Induction of Labour - Intrauterine Death - Summary Clinical Guideline

Reference no.: IP/11:15/F10

Executive summary

To be followed in the event of the death of the fetus in the late second or third trimester, where induction of labour is required. This may be due to a spontaneous intra-uterine fetal death or following termination of pregnancy for fetal abnormality. Termination may have commenced with feticide using intra-cardiac potassium chloride if taking place beyond 20 weeks gestation.

Consent

Valid consent must have been obtained. Blood should have been taken for full blood count and Group & Save, as well as for any other investigations indicated

Second Trimester

In general, sensitivity to Misoprostol (synthetic prostaglandin E1 analogue) increases with gestation and is further increased by both fetal demise and administration of Mifepristone (progesterone receptor blocker) 36 to 48 hours prior to Misoprostol.

Induction of labour with intra-uterine fetal death (IUFD) between 12 and 24 weeks gestation

See body of full guideline – page 3 section 5.1

In-Patient Care

Up to 20 weeks gestation, the most appropriate place for administration of Misoprostol to take place would be on the gynaecology ward. Beyond 20 weeks, administration of Misoprostol should take place on labour ward wherever possible

Implications of a Uterine Scar

The presence of a previous Caesarean section scar significantly increases the risk of uterine rupture, but there is no good trial evidence to identify any one best method of induction in this situation. Women with a uterine scar requiring induction of labour for IUFD should therefore be counselled about the risk of uterine rupture and the appropriate regimen for the gestation (as above) to be commenced with caution

Induction of labour following fetal death in the third trimester

See body of full guideline – page 4 section 6

Multiple Pregnancy

Where two or more fetuses require delivery after they have died, a plan for intrapartum care should be formulated by the Consultant Obstetrician overseeing their delivery.

Gender Determination of Miscarried or Terminated Fetus

It is not always possible to confirm the gender of the fetus below 24 weeks and if this is the case a 2nd opinion must be sought.

Documentation of Initial Examination of the Baby Following Intra-Uterine Fetal Death

Description of the condition of the baby may help estimate the time of intrauterine death, thus helping clarify the events around this time, particularly if a post-mortem (PM) has been declined. This can be carried out by the midwife/obstetrician or paediatrician if present, and documented in the medical records.

Description's to be used are listed full guideline -page 6 section 10.1

Caring for Parents Post Delivery

Place of transfer should be according to mother's preference. The woman may wish to go home, stay on Labour ward, be cared for on the postnatal ward 314 or transfer to the gynaecology ward 209.

Request for Post Mortem

Obtaining consent should be the responsibility of a member of the team suitably trained in obtaining consent. Good practice recommends that consent for examination is obtained for all fetuses, both pre and post 24 week's gestation.

Lactation Suppression

If pharmacological lactation suppression is given, a single oral dose of Cabergoline 1mg post-delivery is the optimal treatment, with fewer side effects and less rebound lactation.