



Pregnancy
Loss
Research
Group

Recurrent Miscarriage Care and Infertility: A National Service Evaluation

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OBJECTIVES

There is a paucity of research into the appropriate clinical care of women/couples with infertility experiencing Recurrent Miscarriage (RM), with a resulting deficit within RM guidelines.

Fertility care in the Republic of Ireland is predominantly within the private sector; thus, current RM practices are largely unknown.

We evaluated RM care provision for women/couples with infertility and RM in the public (19 clinics providing RM care, five fertility clinics) and private sectors (nine fertility clinics).

METHODS

An online descriptive survey was administered via Qualtrics from Nov 2021-Feb 2022.

Clinical leads for pregnancy loss and fertility, Doctors-in-training, Clinical Nurse/Midwife Specialists and Directors of Midwifery within each unit/clinic were invited to complete the survey, with one response per service required.

The survey comprised predominantly multiple-choice questions concerning guideline-based KPIs for RM care, which encompassed five categories: (i) structure of care, (ii) investigations, (iii) treatments, (iv) counselling and supportive care, and (v) outcomes.

RESULTS

Counselling and Supportive Care

Topics routinely discussed with couples with RM and infertility are covered in fig 1.

Sources of guidance for health-care providers included international guidelines (11/24; 46%), national guidelines (12/24; 50%), local guidelines; (9/24; 38%), online resources (15/24; 63%), onsite training (33%; 8/24) and external training (54%; 13/24). 17% (4/18) gave written information to women/couples about infertility and RM.

46% (11/24) provided additional information on support sources within their clinic and external supports.

The response rate was 73%, (24/33; Public: 18/19 RM or gynaecology clinics, 2/5 fertility clinics; Private clinics: 4/9).

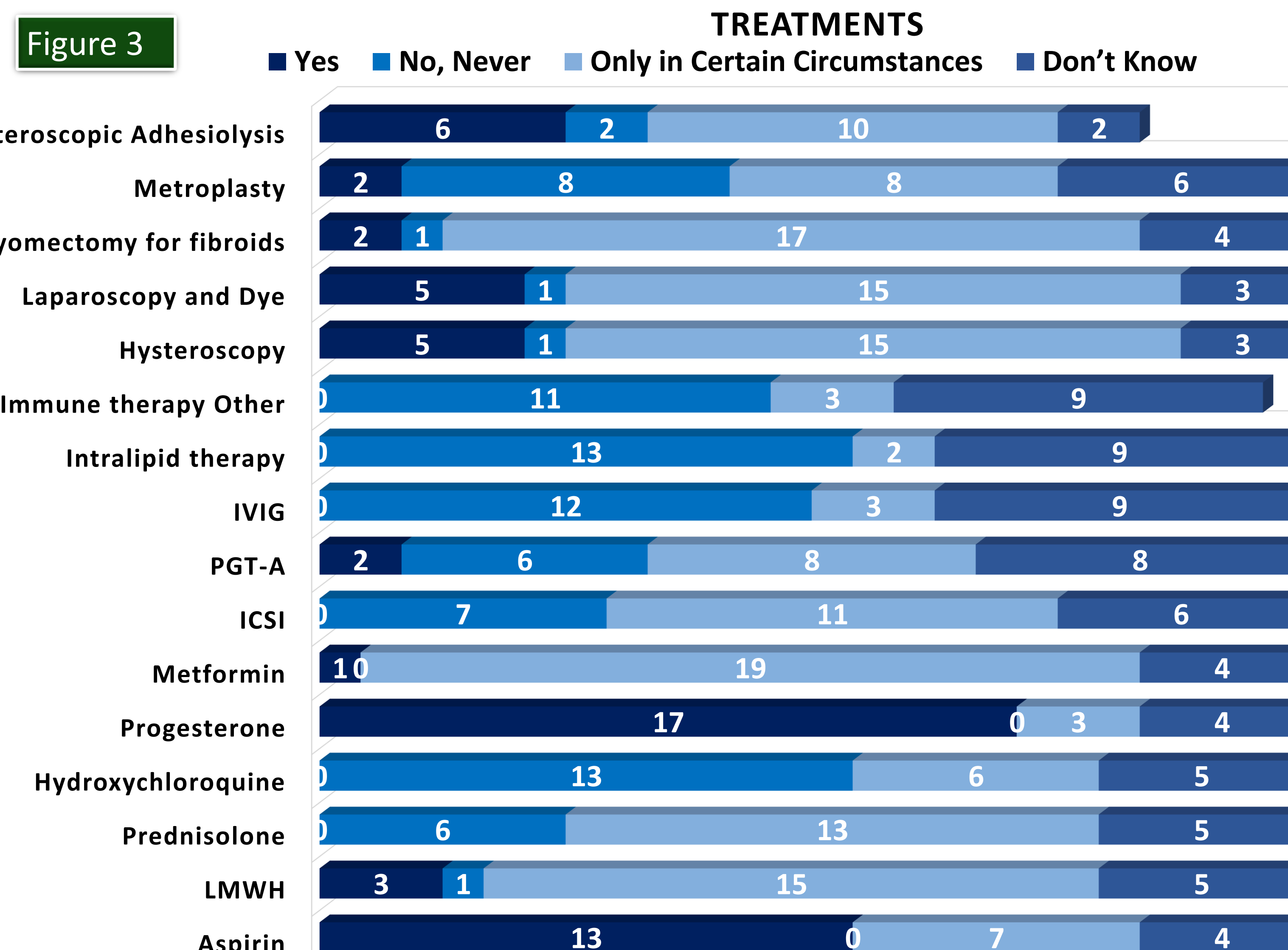
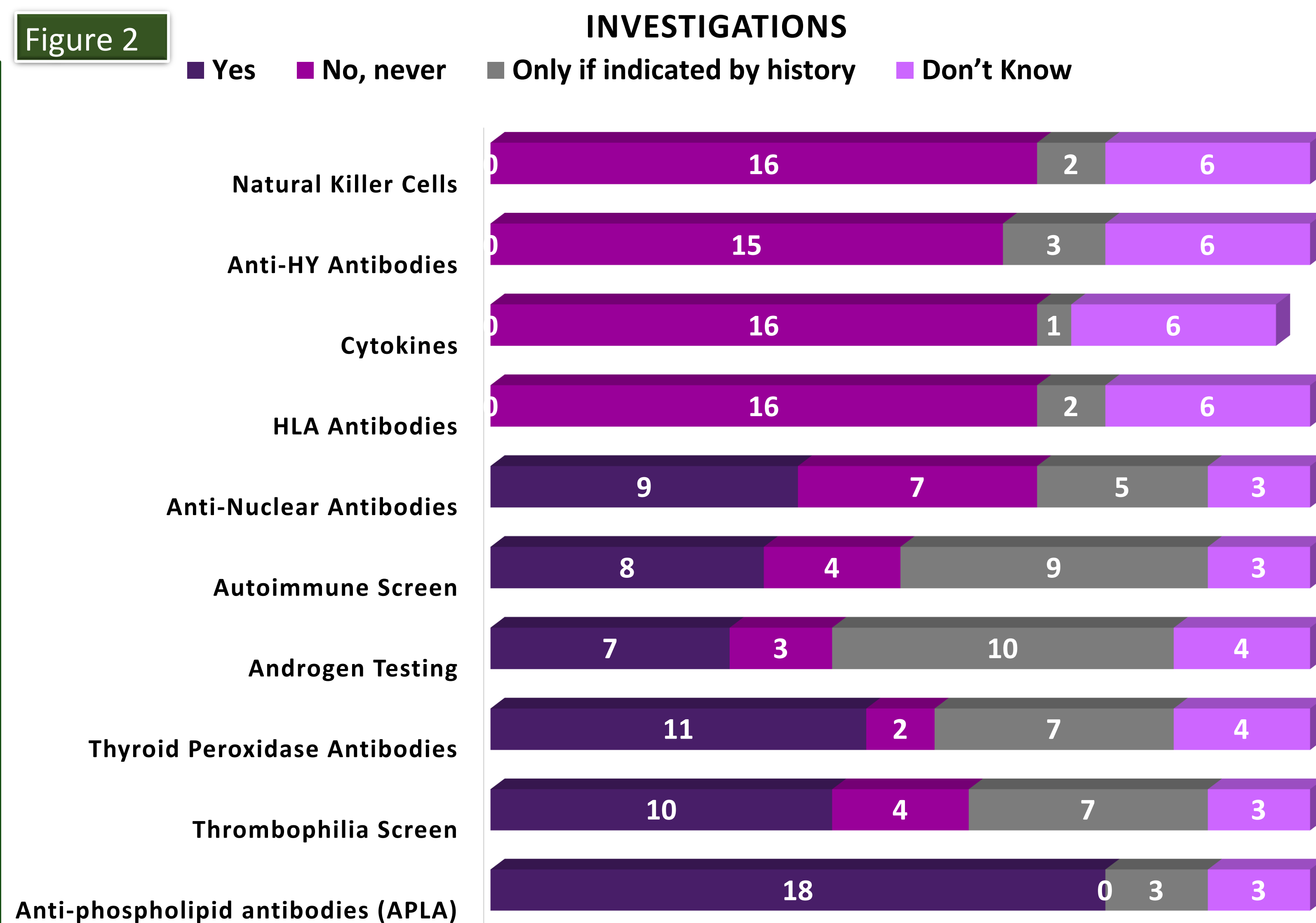
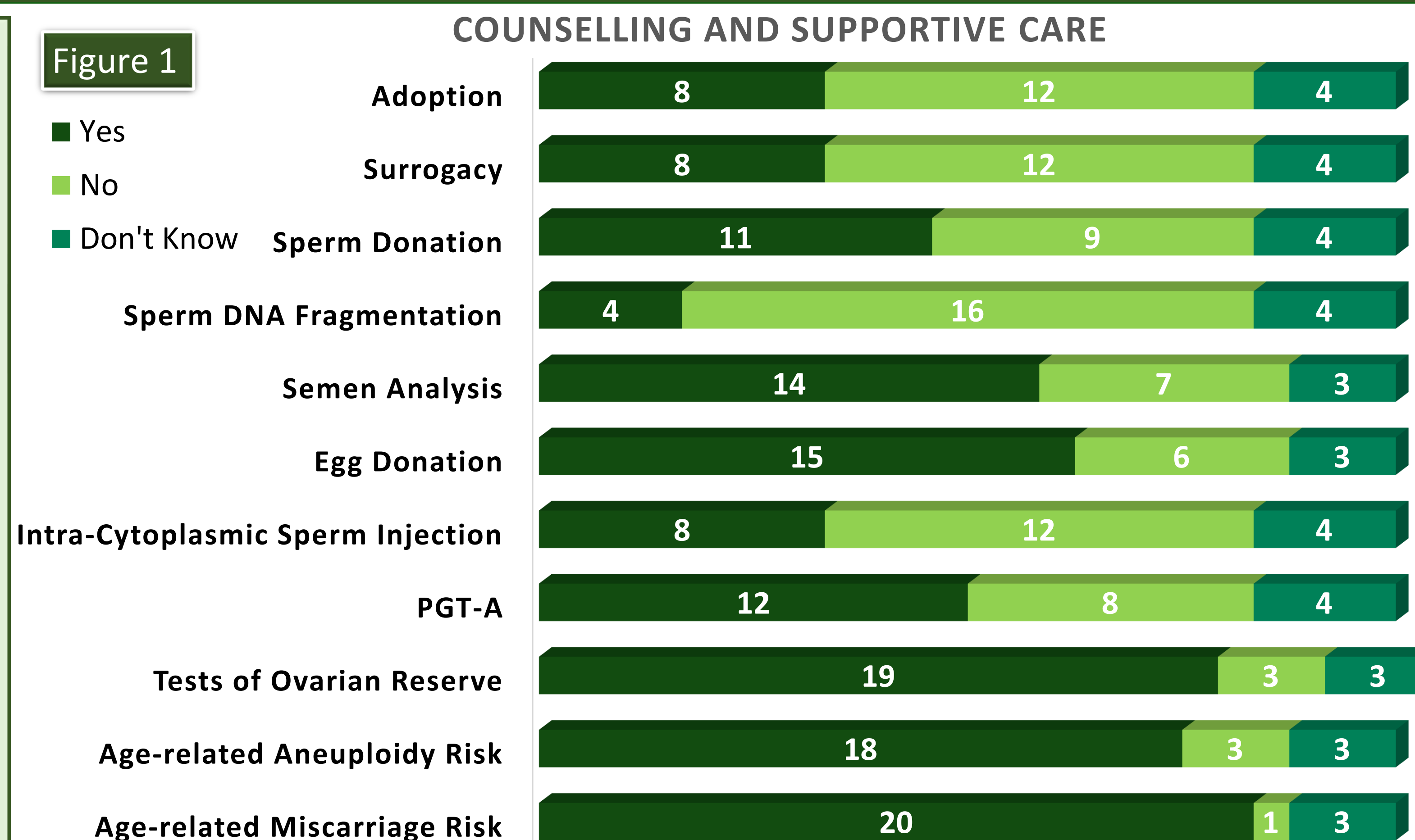
Structure of Care

Public RM clinics reported reduced access to fertility consultations for women with RM and fertility issues (6/18; 33%) or infertility counselling services (5/18; 28%), whereas all private clinics had access to pregnancy bereavement counselling (4/4; 100%) and most had access to RM consultations for women with infertility who experienced RM (3/4; 75%).

Investigations

Blood tests in addition to routine fertility investigations were assessed and are presented in fig. 2.

Most providers would seek imaging in addition to a pelvic ultrasound (79%; 19/24); namely a hysterosalpingogram (71%; 17/24), or MRI (54%; 13/24). 17% (4/24) would perform an endometrial scratch and 22% (5/22) an endometrial biopsy, testing for chronic endometritis (5/5) or uterine Natural Killer cells (40%; 2/5). 17% would perform a vaginal swab. 9% would perform sperm ploidy routinely (2/22) and 5% (1/22) would test DNA Fragmentation.



Treatments

Routine treatments offered are outlined in fig 3. Although progesterone was prescribed most commonly (17/24; 71%), there was variation in the duration of progesterone support (range 8-16 weeks). Just 33% (8/24) provided written instructions on medications prescribed. Two clinics audited subsequent pregnancy outcomes (2/20; 10%)

CONCLUSIONS

While investigations and treatments mostly adhered to the KPIs, there was variation in counselling, imaging and surgical treatments offered. The private provider responder rate was low. Resources are required to improve access in the public sector to fertility care and support services.

Further research exploring barriers and facilitators to the delivery of evidence-based care for women/couples with infertility and RM, as well as their care experiences, could inform service improvements

