

MANAGEMENT OF INTRAUTERINE FETAL DEMISE

1. Patients suspected of having an IUFD on the basis of absent fetal movements and absent FHT should have the diagnosis confirmed by real time ultrasonography.
2. Some grieving mothers will want to await spontaneous consent of labor; baseline coagulation parameters (PT, PTT, platelet count, fibrinogen) should be drawn, and the patient should be seen weekly in MFM clinic.
3. Most women harboring an IUFD will generally wish to have the pregnancy evacuated expeditiously because of the overwhelming psychological burden. These women should be consented for prostaglandin induction, making them cognizant of the possible risks of bleeding, infection, uterine rupture, and failed induction.
4. Admit to hospital, make NPO, and obtain intravenous access and baseline labs as above as well as type and screen.
5. Initially one 20 mg Prostin E₂ vaginal suppository should be inserted high in the vaginal fornix/retrocervically. Every four hours another 20 mg suppository may be inserted until the products of conception are expelled.
6. Oxytocin should not be administered to any patient receiving prostaglandin's for eight hours either before or after because of the risk of uterine or cervical lacerations from use of the two potent agents in combination.
7. Patients receiving prostaglandin's at this dosage level may have a variety of unpleasant side effects, including: pain, fever, nausea/vomiting, diarrhea. These symptoms may be treated as follows:
 - a. Labor pain: meperidine in usual doses IM or IV or epidural anesthesia.
 - b. Fever: acetaminophen rectal suppositories 600 mg q 4h prn temp higher than 38.
 - c. Nausea/vomiting: promethazine 25 mg IM or rectally q 4h prn.
 - d. Diarrhea: lomotil tabs i po q8h prn.
8. Prostaglandin's are relatively contraindicated in patients with asthma, glaucoma, organic heart disease, and prior uterine incisions.
9. It is acceptable to wait 1 - 2 hours for expulsion of the placenta after delivery of the fetus if bleeding is not excessive. After two hours, instrumental removal of the placenta is probably most prudent.
10. Appropriate facilitation of the grief process is of course always in order for these patients and should not be neglected (see Protocol 25).
11. Consent for autopsy is to be strongly encouraged prior to induction. If this is not acceptable to the family and the cause of the IUFD is unknown, consideration should be given to obtaining permission to remove a portion of the umbilical cord for tissue culture for karyotype, and to obtaining vaginal and rectal cultures for group B strep. Other studies which may be appropriately drawn, prior to induction if possible, include a Kleihauer-Betke, studies for the lupus anticoagulant, A1C hemoglobin acute and convalescent titers for CMV, toxo, parvovirus B19; and syphilis serology. Rhesus immune globulin should not be overlooked if the patient is Rh negative. Contraceptive counseling is indicated.

CONSULTATION: Twenty-Four hour consultation is available by calling the Maternal Fetal Medicine service at the University of New Mexico Hospital, 1-888-866-7257.