Understanding Stillbirth and Supporting Loss and Grief

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RN, CM, BCouns, MHStds (loss & grief)
IMPROVE
IMproving Perinatal Mortality Review and Outcomes Via Education

Implementing the PSANZ Perinatal Mortality Guideline
Aims

- To understand definition, incidence, causes and presentations of stillbirth
- To differentiate between a stillborn baby and a baby that requires resuscitation
- To understand basic principles of perinatal grief and what interventions can assist
- To consider impact of vicarious grief and principles of self-care
Stillbirth - definitions

IUFD (Interuterine Fetal Death): Birth of a baby at 20 weeks or greater that shows no sign of life at the birth.

Miscarriage: A baby that is born with no signs of life that is less then 20 weeks of gestation is not a registerable birth and is often referred to as a miscarriage.
Perinatal death in Australia

(Perinatal mortality rate / Stillbirth rate / Neonatal death rate / Total number of births 2010)
## International Comparisons: Stillbirth 28 weeks +

Rates per 1000 births of 193 countries:

<table>
<thead>
<tr>
<th>Country</th>
<th>Rate</th>
<th>Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australia</td>
<td>2.9</td>
<td>15</td>
</tr>
<tr>
<td>Finland</td>
<td>2.0</td>
<td>1</td>
</tr>
<tr>
<td>Germany</td>
<td>2.4</td>
<td>6</td>
</tr>
<tr>
<td>USA</td>
<td>3.0</td>
<td>17</td>
</tr>
<tr>
<td>UK</td>
<td>3.5</td>
<td>33</td>
</tr>
<tr>
<td>France</td>
<td>3.9</td>
<td>41</td>
</tr>
</tbody>
</table>

Indigenous Australians

Rank 56th behind Colombia and Malaysia

The gap indicates that around 300 babies reaching 28 weeks gestation could be saved each year in Australia.
Perinatal death in Australia

- 300,000 births each year
- Perinatal mortality 9.3/1000 births
- Neonatal death rate 2.9/1000 livebirths
- Stillbirth rate 7.4/1000 births (20 weeks or 400gms)

- Stillbirths make up 70% of perinatal deaths
- 90% are antepartum
- Major causes of stillbirths (PSANZ PDC):
  - Congenital abnormality;
  - Spontaneous preterm birth;
- Important associated conditions:
  - Placental insufficiency and fetal growth restriction
  - Modifiable risk factors

30% of stillbirths are unexplained
10 times more common than SIDS
Causes and Associations of Stillbirth

Maternal Conditions:
- Preterm labour
- APH: Abruption, placenta previa
- Pre-eclampsia/ HELLP/Eclamptic fit
- Obstructed labour or fetal hypoxia (free birth, unattended home birth)

Baby Conditions:
- Congenital Fetal Abnormalities
- Congenital Infections (eg Parvovirus, CMV)
- Severe fetal growth restriction
- Feto-maternal hemorrhage
- Cord prolapse or other cord accident
- Unexplained intrauterine fetal death
Background

Unexplained fetal death contribution to fetal death rate by gestation
singleton (n=3180) versus multiple (n=350) pregnancies

<table>
<thead>
<tr>
<th>Gestation at birth</th>
<th>Singleton</th>
<th>Multiple</th>
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<tbody>
<tr>
<td>20-21</td>
<td>2-3%</td>
<td>2%</td>
</tr>
<tr>
<td>22-23</td>
<td>3%</td>
<td>3%</td>
</tr>
<tr>
<td>24-27</td>
<td>5%</td>
<td>1%</td>
</tr>
<tr>
<td>28-31</td>
<td>10%</td>
<td>8%</td>
</tr>
<tr>
<td>32-34</td>
<td>15%</td>
<td>16%</td>
</tr>
<tr>
<td>35-36</td>
<td>25%</td>
<td>36%</td>
</tr>
<tr>
<td>37-41</td>
<td>50%</td>
<td>41%</td>
</tr>
<tr>
<td>42+</td>
<td>20%</td>
<td>10%</td>
</tr>
<tr>
<td>Overall</td>
<td>60%</td>
<td>55%</td>
</tr>
</tbody>
</table>
Major risk factors for stillbirth in high income countries

Maternal overweight and obesity. PAR 12% (8000 stillbirths each year)

Maternal age > 35 years
PAR 11% (4000 stillbirths)

Smoking
PAR 6% (3000 stillbirths)

Primiparity - PAR 14%

But…

− Most stillbirths occur among women who lack these obvious risk factors
Potential pre-hospital presentations

• Already diagnosed IUFD – may or may not be macerated

• Preterm labour (with or without prolonged, preterm rupture of membranes) very small baby, may be one of a multiple pregnancy

• Late miscarriage (15-20 weeks) – baby may be born into toilet

• Unexpected stillbirth (unusual)

• Reduced fetal movements
• Confronting image alert......
Very pre-term baby

Full Term Stillborn Baby

Mater Mothers Bereavement Support Program
Cord Accidents

26 week stillborn baby

36 week stillborn baby

Mater Mothers Bereavement Support Program
Fresh Stillbirth
Stillbirth: Congenital Abnormalities

Hydrops

Cystic Hygroma
How to recognize a stillborn baby

- Check for movement and tone
- Check for pulsating cord
- Check for heart beat
- Check for cry/respirations/gasps
- Check baby’s color
- Check for reflex movement

If none of the above are present the baby has already died (stillborn)
Not stillborn

- Heart activity – even 1-2 beats per minute
- Breathing effort – even a very occasional gasp
- Any spontaneous movement

Importance

- Resuscitate if possible/appropriate
- Acknowledgment validation of what parents observe and remember about their baby
- Legal implications
Stillbirth
To Resus or NOT?

Resuscitation should occur if:
• Confirmed gestational age of at least 24 weeks
• Signs of life

No resuscitation should occur if:
• No signs of life
• Confirmed gestational age of less than 24 weeks
• Baby is already macerated
What about this little one?
Practical Management of a Stillborn baby

- Retrieve baby’s body and dry off
- Clamp and cut umbilical cord
- Wrap baby in towel/sheet/bluey
- Hold and treat the baby as you would a live baby
- Reassure mother and others (baby has died some time ago or is too small to survive) and there is nothing that can be done for the baby
- Support the mother to nurse her baby
**Early Grief Reactions**

<table>
<thead>
<tr>
<th>Reaction</th>
<th>Response</th>
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<tbody>
<tr>
<td>Fear</td>
<td>Safety: physical/emotional. Call partner, control</td>
</tr>
<tr>
<td>Shock &amp; disbelief</td>
<td>Help to experience reality of what has occurred</td>
</tr>
<tr>
<td>Anger</td>
<td>Validation and management not argument</td>
</tr>
<tr>
<td>Blame</td>
<td>Validation and information</td>
</tr>
<tr>
<td>Confusion</td>
<td>Reassurance, facts, information, what happens next</td>
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Extreme Reactions can Occur
Responding to the Mother

- What do you say?
- Reassure her about her own well-being
- Inform her that the baby has died
- Recognize that she has lost a baby (and hoped for child) irrespective of the gestation
- Encourage/support but don’t force her to hold baby
- Acknowledge the shock/disbelief of the death
- Reassure her that you will get her to hospital as soon as possible
- If appropriate reassure her that she is not to blame
- Respect her grief and her baby
Minimizing Trauma

Obstetric emergencies can’t always be prevented, however PTSD doesn’t have to be a consequence.

3 Elements:

Safety, Mastery, Control

• Help to feel safe – physically, emotionally
• Provide reassurance
• Provide information
• Answer questions directly
• Give choices when appropriate
Discussion

• What has been your most difficult situation involving loss and grief?

• What is your worst fear?
Decreased fetal movements (DFM)

- DFM towards term is associated with a doubling of the risk of fetal growth restriction, which is strongly linked to stillbirth
- Fetal growth restriction may be caused by placental dysfunction
- DFM is a possible adaptive response to placental dysfunction
- Women who report DFM (and present with a live baby) have 4 times the risk of stillbirth compared with women who do not report DFM
The problems...

1. **Information provision to women about DFM is currently lacking**
   - 30% report NOT receiving information about fetal movements
   - 70% indicate awareness of fetal movements would NOT help identify a baby at risk
   - 60% say it is normal for movements to decrease towards term
The problems...

2. Current clinical practice for management of DFM is not always aligned with evidence

✓ Asking women about fetal movement is important
✓ Define DFM most commonly by maternal perception of DFM
× Clinicians commonly suggest to drink some cold/iced water
× Ultrasound scan done in <19% of cases
# My Baby's Movements (MBM)

<table>
<thead>
<tr>
<th>Pilot study (development and testing)</th>
<th>Multi-centre trial</th>
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<tbody>
<tr>
<td>Vicki Flenady (CIA)</td>
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<tr>
<td>Glenn Gardener (Site investigator)</td>
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<tr>
<td>David Ellwood</td>
<td>Philippa Middleton</td>
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<tr>
<td>Frances Boyle</td>
<td>Michael Coory</td>
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<td>Susan Vlack</td>
<td>David Ellwood</td>
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<tr>
<td>Aleena Wojcieszek</td>
<td>Caroline Crowther</td>
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<td>Christine East</td>
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<td>Emily Callander</td>
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<td>Frederik Froen</td>
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Sudden Unexpected Infant Death (SUDI) including SIDS

- Now much less common due to public health campaign
- Parents or family member find the baby
- 000 call - emergency resuscitation likely
- Involvement of Coroner (police)
- Guilt/blame
- Questions
- Determination by the Coroner
Finding out why babies die?

- Maternal Blood tests
- Placental pathology (please bring it with you)
- Post-mortem
- Non-invasive examination and imaging

**Why is it important for parents to find out?**
- Will it happen again?
- Did I do something wrong?
- Did someone else do something wrong?
- Why do so many babies die of stillbirth?

But not all parents will choose to undertake further investigations.
Carer’s Grief

Some cases will effect us personally, more likely to be those that resonate with or challenge or confront our assumptive world

- Deal with mortality and existential issues
- Personal philosophy - Self-awareness and self knowledge
- Learn to live with paradox
- Seek out psychological care and protection
- Avoid detachment
- Meaning making including rituals
- Grieve losses as they occur (avoid compassion fatigue)
- Resolve ethical dilemmas
- Personal and professional development
- Healthy life strategies
Compassionate Care

Individuals who care for those in need must first be professionally competent: they should be properly trained in what to do and how to do it, and committed to professional care.

Yet, while professional competence is a primary fundamental requirement, it is not of itself sufficient. We are dealing with human beings, and human beings always need something more than technically proper care. They need humanity. They need heartfelt concern.

Pope Benedict XVI, 2006, p. 52