1 Introduction

The interval between a diagnosis of antepartum fetal death and birth is a time of great distress. When the diagnosis of fetal death has been made and confirmed by ultrasound examination, women require the time and opportunity to adjust. Rushed decisions are unnecessary, except for complications such as placental abruption or severe hypertension. Women should be made aware of the options available to them, given time to consider these options and to decide what they want. They must be allowed the time to start to grieve, and to make decisions in an environment in which they feel secure. Many women will want to return home, even if only for a brief period. It is important to remember to ask the woman how she came to the hospital or clinic. It may be preferable for her not to drive at such a time, or go home unaccompanied.

2 Choosing between active and expectant care

From the physical standpoint, given appropriate means to induce labor after fetal death, there are no overwhelming benefits or hazards for induction of labor over expectant care. The advantages and the disadvantages of both these approaches relate almost exclusively to their emotional and psychological effects. The woman herself is the best judge of these, and she is the one who should make the choice. Her caregivers should assist her by providing her with the information needed to make an informed choice. They should ensure that whatever option she chooses is provided in an empathetic environment.
with as little psychological and physical discomfort as possible (see Chapter 49).

It is wrong to assume that all women desire the most rapid method of delivery when their babies have died in utero. For some women, the uncertainty and the learning of the death are the worst moments; carrying the dead fetus still permits them a feeling of closeness to the baby, that will be lost once it is born.

Many women, on the other hand, are anxious to give birth as quickly as possible. Some may even suggest that this should be done by cesarean section. Discussing the facts and alternatives with the woman and her partner conveys compassion and understanding. Often it will help to defuse initial feelings of anger, suspicion, inadequacy, and guilt, which are typically felt by all, caregivers and women alike, after the sad diagnosis is made.

The main advantage of the expectant option is the absence of any need for intervention. The woman can stay at home, and she will avoid procedures that might turn out to be less effective and more risky than anticipated.

The disadvantages of expectant care are mainly psychological, and relate to the unpredictable and usually long time during which the woman may have to carry the dead baby. Sometimes, she or her relatives may be under the impression that the baby will rot inside her and exude toxins that can poison her. It is important to dispel such fears, although this may not always be successful.

The only physical hazard of the expectant policy relates to a possible increase in the risk of disturbances in blood coagulation. These are most likely to occur when fetal death has been caused by placental abruption. Disorders of coagulation in association with other causes of fetal death are rare. The hypofibrinogenemia that is held responsible for these disorders occurs very slowly and is rarely clinically significant in the first 4–5 weeks after fetal death. By the time that clinically significant alterations in coagulation mechanisms could arise, the chances are that birth will have occurred.

The main advantages of an active policy to effect delivery in the care of women with a dead fetus are that it offers the option of ending a pregnancy that has lost its purpose and that a post-mortem diagnosis may be easier to achieve in the absence of maceration. The disadvantages of an active policy relate to the means through which it is effected. If labor is induced, the efficacy and safety of the method used will be the most influential factor in considering the relative merits of the policy.
3 Choice of methods for inducing labor

A variety of agents and methods have been used for inducing labor after antepartum fetal death. Agents used include saline, oxytocin, the natural prostaglandins, prostaglandin analogs such as 15-methyl-prostaglandin F$_{2\alpha}$, sulprostone, and misoprostol, and the progesterone antagonist mifepristone. Consideration must be given to the route of administration, the choice of prostaglandin, and the choice of other agents where prostaglandins are not readily available.

When intra-uterine fetal death occurs in late pregnancy it is usually possible to induce labor with any of the prostaglandin regimens that are employed for other inductions (see Chapter 40). Methods with which one is thoroughly familiar tend to perform better than those that are only rarely needed and require careful study before being applied. These methods may be less effective, however, at the earlier gestational ages when the sensitivity of the uterus to prostaglandins is lower than it is at term.

Intravenous administration of natural prostaglandins has been superseded because of a high incidence of side-effects compared with local routes. The intra-amniotic route of administration has also been largely superseded by local preparations.

Vaginal administration of prostaglandins or prostaglandin analogs in the form of suppositories, gels, or pessaries, is widely used at present because of its convenience and ease of administration. Prostaglandin E$_1$ (gemeprost, Cervagem) and PGE$_2$ analogs, such as sulprostone, are often used.

When prostaglandins are not available, extra-amniotic infusion of saline, or simply placement of an extra-amniotic balloon without any infusion may be used.

The prostaglandin E$_1$ analog misoprostol has been shown to be effective for the induction of labor at all stages of pregnancy, administered orally or vaginally. As it is not registered for use in obstetrics and gynecology, no manufacturer’s guidelines for route of administration or dosage are available. The main problem is uterine hyperstimulation, which may even result in uterine rupture. Its use at present should be restricted to research protocols to determine optimum and safe regimens.

Mifepristone, a steroid compound that antagonizes progesterone action, has shown promise for induction of labor after fetal death, possibly in combination with prostaglandins to further enhance the success rate. With improvements in techniques with prostaglandins
and prostaglandin analogs alone, the place of mifepristone appears to be limited.

4 Conclusions

In the case of fetal death, the decision whether or not to induce labor should be made on psychological or social grounds, and the woman herself is the best judge of these. Should induction be chosen, the most effective method in the later weeks of pregnancy is likely to be one with which the caregiver has adequate experience from inducing labor in other pregnancies. Earlier in gestation, vaginal administration of prostaglandin analogs appears to be the treatment of choice. Methods employing an extra-amniotic catheter bulb may be considered when prostaglandin analogs are unavailable, unaffordable, or ineffective. In the future, misoprostol may become a useful alternative.

Sources

*Effective care in pregnancy and childbirth*

*Cochrane Library*

*Pre-Cochrane reviews*
Low vs high dose sulprostone for induction after fetal death. Review no. 04474.
Other sources


