1. Patient choice

Mid trimester induction of labour is associated with significant psychological and physical distress to both the woman and her partner. Health professionals must offer support to help the woman and her family cope with the emotional and physical consequences of the death. This must include offering information about specialist support (see bereavement guidelines and postnatal support for parents).

In the event of an intrauterine death, if the woman is physically well, with intact membranes and no evidence of infection or bleeding the choice of immediate induction or expectant management should be offered. If there is evidence of ruptured membranes bleeding or infection, immediate induction is the preferred management option.

2. Mifepristone (RU486) & Misoprostol

Traditional methods using prostaglandin pessaries require repeated vaginal examinations and the process may be painful and protracted. Pre-treatment with the anti-progesterone mifepristone significantly reduces the induction to abortion interval, and in combination with the PGE₁ analogue misoprostol, usually requires a single vaginal examination.

3. Procedure

- Check for confirmation of miscarriage / IUD / abnormality by experienced sonographer and in cases of TOP that the blue form Certificate A, required under the 1967 Abortion Act, has been signed by two appropriate clinicians.
- The woman’s consultant is required to sign the form from pharmacy authorising the unlicensed use of Mifepristone for mid-trimester TOP.
- Arrange a specific time for the Mifepristone to be administered, preferably by the staff who will continue to provide care.
- Explain the method of induction to the woman and her partner thoroughly. Discuss the need for maternal and fetal investigations and warn of the possibility of uterine evacuation for retained products of conception (required in 5% of cases).
- If gestation greater than 21+6 weeks at the expected date of delivery offer fetocide. Where declined warn parents of possibility of the baby being born alive.

4. Fetocide prior to medical termination of pregnancy

Any patient undergoing termination of pregnancy (TOP) beyond a gestational age of 21+6 weeks should be counselled by her consultant regarding fetocide prior to
commencement of a TOP. Any fetus at any gestation may show signs of life following a medical termination of pregnancy and every woman should be counselled of this possibility prior to TOP. Staff should also be aware of this and be prepared for this eventuality. In the circumstances where a fetus is close to, or beyond viability, fetocide is recommended. If a parent opts not to undergo fetocide prior to TOP, the case is to be discussed at consultant level with the paediatric and midwifery staff involved with the patient’s care. This is to plan that appropriate action and care can be given at the time of birth. The fetocide procedure will take place within the ultrasound department and be conducted by either Dr Montague or Mr Welch. If they are unavailable, the patient is to be referred to the Fetal Medicine Unit in St Michael’s Hospital in Bristol for this procedure. Following this the woman will commence the TOP with mifepristone. This is followed by admission to the hospital 36-48 hours later for prostaglandin.

5. Mifepristone followed by Misoprostol

NB – if patient is P4 or more, previous caesarean section or other high risk factors consider using half doses throughout procedure until delivered. If more than one risk factor exists the use of Misoprostol should be avoided. The decision to use medical methods of termination in these situations must be registrar level or above.

Day 1
- Obtain informed consent for termination of pregnancy and ERPC
- Prescribe Mifepristone orally (3x200mg). Mifepristone can be administered by a midwife (as long as a doctor prescribes it).
- Patient to stay on the ward for one hour. Record temperature, pulse and BP.
- Allow home for 36-48 hours. Warn usually asymptomatic but may experience nausea, headache, skin rash, vaginal bleeding and abdominal colic. Patients may readmit themselves earlier if they wish, and should be given a contact number in case she has any problems or worries.
- Offer referral to clinical psychologist, and if accepted arrange for ward visit.

If the woman does NOT wish to go home the midwife should:
- Discuss choices and options for care as above.
- Arrange admission to CDS or Norfolk ward as appropriate
- Inform SHO of decision to stay

Readmission 36 – 48 hours
- Discuss re-admission with the woman. Offer her the choice to be cared for on CDS or Norfolk ward.
- Agree with the woman a time for re-admission, but stress that she can return earlier if she wishes.
- Arrange re-admission with appropriate ward / area.
- IF the woman is being re-admitted to CDS, ask her to report to maternity reception on her return.
- Provide ward / CDS telephone numbers
- Inform CDS and maternity reception of the arrangements and circumstances
- Check that the Misoprostol will be available on her readmission
- Inform the community midwife
- Ensure that the general practitioner is informed

Management
- Site IV line, flush and cap.
- Send blood for FBC, G&S, and maternal investigations as appropriate (see Stillbirth folder).
• VE to assess cervix and insert Misoprostol tabs into posterior fornix (see table 1 for dose regime). This may be given orally dependent upon patient preference. Patient to remain on bed rest for one hour.
• Prescribe Misoprostol for a maximum of four doses.

Table 1. Dose regime for misoprostol

<table>
<thead>
<tr>
<th>Misoprostol</th>
<th>Up to 24 weeks gestation</th>
<th>24 weeks + gestation</th>
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<tbody>
<tr>
<td>1st dose</td>
<td>800 mcg PV</td>
<td>200 mcg PV</td>
</tr>
<tr>
<td>2nd and subsequent doses</td>
<td>400 mcg O/PV every 3 hours</td>
<td>200 mcg O/PV every 6 hours</td>
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</tbody>
</table>

• Side effects are nausea, vomiting and diarrhoea (usually mild). Note that prostaglandin-associated pyrexia is common, transient and not a contraindication to continuing with prostaglandin administration.
• Prescribe appropriate anti-emetics and narcotic analgesia.
• The patient may eat, drink and remain independent as desired.
• Establish whether the parents wish to see or hold the baby when born
• Where fetocide has not been performed ensure the parents are aware of the remote possibility of the baby being born alive
• Vaginal bleeding usually occurs 2 hours after insertion of the pessary.
• Inform on call team if patient not delivered by 1700 hours.
• Consider syntometrine 1 ampoule IM. If delivery of placenta is delayed and there is minimal bleeding then wait four hours until arranging evacuation in theatre, or continue with Misoprostol until the maximum of oral doses has been given.
• The patient must be accompanied home and have a carer with her for the first 24 hours.
• Arrange appropriate follow up according to individual consultant preference.

If the woman remains undelivered after administration of prescribed doses an obstetric registrar must review prior to further treatment. This may be further Misoprostol or ARM and Syntocinon.

6. Misoprostol alone
If immediate commencement of IOL is required then Misoprostol may be used alone. This is on the understanding that Mifepristone will reduce both the pain and the induction-delivery interval.

Regimen:
200 micrograms orally 6 hourly to a maximum of six doses.
• If the delivery of placenta is delayed and there is minimal bleeding then wait four hours until arranging evacuation in theatre, or continue with the Misoprostol until the maximum of oral doses has been given.
• Side effects may include nausea, vomiting and diarrhoea (usually mild). Anti-emetics are only occasionally required.

7. Care of woman during induction and whilst in labour
All care should be provided according to minimum standards in intrapartum care guideline 12 (Induction of labour) and 13 (intrapartum care), with the exception of fetal monitoring.

8. Termination of pregnancy - special note.
If a midwife does not wish to be involved in the management or care of a woman undergoing a termination of pregnancy this **must** be respected and an alternative midwife allocated.

9. **Record keeping**
All entries must have the **date and time** together with **signature and printed name**. Notes to be used are the Perinatal Institute notes. However, not all the records will be appropriate for the woman and her family. Please remain sensitive to parent’s requirements.
Please refer to intrapartum care guideline 15 – appendices that show paperwork to be completed for IUD and stillbirth.
Monitoring and Audit

Auditable standards:
Please refer to audit tool, location: ‘Maternity on cl2-file11’, Guidelines

Reports to:
Clinical Effectiveness Committee – responsible for action plan and implementation of recommendations from audit

Frequency of audit:
Annual

Responsible person:
DAW / Labour ward midwife

Cross references

Antenatal guideline 31: Maternity Hand Held Notes, Hospital Records and Record keeping
Antenatal Guideline 44 – Guideline development within the maternity services
Intrapartum care guideline 12 – Induction of labour
Intrapartum care guideline 13 – Care in labour
Intrapartum care guideline 15 – Management in cases of fetal loss
Postnatal guideline 15: Support for parents
Neonatal care pathway - bereavement

References


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<tr>
<td>Work Address</td>
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| Changes | Use of Misoprostol before and after 24 weeks gestation
Fetocide amended to 21+6 weeks |
| Date Ratified | July 14 | Valid Until Date | July 17 |