Intra Uterine Fetal Death

Dott.ssa Anna Codroma
CASE REPORT

- V.P., female, aged 31
- **Family history:** negative for recurrent diseases
- **Personal history:** negative for allergies, smoking, previous E/P therapy without side effects

**Serology:**
- Toxoplasmosis: IgG -, IgM -
- Rubella: IgG +, IgM -
- Cytomegalovirus: IgG -, IgM -
- Parvovirus B19: IgG -, IgM -
- Varicella Zoster Virus: IgG +, IgM -
- HBV, HCV, HIV 1-2 and Lue: -

- Spontaneous and physiological pregnancy
- I trimester scan: biometry corresponding to amenorrhea
- Ultrascreen: low risk
- II trimester scan: regular morphology and biometry corresponding to amenorrhea
- Repeated serology: unchanged
**CASE REPORT**

02.07.2012

- Emergency evaluation for decreased fetal movements
- Diagnosis of intrauterine late fetal death
- Hospitalization
- Prostaglandins induction of labour
- Vaginal delivery and manual placental removal for failure afterbirth

03.07.2012

- No clinical nor biochemical signs of sepsis, preeclampsia, DIC
- Psychological support

04.07.2012

- Discharge in good clinical conditions
CASE REPORT

- placental histological examination

DESCRIZIONE MACROSCOPICA

Reperto macroscopico (campione pervenuto fissato in formalina) [SC]:
Materiale inviato in esame come “placenta e membrane” del peso di 255 g, di cm 11 x 9, di forma ovale.
Il funicolo (lunghezza cm 12) ha inserzione paracentrale (a cm 2,5 dal margine più vicino) ed appare ispessito per i primi 4 cm di colorito beige.
E’ presente strozzatura di cm 0,8 posta a cm 5 dall’inserzione.
In sezione sono presenti 3 vasi. La gelatina è color marrone e i vasi sembrano trombizzati.
Le membranesono in gran parte assenti.
Il versante fetale presenta evidente varice a ridosso del funicolo; i vasi diretti a metà placenta sono dilatati.
Il versante materno presenta metà placenta lacerata.
Si prelevano:
1) Funicolo.
2) Membrane.
3) Inserzione e vasi trombizzati (macrosezione).
4,5) Placenta (lobo compatto)
6) Placenta (lobo frammentato).

Informazioni cliniche (come segnalate in richiesta):
- Morte endouterina a 30 settimane di gestazione
- U.M.: 04/12/2012
- PARA: 0010
- Ecografia II° livello (02/07/2012): BCF assente

DIAGNOSI

Placenta con trombosi dei vasi del funicolo (1), dei vasi del piatto coriale (3) e di alcuni vasi dei villi staminali (3,4,7) e alterazioni di tipo subischemico di molti villi (3,4,5,6,7).
Membrane senza flogosi di rilievo (2).
Cariotessi endovasale e detriti apoptotici multipli dello stroma dei villi (3,4,5,6,7).
Funicolo con spiccate alterazioni di tipo regressivo delle cellule dello stroma e delle fibre della parete dei vasi, collasso trivasale (1).

L’esaminatore: Prof.ssa S. Chiarelli : VE

5 AGO 2012
CASE REPORT

❖ fetal autopsy

DIAGNOSI ANATOMO-PATOLOGICA

Autopsia N. 113/2012 eseguita il 4-07-2012 alle ore 10,00 dal dott. R. Salmaso

Nato morto con fenotipo dei genitali esterni ed interni femminili, del peso di gr 942, della lunghezza cranio-calcaneale di cm 37,5, cranio-sacrale 25,5 cm e del piede di cm 5,5.

Esame esterno:
Assenza di malformazioni osteo-scheletriche, macerazioni di III° estese al 90% della superficie corporea con diffuso slaminamento dell’epidermide, presenza di bolle, netto accavallamento delle ossa parietali e modica ipertricosi in corrispondenza delle spalle.

Valutazione macroscopica degli organi interni:
Timo nella norma.
Polmoni congesti con petecchie sub-pleuriche.
Cuore con concordanza atrio-ventricolare e ventricolo-arteriosa, setti interatriale ed interventricolare integri. Omogeneizzazione cronica della maggior parte degli organi della cavità addominale.

Valutazione istologica:
Ipoplasia timica di III grado.
Occlusione trombotica completa della vena e di una arteria ombelicale e funicolo marcatamente edematose, la parete delle arterie ombelicali presentano, inoltre, una marcata ipertrofia della tonaca muscolare.
Polmoni in grave ritardo maturativo rispetto alla settimana di gravidanza riferita con angiectasie e congestione. Sezioni del tratto esofago-gastrico, del piccolo e del grosso intestino nei limiti di norma.
Milza e fegato con congestione diffusa.
Renì congesti, con lieve ritardo maturativo rispetto all’epoca gestazionale, ectasia di calici e pelvi.
Apparato genitale nei limiti di norma.

L’esaminatore: Dott. R. Salmaso : /RS
DEFINITION

WHO: “fetal death late in pregnancy”
allows each country to define the gestational age at which a fetal death is considered a stillbirth for reporting purposes

- United States: 20 weeks of gestation as threshold
- International Stillbirth Alliance: 20 weeks
- gestational age unknown: fetal weight threshold used varies from ≥ 350 to ≥ 500 g
- Early stillbirths: 20 to 27 weeks of gestation
- Late stillbirths: >28 weeks of gestation

CEMACH (The Perinatal Mortality Surveillance Report), UK:
‘a baby delivered with no signs of life known to have died after 24 completed weeks of pregnancy’

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- www.stillbirthalliance.org
EPIDEMIOLOGY

- 5.2/1000 in UK 2007
- 6.2/1000 in USA 2005
- 9.2/1000 in Italy from 1994 to 2006 (Italian women)
- 12.9/1000 in Italy from 1994 to 2006 (non-Italian women)
- Over 2.6 million stillbirths ≥ 28 weeks or 1000 g occur each year worldwide
decreased since 1995 when about 3 million stillbirths were estimated worldwide
generally constant since 2000 maybe for:
  - rising obesity rates
  - rising maternal age

estimating problems:
  - Developing countries: most births occur at home in very remote areas
  - Developed countries: induced labors for fetal anomalies premature rupture of membrane

more prevalent risk factors for stillbirth
data completely lacking
categorized as stillbirth

DIAGNOSIS

- Auscultation and cardiotocography should not be used
- Real-time ultrasonography is essential
  Ideally, real-time ultrasonography should be available at all times
  A second opinion should be obtained whenever practically possible
- Mothers should be prepared for the possibility of passive fetal movement
  A repeat scan should be offered
- Other secondary features might be seen:
  - skull with overlapping bones
  - hydrops
  - maceration

Royal College of Obstetricians and Gynaecologists. Green-top Guideline No. 55 Late Intrauterine fetal death and stillbirth; London: RCOG; 2010
ETIOLOGY

- CONGENITAL ANOMALY
  - comosomical defects
  - syndromes
  - abnormalities

- PLACENTA
  - placental bed pathology
  - development
  - parenchima
  - localization
  - umbilical cord complications

- PREMATURITY
  - pPROM
  - preterm labour
  - cervical disfunctions
  - iatrogenic

- INFECTIONS
  - transplacental
  - ascending

- MATERNAL
  - maternal disease
  - maternal trauma

- UNKNOWN

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### Etiology of Fetal Death

#### Perinatal Infection

<table>
<thead>
<tr>
<th>Category</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bacterial</td>
<td>Group B Streptococcus, E coli, Staphylococcus, E. coli</td>
</tr>
<tr>
<td>Cytomegalovirus</td>
<td></td>
</tr>
<tr>
<td>Parvovirus</td>
<td></td>
</tr>
<tr>
<td>Herpes simplex virus</td>
<td></td>
</tr>
<tr>
<td>Rubella virus</td>
<td></td>
</tr>
<tr>
<td>Other viral</td>
<td></td>
</tr>
<tr>
<td>Protozoal, eg Toxoplasma</td>
<td></td>
</tr>
<tr>
<td>Fungal</td>
<td></td>
</tr>
<tr>
<td>Other specified organism</td>
<td></td>
</tr>
</tbody>
</table>

#### Hypertension or Pre-eclampsia

<table>
<thead>
<tr>
<th>Category</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antepartum hemorrhage</td>
<td></td>
</tr>
<tr>
<td>Placental abruption</td>
<td></td>
</tr>
<tr>
<td>Placenta previa</td>
<td></td>
</tr>
<tr>
<td>Vasa previa</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

#### Maternal Conditions

<table>
<thead>
<tr>
<th>Category</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Termination of pregnancy</td>
<td></td>
</tr>
<tr>
<td>Diabetes/gestational diabetes</td>
<td></td>
</tr>
<tr>
<td>Maternal injury</td>
<td></td>
</tr>
<tr>
<td>Accidental</td>
<td></td>
</tr>
<tr>
<td>Non-accidental</td>
<td></td>
</tr>
<tr>
<td>Maternal sepsis</td>
<td></td>
</tr>
<tr>
<td>Systemic lupus erythematosis</td>
<td></td>
</tr>
<tr>
<td>Obstetric cholestasis</td>
<td></td>
</tr>
</tbody>
</table>

12.9% of maternal or fetal infections are more frequent in developing countries.

9.2% of hypertensive disorders.

10 to 20% of maternal deaths are due to malaria in endemic areas.

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ETIOLOGY

<table>
<thead>
<tr>
<th>Perinatal conditions</th>
<th>10.4 % of umbilical abnormalities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Twin-twin transfusion</td>
<td></td>
</tr>
<tr>
<td>Fetomaternal hemorrhage</td>
<td></td>
</tr>
<tr>
<td>Antepartum cord complications</td>
<td></td>
</tr>
<tr>
<td>Uterine abnormalities</td>
<td></td>
</tr>
<tr>
<td>Birth trauma</td>
<td></td>
</tr>
<tr>
<td>Alloimmune disease</td>
<td></td>
</tr>
<tr>
<td>Nonimmune fetal hydrops</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

| Hypoxic peripartum death            |                                   |
| With intrapartum complications      |                                   |
| Uterine rupture                      |                                   |
| Cord prolapse                        |                                   |
| Shoulder dystocia                    |                                   |
| Other                                |                                   |

| Evidence of non-reassuring fetal status in a normally grown infant |                                   |
| No intrapartum complications and no evidence of non-reassuring fetal status. |                                   |

| Fetal growth restriction            | SECOND MOST COMMON TYPE            |
| Unspecified or not known whether placenta examined |                                   |

| Spontaneous preterm birth          |                                   |
| Intact membranes                   |                                   |
| Ruptured membranes                 |                                   |

| Unexplained antepartum death       | FIRST MOST COMMON TYPE (25 to 60 %) |
| With evidence of reduced vascular perfusion on Doppler studies and/or placental histopathology (e.g., significant infarction, acute atherosis, maternal and/or fetal vascular thrombosis or maternal floor infarction) | 23.6 % of placental disease |
| With chronic villitis               |                                   |
| No placental pathology             |                                   |
| Other specified placental pathology |                                   |

## MANAGEMENT

<table>
<thead>
<tr>
<th>Test</th>
<th>Reason(s) for test</th>
<th>Evidence level</th>
<th>Reference(s)</th>
<th>Additional comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal standard haematology and</td>
<td>Pre-eclampsia and its complications</td>
<td>3</td>
<td>3, 19, 42</td>
<td>Platelet count to test for occult DIC (repeat twice weekly)</td>
</tr>
<tr>
<td>biochemistry including CRPs and</td>
<td>Multi-organ failure in sepsis or haemorrhage</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>bile salt</td>
<td>Obstetric cholestasis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternal coagulation times and</td>
<td>DIC</td>
<td>3</td>
<td>19</td>
<td>Not a test for cause of late IUFD</td>
</tr>
<tr>
<td>plasma fibrinogen</td>
<td></td>
<td></td>
<td></td>
<td>Maternal sepsis, placental abruption and pre-eclampsia increase the probability of DIC</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Especially important if woman desires regional anaesthesia</td>
</tr>
<tr>
<td>Maternal thrombophilia screen</td>
<td>Maternal thrombophilia</td>
<td>1++</td>
<td>56-58</td>
<td>Indicated if evidence of fetal growth restriction or placental disease</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>The association between inherited thrombophilias and IUFD is weak, and management in future pregnancy is uncertain\textsuperscript{56,58}</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Most tests are not affected by pregnancy – if abnormal, repeat at 6 weeks</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>Antiphospholipid screen repeated if abnormal</strong></td>
</tr>
</tbody>
</table>

Royal College of Obstetricians and Gynaecologists. Green-top Guideline No. 55 Late Intrauterine fetal death and stillbirth; London: RCOG; 2010
## MANAGEMENT

<table>
<thead>
<tr>
<th>Test</th>
<th>Condition</th>
<th>Value</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal random blood glucose</td>
<td>Occult maternal diabetes mellitus</td>
<td>3</td>
<td>49, 50</td>
</tr>
<tr>
<td></td>
<td>Rarely a woman will have incidental type 1 diabetes mellitus, usually with severe ketosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Women with gestational diabetes mellitus return to normal glucose tolerance within a few hours after late IUFD has occurred</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternal HbA$_1c$</td>
<td>Gestational diabetes mellitus</td>
<td>2+</td>
<td>3, 4, 51–53</td>
</tr>
<tr>
<td></td>
<td>Most women with gestational diabetes mellitus have a normal HbA$_1c$</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Need to test for gestational diabetes mellitus in future pregnancy</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Might also indicate occult type 1 and type 2 diabetes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternal thyroid function</td>
<td>Occult maternal thyroid disease</td>
<td>3</td>
<td>54, 55</td>
</tr>
<tr>
<td></td>
<td>TSH, FT4 and FT3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anti-red cell antibody serology</td>
<td>Immune haemolytic disease</td>
<td>3</td>
<td>59–62</td>
</tr>
<tr>
<td>Maternal anti-Ro and anti-La antibodies</td>
<td>Occult maternal autoimmune disease</td>
<td>3</td>
<td>63</td>
</tr>
<tr>
<td>Maternal alloimmune antiplatelet antibodies</td>
<td>Alloimmune thrombocytopenia</td>
<td>3</td>
<td>64</td>
</tr>
</tbody>
</table>

- Indicated if fetal hydrops evident clinically or on postmortem
- Indicated if evidence of hydrops, endomyocardial fibro-elastosis or AV node calcification at postmortem
- Indicated if fetal intracranial haemorrhage found on postmortem

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Royal College of Obstetricians and Gynaecologists. Green-top Guideline No. 55 Late Intrauterine fetal death and stillbirth; London: RCOG; 2010
**MANAGEMENT**

| Maternal bacteriology: | Suspected maternal bacterial infection including *Listeria monocytogenes* and *Chlamydia* spp. | 1++  
|------------------------|------------------------------------------------------------------------------------------------|-------
| - blood cultures       |                                                                                                 | 32–34, 39, 41, 44, 45 |
| - midstream urine      |                                                                                                 |       |
| - vaginal swabs        |                                                                                                 |       |
| - cervical swabs       |                                                                                                 |       |

**Indicated in the presence of:**
- maternal fever
- flu-like symptoms
- abnormal liquor (purulent appearance/offensive odour)
- prolonged ruptured membranes before late IUFD

Abnormal bacteriology is of doubtful significance in the absence of clinical or histological evidence of chorioamnionitis\(^6\) (Evidence level 3)

In one study, amniotic fluid culture was positive in only 1 of 44 women with IUFD despite evidence of chorioamnionitis in a further 9 women\(^7\) (Evidence level 3)

Also used to direct maternal antibiotic therapy

| Maternal serology: | Occult maternal–fetal infection | 2++
|-------------------|---------------------------------|-----
| - viral screen    |                                 | 30, 32–35, 48 |
| - syphilis        |                                 |       |
| - tropical infections |                              |       |

Stored serum from booking tests can provide baseline serology
- Parvovirus B19, rubella (if nonimmune at booking), CMV, herpes simplex and *Toxoplasma gondii* (routinely)
- Hydrops not necessarily a feature of parvovirus-related late IUFD
- Treponemal serology – usually known already
- Others if presentation suggestive, e.g. travel to endemic areas

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Royal College of Obstetricians and Gynaecologists. Green-top Guideline No. 55 Late Intrauterine fetal death and stillbirth; London: RCOG; 2010
### MANAGEMENT

<table>
<thead>
<tr>
<th>Parental bloods for karyotype</th>
<th>Parental balanced translocation</th>
<th>Parental mosaicism</th>
<th>Indicated if:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>- fetal unbalanced translocation</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- other fetal aneuploidy, e.g. 45X</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Turner syndrome</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- fetal genetic testing fails and history suggestive of aneuploidy (fetal abnormality on postmortem, previous unexplained IUFD, recurrent miscarriage)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Maternal urine for cocaine metabolites</th>
<th>Occult drug use</th>
<th>Indicated if:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1++</td>
<td></td>
</tr>
<tr>
<td></td>
<td>68</td>
<td></td>
</tr>
</tbody>
</table>

With consent, if history and/or presentation are suggestive

<table>
<thead>
<tr>
<th>Fetal and placental: microbiology</th>
<th>Fetal infections</th>
<th>Indicated if:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- fetal blood</td>
<td>2+</td>
<td></td>
</tr>
<tr>
<td>- fetal swabs</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>- placental swabs</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

More informative than maternal serology for detecting viral infections

- Cord or cardiac blood (if possible) in lithium heparin
- Written consent advisable for cardiac bloods
- Need to be obtained using clean technique

---

Royal College of Obstetricians and Gynaecologists. Green-top Guideline No. 55 Late Intrauterine fetal death and stillbirth; London: RCOG; 2010
Postmortem examination has the highest diagnostic yield of all investigations. In 88% a major contributor to death was found in the placentas. MRI loose essential information in 17% of perinatal deaths. Genetic sex can be tested rapidly on skin or placental tissue. QF-PCR with Y markers can provide a highly accurate result within 2 days in more than 99.9% of samples.
MANAGEMENT

- Anti-RhD gammaglobulin as soon as possible
- Written consents must be obtained
- Recommendations about labour and birth:
  - medical condition
  - previous intrapartum history
  - mother’s preferences

- > 85% of women labour spontaneously within three weeks
- the risk of expectant management for 48 hours is low
- 10% chance of maternal DIC within 4 weeks, increasing chance thereafter

---

MANAGEMENT

ASSESS MATERNAL WELLBEING

ACTIVE MANAGEMENT

- pre-eclampsia
- sepsis
- placental abruption
- membrane rupture

DELIVERY AND MANAGEMENT

EXPECTANT MANAGEMENT

- no risk factors

DIC twice weekly

- value of postmortem may be reduced
- the appearance of the baby may deteriorate
- psychological aspects

Royal College of Obstetricians and Gynaecologists. Green-top Guideline No. 55 Late Intrauterine fetal death and stillbirth; London: RCOG; 2010
MANAGEMENT

- Vaginal birth can be achieved within 24 hours in about 90% of women.
- The implications of caesarean delivery for future childbearing should be discussed.

** UNSCARRED UTERUS **

- Prostaglandins +/- Mifepristone
- Vaginal misoprostol
- Oxitocyn in third trimester
- Mechanical methods (trials only)

** SCARRED UTERUS **

- Higher risk with prostaglandins
- SOGC: misoprostol is contraindicated
- No studies on two cesarean sections
- or atypical uterine scar

- atypical pain
- vaginal bleeding
- haematuria on catheter specimen
- maternal collapse

---


Society of Obstetricians and Gynaecologists of Canada. SOGC clinical practice guidelines. Guidelines for vaginal birth after previous caesarean birth. Number 155 (Replaces guideline number 147), February 2005
**MANAGEMENT**

**ANTIBIOTIC PROPHYLAXIS:**

- no need for prophylaxis (RCOG)
- sepsis should be treated with intravenous broad-spectrum antibiotic therapy (including antichlamydial agents)
- 3.1% develop signs of sepsis during induction of labour

**LABOUR ANALGESIA:**

- Diamorphine should be prefered to pethidine
- Regional anaesthesia should be available
- Assessment for DIC and sepsis should be undertaken before regional anaesthesia
- Women should be offered an opportunity to meet with an obstetric anaesthetist

---

- Wagaarachchi PT, Ashok PW, Narvekar NN, Smith NC, Templeton A. Medical management of late intrauterine death using a combination of mifepristone and misoprostol. BJOG 2002;109:443-7
- Royal College of Obstetricians and Gynaecologists. Green-top Guideline No. 55 Late Intrauterine fetal death and stillbirth; London: RCOG; 2010
MANAGEMENT

- **TROMBOPROPHYLAXIS**
  - routinary thromboprophylaxis
  - DIC therapy (discuss with haematologist)

- **SUPPRESSION OF LACTATION**
  - dopamine agonists are effective and well tolerated
  - *cabergoline* is superior to bromocriptine
  - controindicated in hypertension or pre-eclampsia

- **FERTILITY**
  - ovulation returns quickly, as early as day 18
  - aware that is possible to conceive before the first menstrual period

---

FOLLOW UP

- Timing of the first appointment: 6 to 8 weeks (placental and postmortem available)
- Explanation of death, when possible
- Offered general prepregnancy advice
- Inform about risk of recurrence:
  - 12-fold increased risk of intrapartum stillbirth
  - Greater risk of subsequent early IUPDs between 20 and 28 weeks

- No association between inter-pregnancy interval and pregnancy outcome

References:

- Davanzo J, Hale L, Razzaque A, Rahman M. Effects of interpregnancy interval and outcome of the preceding pregnancy on pregnancy outcomes in Matlab, Bangladesh. JOG 2007;114:1079-87
PREVENTION

- Periconceptional folic acid fortification
- Smoking cessation, reduce alcohol intake and recreational drugs
- Weight reduction
- Hypertensive disorders of pregnancy detection and management
- Diabetes of pregnancy detection and management
- Fetal growth restriction detection and management
- Postterm pregnancy (≥41 weeks of gestation) identification and induction
- Skilled birth attendant at birth
- Availability of emergency obstetric care
- Syphilis detection and treatment
- Prevention of malaria
- Reduction of multiple pregnancies
- Avoid delayed childbearing
- Evaluation of decreased fetal movements

never wait longer than two hours if there is absent fetal movements
- call within 12 hours if decreased fetal movements

www.stillbirthalliance.org
Older women experience an increased risk of stillbirth at all gestational ages, and this risk is magnified at term.

PSYCHOLOGICAL AND SOCIAL ASPECTS OF CARE.

...ABOUT FUTURE PREGNANCIES:

- delaying conception until severe psychological issues have been resolved
- unresolved normal grief responses can evolve into post-traumatic stress disorder
- Women with poor social support are particularly vulnerable
- aware about subsequent postpartum depression
- maternal bonding can be adversely affected

---


PSYCHOLOGICAL AND SOCIAL ASPECTS OF CARE.

- call a fetal loss ‘stillbirth’ is important because less grief support is provided after a miscarriage
- stillbirth often has profound emotional, psychiatric and social effects
  - If the woman is unaccompanied, immediate offer to call her partner, relatives or friends
  - do not care for women with symptoms of psychiatric disease in isolation
  - imposing care can worsen the psychological impact:
    - discussions should aim to support maternal/parental choice
  - If a woman returns home before labour: offer a 24-hour contact number
  - Parents should be offered written information to supplement discussions

---

PSYCHOLOGICAL AND SOCIAL ASPECTS OF CARE,

- offer a description of what happens during the procedure and the likely appearance of the baby afterwards
- advise about the potential difficulty in sexing the baby (extreme prematurity, maceration and hydrops)
- Maternity units should have the facilities for producing photographs, palm and foot prints

offer of a leaflet including:
- named carers
- local contact points
- postmortem (nature, benefits and choice)
- baby’s arrangements for transport with dignity
- expectations for physical recovery
- lactation suppression
- registering the birth and addresses of local authority site
- details of national and local parent support groups
- guidance on fertility and contraception
- plan for follow-up
PSYCHOLOGICAL AND SOCIAL ASPECTS OF CARE.

..needs for:

- debriefing for carers
- dedicated associations
- passing ceremonies

..thanks

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