County Durham and Darlington NHS
NHS Foundation Trust

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## Ratification

| | |
|---|---|
| Signature of Chairman of Ratifying Body |  |
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**Document Control Information**

***Version control table***

| Date of issue | Version number | Status |
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***Table of revisions***

| Date | Section | Revision | Author |
|---|---|---|---|
| 15/02/12 | Full | Merged with bereavement guideline | Jackie Hendy |
| 26.4.12 | Full | Updated with drug dosage<br><br>Amendments made re support and communication<br><br>Key performance indicators | Joanne Woodward |
| Jun 2015 | Full | Out of date – for review<br><br>Out of date – for review – Review of drug regime used in other Trusts - No changes to misoprostol regime<br><br>5.6 Where to care for families expanded<br><br>5.1 Included Anti D for IUD as a sensitizing event as recommended by BCSH | EBPG<br><br>Sheila Reed<br><br>E Bouic |
| June 2019 | | Extended till 30 December 2019 | |

## Contents

**1. Introduction**

Stillbirth is common, with 1 in 200 babies born dead.
Overall, over one third of stillbirths are small-for-gestational-age fetuses with half classified as being unexplained.
The stillbirth rate has remained generally constant since 2000.
In addition to any physical effects, stillbirth often has profound emotional, psychiatric and social effects on parents, their relatives and friends.

Fetal abnormalities are uncommon, In England and Wales 2014 there were 3099 terminations for fetal abnormalities. See appendix 3 for breakdown of conditions.

**2. Purpose**

The purpose of this guideline is to support staff in providing care based on best practice and best available evidence when caring for women and their relatives who have a pregnancy loss or who have opted for termination of pregnancy after confirmation of fetal abnormality.

## 3. Scope

This guideline defines the roles and responsibilities of Obstetric and midwifery staff and other disciplines involved in the care and management of women and their relatives who have had a pregnancy loss or who have opted for termination of pregnancy after confirmation of a fetal abnormality.

## 4. Duties

This guideline defines the roles and responsibilities of Obstetric and midwifery staff and other disciplines involved in the care and management of women and their relatives who have had a pregnancy loss or who have opted for termination of pregnancy after confirmation of a fetal abnormality.

Consultant Obstetrician will discuss confirmed diagnosis, and subsequent plan of care for induction of labour. Follow up care will be offered to discuss findings of investigations and selected tests.

- Consultant must ensure that the correct legal paperwork is completed for termination of pregnancy. 2 Doctors to sign.
- Consent forms must be signed for termination for fetal abnormality.
- Reaffirmation of consent must be taken if consent already obtained in tertiary unit.

**5. Management**:

**5.1 Diagnosis**

- To confirm IUD Real-time ultrasound to be performed by trained personnel, allowing direct visualisation of the fetal heart. A second opinion should be obtained whenever practically possible.

- Fetal anomalies are usually diagnosed following ultrasound scan or prenatal invasive tests. Following diagnosis women will be counselled regarding future management of pregnancy and/or offered termination of pregnancy where appropriate. Women who are offered termination of pregnancy for fetal abnormality beyond 21 weeks gestation should be fully counselled and fetocide offered, this will necessitate referral to the Fetal Medicine unit RVI.

- Take blood for Kleihauer once sensitizing event has occurred – Administer Anti D immediately following diagnosis of the IUD **- it is recommended to give it again following delivery as there may be a significant delay between the diagnosis of IUD and the subsequent delivery. (BCSH Guidelines 2014).**

### 5.2 Discussing the diagnosis - Communication

- Ensure all discussions with parents are documented fully in the notes

- When a woman has had an invasive test to confirm fetal abnormality, the result may be given over the phone, see appendix for procedure for informing woman of results over the phone. Woman will be invited in following this initial telephone call to fully discuss the results, implications and further management.

- Where pregnancy loss is unexpected or unexplained the family must be seen as a matter of priority by the Consultant on call and / or the named Consultant**.**

- Except in an emergency a woman who is alone should be asked if she would like to call her partner, relative or close friend to support her.

- Ask if she would like to wait until they arrive before the diagnosis/ problem is explained in detail.

- Ensure woman is not partially clothed or sitting on examination couch for this discussion.

- The diagnosis should be explained clearly using appropriate language and no medical jargon. At parents lead it may be appropriate to discuss the ultrasound findings of severe maceration and gross skin oedema if seen.

- It is important to determine the emotional feelings and needs of the mother and her companions. Ensure they feel fully informed and answer any questions, find out about their views and wishes

- If there are any language or communication support needs – ensure they are addressed – contact language line or other support network - ie Communication Service

- The couple's choice about further management should be supported and they should be offered written information to supplement discussions, these are available in different languages and formats. It is vital to ensure they have time to take in what they have been told, to formulate their questions and express concerns.

- Balance honesty and realism with sensitivity and support. Demonstrate empathetic understanding of the impact of what is being said.

### 5.3 Discussing subsequent care

- The mother's preference should be respected however it is important to assess maternal wellbeing and manage any potential problems, sepsis, pre-eclampsia, placental abruption or membrane rupture are some of the indications for immediate steps towards delivery.

- The options to discuss with the women who have no risk factors are expectant management and Induction of labour. In rare circumstances caesarean birth will need to be considered.

- Following confirmation of a fetal abnormality the women should be counselled regarding all options including continuation of pregnancy and support as well as TOP. If the woman choses to terminate the pregnancy she should be offered medical or surgical management. *NB: post mortem is not possible following surgical TOP.*

### 5.4 Expectant management for IUD

- In well women with intact membranes, labour can be delayed up to 48hours without any physical harm. Ensure woman is given 24 hour contact number for support and information. If there is delay in labour >48 hours, coagulation time and plasma fibrinogen should be done twice weekly and advise that prolonged intervals of delay may reduce the value of post-mortem and alter the appearance of the baby.

### 5.5 Induction of labour: - see appendix 1

### 5.6 Suitable facilities for labour

- It is important to provide appropriate care and facilities which reflect commitment and respect for the parents and their baby.

- A labour ward room that provides appropriate facilities for emergency care. Care in labour should be given by an experienced midwife and continuity of care should be maintained where possible.

- Visiting arrangements should be open and flexible according to the family's wishes, to promote individualised care and facilitating the family to support each other as they wish.

- Medical TOP: If fetal abnormality is diagnosed less than 18 weeks of pregnancy women should be cared for on the gynaecology ward, unless they have no beds available in which case the woman will be cared for in the labour ward.

- If fetal abnormality is diagnosed over 18 weeks the woman will be cared for in the labour ward.

- Surgical TOP: If the woman wishes a surgical TOP this will be arranged with the gynaecology ward up to 11+6 weeks of pregnancy, if the woman is over 12 weeks and wishes a surgical TOP refer to RVI (through fetal medicine)

**5.7 Routine antibiotic prophylaxis or Intrapartum antibiotic prophylaxis for women colonised with group B streptococcus are not indicated.**

**5.8 Pain relief**

- Wherever possible the different options and the advantages, disadvantages and side effects of each, should be discussed carefully beforehand and, where appropriate, during labour
- Women should be offered the opportunity to meet with an obstetric anaesthetist, to discuss analgesia options.

**5.9 Following Delivery**

- A resource/ information file is available to all staff involved in the care of bereaved families.
- Appropriate check list to be used dependant on case specific pregnancy loss – this lists the tasks to be carried out, records all samples that have been sent, ensures paperwork has been completed and that information has been passed to other health professionals.
- For gestation less than 22 weeks it may be difficult to identify the sex of the fetus. Therefore care should be taken in discussing the gender with the parents
- Fundamental principles and choices about their situation and plan of care may differ between individuals depending upon gestation and type of pregnancy loss.
- Immediate post delivery care of mother dependant on her physical condition and wellbeing and type of delivery

**5.10 CREATION OF MEMORY**

- Following full discussion staff may be able to help by offering information and opportunities to create positive memories and physical mementos.
- Parents may wish to spend time with their baby and staff should respect their wishes to do so, equally others may not wish to see their baby.
- Creation of memories, always discussed/ offered to parents and **only** done with their full consent. e.g. footprints, handprints, photographs, locks of hair. Parent's wishes must be followed at all times to avoid unnecessary distress and ensure that they are able to remember their baby the way in which **they** want to.

**5.11 PSYCHOLOGICAL / SPIRITUAL SUPPORT**

- Parents may find it helpful to talk to someone supportive this may be the midwife, obstetrician, bereavement midwife, GP, chaplain
- Many parents get valuable support from national charities and local groups such as SANDS, the Miscarriage Association and ARC. Details of how to contact these groups should be offered to the parents.

- Offer support from members of the clergy including the hospital chaplain. They may wish to have a blessing – explain this can be arranged for them. Families may choose to contact their own member of the clergy.

- Some women, partners or their family may wish to see a professional counsellor. Parents should be offered verbal and written information for pregnancy loss counselling available within the trust so that if in the future they are able to arrange this by self referral. Staff may discuss this with the parents and can make the arrangements for them.

**5.12 SUPPRESSION OF LACTATION**:

- The management of lactation after loss varies – there is no conclusive evidence to show pharmacological methods are more effective than non pharmacological ones.

- Women who use non pharmacological methods in the first week although they have more pain initially have fewer symptoms in the long term ( Sands 2007)

- Women should be given the options of non-pharmacological measures and pharmacological measures for lactation suppression.

- Dopamine agonists successfully suppress lactation and are well tolerated. However it should be avoided in women with hypertension or pre-eclampsia.

- Cabergoline is superior to bromocriptine. Cabergoline is given 1mg per day for 14 days. Bromocriptine is as 2.5 mg twice daily for 14 days. Estrogens should not be used to suppress lactation.

**5**.13 **LEGAL ASPECTS**

- Certification and registration will alter dependant upon the gestation and individual wishes.

- Post mortem issues - the family may have specific views and questions in relation to the post mortem examination, which should be fully discussed prior to gaining written consent.

- Consent should only be obtained by a person with appropriate training. A copy of the consent form should be offered to the family and another kept within maternal Medical Records.

**5.14 CHOICES WITH REGARD TO BABY**

Options for funeral arrangements will differ due to local policies, and parents will need relevant information to be able to make a choice.

Please try to inform/ involve the bereavement support officer to assist with arrangements.

**5.15 DOCUMENTATION**

- Record all discussions with the parents in the notes. This ensures that once a decision has been made it is not raised again unless the parents themselves wish to raise it. Staff should check notes regularly to ensure they know what decisions parents have made.

- Midwife to ensure that the **FETAL/MATERNAL/PLACENTAL INVESTIGATION FORMS** are completed – **see pregnancy loss check lists**
- Senior Obstetrician/ midwife to examine baby and document observations
- When post-mortem examination is arranged the detailed **AUTOPSY REQUEST FORM** should be completed (notes should be reviewed and all relevant information inserted on the form)
- In cases of "Stillbirth" an experienced senior member of medical staff on duty at time of delivery must ensure that **STILLBIRTH CERTIFICATE** is properly completed. This is a legal document – **should be legible, written in black ink and contain no abbreviations.**
- Confirm that Consultant and G. P. have been informed.
- Confirm NorCAS (Fetal Abnormality Survey) form completed where appropriate

### 5.16 DISCHARGE HOME

There should be provision for close co-ordination and communication between all disciplines of staff, especially between hospital and community, to promote increased levels of support for bereaved families**.**

- The Community Midwives, Health Visitor and General Practitioner should be informed of the events.

- Multi-disciplinary agencies, involved in care provision of client should be informed of the events.

- Appointments for antenatal clinics (hospital and community), ultrasound scans and preoperative assessment should be cancelled.

- The woman and family should be seen by a Consultant prior to discharge home

- Inform the relevant Consultants secretary re IUD/ Termination, so they are aware if woman rings up for an appointment or results.

- An appointment should be made with the Consultant once results available to allow discussion re findings and future plans.

- Ensure that contact telephone numbers are given to the family prior to discharge to ensure an easy means of communication with those involved with their care and follow up. Advise family they will need to make an appointment with their own GP for Postnatal check.

- Enquire as to whether the woman would like a community midwife to visit at home and make arrangements for this – this should be encouraged where there is any issues regarding maternal health.

### 5.17 RECOMMENDED INVESTIGATIONS and selective tests

Case specific for recommended and selective tests see appendix 2

## 6. TRAINING

In- house pregnancy loss workshops should be accessible to all staff that may be part of the multi-disciplinary team involved in caring for bereaved families. This ensures that staff are kept up to date with issues surrounding pregnancy loss and encouraged to develop coping strategies with colleagues.
A staff counselling service should be available within the Trust to provide additional support for staff dealing with bereaved families.

## 7. Key Performance Indicators

| **Monitoring Criterion** | **Response** |
|---|---|
| Who will perform the monitoring? | Maternity services |
| What are you monitoring? | • Any pregnancy loss.<br>• Provision of postnatal support for parents in cases of pregnancy loss.<br>• Provision of support to parents who have communication or language support needs.<br>• That all discussions with parents documented in notes.<br>• Ensure parents have information about the relevant support group |
| When will the monitoring be performed | Case by case basis |
| How are you going to monitor? | Safeguard reporting system |
| What will happen if any shortfalls are identified? | Obstetric & Gynaecology Operational Group will address shortfalls and implement action plans |
| Where will the results of the monitoring are reported? | Quarterly Clinical Governance Meeting - Audit results will be presented in conjunction with results from the notes audit. |

| | |
|---|---|
| How will the resulting action plan be progressed and monitored? | Obstetric & Gynaecology Operational Group will monitor and formulate plans, amend guidelines. |
| How will learning take place? | Labour Ward Forums, Mandatory Study Days and Team Meetings. |

## 8. REFERENCES

Qureshi et al, BSCH guideline for the use of anti D immunoglobulin for the prevention of haemolytic disease of the fetus and newborn. Transfusion Medicine. 2014.

Schott J, Henley A, Kohner N. Pregnancy Loss and the Death of a Baby. Guidelines for professionals. 3rd ed. London: Bosun Press, on behalf of Sands (stillbirth and neonatal death society); **2007**.

Royal College of Obstetricians and Gynaecologists Greentop Guideline, 55, October2010. Late Intrauterine Fetal Death and Stillbirth.

West Midlands Perinatal Institute **(2001**) Standards for Bereavement Support

## 9. Associated Documentation

CDDFT Maternal Screening Guideline
CDDFT Fetal Abnormality Guideline
CDDFT Induction of labour Guideline
CDDFT Care of women in labour
CDDFT Operative vaginal delivery
CDDFT Obstetric Haemorrhage

# 10. Equality Analysis / Impact Assessment

| **Full Assessment Form** | **v2/2011** |
|---|---|

| | |
|---|---|
| **Division/Department:** | **Care Closer to Home – Maternity Services** |
| **Title of policy, procedure, decision, project, function or service:** | **Management of intra-uterine death and termination of pregnancy for fetal abnormality** |
| **Lead person responsible:** | **Evidence Base Practice Group – chair** |
| **People involved with completing this:** | **Emma Bouic**<br>**Joanne Woodward**<br>**Sharon Tilley**<br>**Christine Dowson** |

**Type of policy, procedure, decision, project, function or service:**

Existing Yes ☐

New/proposed ☐

Changed ☐

**Step 1 – Scoping your analysis**

**What is the aim of your policy, procedure, project, decision, function or service and how does it relate to equality?**

| |
|---|
| **To ensure women have the safest care that can be given** |

**Who is the policy, procedure, project, decision, function or service going to benefit and how?**

| |
|---|
| **Pregnant women** |

**What outcomes do you want to achieve?**

| |
|---|
| **No incidents – good outcome – good experience for women and their families** |

**What barriers are there to achieving these outcomes?**

| |
|---|
| **Not adhering to guidelines and policies - non attendance at training and education** |

**How will you put your policy, procedure, project, decision, function or service into practice?**

| |
|---|
| **Monitoring incidents and ensuring lessons are learned** |

**Does this policy link, align or conflict with any other policy, procedure, project, decision, function or service?**

| |
|---|
| **None** |

## Step 2 – Collecting your information

**What existing information / data do you have?**

| |
|---|
| **Incident data** |

**Who have you consulted with?**

| |
|---|
| **Clinical colleagues** |

**What are the gaps and how do you plan to collect what is missing?**

| |
|---|
| **N/A** |

## Step 3 – What is the impact?

**Using the information from Step 2 explain if there is an impact or potential for impact on staff or people in the community with characteristics protected under the Equality Act 2010?**

**Ethnicity or Race**

| |
|---|
| No |

**Sex/Gender**

| |
|---|
| No |

**Age**

| |
|---|
| No |

**Disability**

| |
|---|
| **No** |

**Religion or Belief**

| |
|---|
| **No** |

**Sexual Orientation**

| |
|---|
| **No** |

**Marriage and Civil Partnership**

| |
|---|
| **No** |

**Pregnancy and Maternity**

| |
|---|
| **No** |

**Gender Reassignment**

| |
|---|
| **No** |

**Other socially excluded groups or communities e.g. rural community, socially excluded, carers, areas of deprivation, low literacy skills**

| |
|---|
| **No** |

## Step 4 – What are the differences?

**Are any groups affected in a different way to others as a result of the policy, procedure, project, decision, function or service?**

| |
|---|
| **No** |

**Does your policy, procedure, project, decision, function or service discriminate against anyone with characteristics protected under the Equality Act?**

**No If yes, explain the justification for this. If it cannot be justified, how are you**

**going to change it to remove or mitigate the affect?**

| |
|---|
| **N/A** |

## Step 5 –

**If you are in a position to introduce the policy, procedure, project, decision, function or service? Clearly show how this has been decided.**

| |
|---|
| **Agreed at Obstetrics and Gynaecology Operational Group and approved at the quality & Health Care Governance Committee** |

**If you are in a position to introduce the policy, procedure, project, decision, function or service, but still have information to collect, changes to make or actions to complete to ensure all people affected have been covered please list:**

| |
|---|
| **N/A** |

**How are you going to monitor this policy, procedure, project or service, how often and who will be responsible?**

| |
|---|
| **Case by case reporting, reported at Clinical Governance meetings to discuss actions plans and amendments to guidelines.** |

## Step 6 – Completion and central collation

**Once completed this Equality Analysis form must be attached to any documentation to which it relates and must be forwarded to Jillian Wilkins, Equality and Diversity Lead. jillian.wilkins@cddft.nhs.uk**

**Appendix 1**

**INDUCTION OF LABOUR**

- **Initial management** – Mifepristone 200mg orally straightaway if woman chooses (at a later agreed time if preferred).
- Offer prescription for pain relief and Night Sedation.
- Arrange admission for Induction on Delivery Suite 36 – 48 hrs after Mifepristone.
- Warn woman there is possibility of labour starting in the 36-48 hrs after Mifepristone. Advise them to contact Delivery Suite if necessary. Ensure has phone number.
- Advise that may have some bleeding and abdominal cramps – if it is severe need to come to hospital.
- Take blood for Kleihauer – Administer Anti D immediately following diagnosis of the IUD **- it is recommended to give it again following delivery as there may be a significant delay between the diagnosis of IUD and the subsequent delivery. (BCSH Guidelines 2014).**
- As with any sensitising event greater than 20 weeks Repeat Kleihauer to determine if higher than normal dose is required.

**Women with unscarred uterus** – see flow chart

- **Under 27 weeks –**- Misoprostol 100mcg – 6 hourly maximum 4 doses.

If first dose does not lead to effective contractions **double** subsequent dose to 200mcg – **Max daily dosage 800mcg.**

- **After 27 weeks** - Misoprostol 50mcg 4 hourly maximum 6 doses
- If first dose does not lead to effective contractions **double** subsequent dose to 100mcg – **Max daily dosage not exceeding 600mcg.**
- Vaginal misoprostol is as effective as oral and has less side effects

**If delivery not occurred after 24hours**

- Repeat regime
- Ensure evaluation for uterine activity if 2;10 do not repeat.
- Oxytocin if necessary 4 hours following last dose of misoprostol.

- If cervix is ripe oxytocin can be used as per CDDFT Induction of Labour Guideline.

**Women with scarred uterus or parity >5**

| **Under 27 Weeks** | **After 27 weeks** |
|---|---|
| Misoprostol 100mcg – 6hourly – maximum 4 doses | Misoprostol 50mcg followed by 6 hourly – maximum 4 doses |

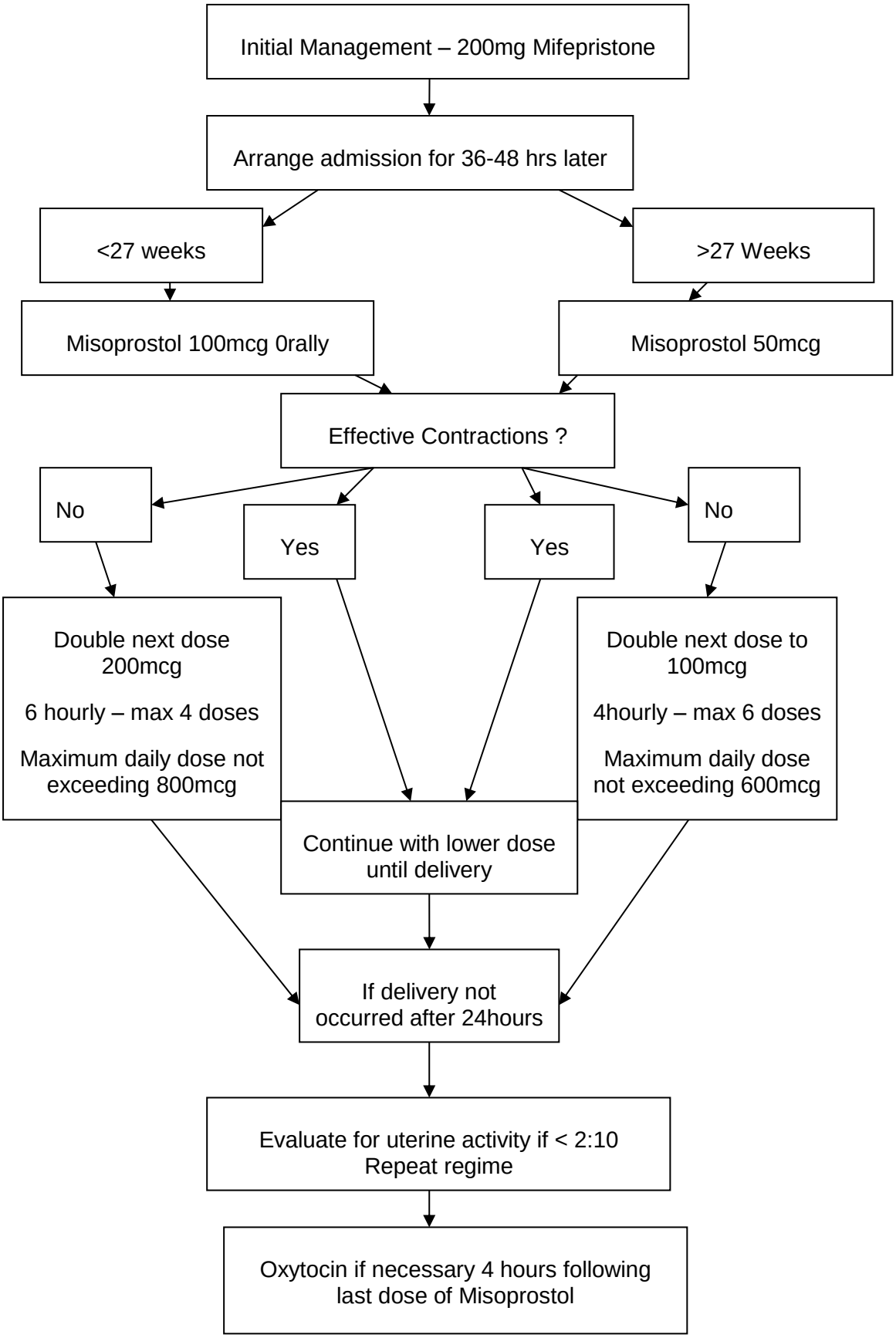
**NB Tablets can be quartered to 50mcg with a tablet cutter – remaining dose must be discarded.**

- Safety and benefits of IOL should be discussed by a consultant. Induction of labour with prostaglandin is safe but not without risk.
- Women with more than two LSCS deliveries or atypical scars should be advised that the safety of induction of labour is unknown.
- Mechanical methods for induction of labour in women with an IUFD should be used only in the context of a clinical trial.

**Retained Placenta**

If bleeding remains minimal, observe up to 1 hour. The Registrar should examine the woman and arrange manual removal under anaesthesia if the placenta is still retained.

**Induction of Labour for Intrauterine Fetal Death – unscarred uterus**


Initial Management – 200mg Mifepristone
Arrange admission for 36-48 hrs later
<27 weeks
>27 Weeks
Misoprostol 100mcg 0rally
Misoprostol 50mcg
Effective Contractions ?
No
Yes
Yes
No
Double next dose 200mcg
6 hourly – max 4 doses
Maximum daily dose not exceeding 800mcg
Double next dose to 100mcg
4hourly – max 6 doses
Maximum daily dose not exceeding 600mcg
Continue with lower dose until delivery
If delivery not occurred after 24hours
Evaluate for uterine activity if < 2:10 Repeat regime
Oxytocin if necessary 4 hours following last dose of Misoprostol

## Appendix 2

## Recommended investigations

- FBC, U& Es, LFT, CRP and bile salt
- Kleihauer
- Maternal serology: Stored serum from booking tests provide baseline serology, Parvovirus B19, rubella, CMV, herpes simplex and *Toxoplasma gondii* (routinely).
- Maternal random glucose and HbA1c.
- Maternal thyroid function
- Fetal and placental microbiology; fetal blood (Cord or cardiac blood), fetal swabs and placental swabs for fetal infections.
- Fetal and placental tissues for karyotype; deep fetal skin, fetal cartilage and placenta
- Post-mortem examination: External examination, autopsy, microscopy, X-ray, placenta and cord.

### Selective Tests

- Maternal coagulation times and plasma fibrinogen in suspected DIC.
- Maternal bacteriology; blood cultures, midstream urine culture, vaginal swabs and cervical swabs in suspected maternal bacterial infection including *Listeria and chlamydia.*
- Maternal thrombophilia screen in IUGR and placental disease.
- Anti-red cell antibody serology Indicated if fetal hydrops evident clinically or on post-mortem.
- Maternal anti-Ro and anti-La antibodies Indicated if evidence of hydrops, endomyocardial fibro-elastosis or AV node calcification at post-mortem.
- Maternal alloimmune antiplatelet antibodies: Indicated if fetal intracranial haemorrhage found on post-mortem.
- Parental bloods for karyotype: Indicated if fetal unbalanced translocation, other fetal aneuploidy, fetal genetic testing fails and history suggestive of aneuploidy.
- Maternal urine for cocaine metabolites indicated in Occult drug use.

# Appendix 3

**Table 9a: Legal abortions: principal medical condition and total mentions of medical conditions for abortions performed under ground E, residents of England and Wales, 2014**

England and Wales, residents — numbers and percentages

| ICD-10 code | Condition | Number of abortions by principal medical condition | | Number of mentions by principal medical condition | | 24 weeks gestation and over | |
|---|---|---|---|---|---|---|---|
| | | number | % | number | % | number | % |
| **Total ground E alone or with any other [1]** | | **3,099** | ***100*** | | | **202 [3]** | ***100*** |
| **Q00-Q89** | **Congenital malformations total** | **1,441** | ***46*** | **2,148** | ***52*** | **156** | ***77*** |
| **Q00-Q07** | **the nervous system total** | **693** | ***22*** | **920** | ***22*** | **83** | ***41*** |
| Q00 | anencephaly | 230 | *7* | 247 | *6* | 3 | *1* |
| Q01 | encephalocele | 31 | *1* | 38 | *1* | 0 | *0* |
| Q02 | microcephaly | 15 | *0* | 20 | *0* | 8 | *4* |
| Q03 | hydrocephalus | 26 | *1* | 35 | *1* | 4 | *2* |
| Q04 | other malformations of the brain | 111 | *4* | 203 | *5* | 31 | *15* |
| Q05 | spina bifida | 181 | *6* | 206 | *5* | 11 | *5* |
| Q06-Q07 | other | 99 | *3* | 171 | *4* | 26 | *13* |
| Q10-Q18 | the eye, ear, face and neck | 5 | *0* | 8 | *0* | 1 | *0* |
| Q20-Q28 | the cardiovascular system | 231 | *7* | 382 | *9* | 30 | *15* |
| Q30-Q34 | the respiratory system | 19 | *1* | 36 | *1* | 2 | *1* |
| Q35-Q37 | cleft lip and cleft palate | 10 | *0* | 29 | *1* | 0 | *0* |
| Q38-Q45 | other malformations of the digestive system | 5 | *0* | 25 | *1* | 1 | *0* |
| Q60-Q64 | the urinary system | 149 | *5* | 223 | *5* | 13 | *6* |
| Q65-Q79 | the musculoskeletal system | 229 | *7* | 397 | *10* | 20 | *10* |
| Q80-Q85 | the skin, breast integument phakomatoses | 5 | *0* | 13 | *0* | 0 | *0* |
| Q86-Q89 | other | 95 | *3* | 115 | *3* | 6 | *3* |
| **Q90-Q99** | **Chromosomal abnormalities total** | **1,148** | ***37*** | **1,230** | ***30*** | **31** | ***15*** |
| Q90 | Down's syndrome | 662 | *21* | 693 | *17* | 12 | *6* |
| Q910-Q913 | Edwards' syndrome | 234 | *8* | 253 | *6* | 9 | *4* |
| Q914-Q917 | Patau's syndrome | 69 | *2* | 74 | *2* | 0 | *0* |
| Q92-Q99 | other | 183 | *6* | 210 | *5* | 10 | *5* |
| | **Other conditions total** | **510** | ***16*** | **788** | ***19*** | **15** | ***7*** |
| P00-P04 | fetus affected by maternal factors | 154 | *5* | 260 | *6* | 3 | *1* |
| P05-P08 | fetal disorders related to gestation and growth | 23 | *1* | 51 | *1* | 5 | *2* |
| P35-P39 | fetus affected by congenital infectious disease | 0 | *0* | 0 | *0* | 0 | *0* |
| P529 | intracranial nontraumatic haemorrhage of fetus | 1 | *0* | 6 | *0* | 0 | *0* |
| P832-P833 | hydrop fetalis not due to haemolytic disease | 48 | *2* | 136 | *3* | 2 | *1* |
| O30 | multiple gestation | 53 | *2* | 59 | *1* | 1 | *0* |
| O41 | disorder of the amniotic fluid | 11 | *0* | 14 | *0* | 0 | *0* |
| Z20-Z22 | exposure to communicable disease | 3 | *0* | 10 | *0* | 2 | *1* |
| Z80-Z84 | family history of heritable disorder | 177 | *6* | 208 | *5* | 1 | *0* |
| E84 | cystic fibrosis | 11 | *0* | 13 | *0* | 1 | *0* |
| G71 | disorder of the muscles | 18 | *1* | 18 | *0* | 0 | *0* |
| | other [3] | 8 | *0* | 8 | *0* | 0 | *0* |
| | not known * | 3 | *0* | 5 | *0* | 0 | *0* |

[1] ICD-10 codes are taken from the International Statistical Classification of Diseases and Related Health problems (Tenth Revision) published by the World Health Organisation (WHO)

[2] the all mentions totals show abortions where more than one medical condition is reported. Totals therefore do not equal the number of abortions performed under Ground E
additional breakdown may be available by ICD-10 code on request.

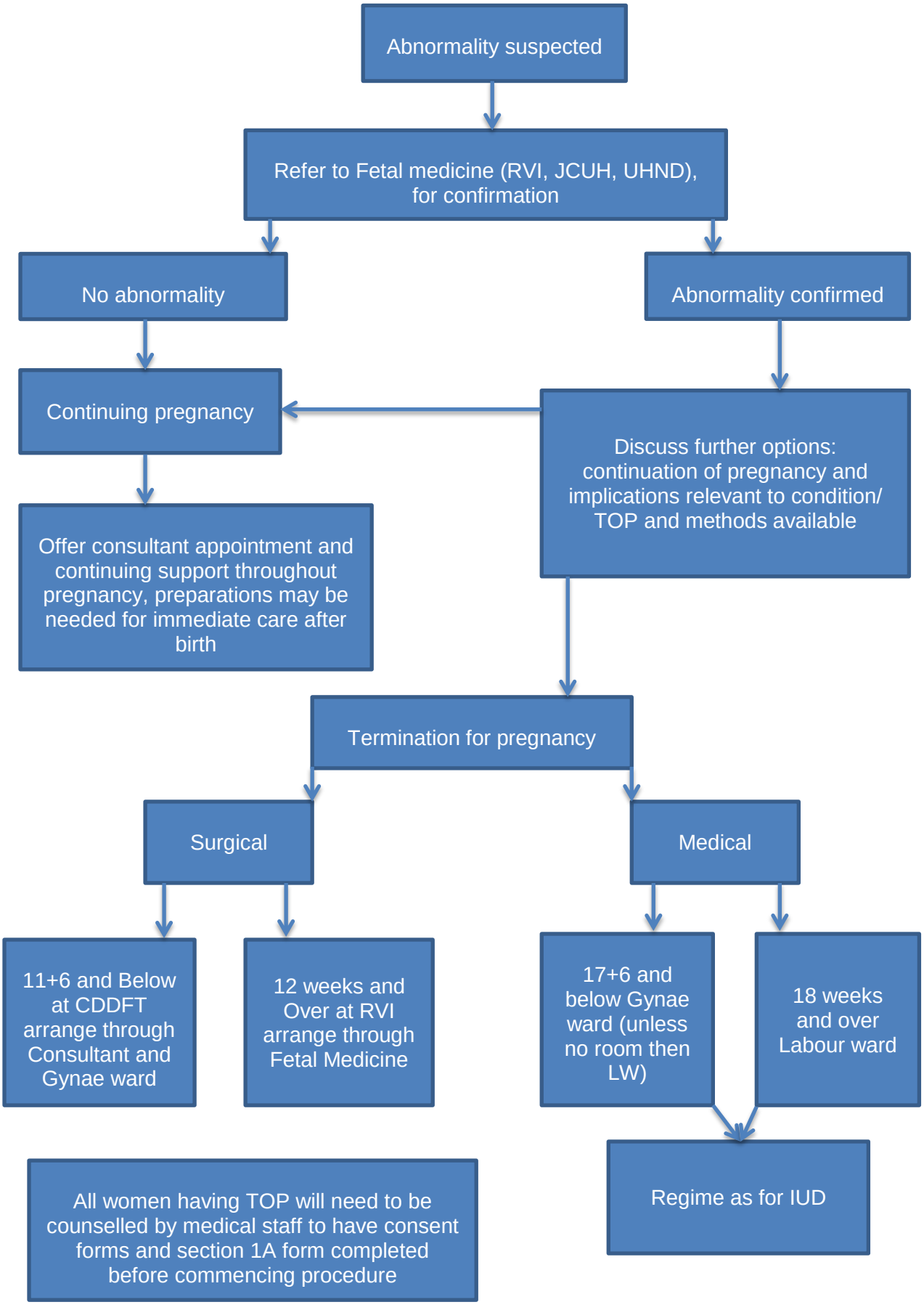
[3] There were an additional 7 ground A and 2 ground B cases performed at 24 weeks and over gestation making the total 211.

* Cases where diagnosis is' not known' are being followed up

Note: percentages are rounded and may not add up to 100

**Abortion statistics, England and Wales: 2014** From: Department of Health First published: 9 June 2015 Part of: Abortion statistics, England and Wales

Appendix 4


Abnormality suspected
Refer to Fetal medicine (RVI, JCUH, UHND), for confirmation
No abnormality
Abnormality confirmed
Continuing pregnancy
Discuss further options: continuation of pregnancy and implications relevant to condition/ TOP and methods available
Offer consultant appointment and continuing support throughout pregnancy, preparations may be needed for immediate care after birth
Termination for pregnancy
Surgical
Medical
11+6 and Below at CDDFT arrange through Consultant and Gynae ward
12 weeks and Over at RVI arrange through Fetal Medicine
17+6 and below Gynae ward (unless no room then LW)
18 weeks and over Labour ward
Regime as for IUD
All women having TOP will need to be counselled by medical staff to have consent forms and section 1A form completed before commencing procedure