Guidelines for External Examination of Stillbirth and/or Fetal Loss

NHS
University Hospitals of Leicester
NHS Trust

Trust Ref: C75/2006

Introduction and who this guideline applies to

Unfortunately a number of pregnancies end in fetal loss or stillbirth. There are many reasons for this. Often there may be no preceding history to help explain what has happened. For the parents it is important to try to find a reason why they have lost a child. Not only can this help with the grieving process, it may also give vital information when planning future pregnancies.

To support this process it is important that in ALL cases of stillbirth and fetal loss at any gestation the baby is examined and a description of the findings are clearly documented. The following guideline aims to assist this process.

This guideline is intended for use by all medical and nursing staff working on the Neonatal Unit involved in the care of stillborn fetus.

Key Points

1. It is important that in ALL cases of stillbirth and fetal loss at any gestation the baby is examined and a description of the findings clearly documented.

2. Where consent for a post-mortem examination has been obtained the appropriate request form needs to be completed accompanied by a summary of clinical details.

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Related documents:

- Stillbirth and Late Fetal Loss - Bereavement Care UHL Obstetric Guideline
- Certification of Stillbirth and Neonatal Death on Labour Ward UHL Obstetric Guideline
- Consent to Hospital Post Mortem Examination UHL Policy
- Deceased Urgent Certification and Release Outside Normal Hours UHL Policy

Process / Procedure

1. Who should be involved:

• The midwife looking after the mother should make the initial examination, then refer to the appropriate medical team accordingly:

- For Infants less than 23 weeks:
Refer to Obstetric team. This should be at either a registrar (ST4 or above) or Consultant level.

- Infants greater than or equal to 23 weeks:
Refer to Obstetric Specialist Registrar or Neonatal team (only if neonatal expertise is required). This should be either a Registrar or Consultant.
It is inappropriate to expect an SHO (ST1-ST3) to perform this duty although important for such trainees to accompany and observe.

• During Office hours (0900-1700hrs, Monday to Friday), other Health Professionals who can be very helpful include the Perinatal Histopathologists (Contact information: appendix 1) or one of the Clinical Geneticists.

• If an external examination by the histopathology department is required the clinician should obtain consent for external examination. This should include consent for X-rays and photos if possible.

• The Geneticists may also be able to give advice if consent has not been given for a post-mortem examination.

NOTE: Out of hours the response from the Neonatal team will be dependent on other priorities on the Neonatal Intensive Care Unit. If they are unable to attend for several hours it will be the responsibility of the Midwifery and Obstetric team to make the appropriate examination.
It is not appropriate to call in senior medical staff from home out of hours for this procedure.

2. Procedure to be followed:

a. Midwife looking after mother makes initial examination and then refers either to Obstetric or Neonatal team for further opinion (see above).

b. Obstetric/neonatal team speak to parents and examine infant (see below) with parents consent (verbal should be sufficient at this stage).

c. Obstetric/Neonatal team document findings (see below) and seek consent for Post Mortem from parents (to include placenta).

d. Placenta to be sent for histological examination regardless of whether consent for post mortem is agreed or declined by mother (This is in line with current obstetric procedure for stillbirths). This should occur in ALL such cases as valuable information can result.

Where consent has been given a Post Mortem Request Form (Appendix 2) should be completed and sent to histopathology.

e. If Post Mortem declined seek consent for Perinatal Histopathologist to undertake external examination, plus X-rays and photos.

f. Consider discussion with Geneticists, depending on findings. In individual circumstances the Geneticists may be able to offer opinion.

g. Points E. and F. should only follow a Consultant to Consultant discussion regarding appropriateness and feasibility of undertaking this.

3. What to look for:

a. Brief general description of the baby.
Note weight, degree of maceration, head circumference and maturity.
List visible features and whether appear normal or abnormal.
If abnormal, then give description. Look at back as well as front of infant.

b. Note number of fingers and toes, plus any limb anomalies.

c. Note any skin markings and distribution.

d. Note any obvious abnormal external signs and extent of abnormality (eg. Size of Exomphalos and contents if visible; level of spina bifida, coverings and size; anal atresia which is easily missed; etc.)

e. Examine mouth for abnormalities such as cleft lip and palate.

f. Note if eyelids fused or not.

g. Look at appearance of eyes (eg. Any coloboma).

h. Note odour if present, plus any secretions (meconium, pus, etc.).

i. Any evidence of a cord incident (Midwifery and Obstetric staff best placed to advise).

j. Examine placenta for abnormalities (Midwifery and Obstetric staff). Placenta should also be sent for histology, with parents consent.

k. Check sutures plus look for any other musculoskeletal abnormalities.

*Please refer to the stillbirth notes booklet that is now in use, which includes a form on which to document the findings - link. Please click on link (see pages 17-19). Paper versions of the booklet can be found in the bereavement documentation areas on delivery suite/labour ward both at LRI &LGH.

4. What should be documented:

All relevant findings based on above examination should be recorded.
This includes important normal findings as well as abnormal findings.
It is not enough to simply state 'Baby appears normal'.

All findings to be documented in the maternal obstetric case notes.

Use of diagrams can be very helpful to support findings. Photographs can also aid with subsequent management but consent from parents must be obtained prior to obtaining these. X-rays can also be useful. Again, consent is required. All entries in medical notes MUST be dated (time and date) and signed with legible signature and grade of person.

3. Education and Training

None

4. Monitoring Compliance

None identified at present

What will be measured to monitor compliance	How will compliance be monitored	Monitoring Lead	Frequency	Reporting arrangements

5. Supporting References

None

6. Key Words

Histopathology, Parents, Post-mortem

The Trust recognises the diversity of the local community it serves. Our aim therefore is to provide a safe environment free from discrimination and treat all individuals fairly with dignity and appropriately according to their needs.
As part of its development, this policy and its impact on equality have been reviewed and no detriment was identified.

CONTACT AND REVIEW DETAILS	
Guideline Lead (Name and Title) R Miralles – Consultant Neonatologist	**Executive Lead** Chief Nurse

2001	Original Guideline AE Currie
2009	Neonatal Guidelines Meeting
2014	Neonatal Guidelines meeting review
Aug 2015	Neonatal Guidelines Meeting review (amendments made)
Aug 2015	Neonatal Governance Meeting (approval)
Sept 2018	Neonatal Guidelines Meeting
Jul 2021	**Details of Changes made during review:** Author review – no significant amendments Added links and reference to the stillbirth notes booklet **Format updated**
July 2021	Neonatal Guideline and Governance Meeting (ratified)

Appendix 1
Histopathology Contact details

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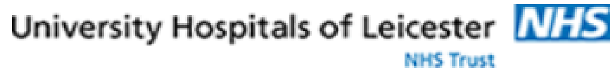
Appendix 2
Post-mortem request form.
To be completed in addition to post-mortem consent form and badgernet summary



CLINICAL INFORMATION FOR FETAL / PERINATAL POST MORTEM

HOSPITAL:_______________ Ward: ___________________ S number baby _________________

Consultant: Paediatrician.________________________ Obstetrician:________________________

Name:____ Sex: m f ? DoB ___/___/___

Address: ____

GP: ____

MOTHER'S DETAILS: DoB/age:__________ ethnic origin: ___________father's eth. origin (if diff.) ______

S number:_____________ Consanguinity: y / n height:__________cm weight___________kg

DEATH REGISTERED AS: livebirth / stillbirth / not registered (miscarriage)

RELEVANT MEDICAL / FAMILY HISTORY:

PREVIOUS PREGNANCIES: G: ___ P: ____

date gestation labour sex outcome

1.__________________________________

2.__________________________________

3.__________________________________

4.__________________________________

date gestation labour sex outcome

5.__________________________________

6.__________________________________

7.__________________________________

8.__________________________________

9.__________________________________

THIS PREGNANCY: booked/unbooked LMP _________ EDD __________

Gestation: by dates:______/40 by scan:______/40 weeks Blood group: ___, RhD pos/neg

Rubella status _________ TPHA pos/neg HBsAg pos/neg HIV pos/neg Antibodies ____________________

Serum screening results: ______________________________ Medications ____________________

threatened abortion: no/yes when _______________

antepartum haemorrhage: no / yes when __________

hypertension: no / yes up to __________________

pre-eclampsia: no / yes when ________________

severe anaemia no / yes

infection risk: low/high(reason) ____________

maternal pyrexia: no / yes when __________

other problem: ______________________

Abnormal USS findings (or send report) ____

____

Antenatal diagnostic procedures/results: ☐amniocentesis ☐ CVS Karyotype: _______________

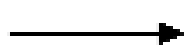
Other: ____

LABOR: onset: spont / medical/surg. IOL for: IUD/other_______________ Augmentation (Syntocinon): yes/no

Presentation: vertex/breech/other:__________ Liquor volume: normal / reduced / increased colour:__________

Rupture of membranes: date _______ time______ 1st stage __h __min 2nd: __h __min 3rd: __h ___min

Last evidence of fetal life: date _______ time_______



DELIVERY: spontaneous / assisted (forceps / ventouse) / CS (elective/emergency) date ________ time______
DEATH: date time

NEONATE: weight _______g Apgars: 1st min ____ 5th min ____ 10th min ____

ABNORMALITIES NOTED: nil / ____

____

____

RESUSCITATION: nil / mucus extraction / oxygen / mask / intubation / other ________________________

____ Curosurf: yes / no

NEONATAL PROBLEMS:

1.______________________________

2.______________________________

3.______________________________

4.______________________________

5.______________________________

PROCEDURES:

1.______________________________

2.______________________________

3.______________________________

4.______________________________

5.______________________________

BRIEF SUMMARY OF LATER SYMPTOMS / TREATMENTS AND MAJOR INVESTIGATIONS (including CPAP/ventilation, IV therapy, fits, episodes of collapse, pneumonia, pneumothorax, bleeding problems, type of feeding etc.; <u>If complex course, please send photocopy of neonatal unit summary / relevant pages of notes):</u>

SUSPECTED CAUSE(S) OF DEATH:

<u>ANY OTHER RELEVANT INFORMATION / SPECIAL POINTS TO BE NOTED AT POST MORTEM:</u>

Referring Doctor / Midwife: ______________________________ Contact number / bleep No____________

Date: ______________________

ALL SPECIMENS SHOULD BE SENT FRESH IN LEAKPROOF, OPAQUE CONTAINERS UNLESS THERE IS AN INFECTIOUS HAZARD (in this case phone to discuss whether the specimen should be fixed in 10% formalin before transportation)

IT IS ESSENTIAL TO SEND THE PLACENTA WITH A FETUS / INFANT.

ALL SPECIMENS MUST BE CLEARLY LABELLED AND ACCOMPANIED WITH COMPLETED REQUEST AND CONSENT FORM