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# A RETROSPECTIVE ANALAYSIS ON THE CAUSE & FACTORS AFFECTING STILL BIRTHS IN A TERTIARY CARE CENTRE IN NAVI MUMBAI.

Gynecology

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## ABSTRACT

Stillbirths continue to pose as a serious challenge in a developing country like India as well as the western, developed countries. A case of intrauterine fetal death with gestational age ≥20 weeks or fetal weight ≥500gm (occurring before the complete expulsion or extraction from its mother) were considered and included in the study. The data suggested that the maximum number of still birth occurred in nulliparous women, & in pregnancy between the gestational age of 37 – 40 weeks. The main cause of the still births, in around 34 cases was abruption placenta & second main cause was hypertension.

## KEYWORDS

Stillbirths, Nulliparous Women , Pregnancy Between The Gestational Age Of 37 – 40 Weeks, Abruption Placenta & Hypertension.

**AIM & OBJECTIVE:**

To determine the rate of still births and to identify the causative factors associated with it. Success of a good antenatal care and obstetrical intervention is a healthy mother and a healthy child at the end of the pregnancy. A retrospective study was conducted.

**INTRODUCTION:**

Stillbirths continue to pose as a serious challenge in a developing country like India as well as the western, developed countries. Success of a good antenatal care and obstetrical intervention is a healthy mother and a healthy child at the end of the pregnancy. Modernisation and developments in medical science have led to better outcomes, with a gradual decrease in number of still births in both developed and developing countries, but not at the same rate. The rate continues to remain high in the developing countries. Due to the advances in the field of obstetrics and neonatology, the period of gestation or the gestational age of viability has been gradually decreasing from 28 weeks to the current 20 weeks. [1] Considering developed countries, a number of studies have reported a stillbirth rate of less than 10 per 1000 delivery. While in developing countries, studies indicated rates of 10 to 40 per 1000. However, some studies indicate these rates to be more than 40 per 1000 delivery in developing countries. [2] There are various obstetrical complications that result in an on going pregnancy into a stillborn baby. Incidence of preeclampsia and eclampsia are on a rise. Other obstetrical complication include antepartum haemorrhage, gestational diabetes mellitus, prolonged or obstructed labour, cord prolapse, congenital anomalies, etc. Several studies reported nonmedical factors such as referral from peripheral health facility, delay in receiving appropriate management, lack of skilled birth attendants and antenatal care as the commonest conditions that lead to stillbirths (Shrestha & Yadav, 2010; Hossain et al., 2009; Onadeko & Lawoyin, 2003; Zupan, 2005). [2]

**METHOD:**

A retrospective study was conducted at MGM medical college and hospital, a tertiary care referral centre in Navi Mumbai, Raigad, Maharashtra. The study was conducted over a period of one year that is from October 1, 2016 to September 30, 2017. The data was systematically analysed and collected from the hospital birth registers. A data collection form was designed for the study. The data was tabulated and analysed as percentages. Precautions were taken to strictly maintain anonymity and confidentiality of the patient's personal information. Cases without proper information or vital status were excluded from the study. A case of intrauterine fetal death with gestational age ≥20 weeks or fetal weight ≥500gm (occurring before the complete expulsion or extraction from its mother) were considered and included in the study.

**RESULT:**

During the period of study, a total number of 3287 deliveries took place out of which 90 cases were still births, that is around 2.74%. The stillbirth rate was found to be 10 per 1000 delivery

The data suggested that the maximum number of still birth occurred in nulliparous women, about 48 and in women between the age group of 21 – 25 years that is about 46. 62 out of these still birth cases were unbooked. A tertiary health care centre admits more high risk patients due to the availability of resources and usually it being a referral centre, similar to where this study was conducted. The data also suggested that the maximum number of still births occurred between the gestational age of 37 – 40 weeks, which was about 32. The sex of the still born baby was male in 47 cases and around 44 cases had a birth weight between 1 – 2 Kg. The data revealed that the main cause of the still births, in around 34 cases was abruption placenta. The second main cause was hypertension(in various forms) in around 29 cases. 16 of the cases had an unexplained still birth.

**TABLE 1: Maternal demographic characteristics.**

| | N | % |
|---|---|---|
| **AGE:** | | |
| <20 | 9 | 10 |
| 21 - 25 | 46 | 51.11 |
| 26 - 30 | 23 | 25.56 |
| >30 | 12 | 13.33 |
| **PARITY:** | | |
| Nulli | 48 | 53.33 |
| Multi | 42 | 46.67 |
| **BOOKING STATUS:** | | |
| Booked | 28 | 31.11 |
| Unbooked | 62 | 68.89 |

**TABLE 2: Still birth characteristics.**

| | N | % |
|---|---|---|
| **GESTATIONAL AGE:** | | |
| <28 weeks | 5 | 5.55 |
| 28 – 34 weeks | 23 | 25.56 |
| 34 – 37 weeks | 19 | 21.11 |
| 37 – 40 weeks | 32 | 35.56 |
| >40 weeks | 11 | 12.22 |
| **BIRTH WEIGHT:** | | |
| 500mg – 1Kg | 14 | 15.55 |
| 1Kg – 2Kg | 44 | 48.89 |
| >2Kg | 32 | 35.56 |
| **SEX :** | | |
| MALE | 47 | 52.22 |
| FEMALE | 43 | 47.78 |

| CAUSE | N | % |
|---|---|---|
| **MATERNAL:** | | |
| Hypertension | 29 | 32.22 |
| Diabetes | 2 | 2.22 |
| Unexplained/Unspecified | 16 | 17.78 |
| Infection | 2 | 2.22 |
| **FETAL:** | | |

| | | |
|---|---|---|
| Fetal distress | 2 | 2.22 |
| Anomalies | 1 | 1.11 |
| **PLACENTA:** | | |
| Abruption | 34 | 37.78 |
| Previa | 3 | 3.33 |
| Cord accidents | 1 | 1.11 |

**TABLE 3: Etiology of still births.**

## CONCLUSION:

Pregnancy related complications or maternal disorders were found to be the most commonly associated risk factors of stillbirth in our study. Majority of woman were either referred from a near by primary health centre or a nursing home. These maternal disorders or obstetrical complications can be detected early on and properly managed through antenatal period by employing standard obstetrical protocols. It is also imperative that electronic fetal monitoring is an important tool in avoiding fresh still births in labouring patients.

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