Treatment options available in the Recurrent Miscarriage Clinic

Psychological Support

Whatever the cause of recurrent miscarriage identified by investigations, it is only normal that women will be very anxious in any future pregnancy. Research has shown that psychological support reduces the risk of miscarriage. The Recurrent Miscarriage Clinic provides such support in the form of frequent clinic visits when required, access to telephone support, and ready access to ultrasound facilities. Many women find weekly ultrasound scans at specific times during what they consider their "danger" periods very reassuring. Both on the NHS and in the private sector, the facility is readily available.

1. Treatment for the antiphospholipid syndrome.

The current most widely used treatment involves low dose (baby) aspirin and low molecular weight heparin. Recent research suggests that aspirin alone may be just as good as the combined therapy. Some women may be apprehensive about self-administering daily injections of heparin. In fact once you have been shown how, it is very easy, virtually painless, and safe. It is similar to giving one-self insulin injections in diabetics, but of course it is short-lived. For the baby, both medications are safe.

2. Treatment when a thrombophilia is identified.

While it may be a subject of debate as to whether thrombophilias cause recurrent miscarriage or not, they increase the risk of blood clots in those affected. Pregnancy itself without thrombophilia increases the risk of blood clots 6-fold. Therefore our general approach to women with thrombophilia is to treat them with a combination of low molecular weight heparin and low dose aspirin. Since the risk of blood clot formation is particularly high in the six weeks following childbirth, treatment is continued during this time. Special precautions are taken during labour and delivery to minimize the risk of excessive bleeding.

3. Treatment for a positive NK cell test.

Strong research evidence points to increased NK cell activity in subsets of women with recurrent miscarriage, or implantation failure in women undergoing IVF treatment. "Immunosuppression" with steroids appears to be a promising treatment, and is under evaluation in some centres both in the USA and the UK. In the Recurrent Miscarriage Clinic, the steroid used is prednisolone at a dose of 25mg given from mid-cycle and continued to 12 weeks if pregnancy occurs. Side-effects are minimal, and may include reversible weight gain, mood changes, sleep disturbance, skin changes and raised blood pressure. Only trace amounts of the steroid will reach the baby, and therefore the treatment poses no significant problems for the fetus in the womb._The steroids are usually supplemented with low molecular weight heparin and low dose aspirin, but the need for the latter is currently being evaluated.

4. Treatment for a weak cervix

Where a "weak cervix" has been diagnosed, the standard treatment is

cervical cerclage, the insertion of a "stitch" around the cervix at 12-14 weeks gestation. The vast majority of stitches are inserted via the vagina. Very occasionally, where a woman has had prior surgery to the cervix and where the cervix has become very short and is damaged and / or scarred, the stitch may need to be inserted through the abdomen (trans-abdominal cervical cerclage). In the latter, a caesarean section delivery will be required, and the stitch will usually be left in place until the woman completes her family. The standard stitch inserted via the vagina is removed at 38 weeks and a vaginal delivery anticipated.

5. Management of chromosomal abnormalities

There is of course no cure for chromosomal abnormalities, but the identification of an abnormality allows for a more accurate counselling and assessment of prognosis. Other couples may need prenatal diagnosis in any future pregnancy. The Recurrent Miscarriage Clinic has ready access to a Genetic Counselling Service.

6. Treatment when bacterial vaginosis is identified

It is well established that bacterial vaginosis (BV)is associated with an increased risk of late miscarriage and preterm birth. Research from our Unit recently showed that early treatment of BV significantly reduces both risks. We also have as yet unpublished evidence to suggest that BV increases the risk of early miscarriage. In the Recurrent Miscarriage Clinic, all women who screen positive for BV are therefore given a short course of oral clindamycin, the antibiotic we used in our research and which we consider the most appropriate to eradicate BV. Treatment is repeated if later screening during the pregnancy shows a recurrence of BV.

7. Other treatments available: Progesterone & Metformin_

Once upon a time progesterone supplements were widely used to treat women with recurrent miscarriage. They fell into disrepute when a meta-analysis failed to show any benefit. However, a meta-analysis is only as good as the studies that are included, and many have since questioned the quality of the studies included in the meta-analysis. In addition, recent powerful research has shown that progesterone supplementation prevents late miscarriage and preterm birth in a subsets of women at risk of both. Extrapolations are therefore being made to earlier pregnancy loss, and some women are being offered progesterone supplementation. We are certainly re-evaluating this treatment in the Recurrent Miscarriage in two groups of women: those with polycystic ovarian disease and miscarriage, and those where no cause for the recurrent miscarriage has been established. Metformin is being evaluated in women with polycystic ovaries where no other pathology has been identified as a potential cause of the recurrent miscarriages.

8. When investigations fail to identify a cause

Some couples are disappointed when investigations fail to identify a cause for their recurrent miscarriages. In fact, not finding a cause should be seen as a very positive outcome, because then the chance of a subsequent successful pregnancy is very high. Where a couple have only had two consecutive miscarriages, when no cause is found they have at least a 70% chance of having a successful. While the figure is slightly lower where there have been three consecutive miscarriages, nevertheless the chances of a

successful pregnancy remain higher than those of further miscarriage. Psychological support is an important therapeutic strategy in these circumstances.

9. Alternative / complementary therapies

The Recurrent Miscarriage Clinic has no expertise in alternative or complementary investigations and therapies. The approach in the Clinic is to adopt a pragmatic approach. Certainly where no cause for the recurrent miscarriages has been established, some couples opt to pursue the complementary therapy route. We support such approaches, while making it clear that it is not an area in which we have any expertise. It is to be hoped that some of the complementary treatments will be subjected to formal evaluations along standard research methodology. While it is difficult to envisage how treatments such as Aromatherapy and Reflexology could cure recurrent miscarriage, nevertheless they are unlikely to cause any harm, and are certainly relaxing and soothing for women who are otherwise fraught with anxiety, stress and tension. Some investigations identify trace mineral deficiencies using hairs, and attribute miscarriages to these deficiencies, usually of zinc, magnesium or selenium. The treatment usually suggested involves dietary supplementation. It seems unlikely that a packet of multi-vitamin supplements purchase from a local pharmacy could be harmful, and we therefore do not discourage this approach.

10. General measures

While there may be no hard scientific evidence for some of the general measures we advise, they appeal to common sense. We therefore advise the following to all couples undergoing investigation and treatment for recurrent miscarriage:

- A healthy, balanced diet
- Avoidance of excess caffeine, alcohol and recreational drugs
- Cessation of smoking
- Avoidance of stress (probably easier said than done)
- Regular exercise

During early pregnancy avoidance of sexual intercourse: there is a link between sexual activity and BV, and sexual activity does alter vaginal flora, even if only transiently.