From the Navy Medicine Female Force Readiness Clinical Community

Supporting a Patient Following Early Pregnancy Loss

Early Pregnancy Loss, also known as a miscarriage or spontaneous abortion, occurs when a pregnancy is lost within the first trimester (13 weeks) of pregnancy. This is a common issue impacting approximately 15% – 25% of diagnosed pregnancies and increases with maternal age.[1] The loss of a pregnancy is often a distressing event that may bring many different, mixed emotions. This can leave the patient and family members feeling overwhelmed or experiencing grief.

This resource has been designed to provide primary care clinicians with guidance on supporting patients with follow-up care after an early pregnancy loss has been diagnosed and treated.

UNDERSTANDING PREGNANCY LOSS

- Most early pregnancy loss is due to severe genetic errors or failure of embryonic development. Patients should know that these issues are not preventable and unlikely to recur. After up to 2 miscarriages, a woman has the same likelihood of success with the next pregnancy.

COMMON SYMPTOMS FOLLOWING EARLY PREGNANCY LOSS

- Whether the patient miscarried spontaneously, required medications, or had a dilation and curettage (D&C), symptoms may persist. Uterine cramping may persist for several days and vaginal bleeding for up to three weeks. Pelvic rest is advised until vaginal bleeding resolves after a completed miscarriage.
- In addition, palpitations, insomnia, fatigue, anorexia, nightmares, loss of focus and social withdrawal are common after miscarriage. Counseling can be helpful.
- **Symptoms requiring medical evaluation:** Heavy bleeding, foul vaginal discharge, or a fever can be signs of infection.

CARE FOR A PATIENT FOLLOWING EARLY PREGNANCY LOSS

- **Emotional Support:** Patients react differently, some with severe grief and some without discernable effects. Emotional reactions can be immediate or delayed and may be triggered by other pregnant patients or children. Counseling can be helpful for those who struggle.
- **Available Resources:**
  - Non-medical counseling through Military OneSource and Fleet & Family Support Center
  - Local support groups through SHARE: Pregnancy and Infant Loss Support, Inc.
  - Online support group for pregnancy loss through Postpartum Support International
  - Training and education on miscarriage management through Training, Education, & Advocacy in Miscarriage Management (TEAMM)
- **Family Planning:** Most patients can either start trying to get pregnant right away, or after they have a period. Recommend to the patient that nothing goes into the vagina until all bleeding stops (i.e., tampons, sex toys, vaginal sex). If patients do not desire a new pregnancy now, they may start any form of birth control immediately.

[1] American College of Obstetricians and Gynecologists, Patient Resources, Early Pregnancy Loss

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ACCESS TO CONVALESCENT LEAVE

- Healthcare clinicians can support patients in accessing convalescent leave following an early pregnancy loss to recover physically and emotionally. More information on eligibility for leave can found in SECNAV INSTRUCTION 1000.10B.
- In addition, healthcare clinicians can waive service women's participation from the Physical Fitness Assessment (PFA) for a set period following a miscarriage while the service member recovers.
- Subject Matter Experts from the Defense Health Agency (DHA) Women and Infant Clinical Community developed the following recommendations for convalescent leave. The guidelines are not official Navy or Marine Corps policy and ultimately, decisions regarding convalescent leave are based on clinician assessment and can differ from these recommendations based best clinical judgment.

GESTATION (WEEKS + DAYS)	CONVALESCENT LEAVE RECOMMENDATION	TESTING RECOMMENDATION	COMMENTS
First Trimester ≤ 12+0	7 days	60 days no Physical Fitness Testing (PFT)	*With or without surgical intervention
Second Trimester 12+1 – 16+0	14 days	180 days no PFT testing	*With or without surgical intervention
Late Second Trimester 16+1 – 19+6	21 days	180 days no PFT testing	If neonate has a fetal weight of 350 grams or more, mother should receive 42 days of convalescent leave. (In cases of multiples pregnancies (i.e. twins, triplets, etc.), if one fetus meets the fetal weight of 350 grams or more, mother should receive 42 days convalescent leave).
Second Trimester 20+0 – 27+6	42 days	365 days no PFT testing	
Third Trimester 28+0 – term	42 days	365 days no PFT testing	

REVIEW OF MODIFIABLE RISK FACTORS FOR SUBSEQUENT PREGNANCY

Some patients have risk factors for pregnancy loss. Addressing risk factors can help patients increase their chance of a healthy pregnancy by optimizing their personal health.

- Patients with **type 1 or type 2 diabetes mellitus** should have adequate glycemic control prior to pregnancy (ideally a hemoglobin A1C of 6.5 or less). This may reduce the risk of pregnancy loss and birth defects.
- Patients with **thyroid disease** should aim to keep their thyroid-stimulating hormone (TSH) levels below 2.5 mIU/L.
- **Tobacco cessation is highly encouraged** as tobacco use is associated with many adverse pregnancy outcomes including pregnancy loss, fetal growth restriction, and preterm birth.
- **Patients who are obese** have an increased risk of recurrent pregnancy loss compared to patients of normal weight. Even modest **weight loss** (5% of body weight) can be associated with improved pregnancy outcomes. Healthy diet and exercise are also important for preparing the body for a successful pregnancy.
- **Avoiding alcohol is recommended**, as women who drink more than 7 drinks a week may have irregularities in their cycles and ovulation. Alcohol is also associated with birth defects including abnormal brain development.
- Patients should be encouraged to **update any immunization deficiencies**, especially live vaccines like Measles, Mumps and Rubella (MMR) if needed, to ensure immunity from vaccine-preventable diseases during pregnancy.