National Women & Infants Health Programme

National Clinical Practice Guideline

Recurrent Miscarriage

INSTITUTE OF OBSTETRICIANS & GYNAECOLOGISTS

ROYAL COLLEGE OF PHYSICIANS OF IRELAND

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Algorithm

Algorithm for investigations Recurrent Miscarriage

Take a complete history from the woman and her partner and consider additional investigations to those listed below accordingly

After **2 consecutive** miscarriages

Thyroid function test

Thyroid antibodies:

- Anti-thyroid peroxidase antibodies

FBC

Thrombophilia

Antiphospholipid syndrome

- Lupus anticoagulant
- Anticardiolipin antibodies (IgG and IgM)
- β2 glycoprotein I antibodies (IgG and IgM)

Consider HBA1c
(To be considered if BMI >30, family history, history of gestational diabetes, high risk ethnicity, history of polycystic ovaries)

Transvaginal Pelvic Ultrasound (with 3D imaging if necessary)

If less than 35 years and **two consecutive** miscarriages and no living children – perform cytogenetics on pregnancy tissue

If less than 35 years and **two consecutive** miscarriages, no living children and no tissue for cytogenetic analysis – perform parental karyotypes

If **35 years or older** and **three consecutive miscarriages** – perform cytogenetics on pregnancy tissue

If **35 years or older** and **three consecutive miscarriages** with no tissue for cytogenetic analysis – perform parental karyotypes

Blood investigations and Transvaginal Pelvic Ultrasound *could* be organised in the community in advance of RM clinic appointment. Cytogenetics and karyotype must be sent from the maternity hospital/unit.

Key Recommendations

No	Recommendation	Grade of recommendation*	Supporting Evidence**
STRUCTURE OF CARE			
Clinical Question 1: When should women/couples with RM receive care/be investigated?			
1	Investigation/evaluation of women/couples with RM can proceed after two consecutive pregnancy losses	Best Practice	GDG
Clinical Question 2: How should the care of women/couples with RM be organised?			
2	Couples should be referred to a RM clinic; this should have the appropriate staffing and clinical expertise, be appropriately located, with access to the required equipment and facilities	Best Practice	GDG/ ESHRE
3	Written information should be given in advance of appointments in the RM clinic, and further written information should accompany explanation of investigative findings, treatments and future pregnancy plans	Best Practice	GDG
COUNSELLING AND SUPPORTIVE CARE			
Clinical Question 3: How should the psychological needs of women/couples with recurrent Miscarriage be addressed?			
4	Psychological counselling and support should be offered to couples with RM and tailored to their needs	Best Practice	GDG

No	Recommendation	Grade of recommendation*	Supporting Evidence**
INVESTIGATIONS			
Clinical Question 4: What epidemiological factors are relevant for women/couples presenting with RM?			
5	Medical, obstetric (for women) and family history should be used to tailor diagnostic investigations for women and men experiencing RM	Best Practice	ESHRE
6	Maternal age and previous pregnancy history offer the best available prognostic information	1B	ESHRE
7	Advise women/couples regarding changes to potentially modifiable risk factors as relevant, including smoking cessation, maintaining a BMI between 19-25, healthy eating and physical activity (normal exercise pattern; not excessive), abstaining from alcohol and drug consumption (including caffeine, which should be reduced to <200mg/day)	2C	RCOG
8	Routine antenatal advice regarding folic acid and vitamin D supplementation should also be given	Adapted	ESHRE/ RCOG
9	Information and explanation about RM should be provided, in particular; the challenge in identifying a cause, the lack of evidence-based treatments and that there is an excellent prognosis for future pregnancy outcome without pharmacological intervention if offered supportive care alone in the setting of a dedicated early pregnancy assessment unit	Best Practice	PHA NI
Clinical Question 5: What are the recommended investigations for women/couples presenting with RM?			
Anatomical investigations			
10	As part of standard investigations for RM, women should have a pelvic ultrasound performed by an experienced ultrasonographer, with 3D ultrasound available if required to diagnose uterine anomalies	2C	ESHRE
11	Magnetic resonance imaging (MRI) is not recommended as first line option for the assessment of uterine malformations in women with RM but can be used where 3D ultrasound is not available and/or to examine complex malformations in greater detail	2C	ESHRE
12	It is recommended that imaging or imaging with hysteroscopy should be used to diagnose uterine septa rather than laparoscopy with hysteroscopy because this approach is less invasive	Best Practice	ASRM

No	Recommendation	Grade of recommendation*	Supporting Evidence**
13	If a Müllerian uterine malformation is diagnosed, further investigation (including investigation of the kidneys and urinary tract) should be considered	2C	ESHRE
14	At a minimum, all women should have a 2D transvaginal ultrasound to exclude any contributory gynaecological pathology	2C	ESHRE
Immunological screening			
15	Women with RM should not be offered routine immunological screening (such as HLA, cytokine and NK cell tests) outside of the research context. Anti-nuclear antibodies may be considered based on individual assessment	2C	RCOG/ ESHRE
Haematology			
16	For women with RM, screening for hereditary thrombophilia should not be undertaken, unless: in the context of research in women with additional risk factors and after consultation with local haematology services	2B	ESHRE
17	For women with RM, we recommend testing for antiphospholipid antibodies after two miscarriages	2C	ESHRE
18	The recommended antibodies for testing are lupus anticoagulant, anticardiolipin antibodies (IgG and IgM), and β2 glycoprotein I antibodies (IgG and IgM)	Adapted	ESHRE
Metabolic and endocrinologic factors			
19	Thyroid stimulating hormone (TSH), thyroid peroxidase antibody (TPOAb) levels and free thyroxine (FT4) levels should be tested routinely in women with RM	Adapted	GDG
20	There is insufficient evidence to support testing prolactin levels, luteal phase insufficiency, androgens, PCOS or vitamin D	Adapted	GDG
21	*In select cases with a relevant menstrual or fertility history*, testing 'day 2-5' hormone profile, LH, FSH, oestradiol and/or testing for ovarian reserve may be appropriate.	Best Practice	PHA NI

No	Recommendation	Grade of recommendation*	Supporting Evidence**
Infectious screening			
22	Infectious screening in asymptomatic women using vaginal swab specimens is not recommended	Best Practice	DGGG, OEGGG and SGGG
Screening for genetic factors			
23	Cytogenetic analysis should be performed on pregnancy tissue of the third and subsequent miscarriage(s) **or** on the second and subsequent miscarriage if aged <35 years **and no prior livebirth**	2C	RCOG
24	For genetic analysis of the pregnancy tissue, standard procedures for testing should have due regard for maternal cell contamination and risk of test failure, as well as the ability to detect chromosomal anomalies especially relevant to recurrent first-trimester miscarriage.	Best Practice	GDG
25	Parents should not undergo routine peripheral karyotyping. Karyotyping may be performed however after individual assessment of risk or if there is no pregnancy tissue available for testing after the third miscarriage **or** second miscarriage if aged <35 and **no prior livebirth**	2C	RCOG
26	All individuals and couples with an atypical parental karyotype result, and a proportion of those with an atypical fetal karyotype, should be offered genetic counselling.	Best Practice	ESHRE
Histopathological Investigations			
27	Any available histopathological results from previous miscarriages should be reviewed to ensure that placental pathologies with a recurrence risk, such as chronic histiocytic intervillositis or massive perivillous fibrinoid deposition, are not missed.	Best Practice	GDG
Investigations for male factors			
28	In couples with RM, it is recommended to assess factors in the male partner that may contribute to sperm health (paternal age, smoking, alcohol consumption, medications, exercise pattern and body weight)	2C	ESHRE
29	Couples with RM should not be offered routine sperm DNA fragmentation screening outside of the research context	2C	RCOG

No	Recommendation	Grade of recommendation*	Supporting Evidence**
TREATMENT			
Clinical Question 6: What are the possible treatments for women/couples presenting with RM?			
Anatomical factors			
30	There is some evidence in favour of hysteroscopic uterine septum resection that suggests a reduction in miscarriage rates, but no improvement in live birth rates. Surgery in this cohort should proceed with caution, with input from a specialist team and ideally in the context of a research trial	2C	ESHRE/ NICE
31	Metroplasty in women with bicorporeal uterus and double cervix (former American Fertility Society (AFS) didelphic uterus) and RM is not recommended due to insufficient evidence that it reduces miscarriage or improves livebirth rates	1C	ESHRE
32	Uterine reconstruction is not recommended for hemi-uterus (former American Fertility Society (AFS) unicornuate uterus) and RM due to insufficient evidence that it reduces miscarriage or improves livebirth rates	1C	ESHRE
33	Selection and treatment of women for hysteroscopic metroplasty of a uterine septum should be done by a multidisciplinary team including specialists in reproductive medicine, uterine imaging and hysteroscopic surgery	Best Practice	NICE
34	Surgical management of acquired uterine anomalies are not recommended due to insufficient evidence at present, but it may be considered for select cases	2C	ESHRE/ GDG
Immunological treatments			
35	Immunotherapies (such as corticosteroids, intralipid, lymphocyte immunity factor, granulocyte colony-stimulating factor, tumour-necrosis factor – α blockers) are not recommended to women with unexplained RM due to insufficient evidence	Adapted	ESHRE
36	Paternal cell immunisation, third-party donor leucocytes, trophoblast membranes and intravenous immunoglobulin in women with previous unexplained RM are not recommended as they do not improve the live birth rate	1A	RCOG
Treatment for thrombophilia			
37	For women with hereditary thrombophilia and a history of RM, antithrombotic prophylaxis should not be used unless in the context of research, or if indicated for VTE prevention	2C	ESHRE

No	Recommendation	Grade of recommendation*	Supporting Evidence**
38	For antiphospholipid syndrome – if laboratory and clinical criteria are fulfilled, referral to local haematology service should be considered and potential for treatment with low dose aspirin (75mg) and prophylactic LMWH in next pregnancy discussed.	Best Practice	GDG
39	For APLS, treatment with low dose (75mg) aspirin should commence before conception and prophylactic LMWH must be initiated as soon as the pregnancy test is positive	2C	ESHRE
Treatment of endocrine factors			
40	Overt hypothyroidism arising before conception or during early gestation should be treated with levothyroxine in women with RPL	1C	ESHRE
41	There is low-quality evidence that levothyroxine treatment of women with mild-moderate sub-clinical hypothyroidism (TSH levels: 4.0-10mIU/l) is associated with improved pregnancy and livebirth rates; there is insufficient evidence of benefit in women with upper normal TSH concentrations (2.5-4.0mIU/l). Treatment of women with upper normal TSH levels may reduce the risk of miscarriage, but the potential benefit of treatment should be balanced against the risks	Adapted	ESHRE/ GDG/RCOG SIP 70
42	There is insufficient evidence to support treatment with levothyroxine in euthyroid women with thyroid antibodies and RM outside a clinical trial	2C	ESHRE
43	400mg twice daily vaginal progesterone may improve livebirth rate in women with one or more miscarriages and vaginal bleeding in a subsequent pregnancy	1B	ESHRE/ NICE
44	Bromocriptine treatment can be considered in women with RM and hyperprolactinemia to increase live birth rate	2C	ESHRE
45	There is insufficient evidence for HCG supplementation or metformin in the treatment of RM	Adapted	ESHRE/ RCOG
Infectious factors			
46	Given the lack of prospective studies linking any infectious agent to RM, any use of antibiotics is not supported by the evidence and therefore should not be recommended	Best Practice	ASRM
47	There is no evidence to recommend endometrial scratching or biopsy in women with unexplained RM.	Best Practice	ESHRE

No	Recommendation	Grade of recommendation*	Supporting Evidence**
Genetic factors			
48	Options for couples with chromosomal rearrangements include attempting a further natural conception, preimplantation genetic testing for structural rearrangements (PGT-SR) or gamete donation	2C	RCOG
49	Currently available data do not support the use of pre-implantation genetic testing for couples with unexplained recurrent miscarriage	2C	RCOG/ ESHRE
Male factors			
50	There is no evidence to recommend treatments for male factors	2C	RCOG
Clinical Question 7: What are the possible treatments for women/couples presenting with Unexplained RM?			
Unexplained RM and empiric treatments			
51	In women with three or more consecutive miscarriages immediately preceding their current pregnancy, empiric vaginal progestogen administration of 400mg twice daily may be of some potential benefit	Best Practice	GDG
52	LMWH and corticosteroids are not recommended for unexplained RM	Best Practice	GDG
53	Women with RM are at increased risk of placental dysfunction and for this purpose low-dose aspirin (75-150mg) is recommended in a future pregnancy, with consideration of LMWH based on individual risk factors and history	Best Practice	GDG
54	While low dose folic acid (0.4 mg/day) is routinely started preconceptionally to prevent neural tube defects, it has not been shown to prevent pregnancy loss in women with unexplained RM	2C	ESHRE
55	Women with risk factors for folic acid deficiency, such as obesity, epilepsy or diabetes mellitus, should be considered for high dose (5mg) folic acid supplementation; in an Irish context, it should be considered for women with RM	Best Practice	GDG

No	Recommendation	Grade of recommendation*	Supporting Evidence**
Future pregnancy planning			
Clinical Question 8: How should women/couples with RM be cared for in a subsequent pregnancy?			
56	As part of their visit to a RM clinic, women/couples should receive written information regarding the results of investigations, treatment plans, contact numbers for available supports, (including the early pregnancy assessment unit and emergency room), in addition to necessary prescriptions and a personalised plan should a further pregnancy loss occur	Best Practice	GDG
57	Provisions should be made for women to receive appropriate supportive care in terms of communication with healthcare professionals, ultrasound examinations and access to services in case of subsequent miscarriage(s).	2C	RCOG
58	Women with an ongoing pregnancy should be triaged for obstetric care according to their birth preferences and their individual additional risk factors for complications associated with RM e.g., preterm birth, intrauterine growth restriction and stillbirth.	Best Practice	GDG

* The recommendations are graded using an adaption of the GRADE approach to evidence, which is further outlined in Chapter 3.

** The recommendations were compiled following a systematic review of guidelines as per the ADAPTE process and the source guideline indicates where adapted and/or adopted recommendations originated. Additional recommendations were derived following an updated review of the literature with GDG consensus and this is indicated within the table.

Chapter 1: **Initiation**

The National Clinical Effectiveness Committee (NCEC) and Health Information and Quality Authority (HIQA) define clinical guidelines as systematically developed statements, based on a thorough evaluation of the evidence, to assist practitioner and patient decisions about appropriate healthcare for specific clinical circumstances, across the entire clinical spectrum[1].

1.1 Purpose

The purpose of this Guideline is to provide a comprehensive, evidence-based guidance for the management of recurrent first-trimester miscarriage (RM) within the Republic of Ireland.

1.2 Scope

Target Users

The Guideline is a resource for all primary, secondary and tertiary health and social care professionals who are involved in the care of women/couples with recurrent miscarriage. It may also be of interest to women/couples with RM, support and advocacy organisations and those involved in research.

Target Population

Women, men, people and/or couples presenting with recurrent first trimester miscarriage within the Republic of Ireland.

A note on language regarding sex/gender: Throughout this document we refer to women and/or couples, noting 'people' within the target population above. In our use of the term 'women' we acknowledge that people who do not identify as cis-gender women are excluded from this descriptor, including people who identify as transgender, gender diverse and gender non-binary [2]. We also appreciate that there are risks to desexing language when describing female reproduction [3,4]. Research is needed in this area to examine the needs of people who do not identify as cis-gender women, and guideline bodies need to address this gap within current guidelines.

1.3 Objective

To provide evidence-based recommendations for the care of women/couples presenting with RM as well as promoting a standardised approach nationally across all maternity units regarding the structure/organisation of care, counselling and supportive care, investigations and treatments.

1.4 Guideline development process

The Guideline Developers agreed to undertake this work under the direction of the Guideline Programme Team (GPT). An Expert Advisory Group (EAG) was commissioned by the GPT. Their role was to critically review the Guideline prior to submission to the National Women and Infants Health Programme (NWIHP) for final approval.

See appendix 1 for EAG membership, appendix 3 for Clinical Advisory Group membership and Appendix 4 for Guideline Programme Process.

Many clinical guidelines regarding RM exist internationally [5]. In developing a national clinical guideline for Ireland, the Guideline Development Group (GDG) decided to adapt existing guidelines and/or guideline recommendations using the ADAPTE process [6].

The Guideline Developers/writing group comprised:

- Dr Laura Linehan, ASPIRE Fellow, Post CSCST [Lead];
- Dr Azy Khalid, Consultant Obstetrician and Gynaecologist, University Hospital Waterford;
- Marita Hennessy PhD, Postdoctoral Researcher, Pregnancy Loss Research Group, University College Cork;
- Ms Jill Whelan, Clinical Midwife Specialist in Bereavement & Loss, University Hospital Waterford;
- Professor Keelin O'Donoghue, Consultant Obstetrician and Gynaecologist, Cork University Maternity Hospital.

1.5 Stakeholder involvement

Stakeholders are people who have a common interest in improving health services. This includes persons that are responsible for delivering and those who receive services related to the clinical guideline.

Members of the RE:CURRENT (Recurrent miscarriage: Evaluating current services) Project [7] Research Advisory Group were consulted in regard to this guideline. RE:CURRENT is a two-year project (2020-2022), funded by the Health Research Board, which aims to evaluate RM care in the Republic of Ireland. The RE:CURRENT Research Advisory Group was formed in 2020 and comprises 22 individuals with clinical, methodological and lived experience: healthcare and allied health professionals, representatives from advocacy and support organisations, those involved in the administration, governance and management of maternity services, academics, and women and men who have experienced RM (Appendix 2).

The RE:CURRENT Research Advisory Group were involved in a modified e-Delphi consensus study which aimed to develop guideline-based key performance indicators for RM care. As part of this process, they discussed, agreed and prioritised recommendations for RM care that had been identified within a systematic review of clinical practice guidelines for RM in high-income countries [5].

In writing this guideline, we also incorporated the views of various stakeholders regarding services and supports for RM in Ireland which were garnered through qualitative interviews conducted by members of the RE:CURRENT Project Team between June 2020 and February 2021 [8]. Interviews were held with 42 individuals involved in the delivery and management/governance of services and supports (including consultant obstetricians and gynaecologists, specialist registrars, clinical midwife/nurse bereavement specialists, midwives, sonographers, medical social workers, public health nurses, and general practitioners; representatives from advocacy and support organisations; those involved in the administration, governance and management of maternity services), and 13 women and seven men who had experienced at least two consecutive first-trimester miscarriages.

This GDG is also grateful to Professor Cathy Allen, Consultant Obstetrician and Gynaecologist, National Maternity Hospital, Dr Samantha Doyle, Clinical and Biochemical Geneticist, National Maternity Hospital, Dr Yvonne O' Brien, Consultant Obstetrician and Gynaecologist, Galway University Hospital and Portiuncula University Hospital for their review of the guideline and contribution of their expertise.

We would also like to thank Jennifer Ui Dhubhgain, Secretary, Miscarriage Association of Ireland and Parent Advocate, RE:CURRENT Project for her review and insights. We are also grateful Prof. Niamh O'Connell, National Haemophilia Director, Consultant Haematologist, National Coagulation Centre, St James's Hospital and Clinical Professor, Dept. of Haematology, Trinity College Dublin and the Coagulation Special Interest Group of the Irish Haematology Society for their review of the guideline and subsequent recommendations.

Finally, the views of members of the RE:CURRENT Research Advisory Group and the Oversight Group for the National Standards for Bereavement Care Following Pregnancy Loss and Perinatal Death were sought on a draft version of this guideline.

1.6 Disclosure of interests

Guideline developers and reviewers bring a range of experiences and perspectives to the work of the national Guideline Programme. It is likely that both Guideline developers and stakeholders/reviewers will have a variety of interests, arising from different contexts and activities done in a professional or personal capacity. These can include employment and other sources of income, speaking engagements, publications and research, and membership of professional or voluntary organisations. The involvement of individuals with relevant content expertise is essential for enhancing the value of Guideline recommendations, but these individuals may also have interests that can lead to conflicts of interest, as may peer reviewers, patient representatives and researchers.

All interests should be declared if, in the view of a reasonable person, they are relevant, or could be perceived to be relevant, to the work of the clinical practice guideline in question.[1] Declaring an interest does not mean there is a conflict of interest.

It is important that interests are openly declared so they can be appropriately managed. Conflicts of interest can bias recommendations and ultimately be harmful to patients and the health system. Disclosures of interests and appropriate management of conflicts of interest, when identified, are therefore essential to producing high-quality, credible health guidelines.[2]

The Guidelines International Network (GIN), a global network of Guideline developers that aims to promote best practices in the development of high-quality guidelines, developed a set of 9 principles to provide guidance on how financial and non-financial conflicts of interest should be both disclosed and managed. It is recommended that Guideline developers follow the GIN principles.[3]

For this National Clinical Practice Guideline, all Guideline developers are asked to complete a conflict of interest declaration form. The response to declared interests will be managed by the Guideline programme team, in accordance with GIN principles. Conflicts of interest may be reported in the published Guideline and declarations of interest can be made available.

The authors have completed and signed a COI statement prior to embarking on guideline development.

1 NICE (2019) Policy on declaring and managing interests for NICE advisory committees https://www.nice.org.uk/Media/Default/About/Who-we-are/Policies-and-procedures/declaration-of-interests-policy.pdf

2 CMAJ 2021 January 11;193:E49-54. doi: 10.1503/cmaj.200651 https://www.cmaj.ca/content/193/2/E49

3 Annals of Internal Medicine, Schünemann HJ, Al-Ansary, LA, Forland F, *et al.* Guidelines International Network: Principles for disclosure of interests and management of conflicts in guidelines, 163(7), 548-53. Copyright © 2015 American College of Physicians. https://www.acpjournals.org/doi/10.7326/m14-1885

Professor Keelin O'Donoghue is Clinical Lead for Guideline Development in Maternity and Gynaecology at the National Women and Infants Health Programme (NWIHP), HSE (2021-) and leads implementation for the HSE's National Standards for Bereavement Care following Pregnancy Loss and Perinatal Death (2017-). In the last five years, she has received research funding for projects related to recurrent miscarriage, perinatal death and maternal-fetal medicine from Science Foundation Ireland, the Health Research Board, the Irish Research Council, the Department of Children and Youth Affairs, the Irish Hospice Foundation, the MPS Foundation and Féileacáin. Prof. O'Donoghue served/serves on the following Committees/Groups (in non-remunerated roles): Institute of Obstetricians and Gynaecologists (IOG) Speciality Training Committee (2014-); Royal Irish Academy Life and Health Sciences Multidisciplinary Committee (2022-); Department of Health National Screening Advisory Committee (2019-2023); Termination of Pregnancy (Review Recommendations National Implementation Group (2023-); Perinatal Mortality National Clinical Audit Governance Committee (2014-); Clinical Advisory Group, NWIHP (2017-); International Stillbirth Alliance Advocacy Working Group (2022-).

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LL is undertaking a Fellowship in Preterm Birth and Pregnancy Loss with the Royal College of Physicians, Ireland, which is funded by the National Doctors Training and Planning Aspire Programme.

Marita Hennessy PhD was a Postdoctoral Researcher on the Health-Research Board-funded RE:CURRENT (Recurrent miscarriage: Evaluating current services) project from 13/01/2020 to 31/07/2022 and the Health Research Board-funded RE:CURRENT Knowledge Translation Acceleration (KTA) project from 01/12/2022 to 30/11/2023 (60% FTE). She was funded by the National Women and Infants Health Programme as a Postdoctoral Researcher, supporting the implementation of the National Standards for Bereavement Care Following Pregnancy Loss and Perinatal Death, from 01/08/2022 (40% FTE from 01/12/2022) to 30/11/2023. Her current (unrelated) Postdoctoral Fellowship, titled 'Supporting maternity care staff in the aftermath of an adverse event: Development and pilot testing of a scalable psychosocial intervention', is funded by Research Ireland (01/12/2023 to 30/11/2025).

Marita was a member of the National Clinical Guideline Expert Advisory Group from April 2021 to December 2024; she had no role in the EAG review of this RM guideline.

1.7 Disclaimer

These guidelines have been prepared to promote and facilitate standardisation and consistency of good clinical practice, using a multidisciplinary approach. Information in this guideline is current at the time of publication.

The ultimate judgement regarding a particular clinical procedure or treatment plan must be made by the Clinician in light of clinical data presented by the patient and the diagnostic and treatment options available. Clinical material offered in this guideline does not replace or remove clinical judgment or the professional care and duty necessary for each specific woman. Clinical care carried out in accordance with this guideline should be provided within the context of locally available resources and expertise.

This Guideline does not address all elements of standard practice and assumes that individual clinicians are responsible for:

- Discussing care with women/couples in an environment that is appropriate and which enables respectful confidential discussion. This includes the use of interpreter services where necessary
- Advising women/couples of their choices and ensure informed consent is obtained
- Provide care with professional scope of practice, meeting all legislative requirements and maintaining standards of professional conduct

- Applying standard precautions and additional precautions, as necessary, when delivering care
- Documenting all care in accordance with local and mandatory requirements.

1.8 Use of language

Within this guidance we use the terms 'woman' and 'women's health'. However, it is important to acknowledge that people who do not identify as cis-gender women are excluded from this descriptor, including people who identify as transgender, gender diverse and gender non-binary[4]. While there has been a trend to remove the word 'woman/women' and use 'gender neutral' language in policy and practice in relation to women's reproductive health and wellbeing, there is no evidence base to inform this change.[5] We also appreciate that there are risks to desexing language when describing female reproduction[6] [7].

Services and delivery of care must be appropriate, inclusive and sensitive to the needs of people whose gender identity does not align with the sex they were assigned at birth. This includes training and education regarding diverse pathways to pregnancy and the use of practices which affirm the sexual and gender identities of all people using Obstetrics and Gynaecology services. Finally, all those using maternal and reproductive health care and services should receive individualised, respectful care including use of the gender nouns and pronouns they prefer.[7]

Language use is key to effectively communicate options, recommendations, and respectfully accept a woman's fully informed decision[8]. With this in mind, the use of birth is preferable to the term delivery in all circumstances and is used consistently where possible throughout the guidelines. It is acknowledged that in some circumstances (e.g. in the case of a medically indicated intervention or surgery) and in some contexts, substituting with the term delivery is considered appropriate and this term may be used instead.

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1.9 Adopting a trauma-informed approach to maternity care

Many women accessing maternity services may have experienced historical or current trauma prior to, or during pregnancy – including emotional, physical, sexual abuse, rape and torture. The perinatal period (pregnancy, birth and the postpartum) can be a time when previous trauma is triggered[9]. Maternity care procedures which may seem routine and 'non-invasive' to healthcare professionals (HCPs), e.g. abdominal palpation or providing breastfeeding support can be triggering for some women with a history of trauma, as can intimate procedures such as vaginal examinations[10].

Trauma-informed care (TIC) is a developing approach to healthcare which recognises the importance of psychological safety, and the need to prevent or resist re-traumatisation of individuals[11]. It is based on 4 key principles (known as the 4Rs): [1] realisation of trauma; [2] recognition of trauma; [3] responding to trauma and [4] resisting re-traumatisation[12,]. A trauma-informed approach to maternity care means that all staff in an organisation have an understanding of the impact of trauma on individuals, families and organisations[13]. While a universal approach is yet to be agreed, within clinical practice and research, many organisations recognise the need to move towards becoming trauma-informed in the provision of maternity care[15, 14]. Such an approach requires commitment, investment and transformation within maternity services.

In simple terms, HCPs should recognise the impact of women's previous or current history of trauma (whether disclosed or not) and adopt a universally sensitive approach to care provision that recognises the impact of trauma on service users and HCPs. Examples of this include ensuring clear communication and consent is sought before any procedures/interventions, ensuring women are provided with dignity and respect at all times.

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Chapter 2:
Clinical Practice Guideline

Background

Prevalence

Miscarriage is generally defined as the spontaneous loss of a pregnancy before it reaches viability, that is 24 weeks of gestation, and occurs in approximately 15% of pregnancies. [9] The population prevalence of women who have had one miscarriage is 10.8%, two miscarriages is 1.9%, and three or more miscarriages is 0.7%. [9]

Terminology and definitions

The terminology and definitions regarding RM or pregnancy loss vary across countries and professional bodies. [5] The European Society for Human Reproduction and Embryology (ESHRE) and the American Society of Reproductive Medicine (ASRM) use the term 'recurrent pregnancy loss', (RPL) [10,11] whereas the Royal College of Obstetricians and Gynaecologists (RCOG) in the UK use the term 'recurrent miscarriage'[12]. In its 2017 guideline, and in a draft revision to this guideline to be published in 2022, ESHRE defines recurrent pregnancy loss as the loss of two or more pregnancies before viability. Disagreements amongst guideline group members were noted, however, with some stating that they would continue to use a definition of three or more consecutive losses in their clinical practice [10]. The ASRM also recommends clinical evaluation after two first-trimester clinical pregnancy losses [11]; this is supported by the American College of Obstetrics and Gynaecology [13].The RCOG retains a definition of three (non-consecutive) miscarriages, with the clinical discretion to recommend extensive evaluation after two first trimester miscarriages, if there is a suspicion that the miscarriages are of a pathological and not a sporadic nature [12].

In the present guideline, we adopt the term 'recurrent miscarriage', which we define as two or more consecutive first trimester miscarriages. The GDG have decided to retain the definition of consecutive after consideration of the current care practices across the Republic of Ireland and the relevant resources. The focus is on recurrent first-trimester miscarriage given that this should be treated differently to second-trimester miscarriage [14,15]. We include primary RM (i.e. RM without any livebirths or pregnancies beyond 24 weeks gestation) and secondary RM (i.e. RM after one or more previous pregnancies progressing beyond 24 weeks gestation). A pregnancy within our definition includes those confirmed by either serum or urine b-hCG (i.e. biochemical pregnancies) as well as those documented by ultrasonography or histopathological examination. We include molar pregnancy in our definition of recurrent miscarriage. Although molar pregnancy is a distinct type of pregnancy loss, with a defined care pathway and follow-up, women experiencing molar pregnancy consider their loss similarly to miscarriage and 67% of clinicians would include molar pregnancy in their definition of RM.[8,16] Pregnancy losses both after spontaneous conception and after artificial reproductive technology (ART) treatments are included in the definition. We make no distinction as to whether miscarriages occurred with the same partner(s) or gamete donor(s). We exclude ectopic pregnancy, however, we acknowledge that women/couples experiencing sequential ectopic pregnancies may require additional supports in subsequent pregnancy as offered to those experiencing RM, such as that offered by Bereavement Midwives or formal counselling. This should be facilitated, in addition to early pregnancy ultrasounds.

We refer to RM in our guideline, however there are variations on this definition in the literature and there is overlap with the term RPL. The term RM will be used throughout to refer to first-trimester miscarriage, with specific variations as per the literature defined as necessary. RPL refers to two or more first or second-trimester miscarriages unless specified.

Risk factors associated with RM

Associated risk factors for RM are outlined in Table 1.

Table 1: Risk factors associated with RM

Epidemiological Risk Factors associated with RM	Additional Associated Factors
Maternal age	Uterine anomalies (congenital and acquired)
Paternal age	Immunological factors
Previous obstetric history	Thrombophilias (Inherited and acquired)
Ethnicity	Endocrine factors
Smoking	Infectious agents
Alcohol	Genetic
Caffeine	Male contributory factors
Body mass index (BMI)	
Stress	

The association of each factor with RM is discussed in detail in their relevant investigative section below.

Significance: The clinical and economic impact of RM

Recurrent miscarriage is associated with future obstetric complications, including increased risk of preterm birth, small-for-gestational-age, fetal growth restriction, antepartum haemorrhage, placental abruption, and stillbirth [9,17,18]. It is also a predictor of longer-term health conditions, including cardiovascular disease and venous thromboembolism, and has mental health consequences [9].

Women, and to a lesser extent, their partners, are at significant risk of symptoms of anxiety, depression and post-traumatic stress disorder after an early pregnancy loss, this is even more pronounced for people who experience RM [19]. RM has significant psychological consequences for women and their partners, including grief (which could represent a normal, uncomplicated and adaptive response to loss; 'pathological grief' can develop however), elevated anxiety and depressive symptoms [20,21] and even extend to suicidality [22]. A recent Irish study, conducted as part of the RE:CURRENT Project, found that women with RM experience a poorer health related quality of life (50% scored well below the population norm relating to mental health, indicating the likelihood of experiencing depression)[23].

Studies examining the needs and care experiences of women and/or their partners with RM highlight the need for more information, psychological support, the inclusion of partners in consultations, and appropriate follow-up care [8,24-29].

The financial impacts of RM for women/couples in Ireland were also highlighted within the RE:CURRENT Project: women experienced decreased work productivity (70%) and substantial out-of-pocket costs for travel to RM care appointments and other medical expenses, such as additional scans and attending fertility services[30].

Recommendations relevant to this Guideline can also be found in:

- National Clinical Practice Guideline: In Vitro Fertilisation (IVF) and Intracytoplasmic Sperm Injection (ICSI). [15]
- National Clinical Practice Guideline: First Trimester Miscarriage[16]
- National Clinical Practice Guideline: The Diagnosis and Management of Ectopic Pregnancy [17]
- National Clinical Practice Guideline: Fertility-Investigation and Management in Secondary Care [18]

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Section 1: Structure and organisation of RM care

Introduction

As noted earlier, definitions of RM vary internationally. This can impact on when women/couples receive care for RM, including access to investigations. Some guideline bodies recommend clinical investigation after two non-consecutive losses, [10,11,13] while some continue to recommend investigation after three losses, with discretion to recommend extensive evaluation after two first trimester miscarriages [12]. Variation in referral criteria and practice in Ireland has been noted, with some maternity units/hospitals using a criterion of three consecutive miscarriages, while others adopt a criterion of two consecutive miscarriages, with or without provisions for specific circumstances, e.g. maternal age, or no living children [8,30,31].

In a recent study of stakeholder views on how RM is and/or should be defined, participants felt that a standardised definition of RM was needed, one which considered research evidence, individual needs, and healthcare resources [8]. They also highlighted that the definition of RM is a route to finding an answer and/or validating women/couples' experience of loss, and sometimes where RM is rigidly defined as three consecutive miscarriages, efforts are made to work around this, with associated impacts.

Clinical Question 2.1: When should women/couples with RM receive care/be investigated?

Evidence Statement

The results of a systematic review of the evidence on the prevalence of abnormal test results for RM among patients with two versus three or more pregnancy losses, were supportive of investigations after two pregnancy losses in couples who had experienced RM [32]. However, the authors stressed the need for additional studies on the prognostic value of test results [32]. Following their systematic review of the literature, co-authors of the recent Lancet series on miscarriage proposed a graded approach whereby women/couples are offered appropriate investigations after a second miscarriage, and a full panel of investigations following a third or subsequent miscarriage [33]. This evidence supports the guidelines, from ESHRE, American College of Obstetrics and Gynaecology (ACOG), and ASRM, respectively, which recommend clinical investigation after two miscarriages [10,11,13].

There is some debate as to whether losses/miscarriages should be consecutive or not; however, the evidence is limited to make a firm conclusion [10], with some studies noting no reason to restrict to consecutive miscarriages [34,35]. The ACOG, ASRM and RCOG continue to recommend investigation after a defined number of consecutive miscarriages [11,13,36].

Our recommendation is to commence investigations after two consecutive miscarriages. Ultimately, the decision on when to start investigations should be decided by the doctor and the woman/couple, taking into account their individual history and risk factors, as the result of shared decision-making, and cognisant of available resources in individual clinical services [10].

In keeping with the Lancet series recommendations, women/couples with any number of non-consecutive miscarriages should not be denied access to supportive care in the form of early scans, psychological supports or counselling [33].

Recommendations

1. **Investigation/evaluation of women/couples with RM can proceed after two consecutive pregnancy losses**

Section 2: Organisation of RM care

Clinical Question 2.2: How should the care of women/couples with RM be organised?

Evidence Statement

The evidence to support this recommendation is largely derived from expert consensus, specifically from the ESHRE guidelines [10], subject to minor wording changes when adapting to the Irish context. An additional point is made regarding interpreter services and information provision in different languages further to consensus of the RE:CURRENT Research Advisory Group.

Clinical Practice

Recurrent miscarriage clinic

Couples should be referred to a RM clinic. A dedicated RM clinic is an outpatient clinic that offers specialist investigations, support and, if possible, treatment of couples with RM. It is a non-acute service, and the couples should preferably be seen and tested prior to a new pregnancy. The following are components of a RM clinic:

Staffing/expertise:

- Experienced staff members (obstetricians/gynaecologists/fertility doctors/specialised nurses) and with appropriate listening skills are part of the RM team.
- Ideally there should be trained and qualified staff (e.g. psychologists/social workers/counsellors/psychotherapists) either onsite or accessible, who offer support tailored to the psychological needs of the couples. Where available, this might be within a RM clinic.
- There should be experienced ultrasonographers within the early pregnancy clinic trained in the care of women with pregnancy loss, as well as in 3D ultrasound.

Location/equipment/facilities:

- The outpatient RM clinic is ideally a separate clinical space and should not be located next to an antenatal clinic, antenatal ward, or other areas where pregnant women may be seen/attend.
- If this is not possible due to the limitations of location, every effort should be made to minimise the impact on women/couples experiencing RM, for example, a separate waiting room could be made available, women could be escorted directly from the hospital entrance to the clinic or RM appointments could be provided for off-peak times
- The team in the RM clinic should have access to the appropriate laboratories for genetics, biochemistry, and haematology testing (onsite/external).
- Virtual clinics have proved to be useful and effective in recent times. There are currently no studies examining their use in RM care to demonstrate any benefits or harms. The GDG suggests that while virtual clinics may be offered, they should remain optional.

Information provision and plans:

- In advance of the first visit/appointment, providing written information for women/couples about what to expect can help to reduce anxiety and manage expectations. All women/couples should receive an information leaflet and the summary of sources of support at an early stage in the pathway. This will facilitate repeated discussion as appropriate.
- Each individual and/or couple should have a tailored investigation plan which is explained to them, including details about expected timeframes where known; and a tailored management plan should follow for any immediate treatment and future pregnancy.
- The first visit should allow time for the clinician to review the individual's history, to answer questions and to propose a plan for investigations and, perhaps, treatment.
- The first visit is the opportunity to provide general information about RM incidence, causes and investigations and to link it to the individual's history. Staff should be aware that many women/couples with RM will already have information from a variety of sources, and some explanation and updating may be needed. Information leaflets from professional and/or reputable societies or the clinic should be offered. In addition, clinics can organise information sessions for women/couples with RM.
- Where required, interpreter services should be provided, and information should be provided in languages other than English. Care should be sensitive to cultural/ethnic backgrounds [RE:CURRENT Research Advisory Group].

Recommendations

2. **Couples should be referred to a RM clinic; this should have the appropriate staffing and clinical expertise, be appropriately located, with access to the required equipment and facilities.**
3. **Written information should be given in advance of appointments in the RM clinic, and further written information should accompany explanation of investigative findings, treatments and future pregnancy plans.**

Section 3: Supportive Care

Introduction

RM is associated with significant psychological distress which may lead to more significant long-term mental health conditions if appropriate psychological care and supports are not provided [22]. This distress can be amplified for women with co-existing infertility [37,38]. Male partners are also affected by miscarriage, with feelings of grief exacerbated by being excluded from supportive care [39-41]. It is therefore important to take a holistic and couple-centred approach to RM care to best meet their needs [27].

Preferred supportive care in subsequent pregnancies as chosen by women with RM included:

- Early and frequently repeated ultrasounds
- BHCG monitoring
- Practical advice concerning lifestyle and diet
- Emotional support in the form of counselling
- A clear management policy for the first trimester and any medications [25].
- Continuity of care with a single doctor who listened to and understood their concerns, with knowledge of their history and RM care, exhibiting empathy and awareness of their emotional needs was also preferred [24].

Supportive care should be offered following the first and subsequent miscarriages, according to the needs of the individual woman/couple.

Clinical Question 2.3: How should the psychological needs of women/couples with recurrent miscarriage be addressed?

Evidence Statement

The evidence to support this recommendation is largely derived from expert consensus within the ESHRE [10] and Public Health Agency NI [42] guidelines, subject to minor wording changes when adapting to the Irish context.

Clinical Practice

Women/couples' psychological states and needs will vary. Whilst no single model of care will suit every individual's need, the following elements will be appreciated and should be considered:

Recognition of the patient as an individual; time for questions, information, repetition and discussion; good listening; respect: clear and sensitive language; honesty; shared planning; supportive care in the next pregnancy/ies; kindness [10].

Women/couple's preferred type of support, experience of recurrent miscarriages/other pregnancy loss, additional fertility issues, financial, social and personal circumstances and emotional needs should be taken into account when considering support options [10].

Psychological counselling and support should be offered to couples with RM; these may be formal therapies where appropriate or informal supportive resources.

The following options of support should be highlighted: (i) bereavement services within the hospital, (ii) community and voluntary sector resources – these need to be credible/trustworthy [42].

Recommendations

4. **Psychological counselling and support should be offered to couples with RM and tailored to their needs**

Section 4: Investigation of RM

Introduction

As mentioned in section 2.3, the first visit should allow adequate time for a full medical and family history of both partners to be taken. The identification of individual epidemiological and medical risk factors should tailor diagnostic investigations.

CLINICAL INVESTIGATIONS

The investigation of women and couples with RM includes anatomical, immunological, haematological, endocrine, infectious, genetic and male factor conditions. The section which follows clinical question 2.5 will lay out the recommended investigations in each category.

Investigations could be instigated by a woman's GP in the community, but some investigations such as parental karyotype and cytogenetics must be sent from a maternity unit.

Clinical Question 2.4: What epidemiological factors are relevant for women/couples presenting with RM?

Evidence Statement

The evidence to support this recommendation is largely derived from evidence underpinning the ESHRE updated 2023 guideline [43], RCOG updated guideline [36] and the Public Health agency of Northern Ireland guideline [42] in addition to an updated search of the relevant literature.

Maternal Age

It is recognised that miscarriage risk increases with maternal age, in addition to infertility, ectopic pregnancy, second-trimester miscarriage, stillbirth, and maternal morbidity [44,45] The risk of miscarriage is approximately 12% for women aged 20-29 and rises to 65% at age 45 [9]. This is directly related to an age-related increase in embryonic trisomy, particularly trisomies on chromosomes 13, 14, 15, 16, 18, 20, 21, and 22 [9]. The risk of trisomy 16, the most common cause of miscarriage, rises linearly from 20 to 40 years of age, whereas the risks of other trisomies rise after the age of 35 [9]. Chromosomal abnormalities are found to be the primary cause of sporadic miscarriage in up to 60% of cases [9].

As explained by Rai and Regan, RM is identifiable as a distinct entity, rather than sequential sporadic miscarriages, as it may occur with a normal fetal karyotype, (particularly in women aged under 36), it has a higher incidence rate than would be expected by chance alone (1% vs 0.34%) and is related to past obstetric history [46,47]. It must be acknowledged however, that the incidence of three sporadic miscarriages (i.e. RM occurring by chance) increases significantly with age, 0.13% at age 20-24 vs 13% at age 45, i.e. a 100-fold increase [48]. It follows that the incidence of two sporadic miscarriages by chance alone also increases with age, 1.21% at age 20 vs 26% at age 45 [36]. This must be sensitively explained during counselling and is of particular relevance to women over 35 with cytogenetics results demonstrating aneuploidy.

Maternal age is an important prognostic indicator for future obstetric complications and livebirth [49,50], alongside previous obstetric history [51]. Therefore, maternal age must be taken into account when counselling regarding prognosis for future pregnancy.

Paternal age

A systematic review has shown an increased risk of spontaneous miscarriage with paternal age greater than 45 years [52]. A direct association with paternal age and RM has yet to be proven. However, a recent study has shown that when combined with other characteristics such as number of previous pregnancy losses, maternal age, maternal and paternal BMI, maternal smoking status, and mode of conception, the probability of an ongoing pregnancy after unexplained RM declined with increasing paternal age [53].

Previous obstetric history

Previous miscarriages impact on future pregnancy success. The chance of livebirth decreases according to the number of preceding losses [51,54]. A recent systematic review has reported subsequent miscarriage rates of 11.3%, 17.0%, 28.0%, 39.6%, 47.2% and 63.9% for women with 0, 1, 2 or 3, 4, 5 and 6 or more previous miscarriages respectively [55].

Two studies have shown that previous livebirth does not protect against miscarriage in subsequent pregnancies [56,57]. A larger register-based study over 40 years showed the chance of a livebirth in a pregnancy is higher for those women with a history of livebirth or consecutive livebirths in the immediately preceding pregnancies compared to a first-trimester miscarriage, consecutive miscarriages, second-trimester loss or stillbirth [58]. A thorough obstetric history detailing the order of livebirths, miscarriages and other adverse pregnancy outcomes may assist in counselling women with RM regarding their prognosis for a future livebirth.

Ethnicity

A retrospective cohort study of 196,040 women demonstrated that compared with white Europeans, the odds of a previous miscarriage were increased in black African (adjusted odds ratio [aOR] 1.20; 95% confidence interval [CI] 1.12-1.29) and black Caribbean women (aOR 1.31; 95% CI 1.21-1.41) [59].

Smoking

A systematic review demonstrated that any active smoking was associated with increased risk of miscarriage (relative risk ratio (RRR) 1.23, 95% confidence interval (CI): 1.16, 1.30; n = 50 studies) [60]. The risk of miscarriage increased with the amount smoked (1% increase in relative risk per cigarette smoked per day) [60]. Second-hand smoke increased the risk of miscarriage by 11% [60]. Significant negative outcomes were detected in the female smokers compared with non-smokers undergoing artificial reproductive technology (ART) including decreases in live birth rate per cycle (OR = 0.52, 95% CI 0.37-0.74), in clinical pregnancy rate per cycle (odds ratio (OR) 0.59, 95% CI 0.51-0.68), in number of retrieved oocytes (mean difference (MD) = –0.87, 95% CI –1.39 to –0.25), and in average fertilisation rate (MD = –4.80, 95% CI –8.49 to –2.02), as well as a significantly increased miscarriage rate per pregnancy (OR = 2.48, 95% CI 1.79-3.43) [61]. In a meta-analysis of eight studies, paternal smoking of >10 cigarettes per day in the preconception period was found to be associated with an increased risk of pregnancy loss, after adjustment for maternal smoking status (1-10 cigarettes per day) aOR 1.01; 95% confidence interval [CI], 0.97-1.06; 11-19 cigarettes per day, 1.12; 95% CI, 1.08-1.16; ≥20 cigarettes per day, 1.23; 95% CI, 1.17-1.29) [62].

Therefore, given the association between smoking and poor obstetric outcomes in addition to miscarriage, it is recommended that women are encouraged to stop smoking in advance of trying to conceive. Male partners should also be encouraged to quit smoking both to reduce the risk of miscarriage and to minimise second-hand smoke inhalation for their partner.

Alcohol

Alcohol has a clear negative impact on pregnancy and neonatal outcomes, including the fetal alcohol spectrum disorders. Therefore, it is advisable that women avoid consumption of alcohol during pregnancy [43].

A large Chinese study of 4.5 million women demonstrated that preconception alcohol consumption was associated with higher odds of miscarriage, and an increasing risk was found with paternal and maternal alcohol consumption. Compared with non-drinkers, the aOR of miscarriage was 1.06 (95% CI 1.02 to 1.10) and 1.59 (95% CI 1.15 to 2.20) in maternal occasional drinkers and regular drinkers, respectively. Compared with couples in which neither the male nor the female consumed alcohol, the aOR for miscarriage among women was 1.09 (95% CI 1.07 to 1.10), 1.13 (95% CI 1.06 to 1.21) and 1.12 (95% CI 1.07 to 1.17) in the couples in which only the female drank alcohol, only the male drank alcohol, and both drank alcohol, respectively. Conversely, the aOR was 0.58 (95% CI 0.51 to 0.65) in women with alcohol abstinence compared with alcohol drinkers [63]. However, a separate systematic review did not find an association between RM and alcohol consumption [64].

Women and their partners should be advised to limit alcohol consumption if trying to conceive. Women who are concerned that previous consumption may have had a role in pregnancy loss should be reassured that there is no causal association [43].

Caffeine

The evidence for an increased risk of RM with caffeine consumption has been conflicting, with observational studies reporting an increased risk of RM [65,66] and others reporting no association [67,68]. The risk of RM has been shown to increase with higher doses of caffeine intake with those consuming >300mg/day at highest risk [65,66].

This guideline, in line with RCOG guidance, recommends that women aim to consume no more than 200mg caffeine per day [36].

Body Mass Index (BMI)

Pregnant women with a BMI >30 are at greater risk of a variety of pregnancy-related complications compared with women with a BMI ≤30, including pre-eclampsia and gestational diabetes [69]. A systematic review and subsequent meta-analysis has shown that women with a BMI < 18.5 and women with a BMI ≥ 25 have higher odds of RM than the general population (OR 1.2, 95% CI 1.12-1.28 and OR 1.21, 95% CI 1.06-1.38, respectively) [64]. In women with RPL, having BMI ≥ 30 and BMI ≥ 25 has increased odds of further miscarriages (OR 1.77, 95% CI 1.25-2.50 and OR 1.35, 95% CI 1.07-1.72, respectively) [64]. The quality of the evidence for these findings was low or very low, however. Women trying to conceive should be advised that a BMI ≥ 18.5 and <25 is associated with decreased risk of miscarriage.

Stress

Women with RM have been shown to have higher levels of stress in addition to established mental health conditions such as post-traumatic stress, anxiety and depression [19,54]. Whether stress is in itself a cause of RM has yet to be definitively proven, with some studies showing an association [70,71] and others failing to show that stress is a factor in pregnancy loss [72,73].

The potential association between stress and miscarriage is of concern to women with RM (this may include other stresses such as work-related or significant life-event related stressors, other than the direct stress of RM) and thus women and their partners should be reassured that there is no evidence of a direct causal association and any specific concerns should be addressed [36].

Pre-existing mental health issues and any impact of RM or concerns should be addressed, and additional supports provided. Prescribed medications such as anti-depressants should be identified, and women should be advised that they should not be stopped abruptly in early pregnancy without discussion with their GP/mental health physician and that drugs such as SSRIs may be continued in pregnancy if deemed necessary.

Clinical Practice

The following are the adapted/adopted recommendations with approximate GRADE recommendation rating (see Appendix 7) with source guideline and strength of recommendation and evidence in square brackets. GPP = Good practice point, NS = not specified.

- The first visit is an opportunity to obtain a detailed maternal medical history in addition to a thorough obstetric history, family history and social history. Details regarding past fertility treatment should also be noted. A full history should also be taken from a male partner to examine contributory medical, fertility, behavioural or weight-related factors. These histories should be used to tailor subsequent diagnostic investigations [43]. **Best Practice** [ESHRE 2022; GPP]
- Women should be sensitively informed that the risk of pregnancy loss is lowest between the ages of 20 and 35, with a significant increase after the age of 40 [43]. **1B** [ESHRE; strong, 3]
- Maternal age and previous pregnancy history offer the best available prognostic information [43]. **1B** [ESHRE; strong, 3]
- Factors that infer increased future obstetric risk, such as preterm birth, in women with RM such as ethnicity, BMI and smoking should also be discussed and considered in any subsequent antenatal care plans [36]. **2C** [RCOG; ethnicity (2+, D) smoking (2+D), BMI 2++, B)]
- Paternal age is also associated with miscarriage, as is sperm quality [74,75]. Therefore, male contributory factors should be examined. **2C** [ESHRE; Conditional, 2]
- Advise women/couples regarding changes to potentially modifiable risk factors as relevant, including; smoking cessation, maintaining a BMI between 19-25, healthy eating and physical activity (normal exercise pattern; not excessive), abstaining from alcohol and drug consumption (including caffeine, which should be reduced to <200mg/day) [36,43]. 2C [RCOG;2D-]
- Where applicable, weight management supports/referrals should be provided in line with HSE Model of Care [76], as should smoking cessation supports,[77] with the informed consent of the woman. **Best practice** [GDG; GPP]
- Routine antenatal advice regarding folic acid and vitamin D supplementation should also be given [42]. **Best practice** [PHA NI; GPP]
- Information and explanation about RM should be provided, in particular; the challenge in identifying a cause, the lack of evidence-based treatments and the excellent prognosis for future pregnancy outcome without pharmacological intervention if offered supportive care alone in the setting of a dedicated early pregnancy assessment unit. **Best practice** [PHA NI; GPP]
- It is important to emphasise to women with unexplained RM that the chance for a future successful pregnancy can exceed 50%-60% depending on maternal age and parity [42]. **Best practice** [PHA NI; GPP]

Recommendations

5. Medical, obstetric (for women) and family history should be used to tailor diagnostic investigations for women and men experiencing RM
6. Maternal age and previous pregnancy history offer the best available prognostic information
7. Advise women/couples regarding changes to potentially modifiable risk factors as relevant, including; smoking cessation, maintaining a BMI between 19-25, healthy eating and physical activity (normal exercise pattern; not excessive), abstaining from alcohol and drug consumption (including caffeine, which should be reduced to <200mg/day)
8. Routine antenatal advice regarding folic acid and vitamin D supplementation should also be given
9. Information and explanation about RM should be provided, in particular; the challenge in identifying a cause, the lack of evidence-based treatments and that there is an excellent prognosis for future pregnancy outcome without pharmacological intervention if offered supportive care alone in the setting of a dedicated early pregnancy assessment unit.

Clinical Question 2.5: What are the recommended investigations for women/couples presenting with RM?

Investigations are covered according to category. In appendix 5, a summary of suggested bloods to be taken prior to review at the RM clinic are listed. Appendix 6 is a suggested algorithm for the investigation of RM.

ANATOMICAL INVESTIGATIONS

Evidence Statement

Uterine anomalies have been associated with RM. These can be congenital or acquired.

The recommendations in this section are derived from existing guideline recommendations [11,36,43,78] with updated literature searches where relevant, in addition to supporting literature for each association to illustrate clinical significance.

A. Congenital uterine anomalies

A systematic review and meta-analysis found the prevalence of uterine anomalies diagnosed 5.5% [95% CI, 3.5-8.5] in women with no history of RM or infertility, 8.0% (95% CI, 5.3-12) in infertile women, 13.3% (95% CI, 8.9-20.0) in those with a history of miscarriage and 24.5% (95% CI, 18.3-32.8) in those with miscarriage and infertility.[79] The most common anomaly in the unselected population was arcuate uterus, which was not more prevalent in women with miscarriage [79]. Canalisation defects, namely septate uterus, were significantly more common in women with a history of miscarriage (5.3%; 95% CI, 1.7-16.8,P=0.021) or miscarriage and infertility (15.4%; 95% CI, 12.5-19,P=0.001) [79]. Unification defects such as bicornuate, unicornuate or didelphic uteri were also more prevalent in women with miscarriage (2.1%; 95% CI, 1.4-3,P=0.001) or miscarriage and infertility (4.7%; 95% CI, 2.9-7.6,P=0.001) than in the unselected population (0.4%; 95% CI, 0.2-0.6) [79].

A systematic review and meta-analysis to determine the clinical implications of congenital uterine anomalies found that women with septate (RR 2.65, 95% CI 1.39-5.06) and bicornuate uterus (RR 2.32, 95% CI 1.05-5.13) had a significantly increased probability of first-trimester spontaneous miscarriage compared with their controls [80]. There were insufficient studies to examine specific anomalies and recurrent first-trimester miscarriage risk, but overall women with RM and congenital anomalies were at increased of first and/or second-trimester miscarriage compared to women with unexplained RM RR 1.13 (95% CI 1.06-1.22) [80].

B. Acquired uterine anomalies

i. Fibroids

A large meta-analysis demonstrated no association between fibroids and miscarriage, however it did not examine for differences between submucosal, intra-mural or subserosal fibroids, which has been shown to be of relevance for fertility and spontaneous miscarriage [81,82]. Submucosal fibroids have been shown to have an association with second-trimester miscarriage, but further studies are needed to determine such an association with recurrent first-trimester miscarriage [83].

ii. Adhesions

Intrauterine adhesions are more prevalent among women having two or more miscarriages, with surgical management of miscarriage a likely risk factor [84]. Women with identified and treated adhesions had fewer ongoing pregnancies and live births in addition to a prolonged time to a live birth [85].

iii. Polyps

There is no evidence to link endometrial polyps and RM [43].

Clinical Practice

- Although the role of uterine anomalies in first-trimester RM is debatable, assessment of uterine anatomy is widely recommended [11]. **Best practice** [ASRM, NS]
- The preferred technique to evaluate the uterus is transvaginal 3D ultrasound, which has a high sensitivity and specificity, and can distinguish between septate uterus and bicorporeal uterus with normal cervix (former American Fertility Society (AFS) bicornuate uterus) [43]. **2C** [ESHRE; conditional, 2]
- The RM clinic should have excellent ultrasound provision and offer 3D ultrasound or additional saline or gel infusion sonography if indicated. **Best practice** [GDG; GPP]
- Sonohysterography (SHG) is more accurate than hysterosalpingography (HSG) in diagnosing uterine malformations. It can be used to evaluate uterine morphology when a 3D Ultrasound is not available. **2C** [ESHRE; conditional, 2]
- Magnetic resonance imaging (MRI) is not recommended as first line option for the assessment of uterine malformations in women with RM but can be used where 3D ultrasound is not available and/or to examine complex malformations in greater detail [43]. **2C** [ESHRE; conditional, 2]
- MRI results should be interpreted by radiologists with experience in gynaecological imaging, in the context of relevant ultrasound imaging and a multi-disciplinary meeting should be undertaken prior to any surgical treatment of congenital uterine anomalies.
- It is recommended that imaging or imaging with hysteroscopy should be used to diagnose uterine septa rather than laparoscopy with hysteroscopy because this approach is less invasive [78]. **Best practice** [ASRM; B, NS]

- If a Müllerian uterine malformation is diagnosed, further investigation (including investigation of the kidneys and urinary tract) should be considered [43]. **2C** [ESHRE; conditional, 2]
- At a minimum, all women should have a 2D transvaginal ultrasound to exclude any contributory gynaecological pathology [43]. **2C** [ESHRE; conditional, 2]

Recommendations

10. As part of standard investigations for RM, women should have a pelvic ultrasound performed by an experienced ultrasonographer, with 3D ultrasound available if required to diagnose uterine anomalies
11. Magnetic resonance imaging (MRI) is not recommended as first line option for the assessment of uterine malformations in women with RM but can be used where 3D ultrasound is not available and/or to examine complex malformations in greater detail
12. It is recommended that imaging or imaging with hysteroscopy should be used to diagnose uterine septa rather than laparoscopy with hysteroscopy because this approach is less invasive
13. If a Müllerian uterine malformation is diagnosed, further investigation (including investigation of the kidneys and urinary tract) should be considered
14. At a minimum, all women should have a 2D transvaginal ultrasound to exclude any contributory gynaecological pathology

IMMUNOLOGICAL INVESTIGATIONS

Evidence Statement

There has been much interest in immunological factors such as human leukocyte antigens (HLA), cytokines and peripheral and uterine natural killer (NK) cells and their potential role in RM.

The recommendations in this section are derived from the RCOG and ESHRE guidelines in addition to updated relevant literature.

Human Leukocyte Antigens (HLA)

HLA alleles and HLA sharing were found to be associated with RM in one systematic review, however the included studies had a high degree of selection and inclusion bias, thus must be interpreted with caution [86]. There is a paucity of information on subsequent pregnancy outcomes in women with these findings and thus the significance of these associations is yet to be determined.

HLA-C antibodies have been shown to be raised in women with RM [87] and to be higher in women who have previous miscarriage compared to a previous livebirth [88], but their association with RM has not been definitively proven [89].

Cytokines

It has been theorised that pro-inflammatory conditions, such as an increased ratio of inflammatory Th1 cytokines (in particular TNF-α) to anti-inflammatory cytokines may contribute to RM [90]. A review of immunological testing in RM concluded that while some abnormal cytokine profiles are associated with RM, the intrinsic variations in cytokine levels makes reliable measurement and interpretation difficult [91]. Moreover, cytokine polymorphism studies have found that no corresponding cytokine gene polymorphism has been strongly associated with RM [92-94]. Therefore, greater study is required on the role of cytokines in RM.

Natural Killer Cells (NK)

NK cells are part of the innate immune system and may be classified according to their degree of CD 56+ expression (bright or dim) and their location (peripheral or uterine), with uterine NK typically being predominantly CD56+ bright [95]. An updated systematic review and meta-analysis found that the CD56+ uterine NK level in women with RM was not elevated compared with controls, however in subgroup analysis of mid-luteal endometrial samples, women with RM had significantly higher levels of CD56+ uterine NK (standardised MD 0.49, CI 0.08, 0.90; P = 0.02; I2 88%; 1100 women) [96]. However, there was no difference in pregnancy outcome in women with RM stratified by uterine NK level, and no significant correlation between peripheral NK and uterine NK levels in women with RM [96]. Overall the findings indicated that measurements made on peripheral NK do not predict uterine NK level or activity [96]. There was also significant heterogeneity between the studies, with differences in collection technique and reference ranges. Combined with the complexity of NK cells interactions, it is not yet possible to conclude if raised uterine NK cells are an association or consequence of RM.

Anti-Nuclear Antibodies (ANA)

Two meta-analyses have confirmed an association between RPL (defined as two miscarriages prior to viability) and ANA positivity [97,98]. ANA positivity was associated with increased RPL risk, particularly with higher ANA titres [98]. Additionally, this has been observed in an updated review and meta-analyses which also suggested a lower pregnancy rate in women with ANA positivity undergoing IVF [99]. ANA positivity is common amongst the general population and clearer guidance is needed regarding which antibody sub-types (speckled, etc.) or extractable nuclear antigens are of greatest clinical significance in women with RM [100]. Correlation with clinical history should guide further testing or specialist referral.

Anti-HY antibodies

Anti-HY antibodies are antibodies directed against male-specific minor histocompatibility (HY) antigens expressed on most or all nucleated cells from males [43]. A single observational study implicated these antibodies in reduced livebirth after RM, but additional evidence has not been forthcoming [101]. Thus, measurement is not recommended in clinical practice.

Clinical Practice

- Human leukocyte antigen determination in women with RM is not recommended in clinical practice [43]. **2C** [ESHRE; conditional, 2]
- Cytokine (including cytokine gene polymorphisms) testing should not be used in women with RM in clinical practice [43]. **2B** [ESHRE; conditional, 3]
- Measurement of anti-HY antibodies in women with RM is not recommended in clinical practice [43]. **2C** [ESHRE; conditional, 2]
- Antinuclear antibodies testing could be considered for explanatory purposes [43]. **2C** [ESHRE; conditional, 2]
- There is insufficient evidence to recommend natural killer (NK) cell testing of either peripheral blood or endometrial tissue in women with RM outside of clinical studies [43]. **1C** [ESHRE; strong 1]

Recommendations

15. **Women with RM should not be offered routine immunological screening (such as HLA, cytokine and NK cell tests) outside of the research context. Anti-nuclear antibodies may be considered based on individual assessment.**

INVESTIGATIONS FOR THROMBOPHILIA

The recommendations in this section are taken from the ESHRE, British Society of Haematology guidelines and DGGG, OEGGG and SGGG guidelines with updated relevant literature [43,102,103].

Evidence Statement

Thrombophilic disorders associated with RM can be acquired or inherited.

Acquired

Antiphospholipid syndrome is an acquired autoimmune condition defined as the association between antiphospholipid antibodies (lupus anticoagulant (LA), anticardiolipin antibodies (ACA, IgG and IgM), and β2 glycoprotein I antibodies (aβ2GPI, IgG and IgM)) and thrombosis (venous, arterial or microvascular) with pregnancy morbidity.

Pregnancy morbidity includes:

a) one or more deaths of a fetus (without any attributable congenital anomaly) after ten weeks' gestation

b) one or more preterm births of a neonate up to 34 weeks due to eclampsia/pre-eclampsia or placental insufficiency

c) three or more miscarriages less than ten weeks' gestation [104].

However, a later publication demonstrated no difference in diagnostic yield for antiphospholipid syndrome after three miscarriages compared to two miscarriages, thus the ESHRE GDG took the decision to implement antiphospholipid antibody testing after two miscarriages [105].

Overall, antiphospholipid antibodies have been shown to have an association with RM, although the association appears stronger with second-trimester loss [106,107]. Testing for antiphospholipid antibodies is in line with the British Haematology Society Guideline which states, "For women with recurrent or late pregnancy loss, screening for antiphospholipid antibodies can be considered as the results aid risk stratification and treatment decisions" (Evidence grade 2B)[102].

It is important to check with local laboratories prior to ordering antiphospholipid antibodies, as they may require written consent from the woman in advance.

Inherited

There is conflicting evidence as to whether inherited thrombophilias such as factor V Leiden (FVL), prothrombin gene mutation, protein S, protein C, Anti-Thrombin or MTHFR mutations are associated with recurrent pregnancy loss (RPL), that is, first and second-trimester miscarriages.

An updated systematic review and meta-analysis has reviewed the associations between inherited thrombophilias and RPL, and whether the association varied according to first or second-trimester losses or two or three losses [108]. Analysis of pooled data from 81 studies indicated a significant association between FVL mutation and RPL (OR: 2.44, 95% CI: 1.96-3.03), for both heterozygous (OR 2.07, 95% CI 1.57,-2.72) and homozygous status (OR 2.76, 1.34-5.71)[108]. Compared to the reference group, the risk of early RPL (OR 1.69, 95% CI: 1.18-2.41) and late RPL (OR: 5.07, 95% CI:2.22-11.57) were significantly higher among pregnant women with the *FVL* mutation [108].

Analysis of pooled data from 64 studies indicated a significant association between the prothrombin gene mutation and RPL (OR: 2.08, 95% CI: 1.61-2.68) [36]. Nonetheless, there was no significant difference in the risk of first or second-trimester losses with the prothrombin gene mutation. A more

recent study of 1155 women with RM in the UK found that inherited thrombophilias (FVL, prothrombin gene, anti-thrombin, protein S and C deficiencies) were equally prevalent in a RM population compared to the general population [109].

Screening for FVL is initially done by checking for Activated Protein C resistance, 90% of APCR is caused by the presence of FVL gene mutation. The test for APCR is not a genetic test. APCR is tested by performing an APTT with and without activated protein C and a resultant reduced ratio between these two results would prompt formal clotting and molecular tests (usually PCR) for the FVL gene mutation [110]. Subsequently formal consent should be sought for the genetic test with adequate explanation of the ramifications of such testing for the individual and their family. However, it is important to check local laboratory policy regarding written consent for the APCR test and subsequent FVL test as it may be required in advance.

Meta-analysis from ten studies indicated a significant association between deficiency of PS and RPL (OR: 3.45, 95% CI: 1.15-10.35) [111]. However, considering the limited number of included studies and substantial between-study heterogeneity, the result should be interpreted with caution.

Analysis of pooled data from seven studies showed no significant association between anti-thrombin deficiency and RPL (OR: 0.83, 95% CI: 0.29-2.36) and analysis of pooled data from nine studies showed no significant association between Protein C deficiency and RPL (OR: 1.98, 95% CI: 0.97-4.04) [108]. The authors note that in addition to heterogeneity of studies, controlling of confounders was limited and thus these associations may be confounded by other risk factors for pregnancy loss.

The MTHFR C677T mutation has been shown to be associated with RM in one systematic review [112], but not in others [113,114].

Considering the association between FVL and miscarriage, particularly with second-trimester miscarriage, the GDG had considered FVL screening to be of relevance to future pregnancy management and identifying potential causative factors of RM. However, following consultation with the Coagulation Special Interest Group of the Irish Haematological Society, testing for FVL and other inherited thrombophilias are *not* recommended in the investigation of RM in line with the British Society for Haematology Guideline 2022 [102], and with the concerns that FVL screening would not fulfil the WHO criteria for a screening programme and may cause potential harms such as anxiety, unnecessary treatment, implications for other family members and cost. This is in keeping with the ESHRE RPL draft guideline which limits inherited thrombophilia testing to those with additional risk factors [43]. The RCOG draft guideline recommends limited inherited thrombophilia testing (FVL, Prothrombin gene and protein S deficiency) in second-trimester miscarriage, but with the caveat that there is limited evidence that treatment improves outcomes [36]. If women have a significant family or personal VTE history alongside a RM history or other adverse pregnancy outcome arising from thrombosis, testing and/or treatment could be discussed with local haematology services if uncertainty arises.

Clinical Practice

- For women with RM, screening for hereditary thrombophilia should not be undertaken, unless:
  - in the context of research
  - in women with additional risk factors and after consultation with local haematology services, **2B** [ESHRE; conditional, 3]
- Any screening undertaken for inherited thrombophilia should be accompanied with adequate counselling as to the implications of such screening (pregnancy risks, potential for affected family members, etc.) and the lack of evidence that antithrombotic prophylaxis improves subsequent pregnancy outcomes. **Best practice** [GDG]

- Testing for non-criteria antiphospholipid syndrome based on clinical and laboratory parameters should be undertaken in women with RM, particularly if clinical manifestations are present (livedo reticularis, ulcerations, renal microangiopathies, neurological disorders and cardiac manifestations) [103]. **Best practice** [DGGG, OEGGG and SGGG; ++, expert]
- For women with RM (two or more miscarriages before ten weeks of gestation), we recommend screening for antiphospholipid antibodies [43]. **2C** [ESHRE; strong, 2]
- The recommended antibodies for testing are lupus anticoagulant, anticardiolipin antibodies (IgG and IgM), and β2 glycoprotein I antibodies (IgG and IgM) [43]. **Best practice** [ESHRE; adapted]
- Monitoring of plasma coagulation markers (D dimers, prothrombin fragments, etc.) during pregnancy is not recommended in women with RM. Determination of these markers must not be used as an indication to initiate therapy to prevent miscarriage [103]. **Best practice** [DGGG, OEGGG and SGGG; +++, expert]

Recommendations

16. For women with RM, screening for hereditary thrombophilia should not be undertaken, unless:
    - in the context of research
    - in women with additional risk factors and after consultation with local haematology services **2B** [ESHRE; conditional, 3]
17. For women with RM (two or more miscarriages before ten weeks of gestation), we recommend screening for antiphospholipid antibodies
18. The recommended antibodies for testing are lupus anticoagulant, anticardiolipin antibodies (IgG and IgM), and β2 glycoprotein I antibodies (IgG and IgM)

ENDOCRINE INVESTIGATIONS

Evidence Statement

Recommendations in this section have been adapted from ESHRE and Public Health Agency for Northern Ireland guidelines with updated literature.

Thyroid disease

Due to the adverse outcomes linked with overt hyper- and hypothyroidism in pregnancy, and clear indications for treatment, the focus of research in thyroid disease and RM is whether RM is linked to sub-clinical hypothyroidism and the presence of thyroid antibodies.

Subclinical hypothyroidism is a biochemical diagnosis defined by raised levels of serum TSH, above the accepted laboratory reference range, accompanied by normal concentrations of circulating thyroid hormones (free thyroxine (FT4) and free triiodothyronine (FT3).[115] SCH is usually asymptomatic and may represent the earliest stages of thyroid dysfunction, which can progress to overt hypothyroidism (OH). [115] There is debate as to what constitutes a raised TSH level, 4.0mIU/l is generally accepted, but in certain populations (e.g. women with RM or infertility) this was reduced to 2.5mIU/l. These variations have contributed to heterogeneity between studies, as well as in clinical practice. The RCOG have suggested that upper-normal TSH level is 2.5-4.0mIU/l and that mild-moderate subclinical hypothyroidism encompasses TSH values above 4.0mIU/l up to 10.0mIU/l [115]. A TSH value above 10.0mIU/l, even combined with normal free T4, is considered to represent OH [115].

A systematic review and meta-analysis estimated the prevalence of sub-clinical hypothyroidism to be 12.6% in RM populations [116]. Current evidence suggests no association between subclinical hypothyroidism and RPL when RPL is defined by non-consecutive pregnancy losses (five studies) [116]. Just one of these studies, by Triggianese et al., suggests that there may be an association between subclinical hypothyroidism and consecutive RPL [117]. Within the systematic review, the definition of sub-clinical hypothyroidism also varied with cut-offs of 2.5 and 4.0mIU/l. A review by the RCOG concluded that mild-moderately raised levels of TSH (>4.0-10.0 mIU/l) during pregnancy are associated with sporadic miscarriage, but insufficient evidence of this association exists for upper normal TSH levels (2.5-4.0 mIU/l) or for RM [115].

Meta-analysis of the 17 studies that provided data comparing the prevalence of thyroid autoimmunity (that is having thyroid peroxidase antibodies (TPOab) or anti-thyroglobuin antibodies) in a cohort of women with RPL to those without RPL revealed a statistically significant association between thyroid autoimmunity and RPL (OR 1.94; 95% CI, 1.43-2.64) [116]. Additional sensitivity analysis that excluded studies that did not have an entirely euthyroid cohort demonstrated that the association between thyroid antibodies and RPL remained statistically significant [116].

Polycystic Ovarian Syndrome (PCOS)

PCOS is characterised by oligo- or an-ovulation, hyperandrogenism, and antral follicular excess on ultrasound [118]. A recent study has estimated the prevalence of PCOS in a single RM cohort to be 9.5%, with pooled prevalence from three studies estimated at 14.3% [119].

Women with PCOS revealed significantly higher luteinising hormone, testosterone, and Anti-Mullerian Hormone (AMH) levels ($p < 0.05$) than the control group without PCOS, which had been noted in other studies [120,121]. While hyperandrogenaemia, obesity and hyperinsulinemia are postulated to be contributory to RM in this cohort, the role of raised luteinising hormone is unclear [120]. Women with PCOS were significantly more likely to experience a further miscarriage (71.4% versus 53.6%; $p = 0.031$). These findings are consistent with previous reports which showed that women with PCOS had a higher risk for first trimester miscarriages [122].

Diabetes

Women with well-controlled diabetes are not at increased risk for RM. Poorly controlled diabetes and a high HbA1c is associated with fetal anomalies and RM [123]. However, in a RM cohort clinically significant glucose levels were only found in 0.3% of women [124]. Therefore, evaluation for diabetes is likely better reserved for high risk or symptomatic women.

Prolactin

Hyperprolactinaemia has a low prevalence in RM populations, with a single study demonstrating high prolactin in 1.2% of women tested (6/465) [125]. There is insufficient evidence to suggest asymptomatic hyperprolactinaemia is associated with RM. There has been conflicting evidence as to whether high or low normal levels of prolactin contribute to miscarriage, which requires further study [126,127].

Ovarian reserve testing

Given the associations between RM and aneuploidy and advanced maternal age, it is a reasonable hypothesis that diminished ovarian reserve and RM would also be associated [128]. To date, women with a history of aneuploid pregnancy have not been definitively proven to have diminished ovarian reserve or earlier menopause [129-131]. Women with diminished ovarian reserve have been shown to have higher rates of miscarriage [132]. In a systematic review, women with RPL (variably defined) were more likely to have diminished ovarian reserve (various markers of ovarian reserve were included such as AMH, antral follicle count follicle-stimulating hormone (FSH), luteinizing hormone (LH), estradiol, and FSH:LH ratio) [133]. AMH levels have been shown to be lower in women with unexplained RPL and in

younger women [134]. Nonetheless, a universal definition of diminished ovarian reserve and gold standard diagnostic test are required to confirm this association and determine the role of ovarian reserve testing for women with RM.

Clinical Practice

- Thyroid stimulating hormone (TSH), thyroid peroxidase antibody (TPOAb) levels and Free thyroxine (FT4) levels should be tested routinely in women with RM (ESHRE, adapted by GDG)
- Prolactin testing is not recommended in women with RM in the absence of clinical symptoms of hyperprolactinemia (oligo/amenorrhea) [43]. **2C** [ESHRE; conditional, 2]
- Ovarian reserve testing is not routinely recommended in women with RM but may be considered in women with risk factors for sub-fertility or low ovarian reserve (e.g. women with family history) or women demonstrating signs of premature ovarian failure [43]. **Best practice** [ESHRE; adapted]
- A 'day 2-5' hormone profile [Follicle stimulating hormone (FSH), oestradiol, FSH/luteinising hormone (LH) ratio] may be considered based on individual assessment [42]. **Best Practice** [PHA NI; NS]
- Luteal phase insufficiency testing is not routinely recommended in women with RM [43]. **1C** [ESHRE; strong, 2]
- Androgen testing is not routinely recommended in women with RM [43]. **1C** [ESHRE; strong, 2]
- Assessment of PCOS, fasting insulin and fasting glucose is not recommended in women with RPL to improve next pregnancy prognosis [43]. [ESHRE; strong, 2] **1C**
- Vitamin D measurement in women with RM is not recommended [43]. **Best practice** [ESHRE; adapted]

Recommendations

19. **Thyroid stimulating hormone (TSH), thyroid peroxidase (TPO)-antibody levels and Free thyroxine (FT4) levels should be tested routinely in women with RM**
20. **There is insufficient evidence to support testing prolactin levels, luteal phase insufficiency, androgens, markers for PCOS or vitamin D**
21. **In select cases with a relevant menstrual or fertility history, testing 'day 2-5' hormone profile, LH, FSH, oestradiol and/or testing for ovarian reserve may be appropriate**

INVESTIGATIONS FOR INFECTION

Evidence Statement

Recommendations in this section have been adapted from the DGGG, OEGGG and SGGG guideline, with updated literature.

Systemic infections with malaria, brucellosis, cytomegalovirus and human immunodeficiency virus, dengue fever, influenza virus and of vaginal infection with bacterial vaginosis, are associated with increased risk of miscarriage [135]. The effects of Chlamydia trachomatis, Toxoplasma gondii, human papillomavirus, herpes simplex virus, parvovirus B19, Hepatitis B and polyomavirus BK infections remain controversial, as some studies indicate increased miscarriage risk and others show no increased risk [135]. There has been increased interest in the vaginal microbiome, with lactobacillus depletion linked to first-trimester miscarriage [136,137]. Infection is also linked to chronic endometritis, which has also been linked to RM [138]. Greater study is required to understand the role of infections and to determine what characteristics of the vaginal microbiome in women with RM may be significant.

Clinical Practice

- It is important to consider potential contributory infections when taking a history from women with RM, which may offer an explanation for a very small number of women. **Best practice** [GDG]
- Infectious screening using vaginal swab specimens is not recommended in *asymptomatic* women with RM [103]. **Best practice** [DGGG, OEGGG and SGGG; +++, expert]

Recommendation

22. Infectious screening in asymptomatic women using vaginal swab specimens is not recommended

GENETIC INVESTIGATIONS

Evidence Statement

Recommendations in this section come from the RCOG and ESHRE 2022 updated draft guidelines, in addition to updated literature and consultation with a Clinical Geneticist

A. Chromosomal analysis of pregnancy tissue

Fetal aneuploidy is the most commonly identified cause of sporadic and recurrent miscarriage, particularly in the first-trimester [139]. Chromosomal analysis offers an explanation for approximately 70% of women/couples with RM, although this figure may improve as newer techniques identify greater numbers of chromosomal anomalies [140,141].

As mentioned previously, fetal aneuploidy is associated with maternal age [142]. Chromosome anomalies in miscarriage specimens include trisomies, monosomies, polyploidies and structural anomalies. Trisomies are the most common numeric chromosome error, with trisomy 16 and 22 being the most frequent, while Monosomy X is the most frequent sex chromosome error [143]. Trisomies in particular are associated with maternal age >35 years [144,145], whereas unbalanced translocations are to be found more frequently in pregnancy tissue of younger women (aged <35) presenting with RM [145]. In a meta-analysis of RM cohorts, aneuploidy was less likely with successive miscarriages [146], but this trend was only evident in women aged under 35, with higher aneuploidy rates persisting in women aged over 35 [144,147,148].

While ESHRE has recommended array-CGH as the optimal test for cytogenetic testing, it must be borne in mind that their guideline encompasses first and second-trimester miscarriage, which may have very different aetiologies. Array CGH allows for high-resolution analysis of sequences mapped to specific regions and compared to test and control DNA [149]. Array CGH can be performed on fresh or paraffin-embedded tissue, allowing retrospective testing of miscarriage tissue saved from a prior dilation and curettage [149].

The ESHRE draft guideline suggests that array-CGH is superior as it has a reduced rate of maternal cell contamination (MCC) and does not require cell culture [43]. However, this fails to take into consideration steps taken by (some) laboratories such as sorting, dissecting and cleaning each sample and regular auditing of ratios of identified normal female to male karyotype to ensure MCC is minimal [150]. Culture failure due to fungal or bacterial contamination is an accepted risk in traditional karyotyping, however reflexive use of additional molecular technology using DNA can salvage genetic analysis, with reported success rates comparable to QF-PCR and assay regimens [151]. These molecular tests can detect common aneuploidies and nine microdeletion syndromes in addition to alterations in the p and q arm of all chromosomes [151]. Comparatively, a failed array may result in the complete loss of genetic material and repeat array is not always possible.

Another disadvantage is that array-CGH cannot detect balanced translocations, inversions, triploidy, tetraploidy, mosaicism or maternal cell contamination [149]. Single nucleotide polymorphisms (SNP) are locations within non-coding regions of the genome where one nucleotide is highly variable between individuals. Using a SNP microarray, these nucleotide polymorphisms of the pregnancy tissue can be characterised and then compared to a maternal sample [149]. This allows clinicians to identify maternal cell contamination, parental origin of aneuploidy and unbalanced chromosome segments and placental mosaicism. However, the SNP array is unable to detect balanced translocations, inversions or tetraploidy [149]. Arrays are an evolving technology and will produce significant numbers of results where interpretation remains difficult, e.g. families with rare CNVs whose significance may be uncertain until further examples are reported [152].

There are also specific benefits to traditional karyotype in the investigation of first-trimester miscarriage. Half of first-trimester miscarriage is caused by large chromosomal abnormalities, such as trisomy, which would be detected by karyotype [142,153]. Karyotype analysis allows for cell-by-cell analysis which can identify abnormal male or female cell lines separate to that of a normal male/female allowing for the detection of mosaicism in addition to MCC [149]. Karyotyping is crucial in identifying Robertsonian unbalanced translocations and determining the recurrence risk [154]. Laboratories should perform QF-PCR prior to performing an array-CGH on pregnancy tissue in first-trimester miscarriage [152]. This allows for early identification of molar pregnancy and trisomies 13, 18 and 21, which allows for deferral to karyotype if T13 or T21 is detected [155]. Karyotype will detect an unbalanced Robertsonian translocation and importantly, the balanced carrier [154]. The recurrence risk can be 100% for 13;13 and 21;21 Robertsonian carriers, which would be missed if array-CGH alone was performed [154].

In the absence of a national genetics laboratory or a standardised operating procedure (SOP) for preparation of pregnancy tissue to ensure consistency, it is important that efforts are made to ensure the testing is performed in accredited laboratories with appropriate clinical governance. Clinical leads should liaise with laboratories to ensure that the SOP for first trimester cytogenetic testing provides the "best test", i.e. one that allows for comprehensive fetal karyotyping with due reference to maternal cell contamination while minimising the potential for inaccurate or "failed" results. The National Strategy for Accelerating Genetic and Genomic Medicine in Ireland, was published at the end of 2022, and while it mentions a fetal medicine genetics service, the precise details of this framework and a timeframe for a clinical guideline remain unclear [156].

B. Parental Karyotype

Parental chromosomal anomalies are also associated with RM. These can be classified into structural and numeric anomalies. Structural includes balanced reciprocal translocations, Robertsonian translocations, inversions, deletions and duplications, whereas numeric refers to anomalies such as trisomies or monosomies [157]. Of these, parental balanced translocations are the most commonly identified in RM cohorts.

The format of the parental testing will vary according to whether a translocation or other anomaly is detected in pregnancy tissue. The testing may be performed by karyotyping (full or targeted), fluorescent in situ hybridisation (FISH), quantitative PCR, quantitative fluorescent PCR, Multiplex Ligation-dependent Probe Amplification (MLPA), or rarely microarray.[158] More than one technique may be used.

The prevalence of structural chromosomal anomalies was 5.3% for couples with two miscarriages and 6.6% with three, in a systematic review, with more recent studies reporting 4.4% and 3.7%, respectively [157,159,160]. Chromosomal anomalies have been shown to be more common in the female partner and in younger couples [157]. However, although miscarriage rates have been reported to be higher among couples of with balanced translocations, livebirth rates are reassuring, with low reported rates of unbalanced chromosomal abnormalities [160-162].

It must be noted that for some parental structural rearrangements, there is a risk of miscarriage only. With other more high-risk re-arrangements, there can be a risk of an ongoing pregnancy with a risk of a fetus with an unbalanced form which may present postnatally only with significant disability. Referral to clinical genetics is required in a family with a structural re-arrangement to facilitate future pregnancy planning. This should be timely.

Parental karyotyping does not need to be undertaken when fetal karyotype demonstrates a trisomy that is reported to have arisen from non-disjunction.

NOTE: In the absence of routine parental karyotyping, there must be a reasonable level of chromosomal analysis on pregnancy tissue to detect potential translocations and to afford women/couples a possible explanation for their miscarriage. This should be considered in the management of a third or subsequent miscarriage, or the second or subsequent miscarriage in women under 35 with no prior livebirth, i.e. consideration should be given to surgical management or inpatient medical management to ensure pregnancy tissue is collected for cytogenetics. Staff caring for women experiencing spontaneous miscarriage in emergency room/wards/delivery suites should be educated in the preservation and processing of pregnancy tissue for cytogenetic analysis. Due diligence should also be paid to the processes for respectful treatment of fetal tissue.

Clinical Practice

- Cytogenetic analysis should be performed on pregnancy tissue of the third or subsequent miscarriage(s) or on the second or subsequent miscarriage if aged <35 years and no prior livebirth [36]. **2C** [RCOG 2-, D]
- For genetic analysis of the pregnancy tissue, standard procedures for testing should have due regard for maternal cell contamination and risk of test failure, as well as the ability to detect chromosomal anomalies especially relevant to recurrent first-trimester miscarriage. **Best Practice** [Expert consensus; GDG]
- Parents should not undergo routine peripheral karyotyping. Karyotyping may be performed however after individual assessment of risk or if there is no pregnancy tissue available for testing after the third miscarriage or after the second miscarriage if aged < 35 years and no prior livebirth [36,43].**2C** [RCOG; 3, D/ESHRE Conditional, 2]
- Parental peripheral blood karyotyping should be performed for couples in whom testing of pregnancy tissue reports an unbalanced structural chromosomal abnormality. **2C** [RCOG;3, D]
- All individuals and couples with an abnormal parental karyotype result, and a proportion of those with an atypical fetal karyotype, should be offered genetic counselling (this decision must be made by a consultant/senior level clinician) and discussion of possible treatment options relevant to their individual situation considered [43]. **Best Practice** [GDG; adapted from ESHRE]

Recommendations

23. Cytogenetic analysis should be performed on pregnancy tissue of the third or subsequent miscarriage(s) or on the second or subsequent miscarriage(s) if aged <35 and no prior livebirth
24. Genetic analysis of the pregnancy tissue should be performed in an accredited laboratory and standard procedures for testing should have due regard for maternal cell contamination and risk of test failure, as well as the ability to detect chromosomal anomalies especially relevant to recurrent first-trimester miscarriage.
25. Parents should not undergo routine peripheral karyotyping. Karyotyping may be performed however after individual assessment of risk or if there is no pregnancy tissue available for testing after the third miscarriage or after the second miscarriage if aged < 35 years and no prior livebirth
26. All individuals and couples with an abnormal parental karyotype result, and a proportion of those with an atypical fetal karyotype, should be offered genetic counselling

HISTOPATHOLOGICAL INVESTIGATIONS

Evidence Statement

Routine histopathological examination of pregnancy tissue, where available, is recommended [163].

In addition to identifying hydatidiform moles, additional contributory pathology such as chronic histiocytic intervillositis (CHI) and massive perivillous fibrin deposition (MPFD) and impaired trophoblast invasion may be seen [164]. These features are more likely to be seen in the late first trimester. In particular, CHI and MPFD have a recurrence risk and would merit treatment with aspirin, LMWH, and other immunotherapies (such as hydroxychloroquine, prednisolone or azathioprine) and additional antenatal surveillance in a subsequent pregnancy due to associations with growth restriction and pregnancy loss [165-167].

Review of any previous histopathological results as part of RM clinic work-up is therefore important to ensure such diagnoses are not missed. If indicated, a repeat pathological review may be requested.

Clinical Practice

- Any available histopathological results from previous miscarriages should be reviewed to ensure that placental pathologies with a recurrence risk, such as chronic histiocytic intervillositis or massive perivillous fibrinoid deposition, are not missed.

Recommendations

27. Any available histopathological results from previous miscarriages should be reviewed to ensure that placental pathologies with a recurrence risk, such as chronic histiocytic intervillositis or massive perivillous fibrinoid deposition, are not missed.

INVESTIGATIONS FOR MALE FACTORS IN RM

Evidence Statement

The following recommendations have been adapted from the RCOG 2021 draft guideline and the ESHRE 2022 draft guideline update.

There is increasing recognition of the role of male factors beyond the parental karyotype in RM.

A recent review identified that male BMI and age contribute to unexplained RM [168]. There are several case-control studies and a recent meta-analysis which demonstrate the rate of sperm aneuploidy in male partners of women with RM is higher, even where other semen parameters are within range (or typical) [169,170]. Sperm DNA fragmentation are breaks in the genome of spermatazoa [171] which have also been shown to be present more frequently in male partners of women with RM [170,172-176]. However, this association has not been extensively examined with regards to pregnancy outcomes. One systematic review and meta-analysis demonstrated a lower pregnancy rate, and higher miscarriage rate, for couples where high levels of sperm DNA fragmentation existed in IVF and in intra-cytoplasmic sperm injection (ICSI) [177].

Semen quality and sperm DNA fragmentation may be affected by modifiable risk factors such as smoking, alcohol consumption, weight status and presence of a varicocoele, but the degree to which such interventions may improve sperm quality and reduce RM risk or improve livebirth rate remains unclear [178].

While there is an increasing body of evidence to suggest an association between sperm DNA damage and RM, greater evidence that sperm aneuploidy or DNA fragmentation significantly affects pregnancy outcomes is required to recommend routine testing. Evidence to support any subsequent interventions or ART is also required. Moreover, considering current reproductive medicine services in Ireland, the andrology services required to offer this kind of analysis routinely would require a substantial input of resources.

Clinical Practice **

- In couples with RM, it is recommended to assess factors in the male partner which may contribute to sperm health (paternal age, smoking, alcohol consumption, exercise pattern and body weight) [43]. **2C** [ESHRE; conditional, 2]
- Evidence indicates that sperm DNA fragmentation testing is most beneficial in patients with unexplained and idiopathic infertility, RPL, varicocele, opting for ART and in those with lifestyle/ environmental risk factors [179]. **Best practice** [Argawal, NS]
- Couples with RM should not be offered routine sperm DNA fragmentation screening out of the research context [36]. **2C** RCOG; 4, D]

Recommendations

28. **In couples with RM, it is recommended to assess factors in the male partner may contribute to sperm health (paternal age, smoking, alcohol consumption, exercise pattern and body weight)**
29. **Couples with RM should not be offered routine sperm DNA fragmentation screening out of the research context**

Section 5: Treatment of RM

Introduction

Treatments should also be tailored from the medical history and investigative findings.

The risks and benefits of any treatment should be discussed with the woman/couple and written information given alongside the prescription/scheduled procedure.

Possible treatments for specific conditions are laid out below. Additional evidence which has become available in the published literature after the publication of the 2021/2022 RCOG and ESHRE updates is included for the currency of the guideline.

Clinical Question 2.6: What are the possible treatments for women/couples presenting with RM?

ANATOMICAL TREATMENTS

Evidence Statement

The recommendations in this section stem from the ESHRE and RCOG guidelines, The Thessaloniki ESHRE/ESGE Consensus on diagnosis of female genital anomalies, the NICE guideline, "Hysteroscopic metroplasty of a uterine septum for primary infertility" as well as updated literature.

Congenital uterine anomalies

a. Hysteroscopic uterine septum resection

This minimally-invasive technique has been studied in women with first and second-trimester miscarriage. A 2021 systematic review showed that hysteroscopic septum resection was associated with a lower rate of miscarriage (OR 0.25, 95% CI 0.07-0.88) compared with untreated women. No significant effect was seen on live birth, clinical pregnancy rate or preterm delivery [180].

More recently, Carrera *et al.* updated this evidence to include the findings of the long-awaited TRUST randomised control trial in their analyses [181]. The pooled OR for miscarriage was 0.45, (95% CI, 0.22–0.90). When the analysis was performed according to the type of septum, pooled OR in complete septum subgroup was 0.16 (95% CI, 0.03–0.78), 0.36 (95% CI, 0.19–0.71) in the partial septum subgroup and 0.58 (95% CI, 0.20–1.67) in those studies not differentiating between complete or partial septum. Again, no significant differences were found between the two groups in OR of clinical pregnancy, term live birth, or risk of caesarean delivery. There was a significant decrease in the frequency of preterm birth in patients who underwent partial septum resection (OR = 0.30, 95% CI, 0.11–0.79) [181].

The TRUST trial alone demonstrated no evidence of a difference in clinical pregnancy, ongoing pregnancy, pregnancy loss or preterm birth rates. but was limited by its small sample size, (n=80), and was not powered to evaluate any differential effect of septum resection in women with pregnancy loss compared with those presenting with subfertility, or according to the number of pregnancy losses [182].

In their 2024 guideline on the management of uterine septum, the ASRM have, on the same evidence presented above, recommended to offer hysteroscopic septum incision to patients with a septum and a history of RM in a shared decision-making model (Strength of Evidence: B; Strength of Recommendation: Moderate)[183].

On review of this and other available evidence, this GDG acknowledges that while there is some evidence that hysteroscopic uterine septum resection decreases miscarriage, there is no significant difference in livebirth rates. Additionally, there remains no consensus on clinically significant uterine septum depth. Therefore, surgery in this cohort should proceed with caution and ideally in the context of research [36].

b. Surgeries for other congenital uterine anomalies

Currently, abdominal or laparoscopic metroplasty for fusion or unification defects is generally not advisable owing to its potential association with significant intraoperative and postoperative complications and lack of evidence to support improved reproductive outcomes [184].

Acquired uterine anomalies

A. Myomectomy for fibroids

There are no studies assessing myomectomy in women with RM and fibroids. Following a Cochrane review on surgical treatment of fibroids for subfertility, the authors concluded that it was uncertain if myomectomy improved clinical pregnancy rate for women with any type of fibroid (sub-mucosal, intra-mural or sub-serosal) [185]. It was also uncertain whether myomectomy for any of the described types of fibroids had any effect on the miscarriage rate [185]. The uncertainty stems from the very low-quality evidence, with the main limitations being due to serious imprecision, inconsistency and indirectness [185]. There is a need for high-quality studies to determine whether myomectomy is of benefit to women with RM and fibroids.

B. Intra-uterine adhesions

Hysteroscopy remains the gold standard for identification of intra-uterine adhesions and hysteroscopic resection the primary treatment, but has not been demonstrated to improve outcomes in RM populations [186]. The use of gels and hormonal treatments appear to improve outcomes, but these have also not been demonstrated in RM populations to date [187].

Clinical Practice

- There is some evidence in favour of hysteroscopic uterine septum resection that suggests a reduction in miscarriage rates, but no improvement in live birth rates [43].**2C** [ESHRE; conditional 1]
- Selection and treatment of women for hysteroscopic metroplasty of a uterine septum should be done by a multidisciplinary team including specialists in reproductive medicine, uterine imaging and hysteroscopic surgery [188]. [NICE; NS]
- Metroplasty in women with bicorporeal uterus and double cervix (former American Fertility Society (AFS) didelphic uterus) and RM is not recommended due to insufficient evidence [43].**1C** [ESHRE; strong, 1]
- Uterine reconstruction is not recommended for hemi-uterus (former American Fertility Society (AFS) unicornuate uterus) and RM [43]. **1C** [ESHRE; strong, 1]
- There is insufficient evidence of benefit for surgical removal of intrauterine adhesions for pregnancy outcome. After hysteroscopic removal of intrauterine adhesions in women with RM, precautions have to be taken to prevent recurrence of adhesions [43]. **2C** [ESHRE; conditional, 1]
- Myomectomy (laparoscopic or open) in women with RM is not recommended due to insufficient evidence that it reduces miscarriage rates [43]. **2C** [ESHRE; conditional, 1]
- There is insufficient evidence supporting hysteroscopic resection of submucosal fibroids or endometrial polyps in women with RM [43]. **2C** [ESHRE; conditional, 1]

- In light of the poor evidence available and heterogeneity of studies and patient selection, the GDG suggests consideration of surgical management of acquired uterine anomalies on an individual basis with respect to factors such as the size of the fibroid/polyp, cavity distortion and gynaecological symptoms. **Best Practice** [GDG]

Recommendations

30. There is some evidence in favour of hysteroscopic uterine septum resection that suggests a reduction in miscarriage rates, but no improvement in live birth rates. Surgery in this cohort should proceed with caution, with input from a specialist team and ideally in the context of a research trial
31. Metroplasty in women with bicorporeal uterus and double cervix (former American Fertility Society (AFS) didelphic uterus) and RM is not recommended due to insufficient evidence due to insufficient evidence that it reduces miscarriage or improves livebirth rates
32. Uterine reconstruction is not recommended for hemi-uterus (former American Fertility Society (AFS) unicornuate uterus) and RM due to insufficient evidence that it reduces miscarriage or improves livebirth rates
33. Selection and treatment of women for hysteroscopic metroplasty of a uterine septum should be done by a multidisciplinary team including specialists in reproductive medicine, uterine imaging and hysteroscopic surgery
34. There is insufficient evidence at present to support the surgical management of acquired uterine anomalies, but it may be considered for select cases

IMMUNOLOGICAL TREATMENTS

There are many immunological medications and therapies in existence that have been suggested as treatments for RM.

Evidence Statement

The recommendations in this section are based on EHSRE, RCOG, and DGGG, OEGGG and SGGG guidelines with updated evidence.

A Cochrane review found paternal cell immunisation, third-party donor leukocytes, trophoblast membranes, and intravenous immunoglobulin provide no significant beneficial effect over placebo in improving the live birth rate [189]. A recent review found no evidence for the use of lymphocyte immunotherapy [190]. Moreover, the controversies for the evidence of its effectiveness are present due to several factors: the methodological quality of studies, lack of consensus on laboratory controls, heterogeneity of the study populations, a lack of immune profiling or established parameters and the different treatment protocols [190].

Intralipid has only been suggested as a treatment for RM in women with elevated uterine natural killer cells, with a systematic review demonstrating that treatment of the target population (women with RPL or recurrent implantation failure) with intralipid led to an improvement in implantation rate, OR: 2.97, 2.05-4.29), pregnancy rate (OR: 1.64, 1.31-2.04), and livebirth rate (OR: 2.36, 1.75-3.17), with a reduction in miscarriage (OR: 0.2, 0.14-0.30) [191]. It must be noted however that although this data includes randomised control trials, these are small heterogenous studies and it is not established which women benefit from such treatment or how to optimally diagnose an abnormal endometrial immune profile [191].

One RCT of etanercept, a TNF-a inhibitor demonstrated increased livebirth rate and fewer miscarriages in the treatment group compared to placebo [192]. A further Chinese retrospective study of 120 women also demonstrated an increase in live-birth for women with a history of RM taking certiolizumab and LMWH in a subsequent pregnancy [193]. However, these small studies are inadequate to recommend such treatment. The side of effects of these medications also include serious maternal and neonatal infection, which must be considered [194].

In addition to improving outcomes for women with antiphospholipid syndrome, hydroxychloroquine has been shown to be of benefit in patients with RM and lupus erythematosus [195,196], as well as some types of placental inflammation [167,197]. While it appears that hydroxychloroquine may be of benefit to women with RM with autoimmune disease [198], two randomised control trials are underway with results anticipated at the end of 2025 to determine if hydroxychloroquine improves pregnancy outcomes in women with RM without any autoimmune disease [199,200].

There are considerable costs associated with immunotherapy and the potential for serious side effects, including transfusion reaction, anaphylactic shock and hepatitis, also demands caution and consideration before prescribing in this cohort [36,189].

Clinical Practice

- Corticosteroids (e.g. prednisolone) should not be administered outside clinical studies as prophylaxis to prevent miscarriage in women with RM but without pre-existing autoimmune disease. They do not improve pregnancy rates and may be associated with an increased risk of adverse pregnancy outcomes [103]. **Best practice** [DGGG, OEGGG and SGGG; ++, expert consensus]
- Intravenous immunoglobulin (IVIG) is not recommended as a treatment of RM [43]. **2C** [ESHRE; strong, 2]
- There is insufficient evidence to recommend intralipid therapy for improving live birth rate in women with unexplained RM [43].**1C** [ESHRE; strong, 1]
- Lymphocyte immunisation therapy (i.e. paternal cell immunisation, third-party donor leucocytes) should not be used as treatment for unexplained RM as it has no significant effect and there may be serious adverse effects [43]. **2C** [ESHRE; strong, 2]
- There is insufficient evidence to recommended granulocyte colony-stimulating factor (G-CSF) in women with unexplained RM [43]. **2B** [ESHRE; strong, 3]
- Paternal cell immunisation, third-party donor leucocytes, trophoblast membranes and intravenous immunoglobulin in women with previous unexplained RM do not improve the live birth rate [36]. **1A** [RCOG;A, 1++]
- Therapy with tumour necrosis factor (TNF)-α receptor blockers should not be given to women with RM outside clinical studies [103]. **Best practice** [DGGG, OEGGG and SGGG; ++, expert consensus]

Recommendations

35. **Immunotherapies (such as corticosteroids, intralipid, lymphocyte immunity factor, granulocyte colony-stimulating factor, tumour-necrosis factor -α blockers) are not recommended to women with unexplained RM due to insufficient evidence**
36. **Paternal cell immunisation, third-party donor leucocytes, trophoblast membranes and intravenous immunoglobulin in women with previous unexplained RM are not recommended as they do not improve the live birth rate**

TREATMENTS FOR THROMBOPHILIA

Evidence Statement

These recommendations are adapted from the ESHRE, RCOG and British Society for Haematology guidelines, along with evidence from updated literature [36,43,102].

A. Inherited thrombophilia

Systematic reviews have failed to show any benefits from low-dose aspirin and low molecular weight heparin (LMWH) for RM in those with inherited thrombophilia or unexplained RM [33]. An updated systematic review of randomised control trials has shown that LMWH alone or in combination with low-dose aspirin have no influence on the miscarriage rate or occurrence of pre-eclampsia, and that LMWH alone has no influence on the livebirth rate [201]. However, it is noted in all reviews that the quality of studies and randomised control trials are variable, with significant heterogeneity and that there is a need for high-quality randomised control trials [33,201]. Preliminary results of the Alife2 Trial published in December 2022 found that live birth rates were 116/162 (71.6%) in the LMWH group and 112/158 (70.9%) in the standard surveillance group [adjusted OR 1.08 (95% CI 0.65 to 1.78) absolute difference 0.7% (95% CI -9.2% to 10.6%)]. Compared with standard surveillance, the use of LMWH did not result in higher live birth rates in women who had two or more pregnancy losses and confirmed inherited thrombophilia [202]. Thus, the guidance remains that routine use of LMWH in women with recurrent pregnancy loss and confirmed inherited thrombophilia is not recommended [102].

However, treatment decisions should be individualised and should involve a discussion with the woman, taking into consideration additional risk factors, such as maternal risk of thrombosis or evidence of previous placental thrombosis [36].

B. Acquired thrombophilia

Low dose aspirin and (LMWH) are widely used to reduce the risk of RM in women with APLS. The American College of Rheumatology and the European Alliance of Associations for Rheumatology (EULAR) agree that with a history of ≥ 3 recurrent spontaneous miscarriages < 10th week of gestation and in those with a history of fetal loss (≥ 10th week of gestation), combination treatment with aspirin and LMWH at prophylactic dosage during pregnancy is recommended [203,204]. An updated systematic has shown livebirth rates were higher with aspirin and LMWH compared to aspirin alone, but the evidence is of low-quality [205].

If aspirin and LMWH are unsuccessful there is little evidence to support the use of prednisolone or hydroxychloroquine [43,204], and the American College of Rheumatology does not recommend the use of prednisolone [203]. IVIG is not associated with increased livebirths and there is insufficient evidence to recommend its use [43,203].

Should a woman with a positive test for APLS become pregnant while awaiting repeat test results, a decision regarding aspirin and LMWH must be made on an individual basis by the relevant consultant with the best available information.

Clinical Practice

- For women with hereditary thrombophilia and a history of RM, antithrombotic prophylaxis should not be used unless in the context of research, or if indicated for VTE prevention [43]. **2C** [ESHRE; conditional,2]
- For antiphospholipid syndrome – if laboratory and clinical criteria are fulfilled, referral to a local haematology service should be considered and potential for treatment with low dose aspirin and prophylactic dose LMWH in the next pregnancy discussed. **Best practice** [PHA NI; NS]
- Treatment with aspirin should commence before conception and LMWH must be initiated as soon as the pregnancy test is positive [43]. **2C** [ESHRE; conditional,1]
- Intravenous immunoglobulin therapy does not improve the live birth rate of women with RM associated with antiphospholipid antibodies compared with other treatment modalities; its use may provoke significant maternal and fetal morbidity [206].**1A** [RCOG 2011; A, 1++]

Recommendations

37. **For women with hereditary thrombophilia and a history of RM, antithrombotic prophylaxis should not be used unless in the context of research, or if indicated for VTE prevention.**
38. **For antiphospholipid syndrome – if laboratory and clinical criteria are fulfilled, referral to local haematology service should be considered and potential for treatment with low dose aspirin and prophylactic LMWH in next pregnancy discussed.**
39. **For APLS, treatment with aspirin should commence before conception and LMWH must be initiated as soon as the pregnancy test is positive.**

TREATMENT FOR ENDOCRINE DISORDERS

Evidence Statement

The recommendations in this section are adapted from the ESHRE guideline with updated evidence from the recent published literature.

A. Thyroid disease

The treatment of euthyroid women with TPOAb with levothyroxine has been debated. The Tablet Trial, which did not have sufficient power to analyse the RM subgroup alone, and T4life trials (which was specifically examining women with two or more miscarriages) found that compared with placebo, levothyroxine treatment did not result in higher live birth rates in euthyroid women who tested positive for TPOAb [207,208].

A further RCT has since been published which examined levothyroxine for the treatment of sub-clinical hypothyroidism or the presence of TPOAb [209]. With RPL (two or more pregnancy losses prior to viability) and sub-clinical hypothyroidism, the rate of live births was significantly higher in the treatment group than in the control group (70.2% vs. 47.1%, $p < .001$), while the rate of pregnancy loss was significantly lower in the treatment group than in control group (21.4% vs. 39.7%, $p < .001$). Similar behaviour was noted for the RPL group that were pregnant and euthyroid with TPOAb, where the levothyroxine treatment group had a higher rate of live births and a lower rate of pregnancy loss than those without treatment

(90.5% vs. 68.3%, $p = .022$ and 7.1% vs. 26.8%, $p = .006$ for treatment vs. control, respectively) [209]. Given the small numbers in these treatment/control groups (n=41 and 42), these results should be interpreted with caution.

It is important to note that within the three trials there were varying TSH cut-offs defining euthyroidism, which determined subsequent levothyroxine treatment.

Thus, although thyroid antibodies are associated with RM, treatment with levothyroxine for TPOAb or anti-thyroglobulin antibodies in euthyroid women is best done within the context of research at present.

A systematic review and meta-analysis found just three studies examining if levothyroxine treatment conferred any benefit to women with sub-clinical hypothyroidism and RM. They found a reduction in miscarriage (risk ratio (RR) 0·20 [0·05, 0·76]) and a small increase in livebirth (RR 1·20 [0·82, 1·75]). All 3 studies were of a low-methodological quality with TSH cut-offs of >4.0 and 4.5mIU/l however. Thus, treatment could be considered preconception or during pregnancy for women with RM and mild-moderate subclinical hypothyroidism (based on TSH levels above the pregnancy and population-specific laboratory-reference ranges, or above 4.0 mIU/l if unavailable)[115]. A 2024 systematic review and meta-analysis of 11 RCTs comprising 2,749 pregnant women with subclinical hypothyroidism. Patients treated with levothyroxine (1,439; 52.3%) had significantly lower risk of pregnancy loss (risk ratio 0.69; 95% confidence interval 0.52-0.91; $p < 0.01$; 6 studies)[210]. The SCH levels were not consistent however and there was no significant reduction in RM according to whether cut-offs of 2.5 or 4.0 mIU/l were used, or if women had TPOabs. There also was no significant association between levothyroxine and live birth (risk ratio 1.01; 95% confidence interval 0.99-1.03; $p = 0.29$; 8 studies)[210].

As the association with TSH levels >2.5m-4.0IU/l and RM is indeterminate, treatment should ideally be in the context of research and merits a discussion with the woman/couple regarding the risks and benefits of treatment in this instance [43].

B. Progesterone supplementation

There has been a move towards recommending progesterone in women with a history of RM and bleeding in the first trimester.

Pair-wise analysis using data from the PROMISE and PRISM trials,[211,212] demonstrated that women with one or more previous miscarriages and early pregnancy bleeding, twice daily dosage of 400mg vaginal micronised progesterone increases the live birth rate compared to placebo (RR 1.08, 95% CI 1.02 to 1.15, high-certainty evidence) [213]. This treatment has also been shown to be cost-effective, leading to the National Institute for Health and Care Excellence committee for the guideline 'Ectopic pregnancy and miscarriage: diagnosis and initial management (NG126)' updating their guidance to recommend the use of vaginal micronised progesterone to treat women with the dual risk factors of a history of one or more previous miscarriages and early pregnancy bleeding [214,215].

There remains uncertainty as to how long progesterone should be taken for, and whether this treatment is of greater benefit at earlier gestations [216]. A further double-blind placebo trial of vaginal micronised progesterone showed no benefit in women presenting with bleeding and a live intra-uterine fetus [217]. More research is needed in this area to determine the optimal timing, dosage and formulation of progesterone for use in RM.

C. Sitagliptin

Sitagliptin is an oral antidiabetic drug, classed as a dipeptidyl-peptidase IV (DPP4) inhibitor. In the recent "SIMPLANT" randomised-control trial, this drug was shown to increase the endometrial mesenchymal stem-like progenitor cells counts in women with RM and reduce endometrial senescence[218]. In other words, it enhanced endometrial receptivity and plasticity. The trial was not powered to assess pregnancy outcomes, however. An adequately powered randomised control trial to evaluate sitagliptin in this cohort is warranted before this medication can be recommended for clinical use.

Clinical Practice

- Overt hypothyroidism arising before conception or during early gestation should be treated with levothyroxine in women with RPL [43]. **1C** [ESHRE; strong, 2]lo
- There is low-quality evidence that levothyroxine treatment of women with mild-moderate SCH (4.0-10mIU/l) is associated with improved pregnancy and livebirth rates; there is insufficient evidence of benefit in women with upper normal TSH concentrations (2.5-4.0mIU/l). Treatment of women with upper normal TSH levels may reduce the risk of miscarriage, but the potential benefit of treatment should be balanced against the risks [115]. [Adapted; RCOG Scientific Impact Paper 70, GDG]
- If women with subclinical hypothyroidism and RM become pregnant again, TSH level should be checked in early gestation (7-9 weeks gestational age), and hypothyroidism should be treated with levothyroxine [43]. **Best practice** [ESHRE; GPP]
- If women with thyroid autoimmunity and RPL are pregnant again, TSH level should be checked in early gestation (7-9 weeks gestational age), and hypothyroidism should be treated with levothyroxine [43]. **Best practice** [ESHRE; GPP]
- There is insufficient evidence to support treatment with levothyroxine in euthyroid women with thyroid antibodies and RM outside a clinical trial [43]. **2C** [ESHRE; conditional, 2]
- On the basis of insufficient evidence, human chorionic gonadotrophin supplementation in pregnancy is not recommended [43]. **2C** [ESHRE; conditional, 2]
- Bromocriptine treatment can be considered in women with RM and hyperprolactinemia to increase live birth rate [43]. **2C** [ESHRE; conditional, 1]
- There is insufficient evidence to evaluate the effect of metformin supplementation in pregnancy to prevent a miscarriage in women with RM [36]. **1C** [RCOG; C, 1++]
- Vaginal progesterone may improve livebirth rate in women with one or more miscarriages and vaginal bleeding in a subsequent pregnancy [43].**1B** [NICE;NS, ESHRE; strong,3]

Recommendations

40. Overt hypothyroidism arising before conception or during early gestation should be treated with levothyroxine in women with RPL
41. There is low-quality evidence that LT4 treatment of women with mild-moderate SCH (4.0-10mIU/l) is associated with improved pregnancy and livebirth rates; there is insufficient evidence of benefit in women with upper normal TSH concentrations (2.5-4.0mIU/l). Treatment of women with upper normal TSH levels may reduce the risk of miscarriage, but the potential benefit of treatment should be balanced against the risks
42. There is insufficient evidence to support treatment with levothyroxine in euthyroid women with thyroid antibodies and RM outside a clinical trial
43. 400mg vaginal progesterone twice daily may improve livebirth rate in women with three or more miscarriages and vaginal bleeding in a subsequent pregnancy
44. Bromocriptine treatment can be considered in women with RM and hyperprolactinemia to increase live birth rate
45. There is insufficient evidence for HCG supplementation or metformin in the treatment of RM

TREATMENT OF INFECTIONS

Evidence Statement

A systematic review and meta-analysis of seven studies of women with chronic endometritis found no difference in implantation rate, clinical pregnancy rate, miscarriage rate or livebirth rate between those women treated with broad spectrum antibiotics (of varying regimens) and women who were untreated [219].

The following is adopted from the ASRM guideline and review of the current evidence by the guideline development group.

Clinical Practice

- There is no evidence to recommend endometrial biopsy or scratching in women with unexplained RM. [43] **Best practice** [ESHRE; GPP]
- Given the lack of a clear association between treating chronic endometritis and pregnancy outcomes, antibiotics are not recommended in the treatment of chronic endometritis [11]. **Best practice** [GDG consensus]

Recommendations

46. Given the lack of prospective studies linking any infectious agent to RM, any use of antibiotics is not supported by the evidence and therefore should not be recommended.
47. There is no evidence to recommend endometrial scratching or biopsy in women with unexplained RM.

GENETIC FACTORS

Evidence Statement

a. Preimplantation genetic testing for structural rearrangements

Women/couples identified as having balanced translocations should meet with a clinical geneticist to discuss the significance of their particular translocation and the management of future pregnancies. The options include continuing to try to conceive naturally or to undergo IVF with preimplantation genetic testing (PGT) for structural rearrangements [36].

PGT is an embryo-selection technique developed to assess the chromosomal or genetic status of an oocyte or embryo prior to embryo transfer. PGT-SR is differentiated from PGT-A in that it is used to detect cases of unbalanced hereditary chromosomal abnormalities, which are a result of one or both parents having a balanced chromosomal rearrangement (e.g. reciprocal translocations, Robertsonian translocations, and inversions) [220].

There is mixed evidence as to which option is more appropriate. PGT-SR did not demonstrate any significant increase in the livebirth rate between either group [220,221]. However it appears to be of benefit to those with at least two pregnancy losses in sub-group analysis [222]. Conversely, a systematic review and meta-analysis of six studies, all of which used the older FISH technique, revealed that this method of PGT was associated with an increased successful pregnancy outcome of translocation carriers (OR = 8.58; 95%CI: 1.40-52.76) [223]. A study using next generation sequencing has shown higher rates of chromosomal abnormalities, including chromosomal unbalanced translocations and aneuploidy, in blastocysts from chromosomal rearrangement carriers, especially from the female carriers [224].

Overall, the evidence is low-quality and insufficient in RM groups to suggest any deviation from the RCOG or ESHRE guidelines. High-quality RCTs are required in order to establish a definite benefit for IVF with PGT-SR for couples with a balanced translocation.

b. Pre-implantation genetic testing for aneuploidy for RM

Given the association between aneuploidy and RM, the selection of euploid embryos through PGT-A has been postulated as a way to reduce miscarriage rates and increase livebirth rates in women/couples with RM. However, the evidence for PGT-A in any IVF to date is conflicting and there is a paucity of high-quality, adequately powered retrospective trials. A Cochrane review found insufficient evidence of any difference between IVF and IVF with PGT-A and advised PGT-A with FISH is likely harmful [225].

Examining newer techniques, Sanders *et al.* conducted a large UK cohort study using the HFEA data (2464 PGT-A cycles), which demonstrated an increased livebirth rate with PGT-A compared to non-PGT-A across all age groups [226]. The STAR trial showed PGT-A did not improve overall pregnancy outcomes in all women, as analysed per embryo transfer or per intention to treat [227]. There was a significant increase in ongoing pregnancy rate per embryo transfer with the use of PGT-A in the subgroup of women aged 35-40 years but this was not significant when analysed by intention to treat [227].

In a large cohort study using clinical outcome reporting system data which examined over 12,000 IVF cycles including women with recurrent pregnancy loss, the use of PGT-A with FET was associated with increased rates of live birth in women with three or more miscarriage (48% vs 34%, $P < 0.001$) and rates of clinical pregnancy (59% vs 47%, $P < 0.001$) [228]. In addition, for women with RM use of PGT-A was associated with a significant decrease in the rate of spontaneous miscarriage (11 vs 13%, $P = 0.02$), and biochemical pregnancy (9.9% vs 11.5%, $P = 0.02$)[228] A smaller study examining PGT-A in a cohort of women with RM also observed a significant decrease of early pregnancy loss rates in the PGT-A group (18.1% vs 75%) and a significant increase in live birth rate per transfer (50% vs 12.5%) and live birth rate per patient (36% vs 12.5%) [229].

The largest systematic review to date of PGT-A in unexplained RM found that compared with those without PGT-A, patients undergoing ART with PGT-A had higher clinical pregnancy rate (OR, 1.76; 95% CI, 1.57-1.98; I^2, 8%;10 studies; 11,093 cycles; low-quality evidence), lower clinical pregnancy loss rates (OR, 0.42; 95% CI, 0.27-0.67; I^2, 69%; nine studies; 5,850 pregnancies; low-quality evidence), and higher LBR (OR, 2.17; 95% CI, 1.77-2.65; I^2, 46%; 10 studies; 11,133 cycles; low-quality evidence) per embryo transfer[230]. The authors acknowledged the low number of RCTs available for analysis and the heterogeneity of studies in regards to participants and methods.

These results must be interpreted with caution, and women/couples with RM must be carefully counselled regarding the specific difficulties with PGT-A. There is much to be learned and perfected with regards to the technique, which is not standardised and there is much heterogeneity among studies and between laboratories [220,231]. There remains a lack of understanding of the biology of the early embryo and the required biopsy techniques, as well as an ignorance of the implantation process [232]. There is a high rate of embryo loss, the potential for non-read or inconclusive results (with low chance of successful second biopsy), and the issue of mosaicism has not been definitively dealt with [220,231,233]. A recent review of PGT-A concluded that "aside from generating significant financial losses for patients and income for practitioners, (PGT-A) offers no benefit and even be detrimental to infertile couples"[232]. The Human Fertilisation and Fertility Authority which govern IVF in the UK designates PGT-A a "code-red" add-on, i.e. not recommended [234]. ESHRE and ASRM working groups on PGT-A have also not recommended it's use [235,236].

Clinical Practice

- Options for couples with chromosomal rearrangements include attempting a further natural conception, preimplantation genetic testing for structural rearrangements (PGT-SR) or gamete donation [36]. **2C** [RCOG; 2-, C]
- There are currently insufficient data to support the routine use of pre-implantation genetic testing for couples with unexplained recurrent miscarriage, while the treatment may carry a significant cost and potential risk [36]. **2C** [RCOG; 2-, C]
- Pre-implantation genetic testing for aneuploidy is currently not recommended for routine clinical use [235]. 2C [ESHRE low, 2]

Recommendations

48. **Options for couples with chromosomal rearrangements include attempting a further natural conception, preimplantation genetic testing for structural rearrangements (PGT-SR) or gamete donation**
49. **Currently available data do not support the use of pre-implantation genetic testing for couples with unexplained recurrent miscarriage**

MALE FACTORS

Evidence Statement

A Cochrane review in 2019 found no evidence that sperm selection with hyaluronic acid had an effect on livebirth or clinical pregnancy, but may reduce miscarriage [237]. The HABSelect Trial demonstrated no difference in livebirth rate for those receiving intra-cytoplasmic sperm injection (ICSI) or physiological ICSI (PICSI) (where sperm are selected according to how they bind to hyaluronic acid) [238], but secondary analysis suggests it may be of benefit for older couples [239]. The HFEA have designated PICSI as a "code red", i.e. not recommended, add-on [240]. To date, no conclusive evidence exists to justify PICSI for RM.

International guidelines for sperm DNA fragmentation offer low grade evidence for anti-oxidants and addressing lifestyle factors, in addition to medium grade evidence for varicocele repair, for men with high levels of sperm DNA fragmentation [171]. Until a role for sperm DNA fragmentation testing is established in RM care, antioxidants and varicocele repair are not recommended solely to prevent RM.

Clinical Practice

There is as yet no evidence to recommend treatments for male factors [36]. **2C** [RCOG; 3, D]

Antioxidants for men are not recommended as they have not been shown to improve the chance of a live birth [43]. **2C** [ESHRE; conditional 1]

Recommendations

50. **There is no evidence to recommend treatments for male factors**

Clinical Question 2.7: What are the possible treatments for women/couples presenting with unexplained RM?

Evidence Statement

These recommendations stem from the RCOG [36] and relevant literature, in addition to GDG discussions.

The impact of RM on subsequent pregnancy

Despite completing investigations, approximately 50% of women/couples will not receive an explanation for RM. Even so, women/couples can be reassured that their chances of achieving a livebirth are high, with livebirth rates of 74-86% in RM cohorts within the international literature [241,242]. However, a history of RM does confer increased risks for future pregnancy, which must be considered in regard to antenatal care and empiric treatments. The Lancet series recently outlined these particular intrinsic risks of RM following a systematic review of international data. [9] The risk of miscarriage itself increases with each miscarriage, as demonstrated in Table 2.

Table 2: Adapted from "Miscarriage Matters: The Epidemiological, Physical, Psychological, and Economic Costs of Early Pregnancy Loss", Quenby et al., The Lancet 2021.

No of miscarriages	Miscarriage risk (95% CI)
0	11 (7.2, 17.6)
1	20·4 (13·8, 30·3)
2	28·3 (19·0, 42·1)
≥3	42·1 (38·0, 46·7)

Women with three miscarriages are over four times more likely than women without a history of miscarriage to have a further miscarriage, OR 4·46 [3·48, 5·72].[243] Thus, it is vital that supportive aspects of care are in place for subsequent early pregnancy.

Quenby *et al.* in the Lancet series also outline that compared to women without a history of RM, specific obstetric risks apply to women with RM for a future pregnancy (Table 3.)

Table 3: Adapted from "Miscarriage Matters: The Epidemiological, Physical, Psychological, and Economic Costs of Early Pregnancy Loss", Quenby et al., The Lancet 2021.

Demographic risks after 3 miscarriages	Adjusted Estimates; Odds ratio [95% CI]
Pre-eclampsia	1.22 [0.86-1.73]
Placental abruption	1.67 [1.21-2.30]
Placenta praevia	2.81 [0.87-9.04]
Preterm Birth	1.76 [1.39-2.22]
Low Birth Weight	1.98 [1.09-3.58]
Stillbirth	1.69 [1.17-2.45]
Cardiovascular complications	1.42 [1.16-1.74]
Venous thromboembolism	6.13 [2.48-15.16]

Preterm birth risk increases with each miscarriage in a stepwise manner [243]. This is potentially linked to repeated surgical management of miscarriage, which may also contribute to abnormal placentation and the increased risk of placental dysfunction but has yet to be proven definitively [243].

The identified cardiovascular and thromboembolic risks extend beyond pregnancy and the reproductive years, demonstrating the significance of RM as a wider and significant women's health issue [243].

Management of Unexplained RM

For women with unexplained RM, a number of treatments are suggested and prescribed, some of which are not included in current international clinical guidance [31,244].

1. Aspirin and/or LMWH

There is conflicting evidence regarding aspirin, LMWH or a combination as a treatment for RM. Several systematic reviews and meta-analyses have found no difference in livebirth rates or miscarriage rates [245-247], of which two included aspirin and LMWH [248,249]. These are at odds with other systematic reviews of LMWH in unexplained RM that showed a reduction in miscarriages rates [250], a reduction in miscarriage rate and improvement in livebirth rate [251] or an improvement in ongoing pregnancies after 20 weeks [252]. These differences likely stem from the variations in LMWH used, differences in dosages and small sample sizes in the trials analysed. A systematic review from China published in February 2025, looked at 22 RCTs which studied women with a history of RM (variable definitions) and LMW, analysed according to preparation and dose[253]. Among the five drugs studied, enoxaparin showed significant benefits. It notably improved live birth rates (RR 1.19, (95% CI 1.06 to 1.36), surface under the cumulative ranking curve 73%; moderate confidence of evidence), reduced the risk of pre-eclampsia (0.53, (0.28-0.92), 85%), lowered preterm delivery (0.59, [0.41-0.86], 85%), and decreased pregnancy loss (0.55, [0.38-0.76], 82%). Further analysis of 7 different LMWH doses revealed that both enoxaparin 20mg (1.53, [1.08-2.25], 89%) and 40mg (1.18, [1.04-1.38], 59%) significantly improved LBR, with the 20mg dose proving more effective. Both doses also significantly reduced the risk of pregnancy loss[253]. However, important limitations to these findings include that the definitions of RM varied and there was unclear data regarding randomisation with trials and other prescribed medications, such as progesterone. This study highlights the important need for robust clinical trials in this area, with scrutiny on formulations and dosages.

The EAGeR trial, a randomised control trial examining aspirin in women with one or two miscarriages (n=1078) showed pre-conception initiated aspirin improved livebirth rates in those with raised C-Reactive protein [254]. Further per-protocol analysis demonstrated that adhering to low-dose aspirin at least four days per week improved pregnancy outcomes (pregnancy rate, livebirth rate and fewer miscarriages) compared to placebo [255]. A second randomised control trial demonstrated that low-dose aspirin did not improve livebirth rates in women with a history of RM (n=400) [256].

While aspirin has not been proven to reduce miscarriage risk, it does have a role in reducing future placental dysfunction, pre-eclampsia and fetal growth restriction risk [257-260], particularly in women over 35, smokers and those undergoing artificial reproductive technology [261-263]. In low-risk nulliparous women, low-dose aspirin has been shown to improve fetal growth and reduced pre-term birth rates as well as pre-term preeclampsia [264,265], although there is no significant reduction in pre-eclampsia and gestational hypertension rates [265]. Routine low-dose aspirin in low-risk nulliparous women has been shown to have a greater health gain and is more cost-effective than “screen and treat” approaches [266].

A recent systematic review and meta-analysis of 10 RCTs examining LMWH in women at high risk of pre-eclampsia without thrombophilia (including RM), found LMWH reduced the incidence of pre-eclampsia (RR = 0.67; 95% CI = 0.50-0.90; P = 0.009)[267]. Interestingly, subgroup analysis found that the prophylactic effect of LMWH was only significant in studies using low-dose aspirin as the primary intervention (RR = 0.59; 95% CI = 0.43-0.81; P = 0.001, Fig. 3), while the result was not significant in studies that did not use aspirin (RR = 1.52; 95% CI = 0.67-3.46; P = 0.32)[267]. The combination of LMWH and LDA was also effective for the prevention of preterm birth (RR = 0.62; 95% CI = 0.46-0.84; P = 0.002) and fetal growth restriction (RR = 0.71; 95% CI = 0.55-0.91; P = 0.007), but had no effect on the incidence of placenta abruption. However, it must be borne in mind that the included RCTs were small and that there was inadequate information on maternal demographics, with a risk of publication bias [267].

In the absence of large multi-centre, randomised clinical trials of aspirin or LMWH in women with risk factors for placental dysfunction such as RM, the GDG has considered the benefits of aspirin as demonstrated above, in addition to the risks posed to women with a history of RM, to be sufficient to justify administration of aspirin in a future pregnancy. An optimal dose for aspirin remains unclear and both 75 and 150mg doses are safe in pregnancy [257,259]. Women with additional risk factors for pre-eclampsia should be prescribed 150mg aspirin as per national/international guidelines. On review of the evidence, the GDG maintain its recommendation that LMWH should be reserved for those with additional risk factors for venous thrombo-embolism or pregnancy loss, previous adverse pregnancy outcomes or for higher-order miscarriage after other therapies have been unsuccessful.

Aspirin and LMWH have been subject to countless RCTS and there is no significant evidence to suggest maternal or fetal harm from use in pregnancy [268-270]. Nonetheless, a careful medical history should exclude any risks of bleeding or previous bleeds, particularly intracranial haemorrhage. Women should also be advised around the timing of these medications and when to hold doses, especially if they have concerns that they might be miscarrying or towards the end of pregnancy when spontaneous labour may occur.

2. Prednisolone

A recent systematic review and meta-analysis suggested oral immunosuppressants such as prednisolone or cyclosporine A may be of benefit to women with unexplained RM [271]. Oral administration of cyclosporine A or prednisolone increased live birth rate (OR = 3.6, 95% CI: 2.1-6.15, $p < 0.001$) and ongoing pregnancy rate (OR = 8.82, 95% CI: 2.91-26.75, $p = 0.0001$) and also reduced miscarriage rate (OR = 0.21, 95% CI: 0.08-0.52, $p = 0.0007$). However there was significant heterogeneity between studies, a moderate to severe risk of bias and dosing regimens were inconsistent [271].

Moreover, prednisolone has been suggested to be associated with adverse pregnancy outcomes such as oral cleft, fetal growth restriction, preeclampsia and gestational diabetes mellitus, and while a systematic review was failed to demonstrate conclusive evidence of any such association, corticosteroids should only be prescribed when there is a clear indication for use and evidence of benefit for treating an underlying maternal condition. [272]. Similarly, cyclosporine A use during pregnancy appears to be associated with premature delivery and low birthweight infants [273]. Comorbidities such as hypertension, pre-eclampsia and gestational diabetes mellitus are also reported at higher incidences than the general population [273]. Thus, there is a need for greater evidence before prednisolone or cyclosporin A can be recommended in women with unexplained RM.

3. Progesterone

Progesterone is one of the most widely used empiric treatments for recurrent miscarriage [244].

An updated systematic review and meta-analysis showed that following progesterone treatment, the miscarriage rate for women with recurrent miscarriage was reduced and livebirth rate was increased, but these results were not statistically significant [245]. The livebirth rate was higher for the subgroup of women with a history of three or more miscarriages than the subgroup of women with a history of two or more miscarriages. The authors suggest that micronised vaginal progesterone treatment can therefore be considered for asymptomatic women with recurrent miscarriage and is likely to be more effective in women with a high number of previous miscarriages, given that there are no safety concerns for the use of micronised progesterone or dydrogesterone [213,274]. This suggestion was taken on board by NICE, and progesterone 400mg twice daily up to 16 weeks was recommended in their 2021 guideline for women with threatened miscarriage and a history of one miscarriage [275]. However, FIGO recognises the limitations of the evidence available and while it does not recommend the use of progesterone (in any dose, formulation or timing), it is not contraindicated [276]. On review of the available evidence, the GDG recommends that progesterone be used up to 12 weeks only, unless additional risk factors for preterm

birth are present, or the woman has further episodes of bleeding after 12 weeks. The dosage of 400mg twice daily is derived from the RCTs, but may cause local irritation and thus lower dosages of 200mg twice daily/400mg once daily can be used [276].

Safety Note

Sound-alike look-alike drug (SALAD) errors have occurred in maternity care with serious or extreme consequences. If a prostaglandin analogue, e.g. misoprostol or dinoprostone, is used in error during pregnancy, serious patient harm including preterm delivery and foetal/neonatal death may occur.

The following mix-ups have occurred:

- Progesterone (CycloGEST®) and misoprostol (CytoTEC®)
- Progesterone and Prostin E2®(dinoprostone)

Such errors have been reported in Ireland and internationally in women receiving progesterone supplements to maintain a pregnancy in the context of RM or preterm birth [277]. Women should be informed at the time of prescribing what their prescribed medications are and why they are being prescribed and advise that they check prescriptions with their pharmacist or with any staff administering medication in hospital prior to taking any medication.

4. Folic Acid

As discussed at length in the updated ESHRE guideline, folic acid has not been shown to reduce the risk of miscarriage in women with RM [43]. However in an Irish population, it must be borne in mind that food is not fortified with folic acid and Ireland has a higher incidence rate of babies born with neural tube defects than the rest of Europe, and thus folic acid supplementation in pregnancy is of particular importance[278]. High risk groups such as women with obesity, epilepsy, or diabetes mellitus are advised to take a 5mg dose of folic acid to reduce the risks of neural tube defects and in an Irish context, this may include women with RM [279,280].

The decision regarding empiric treatments should be after assessment of individual risk factors, particularly age of either parent, previous number of miscarriages, previous failed treatments, fertility history and ART use, as well as the wishes of the woman/couple. The uncertain effectiveness of these agents must be explained, and the potential risks associated with individual treatments should be outlined.

Clinical Practice

- Women with unexplained RM have an excellent prognosis for future pregnancy outcome without pharmacological intervention if offered supportive care alone in the setting of a dedicated early pregnancy assessment unit. **2B** [RCOG; 2+]
- LMWH or low dose aspirin are not recommended for the sole intention of reducing miscarriage risk, as there is conflicting evidence that they do not improve live birth rate in women with unexplained RM [43]. **1C** [ESHRE; strong, 3]
- However, women with RM are at increased risk of placental dysfunction and for this purpose low-dose aspirin (75-150mg) is recommended in a future pregnancy, with consideration of LMWH based on individual risk factors and history. **Best practice** [GDG]
- Corticosteroids/glucocorticoids should not be administered outside clinical studies as prophylaxis to prevent miscarriage in women with RM but without pre-existing autoimmune disease as they do not improve pregnancy rates and may be associated with adverse pregnancy outcomes. **Best practice** [DGGG, OEGGG and SGGG; ++, expert]

- In women with three or more consecutive miscarriages immediately preceding their current pregnancy, empiric progestogen administration of 400mg vaginally twice daily may be of some potential benefit [245]. **Best practice** [GDG]
- While low dose folic acid (0.4 mg/day) is routinely started preconceptionally to prevent neural tube defects, it has not been shown to prevent pregnancy loss in women with unexplained RM [43].**2C** [ESHRE, Strong 2]
- Women with risk factors for folic acid deficiency, such as obesity, epilepsy or diabetes mellitus, should be considered for high dose (5mg) folic acid supplementation; in an Irish context, it should be considered for women with RM. **Best practice** [GDG]

Recommendations

51. In women with three or more consecutive miscarriages immediately preceding their current pregnancy, empiric vaginal progestogen administration of 400mg twice daily may be of some potential benefit
52. LMWH and corticosteroids are not recommended for unexplained RM
53. Women with RM are at increased risk of placental dysfunction and for this purpose low-dose aspirin (75-150mg) is recommended in a future pregnancy, with consideration of LMWH based on individual risk factors and history
54. While low dose folic acid (0.4 mg/day) is routinely started preconceptionally to prevent neural tube defects, it has not been shown to prevent pregnancy loss in women with unexplained RM
55. Women with risk factors for folic acid deficiency, such as obesity, epilepsy or diabetes mellitus, should be considered for high dose (5mg) folic acid supplementation; in an Irish context, it should be considered for women with RM

Section 6: Future Pregnancy Planning

Clinical Question 2.8: How should women/couples with RM be cared for in a subsequent pregnancy?

On completion of the visit to a RM clinic, it is important that clear plans are in place for future pregnancy for the woman/couple.

Qualitative work with couples experiencing RM has demonstrated that the first trimester of a subsequent pregnancy is a time of stress and anxiety, where women/couples experience a turmoil of emotions and hypervigilance [281]. While women/couples employ their own coping strategies and divide the difficult time period into personal milestones, they found that ultrasound was a valuable source of reassurance, albeit short-lived [281]. Regular ultrasounds in this period have been shown to be an important part of supportive care for RM cohorts [57,282], and they are desired by women/couples [24,281,283].

Couples also valued the environment of the EPC, away from busy emergency or antenatal areas [284]. Empathy and compassion from staff were highlighted as additional sources of support in the first-trimester, especially when the anxiety this period poses to those experiencing RM was acknowledged [281]. Staff knowledge and competence in RM care was particularly appreciated, as was continuity of care [283,284].

As discussed in 6.8, RM confers additional risks in a subsequent pregnancy and thus it is recommended that, at a minimum, women with a history of RM should book in a consultant led antenatal clinic to facilitate additional surveillance for associated obstetric complications. Ideally, this would be a "high-risk" clinic or perinatal medicine clinic.

However, this must align with women's preferences for obstetric care and their individual medical and obstetric history. Where women wish to be accommodated in midwifery-led or "Supportive Care" pathways, this should be discussed with their consultant at booking to individualise their antenatal care plan.

GDG note:

During the guideline review process, it was queried if women should abstain from pregnancy while awaiting review and how to proceed in the scenario where a woman became pregnant while awaiting clinical review or repeat testing on tests such as ACLA.

Women/couples should consider their own personal circumstances, particularly concerning fertility, in delaying pregnancy to await investigative results, potential treatments and advice from the RM clinic. When the initial decision to refer to a RM service is made, women should be given contact details of the RM service (i.e. Bereavement Midwifery Specialist) in their local hospital to seek advice and obtain supportive services such as early pregnancy scanning should they become pregnant prior to review.

Evidence Statement

These recommendations stem from the RCOG, in addition to GDG discussions.

Clinical Practice

- As part of their visit to the RM Clinic, women/couples should receive
  - written information regarding their results of any investigations performed
  - written instructions regarding any treatments
  - prescriptions for any necessary medications
  - details on when to start or stop any medications in future pregnancy
  - instructions for support persons to contact if they become pregnant (of particular importance to those who may be conceiving via ART elsewhere)
  - details on how to arrange an early pregnancy unit appointment for reassurance scans and how many scans to expect as per local policy
  - details for the local maternity emergency room and early pregnancy assessment unit **Best practice** [GDG]
- A personalised plan should also be in place for further pregnancy loss and necessary investigations, e.g. aware that cytogenetic testing may need to be done on pregnancy tissue and to request surgical management of a future miscarriage. It is vital that contact numbers for relevant support persons are available to facilitate these plans for investigations, as well as to provide psychological support [36]. **Best Practice** [GDG]
- Provisions should be made for women to receive appropriate supportive care in terms of communication with relevant healthcare professionals, ultrasound examinations and access to services in case of subsequent miscarriage(s) [36]. **2C** [RCOG; 3, D]
- Women with RM who become pregnant again should also be booked into a consultant-led antenatal clinic at a minimum, ideally a “high-risk” or perinatal medicine clinic. [36]. **2C** [RCOG; 3, D]

Recommendations

56. **As part of their visit to a RM clinic, women/couples should receive written information regarding the results of investigations, treatment plans, contact numbers for available supports, (including the early pregnancy assessment unit and emergency room), in addition to necessary prescriptions and a personalised plan should a further pregnancy loss occur**
57. **Provisions should be made for women to receive appropriate supportive care in terms of communication with healthcare professionals, ultrasound examinations and access to services in case of subsequent miscarriage(s)**
58. **Women with an ongoing pregnancy should be triaged for obstetric care according to their birth preferences and their individual additional risk factors for complications associated with RM e.g., preterm birth, intrauterine growth restriction and stillbirth.**

Chapter 3: **Development Of Clinical Practice Guideline**

In developing a national clinical guideline for Ireland, the guideline development group (GDG) decided to adapt existing guidelines and/or guideline recommendations using the ADAPTE process [6].

The ADAPTE process for guideline adaptation takes into consideration that guideline development utilises significant resources [6]. It "takes advantage of existing guidelines in order to enhance the efficient production and use of high-quality guidelines" [6]. Moreover, it allows for recommendations to address specific health questions in the context of particular health settings as well as considering relevant needs, priorities, legislation, policies and resources [5].

The ADAPTE process has three main phases:

1. Set-up phase (steps 1-6)

The set-up phase is primarily the assembly of the team to be involved and planning for the resources and skills required.

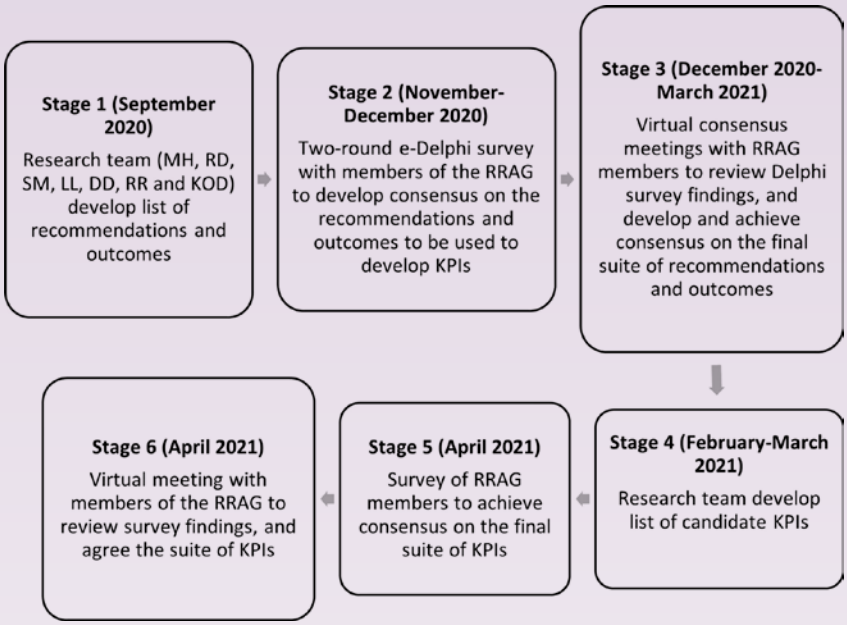
This process over-lapped significantly with the initiation of the RE:CURRENT Project and establishment of its RAG.

2. Adaption phase (steps 7-18)

The adaption phase is the longest part of the ADAPTE process. It involves a systematic review of guidelines, screening the selected guidelines using the AGREE II tool, narrowing down guidelines based on quality, currency, content, consistency and considering the acceptability and applicability of recommendations [5].

As part of the RE:CURRENT Project, a systematic review of guidelines on RM was undertaken and the AGREE II tool was also used to assess guidelines [5,6]. This aligns with the 'Search and Screen and Assess' guidelines aspects of the ADPATE process [8-10]. Recommendations from these guidelines were extracted in order to facilitate the development of Key Performance Indicators (KPI) for RM care [6,285]. These recommendations were discussed with the RAG regarding their quality, currency and feasibility and voted on by the RAG for inclusion for KPI development [285]. This aligns very closely to steps 11-17 and is outlined in Fig. 1.

Fig 1: KPI development process (RRAG; RE:CURRENT RAG)



3. Finalisation phase (steps 19-22)

This phase relates to external review and acknowledgement, which is covered in later chapters of this guideline.

We acknowledge that the RE:CURRENT RAG was not assembled for the purposes of guideline development and does not fully equate to a GDG. However, to essentially replicate this lengthy and complex process with a similar group of stakeholders to produce similar results and recommendations would not be economically prudent. Thus, the decision was made to proceed to guideline development (led by members of the RM GDG) with adoption or adaption (following an updated review of the literature, where necessary) of the recommendations identified and agreed by the RE:CURRENT RAG, subsequent to discussion by the GDG.

The GDG used the information gathered from the guidelines as well as at consensus meetings to generate recommendations from the evidence. This involved meetings for discussions about which recommendations from existing guidelines to adopt and/or adapt. The AGREE II scores had some bearings on which guidelines to include, but ultimately the currency and standing of the RCOG and ESHRE guidelines meant they were the best candidates for adaptation. Select recommendations on niche topics were retained from other guidelines also.

Good Practice Points were developed by the GDG to provide guidance on important aspects of RM management that had little existing evidence base but were agreed by GDG consensus.

3.1 Literature search strategy

A systematic review of international guidelines on RM from high-income countries was undertaken [5]. Subsequent to this, two professional bodies updated their guidance [36,43]. Any new recommendations within these were incorporated into the guideline development process.

A further review of the wider literature was undertaken by LL in May 2022 to ensure that the evidence was up to date. This was a topic-specific search of Google Scholar, PubMed and the Cochrane database focused on those studies published between 2020 up to end of May 2022, e.g. "miscarriage" AND "antiphospholipid syndrome"/RM AND "antiphospholipid syndrome"/"recurrent pregnancy loss" AND "antiphospholipid syndrome" with additional terms added as necessary, e.g. "recurrent miscarriage" AND "antiphospholipid syndrome" AND "aspirin", etc.

The literature was again reviewed by LL in April 2025 to check for any significant clinical evidence. This was a more limited search, restricted to high-quality evidence (such as systematic reviews or randomised control trials) which might have implications for clinical practice. The topic-specific search was repeated as above.

3.2 Appraisal of evidence

Guidelines were appraised as outlined in the systematic review described in 3.1 and following that systematic approach to searching, screening and appraisal, this review has identified a number of evidence-based recommendations for the management of RM, adapted to reflect care in the Irish healthcare setting.

3.3 AGREE II process

While being developed, the Guideline was assessed using the AGREE II checklist (Appendix 8) as recommended by the Department of Health in the 'How to Develop a National Clinical Guideline: a manual for Guideline developers', 2019.[19]

The purpose of AGREE II is to provide a framework to:

1. Assess the quality of guidelines;
2. Provide a methodological strategy for the development of guidelines; and
3. Inform what information and how information ought to be reported in guidelines

3.4 Literature review

Details of supportive evidence-based literature for this Guideline are reported in chapter two.

As mentioned previously, a systematic review of guidelines was undertaken and appraisal of the selected guidelines was done as part of the RE:CURRENT Project and detailed methods are described within the published paper [5].

Briefly, the review was conducted by MH with the RE:CURRENT Team and LL assisted in the AGREE II appraisal [5]. Data extraction and creation of matrices was completed by MH, with recommendations condensed through a review process with the other members of the RE:CURRENT Team and these recommendations were discussed, agreed and prioritised by the RAG in a modified e-Delphi study [285].

19 Department of Health (2019). How to develop a National Clinical Guideline. Available at: https://www.gov.ie/en/collection/cd41ac-clinical-effectiveness-resources-and-learning/

Further reviews of the literature were undertaken in May 2022 and April 2025 by LL. Evidence was appraised according to study design, study sample size, methodology, primary and secondary outcomes as well as applicability and relevance to the PICOH question. Individual study findings are outlined as relevant in Chapter 2. In the guideline, the evidence to support the association of various factors with RM is provided. Updated evidence pertaining to individual investigations and treatments is presented in each section, particularly the study design and strength of evidence, alongside the adapted recommendations from the international guidance. However, to minimise overlap, not all original evidence supporting every recommendation for each investigation and treatment is presented here but is present within the guidelines of origin.

3.5 Grades of recommendation

A number of international guidelines were used in creating recommendations for this guideline as previously outlined. These guidelines are supplemented by an updated review of the literature to maintain the currency of this guideline. Additionally, supporting evidence for the association of various factors with RM is provided for background information and comprehensiveness.

Due to the number of international guidelines used in this guideline and the variation in how the evidence and strength of recommendations were graded, it was decided by the GDG to retain the grading as per guidelines of origin. Primarily this was simply because to collate this evidence and to integrate the various grading systems from each individual guideline into updated recommendations according to GRADE would require resources beyond that of the GDG, but additionally, there was seldom sufficient high-quality evidence to warrant the adjustment of recommendations. Thus, evidence strengths from international guidelines were retained and approximately translated into GRADE as per appendix 7. The GDG accepts that this translation may not be wholly accurate. Good practice points or consensus points are highlighted as such.

GRADE offers a transparent and structured process for developing and presenting evidence summaries and for carrying out the steps involved in developing recommendations [286]. While we acknowledge that for this particular work an extensive GRADE approach is not possible, we have used the suggested language set out in the GRADE table when making recommendations.[20]

3.6 Future research

An important outcome of the guideline development process is in highlighting gaps in the evidence base. These are identified throughout the guideline.

Some suggested topics in this broad area include:

- Establishing associations with RM, for example, hereditary thrombophilia, ovarian reserve, subclinical hypothyroidism, TPOAbs, sperm DNA fragmentation, acquired uterine anomalies
- There is a need for robust RCTs in RM populations to determine the efficacy of suggested treatments, in particular PGT-A, levothyroxine for subclinical hypothyroidism and/or TPOAbs, progesterone, sitagliptin
- The experiences and needs of gender diverse/LGBTQ+ people who have and/or are experiencing RM.

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20 SMFM adopts GRADE (Grading of Recommendations Assessment, Development, and Evaluation) for clinical guidelines. Society for Maternal-Fetal Medicine (SMFM), Chauhan SP, Blackwell SC. Am J Obstet Gynecol. 2013 Sep;209(3):163-5. doi: 10.1016/j.ajog.2013.07.012. PMID: 23978245 https://pubmed.ncbi.nlm.nih.gov/23978245/

Chapter 4: Governance and Approval

4.1 Formal governance arrangements

This Guideline was written by the Guideline Developers under the direction of the Guideline Programme Team (GPT). An Expert Advisory Group was formed to review the Guideline prior to submission for final approval with the National Women and Infants Health Programme. The roles and responsibilities of the members of each group and their process were clearly outlined and agreed.

4.2 Guideline development standards

This Guideline was developed by the Guideline Developer Group (GDG) within the overall template of the HSE National Framework[21] for developing Policies, Procedures, Protocols and Guidelines (2023) and under supervision of the Guideline Programme Team (GPT).

A review was conducted by a group of experts, specialists and advocates (the EAG) prior to approval by the Clinical Advisory Group (CAG) of the National Women and Infants Health Programme (NWIHP) with final sign off for publication by CAG Co-Chairs, the Clinical Director of NWIHP and the Chair of the IOG, see appendix 3 for list of CAG members.

21 Health Service Executive (2023). How to develop HSE National Policies, Procedures, Protocols and Guidelines (PPPGs).

Chapter 5: Communication and Dissemination

A communication and dissemination plan for this Guideline has been developed by the GPT and endorsed by NWIHP.

Effective ongoing clear communication is essential in explaining why the guideline is necessary and securing continued buy-in. It provides an opportunity to instil motivation within staff, helps overcome resistance to change and gives an opportunity for feedback[22].

The Clinical Guideline will be circulated and disseminated through the Guideline Programme Team as well as through the professional networks who participated in developing and reviewing the document.

Senior management within the maternity units are responsible for the appropriate dissemination of new and updated guidelines. Local hospital groups including guideline committees will also be instrumental in the circulation of new and updated guidelines and promoting their use in the relevant clinical settings.

The HSE will make this guideline available to all employees through standards networks as well as storing it in the online PPPG repository. Electronic versions available on the NWIHP https://www.hse.ie/eng/about/who/acute-hospitals-division/woman-infants/clinical-guidelines/ and RCPI websites (https://www.rcpi.ie/faculties/obstetricians-and-gynaecologists/national-clinical-guidelines-in-obstetrics-and-gynaecology/) and other communication means can be used to maximise distribution. The NWIHP website will also provide a training webinar introducing each guideline and where relevant a downloadable version of the recommended algorithm will be available.

In the case of this Guideline, a plain language summary should be made available for people experiencing RM given findings from the RE:CURRENT Project which highlighted the lack of RM information resources available. This would support informed decision-making, providing evidence-informed guidance and help prepare people attending appointments.

22 Department of Health (2018). NCEC Implementation Guide and Toolkit. Available at: https://health.gov.ie/national-patient-safety-office/ncec/

Chapter 6: **Implementation**

6.1 Implementation plan

Implementation was considered at the beginning, and throughout the Guideline development process. The local multidisciplinary clinical team, senior executive and clinical management in each maternity and gynaecology unit are ultimately responsible for the appropriate structured adoption and implementation of the Guideline within their area of responsibility. They must ensure that all relevant personnel under their supervision have read and understood the Guideline and monitor both its effectiveness and adoption.

Within each site, local multidisciplinary teams are responsible for the clinical implementation of Guideline recommendations, and ensuring that their local clinical practices and processes reflect and are aligned with the Guideline recommendations.

The following have been put in place to help facilitate the implementation of this Guideline.

- Quick Summary Document (QSD) for clinical staff (includes key recommendations, auditable standards, algorithms and recommended reading)
- Clinical Guideline mobile application
- Plain language summary

6.2 Education plans required to implement the Guideline

It is acknowledged that this Guideline should be complemented by ongoing education, training and assessment where required.

This Guideline's education plan could include:

- Formal launch of the guideline
- Presentation at local levels
- Use of summary documents and algorithms
- Awareness campaign through relevant media including websites such as the NWIHP, RCPI and www.pregnancyandinfantloss.ie.

6.3 Barriers and facilitators

To ensure successful implementation of guidelines, it is first necessary to look at potential barriers and facilitators. Taking these into account when developing the implementation plan should improve levels of support from relevant users. (DOH 2018, 2019)

Barriers may be categorised as internal (specific to the Guideline itself) or external (specific to the clinical environment). The Guideline Development Group has aimed to address any internal barriers during the development of this Guideline.

Potential external barriers include:

- Structural factors (e.g. budget or service redesign)
- Organisational factors (e.g. lack of facilities or equipment)
- Individual factors (e.g. knowledge, skills, training)
- Patient perceptions

In the case of this Guideline, it will be necessary to examine possible barriers and consider implementation strategies to address them. By example, this may include discussion with relevant management groups with regards budgetary impact or providing training to the relevant staff.

Findings from the RE:CURRENT Project highlight variation in RM practices nationally, with maternity units/clinics using a range of international RM guidelines, with some having adapted/adopted their own RM guidelines locally. The need to support champions (locally/regionally/nationally), provide resources (suitably trained staff, facilities, access to laboratories, timely access to genetic counselling), and highlight the evidence to support practice changes were identified facilitators and should be addressed as part of guideline implementation.

6.4 Resources necessary to implement recommendations

The implementation of this Guideline should be undertaken as part of the quality improvement of each hospital. Hospitals should review existing service provision against this Guideline, identifying necessary resources required to implement the recommendations in this Guideline.

In the case of this Guideline, funding is required to equip all maternity hospitals with 3D ultrasound and to provide staff training. Currently not all hospitals have access to consistent maternity mental health care services, with few having access to an on-site psychologist or counselling and psychotherapy services and this requires investment. Moreover, women with RM are currently outside the remit of perinatal mental health services.

Consideration may need to be given to improving the provision of hysteroscopic surgery nationally and the required upskilling of gynaecologists. If male factors are to feature more prominently in investigations, there is an urgent need to develop andrology services nationally. Currently andrology services are predominantly within the remit of private fertility services and developing public services would require significant resources, including capital investment for laboratories and the recruitment of skilled staff. Consideration could be given to a national standard operating procedure for first-trimester cytogenetic studies, which would require liaison between laboratories and clinical leads for obstetrics and genetics.

Consideration must be given to provision of required genetic testing within this country and it follows that additional clinical geneticists must be recruited in order to provide the necessary genetics counselling.

Chapter 7: Audit and Evaluation

7.1 Introduction to audit

It is important that both implementation of the guideline and its influence on outcomes are audited to ensure that this guideline positively impacts on the care of the woman. Institutions and health professionals are encouraged to develop and undertake regular audits of Guideline implementation. Personnel tasked with the job of conducting the audit should be identified on receipt of the most recent version of the Guideline.

7.2 Auditable standards

Audit using the key recommendations as indicators should be undertaken to identify where improvements are required and to enable changes as necessary. Audit should also be undertaken to provide evidence of continuous quality improvement initiatives.

Auditable standards for this Guideline include:

- Percentage of women/couples receiving the recommended investigations (100%)
- Percentage of women with pregnancy outcome recorded (100%) – to include numbers who:
    - Achieve a new pregnancy
    - Achieve a new pregnancy without any form of artificial reproductive technology (ART) OR with all forms of ART
    - Go on to experience: a first trimester miscarriage/a second trimester miscarriage/fetal growth restriction/placental abruption/pre-eclampsia/baby born at ≥37 weeks' gestation/stillbirth/ neonatal death (defined as: death of a live born baby occurring within 28 completed days of birth)
    - Achieve a new pregnancy within six months of their last miscarriage/≥6 months and <12 months of their last miscarriage.
- Numbers of parents with an abnormal karyotype referred for genetic counselling annually/waiting times/number who conceive without receiving counselling

7.3 Evaluation

Evaluation is defined as a formal process to determine the extent to which the planned or desired outcomes of an intervention are achieved[23].

Implementation of this Guideline will be audited periodically at national level, with standards for this set by the NWIHP. Evaluation of the auditable standards should also be undertaken locally by senior hospital clinical management to support implementation.

23 Health Information Quality Authority (2012). National Standards for Safer Better Healthcare [Internet]. Available from: https://www.hiqa.ie/reports-and-publications/standard/national-standards-safer-better-healthcare

Chapter 8: Revision Plan

8.1 Procedure for the update of the Guideline

It may be a requirement to amend, update or revise this Guideline as new evidence emerges. This Guideline will be reviewed at national level every three years, or earlier if circumstances require it, and updated accordingly.[24]

The Guideline Development Group will be asked to review the literature and recent evidence to determine if changes are to be made to the existing Guideline. If the Guideline Development Group are unavailable, the GPT along with the NWIHP senior management team will select a suitable expert to replace them.

If there are no amendments required to the Guideline following the revision date, the detail on the revision tracking box must still be updated which will be a new version number and date.

The recommendations set out in this Guideline remain valid until a review has been completed.

8.2 Method for amending the Guideline

As new evidence become available it is inevitable that guideline recommendations will fall behind current evidence based clinical practice. It is essential that clinical guidelines are reviewed and updated with new evidence as it becomes available.

In order to request a review of this guideline one of the following criteria must be met:

a. 3 years since the guideline was published

b. 3 years since last review was conducted

c. Update required as a result of new evidence

Correspondence requesting a review of the guideline should be submitted to the National Women and Infants Health Programme. Any such requests should be dealt with in a timely manner.

24 Health Service Executive (2023). How to develop HSE National Policies, Procedures, Protocols and Guidelines (PPPGs).

8.3 Updated Literature and Recommendations 2025

The following changes have been made to the Guideline following a review of the literature in April 2025.

Anti-nuclear antibodies

Further literature on anti-nuclear antibodies has been added. The relevant recommendation (15) has been changed to:

> 15. Women with RM should not be offered routine immunological screening (such as HLA, cytokine and NK cell tests) outside of the research context. Anti-nuclear antibodies may be considered based on individual assessment.

Thyroid Antibodies

This section has been adapted to include the recommendations of the 2025 RCOG Management of Thyroid Disorders in Pregnancy Green-top Guideline No. 76.

The following was added to clinical practice:

> If a woman is already known to be positive for TPOAb but euthyroid, they should be offered thyroid function test measurements in the first trimester (preferably at first contact with a healthcare professional, including primary care booking) and at 20 weeks of pregnancy to detect development of hypothyroidism, which should be treated. **2C** [RCOG; C, 2++]

Hysteroscopic Uterine Septum Resection

This section has been adapted to include the 2024 ASRM Guideline on the management of uterine septum. The ASRM have recommended offering hysteroscopic septum incision to patients with a septum and a history of RM in a shared decision-making model (Strength of Evidence: B; Strength of Recommendation: Moderate)[183].

The wording of the recommendation (30) has been changed to:

> 30. There is some evidence in favour of hysteroscopic uterine septum resection that suggests a reduction in miscarriage rates, but no improvement in live birth rates. Surgery in this cohort should proceed with caution, with input from a specialist team and ideally in the context of a research trial

Treatment of Thyroid Disease

This section has been adapted to include the updated evidence and recommendations of the 2025 RCOG Management of Thyroid Disorders in Pregnancy Green-top Guideline No. 76.

The following has been added to the Clinical Practice section:

> Pre-pregnancy, in women with overt hypothyroidism and severe subclinical hypothyroidism (TSH > 10 mU/L, accompanied by normal fT4), titration of levothyroxine to achieve a preconception TSH ≤ 2.5 mU/L is recommended. **2B** [RCOG; B, 2+]

Pre-pregnancy, in women with subclinical hypothyroidism (TSH between the upper limit of the non-pregnant range and 10 mU/L, accompanied by normal fT4), particularly those already known to be TPOAb positive, treatment with levothyroxine should be considered starting preconception, with titration to achieve a preconception TSH ≤ 2.5 mU/L. 2-, **2C** [RCOG; C, 2-]

Levothyroxine treatment is not recommended for women with TPOAb in the absence of thyroid dysfunction during pregnancy **1A** [RCOG; A, 1++]

Pre-implantation Genetic Testing

This section was updated with the latest literature and recommendations from the EHSRE and ASRM working groups on Pre-Implantation Genetic Testing [235,236].

As a result, the following was added to the Clinical Practice section:

Pre-implantation genetic testing for aneuploidy is currently not recommended for routine clinical use [235]. 2C [ESHRE low, 2]

Recommendation (49) has been changed to:

49. Currently available data do not support the use of pre-implantation genetic testing for couples with unexplained recurrent miscarriage

Empiric Treatments

This section was adapted to include the latest evidence on aspirin and low-molecular weight heparin. It also incorporates the FIGO recommendations on progesterone, but there was no change in the recommendations [276].

The following change was made to clinical practice:

However, women with RM are at increased risk of placental dysfunction and for this purpose low-dose aspirin (75-150mg) is recommended in a future pregnancy, with consideration of LMWH based on individual risk factors and history. **Best practice** [GDG]

Recommendation (53) has been amended to:

53. Women with RM are at increased risk of placental dysfunction and for this purpose low-dose aspirin (75-150mg) is recommended in a future pregnancy, with consideration of LMWH based on individual risk factors and history.

Minor changes

Additionally, several minor changes were made to include relevant updates in the published literature, but these did not result in any changes to clinical practice or recommendations.

The algorithm was amended to state:

> **If less than 35 years** and **two consecutive** miscarriages and no living children – perform cytogenetics on pregnancy tissue
>
> If **35 years or older** and **three consecutive miscarriages** – perform cytogenetics on pregnancy tissue

Antinuclear antibodies have also been removed from the algorithm and the suggested list of blood tests.

Chapter 9: **References**

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Supporting Evidence

GRADE: http://www.gradeworkinggroup.org/

AGREE: http://www.agreetrust.org/agree-ii/

HSE: https://www.hse.ie/eng/about/who/qid/nationalframeworkdevelopingpolicies/

Glossary
(For the Purpose of this Guideline)

AGREE Appraisal of Guidelines for Research and Evaluation

ACOG American College of Obstetricians and Gynaecologists

CAG Clinical Advisory Group

EAG Expert Advisory Group

GDG Guideline Development Group

GPT Guideline Programme Team

GRADE Grading of Recommendations, Assessments, Developments and Evaluations

HIQA Health Information and Quality Authority

HSE Health Service Executive

ICSI Intracytoplasmic Sperm Injection

IOG Institute of Obstetricians and Gynaecologists

FIGO International Federation of Gynaecology and Obstetrics

NICE The National Institute for Health and Care Excellence

NCEC National Clinical Effectiveness Committee

NWIHP National Women and Infants Health Programme

PICSI Physiological Intracytoplasmic Sperm Injection

PPPG Policy, Procedures, Protocols and Guidelines

RAG Research Advisory Group

RCOG Royal College of Obstetricians and Gynaecologists

RCPI Royal College of Physicians of Ireland

RM Recurrent miscarriage

Appendix 1:
Expert Advisory Group Members 2021-

Attendee	Profession	Location (2021)
Dr Fergus McCarthy	Consultant Obstetrician, Gynaecologist, Senior Lecturer and Maternal-Fetal Medicine Sub-specialist	Cork University Maternity Hospital, University College Cork
Dr Mairead Butler	Consultant Obstetrician and Gynaecologist	University Hospital Waterford
Prof. Declan Keane	Professor of Obstetrics and Gynaecology	National Maternity Hospital Dublin, Royal College of Surgeons in Ireland
Dr Katherine Astbury	Consultant Obstetrician and Gynaecologist Gynaecology Oncology Sub-specialist	University Hospital Galway
Dr Sarah Petch	Specialist Registrar, Obstetrics and Gynaecology	National Maternity Hospital Dublin
Dr Orla Donohoe	Specialist Registrar, Obstetrics and Gynaecology	Sligo University Hospital
Prof. John Murphy	Consultant Neonatologist and Clinical Lead for the National Clinical Programme for Paediatrics and Neonatology	National Women and Infants Health Programme
Ms Siobhan Canny	Group Director of Midwifery	Saolta University Health Care Group
Ms Fiona Hanrahan	Director of Midwifery and Nursing	Rotunda Hospital Dublin
Ms Margaret Quigley	National Lead for Midwifery	Office of Nursing and Midwifery Services Director
Prof. Valerie Smith	Professor of Midwifery	School of Nursing and Midwifery, Trinity College Dublin

Attendee	Profession	Location (2021)
Ms Triona Cowman	Director of the Centre for Midwifery Education	Centre for Midwifery Education, Coombe Women & Infants University Hospital
Ms Janet Murphy	Advanced Midwifery Practitioner	University Hospital Waterford
Dr Ciara McCarthy	General Practitioner and ICGP Women's Health Lead	Irish College of General Practitioners
Mr Fergal O' Shaughnessy *And* Dr Brian Cleary *(Shared nomination)*	Senior Pharmacist, Honorary Lecturer *And* Chief Pharmacist, Honorary Clinical Associate Professor and Medications Lead, Maternal & Newborn Clinical Management System	Rotunda Hospital Dublin Royal College of Surgeons in Ireland
Ms Marie Finn	Medical Social Work Counsellor	Saolta University Health Care Group
Ms Marie Culliton	Lab Manager/Chief Medical Scientist	National Maternity Hospital Dublin
Ms Marita Hennessy	Post-Doctoral Researcher	Pregnancy Loss Research Group,INFANT Centre, University College Cork
Ms Niamh Connolly-Coyne *And* Ms Mandy Daly *(Shared nomination)*	Board of Directors	Irish Neonatal Health Alliance
Ms Georgina Cruise	Service Manager	Patient Advocacy Ireland
Ms Caroline Joyce	Principal Clinical Biochemist PhD Candidate	Cork University Hospital University College Cork
Dr Richard Duffy	Consultant Perinatal Psychiatrist	Rotunda Hospital Dublin
Ms Clare Farrell	Physiotherapy Manager	Coombe Women & Infants University Hospital
Ms Fiona Dunlevy *And* Ms Sinéad Curran *(Shared nomination)*	Dietician Manager	Coombe Women & Infants University Hospital National Maternity Hospital
Dr Nicholas Barrett	Lead for Obstetric Anaesthesiology services	Limerick University Hospital
Dr Brendan Fitzgerald	Consultant Perinatal Pathologist	Cork University Hospital
Dr Niamh Conlon	Consultant Histopathologist	Cork University Hospital
Ms Georgina Cruise	Service Manager	Patient Advocacy Ireland

Appendix 2: **Members of the RE:CURRENT Research Advisory Group 2020-2022**

Name	Affiliation
Ms Úna Cahill	A/Assistant Director of Midwifery, Cork University Maternity Hospital
Ms Ríona Cotter	Programme Manager for the Implementation of the National Standards for Bereavement Care Following Pregnancy Loss and Perinatal Death, Cork University Maternity Hospital
Ms Mairie Cregan	Chairperson and Co-Founder, Féileacáin
Ms Carrie Dillon	Bereavement Clinical Midwife Specialist, University Hospital Kerry
Dr Linda Drummond	Project Lead, National Care Experience Programme, Health Information Quality Authority (HIQA)
Ms Angela Dunne	Director of Midwifery, National Women & Infants Health Programme
Dr Minna Geisler	Consultant in Reproductive Medicine, Waterstone Clinic & Consultant Obstetrician and Gynaecologist, Cork University Maternity Hospital
Dr Trish Horgan	General Practitioner, Broad Lane Family Practice, Cork
Dr Azy Khalid	Consultant Obstetrician and Gynaecologist, University Hospital Waterford
Mr Con Lucey	Parent Advocate
Ms Mary McAuliffe	Head of Clinical Services, Waterstone Clinic
Dr Moya McMenamin	Consultant Obstetrician and Gynaecologist, Cork University Maternity Hospital
Dr Yvonne O'Brien	Consultant Obstetrician and Gynaecologist, Galway University Hospital and Portiuncula Hospital Ballinasloe [01/09/2020]
Ms Orla O'Connell	Clinical Midwife Specialist in Bereavement & Loss, CUMH
Ms Anne O' Flynn	Clinical Nurse Specialist Perinatal Mental Health, Cork University Maternity Hospital
Ms Aideen Quigley	Risk & Quality Project Manager, National Women & Infants Health Programme
Ms Margaret Quigley	National Lead for Midwifery, Office of Nursing and Midwifery Services Director (ONMSD)
Ms Rachel Rice	Parent Advocate & School of Applied Social Studies, UCC
Dr Nóirín Russell	Consultant Obstetrician and Gynaecologist, Cork University Maternity Hospital

Name	Affiliation
Ms Jennifer Uí Dhubhgain	Parent Advocate & Secretary, The Miscarriage Association of Ireland
Ms Anna Maria Verling	Midwife
Ms Jill Whelan	Clinical Midwife Specialist in Bereavement & Loss, University Hospital Waterford

Appendix 3:
NWIHP/IOG CAG Membership (2022)

Dr Cliona Murphy (Chair). Consultant Obstetrician and Gynaecologist, Coombe Women and Infants University Hospital. Clinical Director, National Women and Infants Health Programme.

Dr Sam Coulter-Smith. Consultant Obstetrician and Gynaecologist, Rotunda Hospital. Chair, Institute of Obstetricians and Gynaecologists.

Angela Dunne. Director of Midwifery, National Women and Infants Health Programme.

Kilian McGrane. Director, National Women and Infants Health Programme.

Dr Peter McKenna. Clinical Lead, Obstetric Event Support Team, National Women and Infants Health Programme.

Prof. John Murphy. Clinical Lead Neonatology, National Women and Infants Health Programme.

Prof. Maeve Eogan. Consultant Obstetrician and Gynaecologist, Rotunda Hospital. Clinical Lead, Sexual Assault Treatment Units, National Women and Infants Health Programme.

Dr Aoife Mullaly. Consultant Obstetrician and Gynaecologist, Coombe Women and Infants University Hospital. Clinical Lead, Termination of Pregnancy Services, National Women and Infants Health Programme.

Prof. Keelin O'Donoghue. Consultant Obstetrician and Gynaecologist, Cork University Maternity Hospital. Clinical Lead, National Guidelines, National Women and Infants Health Programme.

Prof. Nóirín Russell. Consultant Obstetrician and Gynaecologist, Cork University Maternity Hospital. Clinical Director, Cervical Check.

Prof. Richard Greene. Consultant Obstetrician and Gynaecologist, Cork University Maternity Hospital. Clinical Director, National Perinatal Epidemiology Centre, University College Cork.

Prof. John Morrison. Consultant Obstetrician and Gynaecologist, University Hospital Galway. Clinical Director, Saolta Maternity Directorate.

Dr Suzanne O'Sullivan. Consultant Obstetrician and Gynaecologist, Cork University Maternity Hospital. Director of Education and Training, Obstetrics and Gynaecology, Institute of Obstetricians and Gynaecologists.

Prof. Fergal Malone. Master, Consultant Obstetrician and Gynaecologist, Rotunda Hospital.

Prof. John Higgins. Cork University Maternity Hospital, Consultant Obstetrician and Gynaecologist, Clinical Director, Ireland South Women and Infants Directorate.

Dr Mendinaro Imcha. Clinical Director, Consultant Obstetrician and Gynaecologist, University Maternity Hospital Limerick.

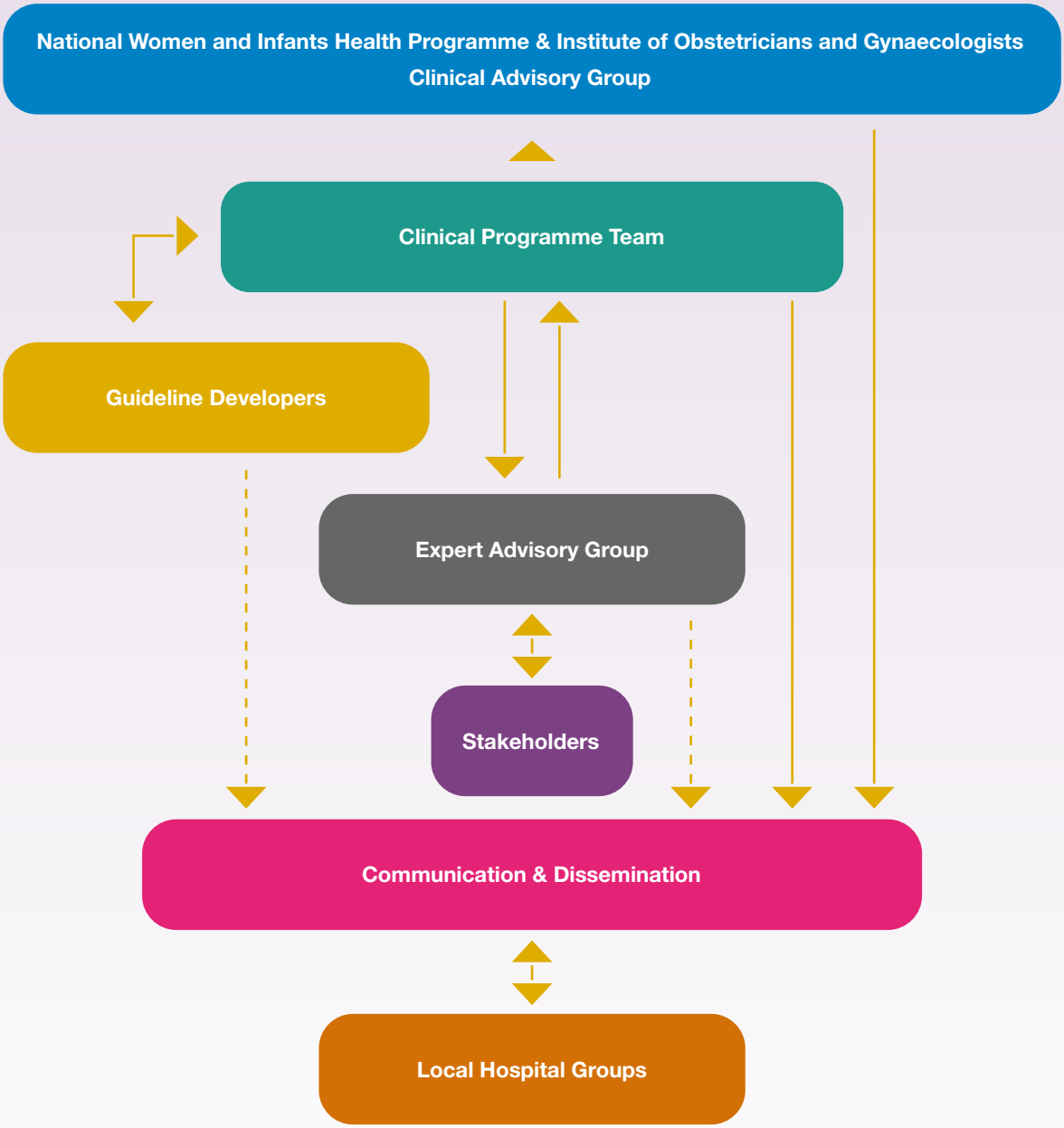
Prof. Shane Higgins. Master, Consultant Obstetrician and Gynaecologist, National Maternity Hospital.

Prof. Mike O'Connell. Master, Consultant Obstetrician and Gynaecologist, Coombe Women and Infants University Hospital.

Dr Brian Cleary. Chief Pharmacist, Rotunda Hospital. Medications Lead, Maternal and Newborn Clinical Management System Project.

Appendix 4:
Guideline Programme Process

Guideline Programme Process



Appendix 5:
Blood Investigations Checklist Sample

Recurrent Miscarriage Clinic

Blood tests to investigate recurrent miscarriage

Test	Department	Bottle **
Thyroid function test	Biochemistry	Red
Thyroid antibodies: • Anti-thyroid peroxidase antibodies	Biochemistry	Red
FBC	Haematology	Purple
Thrombophilia Antiphospholipid syndrome • Lupus anticoagulant • Anticardiolipin antibodies (IgG and IgM) • β2 glycoprotein I antibodies (IgG and IgM	Haematology	Red/Purple
HBA1c **(To be considered if BMI >30, family history, history of gestational diabetes, high risk ethnicity, history of polycystic ovaries)**	Haematology	Purple

** may vary in each maternity unit according to phlebotomy/laboratory products used, verify with local laboratory prior to taking bloods.

Appendix 6: **Grades of Recommendation** [25]

Grade of recommendation	Clarity of risk/ benefit	Quality of supporting evidence	Implications	Suggested Language
1 A. Strong recommendation, high-quality evidence	Benefits clearly outweigh risk and burdens, or vice versa	Consistent evidence from well-performed randomised, controlled trials or overwhelming evidence of some other form. Further research is unlikely to change our confidence in the estimate of benefit and risk	Strong recommendations can apply to most patients in most circumstances without reservation. Clinicians should follow a strong recommendation unless a clear and compelling rationale for an alternative approach is present	We strongly recommend… We recommend that …should be performed/ administered… We recommend that … is indicated/ beneficial/ effective…
1 B. Strong recommendation, moderate-quality evidence	Benefits clearly outweigh risk and burdens, or vice versa	Evidence from randomised, controlled trials with important limitations (inconsistent results, methodologic flaws, indirect or imprecise), or very strong evidence of some other research design. Further research (if performed) is likely to have an impact on our confidence in the estimate of benefit and risk and may change the estimate	Strong recommendation and applies to most patients. Clinicians should follow a strong recommendation unless a clear and compelling rationale for an alternative approach is present	We recommend… We recommend that … should be performed/ administered… We recommend that … is (usually) indicated/ beneficial/ effective…

25 SMFM adopts GRADE (Grading of Recommendations Assessment, Development, and Evaluation) for clinical guidelines. Society for Maternal-Fetal Medicine (SMFM), Chauhan SP, Blackwell SC. Am J Obstet Gynecol. 2013 Sep;209(3):163-5. doi: 10.1016/j.ajog.2013.07.012. PMID: 23978245

Grade of recommendation	Clarity of risk/ benefit	Quality of supporting evidence	Implications	Suggested Language
1 C. Strong recommendation, low-quality evidence	Benefits appear to outweigh risk and burdens, or vice versa	Evidence from observational studies, unsystematic clinical experience, or from randomised, controlled trials with serious flaws. Any estimate of effect is uncertain	Strong recommendation that applies to most patients. Some of the evidence base supporting the recommendation is, however, of low quality	We recommend… We recommend that … should be performed/ administered… We recommend that … Is (maybe) indicated/ beneficial/ effective…
2A. Weak recommendation, high-quality evidence	Benefits closely balanced with risks and burdens	Consistent evidence from well-performed randomised, controlled trials or overwhelming evidence of some other form. Further research is unlikely to change our confidence in the estimate of benefit and risk	Weak recommendation: best action may differ depending on circumstances or patients or societal values	We suggest… We suggest that … may/might be reasonable…
2B. Weak recommendation, moderate-quality evidence	Benefits closely balanced with risks and burdens, some uncertainty in the estimates of benefits, risks and burdens	Evidence from randomised, controlled trials with important limitations (inconsistent results, methodologic flaws, indirect or imprecise), or very strong evidence of some other research design. Further research (if performed) is likely to have an impact on our confidence in the estimate of benefit and risk and may change the estimate	Weak recommendation; alternative approaches likely to be better for some patients under some circumstances	We suggest… We suggest that … may/might be reasonable…

Grade of recommendation	Clarity of risk/ benefit	Quality of supporting evidence	Implications	Suggested Language
2C. Weak recommendation, low-quality evidence	Uncertainty in the estimates of benefits, risks, and burdens; benefits may be closely balanced with risks and burdens	Evidence from observational studies, unsystematic clinical experience, or from randomised, controlled trials with serious flaws. Any estimate of effect is uncertain	Very weak recommendation: other alternatives may be equally reasonable.	We suggest… is an option We suggest that … may/might be reasonable.
Best practice	A recommendation that is sufficiently obvious that the desirable effects outweigh undesirable effects, despite the absence of direct evidence, such that the grading of evidence is unnecessary			We recommend… We recommend that … should be performed/ administered… We recommend that … Is usually) indicated/ beneficial/effective

Appendix 7: **AGREE II checklist**

AGREE Reporting Checklist 2016

This checklist is intended to guide the reporting of clinical practice guidelines.

CHECKLIST ITEM AND DESCRIPTION	REPORTING CRITERIA	Page #
DOMAIN 1: SCOPE AND PURPOSE		
1. OBJECTIVES *Report the overall objective(s) of the guideline. The expected health benefits from the guideline are to be specific to the clinical problem or health topic.*	☐ Health intent(s) (i.e., prevention, screening, diagnosis, treatment, etc.) ☐ Expected benefit(s) or outcome(s) ☐ Target(s) (e.g., patient population, society)	
2. QUESTIONS *Report the health question(s) covered by the guideline, particularly for the key recommendations.*	☐ Target population ☐ Intervention(s) or exposure(s) ☐ Comparisons (if appropriate) ☐ Outcome(s) ☐ Health care setting or context	
3. POPULATION *Describe the population (i.e., patients, public, etc.) to whom the guideline is meant to apply.*	☐ Target population, sex and age ☐ Clinical condition (if relevant) ☐ Severity/stage of disease (if relevant) ☐ Comorbidities (if relevant) ☐ Excluded populations (if relevant)	
DOMAIN 2: STAKEHOLDER INVOLVEMENT		
4. GROUP MEMBERSHIP *Report all individuals who were involved in the development process. This may include members of the steering group, the research team involved in selecting and reviewing/ rating the evidence and individuals involved in formulating the final recommendations.*	☐ Name of participant ☐ Discipline/content expertise (e.g., neurosurgeon, methodologist) ☐ Institution (e.g., St. Peter's hospital) ☐ Geographical location (e.g., Seattle, WA) ☐ A description of the member's role in the guideline development group	

CHECKLIST ITEM AND DESCRIPTION	REPORTING CRITERIA	Page #
5. TARGET POPULATION PREFERENCES AND VIEWS *Report how the views and preferences of the target population were sought/considered and what the resulting outcomes were.*	☐ Statement of type of strategy used to capture patients'/publics' views and preferences (e.g., participation in the guideline development group, literature review of values and preferences) ☐ Methods by which preferences and views were sought (e.g., evidence from literature, surveys, focus groups) ☐ Outcomes/information gathered on patient/public information ☐ How the information gathered was used to inform the guideline development process and/or formation of the recommendations	
6. TARGET USERS *Report the target (or intended) users of the guideline.*	☐ The intended guideline audience (e.g. specialists, family physicians, patients, clinical or institutional leaders/administrators) ☐ How the guideline may be used by its target audience (e.g., to inform clinical decisions, to inform policy, to inform standards of care)	
DOMAIN 3: RIGOUR OF DEVELOPMENT		
7. SEARCH METHODS *Report details of the strategy used to search for evidence.*	☐ Named electronic database(s) or evidence source(s) where the search was performed (e.g., MEDLINE, EMBASE, PsychINFO, CINAHL) ☐ Time periods searched (e.g., January 1, 2004 to March 31, 2008) ☐ Search terms used (e.g., text words, indexing terms, subheadings) ☐ Full search strategy included (e.g., possibly located in appendix)	
8. EVIDENCE SELECTION CRITERIA *Report the criteria used to select (i.e., include and exclude) the evidence. Provide rationale, where appropriate.*	☐ Target population (patient, public, etc.) characteristics ☐ Study design ☐ Comparisons (if relevant) ☐ Outcomes ☐ Language (if relevant) ☐ Context (if relevant)	

CHECKLIST ITEM AND DESCRIPTION	REPORTING CRITERIA	Page #
9. STRENGTHS & LIMITATIONS OF THE EVIDENCE *Describe the strengths and limitations of the evidence. Consider from the perspective of the individual studies and the body of evidence aggregated across all the studies. Tools exist that can facilitate the reporting of this concept.*	☐ Study design(s) included in body of evidence ☐ Study methodology limitations (sampling, blinding, allocation concealment, analytical methods) ☐ Appropriateness/relevance of primary and secondary outcomes considered ☐ Consistency of results across studies ☐ Direction of results across studies ☐ Magnitude of benefit versus magnitude of harm ☐ Applicability to practice context	
10. FORMULATION OF RECOMMENDATIONS *Describe the methods used to formulate the recommendations and how final decisions were reached. Specify any areas of disagreement and the methods used to resolve them.*	☐ Recommendation development process (e.g., steps used in modified Delphi technique, voting procedures that were considered) ☐ Outcomes of the recommendation development process (e.g., extent to which consensus was reached using modified Delphi technique, outcome of voting procedures) ☐ How the process influenced the recommendations (e.g., results of Delphi technique influence final recommendation, alignment with recommendations and the final vote)	
11. CONSIDERATION OF BENEFITS AND HARMS *Report the health benefits, side effects, and risks that were considered when formulating the recommendations.*	☐ Supporting data and report of benefits ☐ Supporting data and report of harms/side effects/risks ☐ Reporting of the balance/trade-off between benefits and harms/side effects/risks ☐ Recommendations reflect considerations of both benefits and harms/side effects/ risks	
12. LINK BETWEEN RECOMMENDATIONS AND EVIDENCE *Describe the explicit link between the recommendations and the evidence on which they are based.*	☐ How the guideline development group linked and used the evidence to inform recommendations ☐ Link between each recommendation and key evidence (text description and/or reference list) ☐ Link between recommendations and evidence summaries and/or evidence tables in the results section of the guideline	

CHECKLIST ITEM AND DESCRIPTION	REPORTING CRITERIA	Page #
13. EXTERNAL REVIEW *Report the methodology used to conduct the external review.*	☐ Purpose and intent of the external review (e.g., to improve quality, gather feedback on draft recommendations, assess applicability and feasibility, disseminate evidence) ☐ Methods taken to undertake the external review (e.g., rating scale, open-ended questions) ☐ Description of the external reviewers (e.g., number, type of reviewers, affiliations) ☐ Outcomes/information gathered from the external review (e.g., summary of key findings) ☐ How the information gathered was used to inform the guideline development process and/or formation of the recommendations (e.g., guideline panel considered results of review in forming final recommendations)	
14. UPDATING PROCEDURE *Describe the procedure for updating the guideline.*	☐ A statement that the guideline will be updated ☐ Explicit time interval or explicit criteria to guide decisions about when an update will occur ☐ Methodology for the updating procedure	
DOMAIN 4: CLARITY OF PRESENTATION		
15. SPECIFIC AND UNAMBIGUOUS RECOMMENDATIONS *Describe which options are appropriate in which situations and in which population groups, as informed by the body of evidence.*	☐ A statement of the recommended action ☐ Intent or purpose of the recommended action (e.g., to improve quality of life, to decrease side effects) ☐ Relevant population (e.g., patients, public) ☐ Caveats or qualifying statements, if relevant (e.g., patients or conditions for whom the recommendations would not apply) ☐ If there is uncertainty about the best care option(s), the uncertainty should be stated in the guideline	
16. MANAGEMENT OPTIONS *Describe the different options for managing the condition or health issue.*	☐ Description of management options ☐ Population or clinical situation most appropriate to each option	

CHECKLIST ITEM AND DESCRIPTION	REPORTING CRITERIA	Page #
17. IDENTIFIABLE KEY RECOMMENDATIONS *Present the key recommendations so that they are easy to identify.*	☐ Recommendations in a summarized box, typed in bold, underlined, or presented as flow charts or algorithms ☐ Specific recommendations grouped together in one section	
DOMAIN 5: APPLICABILITY		
18. FACILITATORS AND BARRIERS TO APPLICATION *Describe the facilitators and barriers to the guideline's application.*	☐ Types of facilitators and barriers that were considered ☐ Methods by which information regarding the facilitators and barriers to implementing recommendations were sought (e.g., feedback from key stakeholders, pilot testing of guidelines before widespread implementation) ☐ Information/description of the types of facilitators and barriers that emerged from the inquiry (e.g., practitioners have the skills to deliver the recommended care, sufficient equipment is not available to ensure all eligible members of the population receive mammography) ☐ How the information influenced the guideline development process and/or formation of the recommendations	
19. IMPLEMENTATION ADVICE/TOOLS *Provide advice and/or tools on how the recommendations can be applied in practice.*	☐ Additional materials to support the implementation of the guideline in practice. For example: • Guideline summary documents • Links to check lists, algorithms • Links to how-to manuals • Solutions linked to barrier analysis (see Item 18) • Tools to capitalize on guideline facilitators (see Item 18) • Outcome of pilot test and lessons learned	

CHECKLIST ITEM AND DESCRIPTION	REPORTING CRITERIA	Page #
20. RESOURCE IMPLICATIONS *Describe any potential resource implications of applying the recommendations.*	☐ Types of cost information that were considered (e.g., economic evaluations, drug acquisition costs) ☐ Methods by which the cost information was sought (e.g., a health economist was part of the guideline development panel, use of health technology assessments for specific drugs, etc.) ☐ Information/description of the cost information that emerged from the inquiry (e.g., specific drug acquisition costs per treatment course) ☐ How the information gathered was used to inform the guideline development process and/or formation of the recommendations	
21. MONITORING/ AUDITING CRITERIA *Provide monitoring and/or auditing criteria to measure the application of guideline recommendations.*	☐ Criteria to assess guideline implementation or adherence to recommendations ☐ Criteria for assessing impact of implementing the recommendations ☐ Advice on the frequency and interval of measurement ☐ Operational definitions of how the criteria should be measured	
DOMAIN 6: EDITORIAL INDEPENDENCE		
22. FUNDING BODY *Report the funding body's influence on the content of the guideline.*	☐ The name of the funding body or source of funding (or explicit statement of no funding) ☐ A statement that the funding body did not influence the content of the guideline	
23. COMPETING INTERESTS *Provide an explicit statement that all group members have declared whether they have any competing interests.*	☐ Types of competing interests considered ☐ Methods by which potential competing interests were sought ☐ A description of the competing interests ☐ How the competing interests influenced the guideline process and development of recommendations	

From: Brouwers MC, Kerkvliet K, Spithoff K, on behalf of the AGREE Next Steps Consortium. The AGREE Reporting Checklist: a tool to improve reporting of clinical practice guidelines. BMJ 2016;352:i1152. doi: 10.1136/bmj.i1152.

For more information about the AGREE Reporting Checklist, please visit the AGREE Enterprise website at http://www.agreetrust.org.