Miscarriage UK

Because every loss matters

Supporting you through miscarriage

We're sorry that you're going through a miscarriage. It can be a painful and deeply difficult experience.

You don't need to read this booklet in order. It's divided into sections, so you can go straight to what feels like the most relevant part and come back to other sections when, and if, it feels right.

Reaching out for support after pregnancy loss can feel difficult. We are here to offer support in ways that work for you.

Our support line

Our support line is a safe space to talk, ask questions, or simply share how you're feeling and be heard. We're here from 9 am to 8pm on Mondays, Wednesdays and Fridays, and 9 am to 4pm on Tuesdays and Thursdays. Interpretation and BSL are available.

Message us

Sometimes it's easier to type than speak. Our live messaging connects you with trained staff who will listen, offer emotional support, and share trusted information and resources with you. It's open the same hours as our support line and is a safe, quiet space to talk through things at your own pace.

Email support

We know that sometimes it's hard to talk, or you may need time to express your feelings. Our email support gives you the space to share your thoughts and feelings. We aim to respond within two working days, and everything you share will be treated with kindness and sensitivity.

Online support

Our online support options give you the chance to connect in a way that feels right for you. Whether that's by reading lived experience stories from our community, signing up to our newsletter or finding community through our private Facebook groups.

Support groups

Meeting others who understand your experience can make a big difference. Our support groups are a safe space to talk, listen, and connect with others affected by pregnancy loss. All our support groups (online and in-person) are guided by experienced facilitators.

Contents

Understanding miscarriage

Types of miscarriage

Miscarriage is when a baby (or fetus or embryo) dies in the uterus, or a pregnancy stops developing, before 24 weeks of pregnancy. A loss from 24 weeks is called a stillbirth. Miscarriage is sadly far more common than many people realise. No one knows exactly how many miscarriages happen because official records are not kept. But experts estimate that more than one pregnancy in every five ends in miscarriage. There are several different types of miscarriage:

Anembryonic pregnancy

Sometimes called a 'blighted ovum', this is when a scan shows a pregnancy sac without a baby or fetus inside it. The embryo has stopped growing at an early stage but the sac where the baby should develop has continued to grow.

Missed miscarriage

When the baby has died but is still in your uterus. This is sometimes discovered during a routine scan and may come as a complete shock, especially if you have had no sign that anything was wrong. You may still feel pregnant and may still have a positive pregnancy test.

Complete miscarriage

When the baby has died or not developed and your uterus (womb) has emptied naturally. You may have had pain and heavy bleeding over several days.

Incomplete miscarriage

When the miscarriage has started naturally but the uterus has not emptied completely. You will probably still have pain and heavy bleeding.

Recurrent miscarriage

The medical term for three or more miscarriages, whether or not you have had healthy pregnancies in between.

Second trimester (late) miscarriage

A miscarriage that happens between 14 and 24 weeks of pregnancy. Second trimester miscarriages are much less common than earlier miscarriages, and more often mean you need treatment in hospital.

Scan the QR code to read more about second trimester loss on our website.

Other types of early pregnancy loss

Pregnancy of unknown location

This is when a pregnancy test is positive, but no pregnancy is visible on a transvaginal ultrasound. It is a temporary diagnosis, often requiring blood tests after two days and/or a repeat ultrasound scan to determine if it is a very early pregnancy, a miscarriage or an ectopic pregnancy.

Ectopic pregnancy

An ectopic pregnancy is one that develops outside the cavity of the womb. Around 1 in 90 pregnancies in the UK are ectopic and for some women, this can be a life-threatening condition.

You can read more about ectopic pregnancy on our website and in our separate leaflet.

Molar pregnancy

Molar pregnancy is very rare – affecting about 1 in 600 pregnancies. It happens when there is a problem with the fertilised egg and the pregnancy doesn't develop as it should. Unfortunately, molar pregnancies cannot survive and require a surgical procedure to remove the tissue.

Molar pregnancies require specialist follow up care, with regular blood and urine tests over weeks or months, to ensure there are no remaining abnormal cells.

You can read more about molar pregnancy on our website.

Choices for managing a miscarriage

A miscarriage will usually happen naturally in time, and some people choose to wait for this to happen. The process can be aided or 'managed' by medical treatment (drugs) or surgery if you prefer.

You should be able to choose what treatment to have and be given information to guide your decision. Unless you need emergency treatment, you should be given time to choose the right way for you. These can be difficult choices to have to make at a distressing time.

Expectant management

Waiting to let the miscarriage happen naturally. Doctors often recommend this, especially in the first eight or nine weeks of pregnancy. National (NICE) guidance also states that natural management should be the first method to consider.

Medical management

Treatment with oral medication and/or vaginal tablets (pessaries) to start or speed up the process of a missed or incomplete miscarriage. This isn't suitable for women with some health conditions.

Surgical management

A procedure to remove the pregnancy tissue. It may be done under general anaesthetic, so you are asleep: in this case you might hear it called a 'D&C' or dilation and currettage. It can also be completed with local anaesthetic, where you stay awake: in this case you will hear it called an 'MVA' or manual vacuum aspiration.

It may help to know that research shows:

- the risks of infection or heavy bleeding or scarring/damage are very small with all three methods
- your chances of having a healthy pregnancy next time are equally good whichever method you choose
- women cope better when given clear information, good support and a choice of management methods

You can find more information on management of miscarriage on our website, or in the following pages.

Expectant management	
What happens?	This means waiting for a miscarriage to happen by itself. It can take anything from days to weeks before the miscarriage begins. Sometimes expectant management happens while you are waiting for a surgical procedure.
Will it hurt?	The experience of a miscarriage is very variable. Most women have cramps and these can be extremely painful, especially when the pregnancy tissue is being pushed out. You are also likely to bleed very heavily and pass clots. These can be as big as the palm of your hand. You may see the pregnancy sac, which might look different from what you expected. You may - especially after 10 weeks - see something recognisable as a baby.
Advantages	You may want your miscarriage to be as natural as possible and to be fully aware of what is happening. You may also find it easier to say goodbye if you see the tissue and possibly the baby as it passes.
Disadvantages	You may find it difficult not knowing when the bleeding and cramping will start. You may be anxious about how you will cope with pain and bleeding, especially if you are not within easy reach of the hospital. You might be frightened about seeing the remains of your baby. You might find it upsetting or difficult to have follow-up calls or appointments to check on progress - although some women find this reassuring. You might be too upset to wait for the miscarriage to happen naturally once you know your baby has died.
Risks	Infection affects about 1 in 100 women. Haemorrhage (extremely heavy bleeding) - about 2 in 100 women have bleeding bad enough to need a blood transfusion. Some may need emergency surgery to stop the bleeding. Sometimes a miscarriage doesn't complete itself properly even after a few weeks - and some pregnancy tissue remains in the uterus. You may need an operation to remove it.

Medical management	
What happens?	This means treatment with pills and/or vaginal tablets (pessaries) to start or speed up the process of a missed miscarriage. The exact treatment your hospital offers may depend on the current practice and the details of your miscarriage. You might have some or all of your treatment in hospital, or you might be given some of the medication to use at home. You may need more than one dose of the medication before the miscarriage happens.
Will it hurt?	Most women have cramps that can be extremely painful, especially when the pregnancy tissue is being pushed out. You are also very likely to bleed very heavily - more than with a normal period - and pass clots. These can be as big as the palm of your hand. You may need to use extra-absorbent pads, possibly even more than one at a time. You may see the pregnancy sac, which might look different from what you expected. You may - especially after 10 weeks - see a recognisable baby.
Advantages	Some women see medical management as more natural than having an operation, but more controllable than waiting for nature to take its course. You may prefer to be fully aware of what is happening, to see the pregnancy tissue and perhaps the fetus.
Disadvantages	The medication may make you feel sick and can cause diarrhoea and flu-like symptoms. The hospital team should provide you with anti-sickness tablets. You may find the process painful and frightening. You may be anxious about how you will cope with pain and bleeding, especially if you are not in hospital at the time. You may be frightened about seeing the remains of your baby. Bleeding can continue for up to three weeks after the treatment and you may need several follow-up scans to check on progress. Some women end up having an operation anyway.
Risks	Infection affects about 1-4 women in every 100. Haemorrhage affects about 2 in 100 - the same as for expectant management. Some may need emergency surgery to stop the bleeding. Retained tissue - medical management is effective in 80-90% of cases. If it is not, or if you have an infection, you may be advised to have surgical management to complete the miscarriage.

Surgical management (SMM)	
What happens?	This can be done under general anaesthetic (while asleep) or while awake (in which case local anaesthetic is used, and the procedure is often referred to as an 'MVA'). You might be given pills or vaginal pessaries beforehand to soften the cervix (the neck of the uterus). The cervix is then dilated (stretched) gradually and a small suction tube is used to remove the pregnancy tissue. The whole procedure usually takes about 5-10 minutes. A sample of the tissue is usually sent for testing to check that it is normal.
Will it hurt?	If you are given tablets or pessaries before the operation, these may cause cramping pain and perhaps some bleeding as the cervix opens. Having a general anaesthetic means you will not feel anything during the operation itself; and there are no cuts or stitches. With an MVA, most women feel some pain during the procedure, which can range from mild discomfort to a very intense cramping pain. The injection of local anaesthetic into your cervix might feel uncomfortable, but it only lasts for a few seconds. It's likely you'll then feel some pain or cramping as the tissue is removed and the uterus contracts. You can be given additional pain relief, such as nitrous oxide (gas and air).
Advantages	You know when the miscarriage will happen and can plan around that. With a general anaesthetic you won't be aware of what's going on.
Disadvantages	You might worry about anaesthetics, surgery and being in hospital. You may prefer to let nature take its course and to remain aware of the process. If you have a general anaesthetic, you may need to arrive at the hospital early, not eat or drink beforehand, and arrange to be picked up afterwards. The anaesthetic might make you feel groggy or unwell for a few days.
Risks	About 2-3 women in every 100 get an infection. In fewer than 1 in 200 cases, the operation can perforate (tear) the uterus; damage to other organs is rarer still. Haemorrhage risk is very low, affecting 1-2 per 1,000 cases. In around 5 in 100 cases, some pregnancy tissue remains in the uterus and a second operation is needed to remove it. Very rarely, the general anaesthetic can cause a severe allergic reaction. With an MVA, there is a very small risk of having a reaction to local anaesthetic. There is a very low risk of scarring/adhesions. Very rarely, someone may experience severe adhesions (known as Asherman's syndrome) that may result in difficulty getting pregnant in the future. This is a risk regardless of how a miscarriage is managed.

When should I seek urgent help?

You should seek immediate medical advice if you:

- have severe bleeding: soaking through your pad every half hour to an hour and losing large clots
- feel very dizzy or faint
- are experiencing severe stomach pain that isn't eased by over-the-counter pain relief
- have signs of a fever - feeling very hot or cold and shivery
- your discharge or bleeding looks unpleasant or smells offensive, indicating possible infection

You may already be under the care of an early pregnancy unit who you can talk to for advice. If not, or you have any of these symptoms when they are closed, then you can attend A&E, ring NHS 111 or call 999 for an ambulance.

Choices for your baby's remains

We are so sorry that you are facing this decision.

When a baby dies before 24 weeks of pregnancy, there is no legal requirement to have a burial or cremation. Even so, hospitals should give you options, taking into account your personal, religious or cultural needs or beliefs. As a minimum, you should be able to choose cremation, burial or incineration (these are normally with the remains of other miscarried babies) or having the pregnancy remains returned to you.

If you miscarry in the hospital, the staff should support you to make the choice that is right for you, If you prefer, you can still make your own arrangements.

If you miscarry at home or somewhere else outside a hospital, it is common to pass the remains of the pregnancy into the toilet (this can happen in hospital, too). You may look at them and you might see a pregnancy sac and/or the fetus - or something you think might be the fetus.

You may want to simply flush the toilet - many people do that automatically - or you may prefer to remove the remains for a closer look. That's natural too.

You can, if you have been treated in hospital, take the remains there for sensitive disposal. It's important to know, though, that while the hospital might be able to confirm them as pregnancy remains, they probably won't carry out any tests on them.

If you decide to keep the remains, there is no requirement to take them for disposal – you can make your own arrangements if you wish to. This could include burying the remains in your garden (there is guidance around this) or in a planter, or you could speak to a funeral director about burial in a cemetery (there may be a cost for this).

Find more information on our website.

Remembering your baby

Many people want to do something special to remember their baby or help them say goodbye.

Can we have a memento of the baby?

If you had a scan before an early miscarriage, you may be able to request a copy of the scan image from the hospital or clinic.

After a second trimester (late) miscarriage staff in the hospital may offer to take photos of the baby, and hand or footprints. If you are not ready to see these at the time, the hospital can save the images for you, in case you want to see them later.

Optional certificates are now available in England, Scotland and Northern Ireland. A similar scheme will be launched in Wales, but there is no date for this yet.

We have our own certificates available from our online shop.

Can we know the baby's sex?

This is sometimes possible, but usually only after second trimester miscarriages, or if you have genetic testing.

What about a blessing for the baby?

You may be able to ask the hospital chaplain to hold a short service or say a prayer for your baby. Or you could ask a representative of another faith if you prefer. Some hospitals host regular services of remembrance for babies who die in pregnancy.

Every Loss Remembered

Every Loss Remembered is a shared, public online space where people affected by pregnancy loss can come together in remembrance.

You can add a name, message or image in memory of your loss or losses. Your dedication will become part of a growing collection recognising every loss and every experience.

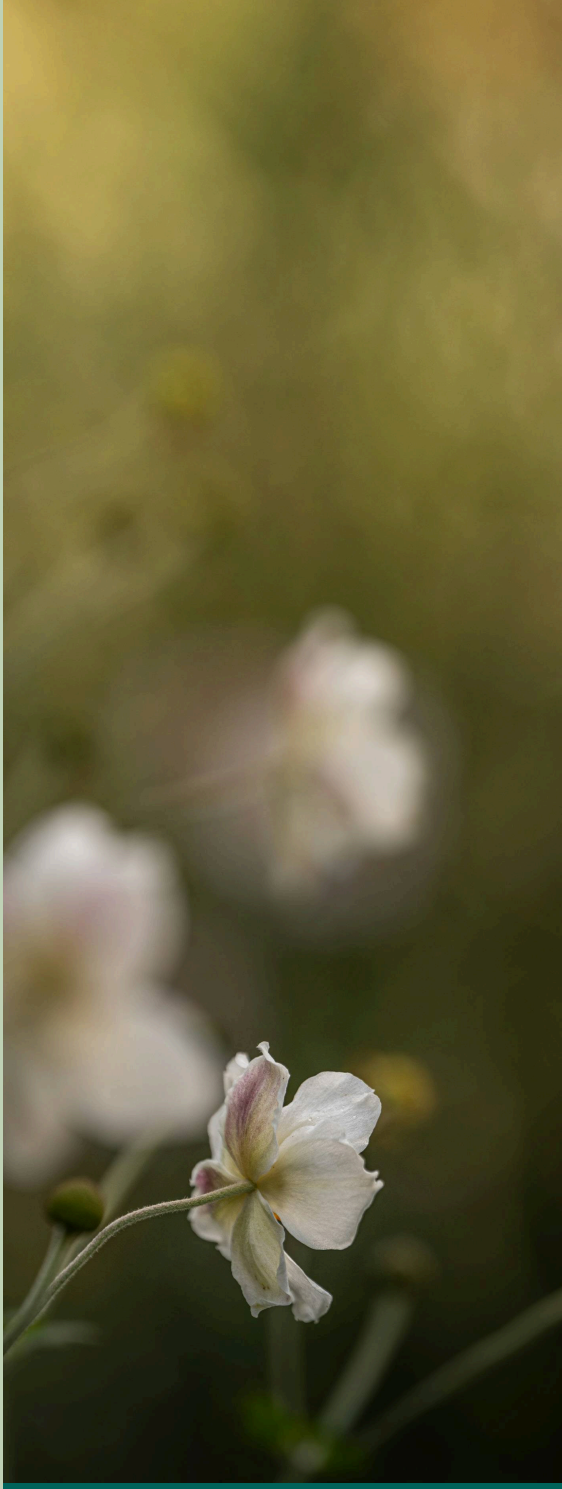
There is also the option to create your own tribute page that you can personalise with photos, music and videos.

Find out more by scanning the QR code.

What else can we do?

We have lots of ideas on our website, but you might like to think about:

- Asking if the hospital has a book of remembrance, where your baby's details can be recorded
- Finding out if there is a local garden of remembrance, where you could arrange a personal memorial
- Planting flowers or a tree, or scattering some wild seeds, in memory of your baby.
- Making a donation to a favourite charity
- Writing a letter or poem to your baby.



After a miscarriage

The impact of a miscarriage can be felt both physically and emotionally. You may feel unwell for a week or often longer, especially if you are bleeding heavily; and you may need to rest and sleep more than usual.

Physical recovery after a miscarriage

Everyone is different, but it can take anything from a few days to a few weeks to recover physically from a miscarriage. You may find that you are particularly tired or feel generally run down.

You may feel better or simply relieved once the physical process has happened, especially if it took a long time or if there was a long period where it wasn't clear if you were miscarrying or not. All sorts of things can have an impact on your recovery, including how much bleeding you have had and how long the process has taken.

There are no absolutes, but if you are worried that it is taking you a long time to recover physically, talk to your GP.

Periods after miscarriage

How long might it take for my period to return?

Everyone is different and this can vary depending on how quickly your hormone levels settle. As a guide it can take between 4 to 8 weeks for your periods to return. For some people this can be a little shorter and for others this can be a bit longer. It doesn't mean that anything is wrong, but if you haven't had a period within this time, it might be an idea to consult your GP or hospital doctor in case some extra tests are needed.

What might my first period after miscarriage be like?

Again, this may be different from person to person. For some it can be heavier and more painful than normal and it might also last a bit longer, too. There can sometimes be some small blood clots or tissue that comes away; this can be upsetting to see but is not a cause for concern.

For other people the first period might be much lighter and shorter than they are used to, perhaps especially after surgical management of miscarriage, and subsequent periods usually do get back to a more normal flow and length.

My cycle and periods are different after my miscarriage - is there something wrong?

Irregular periods after a miscarriage can be very common. Your body has been through some big hormonal changes, and it can take a few months before it gets back to a more predictable pattern.

If your cycle was irregular before the miscarriage, it is likely that it will stay that way afterwards, too. If your periods were like clockwork before your miscarriage, more often they will quickly get back to that pattern. If they haven't returned to your normal pattern after 3-6 months, then do talk things through with your GP.

For more information scan the QR code to view frequently asked questions.

When can we have sex?

Because of the risk of infection, it is important that you do not have sex until your bleeding has completely stopped and you have had a negative pregnancy test.

Having sex again - or thinking about it - often brings mixed emotions. It can be a chance to feel close, but for some people it can also be a reminder of what they have lost. One of you might want to have sex sooner than the other.

Having sex also raises the question of when or if to try for another baby.

How long should we wait before trying again?

The usual advice is to wait until after your first period. This makes it easier to work out the date of conception and so to know if a future pregnancy is developing as expected. Your doctor may advise you to wait for longer if you've had problems such as an infection or retained tissue, or are waiting for test results.

We talk about this more on page 36.

What about contraception?

It's possible to get pregnant before your first period. So, if you want to wait, use contraception. You can talk about options with your GP or sexual health clinic.

What about follow-up treatment?

There is currently no standard follow-up care after a miscarriage, so this varies across the UK.

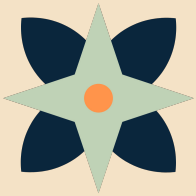
You may be offered a follow-up appointment at the hospital, but if not, you can contact your GP or midwife with any questions or worries.

Subfertility & IVF

What if I have suffered from subfertility, or this was an IVF pregnancy?

Deciding whether and when to try again after a miscarriage following fertility treatment is a deeply personal decision. While the timing varies for each individual, there is often no medical need to rush. Many women can safely begin trying again after one full menstrual cycle, once they feel physically recovered and emotionally ready.

One of the most difficult aspects can be the uncertainty about the future. You may feel hopeful about trying again, or unsure how much more you can go through. You might begin to think about other ways of becoming a parent, such as adoption or fostering, or consider different paths for the future.



Going back to work

When can I go back to work?

This really depends on how you feel, physically and emotionally. Some people feel ready to return to work fairly quickly, while others might need longer. You may gain comfort from the routine of work and the support of your colleagues, or you might not be ready to face work for a while.

Your workplace policies, such as whether you get paid leave, might also dictate how much time off you feel you can take.

We talk more about returning to work on page 25.

The emotional impact

How you might feel

Every miscarriage is different; and there is no right or wrong way to feel about it.

Your feelings, whatever they are, are valid.

You might feel:

- sad and tearful
- shocked and confused
- numb
- angry
- jealous
- guilty
- empty and lonely
- panicky and out of control
- unable to cope with everyday life
- relief - if there were days or weeks of uncertainty or pain; or maybe if you didn't want, or were not sure how you felt about, this pregnancy

Or many of these things all at once.

How long will I feel like this?

Your feelings are unique to you. They may last longer than you – or your friends and family – expect. Or you might be able to move forward quicker than you thought.

Even when you start to feel better, there may still be some tough times. You might get upset when your periods return. It can take you back to the physical experience of your loss, and it can feel like a cruel reminder that you are no longer pregnant.

Sometimes a bad day comes out of the blue. But sometimes it happens for a reason, like if a friend tells you she's pregnant or has a baby. Bad days often come on particular dates – like the day the baby was due, or the anniversary of the miscarriage.

Finding your way through these feelings may not be a straightforward process. Being kind to yourself, talking to people you trust and finding the right help can make a big difference. If you are finding it difficult to move forward, we can help you think through your next steps.

Where can I go for help and support?

Whatever your circumstances, you don't need to go through this alone.

You might want to

- Talk to your partner, family or friends
- Speak to the hospital chaplain or another faith leader
- Talk to your GP or healthcare team
- Get in contact with charities like us at Miscarriage UK

We offer support in many different ways - hopefully one of them will feel right for you.

- Call or message our support team
- Join our private Facebook groups and connect with others
- Sign up for an online support group with people with similar experiences

You might also find it helpful to read experiences and stories on our social media channels and website.

We also have a counselling directory where you can find a professional with specialist knowledge of pregnancy loss.

Getting your questions answered

If you have questions or worries about your loss, you could turn for help to:

- Your GP, practice nurse or midwife
- The staff at the hospital where you were seen
- Our support team and website - we can't give medical advice, but we can help you to make sense of your experience

Support for partners

It is sometimes assumed that miscarriage is easier for the person who was not physically pregnant.

But this is your loss, too, and your feelings are valid.

There is no right or wrong way to feel. You might feel the same way as your partner, or struggle to understand what they are experiencing. You might feel very sad and upset, or you might not yet have felt an attachment to the baby or pregnancy.

However you feel, if you need to talk, we are here for you, too.

Common feelings include:

- shock
- anger
- a sense of loss
- isolation and loneliness
- guilt
- failure
- numbness
- helplessness and frustration
- difficulties concentrating
- lack of interest in sex
- anxiety – about your partner, the relationship or a future pregnancy
- impatience – to get back to normal or try again
- relief – if there were days or weeks of uncertainty or pain; or maybe if you didn't want, or were not sure how you felt about, this pregnancy

It's common for partners to feel helpless during pregnancy loss. You can't control what's happening and may not even understand what is going on. You may be shocked and concerned at the sight of blood and blood clots and it is hard to see someone you care about in pain and distress.

There is more information for partners, including specific information for partners from the LGBTQ+ community, and navigating relationships on our website.

Looking after your mental health

If you are feeling suicidal right now, please consider one of these courses of action:

- Go to your local A&E department or call 999
- Contact your GP for an emergency appointment or to speak to the out of hours team
- Use Mind's 'I need urgent help' tool

Pregnancy loss can affect your mental health in different ways. You may find you need more support for a while.

For some people, pregnancy loss can contribute to mental health difficulties, or make existing ones harder to manage. You might receive a diagnosis such as post-traumatic stress disorder (PTSD), anxiety or depression, or experience symptoms that affect your day-to-day life.

This can include things like intrusive thoughts, flashbacks or nightmares. For some, it's not only the loss itself, but what happens afterwards that has an impact.

You might experience:

- persistent negative thoughts about yourself
- ongoing worry or overthinking
- feeling lonely or isolated
- feeling misunderstood by others
- a worsening of an existing mental health condition
- returning to coping strategies you've used in the past

Specific diagnoses

Although more research is needed, pregnancy loss has been linked to some specific mental health problems such as:

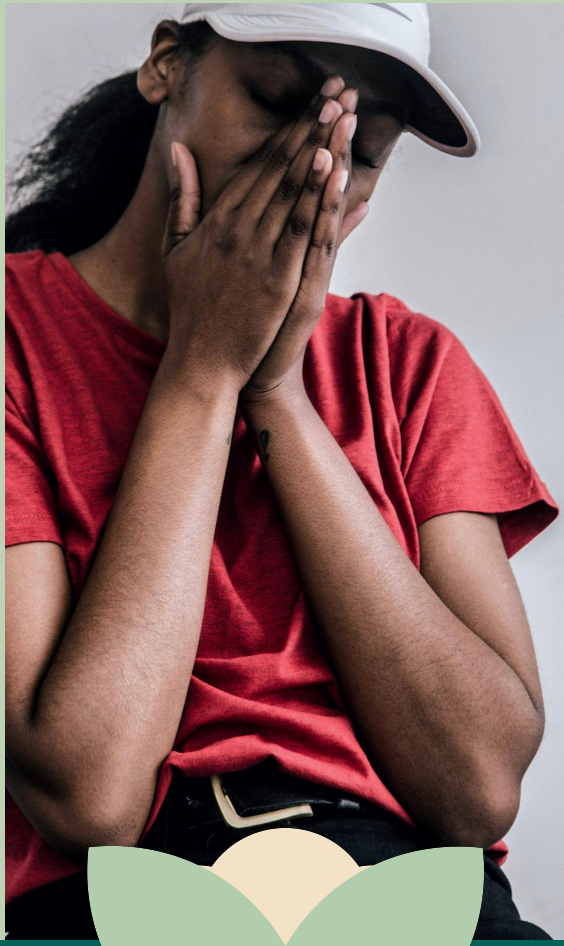
- Depression
- Anxiety
- Post Traumatic Stress Disorder (PTSD)
- Obsessive Compulsive Disorder (OCD)

Find out more about pregnancy loss and mental health on our website.

Symptoms and difficult experiences

Not everyone is diagnosed with a specific mental health problem. But you might still have symptoms that are upsetting and difficult to live with. If you experience any of these, you may want some extra support.

- Flashbacks – feeling as if you are re-experiencing your loss, as if it is happening now
- Panic attacks – you may feel sweaty, sick, disconnected, shaky and out of control
- Self-harm – hurting yourself to help deal with overwhelming emotions and painful thoughts
- Suicidal feelings – thinking the world would be better off without you, having thoughts about death, or making a plan to end your life
- Insomnia or problems with sleep – finding yourself unable to sleep because you are worrying and thinking a lot about your loss, or for another reason
- Nightmares – having nightmares related to your loss when you do sleep
- Feeling tired all the time – even if you have managed to get enough sleep
- Intrusive thoughts – not being able to control when images or thoughts related to your loss appear in your mind
- Difficulty concentrating or remembering things
- Phobias - feeling very scared or anxious about something specific, perhaps related to your loss (but not always)



Talk to your GP or self-refer for talking therapies

Your GP can make a diagnosis, prescribe medication, tell you more about local support and refer you to counselling or additional support on the NHS. It can help to write things down beforehand, so you know what you want to say. You can also self-refer yourself for talking therapies without going through your GP.

You can find more suggestions around talking to your GP or health professional on our website.

Medication

You may be offered medication. You might be worried about starting this, especially if you are thinking about trying again. Talk to your doctor about what's right for you. They should explain the risks of both taking and not taking medication, the safest medications for you and other possible options.

Counselling

You can speak to your GP or self-refer for talking therapies on the NHS, though there is likely to be a wait. You might also be able to access counselling through a charity, or through your work – many employers have Employee Assistance Programmes which offer a number of sessions. You can, of course, see a private counsellor if you are able to.

You don't need to have reached crisis point to seek additional support. You might find that talking to a counsellor helps you stay well.

We have more information about counselling and a directory of specialist counsellors on our website.

Looking after your wellbeing

Looking after your wellbeing can help you feel more resilient. Mindfulness, yoga, acupuncture or gentle exercise might help you to feel calmer and more able to cope. You can read more about ways to look after yourself on our website.

Miscarriage and work

When can I go back?

This really depends on how you feel, physically and emotionally. Some people feel ready to return to work fairly quickly, while others might need longer. You may gain comfort from the routine of work and the support of your colleagues, or you might not be ready to face work for a while.

Your workplace policies, such as whether you get paid leave, might also dictate how much time off you feel you can take.

Your rights at work

If you live in Northern Ireland, you are entitled to two weeks' paid parental bereavement leave following a pre-24-week pregnancy loss. This applies to both intended parents.

Unfortunately, this leave is not yet available in the rest of the UK. However, following our Leave for Every Loss campaign, the Westminster Government has agreed to define pre-24-week pregnancy loss as a bereavement in future employment law, allowing people to take a minimum of one week's leave. However, this bereavement leave is currently unpaid, and the law changes do not come into effect until the second half of 2027. In the meantime, the following applies:

Outside of Northern Ireland, or unless your employer has enhanced pregnancy loss policies, if you need time off after a miscarriage, whether for physical or mental health reasons, you will likely need to take it as sick leave. This should be recorded by your employer as pregnancy-related sickness. This means it cannot be used against you in any way, for example in decisions about discipline, promotion or redundancy. Any employer who uses your miscarriage absence in this way risks breaking the law.

You can self certify this for the first seven days. After that, a GP or other medical practitioner will need to provide a fit note confirming it is pregnancy related. There is no set limit on this type of absence, if it continues to be certified in this way, but you will need to keep providing fit notes.

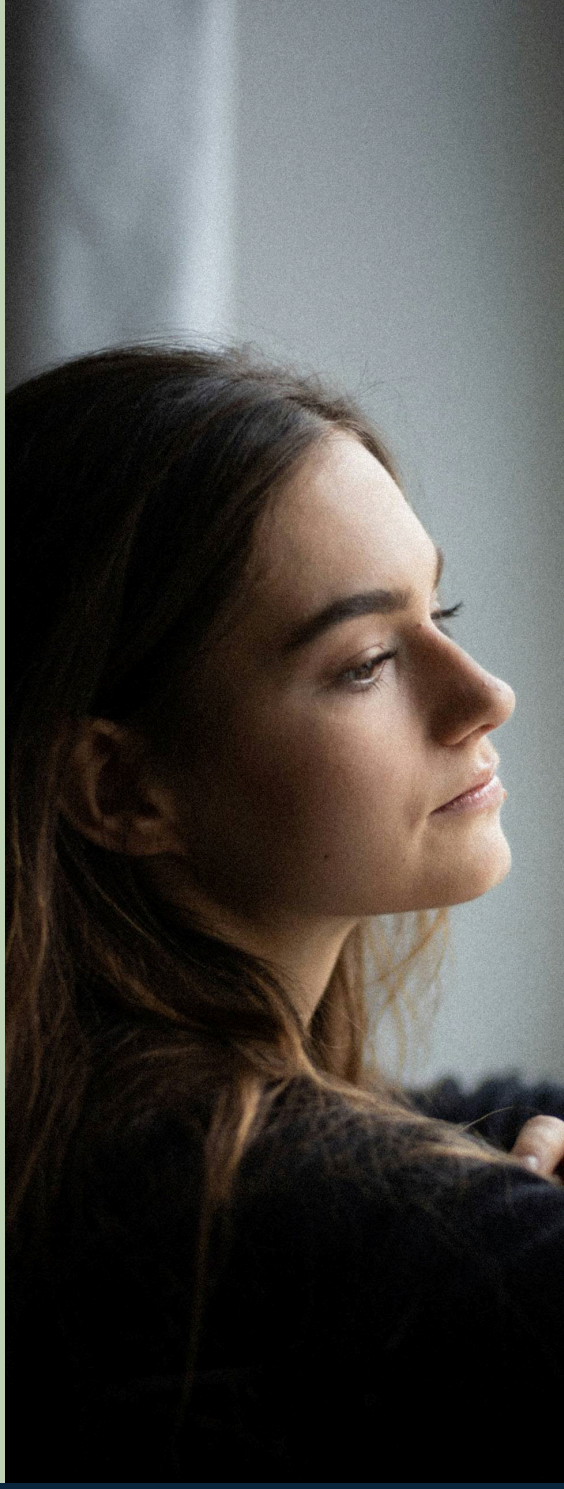
If you return to work but then feel you need more time off, you can ask your GP to continue certifying your leave. If your GP is reluctant to do this, you can ask to see another doctor or ask for a second opinion.

If you decide not to tell your employer about your miscarriage and are off for more than seven calendar days, you will still need a fit note. You can ask your doctor not to share detailed information, but this means your absence may not be protected as pregnancy related.

If you are in Northern Ireland and have taken your parental bereavement leave, you can still take an additional period of sick leave if you need it, adhering to usual sickness leave rules.

Self-employed

If you are self-employed, you may have the flexibility to choose when and how you go back to work, but of course you will still need to make decisions based on your workload and finances.



Partners

If you are the partner of someone who has experienced a physical loss, you are not currently legally entitled to pregnancy-related leave or sickness absence. Some workplaces may have provisions for partners in a pregnancy loss policy or may offer compassionate leave (paid or unpaid). Others may ask you to take unpaid leave or use annual leave if you need time off.

From late 2027, this will change and partners will be legally entitled to take a minimum of one week's bereavement leave, albeit bereavement leave is presently unpaid.

As mentioned earlier, if you live in Northern Ireland, the rules are different and both intended parents can take up to two weeks' of paid parental bereavement leave.

For partners who are self-employed

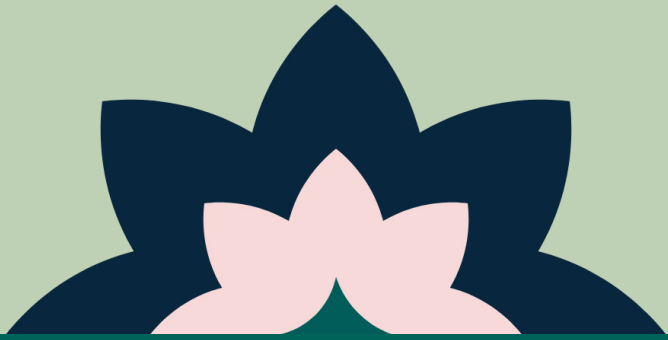
Like the guidance for those who have physically experienced the loss, if you are self-employed, you may have the flexibility to choose when and how you go back to work, but of course you will still need to make decisions based on your workload and finances.

Pay

Whether you are paid for taking time off will depend on your employment contract and your organisation's policies.

If your employer offers paid sick or compassionate leave, you should be paid in line with their policies. As a minimum, most people are entitled to Statutory Sick Pay (SSP) which is payable from the first day of your absence from work. If you do not qualify for SSP you may be able to claim Universal Credit or other allowances.

You can talk to Citizens Advice about this.



Your return to work

A phased return

You could ask your manager or employer for a phased return, where you work reduced hours or on different duties at first, if you think this would help you. You don't have an automatic right to a phased return but it's worth asking.

Flexible working

Some people find flexibility or adjustments to their job can help them return to work more quickly. You are entitled by law to reasonable adjustments to help you do your job if you have a disability – this includes mental health problems.

You are not legally entitled to reasonable adjustments for other reasons but your organisation may have a policy that outlines anything they can offer in terms of flexible working and adjustments. It might be helpful to make a list of anything that might be difficult and what adjustments could help.

You could discuss this with your manager at a return-to-work meeting or by email beforehand.

Confidentiality

You have a right to keep your miscarriage private if you choose. Your manager should ask you what, if anything, you would like other people at work to know.

We have more information on miscarriage and work on our website - scan the QR code to view,

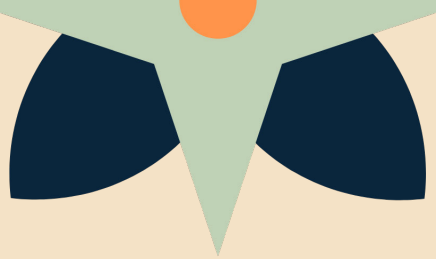
Why do miscarriages happen?

Things that don't cause miscarriage

People often worry about these things in pregnancy, but they are not linked to an increased risk of miscarriage

- Anxiety
- Exercise
- Working full-time
- Work that involves sitting or standing for long periods
- Heavy lifting
- Sex
- Flying
- Eating spicy food
- Being pregnant for the first time
- Getting pregnant soon after a previous birth or miscarriage
- Living near electric pylons or mobile telephone masts
- Not wanting to be pregnant or thinking about termination

There is still a lot we don't know about the causes of miscarriage. Sadly, most people don't find a clear cause for their miscarriage(s), even if they have tests. You may never know exactly why you miscarried and that uncertainty can be very hard to live with. It might be helpful to know that most women who miscarry - even several times - go on to have a healthy pregnancy in the end. And that often happens without treatment at all.



Known causes of miscarriage

Chromosome problems

Over half of all miscarriages are caused by random (one-off) genetic faults in the egg or the sperm, or in how the fertilised egg develops. These faults usually mean that the pregnancy cannot develop into a healthy baby.

Antiphospholipid syndrome (APS)

This is a blood clotting disorder. It happens when your immune system makes abnormal antibodies that can cause blood clots in the placenta or stop the embryo from implanting properly, causing an early miscarriage. If you are found to have APS, you will be treated with low dose aspirin tablets and heparin injections. However, you **should not** start taking aspirin unless it has been prescribed by your doctor.

Cervical weakness

Your cervix is a 'gateway' between your uterus and vagina, and it normally dilates (opens) during labour to allow the baby to be born. If the cervix is weakened or damaged, it might dilate too early in pregnancy. This is a known cause of some second trimester (late) miscarriages.

Infection

If you suffer from a serious infection during pregnancy, it can lead to miscarriage. Infections that cause very high temperatures and others such as rubella (German Measles), listeria, parvovirus and malaria may cause miscarriage.

Risk factors for miscarriage

Age

Miscarriage risk increases with age. It is highest if you are over 40 and miscarriages may also be more common if the biological father is over 40.

Previous miscarriages

Risk increases with the number of miscarriages you have had in the past. However, even if you have had multiple miscarriages, your chances of a healthy pregnancy are still likely to be good.

Fertility problems

The risk of miscarriage increases if it has taken more than a year to conceive. If you've had fertility treatment, there is a higher chance that you might have a miscarriage. Some fertility problems can also increase the risk of miscarriage.

Abnormally shaped uterus

A small number of women (up to 6 in 100) have an irregularly shaped uterus such as a septate uterus (divided down the centre) or a unicornuate uterus (where the uterus is only developed on one side) which may increase your chance of miscarriage, usually after 14 weeks.

Fibroids or scar tissue

Fibroids are harmless growths that can develop inside the uterus or, more rarely, outside the uterus. Small fibroids are fairly common and don't usually cause problems in pregnancy, but large ones can be a cause of miscarriage.

Ethnicity

Research has shown that Black women are 43% more likely to experience miscarriage than white women. The reasons for this are complex and more research is needed, but we do know that some health conditions that can increase the risk of miscarriage are more common among Black women. Systemic inequalities and bias in healthcare are also likely to be a factor.

We have specific information about Black baby loss on our website.

Weight and lifestyle

Being very overweight or very underweight increases miscarriage risk. Smoking or drinking more than the recommended maximum amount of alcohol or caffeine may also increase your risk.

Hormonal problems

There are several hormonal conditions that may be linked to a higher chance of miscarriage.

Polyendocrine metabolic ovarian syndrome (PMOS), previously referred to as Polycystic ovarian syndrome (PCOS), is associated with an increased risk of miscarriage, and it can also mean that it takes longer to conceive.

Diabetes that is well controlled does not increase miscarriage risk. Poorly controlled diabetes may mean a higher chance of miscarriage.

Thyroid problems that are well controlled do not increase miscarriage risk. Untreated thyroid disease or high levels of thyroid stimulating hormone (TSH) or thyroid antibodies may increase miscarriage risk.

Prolactin imbalances may increase the risk of miscarriage. Your doctor will speak to you about possible treatments.

Medication

It is very unlikely that any medication you were prescribed or bought over the counter caused your miscarriage. If you are concerned about the impact of any medication that you take on a pregnancy, please discuss this with your doctor before stopping it.

Stress and work

Research suggests that there is a link between stress and miscarriage but there is no clear evidence that stress actually causes miscarriage. You may be able to reduce your stress levels to some extent, but for most people, living with a level of stress is unavoidable.
Your risk of miscarriage may be higher if you are exposed to workplace hazards such as toxic chemicals, solvents, lead or radiation. Research also suggests that working nights, shifts and/or long hours are linked to increased miscarriage risk, but again, don't necessarily cause it.

Progesterone treatment

You may have heard about progesterone and that it can help prevent miscarriage. Research has shown that for women with bleeding or spotting in early pregnancy and with a history of miscarriage, progesterone treatment slightly reduced their chances of miscarrying.

Medical trials have shown the benefits of progesterone increase in line with the number of previous miscarriages. For women with three or more previous miscarriages and early pregnancy bleeding, progesterone was shown to increase their chances of a healthy pregnancy by 15%.

As a result, NICE guidance recommends that women with a history of miscarriage and early pregnancy bleeding, should be offered progesterone. If you meet these criteria and are not offered it, talk to your health professional.

We have further guidance about progesterone on our website, which you can find by scanning the QR code.

How causes and risks may affect you

The Tommy's Miscarriage Support Tool calculates the chance of your next pregnancy being successful, based on the information you give. Users are given information on tests and treatments available to them, in line with the latest NHS and NICE guidelines, positive lifestyle changes to decrease pregnancy complications and signposting to mental health support. Those who complete the tool and are predicted a higher risk of miscarriage are offered a 1:1 video appointment with a Tommy's midwife.

You can read more by scanning this QR code.

Recurrent miscarriage and investigations

What is recurrent miscarriage?

In the UK recurrent miscarriage means having three or more miscarriages, even if you have a healthy pregnancy or pregnancies in between. It affects about 1 in every 100 couples trying for a baby.

Support and testing for recurrent miscarriage

Support and investigations for recurrent miscarriage vary across the UK.

In England, Wales and Northern Ireland, you will not usually be offered additional support or investigations until you have had three miscarriages.

If you live in Scotland, in line with the Miscarriage Patient Charter, you should receive personalised support and advice after a first or second miscarriage. But you will still have to have three miscarriages before you are offered testing.

Wherever you live, you might be offered tests after two losses if:

- you are in your late 30s or older
- it has taken you a long time to conceive
- your doctor suspects an underlying cause

Unfortunately, this is not a standard approach and even if these points apply to you, it doesn't mean you will definitely be offered earlier testing.

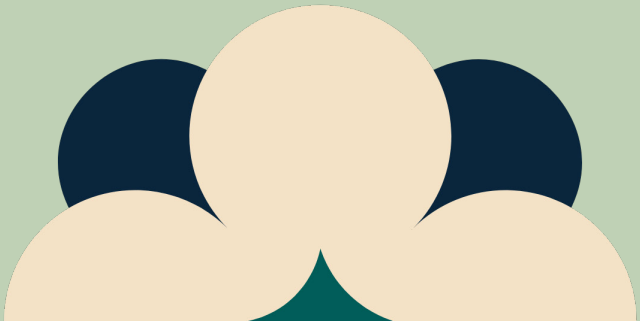
If you had a second trimester (late) loss, where your baby died after 14 weeks of pregnancy, you should be offered tests afterwards.

Tests and treatments for recurrent miscarriage

Type of test	How is it carried out?	Treatment
Genetic testing	For this investigation, tissue from the miscarriage is tested for abnormalities in the baby's chromosomes. If it isn't possible to test the pregnancy, or if the results suggest a chromosome problem that could be inherited (e.g. an 'unbalanced translocation'), you and your partner will be offered blood tests to check for any inherited chromosome problems that might cause recurrent miscarriages. It can take several weeks to get results from these tests.	If tests on the pregnancy tissue show a chromosome problem, that usually means that this is a 'one-off' problem and you have a good chance of a healthy pregnancy next time. If you or your partner are found to carry a balanced translocation, you should be offered genetic counselling to help you to decide about future pregnancies.
Blood clotting problems	Antiphospholipid Syndrome (APS) is checked for by blood test. You will need to have two blood tests taken at least 12 weeks apart and at least 6 weeks after your miscarriage. If both tests are positive, this will confirm APS. You may also be offered blood tests for inherited blood clotting disorders (thrombophilias).	If you have APS you will likely be treated with low dose aspirin tablets and heparin injections in a future pregnancy. Together, these make your blood less likely to clot and can increase your chance of having a healthy pregnancy. Your doctors will advise when to start each treatment. If tests show you have an inherited blood clotting problem, you may be offered heparin injections in your next pregnancy, depending on your individual circumstances.
Abnormally -shaped uterus	You should be offered a pelvic ultrasound scan to check the shape of your uterus. If your uterus looks an unusual shape (e.g. 'septate', where the uterus is divided in two) you may be offered additional tests to investigate this further.	If you have a septate uterus, you may be offered an operation to correct this. It is unclear whether surgery for fibroids or other conditions that affect the internal shape of your uterus reduces your risk of miscarriage. Your doctor should talk with you about the potential benefits and risks of surgery.

Tests and treatments for recurrent miscarriage

Type of test	How is it carried out?	Treatment
Hormonal problems	You may be offered blood tests to check for Polyendocrine metabolic ovarian syndrome (PMOS). You might be offered thyroid tests, including thyroid antibody tests, and tests of prolactin level. You might also be offered tests for diabetes if your medical history suggests this may be an issue.	There is no clear recommended treatment for either PMOS or a prolactin imbalance, but you may be offered medication for these conditions as part of clinical research trials. If you are found to have diabetes or thyroid disease, you will be supported to control this as well as is possible before and during your next pregnancy.
Cervical weakness	If your doctor thinks that one or more of your miscarriages might be due to a problem with your cervix, you may be offered regular scans of your cervix in your next pregnancy.	Some women are treated with a 'cervical stitch', an operation that may reduce the risk of the cervix opening too early during pregnancy. The Royal College of Obstetrics and Gynaecology has a very helpful leaflet about cervical stitch:



Unexplained recurrent miscarriage

More than half of the couples who have investigations for recurrent miscarriage don't come away with an answer. Unfortunately, without a known cause, there isn't any form of treatment that can prevent a further loss.

Some research has shown that women with unexplained recurrent miscarriage are more likely to have a healthy pregnancy next time if they have supportive care at a specialist unit. This includes being able to have regular scans or to talk to the specialist staff. It is not clear why or how this makes a difference, but it may reduce stress.

Sometimes a different future

It can be very painful to go through repeated miscarriages. You might be determined to keep on trying. But there may come a time when it gets too much, and you begin to think about other options.

You can find more information and support for recurrent miscarriage by scanning the QR code.

Deciding to stop trying can be difficult – and it's a decision you might make and 'un-make' several times. It is a normal and understandable reaction as you think about a very different future from the one you were planning. Above all, moving on is a journey – one of finding and building a new life and a different sense of identity and purpose.

We have more information and stories about this on our website:

Trying again

Experiencing a loss or losses can change the way you think and feel about another pregnancy. There may be practical and emotional considerations, too.

When is it safe to try again?

The usual advice is to wait until after your first period. This makes it easier to work out the date of conception and so to know if a future pregnancy is developing as expected. Your doctor may advise you to wait for longer if you've had problems such as an infection or retained tissue, or are waiting for test results.

It can be difficult to live with uncertainty around dates and the size of the pregnancy, especially in a pregnancy after loss, and you might not want to add to any anxiety around that.

If you do conceive in the first cycle, it does not make you more likely to have a miscarriage than if you had waited.

There is some evidence that conceiving in the first six months after miscarriage lowers your risk of loss next time. However, researchers also emphasised that it's important not to rush into trying again, but to wait until you feel physically and emotionally ready.

I want a baby but it's no longer that simple

You may be worried about the emotional and/or physical impact of another loss. If you don't know what caused your previous loss or losses, you may be worried you can't make any changes to stop it happening again.

There may be additional factors such as the cost of treatment.

I'm feeling pressure to start thinking about another pregnancy

You may also be feeling pressure to start trying again from external sources or because of your personal circumstances. This can be particularly hard if you don't feel ready.

I want to be pregnant again as soon as possible

There are lots of different reasons why you might want to be pregnant again quickly. These may outweigh some of the concerns above or sit alongside them.

I really want to get pregnant again but I have to wait

Even if you really want to get pregnant again straight away, your previous loss may mean you have to wait. You may be advised to wait after treatment or surgery or be in follow-up care after a molar pregnancy or waiting for investigation results.

This can be a difficult time.

I want to get pregnant but I miscarried an IVF pregnancy

Losing a baby after fertility problems or treatment can be devastating. It's often hard to find out exactly why a pregnancy loss has happened, this can make it harder to cope.

If you've had fertility treatment, there is a higher chance that you might have a miscarriage. That's not because of the treatment itself but because:

- Women who've had fertility treatment are often older – and that increases the chance of miscarriage
- Some problems can also increase the risk of miscarriage
- Women who have fertility treatment often know they are pregnant very early on, so they will be more aware than most if they have had an early miscarriage

One of the most difficult aspects can be the uncertainty about the future. You may feel hopeful about trying again, or unsure how much more you can go through. It may be that this was your last attempt to have a child. Perhaps it took you a long time to get pregnant, or you have already had several miscarriages. Maybe there are other reasons why you feel you can't try again such as the cost of further fertility treatment.

You might start thinking about other ways of being a parent, like adoption or fostering. You may consider supporting a child with particular needs, perhaps as a learning mentor or by volunteering with a children's charity.

You may decide that you will learn to live without children and move on to a different kind of future. It's important to know that your feelings are likely to change over time and you might make and 'un-make' these decisions several times.

What can I/we do to help us feel more confident in a new pregnancy?

A miscarriage is very unlikely to have been caused by anything you did or didn't do. Many of us will have some risk factors we cannot change. There are some things, however, that may help and taking these steps may also help you feel more in control.

- Follow NHS conception and pregnancy advice as best you can. This includes guidance on weight, smoking, alcohol and caffeine as well as foods to eat and avoid.
- You can begin to take a pregnancy multivitamin that contains both vitamin D and folic acid at any time before or as you start trying again. Talk to your doctor or midwife if you have any concerns.
- Discuss with your doctor any regular medications you are taking. If there is any increased risk, you may be able to change medications. Do not just stop taking medication that has been prescribed to you. Your doctor will help you make an informed decision about the risks (if there are any) and the benefits. Do not take anything – including aspirin – that has not been prescribed for you.
- If you have had or been offered treatment to reduce your risk of miscarriage, discuss this with your doctor before trying to conceive.

Pregnancy after loss

Looking after yourself in a new pregnancy

Pregnancy after a previous loss or losses can be really tough. Many people experience challenging mixed emotions including guilt, fear, anxiety, worry, hope and relief.

Living with uncertainty takes strength and courage, especially when you have had experience of things going wrong in the past. No statistics, information or scans can remove the uncertainty and anxiety completely. But there are things that might help.

One day at a time

You might find it easier to focus on the day or week of pregnancy you are at right now, rather than thinking further ahead. You can find suggestions and ideas that might help at different stages of your pregnancy on our website.

Finding ongoing support

You may have already had your booking appointment with a midwife you can talk to. If not, you could ask your practice nurse or GP what help they can offer. You might want to ask to be referred for counselling, if possible.

Counselling can give you the tools and techniques to manage ongoing uncertainty and help you cope with your feelings about your previous loss or losses and your current pregnancy.

Finding a community

Feeling like you are having a different experience of pregnancy to those around you can be isolating, especially if friends and family don't really understand.

Talking to others going through something similar or listening to them and their stories can help you feel less alone.

Here are some ideas to help you connect with others:

- Talk to us. Call or message us to speak to one of our support team.
- Connect online. Many people find the support on our Facebook groups helpful. You can choose to join an early or later pregnancy after loss group and search posts to find others who are at a similar stage to you. We also have online pregnancy after loss support groups.
- Connect in an app. Some pregnancy apps recognise the experience of those who are pregnant after loss. They may have communities of users who can help you feel less alone.
- Read other people's stories. Sometimes just reading about others' experiences can help you feel less alone. Find personal stories, including those about pregnancy after loss, on our website:
- Create your own community. Perhaps you could make a small messaging group of people you trust to support you. These may be friends or people you meet online who understand how you feel.

Looking after yourself

Lots of people who have experienced pregnancy loss feel let down by their body. Even starting along the path of pregnancy after a loss or losses takes courage and strength.

This is a physically and emotionally demanding time for you. You are doing an incredibly difficult thing. It is not selfish to take time for yourself.

Different things work for different people so you might need to try a few things out:

- Some people find that journalling and writing and reading positive coping statements helps them manage uncertainty and anxiety in early pregnancy. We have more information on our website.
- Many people find pregnancy yoga helpful. Other relaxation techniques like hypnotherapy and meditation can also help you feel calmer.
- Some people find practising mindfulness a helpful way to deal with anxiety and other difficult emotions.
- Take time to do things you enjoy, whether that is walks or other gentle exercise, gardening, cooking or just downtime with a film.
- Talk to your manager about possible adjustments at work if you feel that might be helpful.
- If you are finding it hard to cope on your own, struggling to manage everyday tasks or feeling hopeless, you may need additional support and you should speak to your health professional.
- Our website has more information on looking after your mental health and has some suggestions to help you improve your wellbeing.

Remembering the baby or babies you lost

You may be grieving for the baby or babies you lost while hopeful for the baby you are pregnant with now. Some people find it helpful to make sense of these complex emotions by finding a way to stay connected to the baby or babies they have lost.

You might like to write or talk to them or spend some time in a place where you like to remember them.

Medical support and scans

In some cases, you may be able to access additional NHS support and scans. You may choose to access extra scans privately. Our website has more detailed support to help you cope before and after scans.

Extra check-ups or scans on the NHS

Additional scans can offer some reassurance, although many people find this comfort only lasts for a short time. Some people feel that the stress of a scan isn't worth the level of reassurance they receive and they would rather wait or be scanned as little as possible.

Some Early Pregnancy Units may be willing to offer you extra scans or support on the NHS. However, this very much depends on the policies of individual hospitals or the capacity and availability of scan appointments

Private scans

It can feel very difficult if you have experienced a loss or losses but you are not offered any additional care early in pregnancy. Some people choose to have one or more private scans. If you had a missed miscarriage that was diagnosed at your dating (12 week) scan last time, you may want to have a scan to find out sooner if there is any sign that anything is wrong.

If there are any concerns, you will be advised to contact your GP or local Early Pregnancy Unit to be assessed.

The best time to have a scan is from about 7 weeks' gestation, when it should be possible to see the baby's heartbeat in a normal pregnancy. It may be possible to see a heartbeat before this time, but if it is not seen that might cause you more anxiety and make waiting for another scan even more difficult.

There is presently very little regulation around private scanning and the quality provided can vary significantly. Try to find a provider who is regulated by the Care Quality Commission.

We provide more information about NHS scans and private scans on our website.

Should I get progesterone?

Progesterone can help some people, but it is not a treatment that can prevent every miscarriage.

The strongest evidence is for people who are bleeding in early pregnancy and have had at least one previous miscarriage.

If this is you, speak to your EPU, GP or other healthcare professional about whether progesterone is appropriate for you.

Find out more about progesterone by scanning the QR code.

About Miscarriage UK

Pregnancy loss can be a difficult and often isolating experience. Sadly, too many people go through it without the support or information they need.

Miscarriage UK is the leading charity supporting people affected by pre-24-week pregnancy loss, including miscarriage, ectopic pregnancy and molar pregnancy. We provide confidential and empathetic support services and clear, evidence-based information, and work with healthcare professionals to improve care and build confidence in compassionate communication.

We also support employers to respond better to pregnancy loss, including successfully campaigning for changes in the law to introduce bereavement leave for pre-24-week loss. Alongside this, we continue to campaign to improve care, policy and public understanding, so that no one is left to navigate pregnancy loss alone.

Because every loss matters.

"I will always support your charity for the amazing care and compassion shown to parents and family members going through such an awful time. Thank you to all of you for helping us through the dark days."

However you're feeling, you're not alone in this.

0303 003 6464
info@miscarriageuk.org
miscarriageuk.org

Mon, Weds & Fri: 9am - 8pm
Tues, Thurs: 9am - 4pm

I've been feeling....

Questions I want to ask....

Miscarriage UK

Because every
loss matters

In loving memory of

_____

_____

Always remembered, forever treasured.

This booklet has been made possible through donations from people who have experienced loss themselves. We receive limited statutory funding, so every contribution makes a difference.

Please donate today, and help make sure no one else has to face this heartbreak alone.

Miscarriage UK