SLCOG Sri Lanka Journal of Obstetrics and Gynaecology

Management of stillbirth

Guideline No: 01
March 2022

Please cite this paper as: Ranaweera AKP, Rishard M on behalf of Sri Lanka College of Obstetricians and Gynaecologists. Management of stillbirth

Sri Lanka College of Obstetricians and Gynaecologists

Guideline for care of a woman who has had an intrauterine foetal death after 24 weeks (Stillbirth)

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1. Introduction

The death of a baby at any gestation is a devastating loss to parents and family. Some may never recover from such an experience. Affected women and families are known to have intense, protracted grief reactions and to develop depression. Recognising and responding to the needs of the parents at this distressing time represents a challenge to all health professionals. The parents have many difficult and often painful decisions to make; decisions which once made, cannot be changed and may have lasting consequences. This guideline is intended to provide guidance for the multidisciplinary team, in the care and management of a woman with an intrauterine foetal death (IUFD) after 18 weeks gestation and to provide support for her and her family.

The aim is to deliver quality care that is equitable, demonstrating an empathetic, sympathetic approach that reflects the needs of the local population, taking into account the cultural diversities, religious beliefs and ethnic origins. Parents should be treated with respect and dignity and care should be parent-centred. Identifying and meeting the needs of parents should be regarded as an investment in their future health and well-being and this will involve spending extra time with parents. In addition to good emotional support, women should receive excellent physical care during and after loss.

All hospitals caring for pregnant women should have a bereavement service to streamline the care for women experiencing stillbirths. Please refer to Annexure 1 on how to establish a bereavement service.

2. Definition

2.1. Still birth

A stillbirth is defined as a baby who "after complete extraction or expulsion from its mother after the 24th week of pregnancy, did not breathe or show other signs of life".

The incidence of stillbirth in Sri Lanka is around 1 in 200 (0.5%) (2018-5.9 per 1000 total births). However, a stillbirth death certificate is to be issued only if gestation is >28weeks or when gestation is unknown if foetal weight is >=1000g.

The following are common conditions which may cause an IUFD: Antepartum Causes of Death include:

- Congenital malformation
- Congenital foetal infection
- Antepartum haemorrhage
- Pre-eclampsia
- Maternal disease e.g. diabetes mellitus
- Maternal and foetal infection
- Cord prolapse
- Uterine rupture
- Idiopathic hypoxia-acidosis

Sri Lanka Journal of Obstetrics and Gynaecology 2022; **44:** 55-64

DOI: http://doi.org/10.4038/sljog.v44i1.8045

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2.2 Non-viable foetus

Less than 24 weeks gestation and where there is no evidence of life at delivery.

2.3 Neonatal death

Death within 28 days after live birth whatever duration of pregnancy.
(Calculated as following – Day of birth as Day 0)

3. When IUFD is suspected

In a situation where there is a suspicion of the absence of foetal heart sounds on auscultation or cardiotocography, ultrasound examination to make a definitive diagnosis must be undertaken without delay.

When a nursing officer (NO) or a midwife cannot hear a foetal heartbeat, the Intern Medical Officer (IMO) must be informed immediately. The patient must be told that an USS is needed to assess the baby. The mother must also be assessed to ensure that there are no immediate risks to her life (e.g. from sepsis, preeclampsia, haemorrhage, uterine rupture, un-controlled diabetes, etc). If suspected of a life-threatening condition, call for help immediately. The patient should be managed accordingly.

Even when a patient has no evidence of a life-threatening condition, the Medical Officer (MO) should attend immediately. Every effort must be taken to arrange for an USS as quickly as possible by the most experienced person available.

A second opinion must be obtained whenever feasible.

4. Diagnosis of an IUFD

The SHO, Registrar, Senior Registrar or Consultant is responsible for confirming foetal demise by ultrasound and for notifying the parents.

Keeping a woman in suspense without a definite diagnosis is very traumatic for her. This situation must be avoided at all costs.

It is important that the woman and her family are given the diagnosis unambiguously. Care must be taken to use clear, unambiguous language, taking into consideration any specific communication needs the parents may have. The most experienced practitioner available must be involved in breaking the news.

It is best that the news is broken in a private environment. The presence of a companion will be very helpful. Avoid making any comments that would make the woman or the staff feel guilty for the death of her baby even if there are obvious deficiencies. Expect a variety of emotions – anger/aggression/silence and avoid reacting to these emotions with aggression.

Address concerns regarding safety of the mother. Avoid speculation regarding the cause until results of investigations are available, unless there is an obvious cause.

4.1. Mothers should be prepared for the possibility of passive foetal movements. A repeat scan should be offered if a mother reports passive foetal movements following the scan to diagnose IUFD.

4.2. The responsible consultant and consultant on-call, both should be informed when an IUFD has been confirmed.

4.3. The Bereavement Support Nursing Officer should be informed as soon as possible.

4.4. In the event of an intrapartum stillbirth, the consultant on-call should be notified immediately, to provide support for the patient and staff. The responsible consultant should be informed as well.

4.5. If the woman is unaccompanied, an immediate offer to contact her relatives should be made (If no mobile phone with patient, offer to contact relatives through hospital exchange)

4.6. Discussions should be aimed at supporting maternal / parental choice.

4.7. A plan of care should be discussed, agreed with the woman and documented in her notes.

4.8. The SHO/ Registrar / Senior Registrar /Consultant should describe to the woman and her family what to expect, with regards to the induction procedure, labour and delivery.

4.9. Parents should be offered written information to supplement discussions (Give Information Leaflet).

After confirming the diagnosis and excluding a life-threatening condition (from history, examination and initial investigations), the patient may be discharged if she prefers to be at home. Readmit the following day. Patients should be managed in the Ante-natal side of the ward away from postnatal ward and new-borns. Preferably a special room/ward away from Antenatal/ Postnatal ward should be ideal and should be incorporated in future planning.

It should be recognized that some women are unable to access information due to language barriers, so interpreters (not another pregnant woman) should be engaged where required to ensure full understanding and dialogue.

5. Investigations

Tests aim to identify the cause of the IUFD thus providing the answer to the parents' question 'why?' The general principles of investigations are:

5.1. Clinical assessment and laboratory tests are recommended in order to assess maternal wellbeing and to determine the cause of death, the chance of recurrence and a possible means of avoiding further pregnancy complications.

5.2. Parents should be informed that no specific cause is found in almost 30% of stillbirths.

5.3. Parents should be informed that when a cause is found, it can crucially influence care in a future pregnancy.

5.4. Tests should be directed to identify scientifically proven causes of IUFD.

5.5. The following is a list of maternal investigations required. These recommendations are based on consensus on their cost effectiveness. The list is not exhaustive and the clinical circumstances may dictate additional tests or no need for some. Please consult with Registrar/Senior Registrar/Consultant if unsure of which test to undertake.

This guideline recommends a set of "Core Investigations" in all cases of IUFD. In cases where there appears to be an 'obvious' clinical aetiology, there could be an underlying and/or associated cause. However, discretion must be exercised in cases with lethal foetal anomalies.

The investigations are divided as those that are recommended:

A. At the time of diagnosis

B. Immediately following delivery

C. Six weeks following delivery

A. Core investigations: To be completed at the time of diagnosis of IUFD

a. A comprehensive maternal, family and social history

b. Ultrasound to measure amniotic fluid volume and detect possible foetal anomalies.

c. Blood investigations:

i. Full blood count

ii. CRP

iii. Kleihauer-Betke test

iv. Unexpected antibodies (irrespective of Rhesus status of mother)

v. Blood tests for TORCH screening.

vi. VDRL

vii. HIV screen

viii. Serum AST/ALT/Bile Acid

ix. Serum TSH

x. HbA1c RBS

xi. APTT and PT/INR

xii. Urine full report and culture

xiii. HVS and Cervical swab

B. Core investigations following birth

a. On the baby

i. External examination

ii. Ear swab for culture

iii. Blood from the cord or by cardiac puncture for:

1. Microbiological culture

2. Full blood count

3. Blood group and Rhesus

4. Coomb's test

5. If there are skeletal dysmorphic features, an X Ray examination of the baby is recommended (Arrange from the Radiology department)
6. Autopsy, preferably by a Perinatal Pathologist.
7. Genetic studies

b. Examination of placenta, cord and membranes Placenta and membranes must be sent for histopathological examination even where consent for autopsy is not given

c. Cultures (Skin, Placenta)

C. Six weeks following delivery

Refer to Heamatology unit to screen for thrombophilia should be undertaken six weeks postnatally where a foetal death is associated with foetal growth restriction, pre-eclampsia, abruptio placentae, maternal thrombosis and/or maternal family history of thrombosis, vasculitis or thrombosis on placental histology or remains unexplained following core investigations. These tests include:

d. Screening for APLS

e. Screening for inherited thrombophilias

Selective tests

These are tests that could be arranged selectively, based on need following discussions with the patient.

A. At the time of diagnosis

a. Maternal blood for parvo virus B19

b. Anti Ro/La antibodies where the foetus is hydropic

Essential Investigation	**Tests to be done if CLINICALLY INDICATED**
FBC	Lupus Anticoagulant
Group and Save	Anticardiolipin Antibodies
HbA1c and RBS	Parvo Virus B19 Screen
Coagulation Screen	Red Blood Cell Antibodies (If Mother Rhesus Negative)
LFTs and U and Es	Chromosome Analysis
TFT's	TORCH Screen – Only done if there are known foetal abnormalities, maternal symptoms of infection or maternal contact with a known case of infection
CRP Urine culture	HVS / Blood Cultures (If maternal fever, flu like symptoms, offensive liquor, prolonged rupture of membranes was present prior to IUFD)
Bile Acids	Other (please specify)

6. Post-mortem examination

Parents should be offered a full post-mortem examination to explain the cause of an IUFD. The timing of discussion for a pathological post-mortem examination will vary from case to case. There is no right or wrong time but ideally the discussion should begin before the baby is born. It is important to be sensitive to the cultural and religious needs of parents and to also not make assumptions that certain cultural groups will automatically decline post-mortem and therefore do not need a full discussion.

6.1. Pathological postmortem can be offered only when there is no accusation from parents regarding the care received. There should not be any suspicion regarding a criminal cause.

6.2. Parents should be advised that post-mortem examination provides more information than other (less invasive) tests and this can be crucial to the management of future pregnancies.

6.3. Parents should also be advised that on some occasions a post-mortem examination may fail to yield information regarding the cause of death.

6.4. Parents should be advised that while a limited post-mortem (e.g. external examination only) may still provide useful information, it is less likely to offer information regarding the cause of death when compared with a full post-mortem.

6.5. Individual, cultural and religious beliefs must be respected and attempts to persuade parents to choose a post-mortem must be avoided.

6.6. Consent should be obtained only from persons trained in gaining consent for post mortems. Junior doctors and nursing officers/midwives can be present at the consultation for training purposes and can act as witnesses.

6.7. Parents should be given a description of the procedure which should include how the baby is treated with dignity and the likely appearance of the baby afterwards.

6.8. Use an information leaflet to explain.

6.9. It is important to fill the pathological request form completely.

If there is a suspicion for a criminal cause (physical abuse/trauma) or accusation regarding the care by patient or relatives, parents should be counselled regarding an inquest. Police post should be informed to carry out the inquest. Need for a judicial postmortem will be determined by the coroner.

7. Induction of labour (IOL) following an IUFD

Recommendations for labour and delivery should take into account the mother's preference, her medical history and previous intrapartum history, if any.

Immediate steps towards delivery to be taken if there are signs of sepsis, pre-eclampsia, placental abruption or ruptured membranes.

If these are absent then a more flexible approach can be discussed. The SHO/Registrar/Senior Registrar or Consultant should discuss and document a plan of care for IOL, depending on the gestation of the pregnancy.

The current guideline from SLCOG/National on use of misoprostol should be used.

Every effort should be taken to promote vaginal delivery unless medically indicated.

Regime before 28 weeks gestation, low risk

- Mifepristone 200mg should be administered orally if available.
- Observe the woman for 1 hour post administration. Check blood pressure, pulse and temperature. If no side effects such as vomiting, diarrhoea and pyrexia. If there are no contraindications, if a patient prefers to go home she can be discharged.
- She should come immediately to the hospital if she starts to have vaginal bleeding, develops back ache or starts contracting.
- Re-admit to hospital 36-48 hours after administration of mifepristone. The SHO, Registrar, Senior Registrar or Consultant should review the woman and her partner to confirm the process and answer any questions they may have, prior to recommencing IOL process.
- Administer misoprostol according to the guideline into posterior fornix of the vagina. Side effects of misoprostol include diarrhoea and vomiting, shivering and pyrexia.
- Continue the regime in the guideline. Even if the mother is contracting the regime should be continued as risk of uterine rupture is minimal at this gestation.

- If labour has not started after completing one cycle of misoprostol, the woman should be reviewed by the Consultant and further cycles of misoprostol should be commenced.
- Avoid performing a hysterotomy as much as possible. Conservative management can continue up to two weeks without any increased risks there after close monitoring is needed (FBC, CRP and clotting profile).

Regime after 28 weeks gestation and for high risk pregnancies (e.g. 1 previous uterine scar, multiple pregnancies).

- Follow National Guideline for use of misoprostol
- If the woman is contracting, completion of misoprostol regime may still be given at gestations up to 32 weeks, unless she has had a previous caesarean section. After 32 weeks, the use of repeated doses of misoprostol for a woman who is already contracting should be used cautiously and should be discussed with the on-call Consultant / Registrar.
- For women with more than one previous lower segment caesarean section or classical section, the risk of uterine rupture is increased. Therefore, adherence to national guidelines is a must with a smaller dose of misoprostol, ensuring that administration is stopped once contractions begin.

8. Care in labour

One to one care by an experienced labour room staff member should be provided in an environment that pays special heed to emotional and practical needs, without compromising safety. Vaginal birth is the recommended mode of delivery for most women but caesarean birth may need to be considered for some.

- Delivery should be done in the labour ward unless the woman is herself unwell or has a medical condition which would necessitate close monitoring. (Eg. High Dependency or Intensive care unit.)
- All staff caring for the woman should introduce themselves and acknowledge the woman's/ couple's loss. The absence of this basic communication is often experienced by women and their partners as showing lack of care and support.
- The staff member will discuss the pain relief available to the woman. Normally this is pethidine or morphine. The woman can normally also have an epidural should she wish it, but the anaesthetist may require a full blood count (FBC) to check the platelets, due to the small risk of a coagulopathy with an IUFD (see analgesia section.)
- The midwife should take some time with the woman/ partner to gently explore what their wishes are regarding seeing the baby at delivery. The women/ couple may or may not want to see the baby. If the woman/couple do not want to see the baby at delivery, it is important to record this, as very often one or other of them may change their mind later. Either way, the midwife can reassure them that their wishes will be respected. The midwife may wish to discuss this with the bereavement nursing officer.
- All documentation should reflect all discussions and decisions made by parents, in order to aid the handover process and to make staff aware of the situation.
- Unless safety is compromised, having birthing companion should encouraged.
- Once contractions are regular and painful woman should be monitored closely.
- General labour care should then be provided and recorded in the partogram as you would for any labouring woman.
- Vaginal examinations done as routine to check progress.
- Artificial Rupture of Membranes (ARM) should be avoided.
- If oxytocin is required, it can be commenced with intact membranes.
- Women undergoing VBAC should be monitored closely for signs of scar rupture.
- Active second stage should not commence until the presenting part is clearly visible and review should be sought if not delivered within 2 hours of full cervical dilatation.
- Active management of third stage should be done.

9. Analgesia

The options and availability for analgesia should be discussed before it is required. It is essential to provide effective analgesia throughout labour and postpartum period.

- Pethidine (intramuscularly) or morphine (subcutaneous) should be used as the drug of choice for bereaved mothers as it is a more effective analgesia and has a longer duration of action.
- Assessment for Disseminated Intravascular Coagulation (DIC) and sepsis should be made prior to administering regional anaesthetic, as DIC increases the risk of subdural and epidural haematoma and maternal sepsis may result in epidural abscess formation.

10. Immediately after delivery of the baby

- Treat the baby with the respect you would accord a live baby.
- Offer all parents the chance to see and hold their baby. However, their wishes in this respect are paramount, and you should not put any undue pressure on them, one way or another.
- If parents wish to see their baby after the delivery, please ensure that the baby is presentable.
- The baby will need to be weighed and should have 2 name bands attached, the same as with a live birth.
- When parents are ready to let the baby go, wrap the baby sensitively and place him / her in the box for transfer to the mortuary.

Documentation

- A doctor should examine the baby and the placenta for gross foetal anomalies and document.
- Complete the labour page notes, partogram and labour summary page as you would for any birth.
- Record the stillbirth in the Birth Register.
- Institutional data collection forms should be completed by the house officer/medical officer.
- Placenta should be sent for histological evaluation and no consent is needed.
- A stillbirth certificate must be issued.
- It is important to complete the stillbirth certificate as soon as possible after the stillbirth.
- Help the parents to register the stillbirth.

11. Other investigations

Staff providing care for the woman is expected to make certain that all samples are correctly prepared, labeled and transferred in order to ensure that investigations can proceed without delay.

- A placental swab should be taken for culture and sensitivity if there is maternal pyrexia, prolonged rupture of membranes or suspected infection.
- If foetal karyotype is requested, a small placental tissue sample should be taken from close to (but not immediately adjacent to) the insertion of the cord and stored in a dry container.
- If the placenta is being sent for histology it should always be placed in a bucket and covered with formal saline solution.
- If a post-mortem is requested the placenta should also be placed in a bucket and covered with formal saline solution and sent with the baby to the mortuary.

12. Religious and spiritual advice

Each culture has its own way of dealing with the dead. This will enable the grieving process to complete and have a closure. Patient wishes should be respected. Any request which does not disturb the hospital activities significantly should be granted (Visit by a religious person, releasing the body within 24 hours or early as possible, etc). If the mother wants to attend the funeral of the baby it should be granted, and patient may be given a leave to attend. There is no need for a "burial chit" to discharge the patient.

13. Funeral arrangements

- Foetuses less than 24 weeks are considered miscarriages and should be discarded appropriately. However, instances where patient wish to take the foetus home this should be respected and the foetus handed over to the parents.
- For any baby from 24 weeks gestation, there are three options for the patient and this should be considered as her right.

  I. Take the baby and do their own funeral arrangements. This should be encouraged as this will help for proper grieving process.

  II. Hospital to arrange funeral proceedings. Instances where, the patient does not wish to take the baby home for their funeral arrangements, the hospital should discard the foetus appropriately.

III. If parents wish to donate the foetus of rare conditions or medical significance to preserve for future learning purposes, it should be organized with the relevant institution.

14. Counselling service

Initial and subsequent counselling should be done by the bereavement nursing officer. However, if she feels that the patient and/or the relatives need more advanced counselling, they should be referred to professional counsellors or psychiatrists.

15. Discharge from the hospital

- Discharge the patient as quickly as possible when there is no medical reason to keep the patient in ward.
- No need for a burial chit to discharge the patient.
- Consider giving the lactation suppressant Cabergoline (0.5 mg x 1dose if lactation is not established) – if there are no contraindications.
- All women will be offered a follow-up appointment with their Obstetric Consultant in approximately 6-10 weeks, to discuss the findings of the investigations.
- **A comprehensive diagnosis card / medical record** including the relevant history, investigations, procedures and clear follow up plan should be provided to the patients.
- Relevant Public Health Midwife (PHM) and the relevant MOH should be informed over the phone.
- A designated emergency contact number should be provided for the patient/relatives to contact in case of an emergency or any inquiry.
- Patient should be adviced to seek medical attention immediately if they
  - Develop fever, severe abdominal pain
  - Heavy bleeding
  - Purulent discharge from vagina or wound site
  - Have suicidal ideas (Relation can also inform)
- If indicated, follow-up with other specialties or special clinics should be arranged.
- Appropriate contraception advice should be offered.
- Once the investigations are completed, there is no medical reason to delay future pregnancies.

Annexure – Establishment of a bereavement and still birth care service

3.1 All units caring for pregnant women should have an established system to provide to care for women who experience IUFD

3.1.1 The objectives of this service should include

I. Provide compassionate care for the woman during this difficult time.

II. Make sure evidence based appropriate investigations are carried out to find a cause.

III. Provide basic counselling for woman and family members.

IV. Identify women and family members who require further mental health support.

V. Plan future pregnancies depending on the findings of the investigation process.

VI. Provide care during future pregnancies if needed.

3.1.2 At least one nursing officer should be trained in provision of care for these women.

3.1.3 Bereavement Care Nursing Officer.

Training

She should be trained at least 6 months in counselling under a professional familiar with this guideline.

She should attend workshops, conferences regarding care for still births and counselling.

Duties

When a patient is referred to her, she should attend to her physical as well as psychological needs.

Provide counselling to the patient as well as family members.

She should be the contact person who liaises with the patient and the staff.

Arrange investigations as described in this guideline to find a cause.

Care for the patient during labour or oversee the care provided by a designated other staff for the patient during labour.

Make sure the placenta is sent for histological examination after delivery.

Encourage post-mortem examination of the foetus, if indicated, to complete the investigation process to find a cause for stillbirth.

Care for her during the postpartum period.

Provide guidance matters concerning still birth registration, funeral arrangements and other institutional proceedings pertaining to still births.

She should have an emergency contact number/ Hotline for the patient to contact her (Phone should be provided).

Identify patients or family members with significant psychiatric issues and arrange referrals to obtain psychiatric input.

Organise a meeting with a consultant after investigation results are available usually after 6 weeks.

Liaise with patients to execute the plan for future pregnancies including appropriate referrals.

In subsequent pregnancies provide care and liaise with the obstetrics team to carry out the plan of management.

References

1. University obstetric unit, De Soysa Hospital for women. Guidelines for Care of a woman who has had an Intrauterine Foetal Death after 24 weeks (Stillbirth) and Late 2nd Trimester Miscarriage after 18 weeks (Rosebud Guideline). 2018.
2. National Institute for Health and Clinical Excellence (2008). Induction of Labour. London. NICE
3. Nursing and Midwifery Council (NMC) Circular (2007). The Care of Babies Born Alive at the Threshold of Viability. NMC. London.
4. Royal College of Obstetrician and Gynaecologists (2010). Late Intrauterine Foetal Death and Stillbirth. Greentop Guideline No 55. RCOG. London.
5. Royal College of Anaesthetists, Royal College of Midwives, Royal College of Obstetricians and Gynaecologists, Royal College of Paediatricians and Child Health (2007). Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour. RCOG Press. London.
6. Royal College of Obstetricians and Gynaecologists (2008). Standards for Maternity Care. RCOG Press. London
7. Schott et al (2007) Pregnancy Loss and the Death of a Baby: Guidelines for Professionals. 3rd Edition. Stillbirth and Neonatal Death Society. Bosun Press. London.