

THE Journal of Obstetrics & Gynaecology of India

Vol. XXXVIII No. 4

AUGUST 1988

Editorial

INTRA-UTERINE FOETAL DEATH—AN OBSTETRIC CHALLENGE

Foetal demise can occur at any time during the course of a pregnancy. Only rarely the exact cause of foetal death is obvious as in a case of cord prolapse, often maternal conditions like hypertension, diabetes, high fever and others can be recognized as factors associated with increased propensity to foetal death, however, in a substantial proportion of cases there is no clue as to why such an event occurred. Every obstetrician has to face this difficult dilemma of caring a patient who has had an unblemished prenatal course until the foetus dies unexpectedly and without obvious cause.

Foetal death is first suspected in the later months of pregnancy when the patient reports her inability to appreciate foetal movements, in the earlier weeks of pregnancy, failure to gain weight, lack of abdominal enlargement or an abatement in the symptoms of pregnancy is suspicious of occurrence of foetal death.

Clinical examination, attempts to demonstrate foetal heart sounds on a doppler, ultrasonographic scanning and X-Rays in selected cases will help in arriving at the diagnosis.

The natural outcome of such a pregnancy can be variable, depending on gestation age, and the cause of foetal death. Most patients will go into sponta-

neous labour with 2-3 weeks of the event. However, prolonged retention of a dead foetus can be associated with complications leading to enhanced maternal morbidity and occasionally a maternal death. Thromboplastins released from the dead products of conception into the maternal vascular system can lead to a consumptive coagulopathy. This condition develops relatively late after foetal death and its course is insidious. Serial laboratory observations reveal a fall in the fibrinogen levels, platelet count and accumulation of fibrinogen degradation products usually 4 weeks after the occurrence of foetal death. The haematologic alterations are reversed by the timely administration of heparin, confirming that the underlying cause is disseminated intravascular coagulation (DIC).

Management: The therapeutic options available to the clinician are as follows:

1. *Expectant Management:* In view of the natural history of a marked tendency to spontaneous delivery, expectant observation is often a safe and effective alternative. During the period of observation a close haematologic monitoring of bleeding time, clotting time, platelet count and fibrinogen estimation twice in a week to safeguard against coagulopathy may be considered reasonable. At

the first sign of deterioration, prompt measures to terminate that pregnancy should be adopted.

Although expectant management is safe medically, it is intolerable and unacceptable psychologically to most women, who insist upon early evacuation of the uterus. Alternative modes of terminating such pregnancies therefore require consideration.

2. *Suction evacuation*: Dilatation of the cervix followed by suction evacuation is a safe alternative where the size of the uterus does not exceed 14 weeks of gestation; however, surgical skill and judgement are taxed to the limit, as haemorrhage, incomplete evacuation, difficulties in cervical dilation and trauma to the uterus pose real problems. Prior cervical ripening with the help of laminaria tents, or priming the cervix with prostaglandins are useful preliminary adjuncts. Such procedure must be performed in a theatre with an anaesthesiologist in attendance and blood transfusion facilities at hand.

3. *Extra-ovular instillation of Ethacridine Lactate*: Instillation of 100-150 ml of Ethacridine Lactate extra-ovularly followed by instillation of prostaglandins

extra-ovular in a single dose, 6 hours later has been reported to give satisfactory results.

4. *Amnio-infusion of hypertonic saline* is considered risky and not recommended.

5. *Intravenous oxytocin*: Oxytocin is a familiar and relatively safe drug. However, in clinical practice, it is observed that large doses have to be employed. The risk of water intoxication have to be borne in mind.

6. *Prostaglandins*: Prostaglandin E₂ vaginal suppositories provide a simple means for ripening the cervix prior to evacuation. However, as these are not easily available, parenteral prostaglandins can be alternatively used effectively. Inj. 15-S-15 methyl PGF₂ available as Inj. Carboprost, can be given in IM doses at periodic intervals to obtain satisfactory uterine activity leading to evacuation of the uterus. However, it must be remembered that apart from its cost and availability, PGs carry a high incidence of undesirable side-effects like gastrointestinal symptoms, fever, cardiovascular and respiratory effects and the occasional serious complications of uterine rupture and myocardial ischaemia.

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