Guideline No: 6 Medical Management of 2\textsuperscript{nd} Trimester Miscarriage (13-22 weeks) or Termination of Pregnancy for Fetal Abnormality Prior to 22 Weeks

VERSION

AMENDMENTS:
Appendices on private funeral arrangements. Changes to be more in-line with NICE.

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NAME AND DESIGNATION OF GUIDELINE AUTHOR(S):
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APPROVED BY:
1. DCGSG
2. MCGS

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1. Intranet
2. Clinical Areas

<table>
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1.0 INTRODUCTION

1.1 Indications

a. Termination of pregnancy on maternal, medical or fetal abnormality grounds

In all cases of termination the blue 1967 Abortion Act Forms should be completed by two appropriate clinicians, one of whom will usually be the consultant under whose care the patient is booked or the consultant making the diagnosis. The notification should be completed and forwarded to the Department of Health within 14 days by the consultant under whose care the patient is booked.

Propagation of a miscarriage where this is inevitable (e.g. with an open os) is NOT a termination of pregnancy (even if the fetus is alive) and does not require the completion of Form A or notification to the Department of Health.

b. Confirmed intra-uterine fetal death

The protocol below may be used in cases of confirmed fetal death in utero. If fetal chromosome studies are indicated (most cases) then amniocentesis can be discussed with the patient and performed either at the time of initiating the protocol or on admission to hospital

** If miscarriage and patient required immediate commencement or wishes to avoid the 36 hour delay incurred by using Mifepristone, use Guideline Regime 2**
2.0 GUIDELINE REGIME 1 – Preferred regime for medical abortion/management of miscarriage

This should be the normal regime for ending pregnancies between 13 and 22 weeks. It results in a shorter “active” period in the hospital. It also requires less medication and therefore reduces the risk of complications. There are no absolute contra-indications to Mifepristone except previous allergy to Mifepristone, but patients on systemic steroids or with severe asthma should only be entered into this regime under the direct agreement of a Consultant and should then be managed on the labour ward with a clearly defined plan of care.

2.1 Regime
Mifepristone is only to be administered on licensed premises. It is given in the presence of a clinician as 200 mg orally.

Patient should be observed for one hour in the unit i.e. pulse, BP and temperature.

Patients given Mifepristone and discharged to await the start of Misoprostol should be warned that if any adverse event occurs, e.g. bleeding or feeling unwell, that they should immediately be brought to the Hospital, if necessary by ambulance for assessment.

The patient can then be discharged with the plan to admit at 9am to the unit at 36-48 hours later.

The patient should be admitted to an appropriate bed (see below).

On admission, Misoprostol 800 micrograms will be administered to the posterior vaginal fornix by clinical staff.

Misoprostol 400 micrograms will then be administered orally at four hourly intervals to a maximum of four doses.

If the placenta is retained and there is minimal vaginal bleeding, wait four hours before proceeding to evacuation under anaesthetic in theatre. The course of Misoprostol may be continued up to a maximum of four doses of Misoprostol whilst awaiting spontaneous delivery of the placenta. If there is more than minimal vaginal bleeding the duty Registrar should proceed to immediate evacuation in theatre (blood should be sent for group and save).

2.2 Admission
Patient should be admitted to the Gynaecological Unit. Patients may be admitted to the Labour Ward if there are medical indications for close monitoring.
2.3 **Pain Relief**
Should be prescribed from the full range, including Diamorphine and patient controlled analgesia.

2.4 **Side Effects**
Nausea and vomiting occasionally requiring anti-emetics may be noted as more doses of Misoprostol are given. Diarrhoea is a recognised side effect.

**INFORM CONSULTANT TEAM IF PATIENT NOT DELIVERED BY 9AM NEXT DAY**
3.0 GUIDELINE REGIME 2 – For immediate commencement of medical induction

This should not routinely be used for termination of pregnancy but examples of situations where it may be appropriate:

- incomplete miscarriage (e.g. ruptured membranes)
- inevitable miscarriage (e.g. open os)
- miscarriage where for psychological, clinical or other reasons the patient cannot wait the 36 hours required following the Mifepristone dose

3.1 Guideline Regime

- Omit Mifepristone

- Misoprostol 400 micrograms given orally and repeated at four hourly intervals to a maximum of six doses

OR

- Misoprostol regime as per Guideline Regime 1

3.2 Post Mortem Examination

Post mortem examination should not routinely be performed at gestations <14 weeks.

Post Mortem Examination at gestations >14/40 may be requested by the parents or for clinical reasons (e.g. fetal abnormality on ultrasound). Post Mortem Examination may also provide information relevant to future pregnancies, and help families come to terms with their loss.

Post mortem consent should only be performed by appropriately trained staff and MUST include BOTH the Alder Hey Hospital booklet (“Consent to a Hospital Post-Mortem Examination on a Baby or Child”) AND the Alder Hey request form (“Request for fetal, perinatal or infant post mortem examination”).

Care should be taken when completing the form with the parents so that multiple options are not ticked inadvertently. If tissue is requested to be returned to the fetus prior to funeral arrangements then the parents should be informed that this could potentially cause a delay.

After completion,

- Give the consent booklet to the parents
- Yellow sheets detached and placed in medical records
- Blue sheets (PM request form) to be sent to Alder Hey with fetus and copy of mother’s case notes with 6 case sheet stickers (via Arrowe Park Hospital Pathology)
If unsure, call the paediatric pathologists at Alder Hey for advice.

Patients should be assured that following histological examination remains will be disposed of sensitively in line with RCOG\textsuperscript{10} and RCN\textsuperscript{11} guidelines by incineration/cremation.

Methods of disposal chosen by the woman or couple may include a privately arranged cremation or burial and these wishes should be accommodated.

If the woman or couple decide to bury the products/fetus themselves, the Department of Health has advised that for gestations <24 weeks (unless registered as a live birth), there is no legal prohibition on where the products/fetus is buried, provided there is:

- No danger caused to others.
- No interference with any rights that other people may have over the land used\textsuperscript{10}.
- No danger to water supplies or watercourses.
- No chance of bodily fluids leaking into or onto adjoining land.

In addition, the following should be considered:

- The fetal tissue must be buried at a depth of at least 18 inches (45cm) permission must be obtained from the landowner if the parents do not own the land.
- Careful thought must be given when considering burial in a garden, taking into account what would happen if the parents moved house or the land is used for new purposes in the future.

3.3 Discharge from Hospital
Patients may be discharged a minimum of twelve hours after delivery of the placenta if clinically stable.

3.3.1 Contraception
Contraception should be discussed prior to discharge with hormonal methods of contraception being started two weeks after discharge.

3.3.2 Rhesus Prophylaxis
Rhesus prophylaxis with Anti-D immunoglobulin should be administered where appropriate within 72 hours of the onset of bleeding (dose 1500 international units). Kleihauer test should be performed at the completion of delivery of all Rhesus negative patients.
3.3.3 Follow Up
Follow up appointments should be arranged prior to discharge with the relevant consultant.

4.0 REFERENCES


Goh S, Thong K. Induction of second trimester abortion (12–20 weeks) with mifepristone and misoprostol: a review of 386 consecutive cases. Contraception, Volume 73, Issue 5, Pages 516-519


Schaff EA et al. Randomized trial of oral versus vaginal misoprostol at one day after mifepristone for early medical abortion. Contraception 2001; 64(2): 81-5

The Care of Women Requesting Induced Abortion. RCOG Clinical Effectiveness Support Unit. Evidence-based Clinical Guideline No.7.


Wagaarachchi PT et al. Medical management of early fetal demise using a combination of mifepristone and misoprostol. Hum Reprod 2001; 16(9): 1849-53
5.0 RELATED DOCUMENTS
Guideline No. 1 Summary of Medical Management of Pregnancy Loss and Medical Termination of Pregnancy

6.0 APPENDICES
Appendix 1 – Termination of Pregnancy (TOP) Prescription Card

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Drug</th>
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<th>Route</th>
<th>Frequency</th>
<th>Prescriber’s Signature</th>
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When required medication

<table>
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<td>Paracetamol</td>
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<td>4 hourly</td>
</tr>
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### Appendix 2 - Medical Miscarriage Prescription Chart

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<th>Frequency</th>
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Appendix 3 - Private Funeral Arrangements for Products of Conception below 14 weeks Gestation

Women may decide to make private funeral arrangements for the miscarriage/products of conception from an evacuation of a pregnancy, of less than 14 weeks gestation.

Considerations

Ring Sandy Smith/Janice Horn, Histopathology (Ext 2570), to clarify whether the remains been reported on, are still in the laboratory or have they been sent to Landican.

If remains available:
- Explain the situation to Sandy Smith/Janice Horn and ask to put a stop on the release of the remains while discussions are continuing with the woman.
- Document all the discussions with the woman and the Laboratory in the notes, ensuring that the woman realises that the fetus will not look as it may have done on the USS. i.e. In the case of an ERPC, in pieces.

If the woman confirms that she wants to arrange private funeral arrangements:
- Note the chosen funeral director.
- Inform Sandy Smith/Janice Horn in Histopathology (Ext 2570)
- Inform Sheena Murray in the Bereavement Office (Ext 2063) that the woman requests a private funeral arrangement for a fetus below 14 weeks gestation and state her chosen funeral directors.
- Get the woman to sign and date a release of the products of conception letter (Example below).
- Photocopy the signed and dated letter, ensuring there are 3 copies in total. File the original copy in the hospital notes and take the other 2 copies to Sandy Smith/Janice Horn in Histopathology. They will give a copy to the Bereavement Office.
- On receipt of the letter in the laboratory and following the histology being reported, the products of conception will go, appropriately labelled with at least two identifying markers, to the mortuary were they will be picked up by the funeral directors acting on the woman’s behalf.
- Nurses/Midwives check what paperwork the individual funeral directors require e.g. Landican cremation form.
Appendix 4

Nurse/Doctor/Research Midwife

Medical Secretary: ..............................
Direct Dial: ..............................
Fax No: 0151-604 7340

Our ref:
20 September 2012

Mrs A N Other
123 Computer Drive
Wirral
CH00 000

Dear Mrs Other

Following your recent loss, you informed me that you would like to make private funeral arrangements with the ............................................ Funeral Directors in ................................., Wirral.

In order to arrange this, we would require your signature to enable us to release the products of conception to the funeral directors. Would you please sign and date the release below.

Kind regards.

Yours sincerely

Research Midwife

To: Ms Sandy Smith
Histopathology

I hereby give my consent to the release of products of conception obtained on ............................. to the Co-operative Funeral Directors, Moreton, Wirral.

Name: ........................................ Signature: ........................................
(blocked capitals)

Date: ........................................
**MONITORING COMPLIANCE WITH THE GUIDELINE**

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<td>Obstetric &amp; Gynaecology Audit Meeting</td>
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<td>Responsible individual/group/committee for monitoring of action plan</td>
<td>Clinical Governance Steering Group</td>
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**COMPLIANT WITH:**

1. RCOG Green Top Guideline No. 25. The Management of Early Pregnancy Loss

**AUDITABLE STANDARDS – Guideline 1**

1. Rate of complete expulsion not requiring operative intervention (reported rated 11.5% or less)
2. Percentage of Rhesus negative patients receiving correct dose of Anti-D within 72 hours (100%)

**AUDITABLE STANDARDS – Guideline 2**

1. Decision to treatment, referral to treatment or appointment to treatment times
2. Antibiotic prophylaxis or Chlamydia screening percentages
3. Mifepristone dosage regime used compared to recommended 200 mg
4. Percentage of Rh negative women given Anti-D within 72 hours