

International Journal of Clinical Obstetrics and Gynaecology



ISSN (P): 2522-6614
ISSN (E): 2522-6622
© Gynaecology Journal
www.gynaecologyjournal.com
2024; 8(6): 118-120
Received: 07-11-2024
Accepted: 09-12-2024

Dr. Rita D
Professor and H.O.D, Department
of OBG, NMCH&RC, Raichur,
Karnataka, India

Dr. L Mayuri
Junior Resident 3, Department of
OBG, NMCH&RC, Raichur,
Karnataka, India

Intrauterine fetal demise in pre-eclampsia: A case report

Rita D and L Mayuri

DOI: <https://doi.org/10.33545/gynae.2024.v8.i6b.1550>

Abstract

Introduction: Intrauterine death embraces all fetal deaths occurring both during pregnancy (antepartum death) and during labor (intrapartum)

International Classification of Diseases 10th revision (ICD 10) definitions are as follows:

Late fetal death-1000 g or more or 28 weeks or more or 35 cm or more

Early fetal death-500 g or more or 22 weeks or more or 25 cm or more.

Objective: Pre-eclampsia as a high risk pregnancy with high incidence of intrauterine fetal demise.

Case report: A 22year old, G2P1L1 with previous LSCS, a booked case at NMCH &RC Raichur, her USG with Doppler findings which was done at 18 weeks screened positive for PIH, O/E BP-130/90mmhg Prophylactically Tablet ASPIRIN 75mg OD started. Advised weekly follow up, patient failed to follow up, and presented to OPD after 6 weeks with decreased perception of fetal movements, O/E BP-150/110mmhg. USG DONE showed features suggestive of Intrauterine Fetal Demise

Management: Early fetal demise Urine albumin 2+ other PIH profile was normal. After confirmation of intrauterine fetal demise, patient and the patient attenders were explained regarding the condition and counselled for termination, consent for termination was taken. After correcting anaemia pregnancy was terminated.

Keywords: Early fetal death, intra uterine fetal demise, aetiology, incidences, pre-eclampsia

Introduction

Intra uterine foetal death is an emotional distress for mother, her family and for the obstetrician.

International Classification of Diseases 10th revision (ICD 10) definitions are as follows:

Late fetal death-1000 g or more or 28 weeks or more or 35 cm or more

Early fetal death-500 g or more or 22 weeks or more or 25 cm or more

Miscarriage-pregnancy loss before 22 completed weeks ^[1]

WHO uses stillbirth to mean the ICD definitions of late fetal deaths (ie, birthweight of 1000 g or more with an assumed equivalent of 28 weeks gestation)

The United States National Centre for Health Statistics defines fetal death as the delivery of a foetus showing no signs of life, such as absence of breathing, beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary. Muscles' Intrauterine death embraces all fetal deaths occurring both during pregnancy (antepartum death) and during labor (intrapartum)

^[2]. Most common cause of fetal demise is unexplained. Fetal causes of death are congenital malformation, fetal infections; maternal causes are pre-eclampsia, diabetes mellitus, infection and placental causes are antepartum haemorrhage in the form of abruption or cord accidents. According to an Indian study the most common maternal cause of IUFD was pre-eclampsia and eclampsia (18.33%) followed by anaemia (11.67%). The most common foetal cause was IUGR (6.67%), and the most common placental cause was placental previa (8.33%) ^[3].

Incidence: The estimated average global rate of still births per 1000 live births was 13.9 in 2021. The global burden of stillbirths is unequal, almost 8 in 10 still births occur in sub-Saharan African and south Asian countries⁴. As per the report on global burden of still-births by the UNIGME, in 2019 and 2021, the estimated stillbirth rate of India were 13.9 and 12.2 per 1,000 total births, respectively ^[4].

Case report

A 22 years old Gravida 2, para 1, living 1, abortion 0 with history of 1 previous Cesarean presented to OBG outpatient department with 2 months of amenorrhea for 1st ANC visit dating scan was done confirmed intra uterine pregnancy.

Corresponding Author:
Dr. L Mayuri
Junior Resident 3, Department of
OBG, NMCH&RC, Raichur,
Karnataka, India

Then she had regular antenatal visits at Navodaya OBG her NT SCAN showed (NT ~1.3mm), her TIFFA+ doppler scan was done 5 months of amenorrhea (18 weeks) showed a single live intrauterine fetus of 18 weeks Period of gestation with clotted placenta lake and screened positive for PIH (B/L Umbilical Artery Shows Early Diastolic Notch And High Resistance Flow) and suggested REVIEW SCAN AFTER 2 weeks, She Was Started On T Aspirin 75 mg OD and asked to Follow Up for Review Scan. Patient did not come for any further follow up after that. After 6 Weeks She Presented to OPD with History of 7 months of amenorrhea with decreased perception of fetal movement since one day.

on examination: Pallor: +, Blood Pressure: 130/100mg pulse Rate: 76bpm CVS/CNS/RS: No Abnormalities Detected P/A: Uterus ~20-22 weeks period of gestation relaxed, FHS absent, Previous LSCS scar noted.

Blood investigations: Hb: 8.5g% TLC: 6300/Cumm, PC: 2.6lakh/cumm BG: B positive, Urine Routine, coagulation profile ~ normal serology-non reactive RBS-73mg/dl, TSH-1.25 microIU/ml, LFT-normal range, RFT-normal range, LDH-74 USG obstetrics scan showed features suggestive of intrauterine fetal demise with absent fetal cardiac activity, absent fetal body movements, liquor reduced 1-2cm, Fetal Morphology: Over ridding of cranial bones seen subcutaneous edema noted over the body, minimal pericardial effusion seen, average gestational age by sonography 22 weeks 2days (But according to her dating scan 24 weeks +2 days).



Fig 1: Overlapping of skull bones on ultrasound (Spading sign)



Fig 2: Color Doppler ultrasound showing absence of color in the fetal heart

Management

Patient was counselled regarding her condition i.e. early fetal demise and was admitted. After collecting all investigations anemia correction was done (1 pint of PRBC was transfused), Foleys induction was done following which tablet mifepristone 200mg orally given. Tab labetalol 100mg BD orally was started. After 24 hour's foleys expelled, Injection oxytocin 10 IU given, 1 hour following that

A single dead female fetus with placenta into to weighing 350g (macerated) expelled. Antibiotic coverage was done.



Fig 3: Expelled dead female foetus with placenta

Discussion

The risk factors associated with stillbirths are maternal, fetal, obstetric or associated medical disorders. As reported in a series on 'Ending preventable stillbirths' published in Lancet (2016), 7.4% of stillbirths were contributed by congenital abnormalities, 10% each due to non-communicable diseases, nutrition and lifestyle, 8.0% each from malaria and syphilis and 6.7% due to maternal age more than 35 years. Pro-longed pregnancies were associated with 14.0% stillbirths. About 25-60% stillbirths remain unexplained [1].

An Indian study reported that 68% of still-births were found to have antepartum causes and 32% had intrapartum causes. Among maternal conditions, hypertension (18.2%) and chorioamnionitis (13.8%), and among fetal conditions, growth restriction (19.9%) and congenital anomalies (18.8%) were the leading causes [5].

Conclusion

By understanding the contributing factors, we can seek ways of avoiding recurrence by proper antenatal care and early diagnosis of complications and its proper management. Antenatal screening for, preeclampsia, GDM, previous pregnancy loss and antenatal supervision can play an important role in decreasing the incidence of IUFD. By determining the cause of IUFD the chances of recurrence can be reduced and further pregnancy complications can be prevented. Work-up in a case of intrauterine fetal death (IUFD) must include a detailed history, laboratory evaluation to exclude maternal disease, test for fetal maternal haemorrhage cytogenetic studies, examination of the newborn and placenta and autopsy.

References

1. Lawn JE, Blencowe H, Waiswa P, *et al.* Stillbirths: rates, risk factors, and acceleration towards 2030. *Lancet.* 2016;387(10018):587-603.
2. Maslovich MM, Burke LM. Intrauterine fetal demise. [Updated 2022 Oct 31]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing, 2024 Jan.
3. Shravya MK, Rathnamma P. A retrospective study of intrauterine fetal demise in a tertiary care center. *Int J Reprod Contracept Obstet Gynecol.* 2023;12:590-594.
4. World Bank Group, United Nations Children's Fund; United Nations. Never Forgotten: The situation of stillbirth around the globe: Report of the United Nations inter-agency group for child mortality estimation, 2023. Available from: <https://data.unicef.org/resources/never-forgotten-stillbirth-estimates>. Accessed 2023 May 18.
5. Newtonraj A, Kaur M, Gupta M, Kumar R. Level, causes, and risk factors of stillbirth: A population-based case-control study from Chandigarh, India. *BMC Pregnancy Childbirth.* 2017;17(1):371.

How to Cite This Article

Rita D, Mayuri L. Intrauterine fetal demise in pre-eclampsia-A case report. *International Journal of Clinical Obstetrics and Gynaecology.* 2024;8(6):118-120.

Creative Commons (CC) License

This is an open-access journal, and articles are distributed under the terms of the Creative Commons Attribution-Non Commercial-Share Alike 4.0 International (CC BY-NC-SA 4.0) License, which allows others to remix, tweak, and build upon the work non-commercially, as long as appropriate credit is given and the new creations are licensed under the identical terms.