NOVEMBER 2021

PERINATAL AND PREGNANCY LOSS

GUIDLINES FOR EMERGENCY DEPARTMENT

MANY WOMEN WILL REMEMBER THE CARE THEY RECEIVED DURING THEIR MISCARRIAGE FOR THEIR ENTIRE LIVES.

You can change their entire grief journey by being present.

Recommendations for ED Nurses on Seeing and Showing After Miscarriage

Some women choose to see and/or hold the remains after a miscarriage; others do not. As she is making that decision, hearing someone say, “I don’t think you should” or “We don’t allow that here,” or, trying to induce her to hold the baby when she prefers not to, can be harmful. Such statements may increase the woman’s sense of powerlessness and create a lifetime of wondering. Patients often wonder how the remains/baby will be cared for following miscarriage. You could say, “The baby will go to the laboratory (in some facilities this is the morgue).” We transport with dignity and facilities aim to have a specially designed fabric bag for the transport. You can say, “You can see your baby whenever you want.” The facility may be working toward an annual burial service or have one for inclusion of the remains.

Contents of the Uterus after a Loss

To anticipate what the remains will look like, the nurse or healthcare provider reflects with the pregnant woman on what she can expect to see:

- How many weeks' gestation was the pregnancy (the longer the pregnancy, the greater the likelihood of a visible baby)? In early pregnancy, there may be only blood clots, perhaps the size of a plum, whitish tissue, and watery fluid.
- How long has the baby been dead, or how long has the pregnancy been over, or how long did it take to have the miscarriage (A pregnancy over for a period of time may result in a macerated product and decomposing of conception when passed)?
- If the diagnosis of this miscarriage was a "blighted ovum," this means there was no fetal pole and the embryo/fetus did not develop. The uterus appears empty on ultrasonography. Therefore, there would be no embryo or fetus, but there could be placental tissue. If gestation is far enough along, a formed fetus or baby may be seen.
- Careful explanation using sensitive, compassionate language with slow movements can create a caring, relational scenario with the patient feeling support and warmth from the provider. A sensitive statement from the nurse or care provider would be, "I want to help you be prepared for what you will see.
- Based on what has happened so far, what are you expecting the remains/ your baby to look like?" Then verify or clarify. "Because your miscarriage happened so early, you usually will see tissue, blood, liquid, and maybe a formed (but very tiny) baby. I will let you know what you will see so you feel prepared, and I will be with you if you'd like me to be." Or "Because this miscarriage happened late, there will be a very small baby to see."

Many families consider perinatal loss to be as significant as the loss of a living child!

Viewing Uterine Contents after Surgical Intervention

Surgery (dilation and curettage; dilation and evacuation) typically results in the tissue being disrupted so that an identifiable baby comes out in parts. It might be difficult to see this for both the staff member and the woman. Some nurses have made footprints for the mother when possible as a cherished momento. Respectful handling of tissue after miscarriage or surgery includes placing the remains on something soft (blanket, gauze) or within a special box with a blanket. You might say “We have a special purple box with a tiny blanket inside for your baby’s remains.”

Guidelines for Working with Laboratory Staff

If one or both parents wish to see the baby after an identifiable embryo/fetus/baby has been placed in formalin in the laboratory or morgue, the most important aspect of this viewing is that the baby’s body first be placed in 100% alcohol for a period of time.

Formalin darkens skin tones; alcohol returns the skin to its normal color (the larger the body, the longer this takes). This requires written guidelines regarding rinsing the baby’s body if it has been in formalin; guidelines for parents who wish to remove the baby from the laboratory; checking on state and hospital guidelines, and establishing strong, enduring relationships with laboratory staff. Those who work in the laboratory should understand the tremendous difference they can make in the lives of parents.

The challenge is to simultaneously provide treatment that is both physically and emotionally therapeutic, including holistic and spiritual support for the woman and her family, and providing bereavement care.

The Importance of Respectful Disposition

Clinical experience and research consistently demonstrate that anything that could be **interpreted as disrespectful** to the parents' baby should always be avoided when showing the remains, such as use of emesis basins, buckets, and suction canisters.

- If you do not have a special box or blanket, use something soft, such as gauze or a soft cloth.
- Even if your ED has only curtains separating one patient from another, provide privacy through a soft tone of voice, being seated, engaging both parents or the mother and her support person, assess the meaning of the miscarriage **(e.g., if the woman/mother uses the term "baby" or "my baby," then the provider should use those terms as well—but not before the patient/mother does).**
- Explain when questions are asked, but avoid talking nonstop while the parents are being with their baby. Ask, "Would you like me to step out for a few minutes so you have some time alone?"
- This single snapshot memory stays with parents for a lifetime. Compassionate and respectful care in this singular moment when they see their baby who was miscarried is critical.
- Hold in mind that you are a part of a time in your patient's life in which she knows very little of what to expect. She will remember always the difference you made.

Depending on what the ending of a pregnancy means to a woman, any of the following terms for pregnancy loss may be appropriate: products of conception, fetal remains, miscarriage, stillbirth, and baby

PTSD 7 TIMES MORE LIKELY

- Women who have experienced stillbirth12, miscarriage or ectopic pregnancy 13 are at higher risk of post-traumatic stress disorder (PTSD), anxiety and depression than those who haven't.
- 60-70% of grieving mothers in high income counties reported grief-related depressive symptoms that they regarded as clinically significant.
- One in three women showed a clinically significant level of post-traumatic stress symptoms 5–18 years after stillbirth.
- Sudden or unexpected deaths are more likely to result in prolonged grief reactions.
- 39% of women, 3 months after suffering an early pregnancy loss meet the criteria for probable moderate-to-severe PTSD. No people in the control group did.
- There may be an association between surgically-treated ectopic pregnancies and suicide.
- 68% of mothers and 44% of partners reported four or more negative psychological symptoms at 10 days. 9 months later the figures were still significant with 35% of mothers and 13% of partners experiencing problems
- Much of the available research and current political focus is on mothers and women, but we know that fathers and partners also experience mental health problems following pregnancy or baby loss. In one study, fathers report feeling unacknowledged as a legitimately grieving parent. The burden of keeping these feelings to themselves increased the risk of chronic grief. 21 In June 2019, 62% of men reported feeling suicidal following their experience of pregnancy or baby loss..

If healthcare professionals, such as GPs, do not have a proper understanding of the range and severity of psychiatric illness that bereaved parents are at risk of experiencing, they are less likely to identify those needing help and refer them on for the necessary care

REFERENCES

BLAW-Out-of-Sight-Out-of-Mind-Report-2019.pdf (babyloss-awareness.org)

http://www.nationalperinatal.org/resources/Pictures/2017%20Conference%20PowerPoints/Saturday,%20March%2011,%202017/Interdisciplinary%20Guidelines%20For%20Car%20of%20Women%20Presenting%20To%20The%20Emergency%20Department%20With%20Pregnancy%20Loss%20.pdf