## Contents



## 1. Introduction and Who Guideline applies to

This guideline applies to all UHL staff involved in the care of women undergoing termination of pregnancy in the second and third trimester.

**Legal Liability (standard UHL statement):**

Guidelines issued and approved by the Trust are considered to represent best practice. Staff may only exceptionally depart from any relevant Trust guidelines providing always that such departure is confined to the specific needs of individual circumstances. In healthcare delivery such departure shall only be undertaken where, in the judgement of the responsible health professional' it is fully appropriate and justifiable – such decision to be fully recorded in the patient's notes.

## Background:

This guideline has been prepared following extensive discussion of previously circulated documents. Whilst it is hoped that further discussion will be limited, it is recognised that there are areas of contention. The guideline is only didactic where legal requirements predominate; otherwise it recognises a range of practices as being acceptable.

**Related Documents**

Bereavement Care: Stillbirth and Late Fetal Loss Integrated Pathway

Lactation Suppression UHL Obstetric Guideline

## Legal requirements for termination of pregnancy:

- The 1967 Abortion Act protects women and their doctors from prosecution under the 1861 Offences against the Person Act.
- The Abortion Act was amended by the 1990 Human Fertilisation and Embryology Act. This effectively removed the upper limit for abortion providing specified criteria are met.
- Termination of Pregnancy after 24 weeks should also be accompanied by a stillbirth certificate (Stillbirth (Definition) Act 1992).
- Termination of pregnancy after 24 weeks can be undertaken "…if there is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped." Termination of pregnancy can also be undertaken after 24 weeks if the continuation of the pregnancy would involve risk to the 'life' of the pregnant woman, or to prevent grave permanent injury to the physical or mental health of the pregnant woman.
- Before 24 weeks the Act allows a pregnancy to be terminated if "the continuation of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of the pregnant woman or any existing children of her family.
- Abortion must not result in the birth of a living child that then dies for reasons other than the severe abnormality for which the abortion was performed. A doctor could be accused of murder under the Offences against the Person Act 1861, if the performance of the abortion, led to a liveborn child that died as a consequence of immaturity.
- The exception to this is when the fetal abnormality itself is so severe as to make early neonatal death inevitable irrespective of gestation.
- Prior to commencement of the process of termination of pregnancy, two registered medical practitioners must sign Certificate A. The second signatory must document in the health record that the woman's personal circumstances have been discussed with the lead clinician or that they have seen the relevant abnormal result i.e. FISH.
- After completion of the Termination of Pregnancy, the Abortion Notification Form HSA4 should be completed and returned to the Chief Medical Officer's Office within fourteen days[5].

## 2. Guideline Standards and Procedures

| **Recommendations:** | |
|---|---|
| 1. | The woman, (and her partner when present), should be offered complete and sensitive information prior to making the decision to terminate a pregnancy. |
| 2. | The medical termination of pregnancy integrated pathway should be commenced at the point of decision of termination. |
| 3. | Once the decision to terminate a pregnancy has been reached, fetocide should be offered in all relevant cases. |
| | Fetocide should be offered by appropriately trained practitioners who have the necessary |

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| 4. | ultrasound and invasive procedure skills for pregnancies 20 weeks and beyond. |
| 5. | Anti-D prophylaxis should be offered to all women undergoing a medical termination of pregnancy |
| 6. | Women who delay labour for longer than 48 hours should be advised to have testing for DIC twice weekly |
| 7. | Pre-treatment with mifepristone 200mg orally is recommended for all women undergoing second or third trimester termination of pregnancy/ induction of labour. Where her medical condition permits, it may also be appropriate when termination is being undertaken for reasons of maternal health. |
| 8. | Misoprostol is recommended for cervical ripening and/or induction up to and including 28 weeks gestation. Beyond 28 weeks gestation it is recommended that dinoprostone (Prostin Pessary 3mg) or Propess is used for induction of labour. Misoprostol may be used with caution up to 32 weeks gestation on the discretion of the consultant responsible for the continuing care of the woman. At all gestations there is an absence of evidence for the management of women with one or more caesarean sections and therefore their individual management will need careful consideration. |
| 9. | Where induction with prostaglandin has deemed to fail, or where it is considered not to be appropriate, then the use of a Foley catheter to achieve cervical dilatation is a reasonable alternative. |
| 10. | Amniotomy should be deferred in the presence of a dead fetus, until either delivery is imminent, or other methods of induction have been shown not to achieve delivery. |
| 11. | Management of the third stage |
| 12. | Adequate provision of analgesia is an important part of care |
| 13. | Appropriate examination and investigation should be undertaken to clarify the nature of any fetal abnormality / IUFD, its causation and any recurrence risks associated. |
| 14. | Culturally sensitive measure should be taken to support the family. Needs will vary greatly. Some parents will wish to see their child to confirm the extent of any external malformations. Some will not wish to see their child. |
| 15. | Parents should be advised before birth about the potential difficulty in sexing the baby, when appropriate dependent on gestation and abnormalities present. |
| 16. | All women should be offered follow-up after termination of pregnancy for abnormality. This should take place when all investigations are available. Parents will wish this follow-up as soon as possible, however it is unusual for all investigations to be available much prior to eight weeks following the termination; in some instances it may be considerably longer (including time taken for the post-mortem report). |
| 17. | Carers should be vigilant for postnatal depression in women with a previous IUFD. |
| 18. | All existing appointments should be cancelled. |
| 19. | Lactation suppression should be offered to applicable women. See Lactation suppression following bereavement guideline |
| 20. | Care for the woman should be given by an experienced midwife in a room that pays heed to the emotional and practical needs without compromising safety |

## Recommendation One:

**The woman, (and her partner when present), should be offered complete and sensitive information prior to making the decision to terminate a pregnancy[5].**

This information should be provided by individuals with recognised expertise and should be complete as possible. This may require additional input from geneticists, cardiologists, surgeons, neurosurgeons, the cleft service, neonatologists and relevant support groups as required.

Where there is uncertainty with regard to the exact nature of the diagnosis and/or the prognosis, this uncertainty should be clearly communicated to the woman and her partner.

It is reasonable to insist on a twenty-four hour 'cooling-off' period before acceding to any request for termination of pregnancy. Immediate decisions may be regretted. This advice may be modified where an anticipated result is confirmed e.g. confirmation of Trisomy 18 after the scan finding of multiple markers.

Documentation of any discussion should include:

- Diagnosis
- Prognosis
- Option of continuance and likely outcomes
- Potential adverse effects on maternal health

A full explanation of the termination procedure should be given and written consent obtained, particularly for the fetocide procedure if required or requested.

Where termination of pregnancy has been declined, it is reasonable to arrange a further review and the plan should be documented in the notes, in order that the parents' views are confirmed.

Parents should be offered written information to supplement discussions.

If parents chose to go ahead with the termination of pregnancy the medical termination of pregnancy integrated pathway should be commenced.

## Recommendation Two:

**The medical termination of pregnancy integrated pathway should be commenced at the point of decision of termination.**

- The pathway should be commenced at the point of the decision for a termination. These will be available within antenatal clinic and delivery suite.
- If you have any concerns regarding the paperwork, discuss this with the co-ordinating midwife or fetal consultant.

## Recommendation Three:

**Once the decision to terminate a pregnancy has been reached, fetocide should be offered in all relevant cases**

Fetocide should be considered in the following circumstances;

1) Where there is a request for termination of pregnancy for confirmed fetal abnormality and there is a prospect that the fetus may be delivered showing signs of life, especially after 20 weeks gestation.
2) For selective termination in pregnancies discordant for abnormality.
3) For selective reduction of higher order pregnancies.

4) Under certain circumstances fetocide may not be undertaken e.g. the explicit wish of the parents or because of medical conditions / time. These should be discussed amongst the fetal medicine team and a consensus reached. Parents must be informed that the baby may be born showing signs of life.

5) An amniocentesis or chronic villus sampling can be taken at the same time for genetic testing if the parents accept further testing[6]

6) If the parents decline a fetocide, a fetus born alive with abnormalities incompatible with life should be managed to maintain comfort and dignity during terminal care. This will also be a registerable delivery and a death certificate will need to be issued to the family.

The SOP for fetocide can be found in Appendix 1.

## Recommendation Four:

**Fetocide should be offered by appropriately trained practitioners who have the necessary ultrasound and invasive procedure skills for pregnancies 20 weeks and beyond[1]**

- A competent, trained practitioner must discuss fetocide with the woman and give evidence based information.
- The fetus must be a gestation of 20 weeks or more.
- Fetocide is to be administered by an appropriately trained practitioner only.

## Recommendation Five:

**Anti-D prophylaxis should be offered to all women undergoing a medical termination of pregnancy**

All rhesus negative women undergoing a medical termination of pregnancy will be offered an anti-d injection[5, 7].

## Recommendation Six:

**Women who delay labour for longer than 48 hours should be advised to have testing for DIC twice weekly**

Women who are well and have intact membranes and no laboratory evidence of DIC should be advised that they are unlikely to come to physical harm if they delay labour for a short period, however they may develop severe complications and suffer greater anxiety. Women who delay labour for prolonged periods longer than 48 hours should be advised to have testing for DIC twice weekly[7] .

## Recommendation Seven:

**Pre-treatment with mifepristone 200mg orally is recommended for all women undergoing second or third trimester termination of pregnancy[3, 5]. Where her medical condition permits, it may also be appropriate when termination is being undertaken for reasons of maternal health.**

- Medication regimes can be found in Appendix 2 and can be found in the integrated pathway.

- Completion of the mifepristone checklist (in the pathway) should be recorded prior to administration of mifepristone. Although this will only rarely change administration, medical staff should be informed of any abnormality or relevant maternal condition.
- Mifepristone should be administered by the midwifery staff (with two qualified checkers), who should witness the tablet being swallowed. The tracer number from the mifepristone label should be recorded on the drug chart or in the notes.
- TOP in women with previous caesarean section should be during the working week where possible.
- The woman should be advised not to drink alcohol, smoke, or take non-steroidal anti-inflammatory drugs.
- If vomiting occurs within 30 minutes of administration of mifepristone, a further dose of 200mg orally should be administered.
- The woman should be advised of the possibility of bleeding/contractions prior to her planned readmission, and should be given contact numbers for advice should this occur.
- The woman's GP and community midwife should be informed that mifepristone has been given in the event of a complication in the community setting. The woman should also be encouraged to keep her handheld records with her at all times following mifepristone administration.
- Arrangements should be made for the woman to return after 36-48 hours for administration of prostaglandin, as per recommendation five. *If it is felt by the clinician that the woman requires delivery sooner than this, she should still receive mifepristone in order to facilitate induction of labour.*

### Recommendation Eight:

**Misoprostol is recommended for cervical ripening and/or induction up to and including 28 weeks gestation. Beyond 28 weeks gestation it is recommended that dinoprostone (Prostin Pessary 3mg) is used for induction of labour. Misoprostol may be used with caution up to 32 weeks gestation on the discretion of the consultant responsible for the continuing care of the woman. At all gestations there is an absence of evidence for the management of women with one or more caesarean sections and therefore their individual management will need careful consideration**

Medication regimes can be found in Appendix 2.

**Induction of labour for a woman with a history of lower segment caesarean section**

**Misoprostol is associated with high risk of uterine rupture[4].**

A discussion of the safety and benefits of induction of labour should be undertaken by a consultant obstetrician

- **The choice of medication regime should be documented in the health record**
- Induction of labour for this group of women should take place during working hours
- Mifepristone can be used alone to increase the chance of labour significantly within 72 hours (avoiding the use of prostaglandin). A second dose of Mifepristone may be given 24 hours later.

- Mechanical methods for induction of labour in women with an IUFD should only be used in the context of a clinical trial

- Women with a single lower segment scar should be advised that, in general, induction of labour with prostaglandin is safe but not without risk

- Women with two previous LSCS should be advised that in general the absolute risk of induction of labour with prostaglandin is only a little higher than for women with a single previous LSCS

- Women with more than two LSCS deliveries or atypical scars should be advised that the safety of induction of labour is unknown

- Women undergoing VBAC should be closely monitored for features of scar rupture

- Oxytocin augmentation can be used for VBAC , but the decision should be made by a Consultant Obstetrician

**Induction of labour for woman with a history of lower segment caesarean section**

- If oral administration causes nausea/vomiting/diarrhoea then vaginal administration should be offered.

- The process may need to be repeated 24 hours after completing the first course with ultrasound first to rule out uterine rupture.

- Maternal pyrexia is a well-recognised side-effect of misoprostol using this regime. It does not indicate the presence of infection. Appropriate treatment is the provision of fluids and the regular administration of paracetamol as an anti-pyretic.

The decision should be taken by the consultant responsible for the continuing care of the woman and it is essential that whatever regime is chosen the woman and her partner are aware that there is an unquantifiable risk of uterine rupture/dehiscence. Local data would suggest that this risk is not higher than 5%, but it is not possible to be certain that it is substantially lower than this.

**Given the current state of the evidence it would very difficult to justify giving misoprostol to a woman with a scarred uterus, with a gestation greater than 28 weeks.**

## Recommendation Nine:

**Where induction with prostaglandin has deemed to fail, or where it is considered not to be appropriate, then the use of a Foley catheter to achieve cervical dilatation is a reasonable alternative.**

There is extensive literature around the use of balloon catheters for induction of labour, demonstrating efficacy equal to, if not superior to, prostaglandins. A 30ml Foley catheter balloon is placed within the cervix under direct vision (sponge-holding forceps are usually helpful in achieving this). The balloon is fully inflated and left in situ overnight. Many women will labour because of the mechanical stretch effect and when the balloon is displaced the woman will be suitable for amniotomy.

## Recommendation Ten:

**Amniotomy should be deferred in the presence of a dead fetus, until either delivery is imminent, or other methods of induction have been shown not to achieve delivery**

If amniotomy is performed as part of the induction process, it follows that attempts should be made to achieve delivery within a short a time-frame as is both possible and safe. In practical terms this means that the great majority of women should have an oxytocin infusion started soon after amniotomy. The regime for oxytocin infusion used, should be that contained within the UHL Augmentation of Labour Guideline.

Augmentation with oxytocin, in the presence of intact membranes, would be an alternative acceptable strategy.

## Recommendation Eleven:

**Management of the third stage will be governed by circumstances. For earlier gestation with intact membranes (< 20 weeks), the placenta will usually be expelled at time of delivery of the fetus. If there has been prolonged rupture of membranes then placental retention should be anticipated. For later gestations (>20 weeks), the third stage should be managed actively with either intramuscular syntometrine (or oxytocin if the woman has a history of hypertension) and controlled cord traction.**

The above represents a rough outline; however care often needs to be individualised. In all circumstances there are two important features.

- The first is that blood loss can be significant with placental retention, even at these earlier gestations.

- The second is that incomplete delivery of the placenta is more common at these gestations therefore it is important to ensure that the placenta is complete

## Recommendations Twelve:

**Adequate provision of analgesia is an important part of care**

- Analgesia requirements are driven by both the pain experienced, and the fear of that pain. Consequently psychological support from the midwife caring for the woman is an important part of her analgesia management. Many women will have experience of pain relief from previous labours and deliveries, and may seek refuge with the analgesia that was effective for them on that/those occasion(s). Familiarity with, and confidence in, a particular form of analgesia is important to many of these women[5].

- Early discussion with the duty anaesthetist will allow for a more considered approach to analgesia requirements.

- It should be remembered that uterine action, when it occurs in response to misoprostol, often leads to intense pain followed by rapid delivery. If an epidural is requested late, then delivery may occur prior to effective analgesia.

- Where IV PCA Morphine is used, it should be commenced using a standard dose of 1mg with a 5 minute lock out and the potential to administer 12mg per hour. Observations should be performed and documented on the PCA observation form every 15 minutes for the first hour and then hourly for the duration it is used. These should include respiratory function, sedation and oxygen saturation. Under NO circumstances must the relatives be allowed to press the button and they should be informed of this. A final set of observations should be recorded 30 minutes following delivery.

- Consideration can be given to the administration of regular rectal diclofenac 100mg every 16 hours or 50mg every 8 hours, where this is not contra-indicated. This may temporise further analgesic requirements and has the added effect of being anti-pyretic.

- Assessment for DIC and sepsis should be undertaken before administering regional anaesthesia.

## Recommendation Thirteen:

**Appropriate examination and investigation should be undertaken to clarify the nature of any fetal abnormality, its causation and any recurrence risks associated**

Once parents have made a decision to undergo termination of pregnancy for fetal abnormality they are most interested in causation and recurrence risks. Appropriate investigation is the key to both of these.

Karyotyping is generally best undertaken via amniocentesis, chorionic villus biopsy, or from fetal blood at the time of fetocide. Successful karyotyping can be undertaken in >99% of the relevant pregnancies. If karyotyping is undertaken from fetal skin biopsy following termination of pregnancy, 50% of samples obtained are too poor to process, and less than half of the remainder yield a successful karyotype – overall success rate about 20%[2]. Cord sample and placental biopsy can also be undertaken which is less invasive to the baby. These samples cannot be taken after the placenta is placed in formalin as formalin destroys any genetic material found.

Post-mortem examination of fetuses terminated for abnormality is a very important part of the process. Firstly it provides corroboration of the antenatal diagnosis and acts as a form of audit. Secondly it may yield additional information, which may alter the diagnosis, and hence the recurrence risk. Where internal post-mortem examination is declined, external examination, MRI and x-rays may provide valuable information and consent for this should be sought (see Guidelines for external examination of stillbirth and / or fetal loss.

If a post-mortem is accepted it is important that the placenta is sent in Formalin to the mortuary with the baby. If a post-mortem is declined the placenta should be sent to Histopathology.

## Recommendation Fourteen:

**Culturally sensitive measure should be taken to support the family, needs will vary greatly. Some parents will wish to see their child to confirm the extent of any external malformations. Some will not wish to see their child**

It is important to offer every family the choices on creating memories such as; seeing baby, holding baby and naming baby. If the parents decline it is seen as best practice to offer a second time as it is a highly stressful time for the parents. A guide on this can be found in the document creating memories, offering choices which can be found in the integrated pathways.

All memory making choices should also be offered to parents. If the parents decline, document this clearly in the notes.

## Recommendation Fifteen:

**Parents should be advised before birth about the potential difficulty in sexing the baby, when appropriate dependent on gestation and abnormalities present**

It is not usual practice to sex a baby before 20 weeks gestation. This is because the external genitalia can look very similar between the sexes before this gestation, meaning that the parents could be told the wrong sex causing great distress when the sex is confirmed by diagnostic testing.

- It is advisable that two experienced healthcare practitioners (midwives, obstetricians or neonatologists) should inspect the baby when examining the external genitalia of extremely preterm, severely macerated or grossly hydropic infants. If there is any difficulty or doubt, these babies must be documented as interderminate and an explanation must be given to the parents on why this is the case [7.]

- Caution must also be taken after 20 weeks gestation if there are abnormalities present in the genital area. These babies must be documented as interderminate and an explanation must be given to the parents on why this is the case. Parents should be made aware that occasionally mistakes in sexing babies can still be made.

- If the parents' consent to diagnostic testing it can be advised that the sex will be confirmed by these tests, cytogenetic testing and internal post-mortem examination can confirm the sex of the baby.

- If the parents decline any diagnostic testing we can advise parents that they can decide to sex the baby if they want to.

## Recommendation Sixteen:

**All women should be offered follow-up after termination of pregnancy for abnormality. This should take place when all investigations are available. Parents will wish this follow-up as soon as possible, however it is unusual for all investigations to be available much prior to eight weeks following the termination; in some instances it may be considerably longer (including time taken for the post-mortem report)**

- It is important that women and their families are informed that their follow up appointment will be arranged once all results are available.

- It is important that these women are not given a time frame, as there can often be delays in receiving the results.

- Advise the women that the bereavement team will be in touch to arrange a follow up appointment when all investigations and results are available.

### Recommendation Seventeen:

**Carers should be vigilant for postnatal depression in women with a previous IUFD**

If accepted all bereaved ladies should be offered follow up community midwifery support and bereavement support. These clinicians should be vigilant to look for signs of depression and should refer accordingly to the GP.

### Recommendation Eighteen:

**All existing appointments should be cancelled**

Ensure that all existing appointments are cancelled to prevent any distress to the parents. This should be done at the point of termination of the pregnancy not delivery as the woman could have appointments in the interim and could cause distress. These should include scan appointments, community midwife appointments and antenatal clinic appointments.

### Recommendation Nineteen:

**Lactation suppression should be offered to applicable women. See Lactation suppression following bereavement guideline**

Lactation Suppression Following Bereavement UHL Obstetric Guideline

### Recommendation Twenty:

**Care for the woman should be given by an experienced midwife in a room that pays heed to the emotional and practical needs without compromising safety**

Care of the woman should ideally be provided by an experienced midwife with familiarity of bereavement or if not possible a junior midwife should be supervised by a senior midwife. Care provided should be empathetic and the care provided should be with confidence and compassion.

## 3. Education and Training

None

## 4. Monitoring Compliance

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

## 5. Supporting References (maximum of 3)


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6. Royal College of Obstetricians and Gynaecologists. Green Top Guideline. Amniocentesis and Chorionic Villus Sampling. January 2005.
7. Royal College of Obstetrician and Gynaecologists. Green Top Guideline. Late IUFD and Stillbirth. October 2010


## 6. Key Words

Termination, TOP, Bereavement, Fetocide

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**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.**

| DEVELOPMENT AND APPROVAL RECORD FOR THIS DOCUMENT | | |
|---|---|---|
| **Author / Lead Officer:** | Original Working Party | **Job Title:** Consultant Obstetricians, Clinical Risk and Quality Standards Midwife and Bereavement Midwife |
| **Reviewed by:** | Harriet Jordan, Farah Siddiqui & Oluwafumbi Olajide | |
| **Approved by:** | Maternity Governance Group | **Date Approved:** 15/06/16 |

| REVIEW RECORD | | | |
|---|---|---|---|
| **Date** | **Issue Number** | **Reviewed By** | **Description Of Changes (If Any)** |
| Nov 2016 | V2 | F Siddiqui, C Wiesender, O Navti, F Siddiqui, H Ansar, L Matthews and J Dickens | New drug regime as per RCOG guidance. Update of checklist. Insertion of standard operating procedure for Fetocide |
| Feb 2021 | V3 | H Jordan, F Siddiqui & O Olajide | Recommendations updated and added in. Integrated pathway discussed. Mifepristone checklist removed. |
| | | | |

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| **Date** | **Name** | **Dept** | **Received** |
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**Appendix 1**

| **Standard Operating Procedure for the use of Potassium during Fetocide** | University Hospitals of Leicester NHS NHS Trust |
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## 1. Introduction / Scope

This standard operating procedure aims to provide a step-by-step procedure for the use of strong Potassium for use during a Fetocide. This is to ensure safe and effective care is provided and to ensure the correct solution is used and administrated correctly.
This procedure applies to all Health Professionals who perform or assist with Fetocide within UHL.

## 2. Consent

This procedure should be used in conjunction with the UHL Consent Policy to ensure the woman receives safe care and is able to understand the reasons for care to facilitate co-operation.

## 3. Related Documents

UHL Intravenous Policy B25/2010
UHL Hand Hygiene Policy B32/2003
UHL Personal Protective Equipment Guideline Ref B9/2004
UHL Sharps Policy B8/2013
UHL Infection Prevention Policy B4/2005

## 4. Equipment

- Dressing pack
- A selection of 2ml Luer-Lock Sterile Syringes
- A 10ml Luer-Lock Sterile syringe
- 2 x 10ml syringes with green plunger
- 15% Potassium
- 1% Lidocaine
- EDTA bottles if required
- Skin preparation as per clinicians preference i.e. Tisept / Chlorhexidine
- Sterile gloves for operator
- Sterile gloves for assistant
- 2 sterile trays for syringes
- CVS Needle of appropriate size
- Opsite
- Prescription Chart for Potassium
- Termination form signed by 2 medical practitioners

## Recommendations for the practitioners

Fetocide should be undertaken by appropriately trained practitioners who have the necessary ultrasound and invasive procedure skills.

### Technique for avoiding live birth:

Direct intracardiac injection of up to 13mls of 15% Potassium Chloride[1] has been shown to be safe for the mother and is the preferred technique. Sedation may be required prior to the procedure order to

reduce fetal movement and/or pain. A verbal safety check must be performed at the start of the procedure by all members of the team involved to verify the patient details and the procedure about to be performed.
Where maternal skin local anaesthesia with lidocaine is used, care should be taken to ensure that there is no chance of confusion of the two injections. Intradermal injection of 15% Potassium Chloride represents a significant hazard to the mother .Therefore a syringe with a green barrel must be used for KCL and placed in a separate tray. Lidocaine must be drawn up in a clear syringe and placed in a separate tray. Verbal verification must be made by the person carrying out the procedure and the assistant prior to administration.
The continuance of asystole should be confirmed by further ultrasound assessment no sooner than 20 minutes after administration of Potassium Chloride.

A variety of techniques are described. These include intracardiac injection of 15% Potassium Chloride and intracardiac injection of lidocaine.

None of the standard fetal medicine texts give a direct description and information has been pieced together from the available published papers. The dosage of potassium chloride used in variety of publications has been between 2 and 13mls of 15% KCl (up to 2g) without any demonstrated effect on either maternal serum potassium levels or ECG monitoring (Senat paper 2002 and others). **The concentration used has universally been 15% (2mmols/ml, 2meq/ml).**

Intracardiac Lidocaine has been used (Senat 2003). The technique has its attractions as it would limit the degree of autolysis and maceration change seen with Potassium Chloride, particularly for the post-mortem assessment of cardiac problems. The Senat paper is primarily about funipuncture rather than direct intracardiac injection. It describes dosage ranges from 7-30mls of 1% lidocaine. Toxicity of Lidocaine is directly related to the dosage used. Maximum dosage is 200mg (20mls of 1% lidocaine). Given this, it is likely that some fetuses would require the back-up of Potassium Chloride should they not develop asystole with lidocaine.

**Technique for selective termination in pregnancies discordant for abnormality:**

*The technique used is similar to that described for that to avoid livebirth. It is accepted that at earlier gestations direct intracardiac injection may be technically difficult and intrathoracic injection of similar quantities of potassium chloride is almost certainly as effective.*

Determination of chorionicity is essential.

Very careful consideration needs to be given to any thoughts of reduction with monochorionic twins. The technique chosen has to ensure interruption of the circulation between the fetuses. None of the techniques currently in use in this centre do this. If this is to be considered then it would be appropriate to refer these pregnancies to a centre more practised in these techniques.

With dichorionic twins careful mapping of the pregnancy topography is essential, particularly with regard to twins discordant for aneuploidy. Consequently amniocentesis/chorionic villus sampling should only be undertaken in twin pregnancies by practitioners capable of selective reduction (RCOG guideline).

It is generally considered best if selective reduction is undertaken earlier in pregnancy. This belief is based on the earlier series of twin reductions which all include monochorionic twins using techniques which do not ensure interruption of the twin-twin circulation. There is a paucity of other evidence to

confirm or refute this. The rate of total pregnancy loss is reported be between 6 and 12%, similar to that observed in multifetal pregnancy reduction.

**Technique for selective reduction of higher order pregnancies (also known as multifetal pregnancy reduction – MFPR):**

*The technique used is similar to that described for that to avoid livebirth. It is accepted that at earlier gestations direct intracardiac injection is technically difficult and intrathoracic injection of 2mls or less of 15% potassium chloride at 12 weeks gestation is effective.*

Determination of chorionicity is essential.

Reduction of triplet/quadruplet or higher order pregnancies should be a rare event with improved application of reproductive technologies. Of note is the dramatic decline in triplet pregnancies over the last few years.

It would appear to be appropriate to wait until 12 weeks gestation; there appears to be some natural wastage of these higher order pregnancies. At that time assessment of anatomy and measurement of nuchal translucency can be undertaken. If any fetus is clearly abnormal and/or has a greatly increased nuchal translucency then it would be appropriate to reduce this one first. If not then the most accessible fetus(es) should be chosen. It is generally considered to be good practice to avoid any fetus directly over the cervix unless this is obviously abnormal. The rate of total pregnancy loss depends on the starting number of fetuses; 7% with triplets, 13% with quads and so on.

**Sensitive Disposal of Fetal Remains:**

Please refer to procedures outlined in the UHL Policy for Sensitive Disposal of Fetal Remains if identifiable fetal remains are present following subsequent delivery after selective fetal reduction.

## 5. Procedure

| Procedure / Process for Fetocide | |
|---|---|
| **No** | **Action** |
| **1** | Approach the woman in a professional and caring manner.<br>Operator and assistant to confirm woman's name and address or date of birth.<br>Explain the procedure and risks to the woman and obtain her written consent using an interpreter if appropriate. |
| **2** | Reassure the woman throughout the procedure. |
| **3** | Assistant - before starting the procedure you must wash your hands. |
| **4** | Clean a trolley with Chlorclean or Distel Disinfectant Wipes. You do not need to use any additional solutions if you allow them to air dry but if you dry the tray/trolley with paper towels you must also disinfect using 70% Industrial Methylated Spirits – your trolley now provides an clean surface. |
| **5** | Gathering the equipment you need check the packages are intact and the equipment is in date, place next to the tray on a clean surface or the bottom of the trolley. |
| **6** | Two qualified practitioners must check and sign out the Potassium ampoule together in accordance with the CDA Policy and using the prescription chart. This should be placed on the trolley. |
| **7** | An aseptic non-touch technique (See ANTT Guideline Ref B20/2013) should be used throughout the procedure and in accordance with the preference of the operator. |
| **8** | Operator – perform ultrasound scan to confirm suitable injection site and clean ultrasound probe |

| Procedure / Process for Fetocide | |
|---|---|
| | with Distel Disinfectant Wipes |
| **9** | Assistant - Wash your hands and then pick-up and open the syringes and other equipment required. Arrange in an orderly manner on the trolley ensuring that a sterile field is maintained. |
| **10** | Operator - Checking with an appropriate independent practitioner draw-up Lidocaine into 10ml syringe and Potassium into 2 x 10ml syringes with green plunger. |
| **11** | Operator must confirm with assistant that the 10ml syringe with clear plunger containing Lidocaine is used for infiltration of skin. |
| **12** | Clean skin and perform procedure using ultrasound guidance throughout confirming that CVS needle tip has been visualised. Sterile gel should be applied to the ultrasound probe. |
| **13** | Confirmation of correct position of needle should be made by drawing back fetal cardiac blood. |
| **14** | Operator must confirm with assistant that syringe with green plunger containing the Potassium is being used prior to injection in to the fetal heart from the separate tray. |
| **15** | Potassium should be injected until the fetal heart stops beating. |
| **16** | The amount of Potassium that has been used should be verified between the operator and the assistant and documented in the health record and in the drug register. |
| **17** | Dispose of all sharps, syringes into a sharps container and other equipment into an orange bag and decontaminate the trolley before putting it away. |
| **18** | The woman should be informed that the procedure has been successful and given time with her partner or accompanying relative / friend. |
| **19** | Confirmation of fetal death using ultrasound should be made after 10 - 15 minutes and the woman transferred to the bereavement room. |
| **20** | Document the procedure in the health record and in the drug register. |

**Appendix 2:**

Induction of Labour in cases of intra uterine fetal death or Termination of pregnancy for fetal abnormality

Please note the change in practice when prescribing MISOPROSTOL

NB: women who are, or may become pregnant, should not handle crushed, broken or dispersed tablets

**The choice of medication regime should be documented in the health record**

These changes are an adaption of the RCOG recommendations (2014) according to the gestation and if cases of previous one caesarean section.

In cases where there has been other uterine surgery (particularly to the upper segment e.g. myomectomy) or more than one previous caesarean section, a consensus regarding the best course of management should be reached by discussion with a senior obstetric consultant. The same applies for women who have had a fetal death at term with a history of upper uterine scar or multiple caesarean sections.

- Misoprostol is issued as 200 microgram tablets; the tablets may be cut using a pill cutter (shown below) and administered as:
- 100 micrograms of misoprostol – cut tablet in half

**Induction of Labour Regime**

Give Mifepristone 200mg by mouth followed after 48 hours by:

| **Gestation** | | **REGIME 1**<br><br>**Below 20 weeks** | **REGIME 2**<br><br>**20 - 26+6 weeks** | **REGIME 3**<br><br>**27 - 32 weeks** | **REGIME 4**<br><br>**Over 32 weeks** |
|---|---|---|---|---|---|
| **Dose** | No previous C/S | First dose: 800 micrograms of misoprostol per vaginam.<br><br>Second to fifth dose: 400 micrograms of misoprostol orally | First dose: 200 micrograms of misoprostol per vaginam<br><br>Second to fifth dose: 100 micrograms of misoprostol orally | First dose: 100 micrograms of misoprostol per vaginam<br><br>Second to fifth dose: 100 micrograms of misoprostol orally | Propess or Prostin 3mg |
| **Frequency** | | 3 hourly<br>Max of 4 oral doses | 4 hourly<br>Max of 4 oral doses | 4 hourly<br>Max of 4 oral doses | |
| | | | | | |
| **Dose** | One previous C/S | First dose: 100micrograms of misoprostol per vaginam.<br><br>Second to fifth dose: 200micrograms of misoprostol orally | First dose: 100micrograms of misoprostol per vaginam<br><br>Further doses d/w Consultant | First dose: 100micrograms of misoprostol per vaginam<br><br>Further doses d/w consultant | Propess for 12 hours **or:**<br><br>2nd dose of Mifepristone after 24 hours from first dose and then Propess for 12 hours after 48 hours from 2nd dose of Mifepristone |

In women with previous Caesarean section between 20 and 32 weeks, 100 microgram 4 hourly can be given with caution to a maximum of 4 oral doses or a second dose of Mifepristone.
In women who have had more than one C/S the Consultant Obstetrician should document an individualised management plan.

The doctor prescribing should document in the notes which regime is being followed.

**Failed induction of labour**

Repeat course of misoprostol after >12 hour gap between courses or give a second dose of mifepristone. Discussion should take place with a Consultant Obstetrician

**Appendix 3:**

**Contact details for relevant support organisations**

| | |
|---|---|
| Bereavement Midwives | 07747475441 |
| Babyloss Support Leicester Leicestershire and Rutland | 07400402744 |
| The Laura Centre, Counselling service: | 0116 254 4341 |
| The Jakin Centre, Counselling service | 07599397938 |
| Miscarriage Association: | 01924 200 799 |
| ARC (support around termination for abnormality): | 0207 631 0280 |

**Appendix 4:**

## Last offices

**Time with their baby:**

For parents wishing to see their child, ensure that the baby is dressed appropriately and made as presentable as possible. Parents should be given as much time as they feel that they need to spend with their baby and their privacy respected. If they wish extended family to visit this should be accommodated as much as possible.

If the baby is born alive, again the parents should be given time with their child if they wish. Explanations should be given to the parents that the baby may continue to gasp for a considerable time. Reassurance will be needed for the parents. A medical practitioner needs to view the baby alive. Time of death should be recorded in the notes. The doctor is responsible for completing the neonatal death certificate. The baby needs to be cared for with dignity and to maintain comfort during baby's terminal care.

An on call Chaplin, can be contacted via switchboard, to attend to perform a blessing/ service if the parents so wish.

**There is a book of remembrance**:

Parents can fill in the appropriate card if they wish to make an entry, with an accompanying message or verse, a yearly none religious memorial service is organized by the hospital.

**Preparation for the mortuary:**

The Midwife should make the initial examination of the baby and then refer to the appropriate medical team (see UHL guidelines for External Examination of Stillbirth and / or Fetal Loss).

Two arm bands should be attached to baby. The baby can be sent to the mortuary with clothes on and with soft toys. Please ensure that the toys are labelled. If the parents wish the baby to remain in the clothes and they are having a post-mortem, then an explanation needs to be given that clothes will be removed and may become soiled. An alternative is to take the clothes to the undertaker. The pathologist will honour any requests made, do include a note with the paperwork of any specific requests.

Wrap the baby in a white sheet, gamgee is available to place around the head and neck for extra support. If any leakage is anticipated place a continence sheet directly underneath the baby prior to wrapping in the white sheet.

Ensure that the sheet is securely taped around the baby, and a completed cot card is attached to the top.

Place baby in transport case, ready for transfer to the mortuary. Enclose a completed bereavement form. If post-mortem is requested a computer printout, a post-mortem information form and the completed consent form also need to be included.

Call the porter to take the baby to the mortuary.

**Funeral arrangements:**

There is an information leaflet about burial for the parents to read at their leisure. The options are hospital or private funeral

**Private Funeral:**
The parents contact a funeral director and arrange a funeral of their choice this can be either cremation or burial if the parents opt for a cremation they should be advised we that ashes may not be available dependent on the size of the baby. The costs are variable but generally less then an adult funeral.

**Hospital Funeral:**
This will be a shared funeral service that takes place at Gilroes cemetery. The babies coffins are placed in the chapel and there is a short non-religious ceremony that lasts approximately fifteen minutes. The coffins are placed in a share grave of sixteen. A plaque is provided to mark the babies grave, other permanent fixtures are not permitted. This service is free of charge. If parents wish to opt for a hospital burial they need to telephone patient affairs in office hours to organize the arrangements.

**Hospital Cremation:**
If parents decide to have a cremation, they need to be aware that there will be no ashes recovered from the cremation process. A cremation form (9 if a stillbirth or form 4 if neonatal death) needs to be signed by the doctor and sent to bereavement services.

**Removal of baby from hospital:**
Occasionally parents wish to take their baby home with them. This is permissible providing that they transport the body in a suitable solid container e.g. a casket. The baby must go to the mortuary; under no circumstances can the baby be discharged home direct from delivery suite. Inform the mortuary prior to sending the baby, and out of hours inform the hospital duty manage and the maternity bleep holder. Ensure that the parents are intending to formally bury the baby.

**Stillbirth registration:**
If the baby died in utero after 24weeks gestation then a stillbirth certificate should be issued. Ensure that all parts of the certificate are completed. For cause of death it is acceptable to write unknown. Alongside the signature of the Midwife/Doctor signing the name must be legibly printed, the medical/midwifery qualification must also be complete.

**Neonatal death certificate:**
All of the above but in the section main diseases of infant, this must be completed, and it is not acceptable to write unknown. This certificate must be signed by a medical practitioner who must see the baby alive and once passed away.

If possible make an appointment for the parents at a convenient time for them at the registrations office, prior to their discharge. The registrations office is able to ask professional more questions then the parents themselves. A neonatal death takes significantly longer to register then a stillbirth. Ensure that the parents are given the death certificate on discharge and are aware that they need to register the death before funeral arrangements can precede.

**Discharge home:**
Prior to discharge or at a convenient time the General Practitioner and the Community Midwife should be informed. The couple should be made aware that a Midwife will visit the following day.

Ensure that the parents are aware of telephone numbers of support groups/community Midwife. Leaflets are available for them to take home about SANDS, Babyloss Support Leicester, Leicestershire and Rutland, The Laura centre, etc.

A baby born less then 24wks with no signs of life requires a non-viable fetal burial; send all copies completed by a midwife or doctor to sent to bereavement services.

Complete the MBRACE form if required.

If a post mortem is required send an extra delivery summary, post-mortem consent and information form to the mortuary.

**Remind the parents that a follow up appointment will be made with their consultant once results of investigations are complete.**