Introduction to Pregnancy Loss

Miscarriage and abortion remain a hotly debated topic with lawmakers, passing questionable legislation at best, dangerous at worst, and the general public not only having a vague understanding of what happens during pregnancy loss, but misconstruing it often altogether.

Today on the Jaffercast, we're talking about pregnancy lost, healthcare deserts, And what happened when a pregnancy is not exactly in the location it should be.

I'm your host, Dr. Mark Papadakis, no one particularly special, just another frickin' ER doctor. Subscribe to the show if you liked what you hear and want to support us, and if have questions or comments or want tell me how bad I am doing, Just reach out at jeffordcast at gmail.com.

Let's do this. Here with us again, Dr. Beezer. Hello again. Deke, how are you doing? Mark, thank you for having me back. It's been a while. Yeah, it has been quite a wild, unfortunately.

Life has gotten the best of us and I'm also slacking on my uploads too. So you can totally blame me for this. For those of who are new, who don't recall Dr Beeser, OB-GYN, MFM, maternal fetal medicine, working in New York.

She has dealt with a lot of our topic, as I am sure that you've seen a lots of this stuff. Missed abortion, miscarriage is a very big part of our specialty, unfortunately.

Um, because we read a lot of ultrasounds. So we're sometimes the ones determining the ability of a pregnancy. And a love women come into the ER for vaginal bleeding in pregnancy because I think, oh my God, I've lost a baby.

I'm losing the baby and there's nuance there because sometimes, sometimes yes, we have to deliver the bad news. Other times, no, there are other conditions that cause this, but you know, people think of, in my experience, at least people, think they miscarriage as bleeding, cramping, pregnancy loss.

And that's it. But there's definitely a spectrum for sure about all this. Yes. Unfortunately, not all miscarriages are perceived by the patient, meaning they can be completely asymptomatic.

Sometimes referred to what we call a missed abortion, A miscarriage, but is not aware, doesn't necessarily have symptoms like vaginal bleeding or cramping.

One point might have had a viable heartbeat and then at the next revisit, unfortunately, or show up into the emergency room. And there is no longer a heartbeat.

Yeah. And it's important to also talk about terminology because abortion is a very hot button topic in society.

Bleeding, Cramping, and Early Warning Signs

So when we say abortion, we're not talking about, you know, an abortion clinic or somebody going to have an abortions. This is the medical term that we refer to any type of pregnancy loss.

Yes. If we are talking, if you hear the word abortion don't get triggered. Don't at me, don' at Dr. Beezer. this is literally just a medical terms that use to refer a miscarriage or just pregnancy in general.

So I do want to talk about going back to vaginal bleeding. First of all, you say that pregnancy loss can be asymptomatic and then it's not found until later, empty sac, all of these things can happen.

But I recall you saying last time we talked, any bleeding in the setting of pregnancy is abnormal. Like that's just, we start there. If you have bleeding and you're pregnant, that is not normal.

You can have cramping during your pregnancy. in pregnancy anytime during your pregnancy, which can be a symptom of early pregnancy. However, if you are finding that the cramping is persistent, you were doubled over in pain, and you feel as though you cannot carry on normal daily activities, you should be seen.

Absolutely. So as far as cramping goes, You talk about the quality of pain. What about. The timing of the cramming in the pregnancy? When is it, when is cramps being considered not normal at all during any stage of pregnancy.

Is it just only in first trimester? Yeah. You can have some and then it's gone. It's so hard to say the threshold of normal to abnormal. Everyone is different.

You are uncomfortable. I do suggest that you get checked out. But I want patients to know that there's not always necessarily something wrong if you are experiencing some cramping.

There is the phenomenon called like implantation bleeding or beginning of pregnancy. As the pregnancy is forming, your uterus is slowly timing itself for pregnancy and expanding.

patients can experience cramping and discomfort. There are times where it's truly like a physiologic part of early pregnancy. Again, if you're feeling uncomfortable, you can't carry on daily activities as normal you are doubled over in pain, is associated bleeding, nausea, vomiting, just not feeling well, you should be evaluated.

Yeah, and that kind of leads us into a little bit of ectopic pregnancy because when somebody comes to me, And they say, Hey, I'm having some bleeding.

And by the way, having pain, but not cramping pain. It could be having a sharp pain but that pain is now associated on the side of the abdomen. That raises our suspicions for, is this an ectopic pregnancy?

In the first trimester, second, third trimesters, a whole different ballgame. First trimesters specifically, what is going on in that side your abdomen that where you're having bleeding, you know, or we now know you are pregnant.

Is this in eectopic pregnant? And for people who are unaware, ectopic pregnancy means a pregnancy that has started not in the uterus, but actually now off to the side.

So your ovaries are over here, now suddenly you have a pregnant here but the ureters is here. Something happened in transit where now the baby is no longer in.

The uterus is actually to side here and it's growing.

Ectopic Pregnancy and Dangerous Locations

It's implanted, it is growing and that's a problem because now we get concerned that it could have ruptured eectopic pregnant meaning it grows so big, you've now rupture the fallopian tube and you're bleeding now.

And there are other sites of topics as well. The most common is tubal in the fallopian tube, can have less commonly an ovarian ectopic, cervical eectopic from the cervix.

Can have a cesarean scar eptopic pregnancy if you have history of C-sections. Abdominal ectopics, which I have not seen, but it's most commonly in the tubes.

So that's why we're talking about side pain, your fallopian tubes are hanging off the sides of your uterus. Yeah. And cervical eectopic seems to me very scary and weird at the same time, because that means there's a baby that is developing right where the exit point of the uterus is.

How the heck did that happen physiologically? Rhetorical question, just more out of curiosity than anything else. And also cesarean scar atopic pregnancies are very scary too.

Can leave it. Yes. So speaking in terms of cesarians, speaking terms, of C-sections, I'm seeing a rise in women getting C sections, which to me growing up, it used to be a, not a rare procedure, but something that it happened only if it needed to happen.

And now I feel like I see more people getting C-sections, you know, routinely in a way. I don't know how to really say it. When I was doing my rotations, we had one or two C sections a day.

And I dunno if that's common, I know what it is, but are we seeing rise in these types of ectopic pregnancies? Well, a couple of things. It's complicated.

As is everything, trust me. So as our population becomes more high risk in general, there becomes risk factors for eating a C-section. In some respects, yes, higher rate of cesarean sections for those reasons.

But overall, the American College of Obstetrics and Gynecology for maternal fetal medicine, many hospitals around the country particularly the one I currently work out that was featured in the New York Times recently, Rochester Regional Health, has taken many steps to reduce the number of cesarean sections performed.

Where I did residency at Cooper University Hospital in New Jersey and where I am currently, we were fortunate enough to really work on our cesarian section levels to get it below the national rate, which I believe the low 30%. Um, over a fact, when I was at Cooper, we were in the 25th ish percent for MRC sections.

There are many efforts to decrease the rate of C-sections. However, like I said, our population unfortunately is getting sicker. We in states is not best at maternal healthcare.

So we will have a high rate. Of caesarian section in comparison to many. or developed countries. That being said, with more C-sections come more caesarean genic topic pregnancies.

There's nuance to that statistic as well with, you know, maternal health, and maternal death, those statistics. Because we have a disparity of care across the country, so you can go to, let's say, Germany, it's relatively uniform as far as the care goes, but you go from a place like New York City versus a places like rural somewhere, I don't know I'm not going to call names, obviously, but the number of doctors available per resident drops.

That said, the poverty rate also has something to do with it too. There are people who can't afford to seek prenatal care, that leads to a higher complication rate later in pregnancy, which can lead to more C-sections or things like that.

So, you know, people like to talk about doctors and, oh, well, Bills are so high, but we have so many complications. And we've talked about this before, you know, it's not just about C-section and or not, It's also about preeclampsia.

It is about, help syndrome, liver dysfunction during pregnancy. Is that caught early? Is it caught late? All these things factor into the health of the mother at the time of delivery and even after the care too.

But that's a soapbox. Also the creation of maternal care deserts. If we're unable to offer 24 hour anesthesiology, somebody in-house are readily available.

We cannot offer what's called a trial of labor after a cesarean section or VBAC. So there are certain things that have to be in place in order to. Offer people who have had cesarian sections, the opportunity for vaginal delivery and with increase in maternal care of deserts, that's going to be less and less of an opportunity.

an increase in repeat C-sections. And that's something that we don't talk about often enough too, healthcare deserts, maternal care desert, things like that.

A topic for next time. Yeah, sorry. No, don' apologize. Because this is something the general public, I don"t feel understands enough about, unless until it affects them directly.

But then they're asking questions, well, why can't this happen? Why can"t I do this? Well, Why Can't My Doctors See Me? All of these reasons are part of it, and it's not talked enough, or It's talked about in different contexts, namely, why do doctors kill people?

C-Sections, Maternal Care Deserts, and Access Issues

You know, it's more the humor. That headline plays a lot better than maternal care desert. Like that's way too technical for the New York times or something like that.

I don't know. So as far as ectopic pregnancy goes, we have very limited options because that pregnancy is not viable. Right away we determined that the pregnancy was growing in a spot it shouldn't be.

Wait, say it louder for people who think that they're viable or not. So technically speaking, when we give somebody in the ER or you in office medication to terminate a pregnancy, because it's non-violence growing in a location that one cannot go to term and two will kill the mother.

It is technically an abortion. That's just, that is what it is, you know? And this is one prime example of where state laws over the last now couple of years have run into sound medical practice.

Now that too is a discussion for another time. But ultimately we have to give the mother an abortion because if we don't, that baby grows inside to the point where it ruptures something.

The fallopian tube, the uterus comes out, cervix, who knows? But I've cared for a couple of rupture topics. My colleagues have called, have cared a for couple rupertic topics and all of them have gone emergently to OR because there's bleeding inside the belly and that is not a good situation.

So the challenge for us in the ER and for you guys is. had a diagnosis and how are we sure that this is ectopic versus not? Oh, a couple of things. The thing that is popularly drawn, the emergency room besides a urine pregnancy test is a beta-HCG.

It is at the pregnancy hormone level. We can track and follow. it does not definitively tell us it's an eectopic pregnancy, but it can tell There, this is more likely a normal abnormal pregnancy when we should start to see a pregnancy in the uterus.

And there is a nice diagram that you guys go out of that I didn't know existed until approximately 20 minutes ago. Oh, that diagram is really for diagnosing early pregnancy loss.

So miscarriage takes us step-by-step. We're starting to say something in uterine. takes a step-by-step by one gestational sack. The gestation sack contain a yolk sack, great.

Fetal pole, the heartbeat, so fetal poles, very early stages of a little tiny fetus developing. Till we get to that, I guess, those four things within the uterus, we're not clear where this pregnancy is going.

So this lovely chart we'll share. Yeah. And for those of you who are listening to this in your car, unlike my wife, probably, rather than YouTube, sorry, tough luck, but I will put the link to the description for the episode if you want to bring it up later by yourself.

So this is the guidelines for ultrasound diagnosis of pregnancy failure or loss, where we can apply very conservative findings and not, in an effort to not call a pregnancy a failure too early.

So on the right side are findings that are suspicious, but not diagnostic of a pregnant failure. Whereas on left side, it's definitely pregnancy. It tells us when a patient should follow up with us based off of what we're seeing as well.

Yeah. And this is something that we, in general, know about in the ER. Obviously, if we have obvious ultrasound findings of pregnancy failure, which is what you see here on the left, we are done.

I go to the patient, I give them the sad news that this pregnancy is a failure. It's a miscarriage. And then here's what to expect. The tricky part comes in stuff on the right, because usually what happens, at least for us in the ER, women comes with spotting, maybe a little bit of cramping, and let's say they're at their five week marks, six week mark, since, you know, their period ended, four weeks ago, right?

And now I say, okay, well, just like we talked about in the first episode, I'm getting a blood test, the serum HCG. I was checking all your other blood pounds as well.

And I get a urine test and I am also getting an ultrasound. Let's say you have an elevated serum HDG level, a pregnancy hormone level that's elevated.

Good. But without context, it's a number. You know, I need to put that number into greater context, which is usually when I say at least come back in two days to see if that numbers goes up or if it goes down.

And then we get ultrasound findings like what you're seeing here on the right where it's like, what do I do with this? What's going on? And something that we have to tell our patients is that the heartbeat may not kick in until about week seven to week eight.

So it could just be an early pregnancy. And oftentimes you will see the ultrasound technician or the radiologist, whoever's reading these ultrasounds put in the comments, hey, it Could be in early IOP.

It could be pregnancy failure. Could it be a pregnancy of unknown location. We don't know based on this imaging. This is what they're going by. this is why they don' know.

There's this criteria here. It also clearly outlines when the patient should come back for a repeat ultrasound, because if a patient thinks they should be eight weeks, sometimes that's not always accurate.

Even if they are tracking their period, things can happen. So we need to look a little bit beyond last menstrual period sometimes, or even beta HCGs. Like they don't offer as a whole list of criteria for those who are appropriate candidates for medical management of an ectopic pregnancy versus surgical candidates.

For a topic pregnancy, hemoperitoneum, blood in the abdomen, excruciating pain, certain beta HCG levels we're actually seeing on ultrasound.

Diagnosing Pregnancy Failure on Ultrasound

So it's a medical history and rule you in or out or call management, meaning methotrexate. is an injection that dissolves the pregnancy. This is going to the emergency room to remove the ectopic pregnancy And when we discover that there is an ectopic break in a non-vibral location, you talk about giving abort, they're called abortificants.

That's the general term for them. Methotrexate being the most common one. Let's say we give that. What can a woman expect? So they've gotten the injection in the ER, the go home, now what?

After receiving methotrexy, You can experience a little bit of pain. And what I don't want is you doubled over in pain, excruciating pain or nausea, vomiting.

Don't want that to occur, but a little bit of pain is normal. Can continue to see a bit vaginal bleeding, again, excessive vagina bleeding is not normal, do have to follow your beta HCG levels very closely.

That's how we will know did the methotrexate work, how much your Beta HCD decreases for the next week. So you're getting it drawn the day you receive it and then I believe 48 hours to four days after.

And then again, seven days, after we're looking at that trend. much your beta HCG is dropping. So what about a person who comes in, they received an abortifacant from either you or let's say they've gone to Planned Parenthood now.

Yeah. And that's a different context. That's somebody who wants to terminate their pregnancy that we assume is a, was a viable pregnancy. and they come in with increased bleeding and cramping.

Is it just, this is the pregnancy passing and everything is passing through me now, or is it, just that there is another complication going on? And it's like, what's that complicate?

I guess would be my question. person undergoing. Let's say they, they underwent methotrexate for the ectopic. You say it dissolves the pregnancy. Yeah.

Are they expected to have increased bleeding at all to pass the remnants of that pregnancy at any point in time? Or is this kind of just go away on its own?

You can have a little bit of bleeding and you can't have little a bit a pain, but it's important to pay attention to threshold. Same thing applies. If you're soaking through pads, you are doubled over in pain.

That's not normal. And you need to seek reevaluation. Or sometimes where bethotrexate doesn't work. Sometimes people need either surgical management or a second dose.

The way that we are figuring out that it doesn' work is one beta HCG level is actually going up, kind of plateauing and not falling appropriately. Or if plain and simple, we're doing an ultrasound, it's not changing appearance and you are still in a lot of pain and discomfort.

And what about the person who now has a viable IUP, who terminates the pregnancy, what can they expect after getting, you know, an abortifacant from there?

Can they except increased pain and bleeding compared to the personal who got methotrexate or are they now going to get almost like period cramping and period levels of bleeding with clots?

Patients who receive all depression or just side attack, You absolutely can accept increasing cramps and increase in vaginal bleeding. Again, it's all about amount.

You are heavily bleeding, which you can go through for a period of time. So an hour or two of where you just have very heavy pain can happen. If it is not stopping, you feel lightheaded, dizzy, who are doubled over in pain, uncomfortable.

You need to seek evaluation. And let's say they come into the ER and that that's happening for whatever reason, either methotrexate or any other border weekends now.

So they're having heavy persistent bleeding, worsening, cramping. What's. Happening. what are you concerned about at this point? Concerned about the pregnancy might have difficulty passing on its own.

so for those who were undergoing either termination. already had a miscarriage and were undergoing medical management of their mis carriage, I'm concerned that the patient is not fully passing the pregnancy and has what we call incomplete abortion, or we might have to assist them with a surgical procedure to really remove the pregnant to stop the bleeding.

The body is actively trying to get rid of the Instead, the patient's just bleeding and nothing's actually being removed.

Treatment, Complications, and Types of Abortion

Yeah, and that's a problem because in our situation in the ER, we not only get concerned for just obviously blood

loss and anemia, but we're also thinking this can be a source of a possible infection.

So I see a woman who, I actually saw a person, not too long ago, they had a miscarriage, natural, quote unquote natural mis-carriages. It was just a pregnancy loss, their body was passing it, it stopped.

They still continued to have some pain though, the pain never fully went away. And then they started to spike a fever. And they started to notice a discharge.

And so you have now a recent pregnancy loss for whatever reason, fever and a foul discharge, and now we're concerned that there is actually basically an infection in the uterus that's now caused them to become septic.

That's a much greater problem because now it just doesn't become, the procedure you're talking about is called dilation and cure. You go in and basically, for lack of a better term, Roto-Rooter the Uterus and clean everything out.

And it actually sucks. Pregnancy, tissue, clot, et cetera, out of the uterus. Yeah. So it not only becomes just from that, but now becomes there's now pus, there is something else going on here that you can just easily extract.

You know, we're admitting you for IV antibiotics, probably going to the OR potentially, depending on how bad off you are, how septic you were. And these people come in, you know pretty sick too.

This isn't just a benign thing here. very sick and ultimately, yes, start them on antibiotics. They have to go to the OR. And that's infected. Is it, what's the term for it?

Infected? I'm blanking on it now. In fact, is it endometritis? No. That's after pregnancy. I mean, this sounds like a septic abortion. You're correct.

Yeah. Thank you. All right. But then thankfully, to be fair, it doesn't happen often. Even in people who I've seen have trouble passing the pregnancy, they go for the DNC, They don't obviously get sick.

It's something that has been in there for a while. They may not realize they've had an abortion, but there's remnants there, things like that. So it's not common, thankfully.

I would agree, especially where we live. Thankfully, yes. And for the record, you know, urban, suburban level areas with access to care doesn't happen often.

We're talking about, health care desert, like we were just talking earlier, healthcare deserts, lack of access care, things like that. That is one of those things that unfortunately looks bad for us in terms of how we care for our moms.

So something to think about. Definitely. But anyway. Cat, of course, can happen. We've, we've seen them. So it's not impossible. Not necessarily where we live.

We have seen that. And not necessarily related to somebody who did not get care or was undergoing an abortion. That did that occur in a hospital or a clinic or something like that?

Like sometimes these things unfortunately can just happen. Yeah. I mean, complications arise from every single thing that we do. You know, you have the best healthcare in the world and the most insurance and best doctors and still things can go wrong.

That is the reality of our physiology, unfortunately. And so before we head off, there's technically four types of abortion. We just, we just said it actually off camera.

Incomplete, missed, complete. And what was the other one? See, this is what? Threatened. Thank you. Yeah. Yes. Threaded. Missed, incomplete, and complete, yes.

Complete. All right. So let's run through those. Complete is obviously self-evident, right? It's a miscarriage that happened. By the time you discover it, it's done.

You know, nothing else really to do. were not seeing anything in the uterus anymore and have had a positive pregnancy test, might've had an ultrasound that actually showed either the beginnings of a pregnancy, even unfortunately, a fetal pull with a heartbeat.

But then the patient undergoes significant bleeding, cramping. Now there's no longer anything on the Uterus. Yeah. So that's complete. And then missed is actually what happened to a colleague of mine where they went to their OBGYN and they saw an empty gestational sac.

That was just all sudden. Yeah, or again, you are, I think we touched on it earlier. Um, we're seeing the beginnings in early pregnancy with a heartbeat.

Unfortunately you come back and is no longer a heart beat and be in the presence of vaginal bleeding or some abdominal pain or not have to occur at all.

Yeah. And then we have the other two now. So you have threatened and incomplete. I guess incomplete, we already kind of talked about. We do the DNC. There's still remnants left over.

Is that pretty much accurate? And incomplete something that's a little bit different is the fact that the cervix is then dilated. Pregnancy is trying to come out of the uterus.

The cervic is open preparation for that, whereas Threatened and missed, the cervix is often closed. The body has not caught up to the fact that there could be a miscarriage or has been a mismarriage.

Now, is there a situation where a threatened abortion can be no longer a threated abortion? Like is a threaten abortion reversible? People can stop having their symptoms.

So for example, if you're having vaginal bleeding, we do the ultrasound. We're seeing a heartbeat, that pregnancy is carrying. as normal, you have a follow-up ultrasound one or two weeks just to see how's your bleeding doing?

How, what's going on? Is the pregnancy still viable? Everything is okay. And your vaginal bleeding has stopped. We are still seeing pregnancy with heartbeat that would not consider that a threatened abortion anymore.

Okay. So that's fair. That's good news. All right. Is there anything else you can think of that you personally want, you know, people to know or think about as far as this topic goes?

Anything we may have missed? I think, in general, I just want to encourage patients, if something doesn't feel right, please reach out to your OBGYN. Seek medical care.

Don't sit at home.

Closing Advice and Episode Wrap-Up

Please don't go on the internet. And, well, found this one thread on Reddit where this patient had YZ. You can always find that. Seeking medical care, speaking to your provider, contacting us through the portal.

Always a good idea. The internet is very helpful. At some point, you probably want to hear a medical provider. Yeah, for sure. You don't want assume things that may or may not be true.

you can hear anecdotal stories all the time about anything. Yes. It's all about the care that we give you personally. So good. I just want empower people to utilize the wonderful technology we have.

That's what we're here for, to answer questions. Yeah. All right. Well, Dr. Deezer, thank you so much for coming

back on here. It was a good talk as always.

Thank you for having me. We'll get you back. There's a lot more to talk about in the realm of MFMOB and I'm sure as things progress in healthcare landscape, we'll guess you're back sooner probably rather than later at this point.

Sounds great. Take care. All right, and that does it for another episode. My thanks again to Dr. Teague Beezer for coming on to talk about ectopic pregnancy, miscarriage, maternal healthcare deserts, all things OB-GYN related.

These topics are not only important for the women in our lives, but also for general public. As we face increasing scrutiny from lawmakers and politicians and those with varied interests in the healthcare sector, we're going to have issues come up with maternal health care that are always not well understood.

It's important to get the message out, understand what's going on, approach every topic with a level head, if possible. As always, these topics are often very, very nuanced.

When it comes to your own health, talk to YOUR doctor, find recommendations that are pertinent to YOU, and make solid choices that you feel comfortable with.

Don't take on these choices alone, either. Talk to somebody that's supportive of you, that YOU care about, you KNOW cares about you. And as always… make good choices.

I'll see you next time.