# Stillbirth care

Clinical Guideline Presentation V8


**45 minutes**

Towards CPD Hours

**References:**

Queensland Clinical Guideline: Stillbirth care is the primary reference for this package.

**Recommended citation:**

Queensland Clinical Guidelines. Stillbirth care clinical guideline education presentation E23.24-1-V8-R28. Queensland Health. 2023.

**Disclaimer:**

This presentation is an implementation tool and should be used in conjunction with the published guideline. This information does not supersede or replace the guideline. Consult the guideline for further information and references.

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# Learning objectives

- Identify causes and risks for stillbirth
- Understand communication strategies to support parents
- Identify investigations after stillbirth
- Understand follow-up care including preventative management in future pregnancies

# Abbreviations

- **BMI** Body mass index
- **DIC** Disseminated intravascular coagulation
- **DV** Domestic violence
- **FBC** Full blood count
- **HbA1c** Haemoglobin A1c
- **HELLP** Haemolysis, elevated liver enzymes and low platelets syndrome
- **IOL** Induction of labour
- **LFTs** Liver function tests
- **NBST** Newborn blood screening test
- **PCA** Patient controlled analgesia
- **PSANZ-PDC** Perinatal Society of Australia and New Zealand- Perinatal Death Classification
- **TFT** Thyroid function tests
- **USS** Ultrasound scan
- **≥** Greater than or equal to

# Stillbirth definition

Birth of a baby

- Heart beat, respiration or other sign of life are all absent **and**
- Birth weight ≥ 400 gram and/or
- Gestation ≥ 20+0 weeks

# Incidence Queensland

## Incidence in 2020

- All women–7.9 stillbirths per 1000 births
- Aboriginal and/or Torres Strait Islander women–11.9 stillbirths per 1000 births

## Causes of stillbirth

- Unexplained 32.6%
- Congenital anomaly 27.2%
- Spontaneous preterm birth 12.15%

# Aetiology

## Placental

- Dysfunction/abnormal placentation

## Maternal

- Hypertension, renal disease, diabetes, infection
- BMI > 25/kg/$m^2$
- DV
- Smoking/substance use
- Antiphospholipid syndrome (APS)
- Hypoxic peripartum event

## Fetal

- Chromosomal or structural anomaly
- Infection
- Anaemia (e.g. alpha-thalassaemia)

## Other

- Unknown
- Materno-fetal transfusion
- Spontaneous preterm labour
- Cord accidents
- Multiple pregnancy

# At risk groups

Some groups of women are at greater risk of having a stillbirth

At risk groups include:

- Ethnicity–South Asian, African, Middle Eastern
- Maternal age–less than 20 or greater than 35 years of age
- Multiple pregnancy
- Previous stillbirth
- Prolonged pregnancy
- Living in a rural or remote area and/or those with limited access to health care

# Antenatal care

Ronnie is a 35 year old primigravid woman of South African descent. She reduced her smoking when trying to become pregnant, but gained weight and now has a BMI of 30 kg/m$^2$.

The midwife can encourage and support Ronnie to have:

- Regular antenatal appointments
- Routine screening
- Identification and management of pregnancy risks
- Early pregnancy ultrasound scan

# Advice to women

What will the midwife discuss with Ronnie to reduce her stillbirth risk?

- Reduce lifestyle risk factors:
  - Smoking–support to reduce or quit
  - Obesity–weight gain outside recommended guidelines
- Consider sleep position
- Understand her baby's fetal movements
- Seek advice if:
  - Fetal movements change
  - 'Gut instinct' that something is wrong

# Diagnosis of fetal death

Sadly Ronnie is diagnosed with a fetal death at 36 weeks gestation. What are some strategies that can be used to support Ronnie and her partner Jeff through this difficult time?

- Provide escort and remain with them (e.g. at USS)
- Acknowledge them as parents
- Provide continuity of carer
- Discussions are lead by an adequately trained and prepared healthcare provider
- Ask their preferences for privacy

# Informing parents about fetal death

Hold discussions with parents in a quiet and private area.

- Do not delay informing parents
- Use clear, unambiguous language (e.g. '*your baby has died')*
- Use cues from parents
- Be sensitive and non-judgemental
- Consider other family members
- Refer to support services (e.g. support groups)
- Engage with other relevant healthcare professionals, as appropriate (e.g. social worker, cultural support officers)
- Document discussions and plan of care

# Communication with parents

A midwifery student is working with the midwife caring for Ronnie and Jeff. What advice may be useful for the student?

- Use honest, transparent understandable language
- Offer verbal, written and electronic information; repeat details
- Allow time for questions and discussions

Consider:

- What to say (‘*I’m sorry*’)
- What **not** to say (‘*at least you have other children*’)
- What to do (*listen and talk to parents about their baby*)
- What not to do (*refer to baby as ‘it’, ‘fetus’, ‘products of conception’)*

# Model of care

Parents appreciate genuine engagement, individualised personal care and sensitivity, emotion and empathy from healthcare providers.

What are some considerations when planning care for Ronnie and Jeff?

- Allow time for decision making
- Individualise care to their needs
- Establish their wishes about time and place of birth
  - May wish to stay in hospital for IOL or go home to prepare for the birth
- Provide continuity of care and carer

# Culturally sensitive care

Ongoing support and sensitive care may reduce detrimental psychosocial effects of stillbirth

What care and support can be provided to Ronnie and Jeff and other parents who have a stillbirth?

- Acknowledge cultural, spiritual and religious beliefs and practices
- Aboriginal and/or Torres Strait Islander people may wish elder/community member support
- Offer to assist parents to contact their preferred spiritual, religious and cultural support and services
  - Engage an accredited interpreter, if required

# Labour and birth preparation

Discuss labour and birth options taking into account preferences, medical and obstetric history and safety.

- Provide step by step information
- Advise what to bring (e.g. camera, clothes, blanket, soft toy)
- Discuss and support requests to normalise birth
  - Cutting the umbilical cord
  - Skin to skin contact
- Discuss active third stage management and analgesia options
- Inform about physical appearance of the baby:
  - Gestational age, potential injuries (e.g. skin slippage)

# Labour

- May occur spontaneously
- Timing:
  - Collaborate with parents
  - Consider medical history and previous intrapartum history


## Indications for IOL

- Ruptured membranes
- Infection
- Pre-eclampsia
- Placental abruption
- Woman requests

## Expectant management

- If > 48 hours since fetal death–twice weekly DIC testing
  - Risk increases after 4 weeks (may occur earlier)

# Induction of labour

After three days, Ronnie has not gone into labour, and she and Jeff decide they would like to be induced. What methods may be used for induction of labour after a fetal death?

- Pharmacological
  - Dinoprostone (Prostaglandin E2)
  - Misoprostol (Prostaglandin E1)
  - Mifepristone
  - Oxytocin
- Mechanical
  - Balloon (transvaginal) catheter
  - Artificial rupture of membranes

# Labour and birth care

## Respect and support the parent's wishes in labour and birth

What are the care considerations for Ronnie during labour and birth?

- Ensure preparation and set up of birthing suite
- Provide postnatal care in suitable area away from crying babies
- Provide care by maternity staff
- Adequate analgesia
- Observe for complications
  - Shoulder dystocia
  - Postpartum haemorrhage
  - Amniotic fluid embolism
- Normalise birth (e.g. cutting the cord)

# Post birth care

The impact of stillbirth can last for many years for parents and families.

After a short labour Ronnie gives birth to a baby girl they name Ava. What support can be offered to Ronnie and Jeff with grieving?

- Offer single room away from crying babies
  - Use universal symbol to identify the room (e.g. butterfly or flower)
- Offer options to take Ava home, if desired

# Memory creation

Offer support and guide parents about seeing their baby (normalise their fears), affirm their baby's existence and their parental identity, and help to create valuable memories.

How can Ronnie and Jeff be supported to see and hold Ava?

- Respect their decision if they choose not to see or hold their baby
- Support them to bath, cuddle and dress their baby
- Assist with memory creation
- Speak with respect to and about Ava–use their baby's name and handle baby with care

# Postnatal care

The midwifery student asks what postnatal care Ronnie will need.

- Debriefing and support–offer and repeat information
- Refer to social worker/psychologist/bereavement midwife
- Usual postnatal care
- Management of any maternal medical conditions
- Lactation advice–suppression or milk donation
- Contraception advice and postnatal exercises
- Refer to home visiting service and notify general physician
- Discharge when clinical and psychological condition permits
- Postnatal review

# Documentation

What documentation is required in Queensland following a stillbirth?

- Cause of Death Certificate (form 9)
- Perinatal Supplement (form 9A)
- Birth registration application
- Perinatal data collection form
- Centrelink claim form for bereavement payment

**Classification**

- Use the PSANZ-PDC
- Record data using the APMCAT

# Maternal medical conditions

Consider maternal conditions requiring further investigation and management

- Investigate and manage conditions (e.g. pre-eclampsia, HELLP syndrome)
- FBC detects infection, maternal anaemia, autoimmune disease, elevated platelets
- If renal disease or pre-eclampsia–renal function tests (urea and creatinine)

# Investigation of stillbirth

Cause of fetal death most likely to be found from:

- Placental histopathology and chromosomal microarray
- Autopsy of baby

# Maternal investigations

Offer investigations targeted towards the woman's obstetric history and circumstances of the baby's death

- Medical, obstetric, social, family, travel history
- Core maternal test– Syphilis serology, Kleihauer-Betke or flow cytometry to detect feto-maternal haemorrhage
  - Preferably test before the birth

Selective tests

- Based on history and clinical presentation
- Blood group and antibody screen; drug screen; LFTs and non-fasting bile acids; TFTs; HbA1c; thrombophilia; infection

# Baby and placental investigations

What core investigations are recommended after a baby is stillborn.

- Physical exam, anthropometric measurements, clinical photographs, medical imaging
- Surface swabs of ear and pharynx–anaerobic/aerobic bacteria
- Blood–microbiology, haematology, chromosomal analysis, NBST
- Cord exam–thrombosis, true knot, infection (culture fetal surface)
- Placenta–detailed macroscopic examination of the placenta and cord and document findings (normal and abnormal)

# Benefits of autopsy

Why is autopsy recommended to all women who have a stillbirth?

- May help find the cause of fetal death
- Informs genetic counselling
- May help plan and mange future pregnancies
- Enhances medical knowledge and may help other families
- May inform the emotional and bereavement support needed
- Informs auditing of perinatal outcomes

# Autopsy

In Queensland the autopsy rate has dropped to 38.3%

- Autopsy is the gold standard for investigation of stillbirth
- Recommend to all women
- If declined, discuss:
  - Non-invasive/minimally invasive autopsy
  - Complete external examination, clinical photography, imaging

# Follow-up care

Arrange follow-up care with an experienced medical clinician involved in the woman's antenatal care.

What follow-up can Ronnie and Jeff expect?

- Local healthcare providers notified
- Follow-up phone call
- Information about:
  - Cause of death or interim results/findings
  - Additional investigations that are advised
- If fetal growth restriction, pre-eclampsia, maternal thrombosis, maternal thrombophilia suspected, or stillbirth unexplained at 8–12 weeks–test for thrombophilia
- Next pregnancy advice–risk increased, lifestyle