

# Clinical Management of Second Trimester Pregnancy Loss

## Guideline information

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The guidance uses the term “Woman” (Pronouns she or her) to describe individuals whose sex assigned at birth was female, whether they identify as female, male or non-binary. It is important to acknowledge it is not only people who identify as women for whom it is necessary to access women’s health and reproductive services. Therefore, this should include people who do not identify themselves as women but who are pregnant or have recently given birth. Obstetric and midwifery services and delivery of care must therefore be appropriate, inclusive and sensitive to the needs of those individuals whose gender identity does not align with the sex that they were assigned at birth.

Clinical documents only:

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N/A

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Summary of document:

The purpose of this guideline is to deliver gold standard care in the management of women who experience pregnancy loss between 13+0 and 23+6 weeks.

Scope:

Women who experience pregnancy loss between 13+0 and 23+6 weeks.

The guideline is relevant in all clinical areas, including gynaecology and obstetric

To be read in conjunction with:

Patient information:

Include links to [Patient Information Library](#)

Owning group:

Midwifery, Obstetric and Gynaecology Working Control Document Group

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Keywords

Pregnancy loss, miscarriage, fetal loss, medical termination of pregnancy

Glossary of terms:

A miscarriage is described as:

Early — if it occurs before 13 weeks of gestation.

Late — if it occurs between 13 and 24 weeks of gestation.

Threatened miscarriage — when vaginal bleeding, with or without lower abdominal pain, occurs in the first 24 weeks of gestation. Pregnancy may continue.

Inevitable miscarriage — when specific clinical features indicate that a pregnancy is in the process of physiological expulsion from within the uterine cavity. Pregnancy will not continue and will proceed to incomplete or complete miscarriage.

Missed miscarriage (also known as delayed or silent miscarriage) — when a non-viable pregnancy is identified on an ultrasound scan without associated pain and bleeding.

Incomplete miscarriage — when products of conception are partially expelled from the uterus. Many incomplete miscarriages may be missed miscarriages.

Complete miscarriage — when all the products of conception have been expelled from the uterus, and bleeding has stopped.

Abortion / Termination of Pregnancy: Abortion is when a pregnancy is ended so that it doesn't result in the birth of a child.

**Key points:**

Management of either late miscarriage or termination of pregnancy in the second trimester

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## Scope

Women who experience pregnancy loss between 13+0 and 23+6 weeks.

## Aim

The aim of this document is to:

- Provide seamless and high quality, consistent care to women who experience a pregnancy loss in the second trimester
- Provide seamless and high quality, consistent care to women who undergo a termination of pregnancy in the second trimester

## Objectives

The aim of this document will be achieved by the following objectives:

- Ensuring that the latest evidence underpins the care provided
- Ensure high quality, woman centred care is delivered based on national and local recommendations
- Provide seamless care which is inclusive of both gynaecology services and maternity services

## Introduction

The purpose of this guideline is to deliver gold standard care in the management of women who experience pregnancy loss between 13+0 and 23+6 weeks. For stillbirth (from 24+0 weeks) please refer to the Hywel Dda University Health Board Management of Stillbirth Guideline and ICP.

Spontaneous miscarriage is the most common complication of pregnancy, occurring in about one fifth of clinical pregnancies. The miscarriage rate is reduced to approximately 1% if a live fetus has been identified by ultrasonography at 10 weeks gestation in a normal population. Miscarriages occurring in the second trimester of pregnancy are less common and often unexpected. The incidence of miscarriage in the second trimester varies depending on the gestational age in weeks that is used in definitions and also whether the pregnancy has been dated and evaluated using ultrasound. In low risk women the risk is approximately 0.5%

The loss of a pregnancy at any gestation is traumatic for the parents, who deserve to be cared for with empathy and compassion. Commenting about mid-trimester loss a Sands report noted:

*“Poor or insensitive care at this traumatic time adds significantly to parents’ distress. Good care should be universal and should not depend on where a mother happens to live or to be cared for.”*

This guideline is written to support an integrated care pathway to enable optimal care to be given from the point of diagnosis of second trimester pregnancy loss. Whilst this guideline does not cover the management of threatened miscarriage or preterm pre-labour rupture of membranes (PPROM), it would be appropriate for use should either of these conditions result in pregnancy loss before 24 weeks gestation. It is also relevant to situations where maternal well-being is compromised and delivery indicated in the second trimester before 24 weeks gestation.

## Presentation, Diagnosis and immediate care

In women who present with abdominal pain and vaginal bleeding or spontaneously miscarry, the diagnosis may be clinical. However, many do not present in this way in the second trimester. Women may present with a history of ruptured membranes or very subtle signs such as increased vaginal

discharge or feeling pressure in the vagina. In some circumstances the woman may be asymptomatic and the diagnosis made during a routine ultrasound examination.

A thorough clinical history and physical examination are important in the assessment of women presenting with symptoms or signs suggestive of miscarriage. A past obstetric history should be obtained as well as any previous history of miscarriage or cervical surgery (including cervical suture).

Clinical examination should include the woman's vital signs and careful abdominal examination assessing for any uterine tenderness. Sterile speculum examination should be performed by a trained individual in an appropriate environment, ensuring the woman's privacy and dignity. Assess the cervix, look for any vaginal bleeding or pooling of liquor. A high vaginal swab should be sent for microbiological culture and sensitivity. If the membranes are ruptured, digital vaginal examination should be avoided to minimise the risk of ascending infection. If the cervix needs to be assessed with a view to induction, vaginal examination in the presence of ruptured membranes should be deferred until induction so that the examination to birth interval is minimised.

When fetal demise is suspected and the woman is not actively miscarrying this must be confirmed by two-dimensional ultrasound at the earliest opportunity. If the diagnosis is suspected in the community setting, then the woman should be referred to hospital for confirmation.

The optimal method to confirm fetal demise is an ultrasound scan performed by trained sonographers. The fetal chest should be imaged in the transverse plane. Ideally, a four-chamber view of the heart should be identified, though this may be difficult at earlier gestations. Colour flow Doppler is useful to verify the absence of heart activity and copies of thermal images to be stored in Maternal notes.

It is advisable to obtain a second opinion from a suitably trained person whenever possible although it is recognised that this may not always be possible in emergency situations. Consideration should be given to involving sonography to confirm ultrasound findings, images should be retained on PACS and where this is not possible images must be retained within the medical notes

Following the diagnosis and confirmation of a miscarriage the parents must be given time to absorb and accept this news. A clear, sensitive and honest explanation should be given as to what has happened by experienced staff. The language used should be clear.

If the mother has attended on her own, an immediate offer to contact her partner or a family member or friend should be made and support given. Many parents are surprised and shocked that they will still have to give birth vaginally and it is vital that they are fully informed. Questions should be welcomed and encouraged.

A patient information leaflet should be offered such as [Miscarriage Association: Pregnancy Loss patient information \(March 2017\)](#) which is suitable up to 16 weeks, the RCOG leaflet [When your baby dies before birth](#) may be more suitable after 16 weeks (March 2022).

Parents should be included in discussions about management options and their wishes should be taken into account. Some mothers will want to go home and see family members before delivery whilst others will want the induction process to commence as soon as possible. If the mother had been feeling fetal movements before diagnosis, then the possibility of passive movements should be discussed with her and contact numbers should be given.

Although care should be taken not to overload the parents with too much detail initially, it is important to give adequate information. Where possible, it is good practice to have an early discussion about what to expect in terms of induction, analgesia, birth, appearance of baby, memory boxes and other mementos. Parents also want to know about [investigations which may be offered](#) and [funeral arrangements](#).

## Psychological Support following pregnancy loss

Pregnancy loss can be associated with short term and chronic anxiety and depression not only in the mothers but also partners, fathers, siblings and other family members. Feelings of grief and loss (bereavement reactions) are very common and expected. It is important to ensure that the family are well supported throughout the hospital stay and beyond, with as much continuity of care and carer as possible. Every woman who suffers a pregnancy loss is at risk of depression, but those with psychiatric illness or from a vulnerable social group are at particular risk.

Whilst in hospital the parents should be cared for with respect and dignity, if possible in a single room to ensure privacy during this difficult time. Ideally, these parents should be cared for in a different environment from mothers with healthy babies. A Consultant Obstetrician or Gynaecologist should be made aware of the admission, depending on gestation and place of care. Efforts should be made to provide continuity of care and carer. Care in labour should be given by an experienced midwife or nurse. The partner/family should be able to remain with the mother as long as she wishes.

### Spiritual care

Parents may want the opportunity to see their own religious leader or a member of the local chaplaincy service. This should be facilitated by staff and offered to all families even if they do not have a specific faith. Hywel Dda University Health Board holds an annual remembrance service, which parents should be informed about and may wish to attend.

See support organisations.

## Multiple Pregnancies

Multiples make up approximately 3% of pregnancies in the UK with numbers rising significantly over the past 20 years due to the increasing use of assisted conception techniques such as IVF. Clinicians should be aware that fetal loss occurs more frequently in multiple pregnancies than singleton pregnancies. At gestations less than 24 weeks the fetal loss rate for monochorionic twins is estimated to be 14.2% compared with 2.6% for dichorionic twins.

Clinicians should appreciate the complexity and mixed emotions of couples who experience miscarriage, termination or selective reduction of one or more fetuses with a surviving twin or higher order multiple. The timing and mode of delivery will depend on chronicity, gestation, the presentation of the fetuses and the wellbeing of the surviving baby/babies.

Parents will require support throughout the pregnancy and birth and bereavement care. Parents want to talk about the baby that has died and to acknowledge that they were twins. Some parents may wish to take photographs of the babies together so this should be discussed and offered. The Butterfly Project supports families who have lost a baby from a multiple pregnancy. Their guideline for professionals 'Bereavement from a multiple pregnancy' was published in May 2016. The Butterfly Project | Co-twin loss; Healthcare education; Neonatal Research ([neonatalbutterflyproject.org](http://neonatalbutterflyproject.org))

Parents may also wish to access the Twins Trust resources <https://twinstrust.org/bereavement.htm>

## Second Trimester Termination of Pregnancy

Parents should be cared for with the same compassion as with an unexpected fetal loss. Good communication with the parents and between all health care professionals involved is of primary importance.

The RCOG recommends that “for all terminations at a gestational age of more than 21 weeks + 6 days, the method chosen should ensure that the fetus is born dead”. Termination of Pregnancy (TOP) at this late gestation requires administration of intra-cardiac potassium chloride (KCl) to the fetus, prior to induction.<sup>12</sup> This is a rare event and will be arranged in liaison with a tertiary fetal medicine unit (where the feticide will be performed). Clause E of the Abortion Act form (HSA1) will need to be completed by two doctors prior to performing this procedure. Following all terminations form HSA4 needs to be completed online.

Feticide is performed under ultrasound control with 15% KCl solution injected into either the umbilical cord vein or heart. A further ultrasound scan is performed after 30 minutes to ensure fetal demise. In certain specific situations where the fetus would be expected to die in the immediate neonatal period from the abnormality (anencephaly, limb body wall complex, renal agenesis and lethal skeletal dysplasias) feticide may not be necessary.

The timing of medication for induction will need to be agreed with the fetal medicine unit. Mifepristone 200mg can be given prior to or after the procedure. Following discussion with the woman a time appropriate to her circumstances and clinical service needs should be agreed for her to return for induction to give birth. This is commonly 48hrs after mifepristone but may be earlier.

Ensure that the woman has a 24 hour contact number for the relevant ward or clinical area, should she need advice prior to her planned admission.

The recommended misoprostol dose for second trimester termination is higher than that used for induction for fetal demise. The safety of misoprostol in women with a previous Caesarean section is unknown.

Parents should be provided with the ARC (Antenatal Results and Choices) information booklet. A list of contact numbers and website addresses for other local and national support groups can be found in [Appendix 1](#).

Parents should be informed that at gestations below 21+6 weeks, the baby may be born with signs of life (easily visible heartbeat seen through the chest wall, visible pulsation of the cord after it has been clamped, breathing, crying or sustained gasps, definite movement of the arms and legs.) The baby should be wrapped and treated with respect and dignity. The parents should be given the opportunity to hold their baby if they wish. See Care During Labour and Birth onwards for care during giving birth and postnatal care.

**A baby born with signs of life following a termination of pregnancy who subsequently dies must be referred to the coroner and registered as a live birth and neonatal death irrespective of gestation.**

### **Less than 22+0 weeks**

Parents should be counselled by the obstetric team that their baby cannot survive at this gestation thus it is standard practice for resuscitation not to be carried out. Parents should be informed that their baby may attempt to gasp and move when born, will be kept comfortable and treated with respect, dignity and love.

### **Uncertain gestation**

If the gestation is uncertain, or where there is parental request for resuscitation, they should be given the opportunity to discuss management with the neonatal team. A plan of care should be agreed and documented including the implications of signs of life being seen and any decision to attempt resuscitation. This would not automatically mean that the baby is resuscitated; the final decision lies with the neonatologist present at the birth after careful assessment of the baby. Resuscitation may be appropriate if baby is born vigorous and of an apparently good birth weight.

## **Signs of Life and Referral to the Coroner**

At gestations from 16 weeks onwards, parents should be informed that the baby may be born with signs of life. New guidance was released in November 2020 from MBRRACE-UK. This is national clinical guidance for the determination of signs of life following spontaneous birth before 24+0 weeks of gestation where, following discussion with parents, active survival-focussed care is not appropriate. A short training video which explains the new guidance very clearly is available at <https://www.npeu.ox.ac.uk/mbrpace-uk/signs-of-life>.

The midwife/nurse or other attending health care professional may observe for visible signs of life while holding or wrapping the baby and handing them to the parents (if the parents wish to hold the baby). Subsequent observation for signs of life should be discreet and respectful.

Assessment should be based on persistent, readily evident, visible signs. Listening for a heartbeat with a stethoscope or palpation of the umbilical cord is not necessary. Evident signs of life after birth would include one or more of the following:

- easily visible heartbeat seen through the chest wall
- visible pulsation of the cord after it has been clamped
- breathing, crying or sustained gasps
- definite movement of the arms and legs.

Since fleeting reflex activity including transient gasps, brief visible pulsation of the chest wall or brief twitches or involuntary muscle movement can be observed in babies that have died shortly before birth MBRRACE-UK recommends that such fleeting reflex activity observed only in the first minute after birth does not warrant classification as signs of life

Babies born with signs of life should be seen by a doctor at the earliest opportunity, so that in the event of a live birth and subsequent death, a neonatal death certificate may be issued to the mother. A medical certificate of cause of death may only be signed by a registered medical practitioner and cannot be signed by a midwife or other attending health care professional. In most cases, the obstetrician or gynaecologist is the most appropriate clinician to complete the neonatal death certificate. **Where a doctor has not witnessed the baby showing signs of life but signs of life have been observed by either the midwife /nurse and/or the parents, a doctor must notify the coroner before a neonatal death certificate can be issued.**

The coroner must be notified of all babies born with signs of life following a termination of pregnancy. If using this guidance in Wales but outside of the Hywel Dda Healthboard please check local coroner reporting criteria. The referral should be made electronically or by telephone depending on local policy. An example of a Coroners Referral form can be found on the Health Board intranet page. The coroner will advise on an individual case basis whether a coronial review of the death is required.

## **Management of a Baby Born with Signs of Life Where Active Survival – Focused Care is not Appropriate**

The baby should be treated with dignity, respect and love and comfort care should be provided. Wrap the baby to keep the baby warm and provide the option of family holding the baby. If the family do not wish to see or hold the baby place the baby in an appropriate size Moses basket in an alternative and private environment. A healthcare professional should remain with the baby and the time of death clearly documented, the baby should always be treated with dignity and respect.

## **Registration and Certification**

### **Neonatal Death**

When a baby is born with signs of life and subsequently dies, by law, two registrations are required, regardless of gestation; a live birth and subsequent neonatal death. In this situation there is also a requirement for a burial or cremation.

### **Miscarriage**

If a baby is born without exhibiting signs of life before 24+0 weeks this should be classified as a miscarriage. In the absence of signs of life, legal certification is not required however the parents may wish to have a certificate of birth to commemorate their baby and this should be offered. Sands has several certificates for use, the relevant one should be chosen depending on whether it is to be issued to a single parent (mother or father), a heterosexual couple or a same sex couple

### **Multiple Pregnancies**

When fetal demise in a multiple pregnancy has been confirmed by ultrasound before 24 weeks but birth is after 24 weeks, such as in the case of a single twin demise, fetus papyraceus or multifetal pregnancy

reduction, the demised fetus should NOT be registered as a stillbirth with the registrar even though it was delivered from the mother after 24 weeks.

## **MBRRACE-UK**

MBRRACE-UK is a national collaborative programme of work involving the surveillance and investigation of maternal deaths, stillbirths and infant deaths. Under 24 weeks, deaths eligible for notification at: [www.mbrrace.ox.ac.uk](http://www.mbrrace.ox.ac.uk) are:

- **Late fetal losses** – the baby is born between 22+0 and 23+6 weeks of pregnancy showing no signs of life, irrespective of when the death occurred. Both date of birth and date of confirmation of death should be reported for these cases.
- **Terminations of pregnancy** - resulting in a pregnancy outcome from 22+0 weeks gestation onwards, plus any termination of pregnancy from 20+0 weeks which resulted in a live birth ending in neonatal death.
- **Early neonatal deaths** – death of a live born baby (born at 20 weeks gestation of pregnancy or later or 400g or more where an accurate estimate of gestation is not available) occurring before 7 completed days after birth.

Each maternity unit will have a designated person responsible for reporting relevant fetal losses to MBRRACE-UK, for example the bereavement midwife or pregnancy loss co-ordinator. MBRRACE-UK notifications should be completed within 7 working days as per National Perinatal Epidemiology Unit (NPEU) report (October 2021).

## **Spontaneous Second Trimester Miscarriage**

For women who spontaneously miscarry, please see Care During Giving Birth onwards.

## **Medical Management of Second Trimester Intra-Uterine Fetal Death**

### **Purpose and Scope**

This section is designed to assist nurses, midwives, obstetricians and gynaecologists in the medical management of second trimester miscarriage. This section should not be implemented until a robust diagnosis of miscarriage has been made.

In certain clinical situations the maternal medical condition will necessitate expediting the delivery. Problems related to delayed birth are intrauterine infection if the membranes are ruptured or disseminated intravascular coagulopathy if the fetus is dead for more than 4 weeks.

### **Confirmation of Fetal Death**

Prior to proceeding with medical management it is essential that the fetal death has been confirmed by two appropriately qualified clinicians and there is appropriate recording (including retention of ultrasound images in the woman's notes).

### **Timing**

**Urgent delivery** may be required if there is **sepsis, significant bleeding** or in some cases of **ruptured membranes**.

The method of induction under these circumstances should be customised to the presenting condition and other patient factors including past obstetric and past medical history.

### **Investigations to be performed at presentation**

- Check FBC, Group and Save.
- Clotting screen (>20/40)
- Consider Kleihauer (irrespective of maternal blood group), to assess for and quantify fetomaternal haemorrhage if clinical suspicion eg history of trauma to the abdomen, antepartum haemorrhage, known vasa praevia (gestation >20/40).
- Infection screen (HVS, endocervical swabs, throat swabs, MSSU, CRP, blood cultures) should be performed if maternal infection is suspected, particularly in the presence of pyrexia, flu-like symptoms, abnormal liquor or prolonged rupture of membranes.
- Infection is more likely to occur when the cervix is dilated, if the membranes are ruptured or if the uterine contents have protruded through the cervix.
- Antibiotic administration should be considered on an individual basis.

If the above have been excluded, a senior clinician should discuss the timing and process with the mother and offer a choice of induction of miscarriage or expectant management. If the mother chooses expectant management, then arrangements for review should be made.

- If induction is delayed >48 hours repeat FBC and clotting screen weekly
- Also advise that if expectant management is performed the appearance of the baby may Deteriorate
- All mothers should be given a 24-hour contact number for the relevant ward or clinical area if they are managed as an outpatient for any time between diagnosis and birth
- Advice should be given to return to hospital should the mother experience symptoms such as abdominal pain, vaginal bleeding or have any concerns about her well-being
- Vaginal birth is the recommended mode of birth at gestations under 24 weeks. Extremely rarely a hysterotomy may need to be considered due to:
  - Unsuccessful attempts at induction
  - Deteriorating maternal condition (eg. haemorrhage or sepsis)
  - Other obstetric indications such as multiple previous Caesarean sections, placental site, morbidly adherent placenta or previous trachelectomy with trans-abdominal cerclage.

The decision regarding mode of birth in such complex cases should be made in consultation with a Consultant Obstetrician.

### **Consent**

Written consent should be obtained and documented in the woman's notes prior to commencing the induction process.

### **Drug Information**

A combination of mifepristone and misoprostol is recommended as the first-line pharmacological intervention for induction in second trimester miscarriage. One report found that the combined use of mifepristone and misoprostol was not only safe but also had an average time-to-birth interval less than other induction regimes.

## Mifepristone

An anti-progestogenic steroid is used as pre-treatment. It facilitates uterine response to subsequent administration of a prostaglandin and takes time to work so is usually given before prostaglandin.

Contraindications include – uncontrolled or severe asthma, chronic adrenal failure and acute porphyria.

Cautions – asthma, risk factors for cardiovascular disease, prosthetic heart valves or endocarditis and haemorrhagic disorders.

This drug can only be administered in hospital. Women should be observed when taking this medication.

## Misoprostol (prostaglandin E1)

In the second trimester of pregnancy this is as effective as other prostaglandin preparations. Advantages over other synthetic prostaglandin analogues are its low cost, long shelf-life, lack of need for refrigeration and worldwide availability.

Cautions – inflammatory bowel disease, conditions that are exacerbated by hypotension (e.g. cerebrovascular or cardiovascular disease)

Side effects include fever, nausea, vomiting, abdominal cramping, and diarrhoea. **These are less common if the tablets are given vaginally.**

Serious complications, including uterine rupture, major haemorrhage and cervical tear are rare

## Pre-Induction of Miscarriage

At all gestations, regardless of whether there is a uterine scar, a single dose of 200 milligrams **oral mifepristone** is given after which the mother should be allowed home wherever possible.

Arrangement should be made for admission to hospital 24 hours to 48 hours later (or sooner) if:

- the woman experiences pain or bleeding or has concerns
- she develops an indication for urgent delivery

There is no evidence against earlier induction of labour following mifepristone – induction can occur anytime from 6 hours to 48 hours after administration.

## Induction of Miscarriage

The required amount of misoprostol not only decreases with increasing gestational age but has also been found to be lower in women where the fetus has died in utero.

Vaginal assessment should be performed prior to commencing vaginal misoprostol. The vaginal route is recommended due to the lower incidence of side effects.

Misoprostol is available as 200 microgram scored tablet.

## Induction Regime Table

	Fetal Loss 13+0 – 23+6 Weeks	Termination of pregnancy 13+0 – 23+6 Weeks
Pre-induction	Mifepristone 200milligrams oral once only	
Normal interval mifepristone and misoprostol is 24 hours to 48 hours though this can be shortened if clinically needed.		
Induction	Misoprostol 800 micrograms – 1 dose (PV)	
	Followed by Misoprostol 400 micrograms, 3 hourly (BL / SL / PV)	
Vaginal route preferable due to lower incidence of side effects (gastrointestinal side effects). (Avoid vaginal route if bleeding or signs of infection) Misoprostol can also be given sublingual (under the tongue) or buccal (in the cheek).		

If birth of the fetus is not achieved after the maximum dose of misoprostol, further management should be discussed with the Consultant Obstetrician / Gynaecologist and a repeat course of misoprostol considered 12 hours after the last dose.

### Scarred uterus

The risk of uterine rupture with misoprostol, although small, is increased in women with a second trimester fetal loss and one or more previous Caesarean sections or other uterine scars. This should be discussed with the parents.

All staff should be vigilant to clinical features that may suggest uterine scar dehiscence or rupture, such as maternal tachycardia, atypical pain, vaginal bleeding, haematuria and maternal collapse.

### Women with ruptured membranes

There is no evidence in the literature as to an optimal regime for induction when the cervix is dilated and/or the membranes are ruptured. Although logically in such situations avoidance of multiple digital examinations may reduce the risk of ascending infection, there is a lack of evidence to guide practice. Consideration could be given to alternative routes for administration (oral / buccal)

## Care During Labour and Birth

Women with a second trimester pregnancy loss (miscarriage or termination) should be admitted to a place of care where their emotional and physical needs can be taken into account without compromising safety.

Efforts should be made to provide continuity of care and carer. Care should be given by an experienced midwife or nurse.

The partner/family should be able to remain with the mother as long as she wishes.

It is recommended that the woman uses a bedpan whilst using the toilet during the induction process and during labour, especially at earlier gestations

## Analgesia

Adequate analgesia should be offered. All usual modalities should be made available, including epidural and Remifentanyl at later gestations (when the clotting profile has been confirmed as satisfactory).

If intramuscular opiate analgesia is chosen, then diamorphine should be used in preference to pethidine as it provides better analgesia.

## Sepsis

Women with sepsis should be treated with intravenous broad spectrum antibiotics including cover for Chlamydia (if clinically high risk) after sepsis screening investigations have been performed.

Refer to the Health Board Antibiotics Guideline – Micro Guide

<https://viewer.microguide.global/HDUHB/Abx>

Women with a second trimester loss and GBS colonisation of the vagina do not require antibiotic prophylaxis in labour.

## Third stage

The third stage should be managed actively. First line management should be Syntometrine® (ergometrine 500 micrograms/ oxytocin 5units) 1 ampoule IM or Oxytocin 10 units IM. Women should be informed that there is a higher incidence of retained products of conception (RPOC) compared to first trimester miscarriage especially at gestations of 13-20 weeks. A low threshold for evacuation of retained products of conception (ERPC) should therefore be adopted if the placenta or membranes appear incomplete or if the woman experiences excessive bleeding.

The cord should be clamped and cut and left in-situ.

If there is a delay in delivery of the placenta by more than 30 minutes, the bladder should be emptied and an additional dose of misoprostol can be given (if the woman is actively bleeding, avoid vaginal administration). If there is a delay in completion of the third stage of more than one hour, a senior obstetric review should be sought. Surgical intervention should be considered after two hours and should only be performed by senior obstetrician and a consultant should be on site in the event that a complication is encountered (note the increased risk of uterine perforation) consideration of USS guidance for the procedure. Informed written consent should be sought from the woman after explaining uncommon surgical risks including uterine perforation (1%), cervical tears, intra-abdominal trauma (0.1%), haemorrhage and infection.

**If the woman is not haemodynamically stable or is actively bleeding, consideration should be given to early transfer to theatre.**

## Thromboprophylaxis

A thromboprophylaxis risk assessment should be performed. Whilst miscarriage and termination do not increase the risk of venous thromboembolism per se, associated complications may increase the risk (eg haemorrhage, sepsis.) Low molecular weight heparin should be prescribed if required as per local guidance.

If DIC is present, then ensure this has been successfully managed and discuss the initiation of thromboprophylaxis with a haematologist. Careful consideration should be given to the most appropriate place of care for women with confirmed DIC, a HDU may be a more appropriate setting.

Pregnancy suppresses the protein S and protein C levels and therefore results for analysis of these two factors will not be reliable if taken around delivery. Also, lupus anticoagulant and anticardiolipin antibodies should only be considered significant if two analyses show positive results 3 months apart. Any antiphospholipid screen (APS) screen should include anti B2GP1 antibodies with lupus anticoagulant and anticardiolipin antibodies as per the Sapporo International consensus statement on an update of the classification criteria for definite antiphospholipid syndrome (APS)<sup>25</sup>.

### **Anti-D Prophylaxis**

Anti-D should be administered to non-sensitised Rhesus negative women after birth as per national guidance, unless non-invasive prenatal testing for fetal Rhesus status has been performed and the fetus is known to be Rhesus negative.

## **Care of Baby**

The individual needs of each family should be identified and accommodated. Assistance should be given to facilitate the grieving process including empathic care, appropriate literature and contact telephone numbers.

### **Contact with baby**

Parents should be given the option of seeing and holding their baby whatever the gestation. Some parents may wish to see and hold their baby immediately after birth, others may prefer to wait and some will decline; their decision should be respected. At earlier gestations parents should be prepared for their baby's appearance. Parents are free to change their minds and can ask for their baby to be brought to them whenever they feel ready. Parents may wish other family members to be given opportunity to see/hold baby.

Parents should be offered the use of a cooling cot or cuddle cot if available/appropriate.

Staff should also make the couple aware that the gender of the baby may not be easily identified at earlier gestations. Hence, in cases of uncertainty, the fetal gender should not be assigned. The parents may decide to choose a neutral name for baby.

### **Memory Making**

Memory making can include hand and footprints (though these may not be possible at earlier gestations), cord clamp, identity band. Most parents welcome these tokens and they can be presented in memory boxes.

Many charities offer memory boxes to record and store mementos obtained (for example 4Louis, SIMBA). If parents are not ready to take mementos and/or photographs home, these can be sealed in an envelope so that they can look at them in their own time.

### **Photographs of baby**

Photographs of the baby are valuable and can be taken with the parents' own camera, or by medical photography for babies who have died from 18 weeks. If there is a multiple birth, offer to take photographs of the babies together and/or separately. If parents own film/disposable camera is used, it

is advisable that parents inform film developers that the film is of a sensitive nature. Verbal or written consent is required for photographs to be taken by medical photography. (consent form 7)

### **The Butterfly Project - supporting parents who have lost a baby from a multiple pregnancy**

Parents who have suffered a bereavement from a twin pregnancy (or higher order multiple) face the difficult challenge of dealing with the bereavement, while often simultaneously feeling anxious about the prognosis for surviving multiples. They differ from parents who have lost a singleton in many ways, but one important difference is that parents who have lost a twin born prematurely often remain in hospital for weeks or months while the surviving twin is cared for on SCBU.

Staff attitudes, behaviours and actions have a huge impact on parents both in the short and longer term. Generally, parents appreciate it when staff acknowledge that a surviving baby is a twin, and value the importance of knowing about the circumstance of the loss (e.g. when did it occur) as well as the name of the baby who died.

The Neonatal Research Network [www.neonatalresearch.net/butterfly-project](http://www.neonatalresearch.net/butterfly-project) have developed two concepts:

1. A small sticker of a butterfly that can be put on the front of the mother's notes, including hand held notes, where the loss happens before birth. Where the loss happens after delivery the butterfly could be placed on the medical notes of the surviving twin. However, check with your hospital that this is allowed.
2. A butterfly symbol that is placed inside of, or next to the incubator or cot of any surviving babies. We have found that most parents like to write the name of the baby who died on the card. Remember to individualise care – some parents may not wish for this.

For more information see [appendix 2](#)

## **Postnatal Care of Mother**

### **Lactation**

Suppression of lactation should be discussed if 18+0 weeks or over and cabergoline 1 milligram may be administered orally, unless there is maternal hypertension/pre-eclampsia or puerperal psychosis.

### **Contraception**

Contraception should be discussed before discharge home.

## **Investigation of Miscarriage**

The aim of investigation is to determine the cause of miscarriage. Investigations are closely aligned with the investigations following a stillbirth. There should be clarity as to who is responsible for reviewing and acting upon the results of tests ordered. Establishing a cause and effect relationship may be difficult. Causation is well established for chromosomal and fetal structural problems. However, depending on how extensively the woman wishes to be investigated, the cause of second trimester loss may remain unexplained in up to half of cases

Causes include fetal structural abnormalities, chromosomal abnormalities, maternal uterine abnormalities and cervical insufficiency or incompetence.<sup>26</sup> Many studies have shown weak associations between pregnancy loss after 20 weeks gestation and Factor V Leiden mutation, protein S

deficiency and the prothrombin G2021 mutation.<sup>27</sup> Antiphospholipid antibodies can cause placental thrombosis resulting in an increased risk of second and third trimester pregnancy loss.

Infection has been implicated in 10-25% of second trimester pregnancy losses. Many infectious agents have been suggested, including bacteria, spirochetes, protozoa, viruses and fungi. Bacterial vaginosis has been associated with second trimester pregnancy loss and treating it may reduce risk of late miscarriage in women with a history of preterm birth.

Post mortem examination and placental histology should be offered to all women who experience a second trimester miscarriage. It is recommended that all post mortems and all placental histology from pregnancies 13+6 weeks or above should be processed by pathologists with expertise in perinatal pathology. Within Wales this is the perinatal histopathology service at University Hospital of Wales, Cardiff.

Gestation should not determine whether a post mortem is offered, though parents and clinicians should understand that the information gained at early gestations might not be as helpful. To support parents to make an informed decision regarding post mortem examination,

If parents decline a post mortem the placental examination is vital. Even if nothing specific is identified on placental histology the negative finding is always useful. The placenta may, however, show an unexpected positive finding that may have implications especially in cases such as recurrent pregnancy loss as part of an undiagnosed autoimmune spectrum.

Before offering any investigations, a history should be taken to appreciate the clinical presentation to guide investigations. Under-investigation impedes efforts at gaining an accurate diagnosis however unfocussed investigation could yield results which were not contributory to the loss, thus clinicians should consider the clinico-pathological correlation between abnormal investigation results and the clinical condition.

### **Investigation Following Termination of Pregnancy**

Where there is a known or suspected fetal abnormality, the need for further investigations should be advised by a Consultant Obstetrician / Gynaecologist. Further investigations may not be required for some conditions.

**The following investigations should be offered to ALL parents experiencing a miscarriage**

#### **1. Screen for fetal infections**

- a) Placental swabs from the maternal surface only
- b) Maternal serology for TORCH screen and parvovirus B19 (>18/40)

#### **2. Placental pathology**

This is recommended even if post mortem examination is declined (see previous page). Swabs should be taken prior to wrapping the placenta in sterile water / Saline soaked swabs with the excess drained off prior to transport. The appropriate placental pathology request form should be completed and sent with the placenta as per local policy to UHW

#### **3. Post mortem examination**

Post mortem should be offered to all parents who experience a second trimester loss, though the information obtained may be more limited at early gestations. Post mortem can be full, when all organs are examined, or limited to specific locations e.g. head, chest or abdomen.

The parents should be provided with post mortem patient information leaflet 'A guide to the hospital post mortem examination of a Fetus baby and child'

Another useful source is found below –

<http://www.hta.gov.uk/licensingandinspections/sectorspecificinformation/postmortem/perinatalpostmortem/thesandsperinatalpostmortemconsentpackageincludingformdownloads.cfm>

Offer the parents the opportunity to discuss their options. If a post mortem is accepted, informed written consent should be taken by an appropriately trained individual.

### **Selective Investigation (only perform if there is a clinical indication):**

#### **1. If the mother has fever, flu like symptoms , abnormal liquor (purulent or offensive) or prolonged ruptured membranes**

Maternal infection screening should be performed including

- Listeria monocytogenes and Chlamydia spp
- Maternal blood cultures
- MSSU
- HVS
- Endocervical swabs
- Coronavirus swab
- Influenza swab

#### **2. If history suggests maternal substance abuse**

Consider maternal urine for toxicology (maternal consent required)

#### **3. If hydrops fetalis is present**

- Red cell antibody screen
- Consider maternal anti-Ro and anti-LA antibodies

#### **4. If there is :**

- No obvious cause
- Fetal loss without PPRM or preterm labour
- Fetal growth restriction
- Thrombophilia screen
- At the time of the birth: Lupus anticoagulant, anticardiolipin antibodies, B2GP1 antibodies, Prothrombin gene variants, Protein C, Protein S, Antithrombin
- If anticardiolipin antibodies or Lupus anticoagulant were positive at the time of birth they should be repeated 12 weeks after delivery. Protein S is usually low in pregnancy so may also need repeating to ensure it has normalised
- Thyroid function tests
- HbA1C (both can be taken following delivery)

## Further Management of Baby Including Transfer and Funeral Arrangements

**Inform the parents where the baby will be taken once they go home.**

### **Transfer of baby to the mortuary**

Allow parents the time they wish to spend with their baby before transferring the baby to the mortuary. Prior to transfer, ensure two name bands are completed stating “baby of (mother’s name), mother’s hospital number, date and time of giving birth as well as the hospital the baby was born at”. Attach one name band to the baby. At earlier gestations place the name band around baby’s abdomen.

In the maternity setting, complete the mortuary triplicate book (1 copy wrapped with baby, 1 on top of sheets and 1 to remain in the book) If any personal items, such as a teddy bear, or any jewellery items are to accompany the baby then these should be stipulated in the maternity triplicate book.

Arrange transfer and if parents wish to accompany their baby, inform the mortuary staff and a member of maternity staff must accompany the family.

A member of maternity / gynaecology staff must accompany the family.

### **Taking baby home**

Occasionally the family may wish to take their baby home. This is not always ideal as the baby may deteriorate rapidly and parents should be informed of this, especially if they wish to have a post mortem. The parents’ wishes should be supported. There is no legal reason why they cannot take their baby home or directly to the funeral directors of choice. The baby must be taken home in an appropriate casket. The transport home must be appropriate i.e. private not public transport. Local policy should be followed and relevant paperwork completed.

Whilst there is no legal requirement to bury or cremate babies who are miscarried <24 weeks’ gestation, many families will wish to. There is a legal requirement for a cremation or burial where signs of life have been present but there follows a neonatal death.

Parents should be given details of the options available, which may depend on gestation and the contract held with the funeral director and the crematorium, but include hospital cremation, private burial or private cremation or hospital incineration. Some hospitals offer both individual cremation and shared cremation. In a shared cremation, several babies are cremated at the same time.

Complete ‘Consent for respectful disposal of pregnancy remains (under 24 weeks) Form B with parents (Mother to initial and sign)

If the parents would like the hospital to help them with the funeral arrangements, refer to local hospital policy. Document what arrangements are likely to be carried out. Complete a ‘Disposal of pregnancy remains (<24weeks) certificate of medical practitioner’ (Midwife can complete as well as doctors.), and send to the dedicated individuals in your health board i.e. mortuary or bereavement centre. If the family are arranging their own funeral the certificate of disposal should be sent with the family who should be advised to give it to their funeral director.

If a hospital cremation is chosen complete an ‘Application for individual cremation form’ either in Narberth, Aberystwyth or Llanelli Crematorium and complete a ‘medical form for cremation’ confirming

that fetal remains are less than 24 weeks Gestation., ask the parents what they wish to do with the ashes. If they wish to collect them advise when and where this will occur. If they do not, or if the health board policy is to scatter ashes in a designated place e.g. baby garden, ask the parents if they wish to know when this will occur. At very early gestations, or if the hospital offers shared cremation only then the parents should be informed that there will not be any individual ashes to collect.

Further advice and information on sensitive disposal of fetal remains can be found in the frequently asked questions section of the Human Tissue Authority website: <https://www.hta.gov.uk/faqs/disposal-pregnancy-remains-faqs>

### **After discharge**

Please complete 'Bereavement discharge form' and send to relevant individuals ([See appendix 5](#))

After the parents have returned to their home environment, they can arrange to return to hospital to see their baby if they wish. Follow local policy to advise the parents who they should contact to make arrangements (eg bereavement office, bereavement midwife, mortuary).

When such a request is received:

1. Obtain the parents' contact number
2. Check whether the baby is still on hospital premises, especially if transferred out for post-mortem. Viewings are arranged on an individual basis.
3. Give the parents the name of the person who will meet / accompany them.
4. Check that the baby is lying peacefully; (clothes and hat for the baby if the parents wish at later gestations).

## **Other Postnatal Considerations**

All outstanding appointments with midwifery, ultrasound or medical staff should be cancelled to avoid potential upset. A letter should be sent to the mother's GP to explain that she has had a pregnancy loss.

### **Antenatal screening results**

There should be a robust method of communication with the screening midwife. First and second trimester screening results should still be communicated to the mother in the event of pregnancy loss. This must be done sensitively, for example by letter expressing condolences. See appendix 10 for a template letter.

### **Follow up**

Discuss with the mother, when and where the postnatal follow up should take place. An appointment with the appropriate consultant obstetrician or gynaecologist should be offered, maintaining continuity where possible. Explain to the parents that several months or more to receive investigation results and the post mortem report. If the parents do not wish to return to see the consultant, it is good practice to send a letter to the family and the mother's GP.

## **Follow Up Visit**

Follow up of parents after a pregnancy loss is a key element of care, with an opportunity to assess maternal recovery both physically and psychologically as well as to convey information about investigations performed and agree a management plan for future pregnancies if considered in the future.

Particular care should be taken with women with a history of psychiatric illness and the vulnerable groups of women, with a high standard of communication between all health professionals such as the psychiatrist, GP and health visitor.

Preparation is essential for any such consultation as parents who have experienced a pregnancy loss should not have the trauma of an unprepared consultation added onto that experience. It should be noted what the parents' wishes are for follow up appointments.

If the parents have given the baby a name, health care professionals should use the baby's name in discussions with the family.

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## Appendix 1 – Support Organisations and Groups

<b>ARC Antenatal Results &amp; Choices</b> Support for parents whose baby is diagnosed with a fetal abnormality in pregnancy. Helpline: 0207 713 7356 (available Tuesday & Thursday evenings 8pm to 10pm). Website: <a href="http://www.arc-uk.org/">www.arc-uk.org/</a>	<b>Cruse Bereavement Care</b> For adults and children who are grieving. Helpline: 0808 808 1677 Website: <a href="https://www.cruse.org.uk/get-help">https://www.cruse.org.uk/get-help</a>
<b>Bliss for babies born sick or premature</b> Family support helpline offering guidance and support for premature and sick babies. Website: <a href="http://www.bliss.org.uk/">www.bliss.org.uk/</a>	<b>Daddies with Angels</b> Advice and support to male family members following the loss of a child/children. Website: <a href="https://www.daddyswithangels.org/">https://www.daddyswithangels.org/</a>
<b>Child Bereavement UK</b> Supports families and educates professionals when a baby or child of any age dies or is dying, or when a child is facing bereavement. Helpline: 0800 028 8840 Website <a href="http://www.childbereavementuk.org">www.childbereavementuk.org</a>	<b>Jewish Bereavement Counselling Service</b> Supporting Jewish individuals through loss and bereavement Helpline: 020 8951 3881 Email: <a href="mailto:enquiries@jbcs.org.uk">enquiries@jbcs.org.uk</a> Website: <a href="http://www.jbcs.org.uk">www.jbcs.org.uk</a>
<b>Child Death Helpline</b> For all those affected by the death of a child. Helpline: 0800 282 986 or 0808 800 6019 Website: <a href="http://childdeathhelpline.org.uk/">http://childdeathhelpline.org.uk/</a>	<b>Lullaby Trust</b> Bereavement support to anyone affected by the sudden and unexpected death of a baby. Helpline: 0808 802 6868 Website: <a href="http://www.lullabytrust.org.uk">http://www.lullabytrust.org.uk</a>
<b>CRADLE</b> Providing a range of services to support anyone affected by early pregnancy loss Website: Home   Cradle Charity	<b>Petals Baby Loss Counselling Charity</b> Free counselling service to support women, men and couples through the devastation of baby loss. Helpline: 0300 688 0068 Website: <a href="http://www.petalscharity.org">www.petalscharity.org</a>
<b>Sands Stillbirth &amp; Neonatal Death Charity</b> Support for families affected by the death of a baby before, during or shortly after birth. Helpline: 0808 164 332 Website: <a href="http://www.uk-sands.org">http://www.uk-sands.org</a>	<b>The Miscarriage Association</b> Support for parents who have experienced miscarriage Helpline: 01924 200799 (9am to 4pm) Email: <a href="mailto:info@miscarriageassociation.org.uk">info@miscarriageassociation.org.uk</a> Website: <a href="http://www.miscarriageassociation.org.uk/">www.miscarriageassociation.org.uk/</a>
<b>Twins Trust</b> Bereavement and special needs support groups Email: <a href="mailto:enquiries@twinstrust.org">enquiries@twinstrust.org</a> Website: <a href="http://www.twinstrust.org/bereavement">www.twinstrust.org/bereavement</a>	<b>The Compassionate Friends UK</b> Offering support to bereaved parents and their families Helpline: 0845 123 2304 Email: <a href="mailto:info@tcf.org.uk">info@tcf.org.uk</a> Website: <a href="http://www.tcf.org.uk">www.tcf.org.uk</a>
<b>Tommy's</b> Information and support for parents on coping with grief after having a stillborn baby. Bereavement-trained midwives available Monday to Friday, 9am to 5pm Helpline: 0800 0147 800 Website: <a href="http://tommys.org/stillbirth-information-and-support">tommys.org/stillbirth-information-and-support</a>	

<https://www.miscarriageassociation.org.uk/wp-content/uploads/2016/10/LateMiscarriage-Mar-2017-1.pdf>

- <https://www.sands.org.uk/sands-bereavement-support-book>
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- <https://www.rcog.org.uk/media/bdndy0sb/pi-when-your-baby-dies-before-birth.pdf>
- <https://twinstrust.org/bereavement/booklet.html>
- Guidance on miscarriage and stillbirth for Jewish Parents

Local Support

### **Pembrokeshire and Carmarthenshire SANDS**

Support Meetings:-

The 2<sup>nd</sup> Tuesday of every month at Canaston Bridge Well-being Centre, Canton house, Canaston Bridge, SA67 8EP 6:30pm-8:30pm

Email: [carmspembs@sandsvolunteer.org.uk](mailto:carmspembs@sandsvolunteer.org.uk)

Facebook: Carmarthenshire & Pembrokeshire Sands

### **Antenatal Results and Choices**

Telephone: 0845 077 2290 or 02077137486 via mobile

[www.arc-uk.org](http://www.arc-uk.org)

## Appendix 2

Patient information

<http://www.sands.org.uk/support-you/understanding-why-your-baby-died/post-mortem-examination>

<https://www.miscarriageassociation.org.uk/information/leaflets/> (opens in new tab)

Second Trimester loss (late miscarriage) leaflet can be downloaded from here:

<https://www.miscarriageassociation.org.uk/wp-content/uploads/2023/05/Second-trimester-loss.pdf>

(opens in new tab)

## Appendix 3

Patient information

<http://www.sands.org.uk/support-you/understanding-why-your-baby-died/post-mortem-examination>

(opens in new tab)

## Appendix 4

<http://www.neonatalbutterflyproject.org> (opens in new tab)

## Appendix 5

### Bereavement Discharge Form

Form to be shared with relevant Healthcare Professionals prior to the woman's discharge from hospital



## Bereavement Discharge Form

To whom it may concern,

Please note the following patient has sadly experienced a pregnancy loss and therefore no longer requires any previously planned appointments

Patient ID Sticker	Discharging nurse / midwife:  Date & time:
Contact number:	Is the woman going home to her usual address
Surgery:  Community Midwifery Team:	SIP:
<b>Woman birth details</b>	<b>Infant birth details</b>
Date & time of delivery:	Gender (if known):                      Weight: (if weighed)  Baby's name (if known):
Type of delivery:	Nature of loss: Antenatal IUD                              Intrapartum IUD NND    MTOP / Feticide

		Late miscarriage	
G:	P:	Gestation:	MBL:
Perineum:		VTE score:	
Any outpatient follow-up?			
Additional information (Include all relevant information)			
If over 18/40 has the bereavement midwife been informed?			
CMW discharge given to:		Date:	

Please ensure a copy is;

- Filed in main hospital notes
- Shared with bereavement midwives (if >18/40) [bereavementmaternity.HDD@wales.nhs.uk](mailto:bereavementmaternity.HDD@wales.nhs.uk)
- Shared with GP
- Shared with radiology
- Shared with antenatal clinic

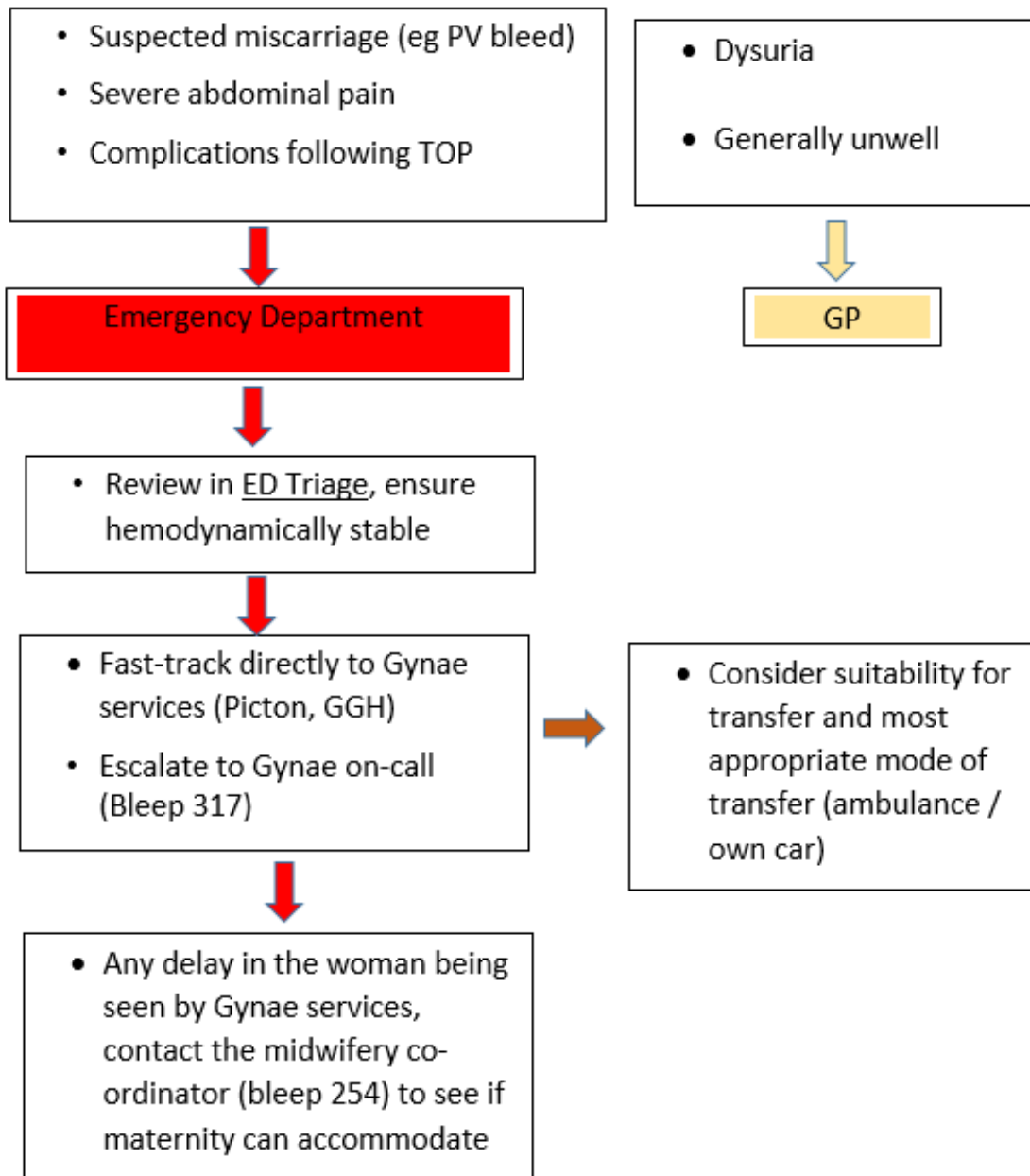
## Appendix 6

Certificate of Birth, these can be found in the memory boxes in both the Maternity Unit and Picton Ward



## Appendix 7

### Complications for Women in Early Pregnancy 14<sup>+0</sup> – 19<sup>+6</sup> gestation referral pathway criteria



Version 1 Apr 2024