PE1443/B

CONSIDERATION OF PETITION PE1443

On behalf of the Scottish Early Pregnancy Network (SEPN), I am grateful for the opportunity to respond to the petition PE1443 submitted by Maureen Sharkey on behalf of SCIM.

Sadly 1 in 5 pregnancies end in miscarriage (possibly 60% if you include biochemical pregnancies), and this can be devastating for the woman, her partner and extended family. After one miscarriage the incidence of miscarriage is no higher (although it is never lower than 20%). Approximately 50% of miscarriages occur because of a chromosomal abnormality occurring at conception. This is not inherited, and identifying this will not alter the management in subsequent pregnancies. There are early pregnancy units throughout Scotland, and each unit has patient information leaflets which are given at the time of loss. Details of support groups are provided to women at the time of loss eg Miscarriage Association contact number and website.

The SEPN strongly believe that in the majority of cases, after one miscarriage women should be reassured that they have a very good chance of having a successful pregnancy. Many units will offer a scan at about 7-8 weeks in the next pregnancy which will hopefully be reassuring (there is some historical evidence that providing TLC has a beneficial effect on pregnancy).

After 2 miscarriages the chance of having a further miscarriage is slightly higher. The incidence of 3 miscarriages is about 1%, making this a ‘clinical entity’ and it is more likely that an abnormality will be found.

Some units will offer investigation after 2 losses eg assessing lupus anticoagulant and anticardiolipin antibody status, and to assume that what GGC do is the same as everywhere else demonstrates a failure to find correct information (it would have been very easy for SCIM to approach all units as the information is freely available on the AEPU website).

After 3 miscarriages couples would be offered a clinic appointment at a recurrent miscarriage clinic or equivalent. Investigations would be performed and advice given. The support of women would usually be provided by the staff at the clinic (midwives and nurses as well as doctors), with the general practitioner being less involved.

I am not aware of SCIM approaching the Scottish Early Pregnancy Network to discuss care of women experiencing pregnancy loss. I have personally approached SCIM in my previous post in Hairmyres as I was keen to build bridges with this group, however they did not display any interest in the work taking place in early pregnancy units at that time.

The SEPN can assure SCIM that the issue of early pregnancy loss is taken very seriously by health professionals working in this area. Each Early Pregnancy Unit is run

by dedicated, hard work, compassionate staff who seek to provide the best care for those suffering from pregnancy loss.

The SEPN meets annually in Scotland and also links with the Association of Early Pregnancy Units to attend their annual meeting (I am the Scottish representative on the AEPU exec committee) to ensure that staff are up to date with knowledge and also have the opportunity to share experiences and meet with colleagues who are passionate about care in early pregnancy units.

At other times the SEPN uses email to update all early pregnancy units on current issues eg in the past 2 months communication has been sent out regarding the Scottish Government advice on sensitive disposal of fetal remains (I was personally on this SLWG); terminology issues on coding of early pregnancy loss currently being addressed with WHO; and AEPU advice to change the term 'evacuation of retained products of conception' to surgical management of miscarriage.

The SEPN would not support the investigation of women following one miscarriage. A positive message of reassurance should be offered with psychological support. The cost of investigation could not be justified for the tiny pick up rate of any abnormality. We agree that all women should have the opportunity to talk to someone who understands, can empathise and reassure them that their feelings are normal. Ideally this would be offered by a qualified counsellor or nurse / midwife with bereavement training who was linked to the early pregnancy unit.

I have previously audited services for recurrent miscarriage in Scotland and the results were presented at the Glasgow Obstetrical Society and the Scottish Early Pregnancy Network meeting in 2009. I am sorry that SCIM are unaware of this work. As you will see from the attached abstract, most of the units in Scotland see women after 2 early pregnancy losses.

http://www.earlypregnancy.org.uk/index.asp Association of Early Pregnancy Units

http://www.earlypregnancy.org.uk/FindUs2.asp?region=Scotland Information about EPAS units in Scotland (correct at time of printing as I phoned each unit to ensure the information was accurate)

http://www.miscarriageassociation.org.uk/ Support group for women.

http://www.simbacharity.org.uk/ Simpson's Memory Box Appeal, offering support and counselling training

http://www.rcog.org.uk/files/rcog-corp/GTG17recurrentmiscarriage.pdf RCOG Green Top Guideline

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Recurrent Miscarriage Service in Scotland – Presented at GOGS, 2009
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Introduction

The Royal College of Obstetricians and Gynaecologists (RCOG) guideline on recurrent miscarriage suggests that attendance at a dedicated early pregnancy unit (EPU) improves the outcome of future pregnancies[(1)], and the Association of Early Pregnancy Units (AEPU) recommend that women who suffer consecutive pregnancy losses are best referred to a designated regional centre for investigation[(2)]. The aim of this audit was to review the services available to Scottish couples with a history of recurrent miscarriage.

Methods

A questionnaire was sent to all 25 EPUs or maternity units in Scotland, all of which are members of the Scottish Early Pregnancy Network (SEPN) asking if the unit had a dedicated recurrent miscarriage clinic; how many miscarriages a woman had to have to attend; was she seen by a midwife, nurse or doctor; how long the appointment was; how many women were seen each week at the clinic; what investigations were performed and what support was offered in subsequent pregnancies.

Results

Twenty two units replied. Eleven of the twenty two units responding have a dedicated recurrent miscarriage clinic while others see women in a gynaecology clinics or by arrangement out with a clinic. Most see patients after 2 consecutive miscarriages regardless of age. 3 units do not see patients until 3 consecutive miscarriages or 2 miscarriages in patients over 35 years of age. All units assess lupus anticoagulant and anti-cardiolipin antibodies; the majority also test parental chromosomes. There was no consensus regarding further investigations between units. Thirteen units offer patients an early reassurance scan in future pregnancies. In 13 of the units women may be deemed suitable for their first visit by a midwife or nurse rather than a doctor while 4 units were run by doctors only. Most appointments were for 30 minutes with 3 allowing 45 and 2 only 15 minutes. Most dedicated recurrent miscarriage clinics saw between 4 and 6 patients in a session.

Conclusion

Services for couples with recurrent miscarriage vary across Scotland; half of units offer a dedicated recurrent miscarriage clinic. These clinics are labour intensive, with appointments lasting between 30 and 45 minutes. Many units are nurse/midwife led with women being seen by a doctor if follow up was required. Smaller units tend to manage these patients within gynaecology outpatient clinics as demand was felt to be insufficient to justify an exclusive clinic. This audit confirms that utilising the SEPN

provides representative data, enables collaborative research to be undertaken and helps units to share their experiences and results. Further audit of patient satisfaction would be useful and smaller units may be linked to the nearest recurrent miscarriage clinic.

(1) RCOG Green top guideline 17, The investigation and treatment of couples with recurrent miscarriage
(2) AEPU Guidelines 2007 ‘Management of recurrent miscarriage’