HUTT maternity
Hutt Valley Maternity Care

HUTT VALLEY DHB

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Facilitated by: Eleanor Martin, Educator	Last reviewed: August 2019
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Mid Trimester Pregnancy Loss Policy

Hutt Maternity Policies provide guidance for the midwives and medical staff working in Hutt Maternity Services. Please discuss policies relevant to your care with your Lead Maternity Carer.

Indications

1) Mid trimester miscarriage (foetal size >12+6/40)
   For miscarriages < 12+6/40 size, see protocol 'miscarriage management'
2) Medical termination of pregnancy for foetal anomaly
   (Termination of pregnancy for indications other than foetal anomaly will be performed at Te Mahoe unit in Wellington)

NB

1) AN IUFD at >20/40 should follow the stillbirth protocol
2) for TOPs or miscarriages at 12/40 – 14/40 size, a surgical TOP or ERPOC can sometimes be performed but this MUST be discussed with the SMO and MUST NOT be performed by a junior registrar.

Purpose

To ensure that women, their partners and whanau facing or experiencing pregnancy loss
To support clinicians in the management of women who have a mid trimester pregnancy loss or mid trimester termination of pregnancy.

Principles

Women should be offered evidence-based information and support to enable them to make informed decisions about management of their pregnancy. Womens' views and concerns are an integral component of the decision making process

Scope

Nursing, medical and midwifery staff in the Maternity Assessment Unit and midwifery and medical staff in maternity.

Definitions

Mid trimester Pregnancy loss: gestation from 12+6 weeks to 19+6days.
Miscarriage: The recommended medical term for pregnancy loss under 20 weeks is 'miscarriage' in both professional and patient contexts. The term 'abortion' should not be used.
Missed miscarriage: a non-viable intrauterine pregnancy. No foetal heart activity is seen, the gestational sac is intact, the cervix is closed and no POC have been passed.

Stillbirth: foetal loss at > 20 weeks gestation or >400g
(R)POC: (Retained) products of conception. When discussing with women & their whānau, use a term such as 'pregnancy tissue', not 'products of conception'.
Recurrent Miscarriage: 3 or more consecutive first trimester miscarriages
ERPOC: Evacuation of retained products of conception
ED: Emergency Department
MAU: Maternity Assessment Unit

Background

Mifepristone is a synthetic steroid, which blocks the action of progesterone that maintains a pregnancy. It also softens the cervix. It works best if followed in 48 hours by Misoprostol.

Requirements prior to giving medication

If mid-trimester miscarriage, formal reported scan documenting absence of foetal heart.

If TOP for foetal anomaly, Abortion Supervisory Committee Forms ASC3 and ASC4 must be signed by two certifying consultants/practitioners, before giving medications and admission to maternity.

The admitting Dr has right of refusal[1] re involvement in TOP management on the grounds of personal beliefs. However, they MUST organise another doctor to do the admission or inform the on call SMO. If the patient is acutely unwell, there is a duty of care and all doctors are legally required to provide emergency care. Likewise midwifery/nursing staff have the right to refuse to care for women undergoing medical inductions. Midwifery and nursing staff are to inform CMM of their preference, in a timely fashion, so appropriate rostering can be arranged.

If > 12+6/40 will be managed on labour ward.

Procedure

In MAU, the admitting Dr should complete the following paperwork:

- Prescribe mifepristone and the misoprostol regime
    - Mifepristone 200mg PO
    - Misoprostol as below:

Misoprostol Dose (mcg)				
1st dose Start time	2nd dose 3 hours	3rd dose 6 hours	4th dose 9 hours	5th dose 12 hours
800	400	400	400	400

- Prescribe appropriate analgesia and anti-emetics (PCA is available on the ward if required).

[1] Clinical staff may decline to care for the woman on the grounds of personal beliefs however appropriate replacement must be found.

Analgesia:
Paracetamol 1g PO 1id
Diclofenac 50mg PR or PO tds
Codeine Phosphate 60mg PO quid
Pethidine 75-100 mg IM q 4 hourly or 25mg IV

Antiemetics:
Prochlorperazine 3mg PO
Metaclopramide 10mg IV / IM / PO
Ondansetron 4mg IV / IM / PO

- Complete lab forms for mid trimester pregnancy loss investigations, if required
- Consent for and chart Anti D if patient is Rhesus negative
- Referral to Gynae Outpatients Clinic for follow up appointment to discuss results
- Counsel the woman on the miscarriage procedure. Discuss cremation/tissue disposal options and sign paperwork as necessary.

Mifepristone should be prescribed in the 'once only' section of the drug chart by the admitting doctor. The mifepristone is kept in the controlled drug cupboard in MAU. It must be signed out of the controlled drug book by two registered practitioners and administered to the woman.

Mifepristone is administered in MAU. Prescribe and (orally) administer 200 milligrams of Mifepristone (1 tablet from a 3 tablet blister-pack of Myfegyne®) to the woman (to initiate the termination / delivery of her pregnancy).

After Mifepristone administration, woman should remain for 60 minutes to ensure that the dose is not vomited and the patient is clinically stable. If the dose is vomited another dose can be given.

If the woman has been fully informed, an hour has elapsed and no adverse effects noted, then she may now leave the MAU. Clear instructions should be given to return in 48 hours (unless symptoms have caused her to return sooner — in which case, consider commencing the next drug regimen, Misoprostol, earlier).

The woman must have written information on how to contact delivery suite if heavy bleeding and must have the ability to return to hospital if necessary.

A bed must be booked in labour ward – contact senior midwife

The RMO/admitting doctor should ensure that the patient is recorded on the RMO handover sheet, to ensure that medical staff on call are aware the patient is in the community, having had Mifepristone.

Give Mifepristone and Misoprostol Information leaflet, SANDS pamphlets, coping with miscarriage booklet.
MAU midwife/nurse to provide info on location, time of admission, what to expect on admission, access to a single room, average length of stay.

The woman is admitted to labour ward 36-48 hours following mifepristone for misoprostol induction. If woman prefers not to wait then she can proceed immediately with misoprostol induction. The benefits of mifepristone are that it reduces the time spent in hospital for the induction of labour process and reduces the number of doses of misoprostol required.

Under 20/40 there are no legal requirements for burying the baby. Parents can take the baby home if they wish or elect for hospital disposal. The parents can contact a funeral director of their choice. Some funeral homes will cremate baby for no charge if <20 weeks. If >20 weeks cremation costs are around $75 and a birth certificate and either HP4720 or HP 4721 form is required.

Offer social worker input:

- Marlene Beasley (social worker) will visit on the ward and call within couple of weeks upon discharge. Ensure referral has been made.
- Te Mahoe has a counselling service for pregnancy loss issues run by Carolyn McIlraith (trained counsellor) which Hutt Valley DHB women can also access if they wish

Contraindications to mifepristone and misoprostol

- Known allergy to misoprostol (cytotec) or mifepristone
- Known ischaemic heart disease or other serious cardiovascular disease
- IUCD in situ
- Porphyria

Precautions (in these situations, must be discussed with SMO

- >35 years of age **and** smoking 20 cigarettes per day or more
- severe asthmatic
- concurrent oral steroid therapy
- history of bleeding diathesis
- chronic adrenal failure
- Note: caution should be exercised in women with a previous caesarean section or scarred uterus as there is a minimal risk of uterine scar dehiscence. If >1 caesarean section or classical caesarean, must discuss with SMO.

Admission to Labour Ward and Misoprostol protocol

- An IV line should be sited at admission and bloods taken for FBC & Group and Hold.
- If Rhesus negative, anti D 625 IU should be administered
- If a PCA is desired, contact the pain service
- The first dose of misoprostol (800 micrograms) is given into the posterior vaginal fornix. Thereafter, 400mcg of misoprostol is given 3 hourly to a maximum of 4 oral doses. In rare cases the oral route may not be tolerated in which case misoprostol can be given vaginally

Misoprostol Dose micrograms				
1st dose Start time	2nd dose 3 hours	3rd dose 6 hours	4th dose 9 hours	5th dose 12 hours
800	400	400	400	400

- If no delivery after final dose of misoprostol for medical review. Likely to recommence the misoprostol regimen the following morning.
- If the membranes rupture, continue with the misoprostol regimen
- Misoprostol should continue between delivery of the baby and the placenta.
- Following delivery of the baby, oxytocin (syntocinon) 5IU is administered IV or IM by the midwife delivering the baby
- Following birth of the baby, the woman should be NBM. IF the placenta is not delivered by one hour or the woman is bleeding then the obstetric RMO is called. It is important not to exert traction on the cord as it is extremely friable. Manual removal of placenta may be required in theatre. The baby will normally be delivered by the midwife caring for the woman unless there is difficulty in which case the registrar should be called. If the registrar is unavailable the SMO on call is to be phoned.

Investigations for mid-trimester miscarriage:

NB: if a TOP for foetal anomaly, these investigations are not required.
Women are offered:
Blood tests:

Yellow Top x3	Pink Top x1	Mauve Top x3	Green Top (x 2)	Blue Top (x 4)
Renal function, Liver function, CMV, Toxoplasmosis, Parvovirus, Rubella, Syphilis serology, Thrombophlia screen. Consider thyroid functions if there is a history of thyroid disease	Kleihauer, Antibody screen	HbA1c, Full blood count, Thrombophilia screen	Chromosome studies	Thrombophlia screen (4 blue top, 1 yellow top and 1 Mauve Top)

Post-mortem of baby & placental histology:
All babies having post-mortem are to be taken to CCDHB to Wellington Mortuary. Harbour City Funerals has the contract to transport babies irrespective of gestational age between hospitals. Contact them for transport. Phone 570 0111.
Ensure the placenta is kept with the baby. If the parents do not wish to have baby returned after PM CCDHB will take care of the baby.

Preparation for transfer of baby and placenta for post mortem (If applicable) (Mortuary address label in pack if required by Harbour City).	**Baby ID bands attached** ☐ **Ensure Death Certificate has been completed in full (HP4721)** ☐ **Give a copy to the parents.** ☐ **Placenta prepared as follows** ☐ • Double bagged • Inside plastic container • Labelled with maternal label • Continue to keep cool **Copy following documents**: ☐ • **Consent for Perinatal Post Mortem (signed)** • **Original Death Certificate** • **Maternal pink booking sheet** • **Any scan reports** • **Copy of this clinical guideline completed** • **Any relevant progress notes**
Preparation of placenta for histology (If applicable) Placental histology will be completed by Kate Strachan (pathologist) **021 827508**	Contact Kate Strachan ☐ Contact lab (to arrange transport to CCDHB) ☐ Placenta prepared appropriately ☐ • Double bagged • Inside plastic container • Labelled with maternal label • Continue to keep cool Copy of following documents ☐ • Body Part Chain of Custody form (plus copy in clinical notes) • Copy of this clinical guideline completed • Maternal pink booked sheet Take placenta and mortuary plus address label to lab ☐

If the parents decide to have their baby cremated regardless of whether the baby has a post mortem or not the parents will need to arrange the cremation with funeral directors of choice.
There may be a cost for cremation, this will be considered on a case by case basis by the funeral directors.

Informed Consent

The right of a consumer to make an informed choice and give informed consent, including the right to refuse medical treatment, is enshrined in law and in the Code of Health and Disability Consumers' Rights in New Zealand. This means that a woman can choose to decline treatment, referral to another practitioner, or transfer of clinical responsibility. If this occurs follow the process map on page 18 of the Referral Guidelines (Ministry of Health, 2012).

Appendix I

Mifepristone and Misoprostol Consent form:

Mifepristone is a synthetic steroid, which blocks the action of progesterone that maintains a pregnancy. It also softens the cervix. It works best if followed in 48 hours by Misoprostol.

Misoprostol is approved only as an anti-ulcer medication in New Zealand but is used world-wide to stimulate uterine contractions and has been found to be safe and effective.

I_____

- Have had explained to me the nature of the condition.
- Have been provided with an assessment of the potential benefits, side effects and risks of the medications and the procedure.
- Have had the opportunity to ask questions and I am satisfied with the explanation and the answers to my questions.

I consent to:

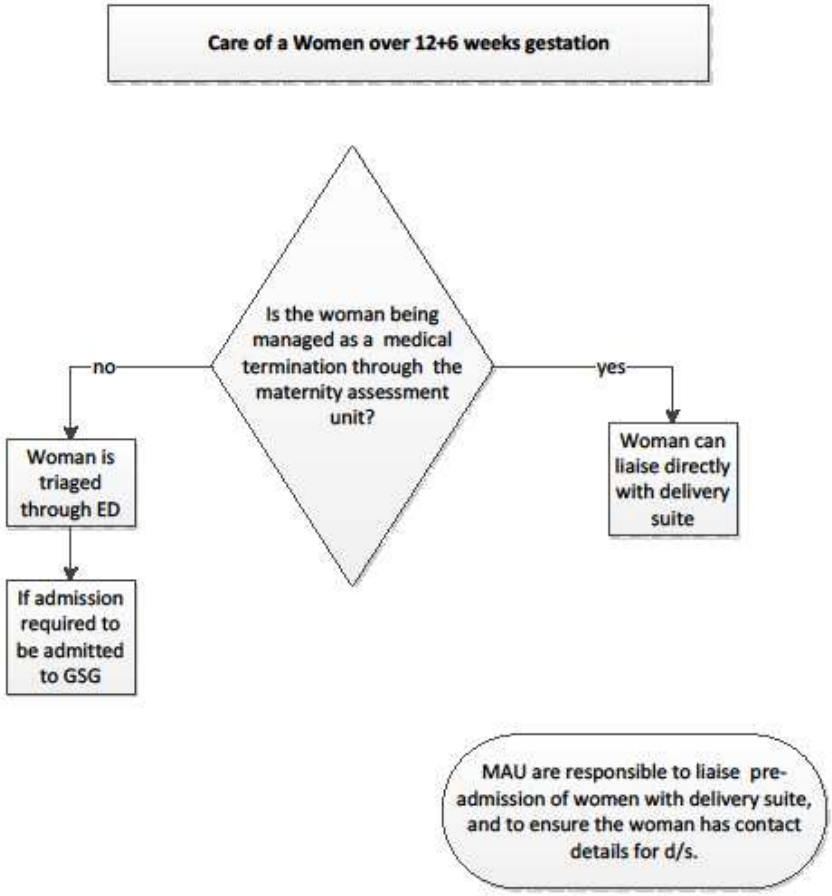
Receiving Mifepristone to assist in the delivery of my pregnancy ❑

Receiving Misoprostol to assist in the delivery of my pregnancy ❑

Signature _____

Medical Officer _____

Date_____


Care of a Women over 12+6 weeks gestation
Is the woman being managed as a medical termination through the maternity assessment unit?
no
yes
Woman is triaged through ED
If admission required to be admitted to GSG
Woman can liaise directly with delivery suite
MAU are responsible to liaise pre-admission of women with delivery suite, and to ensure the woman has contact details for d/s.