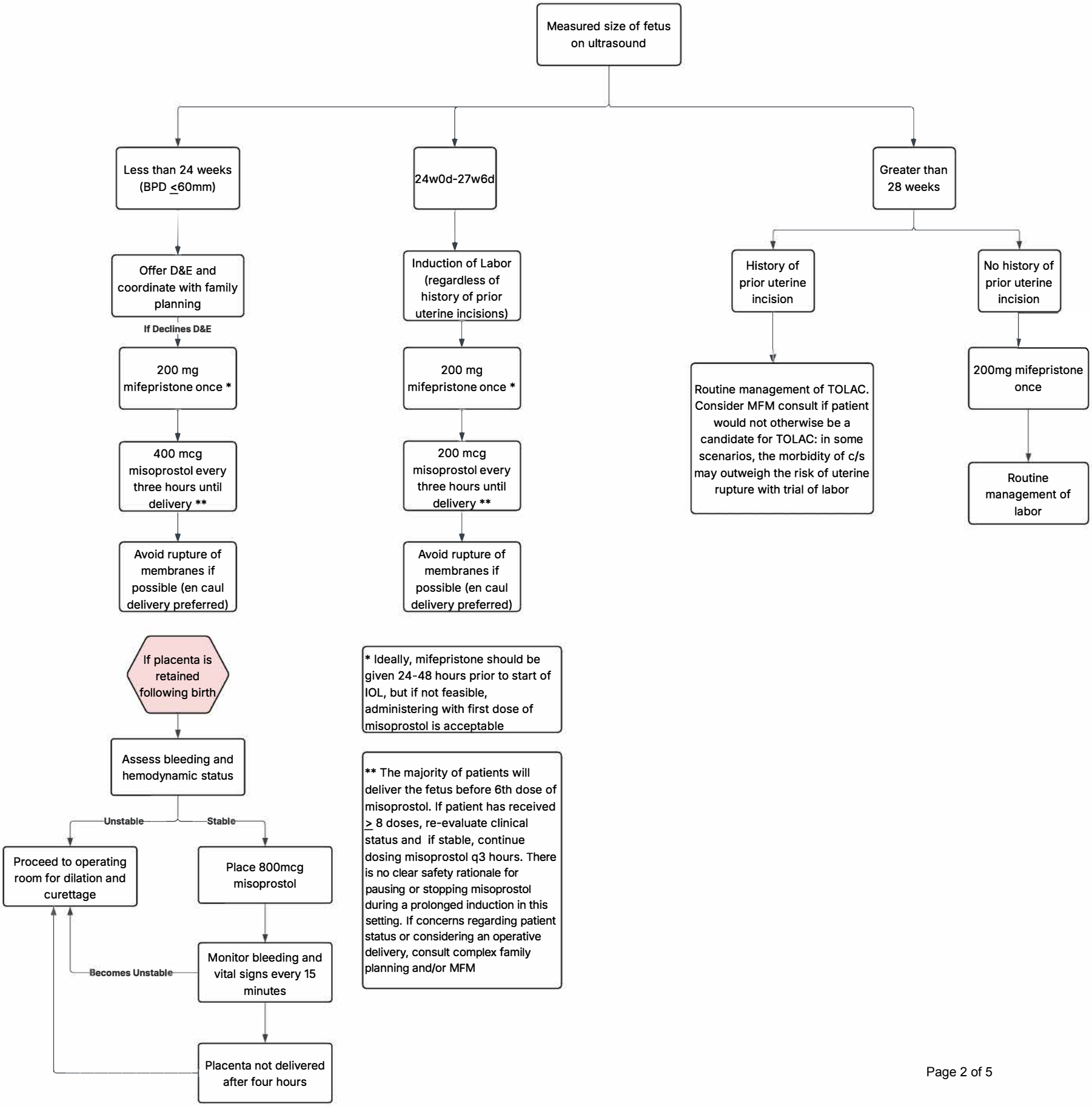
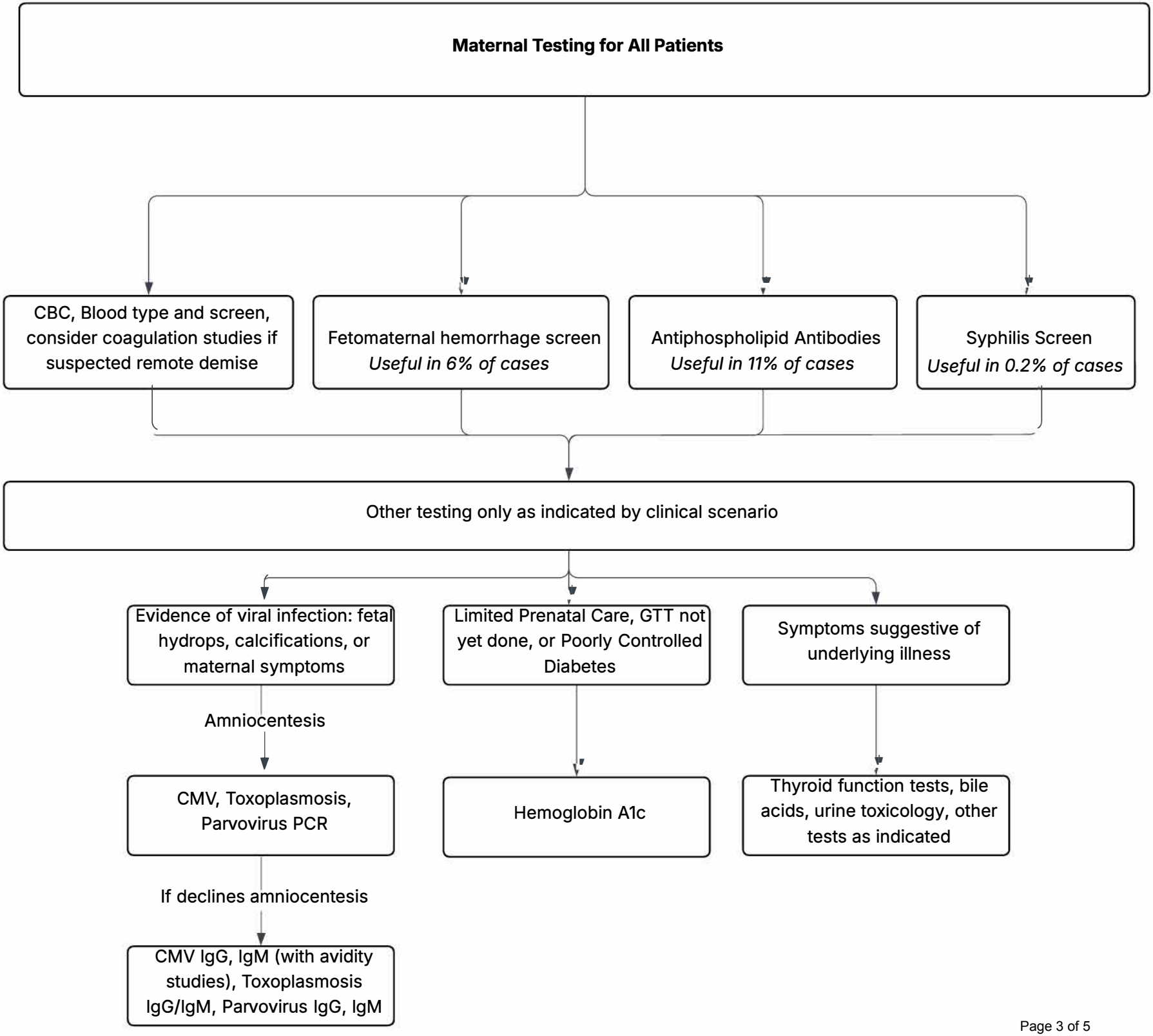
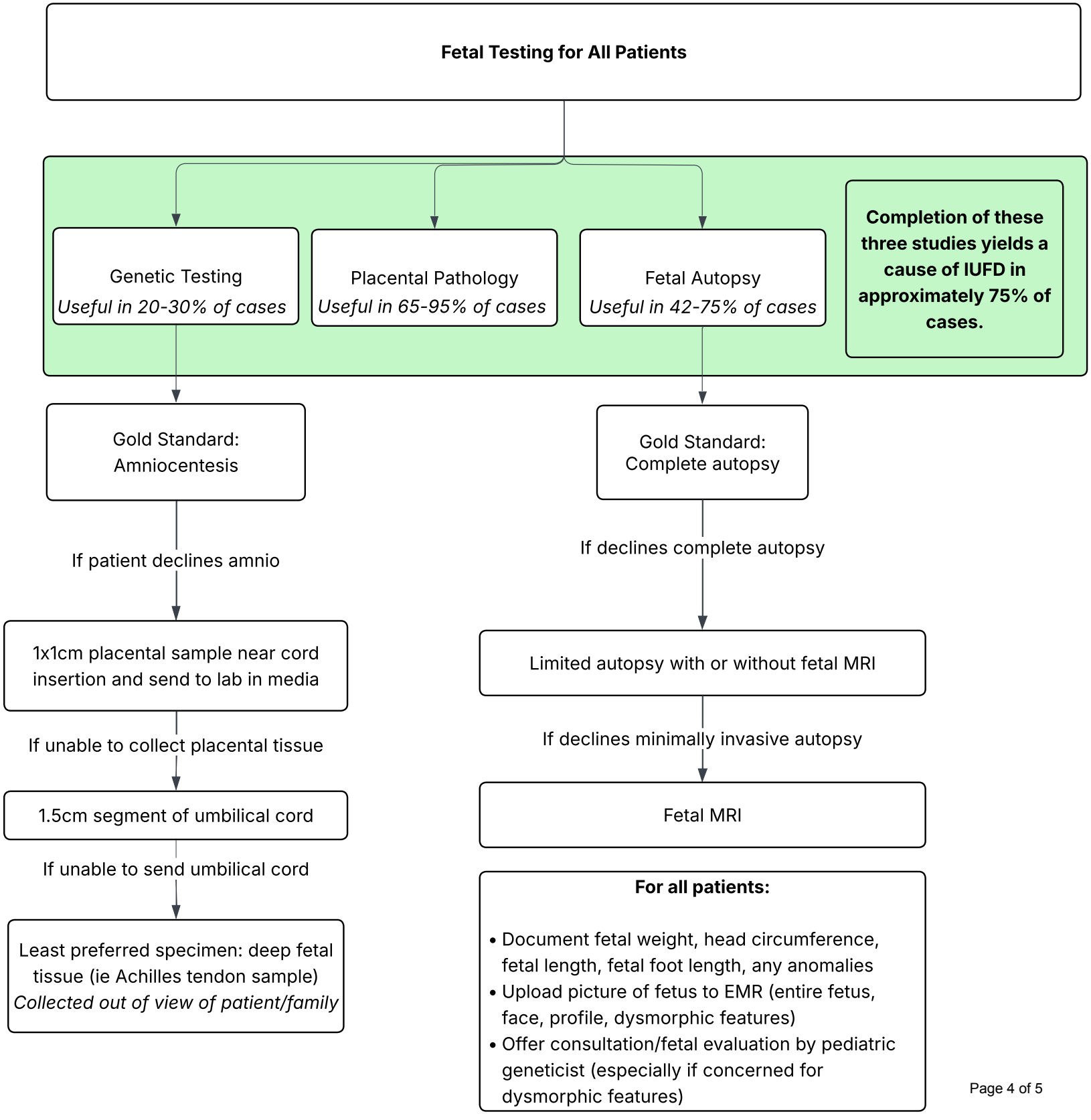
School of Medicine

Safe Maternal Care and Delivery Planning	Causal Evaluation	Emotional Support and Grief Counseling	Postpartum Support and Reproductive Health
❑ Detailed History and physical ❑ CBC, T&S, CMP ❑ Consider coagulation studies ❑Evaluate and treat underlying conditions (stabilize prior to delivery) ❑ Discuss options for mode of delivery ❑ Discuss options for pain control during delivery ❑ Particularly at less than 28 weeks, be prepared for retained placenta ❑ Review options for fetal disposition **See page 2**	❑ Detailed H&P, including screen for substance use ❑ Counsel patient on value of determining cause of stillbirth ❑ Recommend maternal laboratory testing: see page 3 ❑Fetal-maternal hemorrhage screen ❑ Antiphospholipid testing ❑ Syphilis Screen ❑ Other labs as indicated by clinical scenario ❑Recommend fetal testing: see page 4-5 ❑ Placental pathology ❑ Genetic testing ❑ Fetal autopsy / MRI ❑ Document a detailed description of fetus at time of delivery ❑ With permission, upload pictures of fetus to EMR: face, profile, whole fetus, dysmorphic features **See page 3-5**	❑ Acknowledge grief ❑ Remove blame ❑ Ask if there is a preferred name for fetus and document in chart if so ❑ Offer assistance with memory making and memento creation ❑ Discuss expectations of grief and symptoms of mood disorders ❑ Offer chaplain and/or doula support if available ❑ Provide bereavement resources and information on support groups	❑ Discuss milk production and options for lactation suppression or donation ❑ Discuss physical and emotional expectations for recovery ❑ Review standard postpartum return precautions ❑ Offer chaplain and/or social work consultations ❑ Offer referral to perinatal psychiatry ❑ Offer contraception ❑ Clearly document the completed workup in discharge summary ❑ Ensure close outpatient follow-up ❑ Refer to MFM for discussion of testing results and implications for future pregnancy

Adapted from 2025 SMFM Checklist for Newly Diagnosed Stillbirth


Measured size of fetus on ultrasound
Less than 24 weeks (BPD ≤60mm)
24w0d-27w6d
Greater than 28 weeks
Offer D&E and coordinate with family planning
If Declines D&E
200 mg mifepristone once *
400 mcg misoprostol every three hours until delivery **
Avoid rupture of membranes if possible (en caul delivery preferred)
Induction of Labor (regardless of history of prior uterine incisions)
200 mg mifepristone once *
200 mcg misoprostol every three hours until delivery **
Avoid rupture of membranes if possible (en caul delivery preferred)
History of prior uterine incision
Routine management of TOLAC. Consider MFM consult if patient would not otherwise be a candidate for TOLAC: in some scenarios, the morbidity of c/s may outweigh the risk of uterine rupture with trial of labor
No history of prior uterine incision
200mg mifepristone once
Routine management of labor
If placenta is retained following birth
Assess bleeding and hemodynamic status
Unstable
Stable
Proceed to operating room for dilation and curettage
Place 800mcg misoprostol
Monitor bleeding and vital signs every 15 minutes
Becomes Unstable
Placenta not delivered after four hours
* Ideally, mifepristone should be given 24-48 hours prior to start of IOL, but if not feasible, administering with first dose of misoprostol is acceptable
** The majority of patients will deliver the fetus before 6th dose of misoprostol. If patient has received ≥ 8 doses, re-evaluate clinical status and if stable, continue dosing misoprostol q3 hours. There is no clear safety rationale for pausing or stopping misoprostol during a prolonged induction in this setting. If concerns regarding patient status or considering an operative delivery, consult complex family planning and/or MFM


Maternal Testing for All Patients
CBC, Blood type and screen, consider coagulation studies if suspected remote demise
Fetomaternal hemorrhage screen
Useful in 6% of cases
Antiphospholipid Antibodies
Useful in 11% of cases
Syphilis Screen
Useful in 0.2% of cases
Other testing only as indicated by clinical scenario
Evidence of viral infection: fetal hydrops, calcifications, or maternal symptoms
Limited Prenatal Care, GTT not yet done, or Poorly Controlled Diabetes
Symptoms suggestive of underlying illness
Amniocentesis
CMV, Toxoplasmosis, Parvovirus PCR
Hemoglobin A1c
Thyroid function tests, bile acids, urine toxicology, other tests as indicated
If declines amniocentesis
CMV IgG, IgM (with avidity studies), Toxoplasmosis IgG/IgM, Parvovirus IgG, IgM


Fetal Testing for All Patients
Genetic Testing
Useful in 20-30% of cases
Placental Pathology
Useful in 65-95% of cases
Fetal Autopsy
Useful in 42-75% of cases
Completion of these three studies yields a cause of IUFD in approximately 75% of cases.
Gold Standard: Amniocentesis
If patient declines amnio
1x1cm placental sample near cord insertion and send to lab in media
If unable to collect placental tissue
1.5cm segment of umbilical cord
If unable to send umbilical cord
Least preferred specimen: deep fetal tissue (ie Achilles tendon sample)
Collected out of view of patient/family
Gold Standard: Complete autopsy
If declines complete autopsy
Limited autopsy with or without fetal MRI
If declines minimally invasive autopsy
Fetal MRI
For all patients:
• Document fetal weight, head circumference, fetal length, fetal foot length, any anomalies
• Upload picture of fetus to EMR (entire fetus, face, profile, dysmorphic features)
• Offer consultation/fetal evaluation by pediatric geneticist (especially if concerned for dysmorphic features)

Regardless of the type of evaluation, the baby is treated with the utmost care, dignity, and respect at all times.

Fetal MRI

- Still very useful, but may miss some diagnoses found with autopsy
- Recommend performing in combination with either partial autopsy or evaluation by geneticist
- Takes approximately 45-60 minutes (infant to MRI while patient remains on L&D)
- May miss dysmorphic characteristics that could point toward underlying genetic diagnosis
- Evaluation by geneticist may occur at bedside with family involvement
- If patient declines formal external evaluation, recommend placing pictures of fetus into EMR
- No added cost to patient
- Final results available in less than 24 hours

Partial Autopsy

- Still very useful, but may miss some diagnoses found with complete autopsy
- Recommend performing in combination with fetal MRI
- Can be limited to specific organ systems based on patient preferences and/or clinical suspicion for underlying diagnosis
- Biopsies of tissues can be obtained for microscopic evaluation
- Biopsy sites are not visible when fetus is clothed in onesie
- Release of fetus to funeral home within 1-3 days after discharge
- No added cost to patient
- Final results available within 8-12 weeks

Complete Autopsy

- One of the most useful tests in stillbirth workup, more accurate than partial autopsy and MRI
- Useful in up to 75% of cases.
- Up to 1 in 3 families regret not obtaining a fetal autopsy
- Includes internal and external exams with macroscopic and microscopic evaluation
- Release of fetus to funeral home within 1-3 days after discharge
- Incisions are not visible when fetus is clothed in onesie
- No added cost to patient
- Final results available within 8-12 weeks

These algorithms are designed to assist the primary care provider in the clinical management of a variety of problems that occur during pregnancy. They should not be interpreted as a standard of care, but instead represent guidelines for management. Variation in practices should take into account such factors as characteristics of the individual patient, health resources, and regional experience with diagnostic and therapeutic modalities.

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