Care of women with Intrauterine death and Termination for fetal abnormality using Mifepristone & Misoprostol

This guideline should be read in conjunction with


2. Bereavement Booklet. (Also available from Loraine Pearce office)
   a. [99924 - Bereavement over 24.pdf](99924%20-%20Bereavement%20over%2024.pdf)
   b. [99925 - Bereavement under 24.pdf](99925%20-%20Bereavement%20under%2024.pdf)
### Bereavement Guidelines – Contents

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**Introduction**

Stillbirth is common, with 1 in 200 babies born dead. This compares with one sudden infant death per 10 000 live births. There were 4037 stillbirths in the UK and Crown Dependencies in 2007 at a rate of 5.2 per 1000 total births. The overall adjusted stillbirth rate was 3.9 per 1000. In addition to any physical effects; stillbirth often has profound emotional, psychiatric and social effects on parents, their relatives and friends. A clearly documented care plan and integrated multidisciplinary approach can help to support the whole family at this difficult time.

**Principles and standards of care**

- This situation must be handled with the utmost compassion. In cases of intra-uterine death parents may need time to come to terms with the situation.
- Acknowledge the parents feelings and permit them to be alone if they so wish. At other times allow them to express their feelings and concerns.
- Explain the process of induction and what will occur, discuss options of pain relief and encourage the anaesthetist to be involved.
- It is important to discuss what the parents want. They may find it helpful and comforting to have a visit from the hospital Multi-faith Chaplaincy Team. Always offer parents the services of the Team.
- It is important to communicate with parents and discuss whether they would like to see the baby following delivery. Explain in detail that there may be physical changes in the baby. While this should be encouraged, the parent’s wishes must be respected.
- Ask the parents if they would like to take photographs of their baby, who they would like to be present, and where they would like to be. Post mortem can be discussed sensitively and explained to the parents. The parents must be given the booklet ‘Information regarding post-mortem of a baby or a child’, they should also be given the parents information pack, this includes chaplaincy information, burial information, registration of the baby and useful contact details.
- Family involvement must be facilitated where desired by the mother. The mother’s wishes must determine when, and to what extent, hospital staff should facilitate
Management of Intrauterine death/Still birth June 2012

involvement and pass on information. The partner will also need support as do the whole family including siblings and grandparents.

- The significance of the parent’s loss must be acknowledged and appropriate emotional, psychological and spiritual support must be available to assist the grieving process in response to individual need.
- The mother/parents must be treated with dignity and their privacy and cultural beliefs respected.
- All babies, however small, must be handled with care and dignity.
- Staff caring for bereaved families must be given information, appropriate training and support to enable them to offer effective and empathetic care.
- The effectiveness of the service offered to bereaved parents must be monitored to ensure a consistent quality service.

Termination of pregnancy for Fetal abnormality.

- If a severe abnormality has been detected the option of a termination of pregnancy will be discussed with the mother and her immediate family as appropriate. At gestations less than 15 weeks, in most circumstances a surgical termination of pregnancy will be organised although if a post mortem examination is deemed to be very important, medical termination may be discussed. After 15 weeks gestation a medical procedure will be more commonly be undertaken although in some circumstances a surgical procedure may be possible.
- When parents opt for termination of pregnancy, or following the diagnoses of a late intrauterine death, it is generally suggested that there should be an interval of at least 24 hours between the diagnosis and the initiation of the process. Adequate counselling must always be provided during this interval and the patient should be offered written details of the ARC (Antenatal results and choices). The patient’s General Practitioner should be contacted and informed of the diagnosis, preferably by telephone.
- If the termination of pregnancy is being considered after 22 weeks’ gestation fetocide should be discussed and strongly recommended to the parents.
These patients will have the similar induction protocol as patients with intrauterine death (Table 1)

**Clinical management of Intrauterine death / Stillbirth**

1. **Diagnosis**
   1.1. Real-time ultrasonography is essential for the accurate diagnosis of IUFD
   1.2. A second opinion should be obtained whenever practically possible.
   1.3. Mothers should be prepared for the possibility of passive fetal movements. If the mother reports passive fetal movement after the scan to diagnose IUFD, a repeat scan should be offered.

2. **Breaking bad news**
   2.1. If the woman is unaccompanied, an immediate offer should be made to call her partner, relatives or friends.
   2.2. Discussions should aim to support maternal/parental choices.
   2.3. A crucial component is to understand the emotional feelings and needs of the mother and her companion. Empathetic approach should be adopted to understand women’s thoughts and wishes
   2.4. Parents should be offered written information to supplement discussions.
   2.5. Parents should be given time to accept the news and time and space to grieve.
   2.6. Neonatal Team Involvement-the team may have been involved with the mother and family and have been involved in the care.

3. **Communication with parents**
   3.1. The most senior doctor should explain the process of induction, pain relief and postnatal care.
   3.2. The doctor should explain all steps of care and answer all questions from parents.
3.3. Women should be offered an opportunity to meet with obstetric anaesthetist to discuss her analgesic requirements.

3.4. A midwife should be designated to care for the women during her stay on a one to one basis

3.5. The discussion should be empathetic and open; not leading to any specific plan of care.

4. The notes should be thoroughly checked for the patients who have been seen by the neonatologist and care plan is devised for intrapartum care and care of the baby.

5. Preparation – Midwives Responsibility

5.1. After the conformation of diagnosis LW coordinator should be informed who will allocate the midwife for the care of woman.

5.2. Most senior obstetrician and anaesthetist should be informed.

5.3. Room 1 is designated area for women and family with intrauterine loss

5.4. Avoid placing a labouring woman in Rm. 2. When woman with IUD in RM 1.

5.5. Allocated midwife will ensure the designated area is clean and there is no birth equipment in immediate environment including a cot or resuscitaire

5.6. Ensure appliances are clean and in working order. Ensure supply of bread, tea, coffee, butter etc. disposable cups, plates and cutlery.

5.7. Additional bed to accommodate partner. (MSW can assist).

5.8. Reception staff to be informed re admission of patient and instructed to allow relatives / visitors entry at lift bank B. Ensure entry to bathroom from Room 2 is locked.

5.9. Appropriate paper work: Pregnancy loss checklist > 24 weeks. All files and paper work is found in tray on Bereavement filing cabinet in reception on JB ward.

5.10. Familiarise with the contents of pack

5.11. Laminated sign with butterfly logo to be placed on the door.
6. Initial assessment

On admission, make the couple feel as though they are expected. Orientate them to the environment. Inform her that relatives and visitors can use Lift bank B for entry / exit upon suitable identification ie. Patient’s name or ‘room one’.

6.1. General Physical examination (BP, Pulse, Temp etc...)

6.2. Abdominal examination to rule out abruption.

6.3. Vaginal assessment to check the Bishop score and speculum examination to do vaginal swabs, and also assess cervix.

6.4. Base line blood tests should be done which should include FBC, Group and save, clotting profile, kleihuer test, CMV, Rubella, thrombophilia screen, Torch screen, Hb1ac, parvovirus. If mother is pyrexial or any other signs of infection then consider blood cultures, MSU culture, speculum examination, vaginal swabs and throat swabs (full infection screen) \textbf{PLEASE consult to the BOOKLET.}

7. Investigation for intrauterine fetal death

7.1. Paediatric Examination

This may be appropriate to confirm or exclude morphological abnormality soon after birth and should be carried out by the duty registrar.

7.2. X-Ray Examination

This is performed, if indicated, by Dr. Josephine Wyatt-Ashmead (Pathologist). Please write this request in the \textit{limiting post mortem section 2} on the post mortem request form and state that this is the only examination parents are consenting to. It can also be added to section 6 on the form as a request. In addition, please cross through all other pages of the post-mortem consent form as an additional reassurance for the parents. The parents also need to sign the consent form.

7.3. Cytogenics
If the baby is very macerated, collecting specimens for cytogenetics may be impossible or inappropriate as culture/analysis will be impossible due to autolysis of tissue.

7.3.1. **Fetal Blood:** obtained from the cord or by cardiac puncture into a lithium heparin bottle (with parents’ permission). Sent to Kennedy Galton Centre at Northwick Park during weekdays, normal working hours. Send by taxi (request pad in red tray by Lyn Dineen’s desk). Phone Kennedy Galton prior to sending specimen.

7.3.2. Send with a referral form available in bereavement folder.

7.3.3. **OR Skin Snip:** 1cm x 1cm, full thickness (obtained with parents’ permission) from under the arm. Place in sterile container, dry and refrigerate until sent as above to the Kennedy Galton Centre.

7.4. **Microbiology**

7.4.1. Plain swabs from baby

- Throat
- Nose For MC&S and Listeria
- Deep Ear Swabs

7.4.2. Placental swabs for MC&S.

7.5. **Post Mortem**

Should be encouraged sympathetically in all cases. Please consult the booklet.

7.6. **Maternal blood**

- Thrombophilia screen
- Kleiheur test
- Parvovirus
- Autoantibodies
- Chromosomal studies

7.7. **TORCH Screening** Not necessary as these will not recur in a subsequent pregnancy since immunity is conferred by a primary attack.

7.8. **Full 75g Oral Glucose Tolerance Testing for Mother** only indicated if a strong index of suspicion (i.e. large baby) that the woman has developed diabetes in pregnancy. It should be performed (on the ward) within 3 days of delivery.

7.9. **Placenta**
Even if the post mortem is declined for the baby, the placenta should be placed in a dry container, labelled and sent to Pathology Lab on the 2nd floor.

8. **Labour and birth plan**

*The case should be discussed with the consultant in charge.*

8.1. Record care in labour on partogram

8.2. Palpate uterine contractions and document frequency, duration, intensity.

8.3. Bladder care. As per normal labour guidelines. And record on partogramm. Deviation from normal labour progress should be escalated to Obstetrician as in normal labour guidelines.

8.4. Recommendations about labour and birth should take into account the mother’s Preferences as well as her medical condition and previous intrapartum history.

8.5. Women should be strongly advised to take immediate steps towards delivery if there is sepsis, preeclampsia, placental abruption or membrane rupture, but a more flexible approach can be discussed if these factors are not present.

8.6. Well women with intact membranes and no laboratory evidence of DIC can be delayed for a short duration on mother’s request. These mothers can develop severe complications and suffer greater anxiety with longer delays.

8.7. If a woman returns home before labour, she should be given a 24-hour contact number for information and support. It must also be documented in the communication diaries on the labour ward and on the reception that the woman and her partner are expected back

8.8. Women contemplating prolonged expectant management should be advised that the value of post mortem may be reduced.

8.9. Women contemplating prolonged expectant management should be advised that the appearance of the baby may deteriorate.
8.10. Mode of delivery

8.10.1. Vaginal birth is the recommended mode of delivery for most women, but caesarean birth will need to be considered with some patients after discussion with consultant, in order to help the mother and family make an informed decision.

8.10.2. Vaginal assessment should be done by the caring midwife/obstetrician and Bishop score recorded.

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<tr>
<th>Induction protocol for women from 15-25\textsuperscript{6} weeks</th>
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<tr>
<td><strong>Mifepristone 200 mg orally.</strong> This tablet must be taken in the presence of medical staff. The woman must remain in hospital for at least 2 hours after taking Mifepristone in case of adverse patient reaction).Await events for 12-48 hours. The second stage will commence with a Misoprostol 200 microgram tablet administered vaginally followed by Misoprostol 200 micrograms orally every 3 hours to a maximum of 4 doses.</td>
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<td><strong>Mifepristone 200 mg orally.</strong> This tablet must be taken in the presence of medical staff. The woman must remain in hospital for at least 2 hours after taking Mifepristone in case of adverse patient reaction. Await events for 12-48 hours. The second stage will commence with Misoprostol 100 micrograms (half a 200 microgram tablet) administered vaginally followed by Misoprostol 100 micrograms orally every 3 hours to a maximum of 4 doses.</td>
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NB: A Consultant Obstetrician must review the woman the following morning if she has not delivered. This review must
include a full assessment of the clinical situation including the consideration of cephalopelvic disproportion.

In cases of mid trimester IUD, the patient may not always like to wait for 24-48 hours between receiving Mifepristone and misoprostol. In these cases it is advisable to give Mifepristone 200mg and defer the misoprostol until the next day. A 12 hour minimum Mifepristone to Misoprostol treatment interval is recommended

NB. At present there is not enough clinical evidence nor availability of low dose Misoprostol tablets/pessaries (25 to 50 micrograms) to support changing our drug regimen to the recommendations in the RCOG Green-top Guideline No.55 (Late Intrauterine Fetal Death and Stillbirth) which was published in October 2010. After a full review of the recent evidence and consensus among clinicians, the above medical regimen has been agreed which will be subject to a continuous prospective review.

- For complex cases such as cardiac disease consider lower doses such as 50 microgram however full discussion among the team including pharmacist should take place.

Table 1: Induction protocol for women with intrauterine death/termination

**Special circumstances**

8.11. Induction of labour in patients with a previous uterine scar e.g. previous caesarean section or uterine surgery carries a serious risk irrespective of the technique used to achieve that goal. Women undergoing VBAC should be informed of risk of scar dehiscence. The risk of scar dehiscence is low (0.2 - 0.7%) but is associated with 0.1% hysterectomy rate. This risk is in line with VBAC in live children

- A discussion of the safety and benefits of induction of labour should be undertaken by a consultant Obstetrician.
• Women with two previous LSCS should be advised that in general the absolute risk of induction of labour with prostaglandin is only a little higher than for women with a single previous LSCS.
• Patient should be informed of the off licence use of Mifepristone and Misoprostol tablets for this indication.

8.12. Women with a scarred uterus (previous caesarean section/myomectomy scar or breech of cavity for any other reason)

8.12.1. Fetal heart abnormality is usually the early sign of scar dehiscence but does not apply in this circumstance therefore other clinical features such as maternal tachycardia; atypical pain, vaginal bleeding, haematuria and maternal collapse are the red signs.

8.12.2. All the decisions about induction should be done in close consultation with consultant Obstetrician

8.12.3. These patients will have the similar regime as in table 1 but close monitoring is essential.

8.12.4. Oxytocin augmentation can be offered to these patients after full discussion regarding risk of scar dehiscence

8.13. Contraindications

The contraindications to the uses of mifepristone and misoprostol include:

Mifepristone

Severe asthma uncontrolled by therapy, chronic adrenal failure, inherited porphyria and hypersensitivity to mifepristone or any of the excipients. In addition use is not recommended in women with renal failure, hepatic
failure and malnutrition. It should be used with caution in women with risk factors for or with established cardiovascular disease, prosthetic heart valves, those using anticoagulation or who have anaemia.

**Misoprostol**

Hypersensitivity to misoprostol or any of the excipients or to other prostaglandins. Use with caution in women where hypotension might precipitate severe complications e.g. cardiovascular or cerebrovascular disease.

**9. Pain relief during labour**

9.1. Patients should be asked early if they would like to speak to an anaesthetist to discuss options for analgesia. The anaesthetist should be contacted immediately if the woman requests analgesia as remifentanil Patient Controlled Analgesia (PCA) can be offered prior to blood results being available.

9.2. All forms of pain relief, including epidural analgesia and remifentanil PCA, should be available.

9.3. If a patient requests epidural analgesia, a full blood count and clotting screen must be taken to exclude DIC.

**10. Facilities during labour**

10.1. **Room facilities**

10.1.1. To be cared for in Room 1 – Labour Ward. The room should be prepared prior to admission. The soft furnishings and refreshments are locked in the cupboard in the room and the key is with the labour ward coordinator.

10.1.2. Partner should have a bed made available.

10.1.3. The resuscitaire should be removed from the room

10.1.4. The room should be set out with tea and coffee making facilities, the microwave and kettle should be checked and cleaned. The fridge should be checked that it is clean and milk placed in there.

**NB: the fridge is for foodstuffs only.**

**11. Infections**
11.1. Routine use of antibiotics is not needed in labour.

11.2. GBS does not need treatment in labour.

11.3. If there are any signs of infection; intravenous antibiotics should be initiated in line with the Adult Empirical Antimicrobial Treatment guidelines for genital tract sepsis as follow:

**Obstetric & Gynaecological**

**CHORIOAMNIONITIS / GENITAL TRACT SEPSIS / POST-PARTUM SEPSIS / ENDOMETRITIS**

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<th>Common pathogens:</th>
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<tr>
<td>Conform</td>
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<td>Group B streptococci</td>
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<td>Anaerobes</td>
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**First Line Treatment**

- **ERYTHROMYCIN** 500mg IV TDS
- **METRONIDAZOLE** 500mg IV TDS

**Notes:**
- a. HVS and amniotic fluid should be sent urgently and blood cultures taken if pyrexial
- b. A clinical response should be seen within 48–72hrs. If no response seen please discuss with medical microbiology

**Alternative (e.g. Penicillin Allergic)**

- **CLINDAMYCIN** 900mg IV TDS
- **GENOBACTIN** 500mg IV TDS

Delivery

11.4. Obstetrician (Senior SPR) should be present on the labour ward as there is high risk of shoulder dystocia, postpartum haemorrhage and occasional need for instrumental delivery.

11.5. The labour should be recorded and documented contemporaneously in the notes as well as on the partogram. Any deviation from normal labour progress should be discussed.

11.6. Respect parent’s wishes at birth - whether or not they would like to see, hold baby soon after birth or whether they would prefer baby to be cleaned and returned.

11.7. Respect cultural and religious practices.

12. Postnatal care

12.1. Postnatal care should be continued in room 1; the woman should not be transferred. If there is a clinical need to transfer the woman this must be discussed with the maternity bleep holder.

12.2. Routine postnatal examination of the mother should be performed, in line with the care of postnatal women guideline.

12.3. Every care should be taken to ensure the woman and her family have as much or as little time alone as they wish.
12.4. Paper work to be completed must not be the priority of your care; the woman and her family must have the highest level of support offered.

12.5. Kleiheur should be taken if rhesus negative.

12.6. Assessment of needs before discharge

12.7. Suppression of lactation. Cabergoline- (1mg, orally, once only) should be administered as a lactation suppressant (if woman wishes)

12.8. Thromboprophylaxis should be given to all women based on their VTE assessment. This must be completed on admission and then every 24 hours or when the clinical situation changes.

13. Postmortem

13.1. The consent for post-mortem is the responsibility of the most senior person in labour ward.

13.2. The bereavement booklets are available which have the full information about the post-mortem consent forms and relevant paperwork.

14. Communication with all health staff

This includes the community midwives, health visitor, antenatal class coordinator and general practitioner. Other existing carers such as psychiatrists, secondary care specialists and drug workers should also be contacted. It should also include voluntary groups who distribute free items to new mothers, but specific details should not be released to maintain confidentiality. Appointments for antenatal clinics (hospital and community), ultrasound scans and preoperative assessment should be cancelled.

15. Psychological and social issues of care

15.1. Carers must be alert to the fact that mothers, partners and children are all at risk of prolonged severe psychological reactions including post-traumatic stress but their reactions might be very different.

15.2. Perinatal death is associated with increased rates of admission owing to postnatal depression. Unresolved normal grief responses can evolve into post-traumatic stress disorder. Women with poor social support are particularly vulnerable.

15.3. Partners of women with an IUFD can also suffer from severe grief
16. **Options for the funeral of the baby**

The Trust offers all parents a simple, dignified cremation service. This is a free service, which parents may attend and their choices incorporated in the service. The Trust does not offer a burial service, but we can support families to arrange this privately. Information regarding this can be found in the Parents information pack. The “cool room” facilities should also be discussed with the patients.

17. **Chaplaincy (Multi-faith Chaplaincy Team_)**

The multi-faith chaplaincy team is available to bereaved parents at all times, and their services should routinely be offered. The multi-faith chaplaincy team can offer support from all the main religious beliefs and offer blessings for babies and their families.

18. **Registration of baby**

Any baby that is delivered from the 24th week of pregnancy is required to be registered as a stillbirth. The person delivering the baby can issue the certificate or whoever has examined the baby. The parents need to be informed that the stillbirth must be registered at the Old Town Hall in the King’s Road. Information regarding this process is also included in the parent pack. The must be done before a funeral can take place

19. **On-going Parent support**

- Please ensure that the parents have the contact details for Loraine Pearce, bereavement counsellor for on-going bereavement support.
- There is financial support which can be provided, please see leaflets
- There must be nominated consultant to see the parents in the postnatal clinic to discuss all the events, explain any results and the management plan for future pregnancies.
- The system that is provided for parents who require language or communication support is our access to language line. This is an organisation that is used Trust wide and their contact numbers are available in clinical areas.
• Parents are routinely offered information for support groups. This information is in the form of an information sheet and is contained in the parents support pack. This is given to parents before they leave the hospital and is documented in the checklist that supports the midwives practice.

20. Monitoring compliance:

The maternity service will audit and monitor compliance with the approved documentation for ensuring that parent(s) have postnatal support in cases of actual and suspected poor outcome for the newborn, as described at Level 1, in relation to the:

• Documentation of all support and discussions with parent(s).

Where the monitoring has identified deficiencies, there must be evidence that recommendations and action plans have been developed and changes implemented.

References


