Frimley Health
NHS Foundation Trust

Late Fetal Loss (16 weeks to 23+6 weeks 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, Termination of pregnancy, Miscarriage, Late Fetal Loss, misoprostol, mifepristone, funeral, postmortem

Abbreviations

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

Contents

1. Introduction

1.1 This guideline covers late fetal loss 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 Bereavement checklist for fetal loss up to 23+6 weeks gestation for IUD and TOP should be completed on Epic cross-site

2. 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 obsetrician should see the woman and her partner 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 and documented in the woman's notes. Written information leaflets about the process of induction of labour should be given to the woman. 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 should be commenced. Where possible they should be moved to an appropriate environment for review such as the Rowan/Willow Suite.

3. Carbon Monoxide (CO)

3.1 The MBRRACE report now requires a CO reading. 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. Consider 600mg if the woman's weight >100kg and /or nulliparous.

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 (FPH & WPH) if she has any concerns such as bleeding, SROM or abdominal pains.

Bloods should be taken as per the checklist, 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 fetal demise 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 or the Rhesus status of the fetus is unknown. 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 use the appropriate Epic checklist/bereavement pack for fetal loss up to 23+6 weeks of gestation.
See Appendix – Protocol for administration of Mifepristone and Misoprostol

4.3 Flowsheets for induction of labour

Commence the labour flowsheet on Epic at 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 and delivery has not occurred, further management must be discussed with the consultant.

Options may include repeated course of misoprostol.

5. Spontaneous Labour with Inevitable Delivery of Extremely Premature Baby or IUD

These are women who are in spontaneous labour before 22 weeks whose baby is going to inevitably be born with no heartbeat or, if born with signs of life, resuscitation is not being planned due to extreme prematurity. It is important that a full discussion has been had with the woman and her partner, with paediatric team if necessary, about management if signs of life are present after birth and resuscitation is no planned due to extreme prematurity.

5.1 Bereavement room

The woman should ideally use the Rowan suite FPH or Willow Suite WPH. The midwife looking after her should use the appropriate checklist for fetal loss up to 23+6 weeks of gestation.

5.2 Flowsheets for spontaneous labour

Commence use of the labour flowsheet on Epic when the woman is contracting regularly and record all observations, uterine activity and any PV loss.

5.3 Excessive bleeding

Inform the registrar if there is excessive bleeding per vagina and monitor observations every 15 minutes. The woman and her partner will need support and reassurance throughout.

6. Possibility of a Live Birth

Refer to guideline Preterm birth: reducing incidence and management + use of tocolysis.

7. 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.

8. Second and Third Stage of Labour

8.1 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.

8.2 Delivery of baby and placenta

The baby and placenta may be delivered together, if not, clamp and cut the cord immediately and wait**. Do not give syntometrine®**. If the woman's condition is stable and there is no excessive bleeding, observations should continue and two hours should be allowed to deliver the placenta. If a dose of misoprostol was due within this time, it should be given. If bleeding is excessive follow the postpartum haemorrhage guidance.

8.3 Retained placenta

If the placenta is retained beyond two hours, a speculum examination should be undertaken by the registrar/consultant to attempt to deliver.

If bleeding is excessive, give ergometrine 500 micrograms intramuscular.

If the placenta is retained, inform labour ward co-ordinator, anaesthetist and theatre team to prepare for manual removal. It is important to communicate with all members of staff that this is a bereavement case, to avoid inappropriate comments.

9. Post Birth

9.1 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.

9.2 Maternal observations

Observations of respiration rate, temperature, pulse and blood pressure should be recorded on the postnatal flowsheet. A postnatal VTE assessment should also be completed and 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 the woman prior to discharge.

9.3 Lactation suppressant

Please discuss with the woman and obstetric/gynaecological 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.

9.4 Anti- D immunoglobulin

If the woman is Rh negative and the baby is predicted positive, or the status of the baby is unknown a further kleihauer test should be take 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.

9.5 Examination of the baby

The midwife should examine the baby and record in the notes:

- Weight
- Presence or absence of abnormalities
- Number of blood vessels in umbilical cord
- The appearance of the placenta

- Gender. It may be difficult to determine the gender of a baby at early gestation. In this case, check with a second midwife and the sex can be recorded as indeterminate pending further tests if parents wish to find out.
- Label the baby with 2 labels (Baby of MOTHER's name, mums MRN, baby's DOB and address)

9.6 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.

9.7 Paperwork for completion

The midwife should complete:

- The Maternity Bereavement Checklist on EPIC/bereavement pack for fetal loss from 16+0 to 23+6 weeks.

10. Post-mortem

10.1 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.

10.2 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.

10.3 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.

10.4 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.

11. Funeral Arrangements

Note: Parents do not have to register the birth or death of a baby under 24 weeks gestation unless it was a neonatal death. They may request a Baby Loss Certificate from the following Gov.uk website if they wish to https://www.gov.uk/request-baby-loss-certificate - it does not entitle them to any benefits but is a recognition of their baby's birth

11.1 Frimley Park Hospital

The Certificate of Practitioner in respect of fetal remains form (found in pink folder pack in cupboard next to Rowan Suite) should be completed by the midwife or doctor attending the delivery and left for the bereavement midwives in the Rowan cupboard. The midwife should advise the parents of the options concerning funeral arrangements.

Option 1- Own arrangements

If the parents wish to organise the funeral they may wish to contact a funeral director of their choice 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.

Option 2 – Hospital cremation

The hospital can offer an individual cremation service at Aldershot Crematorium. Both the service and the cremation are individual. The baby's ashes can be collected. The woman will be given a form to complete to state her preferences for funeral arrangements. On completion this form should be returned to the bereavement midwives or hospital chaplain. This may be completed pre-discharge or returned by the woman after discharge.

11.2 Wexham Park Hospital

The attending midwife or doctor should complete the Certificate of Medical practitioner, in the bereavement pack. Parents should be given the Funeral Arrangements leaflet. The bereavement midwives can discuss funeral options with the family either before or after discharge.

Option 1 – Own arrangements

Parents can make independent arrangements with a Funeral Director. They will be responsible for contacting a funeral director who will arrange collection of the baby

from the mortuary. Parents should be advised that some Funeral Directors charge a fee for funerals of babies <24 weeks. The midwife should document the parents decision regarding funeral arrangements on the Epic Bereavement Checklist.

Option 2 – Hospital cremation

The hospital can arrange a cremation service, at Slough Crematorium conducted by the hospital Chaplain. Babies are individually cremated; however, parents must be made aware this is a communal service and a small number of other families will be invited to attend. The midwife should document the parents' decision regarding funeral arrangements on the Epic Bereavement Checklist. If they opt for hospital cremation, the appropriate forms in the bereavement pack should be completed.

12. Postnatal Follow-up

Women discharged on Epic should be seen at the next available opportunity by a member of her community team. The community midwives receive notification of delivery and discharge summary once this is completed on Epic. The woman should be given the contact details of the bereavement midwives if not already provided and advised to contact MAMAs Line out of hours if any clinical concerns. 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 a debrief appointment with their consultant approximately 12 weeks after discharge from hospital. All women should be given the opportunity to access counselling following discharge and referral should be implemented if this is accepted. Women can be given information about sources of local peer support, and how to access further support following their pregnancy loss.

13. 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.

14. 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.

15. Equality and Diversity Assessment

This guideline has been subject to an equality impact assessment

16. Auditable Standards

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

17. 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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Further Reading

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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	1st 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	1st 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	1st 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
Mifepristone + Misoprostol	At 36 hours: <1%	6-9 hours	<1%
Misoprostol only (Alternative regimen if mifepristone not available)	At 48 hours: <10%	12-18 hours	<1%

Risks	Failure rate
Failed induction	<1 in 100
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

Without previous caesarean deliveries: **1 in 10,000**

With previous caesarean deliveries: **2.8 in 1,000**

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 f or 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

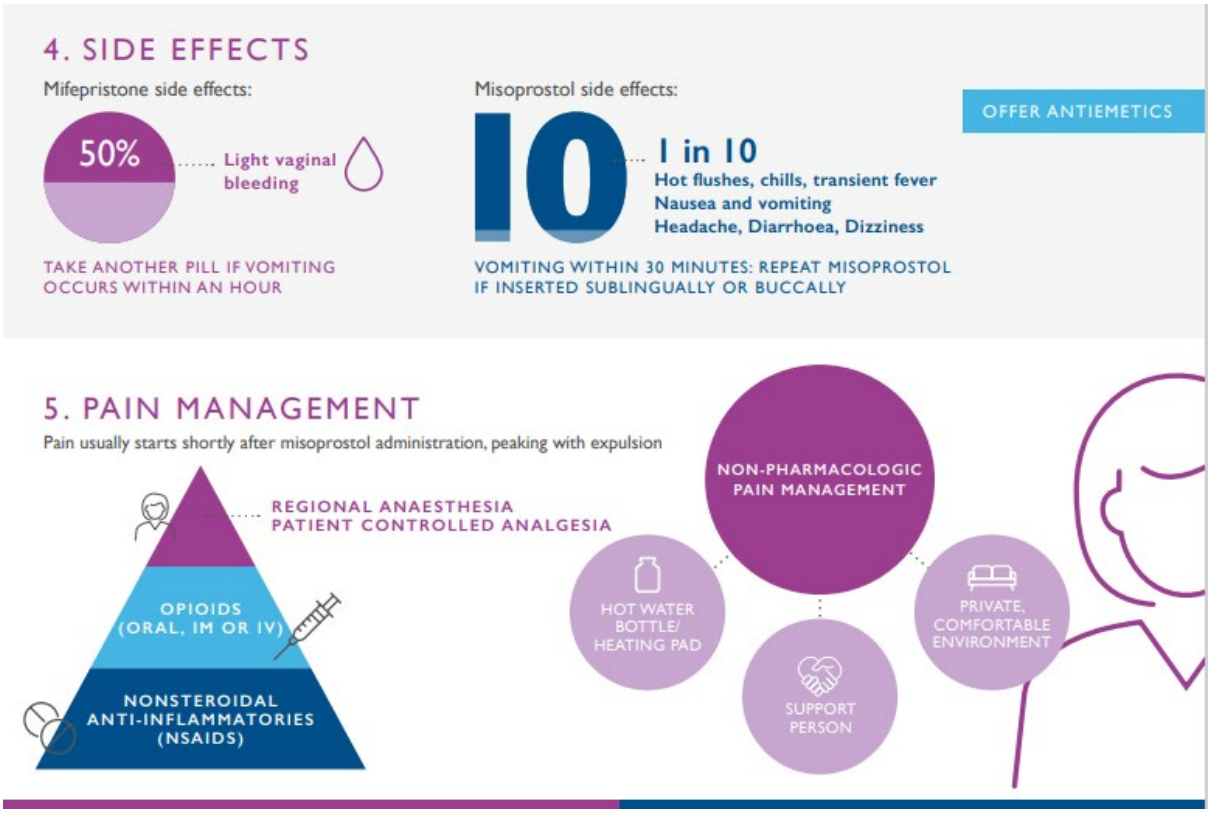
AFTER THE PROCEDURE

- 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 buccal Misoprostol is preferred.



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

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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
2.0	May 2019	Monica Eve, Jo Cox, Claire Litchfield	Final	Updated and approved at OGCGC
2.1	June 2021	Monica Eve, Claire Litchfield	Interim	Removal of Mysodelle. Ratified at cross site Obs clinical governance meeting 28/10/2021. New template applied.
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	Preterm birth: reducing incidence and management + use of tocolysis
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