

Department:	Obstetrics and Gynecology (Ward)		
Document:	Departmental Policy and Procedure		
Title:	Management of Intra Uterine Fetal Death (IUFD)		
Applies To:	All Obstetrics and Gynecology Staff		
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1. PURPOSE:

- 1.1 To provide guidelines for management and care of patients with intra uterine fetal death (IUFD).

2. DEFINITIONS:

- 2.1 **Still Birth** – Death prior to completed expulsions or extraction from its mother of a product of conception, which has completed or passes the 22nd week of gestation.

3. POLICY:

- 3.1 Patient suspected of having IUFD on the basis of absent fetal movement and absent Fetal Heart Rate should have diagnosis confirmed by real time ultrasonography.
- 3.2 Some grieving mothers will want to wait spontaneous; onset of labor; baseline coagulation parameters (PT, PTT, platelet count, fibrinogen), blood group HbA1C, blood sugar should be drawn, and the patient should be seen weekly in the clinic for a maximum of 3 weeks.
- 3.3 Most women harbouring an IUFD will generally wish to have the pregnancy evacuated expeditiously because of the overwhelming psychological burden. These women prior to admission should be consented for induction, making them cognizant of the possible risks of bleeding, infection, uterine rupture, and failed induction.
- 3.4 Consultant will decide upon mode of induction/delivery accordingly.
- 3.5 Other student studies which may be appropriately drawn, prior to induction if possible, include a Kleihauer-Betke, studies for the lupus anticoagulant, acute and convalescent titers for CMV, toxo, parvovirus B19; Hb electrophoresis and syphilis serology. Rhesus immune globulin should not be overlooked if the patient is Rh negative.

4. PROCEDURE:

- 4.1 Review patient's history
 - 4.1.1 Past obstetric, particularly previous embryonic and fetal loss and family history.
 - 4.1.2 History of present pregnancy; bleeding, BP, medication and maternal perception of fetal movement.
- 4.2 Review antenatal investigations:
 - 4.2.1 Ultrasound.
 - 4.2.2 Laboratory investigations.
 - 4.2.3 Fetal assessment.
- 4.3 Check vital signs.
- 4.4 Obtain intravenous access and baseline labs as above as well as type and screen and HVS.
- 4.5 Do confirmatory ultrasound if not done.
- 4.6 Palpate patient's abdomen.
- 4.7 In Labor.

- 4.7.1 Avoid ARM till eminent delivery is anticipated.
- 4.7.2 Adequate analgesia should be provided.
- 4.7.3 Avoid using sedation to help patient to cope.
- 4.7.4 Manage as any other laboring patient with active management of the third stage of labor.
- 4.7.5 Allow parents to see efforts given by the care givers to revive their newborn.
- 4.7.6 The placenta should be examined and sent to histopathological examination. (weight, presence of thrombosis or infarction, hematoma, calcification, vascular and structural abnormality).
- 4.7.7 If fresh stillbirth, draw cord blood for:
 - 4.7.7.1 CBC, blood group, directs antibody test and cytogenetics if there is evidence of congenital anomalies seen either by ultrasound or by examination.

The following delivery, it will be the patient's choice whether she wishes to see the baby or not. She may prefer to wait later until the next day.

Stillborn fetus should be examined by both the Obstetrician and the Neonatologist and the observation should be entered into the notes – patient file.

- 4.7.7.2 General Examination
 - 4.7.7.2.1 State of preservation: fresh or macerated (degree of maceration), intact delivery or intervention.
 - 4.7.7.2.2 Weight and gestational age.
 - 4.7.7.2.3 Measurement: head circumference, chest and abdomen, length of limb.
 - 4.7.7.2.4 Colour, Vernix. White or meconium stained any skin lesion.
- 4.7.7.3 Examine for any other anomalies:
 - 4.7.7.3.1 Craniofacial, neck, trunk and extremities.

- 4.7.8 An X-ray of the skeleton should be arranged if there is an obvious cause (congenital abnormality), a post-mortem of the stillborn baby is arranged if the parents give their consent.

4.8 After the event:

- 4.8.1 Appropriate facilitation of the grief process is of course always in order for these patients and should not be neglected.
- 4.8.2 Allow woman/ family to continue to spend time with the newborn.
- 4.8.3 Encourage woman/ family to call the newborn by the name they have chosen.
- 4.8.4 Every consideration should be given to the information given to the parents.
- 4.8.5 Patient lactation should be suppressed.
- 4.8.6 GTT and Chromosomal analysis should be carried out.
- 4.8.7 If the cause of the IUFD is found to be due to congenital Malformation in a consanguineous marriage, the couple should be interviewed by the Neonatologist and/or the Clinical Geneticist. Advice regarding risks should only be given by experts in this particular field.
- 4.8.8 Contraceptive counselling is indicated.

5. MATERIAL AND EQUIPMENT:

N/A

6. RESPONSIBILITIES:

- 6.1 Physician
- 6.2 Nurses
- 6.3 Midwives

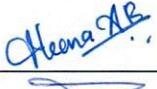
7. APPENDICES:

- 7.1 Antenatal Sheet
- 7.2 Admission form

8. REFERENCES:

8.1 Guidelines for Obstetrics and Gynecology/ Ministry of Health, General Directorate of Health Centers-Riyadh, 2013

9. APPROVALS:

	Name	Title	Signature	Date
Prepared by:	Ms. Hema Robi	Nurse Specialist		January 08, 2025
Prepared by:	Dr. Abdalla Mohamed Albasha	Obstetrician and Gynecologist		January 08, 2025
Reviewed by:	Dr. Mohannad Yaghmour	Head of the Department		January 12, 2025
Reviewed by:	Mr. Sabah Turayhib Al - Harbi	Director of Nursing		January 13, 2025
Reviewed by:	Dr. Thamer Naguib	Medical Director		January 14, 2025
Reviewed by:	Mr. Abdulellah Ayed Al - Mutairi	QM&PS Director		January 15, 2025
Approved by:	Mr. Fahad Hazam Al - Shammary	Hospital Director		January 22, 2025

KINGDOM OF SAUDI ARABIA  وزارة الصحة Ministry of Health		MRN: _____ رقم الملف الطبي:	
Hospital: _____ مستشفى:		Name: _____ الاسم:	
Region: _____ المنطقة/المحافظة:		Nationality: _____ الجنسية:	
Dept/Unit: _____ القسم/الوحدة:		Age: _____ سن: <input type="text"/> Years <input type="text"/> Months <input type="text"/> Days عمر: _____	
		Date of Birth: _____ / 14 H _____ / 20 تاريخ الميلاد:	
		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female الجنس: _____	
ANTENATAL CARE CLINIC VISITS FORM			
Risk factors & Special instructions:			
Physician Signature & ID No.			
Comment / Return Visit			
Hgb.			
Present engagement			
Maturity Assessment	AOG:	AOG:	AOG:
	USS:	USS:	USS:
	FHt.	FHt.	FHt.
Edema			
Urine	Acetone		
	Sugar		
	Protein		
BP			
Wt			
Date			
AOG = AGE OF GESTATION USS = ULTRASOUND BY SCAN FHt = FUNDAL HEIGHT			

Name: _____ الاسم: _____		MRN: _____	رقم الملف الطبي: _____
Physician Signature & ID No.			
Comment / Return Visit			
Hgb.			
Present engagement			
Maturity Assessment	AOG:	AOG:	AOG:
	USS:	USS:	USS:
	Fht.	Fht.	Fht.
Edema			
Urine	Acetone		
	Sugar		
	Protein		
BP			
Wt			
Date			
AOG = AGE OF GESTATION		USS = ULTRASOUND BY SCAN	Fht = FUNDAL HEIGHT

KINGDOM OF SAUDI ARABIA		MRN: _____	رقم الملف الطبي:
 الصحة		Name: _____	الاسم:
		Nationality: _____	الجنسية:
		Age: _____	سن: <input type="text"/> Years شهور: <input type="text"/> Months أيام: <input type="text"/> Days
Hospital: _____		Date of Birth: _____ / 14 / 20	تاريخ الميلاد:
Region: _____			
Dept./Unit: _____		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	الجنس:

MATERNITY PHYSICIAN ADMISSION ASSESSMENT SHEET

Admission Date: _____ / _____ / _____		Time: _____	Admitting Consultant: _____				
Admission From: <input type="checkbox"/> ER		<input type="checkbox"/> OPD	<input type="checkbox"/> Others: _____				
Vital signs	Temp: _____	PR: _____	HR: _____	RR: _____	BP: _____	Pain Score: _____	O ₂ Sat: _____
Height: cm.		Weight: kg.		Mobility: _____			
ALLERGIES: <input type="checkbox"/> No <input type="checkbox"/> Yes specify: _____							
Language Barrier: <input type="checkbox"/> Yes <input type="checkbox"/> No							
Chief complaint: _____							
History of presenting complaint: _____ _____							
Past Obstetrical and Gynecological History: _____ _____							
Menstrual History: _____							
Past Medical History: _____ _____							
Past Surgical History: _____							
Family History: _____							
Current Medications: _____							
Name of Medications	Dose	Route	Frequency				

Name: _____	الاسم: _____	MRN: _____	رقم الملف الطبي: _____
Drug History: _____			
History Of Blood Transfusion:		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Psychosocial History: _____			
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widow <input type="checkbox"/> Separated			
Occupation: _____			
Smoking: <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, how many cigarettes each day? _____			
Educational Level: _____			
Language Spoken: <input type="checkbox"/> Arabic <input type="checkbox"/> English <input type="checkbox"/> Others _____			
System Review:			
Neurological: _____			
Psychiatric: _____			
Cardiovascular: _____			
Respiratory: _____			
Gastrointestinal: _____			
Genitourinary: _____			
Endocrine: _____			
Others: _____			
PHYSICAL EXAMINATION			
General Appearance: _____			
Head and Neck Examination: _____			
Breast Examination: _____			
Chest Examination: _____			
Cardiovascular Examination: _____			
Abdomen Examination: _____			
Neurological Examination: _____			
Musculoskeletal Examination: _____			
Pelvic Examination:			
1.) External Genitalia: _____			

Name: _____	الاسم: _____	MRN: _____	رقم الملف الطبي: _____
2.) Vaginal Examination: _____			
3.) Speculum Examination: _____			
Investigation and Laboratory: _____			
Admission Diagnosis: _____			
Plan of Care:			
1.) Goals: _____ _____			
2.) Medication: _____ _____			
3.) Investigation: _____ _____			
4.) Consultation: _____ _____			
5.) Expected Length of Stay: _____ Days			
6.) Nutrition and Diet: _____			
Education of Patient and Family: _____ _____			
Discharged / Planning / Needs: _____ _____			
Referral Indicated: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Referral Sent To :			
<input type="checkbox"/> Home Care		<input type="checkbox"/> Social Services	
<input type="checkbox"/> Psychiatrist		<input type="checkbox"/> Physiotherapist	
<input type="checkbox"/> Physician		<input type="checkbox"/> Intensives Care (ICU)	
<input type="checkbox"/> Others _____			
PHYSICIAN NAME: _____ Stamp&Signature: _____ Date: ____ / ____ / ____			
Consultant Notes: _____ _____			
CONSULTANT NAME: _____ Stamp&Signature: _____ Date: ____ / ____ / ____			