

Miscarriage: Pregnancy Loss Before 20 Weeks



Pregnancy and
Infant Loss Network

 **Sunnybrook**
PREGNANCY AND
INFANT LOSS NETWORK

“We know it hurts, we’re here to help.”

To access one of Pregnancy and Infant Loss Network’s free peer-led support services please contact us at:

Phone: **1-888-303-PAIL (7245)**

E-mail: **pailnetwork@sunnybrook.ca**

Website: **pailnetwork.ca**



Who You can Call for Help

▶ **Your Healthcare Team**

Contact Information:

▶ **Public Health or Community Nurse**

Contact the health department in your community

▶ **Your Spiritual Care Provider, Clergy, or Elder**

Contact Information:

▶ **Local Crisis Helpline**

Contact Information:

Pregnancy and Infant Loss (PAIL) Network

About Us

We are an organization of peers supporting families who have suffered pregnancy and infant loss. We achieve this through education and peer, online, and telephone support.

PAIL Network is able to offer its services to bereaved families and healthcare professionals with the support of the Ministry of Health and Long Term Care, generous donors, and dedicated volunteers. To learn more about our support services or to make a donation, visit us at pailnetwork.ca.

Thank You

PAIL Network would like to thank Women's College Hospital for their permission to reprint "The Rights of the Baby" and "The Rights of the Parents".

Please Note

While this publication is intended to offer useful information, it is not intended to replace professional health care and medical advice.



Introduction

What to Expect From This Guide

Bereaved parents and healthcare professionals created this booklet to guide you through what to expect when experiencing a miscarriage, which is defined as a pregnancy loss under 20 weeks. This may be a very difficult time in your life, and we want you to know there is help and you are not alone.

We hope this booklet helps you understand the following:

- Miscarriages are unfortunately common and most often due to natural causes
- There are different options for how to manage a miscarriage, whether it takes place at home or in a hospital. We will talk about these options further below.
- Grief is a natural response to a miscarriage
- Many parents feel overwhelming and complicated emotions following a miscarriage, including sadness, shame, guilt, anger, and self-blame. If you feel these things, you are not alone.
- People experience the loss of a pregnancy differently, and there are no right or wrong ways to feel about your loss
- There are many ways you can help yourself heal physically and emotionally after the miscarriage has ended

This booklet is intended as an overview of physical and emotional experiences that may occur during early and late miscarriage. We hope the information in this booklet will help you better understand your miscarriage and ways to find the support you may need.

Throughout this booklet, gender-specific language is sometimes used in explanations (i.e. vaginal bleeding) or to reference existing research or knowledge. We hope this booklet is useful to all childbearing individuals, regardless of their gender identity or sexual orientation.

You may find that all sections of the booklet are not relevant to you or helpful. Please read through this booklet in whatever way is useful for you.



Words, Meanings and Special Terms

Miscarriage

The early delivery of a baby (embryo or fetus) or loss of a pregnancy prior to 20 weeks gestation.

Embryo and Fetus

These are the early developmental stages of a baby and the medical terms frequently used. The early cluster of cells that grows from a fertilized egg is known as the embryo. The embryo will continue to grow until it is called a fetus from 12 weeks until birth. *In this booklet, we will use 'baby' to refer to both an embryo and a fetus.*

Spontaneous Abortion

The medical term for miscarriage.

Missed Abortion/Missed Miscarriage

When the baby dies and stays inside the uterus for at least two weeks before the miscarriage occurs.

Incomplete Abortion/Incomplete Miscarriage

When the baby or pregnancy tissue remains inside the uterus during or following a miscarriage.

Threatened Abortion/Threatened Miscarriage

Miscarriage symptoms, including bleeding and cramping, are happening and the baby is still alive.

Molar Pregnancy

The fertilized egg implanted in the uterus has too many or too few chromosomes and can't develop into a fetus. The cell still grows into an abnormal mass of tissue, triggering pregnancy symptoms. Molar pregnancies need to be treated immediately and followed up by a healthcare provider.



Ectopic Pregnancy

The embryo grows outside the uterus. Usually — but not always — in the fallopian tube. The embryo cannot grow safely and must be removed.

Blighted Ovum

When the embryo does not develop from a fertilized egg.

Uterus

Commonly known as the womb, the uterus is a reproductive organ in the pelvic region. In most cases, this is where a pregnancy develops and a baby grows.

Cervix

Narrow, neck-like tissue that forms the lower part of the uterus. The cervix connects the vagina (birth canal) to the uterus, and opens to allow passage between the two.

Dilation and Curettage (D&C)

A short surgical procedure where the cervix is opened (dilated) and tissues from the pregnancy are removed from the uterus. This is done by removing (scraping or suctioning) the uterine lining while you have pain relief (are under anesthesia). The D&C is done in a hospital operating room and in most cases you can go home on the same day as the procedure.

Misoprostol

A medication (drug) used to initiate a miscarriage. This drug may be prescribed when an ultrasound confirms that your baby has died but the miscarriage hasn't started.

Products of Conception

A medical term to describe the tissues formed in the uterus after conception (e.g. yolk sac, placenta, embryo).



What is a Miscarriage and What Causes It?

Miscarriage is the early delivery of a baby or loss of a pregnancy before 20 weeks gestation. This booklet categorizes miscarriage in two parts:

- Early loss, occurring up to 12 weeks
- Late loss, occurring after 12 weeks but before 20 weeks

After 20 weeks, or if the baby weighs 500 grams or more at birth, the pregnancy loss is called a stillbirth. Because these experiences can be very different from each other, from the language that is used to the services that are provided, we address each one individually. For more information on stillbirth, please see PAIL Network's 'Stillbirth' booklet, or go to pailnetwork.ca.

Miscarriages are a very sad end to many pregnancies and unfortunately common. Researchers estimate that up to one in four recognized pregnancies end in miscarriage. Most early miscarriages are the result of a random error in the baby's chromosomes. In these cases, the baby cannot survive and the pregnancy ends. When this happens, the miscarriage should not affect future pregnancies.

Some of the more common causes of miscarriage include:

- Chromosome or genetic problems with the baby
- Infections
- Hormone problems
- Immune system responses
- Medical conditions
- Problems with the uterus or cervix
- Problems with the placenta

After a miscarriage, many families want to know why it happened. It can be very difficult to not know "why" a miscarriage has happened, but most often the exact cause will never be identified. It is important to remember that most of the time, miscarriages cannot be prevented and are not because of something a person did wrong.



How Should My Miscarriage Be Managed?

During a miscarriage, there are three management options for healthcare providers and families to consider. They are:

- **Expectant:** This means waiting to see if the miscarriage starts or finishes on its own. No medication is given and no surgical intervention happens - families wait to see if the person's body naturally passes the baby and all the pregnancy tissues. In many cases, families wait at home. Talk to your healthcare team about how long you will wait before discussing another option, such as medical or surgical management.
- **Medical:** Medication is used to help the body pass the baby and all the pregnancy tissues. What medication is used and where the miscarriage happens (at home or the hospital) depends on different factors, including where you live, how far along you are in the pregnancy, and your specific set of circumstances.
- **Surgical:** A surgical procedure, called a dilation and curettage (D&C), is done at the hospital. During the procedure, your cervix is opened and the doctor uses special tools or suction to remove the baby and pregnancy tissues. You are given medication so that you do not feel pain during the procedure. Very often, families will go home on the same day as the procedure.

Expectant management (waiting for the miscarriage to start on its own) has the benefit of avoiding the hospital and the anxiety of medical or surgical intervention. Some families feel comfort in being at home and letting their body do what it needs to do.

However, if the miscarriage has not already started, waiting for it to begin can be a source of worry for some people, especially if they are home alone, have other children to care for, or are working. Your primary care provider (doctor, nurse practitioner, or midwife) may be able to follow you closely and provide support so that you do not need to go to the Emergency Department. If you live in a community that has an Early Pregnancy Assessment Clinic, you may be able to have close follow-up there.



If you are farther along in the pregnancy, or if the miscarriage has not begun within a few weeks, you will be referred for medical or surgical intervention. Many healthcare providers will wait up to 6 weeks for the body to miscarry on its own, as long as there are not signs of infection or other complications.

Surgical (a D&C) and **medical** (taking medication) management options often have the benefit of being quicker, and people may choose them because they want the experience to end as quickly as possible. There are few side effects from surgical intervention, but people may have to wait for a spot in the hospital to have the procedure done or travel a long distance to a location that is able to provide this service. We discuss the D&C in more detail in the section ‘Miscarriage at the Hospital’.

Medical intervention is associated with side effects that may include diarrhea, chills, fever, nausea, and vomiting. Depending on how far along you are in the pregnancy or where you live, you may be able to take the medication at home or in your local community. It may also be a faster option than waiting for surgical management.

In some cases, your healthcare provider may decide which method is appropriate for you based on your pregnancy, symptoms, and medical history. Surgical and medical interventions become more common and necessary the further along you are in your pregnancy.

In some cases, you will be asked what you would like to do. If you are given a choice, there are several factors you may wish to consider. Remember: there is no wrong choice. If you are given a choice, choose the method that feels right for you and your family. Talk to your healthcare team about what options are best for you, including the risks and benefits of each management method. Discuss your thoughts, feelings, questions, and concerns with your healthcare team.



What to Expect: Early Miscarriage (Loss from 0-12 weeks)

An early miscarriage is the loss of a pregnancy or baby between the 1st and 12th week of pregnancy. Most miscarriages occur during this time. During a miscarriage, your baby and the associated pregnancy tissues will leave your body. It is important that all parts of the pregnancy come out, because any tissues left behind can cause heavy bleeding or an infection that may interfere with healing or with potential future pregnancies.

Sometimes, the body will miscarry on its own. You may feel some cramping, back pain, or experience bleeding from the vagina. Other times, you may need medical or surgical help from a healthcare professional. This means that you may need medication to help start or complete the miscarriage, or a surgical procedure called dilation and curettage (D&C).

Miscarriages can happen at home or in the hospital. Most often, from a medical perspective, early miscarriage is not considered a serious health concern. There may be exceptions to this, for example when there is very heavy vaginal bleeding or an ectopic pregnancy. We will talk about these in more detail below.

During a miscarriage, many families go to an emergency department or to see their primary care provider for help. Sometimes, they wait for a long time to be seen or have to wait in a room with many other people with very little privacy. Often, they are sent home in the middle of a miscarriage or sent home to wait to see how the miscarriage will progress. This is understandably very distressing for families, especially when they are hoping that healthcare providers will give them answers or stop the miscarriage or when follow-up will not happen for several days. Sometimes, families are told that there are miscarriage signs but that 'only time will tell', and they are sent home and told to follow up within the week, with few answers and no other options. During this time, many families are upset, scared, angry, and confused. If you are feeling this way, you are not alone.



If possible, try to have a friend or partner with you when meeting with doctors or other healthcare providers, as you may be in shock and unable to absorb all the information on your own. If you are alone, you can ask a member of your healthcare team to call a friend or family member for you.

Miscarriage at Home

Miscarriage at home is a common option for families who are experiencing a miscarriage before seven to ten weeks, though this option isn't limited to that time frame. Some families will choose to stay at home the whole time, while others will choose to go to an emergency department or to see their doctor or nurse practitioner at some point. Many families, even if they go to an emergency department or to see their doctor or nurse practitioner, will be sent home to wait for the miscarriage to end, sometimes with medication.

As we now know, a miscarriage, which often starts with vaginal bleeding and cramping, may begin on its own. It may also be helped along or 'induced' using a medication called misoprostol, which is inserted into the vagina (please see the "Late Loss" section of this booklet for more details on misoprostol).

Once the miscarriage has begun, bleeding from the vagina and cramping can continue for up to 7 to 10 days. Cramping and vaginal bleeding usually lasts only a few days if the drug misoprostol is used.

Although early miscarriage is not usually medically serious, it is a very difficult time. Be aware that intense cramping could begin at any time, you will have bleeding from your vagina, and you will likely feel tired.



You may find it helpful to:

- Rest as you are able. Don't put pressure on yourself to lead your "normal" life during this time.
- Have someone at home to help you and to sit with you
- Eat or drink in small amounts
- Get help with child or pet care, making meals, and housework

The experience of miscarrying varies between pregnancies and is affected by the size of the baby and the length of the pregnancy. People with very early miscarriages (less than 7 weeks) will likely find their miscarriage to be similar to a heavy period, with no obvious passing of remains. The further along a person is in a pregnancy, the more likely they are to notice tissue or remains. Very heavy cramping and a feeling of needing to go to the washroom (have a bowel movement) may precede the passing of remains. Knowing this signal may help you to prepare.

Some people will choose to collect the baby or pregnancy tissues. How you manage the remains is a personal choice. Some people will not want to collect them, while others wish to collect them for burial, cremation, or other special traditions. If you wish to collect them, have a small container or box ready. You may want to use a bowl of clean water to wash the remains and avoid using toilet paper or tissues that may stick when handling the remains. If you are in the emergency department, you may wish to ask for a container. Most hospitals will have a collection aid for the toilet, such as a 'urine or toilet hat' or 'urine meter' that you can ask for. You may even be able to bring this home with you.

Once the bleeding has stopped, let your primary healthcare provider know (doctor, nurse practitioner, or midwife). They may arrange for you to have an ultrasound or blood work to make sure the miscarriage is complete and all tissues from your pregnancy are gone. They may also ask you to come in for a follow-up appointment or give you instructions on what to do next.



Miscarriage at the Hospital: Suction Dilation and Curettage (D&C)

Instead of going home and waiting for your miscarriage to end or taking medication, you may be offered a surgical intervention at a hospital. Tissue from the pregnancy can be removed surgically through a procedure called dilation and curettage, or D&C.

A D&C is a short procedure (around 15 minutes) performed under local or general anesthetic. This means that you will not be in pain for the procedure. You may be awake but given medication (local anesthetic) or 'put to sleep' (general anesthetic). The D&C is performed in an operating room. Because of this, D&C procedures are often not offered to a family immediately. Many times, the doctor will need to wait for an opening in the operating room schedule. This may mean that families must wait for the procedure, sometimes several days or even longer. This is understandably very upsetting for many families. If this happens to you, and you are sent home to wait, you may want to discuss with your care team what to do if the miscarriage starts on its own, and when you should come back to the hospital.

During the D&C, the doctor will use medication or surgical instruments to open (dilate) your cervix and then gently scrape the lining of your uterus using a surgical tool called a curette. The scraping is to remove the baby and other pregnancy related tissues. The doctor may use a suction tool instead of scraping. Most families are monitored for 4-8 hours after the procedure, and then sent home the same day. You may need someone to drive you home after the procedure.

Before you leave, discuss with your care team who will provide follow-up for you. Often the care team will suggest seeing your primary care provider (doctor, nurse practitioner, or midwife) for follow-up. Even if they do not, you can call to make an appointment on your own or call on behalf of your partner or loved one. After the procedure, you may still experience some bleeding and cramping. This is normal.



Ectopic Pregnancy

An ectopic pregnancy occurs when a fertilized egg implants itself outside the uterus. This commonly occurs in a fallopian tube. As the pregnancy grows, it will need to be removed or it will threaten the life of the pregnant person. An ectopic pregnancy is dangerous and requires immediate medical attention.

Symptoms of an ectopic pregnancy may include intense, sharp abdominal pain, vomiting, dizziness, and dark vaginal bleeding. Ectopic pregnancies can be treated surgically or medically. The type of management will depend on many factors, which will be assessed and explained to you by your healthcare team.

Recovering from an ectopic pregnancy, both physically and emotionally, will take time as you are dealing with the loss of your baby and potentially the loss of your fallopian tube. This happens sometimes when the fallopian tube is damaged by the ectopic pregnancy.



What to Expect: Late Miscarriage (Loss from 13-20 weeks)

Overview

A late miscarriage is the loss of a pregnancy or baby between the 13th and 20th week of pregnancy.

Similar to an early miscarriage, symptoms of a late miscarriage can include abdominal cramping and/or vaginal bleeding. In some cases, your amniotic sac or “water” (the fluid surrounding the baby in utero) may break, resulting in the feeling of a gush of fluid from your vagina. In other cases, there may be no physical symptoms and the miscarriage is discovered during a routine appointment or ultrasound. This means that you may find out your baby has died during an ultrasound or medical appointment.

Whether labour has started on its own or labour needs to be induced, a miscarriage that occurs later in pregnancy almost always requires medical or surgical intervention, and an admission to hospital for delivery. This is, in part, due to the increased size of the baby and the potential for complications during delivery.

Admission to the Hospital

Every hospital will have its own policies and procedures, and once admitted you will be cared for by a variety of healthcare professionals who have experience caring for people experiencing late miscarriages. Where you are admitted and the staff that will care for you depends on the community in which you live. For example, it may be emergency room staff, maternity staff, surgical staff, or general medicine staff. Sometimes, families will wait for a long time to be seen or have to wait in a room with many other people with very little privacy. Sometimes the staff caring for the family will be very busy with other patients, and you will be left



alone a lot. Other times, specialists will have to be called and a family will have to wait for long periods of time until certain procedures or staff are available. During this time, many families are upset, scared, angry, and confused. If you are feeling this way, you are not alone.

If possible, try to have a friend or partner with you when meeting with doctors or other healthcare providers, as you may be in shock and unable to absorb all the information on your own. If you are alone, you can ask a member of your healthcare team to call a friend or family member for you.

During their miscarriage or after learning of their baby's death, some families will have to wait to be admitted to the hospital. This may happen if the miscarriage was discovered at a routine pregnancy appointment but no physical symptoms are present. Families may be asked to return home and wait for an opening at the hospital, which can often take several days or even longer. Waiting at home while knowing that your pregnancy has ended or your baby has died can be very difficult and frustrating. Many families simply want to hurry up the process.

You may find it helpful to:

- Talk to a professional, such as a social worker or doctor, about taking time off work. Sometimes they can assist you with documentation that you need for your workplace.
- Ask for a contact person at the hospital or for someone from the hospital to give you updates about the timing of your admission
- Ask a close friend or family member to stay with you or check in with you regularly
- Ask for help with making meals, pet or child care, or giving updates to friends and family members



Once admitted to hospital you may request:

- To be admitted to a private room or area, although unfortunately in many hospitals, this is not always possible
- To have a symbol of loss — such as a butterfly or equivalent, hospital-specific symbol — placed on the outside of your door. This is so that all staff entering your room know about your miscarriage.
- To be introduced to your primary healthcare team (doctor, midwife, nurse, anesthetist, social worker, spiritual care provider, etc.) and to have time to ask questions
- To be given the opportunity to identify support person(s) or comfort measures (including a birth plan) to help you cope during the time leading up to, during, and after delivery
- To have the process of labour, induction of labour, and what to expect after delivery explained to you
- To be given options for pain management
- To discuss the plan after delivery. This includes whether you wish to have an examination of the baby or placenta or if you wish to keep the baby or placenta to take home with you, or to have your baby transferred back to your community after you have returned home.

The Process: Medication (Misoprostol or Oxytocin)

Whether you have started to labour on your own or your labour is helped along (induced), the medication most commonly used is called misoprostol. Misoprostol comes in tablet form and is inserted into the vagina. It can also be taken orally at three to four hour intervals.



Misoprostol causes the uterus to contract and is used in aiding the delivery of both your baby and the placenta. Cramping and contractions can begin as soon as half an hour after misoprostol administration and the medication almost always takes effect within the first 12 hours.

Common side effects of misoprostol include: chills, fever, nausea, vomiting, and diarrhea. Not everyone will experience all side effects, but if side effects do occur, medication can be administered to relieve symptoms. Talk to your healthcare team about what you are feeling, and let them know if you are having any of these side effects.

Once misoprostol has started to work, the uterus contracts and your cervix begins to open. Often the cramping is quite strong and painful and comes on very suddenly. Delivery usually follows quickly after.

Even though misoprostol works very well in most circumstances, sometimes labour doesn't progress. This means that even though you are taking misoprostol, the medication is not causing cramping or contractions or the cramping you are having is not strong enough. When this happens, misoprostol will be stopped and a medication called oxytocin will be administered through your veins (in an IV). Oxytocin is a medication that also causes your uterus to contract. If after trying oxytocin, the baby and placenta are still not delivered, your healthcare team will reassess and discuss additional options based on your specific situation. If you would like, ask your healthcare team any questions you have.

Sometimes the use of misoprostol is effective in the delivery of the baby but not all of the pregnancy tissues, such as the placenta. In such cases, your doctor may need to perform a suction dilation and curettage (D&C), which is a surgical procedure. They may also do a manual removal of the placenta or tissues, which means they will use their hand to gently remove them.



Throughout labour, your healthcare team will watch your blood pressure, pulse, and breathing (vital signs) and your labour progress will be closely monitored. During this time you may have your support person or people with you. Many families say that this process is a scary, sad, and tiring time. Ask your healthcare team any questions you have. Some families find it helpful to talk with their healthcare team about what to expect throughout the process and at the time of delivery. Other families do not want to talk about the process or delivery and rely on the healthcare team to tell them information when it's important for them to know. There is no right or wrong way to approach this time, so do whatever feels best for you and your family.

Pain Relief

Your healthcare team will be able to talk to you about pain relief during your miscarriage. You may have even spoken to a doctor who is specialized in providing pain relief (called an anesthetist) prior to the beginning of labour, who will offer various options for pain management. While oral pain medication can be given, the most common pain management option is morphine or fentanyl administered through your veins (intravenously or IV) through something called a 'patient controlled analgesia (PCA) pump'. This pump allows you to be in charge of your own pain relief. It works by having you push a button when you feel you need pain relief. The pump can stay with you for as long as it is needed. While you are using the pump, your healthcare team will watch you closely and talk to you about how you are coping with the pain.



Seeing and Holding Your Baby

Following delivery, you will be given the opportunity to spend time with your baby if you choose to do so. They are your baby, and only you should make this decision for yourself.

Many parents are comforted by contact with their baby, and there is nothing wrong with wanting to see, hold, and touch them, no matter how far along in the pregnancy you are. Some parents know what they would like to do, even before giving birth. Others cannot make that decision until they have given birth. Some parents decide that they do not want to see or hold their baby at all. Sometimes, one person does not want to see or hold their baby, while another person does. Whatever you decide to do, remember that it is a very personal choice, that you can always change your mind, and that your healthcare team will support you.

If you decide to see or hold your baby, you may decide to hold your baby right after birth, or you may wish to wait several hours before making a decision. Sometimes, parents are scared about how the baby will look or about how they will feel. Some parents are worried that they will be traumatized by seeing their baby. In some families, cultural traditions or spiritual beliefs guide whether or not they will see, hold, or name their baby. In other cases, there may not be very much to see or hold at all.

When making your decision, you may find it helpful to:

- Talk ahead of time about the delivery. Your healthcare team can give you some guidance about what to expect. You may decide to see how things go, and to change your mind depending on how you are feeling. For example, if you are in pain or feeling nauseous, you may ask the healthcare team to keep your baby in a safe place until you are ready to see or hold them. Or, you may ask the healthcare team to describe your baby to you first before you decide if you would like to see or hold them right away. Remember, you can change your mind at any time.



- Ask your healthcare team to take your baby at birth and keep them in a safe place until you are ready to see or hold them. Some families request that their baby is kept in the room with them, while others are ok for their baby to leave the room with a healthcare provider until they ask to have them in the room. Others would like to have their healthcare team describe their baby or the pregnancy tissues that have been collected before they see them, to help them prepare.
- Choose to hold your baby but not see them. Your healthcare team can help you with this. They may place your baby in a warm blanket and wrap them gently, so that you can hold them and spend time with them but not see them.
- Ask your healthcare team to describe your baby or what was collected at birth to you.
- If possible, ask your healthcare team to give your baby a bath before you see them.
- Remember that there is no rush. Take as much time as you need. You can also change your mind at any time.

Your healthcare team can also assist with special items, such as photos, birth announcement cards, or memorial items. When possible, some families want to help with giving their baby a bath or dressing their baby. Talk to your healthcare team about what will work best for you, your family, and your baby.

Birth Registration

Your healthcare team will be able to assist you with understanding current Ontario law, which dictates which babies are registered through the Registrar's Office and given a birth certificate. The majority of babies born before 20 weeks will not meet the legal criteria for registration. This is often extremely upsetting to families. If your baby is not born alive, your baby's birth will not be registered



with the Registrar's Office and they will not receive an Ontario birth certificate. Many families find this especially difficult during an already sad and distressing time. If you feel this way, you are not alone.

Many families struggle with the laws around birth and death certificates. For example, a family who has their baby die at 19 weeks of pregnancy may be sad or angry that a baby born one week later would be classified as a stillbirth and have a death certificate, but theirs will not. The rules can seem arbitrary and disrespectful to the life that was lost. If you feel or think these things, you are not alone.

While it may not take away your sadness or frustration about the registration laws, many hospitals offer keepsakes that honour the life and death of your baby, regardless of the time that your pregnancy ends or your baby dies. Some families choose to create their own birth announcements or keepsakes that include details such as their baby's name, weight, and date of birth. Many hospitals will have special cards to give to families that include these important details about their baby.

Rights of the Parents

- To see, touch, hold, and nurture their child with no limitation as to time or frequency
- To be fully informed about the baby, the cause of death, and the process of legitimizing the death (e.g. the funeral)
- To have written and verbal information about:
 - Options available for the burial or funeral
 - Supports available to family members
 - Necessary legal information (e.g. timing of burial, birth registration)
- To receive mementos of their baby (e.g. footprints, picture, certificate of life)



- To acknowledge the life and death of their child, a person in their family
- To choose any type of burial, cremation, or other funeral service
- To be heard and listened to by caring professionals, without judgment or prejudice
- To be cared for by staff who are empathetic, caring, and sensitive to individual responses, behaviour, and choices
- To be treated with respect and dignity
- To have the support of family and/or friends at any time, if the parent wishes
- To seek religious or cultural support for their choices and to be treated with cultural and religious sensitivity
- To be aware of the grieving process; to be able to grieve openly or quietly; and to be informed of, and understand, the feelings and emotions generated by loss
- To understand their future options regarding autopsy and genetic counselling
- To be informed about parent support groups
- To receive follow-up supportive care (at the hospital, primary care practitioner's office, and/or home) by telephone or by visit
- To have the opportunity to evaluate their hospital and community experience

Adapted from Women's College Hospital, Rights of parents at the hospital: At the time of the baby's death. Toronto: Women's College Hospital, 1984.



Rights of the Baby

- To be acknowledged by name and sex
- To be treated with respect and dignity
- To be with the grieving family whenever possible
- To be recognized as a person who has lived and who has died
- To be remembered with specific mementos (footprints, hand prints, pictures, clothes, name band, ultrasound picture)
- To be nurtured (bathed, dressed, wrapped)
- To be buried or cremated
- To be remembered

Women's College Hospital, Toronto, 1984

Source: Health Canada, 1999 Family-Centred Maternity and Newborn Care, Pg. 8.7.

Talk to your healthcare team about the options that are right for you. In some circumstances, you may not know the sex of the baby or choose to have a funeral or ceremony. Your healthcare team will be able to support you and your family to arrange for care that respects your wishes, traditions, and preferences.



Follow-up After Your Miscarriage

If you did not see your primary care provider (doctor, nurse practitioner, or midwife) during your miscarriage, or if you were only seen in an emergency department, you may want to book a follow up appointment to discuss the miscarriage. If appropriate and you live in a community that has an Early Pregnancy Assessment Clinic, you may want to receive follow-up there. If you received care through a maternity unit, they may have suggested a follow-up appointment with the care team that you saw.

At your follow-up appointment, you may want to talk about:

- How you are doing physically (bleeding, pain)
- How you are doing emotionally (feelings, thoughts)
- Considerations for your next pregnancy
- Ideas for support in your community
- A note for time off work or for time that you missed during your miscarriage

Some things to remember:

- When experiencing miscarriage bleeding, always use pads. Do not use tampons.
- Miscarriages are often an emotional emergency. Try to surround yourself with loving people. When possible, be kind to yourself.
- Reach out for support if you need it. Talk to a close friend or family member. Join a support group. Connect with an elder or a community or religious leader. Talk to a professional.
- The Canadian Mental Health Association has a website with information on mental health and mental illness and links to support. The Mental Health Helpline (1-866-531-2600 or mentalhealthhelpline.ca) has information about mental health services in Ontario and links to mental health service providers.
- If you or your family need help in an emergency or are in crisis, go to your local emergency department or call 911. You may also contact a distress centre or crisis line.



Autopsy, Investigation, or Examination of Pregnancy Tissues

After a miscarriage, your healthcare team may recommend an autopsy, investigation, or examination of your baby or pregnancy tissues. This means examining your baby or placenta or pregnancy tissues closely. Whether or not this is offered or available to you may depend on the circumstances of the miscarriage, such as where it happened (home, clinic, hospital) and how far along the pregnancy was. Not every clinic, hospital, or community will offer these services or have them available. Examination requires collection of the pregnancy tissues, which is not always possible. Collection of tissues is easier, for example, during surgical intervention (D&C) and harder during earlier gestations, where there may not be tissue to collect or the miscarriage happens at home.

During the examination or investigation, your pregnancy tissues are examined closely and genetic tests may be performed. Sometimes, tissue samples are taken and assessed microscopically in a lab. Sometimes, samples are taken from the baby or pregnancy tissues and tested for genetic disorders, infection, or other issues. These tests may help determine why the baby died, and are often helpful in cases of molar pregnancies or recurrent miscarriage.

The information gathered may be helpful in planning for future pregnancies. For people who have recurrent miscarriages (two or more miscarriages in a row), testing your blood and the pregnancy tissues for genetic or other issues may be suggested by your healthcare team. If you have experienced multiple miscarriages, it is important to discuss this with your primary care provider (doctor, midwife, or nurse practitioner) to determine what options are available to you.

Your healthcare team will talk to you about whether an investigation is possible or necessary. After, you will get to decide if it is the right choice for you and your family. Sometimes, even if the tests or investigations are done, no reason for your miscarriage or baby's death will be found. In fact, it is more common that the tests don't provide a reason for the miscarriage or the death of the baby.



An autopsy involves an examination of the baby's internal organs and may sometimes identify reasons why the baby died. During the autopsy, the baby is treated with respect and dignity. If you wish, this examination can be limited to the organs of most concern. If you do not want a full autopsy performed, you may want to consider something called a 'limited autopsy'. This allows for an examination completed on the outside of the baby's body, including x-rays and testing of the baby's chromosomes. An autopsy can also confirm the sex of a baby.

If you decide to have an autopsy or investigation, talk with your healthcare team about who will follow-up with you about the results and how long they will take to come back. Sometimes, results can take up to 6 months or even longer. You may wish to request that the results are sent to your primary care provider (doctor or nurse practitioner) so you can follow-up with them in their office. You may also ask to book a follow-up appointment with the doctor who discussed the autopsy with you or with your pregnancy care provider (doctor or midwife). If you live far away from where you received care, you can ask if the healthcare provider is willing to speak to you about your test results over the phone, or if you can have the test results with explanations mailed to your home. You may also be able to make an appointment with your local nursing station to discuss the results.

Your healthcare team will be able to help you decide who will best be able to follow-up with you once the results are back. Even if the results come back and no answers or reason for the miscarriage are found, you can use the appointment to discuss how you are feeling (physically and emotionally) and whether there are any more supports that you need.

You may also wish to speak to the healthcare team if you plan to keep the baby or pregnancy tissues for burial, cremation, or other special ceremonies. This will ensure that the lab or hospital team knows to return everything after they are finished with their investigation.



Funeral, Burial, Cremation, or Other Ceremony or Tradition

Although not required by law for babies born under 20 weeks, parents may choose to honour their baby with a funeral, burial, cremation, or other special ceremony or tradition. It is within your rights to bring the baby from the hospital to the funeral home, or to the family home yourself. You may also choose to hire the services of a funeral director to transport your baby. You may be required to sign a hospital release form to allow the funeral home to transport your baby or for you to take the baby with you. For families who will return home before any investigations or tests are completed, talk to the hospital to make sure the correct process is in place to have your baby and placenta brought back to you or your community. This is especially important for families who live far away from where the investigations or tests are completed. The healthcare institution where you are receiving care should provide you with burial and transportation guidelines.

Hospital cremation of the baby's remains is customary before a baby is 20 weeks, or if your baby has not reached a weight of at least 500 grams. When parents do not make arrangements for a baby who is under 20 weeks, the hospital will automatically arrange for a cremation. You may wish to ask the hospital what their current practice is and consider if this fits with your cultural, spiritual, religious, or philosophical beliefs.

Funeral homes vary in price for their services and it is advised you call around for the cost option that is right for you. If you have miscarried at home please check with your local municipality regarding personal burial by-laws or contact your local funeral home.



Too Much Bleeding is an Emergency

You should seek emergency medical attention from the closest emergency department or nursing station if you are:

- Experiencing bleeding heavy enough that you fill a maxi pad every hour
- Feeling faint
- Having too much pain

Have someone take you (do not drive yourself) or call 911. When it is safe to do so, let your primary care provider (doctor or midwife or nurse practitioner) know.

Physical Healing After a Miscarriage

After the miscarriage your body will gradually return to a non-pregnant state. You may still be experiencing vaginal bleeding similar to a heavy menstrual period. This will slow down over 1-2 weeks. During this time it is important that you prevent infection by following the guidelines below:

- Use only sanitary pads while you are bleeding
- Do not use tampons
- Do not have sexual intercourse until the bleeding has stopped completely
- Do not douche

Consult your healthcare provider or go to the closest emergency department or nursing station if any of the following occur:

- Vaginal bleeding filling one pad an hour
- Vaginal bleeding that does not stop or decrease by 2 weeks
- Vaginal bleeding or discharge that smells bad
- Severe pain in your abdomen
- Chills or a fever over 38.5°C (101.3°F)



Milk Production

After experiencing pregnancy loss your body may start to produce milk. This is more common for people who had their miscarriage after 14 weeks. Many people find milk production very sad and distressing, as this is another reminder of the pregnancy loss or baby that died. If you feel this way, you are not alone.

To alleviate discomfort you may find it helps to:

- Hand express (gently massage and squeeze your breast with your hand) or pump your breasts lightly. Doing this simply for comfort will not increase milk production, and it will help you avoid blockages and infection (called 'mastitis').
- Take a warm shower. It may help the milk leak out enough to provide some comfort.
- Apply cold compresses or a bag of frozen vegetables for 15 minutes. Some people also use frozen cabbage leaves. Repeat as necessary.
- If safe to do so, depending on your medical background, take pain medication such as ibuprofen or acetaminophen as needed. Both of these medications may be purchased over-the-counter. Talk to your healthcare team to see if these medications are right for you. If you take the medications, follow the instructions on the bottle or from your healthcare team.
- Wear a tight fitting bra that does not have an underwire.

Discomfort from milk production should only last a few days and should be gone within a week. If you have any concerns or think you may have an infection, please contact your primary care provider (doctor, midwife, or nurse practitioner).



Menstruation

Most people can expect a menstrual period in about four to six weeks after their miscarriage. Talk to your healthcare provider if this doesn't happen, or if you have any other concerns. Many families say that the first period after a miscarriage is difficult emotionally, because it is another reminder of the loss. If you find yourself feeling this way, know that you are not alone.

It is possible to become pregnant immediately after pregnancy loss, even before your menstrual period has returned. If you do not want to get pregnant during this time and could get pregnant from sexual intercourse, healthcare providers recommend using birth control methods, such as condoms.

Many healthcare providers recommend waiting for one complete menstrual cycle before getting pregnant again. The reality is that the decision to 'try again' is a very personal one, and it depends on the person and their individual circumstances. Some people will want to 'try again' as soon as possible. Some people will be advised to wait until the results come back from the tests done after the miscarriage, in case there is information gained that may help with the next pregnancy. Some people might find it very hard to even think about another pregnancy for a long time, if ever. Other people will have mixed feelings, for example if they feel stressed that they need to 'try again' quickly because they are planning on using fertility treatments, are worried about their age, or it took a long time to get pregnant before.



Grief and Loss

When you experience a pregnancy loss or your baby dies, you may feel deep physical and emotional pain that does not ever go away. We are sorry this has happened to you. Grief is a natural response to loss and deeply personal, which means that everybody grieves differently. Some people move through it easily, while others are deeply affected. After a miscarriage, there is no right or wrong way to feel. Many families say that even if the pain changes over time, it may become stronger again at certain times, for example when you get your next period, on your due date, or when seeing another pregnant person, healthy baby, or family with children.

The following may be experienced after a pregnancy loss:

- Crying and sadness
- Temporary impairment of day-to-day functioning, which means you don't feel like yourself or feel like doing the things you normally do or enjoy
- Avoidance of (staying away from) social activities
- Intrusive thoughts, including feelings of guilt and shame
- Feelings of yearning, numbness, shock, or anger
- Feelings of anger, sadness, or confusion about your personal cultural, spiritual, religious, or philosophical beliefs
- A loss of the feeling of being in control or belief that there is 'good' in the world

We know the time right after a miscarriage can be very challenging for many families. You are not alone in feeling or thinking these things.



Special Challenges

After a miscarriage, families may face unique challenges including:

Lack of Recognition: Families, friends, and healthcare providers may not acknowledge the loss as significant, or may undermine its impact. They may not understand how you are feeling, know how to help, or know what to say. Sometimes families will hear deeply hurtful things, such as:

- “You are young, you can always try again”
- “Once you get pregnant again, you will feel better”
- “At least you didn’t know the baby”
- “Now you have an angel in heaven”
- “This happens to lots of people”
- “It’s God’s will” or “Nature knows best”

Families may feel judged or that there’s a ‘time limit’ imposed upon them for returning to ‘life as usual’. People may wonder or even ask you when you will ‘get over it’.

Complicated Feelings: Families may feel cheated or betrayed. They may feel overwhelming guilt that they should have known something was wrong and/or done something to prevent it. They may feel anger towards themselves, their partner, a healthcare provider, or friend. They may also feel sad or numb or hopeless.

Social Isolation: After a miscarriage, many families say they feel alone and isolated. There are few, if any, shared memories or tangible evidence that the baby existed, and therefore parents may feel they are grieving alone. Parents may feel anxiety about being asked (or not being asked) about their pregnancy and therefore avoid others. They also may avoid being around other pregnancies, babies, and/or children.



You may also feel alone and isolated because some of your closest friends, family members, or co-workers have hurt you. Maybe they said something upsetting to you, or didn't say anything at all to acknowledge your loss. Maybe in your family, you're not supposed to talk about death or sad things or cry openly. Maybe you are feeling misunderstood by them a lot. Because of this, you might be avoiding talking to or spending time with people who used to be a bigger part of your life.

Often, family and friends want to do the right thing, but they may be unsure of how to help or what to say. If possible, let them know how you feel and what you need during this time.

Wondering What Could Have Been: Parents must grieve their dreamed upon future, the family they envisioned, and the life that could have been.

Memorializing Loss: Many families experience that there are few, if any, rituals for the loss of a pregnancy or baby. Most families aren't offered a funeral or memorial service. They may not know how to honour their experience, their loss, or their baby.

If you are feeling alone and isolated and you want more support, you may find it helpful to talk to your care providers about your feelings. Your care providers may be able to tell you about additional supports in your area. Some people only share their thoughts with their partner, best friend, or perhaps through their journal. Many families also find it helpful to talk to other people who have gone through a pregnancy loss. PAIL Network provides peer support for families who have experienced a miscarriage. Whatever you decide, the most important thing is that you get support and help when you need it.



Does Everybody Feel This Way?

Sadness, Shock, Guilt, and Anger

After a miscarriage, many families experience feelings of sadness, shock, anger, and guilt. Sometimes these feelings are connected to a certain event, such as when you are thinking about the baby, when you return to work, when you receive a pregnancy-related email or piece of mail, when your body leaks milk, or on your due date. Sometimes these feelings seemingly come out of nowhere and surprise you when you least expect it.

Many people feel guilty about their pregnancy loss or baby's death and constantly wonder 'if only'. Some people think a lot about what they could or should have done differently, even if they are told by healthcare providers that it was not their fault. Some people are angry that other people have 'easy' pregnancies or very sad when they know that it was the last time they could 'try' for a baby. Other people feel 'numb' after their miscarriage. If you feel or think these things, you are not alone.

We know that far too often, families feel isolated and misunderstood by family members, friends, co-workers, and care providers. You deserve to have the support you need. If you need more support, talk to a trusted person, including your care provider.

You might also consider supports from a:

- Social Worker
- Psychologist, Psychotherapist, Psychiatrist, or other mental health professional
- Public Health Nurse or Community Health Nurse
- Community or Friendship Centre
- Spiritual or religious care provider, community leader, or elder
- Lactation Consultant
- Doula
- Peer support organization such as PAIL Network. You can self-refer by filling out the intake form at pailnetwork.ca



Ideas for Support

You and your family are unique, and what you find helpful and supportive might be different than what others find helpful and supportive. Take what is useful, and leave the rest behind. Some ideas for support include:

- Surrounding yourself with people who are kind, loving, and able to support you and your family
- Talking about your thoughts and feelings with your partner, family, friends, elder, religious leader, community leader, or healthcare providers
- Taking a break from regular activities or responsibilities, and accepting help from others when possible. For example, you may want help with making meals, child or pet care, and housework.
- Honouring your pregnancy or baby in a way that is meaningful to you: donate to a local charity, do something you enjoy while thinking of your baby, attend a memorial event, make a memento box, write a poem or letter to or about your baby, write in a journal, name your baby, have a ceremony for your baby, wear a special piece of jewelry to commemorate your baby, light a candle, or plant a tree
- Connecting with peers: join a bereavement support group, read other people's stories, meet with a friend who will listen to you as you talk, or talk to families that have had a similar experience. Talking with others can be validating and comforting.
- Taking time off work, if possible. Your healthcare providers may be able to assist with documentation that you need.

Whatever you decide to do, the most important thing is that you get support and help when you need it.



Beyond Worry: Anxiety and Depression

After a miscarriage, it is normal for people to have thoughts and feelings that range from sad and angry to shocked and numb. Many of these thoughts and feelings come from grief, which is very common for families who have experienced a pregnancy loss.

Sometimes, certain thoughts and feelings can be a sign of mental health problems such as anxiety or depression. Having anxiety or depression means more than having a bad day or a scary thought. Anxiety and depression can happen to anyone. There is some evidence that the risk for anxiety or depression is higher for people who have experienced a miscarriage.

Diagnosing and treating anxiety and depression is very important, but some things make it harder for families to get the supports and treatment they need. Sometimes feeling sad, negative, angry, or anxious is so difficult that people are not comfortable talking about it. It may be hard for people to believe that someone will understand how they feel. Often people feel ashamed that they are having these thoughts or feelings or are worried that people will think they are a bad or weak person. Some people are worried about being forced to take medication. Some people might not even notice how they are feeling and a loved one may be the person concerned. Maybe you did try to talk to someone about it, but they didn't listen or you felt embarrassed. Finally, many of the thoughts and feelings associated with pregnancy loss or grief are the same as the thoughts and feelings associated with anxiety and depression, making it hard at times for care providers to determine what is happening.

Talking to your family and care team about mental health is important. Signs of anxiety or depression may include:

- Low mood or extreme sadness
- Significant or persistent feelings of worthlessness or hopelessness
- Feeling guilty, inadequate, anxious, or panicked



- Drug or alcohol abuse or a big increase in use
- Changes in how you function every day – not eating, bathing, getting out of bed
- Problems with sleeping
- Difficulty concentrating
- Thoughts of hurting yourself or others

If you have a personal or family history of mental illness, let your care provider know. If you are worried about your thoughts or feelings or want more support, let your care provider know. Book an appointment with your primary care provider (doctor or nurse practitioner). At the appointment, tell your care provider that you would like to talk about your mood, or take the opportunity to talk about your mood when asked “how are you feeling?” It is important to tell your pregnancy care team if you are feeling overwhelmed, finding it difficult to cope, or if you are having thoughts of harming yourself or others. Your care provider will be able to provide screening, follow-up, referrals, and supports for you and your family if necessary.

Some families also find it helpful to:

- Connect with their local Public Health Department. Many Public Health Departments will have Nurses or trained volunteers that can help you and tell you about supports in your community.
- Talk to other parents who have experienced mental illness.
- Join a support group.
- Talk to a mental health professional.
- Get support from a mental health organization. In Ontario, the Canadian Mental Health Association has a website with information on mental health and mental illness and links to support. The Mental Health Helpline (1-866-531-2600 or mentalhealthhelpline.ca) has information about free mental health services in Ontario and links to mental health service providers and organizations. On their website, you can search for local services.



Grief and Your Relationship

If you have a partner, you may find that you each experience grief differently. This is normal. Because no two people grieve the same way or at the same time, you may find that there is hurt or anger or sadness within your relationship. This especially happens when one partner thinks the other is not grieving or when one partner thinks the other does not care about the loss or them.

In some cases, your partner may feel that they are expected to remain outwardly strong to support you. This can hide feelings of loss and sadness as your partner tries to cope themselves. In some cases, one partner may be required to keep working or to care for other children or the home, and they may wish to avoid getting outwardly upset so they can complete their work and tasks.

Many partners say that sexual intimacy after a miscarriage is challenging, especially if one partner is ready and the other is not. Sometimes pregnancy loss makes people feel ashamed of or disappointed in their body. Sometimes physical symptoms, such as pain or bleeding, mean that a person does not feel sexual. Sometimes the sadness or anger means that a person can't connect with their partner in an intimate way.

It is important that partners not blame themselves or each other, and to remember that you are both grieving the same difficult loss. It is important to try to be respectful of each other and where each person is on their grief journey. Talking about your feelings and differences with each other can be helpful. Some families also find it helpful to talk with a trusted person, such as a friend, family member, or professional.



Children and Grief

After a miscarriage, many parents are concerned about their other children.

They may ask themselves:

- Do we tell them about the miscarriage?
- When do we tell them about the miscarriage? How do we tell them?
- How do I answer their questions or reassure them?
- Am I paying enough attention to them?
- Why am I so nervous that something bad will happen to them too?
- Why don't they seem to care about the miscarriage?
- Should I cry in front of my children or show them that I am sad?

If you are thinking or feeling these things, you are not alone. There are no answers to these questions that will be right for every family. While many families find it best to talk about what happened with children, others will choose to not talk about the miscarriage. If you decide to talk about the miscarriage, or if your children ask, you may find it helpful to use explanations that are clear and simple and appropriate for their age. It is ok to let your children know that you are upset that the baby died. It may help to let them know that you love them and that the pregnancy loss was not their fault.

It may be helpful to ask family and friends to help with things such as childcare or special outings for other children. Sometimes, families find keeping a routine for children is helpful. This means having the children do many of their 'regular' activities.

Your child's primary care provider, social worker (school, hospital, or community), child life specialist, educator, community leader, or elder may assist you with ideas on how to support them and how to speak with them in language they will understand. Talking to other parents with children who have experienced a loss may also be helpful. For more information or resources, please go to pailnetwork.ca



Resources

For an up-to-date list of helpful resources, or to get support, please go to pailnetwork.ca.







PREGNANCY AND
INFANT LOSS NETWORK

1-888-303-PAIL (7245)

pailnetwork.ca

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