and feelings are normal. It is just as normal not to grieve as it is to be devastated.

Following a miscarriage, you may have physical reactions:

- Fatigue
- Sleeplessness
- Sighing
- Heart palpitations
- Loss of appetite
- Headaches
- Nightmares
- Withdrawal from social activities

It is also common to have mood swings, which are partially due to the withdrawal of pregnancy-related hormones.

Miscarriages occur in about 15%-25% of all pregnancies, usually between the 7<sup>th</sup> and 14<sup>th</sup> weeks of gestation.

When you have a miscarriage, you are having a birth. The pain you feel during the miscarriage is labor. Your uterus contracts and the cervix, or mouth of uterus, opens. You may have spotting or bleeding, and mild or severe cramping. Sometimes a dilatation and curettage (D&C), or scraping of the uterus, may be necessary, to prevent prolonged bleeding and infection.

After your pregnancy loss, your body may take weeks to return to normal. Uterine cramping may last for several days. Your breasts may be tender, and your milk may even come in. Vaginal bleeding may last for a week or more. If you have heavy bleeding, a foul discharge or fever, promptly call your doctor.

One common misunderstood thought regarding miscarriage is that fathers don't hurt over this type of loss. Often concerns, cards and comments are directed toward the mother. Fathers hurt, too!

Men express their grief in different ways than women, and that's okay. Women, by nature, are more open with their feelings. Fathers sometimes feel that they are expected to be strong for their partner, and to be tender, compassionate, and caring at the same time. Men, by nature, do not always like to vent their feelings. So, they are more likely to "get busy" while they grieve: working extra hours, spending more time in the garage or on outdoor projects. This behavior can be easily mistaken as a lack of caring. Fathers have strong emotional ties to an unborn child. They simply express their feelings in a different way.

# Myths about Miscarriage

*You will feel “all better” in a few days, weeks, or months.*

**Truth:** Every person grieves differently. Healing is attained only after the necessary progression through the stages of grief and mourning.

*God must be punishing you for something.*

**Truth:** Sometimes things just happen. It isn't fair to blame God, yourself, or anyone else. This was an act of Nature, not an act of God. Why? Sometimes there are answers. Most times there are not.

*You should be glad that you wouldn't have to deal with raising a “defective” baby.*

**Truth:** Parents who have experienced the loss of a baby often do not feel as fearful as others by the thought of having a handicapped child. Parents have the capacity to love their child even if the child is less than perfect.

*Grief is all-consuming*

**Truth:** In the midst of such an agonizing time in your life, there will be laughter. Do not feel guilty. Laugh if you want to. Just as you allow yourself to grieve, allow yourself to laugh and smile.

*Eventually you will accept the loss of your baby and forget all about this awful time.*

**Truth:** When you lose a child, your whole future has been affected, not your past. No one can really accept that. But there is resolution in the form of healing and learning how to cope. Give yourself time. Your precious baby will have a place in your heart and you will always remember.

*I know someone else who had a miscarriage and they got over it faster than you are.*

**Truth:** Grief is an individual thing. There is no right way or wrong way to do it. Take your time, be patient with yourself. You will heal in time, and not according to anyone else's schedules... not even your own.

# Ectopic and Molar Pregnancy

## (Courtesy of March of Dimes Resource Center)

### What is an ectopic pregnancy?

Up to 1 pregnancy in 50 is ectopic, which means “out of place” (1, 2). In an ectopic pregnancy, the fertilized egg implants outside of the uterus, usually in the fallopian tube, and begins to grow. Rarely, an ectopic pregnancy implants in the woman’s abdomen, on the outside of the uterus, on an ovary or in the cervix.

### What are the symptoms of an ectopic pregnancy?

Some women with an ectopic pregnancy start out with typical early-pregnancy symptoms, such as nausea and tender breasts. Others have no early symptoms and may not know they are pregnant.

However, about 1 week after a missed menstrual period, a woman may experience slight, irregular vaginal bleeding that may be brownish in color. Some women mistake this bleeding for a normal menstrual period. The bleeding may be followed by pain in the lower abdomen, often felt mainly on one side.

A woman with these symptoms should contact her health care provider promptly or go to a hospital emergency room. Without treatment, these symptoms may be followed in several days or weeks by severe pelvic pain, shoulder pain (due to blood from a ruptured ectopic pregnancy pressing on the diaphragm), faintness, dizziness, nausea or vomiting.

### How is an ectopic pregnancy diagnosed?

An ectopic pregnancy can be difficult to diagnose, so the woman needs to have several tests. These include:

- A **pelvic exam**.
- A series of **blood tests** to measure the levels of a pregnancy hormone called human chorionic gonadotropin (hCG). Levels of this hormone often are low in an ectopic pregnancy.

- A **vaginal or abdominal ultrasound** to locate the pregnancy. A vaginal ultrasound often is used because it can show the pregnancy earlier than an abdominal ultrasound.

If these tests do not confirm an ectopic pregnancy, the provider may need to empty the uterus (a procedure called dilation and curettage or D&C) to determine whether the woman has had a miscarriage or an ectopic pregnancy.

Occasionally, the provider may need to view the abdominal organs directly with a thin, flexible instrument called a laparoscope, which is inserted through a small incision in the abdomen while the woman is under general anesthesia.

### How is an ectopic pregnancy treated?

If the provider finds an ectopic pregnancy, the embryo (which cannot survive) must be removed so that it does not endanger the woman’s life. If the embryo continues to grow, it can cause the fallopian tube to rupture, resulting in life-threatening internal bleeding. Most ectopic pregnancies are diagnosed in the first 8 weeks of pregnancy, usually before the tube has ruptured.

There are two treatments for ectopic pregnancy:

- **Medication:** If the pregnancy is small and the tube has not ruptured, a woman may be treated with a drug called methotrexate. The drug usually is given as a single shot, though some women may need more than one injection. Methotrexate stops growth of the pregnancy and saves the fallopian tube. The woman’s body gradually absorbs the pregnancy.
- **Surgery:** When an ectopic pregnancy is diagnosed before the fallopian tube ruptures, the provider usually makes a tiny incision in the fallopian tube and removes the embryo, preserving the tube. If an

ectopic pregnancy is diagnosed after the fallopian tube has become stretched, or if the tube has ruptured and bleeding has begun, the provider may have to remove part or all of the fallopian tube.

After either of these treatments, the provider monitors the woman for several weeks with blood tests for hCG until levels of the hormone return to zero.

### **What are the risk factors for ectopic pregnancy?**

The most significant risk factor for ectopic pregnancy is sexually transmitted infections (STIs), such as chlamydia. STIs can lead to pelvic inflammatory disease and scarring of the fallopian tubes. Damage to the fallopian tubes increases the risk of ectopic pregnancy. Other risk factors include (1, 2, 3):

- Previous ectopic pregnancy
- Fertility drugs and assisted reproductive techniques (such as in vitro fertilization)
- Pregnancy after failed tubal sterilization
- Previous operations on the fallopian tube
- Endometriosis (when uterine tissue implants outside the uterus)
- Exposure to the drug DES (diethylstilbestrol) in her mother's pregnancy
- Cigarette smoking

For most women, the cause of an ectopic pregnancy is unknown (3).

### **What is the outlook for future pregnancies?**

Many women who have had an ectopic pregnancy can have healthy pregnancies in the future. Studies suggest that about 50 to 80 percent of women who have had an ectopic pregnancy are able to have a normal pregnancy (2, 3). The rates are about the same whether a woman has been treated surgically or with methotrexate (1).

Women who have had an ectopic pregnancy have about a 10 percent chance of it happening again, so they need to be monitored carefully when they attempt to conceive again (2).

### **What is a molar pregnancy?**

In a molar pregnancy, the early placenta develops into an abnormal mass of cysts (called a hydatidiform mole) that resembles a bunch of white grapes. The embryo either does not form at all or is malformed and cannot survive. About 1 in 1,500 pregnancies is molar (4).

There are two types of molar pregnancy:

- **Complete mole:** There is no embryo and no normal placental tissue.
- **Partial mole:** There is an abnormal embryo, and there may be some normal placental tissue. With a partial mole, the embryo begins to develop.

Both types of molar pregnancy are caused by an abnormal fertilized egg. In a complete mole, all of the fertilized egg's chromosomes (tiny thread-like structures in cells that carry genes) come from the father (4, 5). Normally, half come from the father and half from the mother. In a complete mole, shortly after fertilization, the chromosomes from the mother's egg are lost or inactivated, and those from the father are duplicated.

In most cases of partial mole, the mother's 23 chromosomes remain, but there are two sets of chromosomes from the father (so the embryo has 69 chromosomes instead of the normal 46). This can happen when the chromosomes from the father are duplicated or if two sperm fertilize an egg (4, 5).

Molar pregnancy poses a threat to the pregnant woman because it can occasionally result in a rare pregnancy-related form of cancer called choriocarcinoma.

### **What are the symptoms of a molar pregnancy?**

A molar pregnancy may start off like a normal pregnancy. Around the tenth week, abnormal vaginal bleeding, which often is

dark brown in color, usually occurs. Other common symptoms include:

- Severe nausea and vomiting
- Rapid uterine growth (due to the increasing number of cysts)
- High blood pressure
- Cysts on the ovaries

### **How is a molar pregnancy diagnosed?**

Providers use an ultrasound to diagnose a molar pregnancy. The provider also measures the levels of hCG, which often are higher than normal with a molar pregnancy.

### **How is a molar pregnancy treated?**

A molar pregnancy is a frightening experience. Not only does the woman lose a pregnancy, she learns that she has a slight risk of developing cancer. To protect the woman, all molar tissue must be removed from the uterus. This usually is done with a D&C. Occasionally, when the mole is extensive and the woman has decided against future pregnancies, a woman may have a hysterectomy.

After mole removal, the provider again measures the level of hCG. If it has dropped to zero, the woman generally needs no additional treatment. However, the provider continues to monitor hCG levels for 6 months to 1 year to be sure there is no remaining molar tissue (4). A woman who has had a molar pregnancy should not become pregnant again for 6 months to 1 year, because a pregnancy would make it difficult to monitor hCG levels (4).

### **How often do moles become cancerous?**

After the uterus is emptied, about 20 percent of complete moles and less than 5 percent of partial moles persist. The remaining abnormal tissue may continue to grow (4). This is called persistent gestational trophoblastic disease (GTD).

Treatment with one or more cancer drugs cures persistent GTD nearly 100 percent of

the time (4). Rarely, a cancerous form of GTD, called choriocarcinoma, develops and spreads to other organs. Use of multiple cancer drugs usually is successful at treating this cancer.

### **What is the outlook for future pregnancies after a molar pregnancy?**

If a woman has a molar pregnancy, her outlook for a future pregnancy is good. The risk that a mole will develop in a future pregnancy is only 1 to 2 percent (4, 5).

### **Resources**

Parents or other family members who have lost a baby because of ectopic or molar pregnancy may want to read the [bereavement information](#) provided on this Web site.

The Maternal and Child Health Library at Georgetown University provides [information](#) on infant death and pregnancy loss.

### **References**

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