International Journal of Research in Medical Sciences
Pancholi N et al. Int J Res Med Sci. 2018 Aug;6(8):2691-2695
www.msjonline.org
pISSN 2320-6071 | eISSN 2320-6012
DOI: http://dx.doi.org/10.18203/2320-6012.ijrms20183253

Original Research Article

Care of unfortunate mothers with perinatal loss

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Received: 17 May 2018
Accepted: 27 June 2018

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ABSTRACT

Background: Perinatal loss is one of the most traumatic life events. It is indeed a great psychological and emotional shock to not only the mother and father but the entire family and society as a whole. The study aims to take physical and psychological care of mother and father, to help in bereavement process, to know the incidence and prevalence and etiological factors of perinatal loss and to study the outcome of psychological support to mother.
Methods: It was a prospective analytical study. All patients with IUFD and early neonatal loss were studied. Postpartum both mother and father were counselled. Emotional reaction of both mother and father were recorded. A new ritual of giving the mother her baby (dead) was done to those who were willing for that.
Results: The results showed that the incidence of IUFD was 3.7% and early neonatal death was 10.8% per total admissions. The perinatal mortality rate was 63.62 per 1000 live births. There were varied reactions of grief which could be handled by effective counselling. Seeing and holding the baby was associated with fewer anxiety and depressive symptoms than not doing so.
Conclusions: Psychological counselling is very important. The patients are helped to cross over the crisis in their life and made them well prepared for next pregnancy. Counselling and communication skills should be routinely included in all residency programmes. Hospitals should have a separate place for mothers with perinatal loss which would help them to overcome their grief.

Keywords: Live birth, Late foetal death, Neonatal period, Perinatal period, Still birth

INTRODUCTION

God has given us life to see this beautiful world. Perinatal loss is one of the most traumatic life events. It is indeed a great psychological and emotional shock to not only the mother and father but the entire family and society as a whole. As every mother has the right to conclude her pregnancy safely so also the baby got a right to be born alive safe and healthy.[1] The perinatal mortality indicator plays an important role in providing the information needed to improve the health status of pregnant women, new mothers and newborns. That information allows decision-makers to identify problems, track temporal and geographical trends and disparities and assess changes in public health policy and practice.[2] The term "Unfortunate Mothers" is very wide. Any mother, who has lost her baby-whether via abortion, foetal death, neonatal death or even afterwards at any age, is unfortunate.

Even mothers of disabled (differently abled) babies are also unfortunate. For this study, we have limited the definition of unfortunate mother as those mothers who had perinatal loss. This study is an attempt to evaluate various aspects of perinatal loss and to take physical and psychological care of the patients, husband and their relatives and also to prevent it in subsequent pregnancies.

METHODS

This study was a prospective analytical study done in a tertiary care institute. Fifty patients with IUFD and early neonatal loss were studied.

On admission, patient's detailed history was taken, examined thoroughly, investigations done and managed accordingly.

Postpartum, both mother and father were counselled regarding perinatal loss. Emotional reaction of both mother and father were recorded. A new ritual of giving the mother her baby (dead) was done to those who were willing for that. This ritual was inspired by a similar study done by Joanne et al.[3] This ritual was initially not accepted by most of the patients and their relatives. 40 patients showed their willingness for this ritual and 10 patients refused for the same. They were again counselled at their follow up visits. Their emotional reactions were recorded. The patients were followed up for six months post partum to note the incidence of depression and anxiety according to DSM IV criteria (Diagnostic and Statistical Manual of Mental Disorders). Only one patient needed psychiatric reference for depression. In this study, post mortem of the dead foetus or baby was not done due to religious beliefs or refusal by patient's relatives.

RESULTS

Table 1 showed that the incidence of IUFD was 3.7% and early neonatal death was 10.8% per total admission and perinatal mortality rate was 63.62 per 1000 live births. The denominator was taken as the sum of total deliveries in one year plus the number of outside admission in NICU. According to Census India report PNMR was 23, 28, 32 per 1000 live birth in the year 2015, 2012, 2010 respectively.[4-6] The perinatal mortality rate is five times higher in developing than in developed regions: 10 deaths per 1000 total births in developed regions; 50 per 1000 in developing regions and over 60 per 1000 in least developed countries. It is highest in Africa, with 62 deaths per 1000 births, and especially in middle and western Africa, which have rates as high as 75 and 76 per 1000. The perinatal mortality rate in Asia is 50 per 1000 total births, with a peak of 65 per 1000 in South-central Asia, the third highest rate among the sub-regions, lower only than those of Middle and Western Africa.[2]

Table 2 showed that perinatal loss was more in patients having no antenatal visits as compared to those who received it. Perinatal loss occurred in 94% cases with no or only one antenatal visit as compared to 6% cases with two or three antenatal visits, which stresses the significance of regular antenatal care in pregnancy. It not only detects complications earlier but also helps in education of patients.[7,8]

Table 3 showed that 76% of perinatal loss had vaginal delivery, while in 18% cases caesarean section was needed, laparotomy in 6% cases. Caesarean section was required for indications like obstruction, previous c section, primi breech, meconium stained liquor; laparotomy was done for rupture uterus.[9]

Table 1: Incidence.

Characteristics	Number of patients
No. of deliveries	3488
No. of IUFD	131
% of IUFD	3.7
No. of NICU Admissions	1043
No. of babies delivered at institute	696
No. of babies outside delivered and admitted at institute	347
No. of deaths	113
% of early neonatal deaths (per total NICU admissions)	10.8

Table 2: Antenatal visits.

No. of antenatal visits	0	1	2	3
No. of cases	33	14	01	02
% of cases	66	28	02	04

Table 3: Mode of delivery.

Mode of delivery	No. of cases	% of cases
Vaginal delivery	38	76
Caeserean section	09	18
Laparotomy	03	06

Table 4: Birth weight.

Birth Weight (kg)	No. of cases	% of cases
1.0-1.5	05	9.8
1.6-2.0	09	17.64
2.1-2.5	13	25.4
2.6-3.0	20	39.2
>=3.1	04	7.8

Table 4 showed that 64.6% of perinatal loss occurred in those with birth weight above 2.0kg. These were the cases where maximum difficulty was faced during counselling. According to Daftary and Chakravarti, 40% of all stillbirth and 80% of all neonatal deaths were associated with birth weight less than 2.5kg.[10] Babies with a birthweight below the 50th centile are at greater risk of perinatal mortality compared with the 'optimum' ≥50 to <90th centile group.[11]

Table 5 showed that the most common cause of perinatal loss was idiopathic (26%), followed by preecclampsia (14%), oligohydramnios and abruption. According to WHO estimates, in developing countries, asphyxia causes around seven deaths per 1000 live births, whereas in developed countries this proportion is less than one.[12] In a study done in Maharashtra the leading causes of perinatal

deaths were prematurity (19.3%) and complications of placenta, cord and membranes (12.9%) among stillbirths, while low birth weight (36%) and prematurity (26%) accounted for early neonatal deaths.[13]

Table 5: Cause of perinatal loss.

Cause	No. of cases	% of cases
Idiopathic	13	26
Abruption	04	08
Oligohydramnios	04	08
Preecclampsia	07	14
Rupture uterus	03	06
Obstruction	01	02
Cord prolapse	01	02
Congenital anomaly	03	06
Meconium stained liquor/meconium aspiration syndrome	02	04
Fever (*P. Falciparum*)	01	02
Jaundice	01	02
Intra uterine growth retardation	01	02
Birth asphyxia	03	06
Septicemia	03	06
Respiratory distress syndrome	01	02
Congenital heart disease	01	02
Hyaline membrane disease	01	02

Table 6: Complications.

Complications	No. of Cases	% of cases
DIC	02	04
Retained Placenta	01	02
Bladder Injury	01	02
Pueperal Pyrexia	01	02
Emotional Upset	50	100
Breast Engorgement	01	02

Table 6 showed that emotional upset occurred in 100% cases, DIC, retained placenta, bladder injury, puerperal pyrexia, breast engorgement in 4, 2, 2, 2, 2% cases respectively. Necessary steps were taken for complications like blood components were given in DIC, manual removal of placenta done for retained placenta, 2 layer closure of bladder injury, higher antibiotics for puerperal pyrexia, cold packs breast bandage for breast engorgement, psychological care for emotional upset. Table 7 showed that there were varied reactions of grief which could be handled by effective counselling. Grief was more in case when baby was malformed, when the cause of death was idiopathic, in case of twin delivery.[14]

Table 8 showed that psycho social effects of still birth are long lasting and traumatic, leaving those in its wake vulnerable to anxiety and depression. Seeing and holding the baby was associated with fewer anxiety and depressive symptoms than not doing so. This has been substantiated by study done by Joaness et al.[3]

Table 7: Reactions of grief.

Reactions	No. of Cases	% of Cases
Guilt	40	80
Shock	35	70
Anger	20	40
Disbelief	44	88
Confusion	20	40
Depression	01	02
Lonliness	10	20
Numbness	08	16
Sleep disturbance	08	16
Preoccupation with thought of deceased	25	50
Dreaming of deceased	30	60
Withdrawal	35	70
Self blame	30	60

Table 8: Anxiety symptoms v/s depressive symptoms.

	Anxiety symptoms	% of anxiety symptoms	Depressive symptoms	% of depressive symptoms
Patients who had contact with their babies (n=40)	20	50	24	60
Patients who did not have contact with their babies (n=10)	10	100	10	100

DISCUSSION

Perinatal mortality is an important indicator of maternal care, health and nutrition. It also reflects the quality of Obstetric and Paediatric care available. Every effort must be made to reduce perinatal mortality. Neonatal deaths and still births stem from poor maternal health, inadequate care during pregnancy, inappropriate management of complications during pregnancy and delivery, poor hygiene during delivery and the first critical hours after birth and lack of newborn care. Several factors such as women's status in society, their nutritional status at the time of conception, early chills bearing, too many closely spaced pregnancies and harmful practices such as inadequate cord care, letting the baby stay wet and cold, discarding colostrum and feeding other food, are deeply rooted in the cultural fabrics of societies and interact in ways that are not clearly understood.[2]

Counselling of patients, especially when there is perinatal loss, is very important. It is concluded that the death of an infant makes the family prone to develop short term and/or long-term problems in their adaptation to the loss. An integral effort by health professionals is needed to develop systematic ways of helping families to cope with the death of a child.[15] Perception of a compassionate and caring support system helps to reduce feelings of isolation and lend hope.[16] The duration of bereavement reaction after perinatal death was appreciably shortened by support and counselling.[17]

In a public hospital with heavy patient load, there is hardly any time for counselling of patients, the result of which is reflected in patient's as well as relative's anxiety, strong grief reactions, depression, anger. To ensure optimal patient care, physicians must establish effective patient-physician relationships and thoughtfully incorporate their patients' perspectives into their counseling. Historically, these skills are acquired with increasing clinical experience. However, given increasing work-hour restrictions, OB/GYN residents have fewer opportunities to develop these skills. Simulated patient exercises can be utilized in multiple arenas to teach OB/GYN residents communication skills, while simultaneously addressing their clinical knowledge deficits. Early implementation of such a curriculum in an OB/GYN residency will lay the foundation for the development of empathetic and culturally competent physicians.[18]

Crucial ingredients in the psychosocial care of families confronting perinatal loss include:

- Keep the parents fully informed of the baby's medical condition.
- After the baby dies, encourage contact with the baby, name and take pictures of the baby, and construct mementos of the baby (e.g., footprints, baby bracelet, receiving blanket, lock of hair) to validate the loss and promote memories that facilitate grieving.
- Avoid sedating the mother.
- Listen to and encourage parental expression of their grief.
- Educate parents about their grief as a normal healing process.
- Discourage attempts to become pregnant immediately as a means of replacing the dead child.

There is no question that the psychological management of perinatal loss has been dramatically improved. However, the manner in which new insights and interventions are implemented needs to be evaluated.[19] By a thorough counselling, the patients are helped to cross over the crisis in life as well as are prepared for next pregnancy. Hospitals, nurses and doctors should encourage parental contact with the deceased infant and facilitate provision of photos and memorabilia.[20] Hospitals should have separate place for mothers with perinatal loss, which would help them overcome their grief. Counselling and communication skill should be routinely included in all residency programmes.

ACKNOWLEDGEMENTS

Authors would like to thank the patients who agreed to participate in this study and the staff who helped recruit patients.

Funding: No funding sources
Conflict of interest: None declared
Ethical approval: The study was approved by the Institutional Ethics Committee

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Cite this article as: Pancholi N, Rami B. Care of unfortunate mothers with perinatal loss. Int J Res Med Sci 2018;6:2691-5.