Stillbirth care

Clinical Guideline Presentation V7

45 minutes

Towards CPD Hours

References:

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

Recommended citation:

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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
- **IOL** Induction of labour
- **LFTs** Liver function tests
- **NNST** Newborn screening test
- **PCA** Patient controlled analgesia
- **PSANZ-PDC** Perinatal Society of Australia and New Zealand- Perinatal Death Classification
- **SANDS** Stillbirth and Neonatal Death Support
- **TFTs** Thyroid function tests
- **USS** Ultrasound scan

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 and cause in Queensland

Incidence 2012–2013

- All women–6.9 per 1000 births
- Indigenous women–9.0 per 1000 births
  - Risk 4 times greater due to maternal conditions and perinatal infections

Causes 2004–2013

- Unexplained 32.6%
- Congenital abnormality 27.2%
- Spontaneous preterm 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 abnormality
- 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:

- Ethnic–South Asian, South African, African, Middle Eastern
- Maternal age– < 15 or > 35 years of age
- Multiple pregnancy
- Previous stillbirth
- Prolonged pregnancy

Antenatal care

Rennie is a 35 year old primigravida of South African decent. She reduced her smoking when trying to become pregnant but gained weight and now has a BMI of 30 kg/m^2.

You encourage and support Rennie to have:

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

Advice to women

What will you discuss with Rennie to reduce her stillbirth risk?

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

Diagnosis of fetal death

Sadly Rennie is diagnosed with a fetal death at 36 weeks gestation. What are some strategies you can use to support Rennie and Jeff through this difficult time?

- Provide escort and remain with them (e.g. at USS)
- Confirm absent fetal heart by experienced clinician– diagnose after real time ultrasound assessment
- Acknowledge them as parents
- Provide continuity of carer
- Discussion by adequately trained and prepared health care provider
- Do not leave them alone unless they ask

Informing parents about fetal death

Hold discussions with parents in a quiet and private area.

- Do not delay informing parents
- Use quiet and private area
- Use clear, unambiguous language (e.g. '*Your baby has died')*
- Use cues from parents
- Be sensitive and non-judgemental
- Consider other family members (e.g. siblings/grandparents)
- Refer to support services, support groups
- Document discussions and plan of care

Communication with parents

You have a student working with you and they say they feel uncomfortable talking to Rennie and Jeff. What advice to you give 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 health care providers.

What do you consider when planning care for Rennie 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 you provide to Rennie and Jeff and other parents who have a stillbirth?

- Acknowledge cultural, spiritual and religious beliefs and practices
- Aboriginal and Torres Strait Islander people may wish elder/community member support

Labour and birth preparation

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

- Provide step by step information
- Provide analgesia options:
  - Pharmacological–epidural, PCA, nitrous oxide
  - Non-pharmacological–water immersion, heat packs, sterile water injections
- Advise about what to bring (e.g. camera, clothes, blanket, soft toy)
- Inform about physical appearance of the baby:
  - Gestational age, abnormalities, potential injuries (e.g. peeling skin)

Labour

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

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 Rennie has not gone into labour and she and Jeff decide they would like to be induced. What are the induction options 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 Rennie during labour and birth?

- Ensure preparation and set-up of birthing suite
- Provide 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 Rennie has a baby girl that they name Ava. What can you do to help Rennie and Jeff with grieving?

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

Memory creation

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

How can you support Rennie and Jeff to see and hold their baby Ava?

- Support them 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 baby
- Assist with memory creation
- Speak with respect to and about Ava–use baby's name and handle baby with care

Postnatal care

The student asks what postnatal care Rennie will need. What do you discuss with the student?

- 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
- 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 found from:

- Placental histopathology and chromosomal microarray
- Autopsy of baby

Maternal investigations

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

- Medical, obstetric, social, family, travel history
- Core maternal test– Kleihauer-Betke or flow cytometry detects 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 placenta investigations

The student asks what investigations are suggested after a baby is stillborn. What will you discuss?

- Physical exam, anthropometric measurements, clinical photographs, medical imaging
- Surface swabs of ear and pharynx–anaerobic/aerobic bacteria
- Blood–microbiology, haematology, chromosomal analysis, NNST
- Cord exam–thrombosis, true knot, infection (culture fetal surface)

Benefits of autopsy

The student asks you why an autopsy is recommended to all women who have a stillbirth. What reasons do you discuss?

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

Autopsy

In Queensland the autopsy rate has dropped to 32.2%

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

Follow-up care

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

What follow-up can Rennie and Jeff expect?

- Local doctor notified
- Follow-up phone call
- Information about:
  - Cause of death or progress being made
  - Additional investigations that are advised
- If FGR, pre-eclampsia, maternal thrombosis, maternal thrombophilia suspected, stillbirth unexplained at 8–12 weeks–test for thrombophilia
- Next pregnancy advice–risk increased, lifestyle advice