Subject: Cytotec Use In Obstetrics

Policy: Cytotec will be used only for induction of fetal demise or control of post partum hemorrhage.

Purpose: To define the use of Cytotec in OB at MMSC.

Additional Information:

1. ACOG has affirmed that Cytotec is a safe and effective agent for cervical ripening and labor induction when used appropriately.
2. ACOG has affirmed that Cytotec is an effective treatment for post partum hemorrhage in the presence of uterine atony.
3. Oxytocin should not be administered within 4 hours after the last dose of misoprostol (Cytotec).
4. April 2003, the FDA acknowledged the wide spread off label use of Cytotec in Obstetrics.
5. Misoprostol (Cytotec) should not be used in patients with a previous cesarean delivery or prior major uterine surgery.
6. Cytotec can be given vaginally (posterior fornix) or orally for induction and rectally for control of PP hemorrhage.
7. Contraindications for the use of misoprostol (Cytotec) include:
   - Abruptio Placenta
   - Unexplained Vaginal Bleeding
   - Placenta Previa
   - Known Hypersensitivity to Prostaglandins
   - Previous Cesarean Section
   - Inflammatory or Irritable Bowel Disease
8. Cytotec (misoprostol) is absorbed effectively from the rectal as well as oral and vaginal mucosa thus providing a rapid, effective mode of delivery for post-partum hemorrhage.
9. Studies shown Cytotec produces sustained uterine contraction within three minutes of rectal administration without the significant side effects associated with ergotomine.
10. Reported side effects include nausea, vomiting, and diarrhea due to stimulation of GI smooth muscle, hypotension, fever, headache and abdominal pain, uterine hyperstimulation, and tachysystole.

Equipment List:
- Misoprostol (Cytotec) 400 mcg intra vaginal or P.O. for fetal demise Induction
- Misoprostol (Cytotec) 200 mcg tablet, one to five as ordered
- Sterile Gloves
- BP Monitoring
Procedure For Induction Of Fetal Demise:
1. Using 2 identifiers, identify correct patient.
2. Patient History and physical assessment:
   a) Review the patient’s prenatal record for pertinent medical and surgical history. Obtain patient’s age; gravidity, parity, EDD, h/o fetal movement, and specific information regarding any complaints. Assess for signs and symptoms of pre-eclampsia.
   b) Obtain maternal vital signs.
   c) Confirm specific indications for induction.
3. Explain medication and procedure to patient and answer questions.
4. Obtain correct dosage of Misoprostol tablet.
5. Obtain IV access using #18 angiocath prior to initial dosing.
6. Vaginal Dosing
   a) Assist physician in inserting Misoprostol 400 mcg into the posterior fornix.
   b) Encourage 30 minutes of side lying after insertion.
   c) Continuously monitor contractions.
   d) Repeat dose every 2-4 hours x 6 doses.
   e) Withhold repeat dose if
      i) Uterine tachysystole
      ii) Contractions are regular, organized, patterned, palpable and causing discomfort (active labor)
   f) Pitocin may be started 4 hours after last dose of Misoprostol
   g) Notify physician for signs of tetanic contractions.
7. Oral dosing
   a) Administer Misoprostol 400 mcg P.O.
   b) Continue giving Misoprostol 400 mcg P.O. every 2 hours as needed until active labor.
   c) Withhold repeat dose if:
      i) Uterine tachysystole
      ii) Contractions are regular, organized, patterned, palpable and causing discomfort (active labor)
   d) Pitocin may be started 4 hours after last dose of Misoprostol.
   e) Notify physician for signs of tetanic contractions
      i) Hyperstimulation may be treated by lateral positioning.
      ii) IV fluid bolus of 400 cc and Terbutaline 0.25 mg subq may be used if conservative measures are ineffective.
8. Patient may ambulate if absence of uterine hyperstimulation two hours after dosing.
9. Patient status (VS) should be assessed at least every 4 hours after insertion of medication. Uterine activity should be assessed at least every 1-2 hours as indicated by uterine activity and patient condition. Once labor is initiated monitor VS, FHR and contractions in accordance with unit policy.
10. Monitor patients level of pain and intervene appropriately.
References:


