

Intrauterine death (>24 weeks of gestation)

Key Points

- Process of diagnosing an intrauterine death
- Medication for the induction of labour
- Labour and analgesia
- Postnatal care and follow up
- Post mortem and funeral protocols

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Key words: Intrauterine death, stillbirth, termination of pregnancy, misoprostol, mifepristone, funeral, postmortem

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Abbreviations

CO	Carbon Monoxide
CRP	C-Reactive Protein
FPH	Frimley Park Hospital
PCA	Patient controlled analgesia
PV	Per vaginal
Sands	Stillbirth and neonatal death (Charity)
SROM	Spontaneous rupture of membranes
WPH	Wexham Park Hospital

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1. INTRODUCTION

1.1 This guideline covers stillbirth which may be either spontaneous or identified as an intrauterine death with subsequent induction of labour. There is a separate guideline covering termination of pregnancy; '*termination for fetal abnormality*'.

1.2 The Maternity Bereavement Checklist on Epic for stillbirth/TOP after 24 weeks or live birth and early NND should be used in conjunction with this guideline on both sites.

2. DIAGNOSING INTRAUTERINE DEATH

2.1 Once suspected, intrauterine death should be confirmed or refuted by ultrasound imaging of the fetal heart by an obstetrician skilled in real-time imaging or by an ultrasound sonographer. This should be confirmed by a second practitioner.

As soon as the diagnosis is confirmed, a senior obstetrician should see the woman and her family and inform them of the diagnosis. Where possible an explanation, even if only tentative, should be offered and the details recorded in the notes. A plan of management should be discussed with the woman and family and document this in the woman's notes. If the woman is a grand multipara or she has previous uterine scar her management should be discussed with a consultant before starting induction of labour. The Maternity Bereavement Checklist on Epic should be commenced.

3. CARBON MONOXIDE (CO) MONITORING

3.1 MBRRACE recommend a CO reading for all pregnancy losses. It is recommended that, although taken at booking, a CO test should be repeated on diagnosis of an IUD along with all the other tests carried out at this time. This is to gain as much information as possible for the parents. It should be carried out on all women, including non-smokers. It must be addressed in a sensitive way, reiterating that this is offered to all women and acknowledging that high readings can also be due to other environmental factors.

4. INDUCTION OF LABOUR

4.1 Stage one - Administration of Mifepristone & bloods

See Appendix - Protocol for administration of Mifepristone and Misoprostol

Mifepristone 200mg should be prescribed and given to the woman orally.

Following administration of Mifepristone, the woman should remain in the unit for one hour. Half hourly blood pressure recordings should be taken and recorded to monitor for hypotension.

Liaise with labour ward co-ordinator to make arrangements for the woman's admission to labour ward 36-48 hours later for misoprostol regime.

Advise the woman to contact MAMA's Line if she has any concerns such as bleeding, SROM or abdominal pains.

Bloods should be taken as per the Maternity Bereavement Checklist on Epic, consider taking maternal blood for C-Reactive Protein (CRP) measurement where there is a suspicion of Chorioamnionitis. All women should have a Kleihauer taken (this is to screen for feto-maternal haemorrhage which can be a cause of stillbirth and is also needed to assess the dose of Anti-D immunoglobulin required if the patient is Rhesus negative). Women whose blood group is Rhesus negative should receive Anti-D immunoglobulin even if their baby has been predicted to be negative on fFDNA. Please refer to the Trust 'Blood Transfusion Policy for Adult Patients with related guidelines', available on the [Policies page](#) of the intranet.

4.2 Stage Two - Management on labour ward

Ideally, she should use the bereavement suite (Rowan Suite at FPH or Willow Suite at WPH). The midwife looking after the woman should commence the appropriate maternity bereavement checklist on EPIC and administer the first dose of misoprostol. For dose see Appendix One Protocol for Mifepristone/Misoprostol for regime.

4.3 Flowsheets

Commence the use of the labour flowsheet on Epic with the first administration of misoprostol, and use to record all maternal observations, uterine activity and any PV loss. Observations should be undertaken three hourly, unless indicated earlier due to medical condition.

Vaginal examination will need to be performed for administration of the first dose of misoprostol which is normally vaginal administration. Further vaginal examinations may be performed to assess progress following discussion with the woman, although it is not absolutely necessary. Cervical dilation should be recorded on the Flowsheet should vaginal examinations be carried out.

Any vaginal loss (e.g. SROM/PV bleeding) should be recorded.

4.4 Completion of the regime

If the regime relevant to the gestation is completed, no further misoprostol should be given – further management must be discussed with the consultant. Options may include repeated course of misoprostol.

5. ANALGESIA

All pain relief options should be discussed. Epidural analgesia can be offered as a form of pain relief. Consider patient controlled analgesia (PCA) with morphine or remifentanil as these agents have the advantage over pethidine of a longer duration of action and of greater analgesic effect. PCA observations must be recorded appropriately on EPIC. Entonox, pethidine and morphine sulphate solution (Oramorph) are also available for pain relief.

6. SECOND AND THIRD STAGES OF LABOUR

6.1 Birth preferences

Women should have an opportunity to discuss their preferences for birth, such as position, analgesia and whether they would like to see the baby at delivery.

6.2 Delivery of baby and placenta

Once the baby has been delivered, the cord should be clamped and cut. One ampule of Syntometrine® should be given intramuscularly (unless there is a contraindication to the patient receiving ergometrine) and controlled cord traction should be used to deliver the placenta.

6.3 Retained placenta

If the placenta is retained, a speculum examination should be undertaken by the registrar/consultant to rule out it is sitting in the vagina.

If bleeding is excessive follow the 'postpartum haemorrhage' guidance.

If the placenta remains in situ undelivered inform labour ward co-ordinator, anaesthetist and theatre team to prepare for manual removal procedure.

It is important to communicate with all members of staff in theatre that this is a bereavement case, to avoid inappropriate comments.

7. POST BIRTH

7.1 Seeing/holding the baby

The attending midwife should give the woman and her partner the opportunity to see and hold the baby. If they are reluctant, their preferences should be respected and no pressure to view their baby should be exerted. The parents' wishes should be documented in the notes. The parents should be informed that they can change their mind about this should they wish to.

7.2 Maternal observations

Observations of respiration rate, temperature, pulse and blood pressure should be recorded on the postnatal flowsheet within Epic and a postnatal VTE assessment should be completed with medication prescribed if required. Ensure the uterine fundus is well contracted and bleeding is not excessive. Ask the parents if they would like to see a bereavement midwife for further support. The

obstetric consultant or registrar must see and review the woman prior to discharge.

7.3 Lactation suppressant

Please discuss with the woman and obstetric team the use of cabergoline as lactation suppression; there are contra-indications to this such as hypertension and pre-eclampsia (review BNF before prescribing). Supportive measures such as a firm fitting bra and analgesia should be discussed and offered in all cases.

7.4 Anti-D immunoglobulin

If the woman is blood group Rhesus negative and the baby is predicted positive or the status of the baby is unknown a further Kleihauer test should be taken and Anti-D should be administered post birth. Please refer to the Trust's 'Blood Transfusion Policy for Adult Patients with related guidelines', available on the [Policies page](#) of the intranet.

7.5 Examination of the baby

The midwife should examine the baby and record on EPIC:

- Weight
- Presence or absence of abnormalities
- Number of blood vessels in umbilical cord
- The appearance of the placenta
- Gender
- Label the baby with 2 labels (Baby of MOTHER's name, mums MRN, baby's DOB and address)

7.6 Cold cot

A cold cot or cuddle cot should always be used to ensure the baby is kept at an appropriate temperature when they are not being held/cuddled by family. Cold cots can be placed in the room with the parents if they wish.

7.7 Stillbirth certificate & registration

The midwife or attending doctor should complete the stillbirth certificate.

GMC/PIN numbers should be included and signatures should be accompanied by names and qualifications written in clear, capital letters.

- **WPH** - Stillbirth certificate (front and back) will be emailed to Slough registry by delivering midwife with parents contact details. Slough registry will contact parents with an appointment to register baby. The midwife should complete Epic records for stillbirth, i.e. Maternity Bereavement Checklist and Care after Death tab on baby's record
- **FPH** - The midwife should complete the stillbirth certificate and give the original to the bereavement midwives. The Bereavement midwives will email to Guildford registry with the parent details. The parents contact Guildford registry to book their appointment when they are ready. The midwife should complete Epic records for stillbirth, i.e. Maternity Bereavement Checklist and Care after Death tab on baby's record.

8. POST MORTEM EXAMINATIONS

8.1 Taking Consent

Post-mortem examination should always be discussed by a senior obstetrician or a midwife who has undergone training in obtaining consent. The Sands consent form should be completed if the family would like a post-mortem examination. Please refer to the “local information for consent takers” folder for more guidance if needed. This can be found in the Dandelion room at WPH and in the black folder in the Rowan cupboard at FPH. If they decline, the ‘Declining a post-mortem consent form’ must be completed – it is the parents choice but they should be given all the necessary information needed to make an informed decision.

8.2 Changing your mind section

The Sands consent form includes a “Changing your mind” section, which must be completed. The woman should be advised that she may contact the named individual by the specified time if she has changed her mind. This is normally 48 hours after the consent is taken. The post-mortem examination will not take place until that date has passed, and it must be completed. The discussion and the woman’s wishes must be recorded in the notes.

8.3 Frimley Park Hospital Protocol for baby going to mortuary

Send the baby in a body bag in a specialised cardboard coffin box and the placenta (dry) in a labelled pathology laboratory container with the accompanying post-mortem request forms. Please provide as much information as possible on the request forms and include copies of relevant scans to give the pathologist as much information as possible. Please ensure that the baby is dressed as they will not be accepted for PM without this.

The baby must have two name labels with the mother’s details to include-name, DOB, hospital number and NHS no. There must also be two completed late fetal loss identification labels- one goes in the window of the bag and the other on top of the coffin. Labels can be found in the pink packs.

All paperwork should be left for the bereavement midwives in the Rowan cupboard and will be forwarded to the John Radcliffe Hospital Oxford mortuary if a post-mortem examination is requested. If a post-mortem is declined, please ensure the ‘Declining a post-mortem consent form’ is completed and left for the bereavement midwives.

8.4 Wexham Park Hospital Protocol for baby going to mortuary

The baby should be dressed and labelled clearly with two name labels, prior to the transfer (with Baby of MOTHER’s name, mums MRN, baby’s DOB and address). The baby should then be placed in an appropriately sized body bag and a cot card placed in the clear window for easy identification.

If going for post-mortem, the placenta should be dry in a specimen pot, clearly labelled and sent with the baby to the mortuary for transfer. If not going for post-mortem, the placenta should be sent to histology.

The original post-mortem pack and relevant forms as well as copies of all ultrasound scans/genetic test results should accompany baby to the mortuary, prior to transfer these should be scanned and emailed to the Bereavement midwives and be uploaded onto Epic.

Any belongings should be clearly marked with the maternal addressograph and sent with baby in the appropriately sized body bag. A midwife and a porter should transfer the baby in the transfer box to the mortuary and ensure the sign out book on Willow suite is completed when leaving. The midwife should complete the mortuary sign in book on arrival to the mortuary and the porter should sign it. Original paperwork should be left in the box below the sign in book.

9. FUNERAL ARRANGEMENTS

9.1 Parents need to register the stillbirth of their babies and will be given a release form from the registrar; this form is required to proceed with the funeral.

9.2 Frimley Park Hospital

The parents need to make their own funeral arrangements.

They may wish to contact a funeral director of their choice or a list of local funeral directors can be provided who will liaise with the mortuary technician over the collection of the baby. The mortuary will hold the baby for as long as required to organise the funeral. The basic costs of the funeral will be covered by The Children's Funeral Fund for England – this will be claimed back by the Funeral Directors.

9.3 Wexham Park Hospital

The parents need to make their own funeral arrangements.

They may wish to contact a funeral director of their choice or a list of local funeral directors can be provided who will liaise with the mortuary technician over the collection of the baby. The mortuary will hold the baby for as long as required to organise the funeral. The basic costs of the funeral will be covered by The Children's Funeral Fund for England – this will be claimed back by the Funeral Directors.

10. POSTNATAL FOLLOW UP

The community midwives should be notified of the pregnancy loss and should offer postnatal visits to be led by the woman.

The bereavement midwives should be notified of the loss and will follow up with a phone call or visit as required by the woman.

All women should be offered follow up debrief with a consultant approximately 12 weeks after discharge from hospital.

All women should be given information about sources of local peer support, and how to access further support following their pregnancy loss.

11. INFORMING ANTENATAL CLINIC, SCREENING, HEALTH VISITOR AND GP

It is imperative that all members of the multi-disciplinary care team are aware of the pregnancy loss. It is extremely upsetting for women to receive invitations for

appointments, or visits from community midwives who are unaware of the situation. The Maternity Bereavement Checklist advises who should be informed of the loss (GP, antenatal clinic, community midwives, health visitors and if necessary, Child Health and the Safeguarding team) and this should be actioned by the midwife when the loss is diagnosed. The discharging midwife must ensure the Maternity Bereavement Checklist is completed and that a 'Notification of pregnancy loss' letter is sent to the GP via Epic.

12. COMMUNICATION

If there are communication issues (e.g., English as a second language, learning difficulties, visual or hearing impairments, staff should take appropriate measures to ensure the patient (and her partner, if appropriate) understand the actions and rationale behind them. Please make use of the hospitals approved interpreter service or hospital translator/staff list. Please document if these services are unavailable and the reason why.

13. EQUALITY AND DIVERSITY ASSESSMENT

This guideline has been subject to an equality impact assessment.

14. AUDITABLE STANDARDS

- Completion of the Maternity Bereavement Checklist on Epic
- Follow up appointment arranged with the consultant

15. MONITORING COMPLIANCE

This guideline will be subject to a three yearly audit.

The audit midwife is responsible coordinating the audit.

Results will be presented at the department clinical audit meeting.

Action plans will be monitored at the quarterly department clinical governance meeting.

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APPENDIX - Protocol for Administration of Mifepristone & Misoprostol

WARNING : Staff who are or may become pregnant should not handle crushed, broken or dispersed tablets.

Misoprostol tablets are dispensed as 200 microgram tablets, the tablets may be cut with a pill cutter if smaller dose required. Sublingual or buccal administration of misoprostol is advised as this improves absorption and bioavailability.

Protocol for administration of Mifepristone (Mifegyne 200 mg) & Misoprostol (Cytotec 200 micrograms) drug regimes for termination of pregnancy or induction of labour following intrauterine fetal death

Caution with women who have a uterine scar or are a grand multipara and be aware that the uterus is more sensitive to misoprostol as pregnancy advances so risk of uterine rupture increases.

DRUG	GESTATION	DOSE	FREQUENCY
Mifepristone	>12 weeks – all cases	200 mg orally (consider 600mg if weight >100kg and /or nulliparous)	Once
Misoprostol (36 - 48 hours interval post Mifepristone)	12 - 24+6 weeks	1 st dose 800 mcg PV Thereafter at 3 hourly intervals 400 mcg sublingual/buccal	3 hourly until delivery (consider 12hr break after 5 doses)
	25-27+6 weeks	1 st dose 400 mcg PV Thereafter at 4 hourly intervals 200 mcg sublingual/buccal	4 hourly until delivery (consider 12hr break after 4 doses)
	> 28 weeks	1 st dose 200mcg PV Thereafter at 6 hourly interval 100mcg sublingual/buccal	6 hourly until delivery

3. EFFICACY & SAFETY

Regimen	Failure rate	Time to expulsion	Major adverse events	Risks	Failure rate
Mifepristone + Misoprostol	At 36 hours: <1%	6-9 hours	<1%	Failed induction	<1 in 100
Misoprostol only (Alternative regimen if mifepristone not available)	At 48 hours: <10%	12-18 hours	<1%	Retained placenta or retained products of conception	5-8 in 100
				Need for further intervention to complete the procedure	13 in 100
				Infection	<2 in 100
				Severe bleeding requiring transfusion <20 weeks	<1 in 1000
				Severe bleeding requiring transfusion >20 weeks	4 in 1000
				Uterine rupture	<1 in 1000



6. CONTRAINDICATIONS & CONSIDERATIONS

MEDICAL ABORTION

CONTRAINDICATIONS

- Allergies to meds
- TO MIFEPRISTONE
- Severe uncontrolled asthma
- Inherited porphyria
- Chronic adrenal failure

CONSIDERATIONS

- Long term steroids
- Bleeding disorders
- Anticoagulant medication
- Symptomatic anaemia
- IUD in place

7. VENOUS THROMBOEMBOLISM RISK

CURRENTLY FULLY ANTI-COAGULATED:

- Treat in hospital setting
- Advice from haematologist

HIGH RISK OF VTE: THROMBOPROPHYLAXIS NEEDED

- Consider giving LMWH for at least 7 days after abortion

8. CONSENT

Verbal consent valid

Written consent form standard practice
Pre-printed consent forms are useful

Information on method
(and feticide if needed)

Risks & complications

What to expect before,
during and after the abortion

BEFORE THE PROCEDURE

- When to take mifepristone
- Can eat and drink
- Where and when to come
- Need for further investigations/medication adjustment

DURING THE PROCEDURE

- How misoprostol will be taken
- Amount of pain and bleeding
- How pain will be managed
- How long the abortion will take
- May see fetus and placenta
- May see some reflex movements from 16-17 weeks

AFTER THE PROCEDURE

- Amount of pain and bleeding
- When they can go home
- Need for someone to accompany them home
- Whether they can drive
- Need for medication

Women undergoing VBAC should be closely monitored for signs of scar rupture - fetal heart rate abnormality, usually the most common sign of early scar dehiscence, does not apply in this circumstance. Other clinical features include maternal tachycardia, atypical pain, vaginal bleeding, haematuria and maternal collapse.

Misoprostol can be safely used for induction in women with a single previous Caesarean Section and an Intrauterine Fetal Death/TOP. Women with 2 or more previous Caesareans or an atypical scar should be advised that the safety profile is not known but reasonable to proceed with caution.

In the context of ruptured membranes – intravenous oxytocin is less effective than Misoprostol which demonstrates a reduced induction to delivery interval. Gestations <27 weeks will not have effective oxytocin receptors and PV/sublingual or bucal Misoprostol

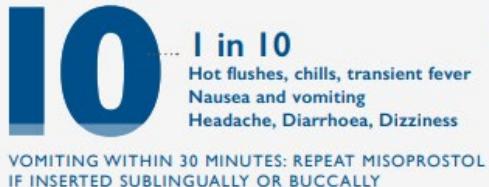
is preferred. For gestations >27 weeks oxytocin can be considered after discussing with a consultant obstetrician (Misoprostol is usually first line).

4. SIDE EFFECTS

Mifepristone side effects:

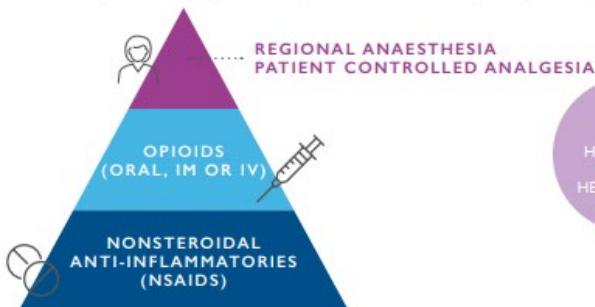


Misoprostol side effects:



5. PAIN MANAGEMENT

Pain usually starts shortly after misoprostol administration, peaking with expulsion



If delivery has not occurred following the above regimes, a consultant review must be undertaken prior to further management.

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Full version control record

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This guideline has been registered with the Trust. However, clinical guidelines are guidelines only. The interpretation and application of clinical guidelines will remain the responsibility of the individual clinician. If in doubt, contact a senior colleague or expert. Caution is advised when using guidelines after the review date.

This guideline is for use in Frimley Health NHS Foundation Trust hospitals only. Any use outside this location will not be supported by the Trust and will be at the risk of the individual using it.

Version History

Version	Date	Guideline Lead(s)	Status	Comment
1.0	Sept 2016	Monica Eve, Tabitha Sturridge, Joyce Cruse	Final	First cross-site guideline
2.0	May 2019	Monica Eve, Jo Cox, Claire Litchfield	Final	Updated and approved at OGCAC
2.1	June 2021	Monica Eve, Jo Cox, Claire Litchfield	Interim	Removal of Mysodelle.
3.0	October 2024	Monica Eve, Anna Kemsley, Cassie Appleton, Anne Deans	Final	Scheduled review, ratified at cross site obstetric clinical governance meeting 01.10.2024

Related Documents

Document Type	Document Name
Guideline	Intrauterine Fetal Death > 24 weeks gestation
Guideline	Termination for fetal abnormality
Policy	'Blood Transfusion Policy for Adult Patients with related guidelines'
Leaflet	Taking a deceased baby home
Leaflet	Deciding on Post Mortem (SANDS)
National Best Practice	National Bereavement Care Pathway