

PURPOSE To outline the trained clinical team member's management of labor for the delivery of a nonviable fetus or intrauterine fetal demise (IUFD) induction.

LEVEL Interdependent

SUPPORTIVE Induction is defined as the stimulation of labor by artificial methods. Misoprostol (Cytotec) and/or Oxytocin (Pitocin) can be used to induce labor in order to enable the delivery of a nonviable fetus, a fetus diagnosed with a condition not compatible with life, or an IUFD. Misoprostol works by stimulating uterine contractions, which result in expulsion of uterine contents. **Documentation of Gestational age is required. Special consideration should be made with patients In the 3rd trimester with a history of a scarred uterus.**

The following are candidates for receiving Misoprostol:

- **Requiring termination of pregnancy from 12th through 20th week of gestation, upon approval from the Ethics Committee.** A fetus diagnosed with anencephaly does not require Ethics Committee approval. The Ethics Committee can be contacted at 253-416-9556.

- Requiring evacuation of uterine contents in the management of missed abortion or intrauterine fetal death.

The following are contradictions for receiving Misoprostol

- Hypersensitivity to dinoprostone (ie; Cervodil, Prostin)
- Patients receiving other oxytocic agents (within 30 minutes of their discontinuation).
- Pitocin (Oxytocin) Policy # 6601.00
Perinatal loss Policy # 6599.00
Admission of laboring pt. Policy # 6501.00
Allow natural death/withholding and/or withdrawing life-sustaining Treatment/non-beneficial care and DNR protocol # 970.00
Death Pronouncement Procedure Policy # 821.50

EQUIPMENT Fetal monitor
IV supplies

ADMINISTRATION

1. If fetus is \leq **24 weeks size:**

- Give Misoprostol 400 micrograms (mcg) orally or vaginally every 3-4 hours per HCP orders until delivery.
- Alternatively, per HCP request, a high dose Oxytocin regimen may be used. If used alone, it should be preceded by laminaria placement for 12 hours to prepare the cervix. It may be implemented 3 hours after the last dose of Misoprostol. **Oxytocin is run every 3 hours then a one hour rest.** Every 4 hours the Oxytocin is increased until delivery occurs or the maximum dose of Oxytocin of 100 units per hour is reached. (The Oxytocin is provided in premixed bags of 100 units in 500 ml which gives a concentration of 0.2 units per milliliter). Use the following chart to determine the rate:

Cycle Every 4 hours	Units per Hour	ml per Hour
1-3 hours	16.6	83
5-7 hours	20	100
9-11 hours	22.4	117
13-15 hours	26.6	133
17-19 hours	30	150
21-23 hours	33.4	167
25-27 hours	36.6	183
29-31 hours	40	200
33-35 hours	43.4	217
37-39 hours	46.6	233
41-43 hours	50	250
45-47 hours	53.4	267
49-51 hours	56.6	283
53-55 hours	60	300
57-59 hours	63.4	317
61-63 hours	66.6	333
65-67 hours	70	350
69-71 hours	73.4	367
73-75 hours	76.6	383
77-79 hours	80	400
81-83 hours	83.4	417
85-87 hours	86.6	433
89-91 hours	90	450
93-95 hours	93.4	467
97-99 hours	96.6	483
101-103 hours	100	500

2. If fetus is \geq **24 week size**, use laminaria first. If cervix is not softened, then start Misoprostol 50mcg orally or vaginally every three hours x 3 doses then start low dose Pitocin. AROM is recommended as soon as possible.
3. **Laminaria use:**
 - If the use of laminaria is desired, the patient may be started in the office/outpatient setting. Before medication is given, it is suggested that laminaria be inserted by the provider the previous day.
 - **Do not use laminaria in GBS+ patients or in cases of suspected Chorioamnionitis.**

- On the day before the intended delivery, the patient is given Misoprostol 50mcg orally or vaginally in the early afternoon (this is to soften the cervix), and instructed to return to the doctors' office in 3-4 hours.
- After the patient returns, 2-3 laminaria are placed in the cervix and kept in place with 4X4's.
- The patient is instructed to remain at rest at home throughout the evening and return to the hospital for admission the next morning.
- Upon admission to the hospital, remove laminaria, and continue induction per HCP orders.

REPORTABLE CONCERNS

Notify HCP if:

- Incomplete expulsion of uterine contents.
- Excessive bleeding
- Untoward side effects
- Inadequate pain relief

LABOR

STEPS	KEY POINTS
4. Assess patient's knowledge of procedure.	
5. Educate patient on purpose of drugs, Expected side effects and analgesia/anesthesia.	Decrease fear and anxiety.
6. Assess psychosocial status and identify appropriate resources available i.e.: pastoral care, social workers, and mortuary.	Review perinatal loss policy and paperwork.
7. Obtain DNR order from OB HCP.	Refer to Protocol # 970.00 "Allow natural death/withholding and/or withdrawing life-sustaining treatment/non-beneficial care and DNR protocol"
8. Obtain baseline vital signs then every 4 hours unless otherwise ordered.	
9. Assess uterine activity by palpitation and subjective reporting.	If less than 24 weeks EFM is not needed to assess uterine activity.

DELIVERY

10. Assess for possible signs of life at time of delivery, (in case of induction of a

Initiate perinatal loss care record. If live birth, (i.e. sustained respirations on own), start admission process. Apgars must be assigned and newborn chart initiated.

11. Provide palliative care.

12. Pronounce death per policy # 821.50.

This policy allows nurses to pronounce death with a physician order.

13. Gather all tissue: i.e. placenta and fetus to be examined by HCP.

14. Send placenta to pathology.

DOCUMENTATION

Document exceptions, reportable concerns and patient responses in the medical record. Include all communication with the Health Care Provider.