



Determinants of Intrauterine Fetal Death among Unbooked Parturients at the University of Port Harcourt Teaching Hospital, Southern Nigeria

Terhemen Kasso, Justina Omoikhefe Alegbeleye and Israel Jeremiah

Department of Obstetrics and Gynaecology, University of Port Harcourt Teaching Hospital, Rivers State, Justina Omoikhefe Alegbeleye, Nigeria

Key words: Intra uterine fetal death, unbooked, Port Harcourt, Nigeria, risk factors

Abstract: The death of the fetus in-utero can leave both the mother and the attending clinician devastated. Most intrapartum deaths in developing countries are due to causes that are largely preventable. The situation is worse in the unbooked patient who had no access to skilled attendance. To determine the prevalence and risk factors of intrauterine fetal death among unbooked parturient at the University of Port Harcourt Teaching Hospital. A retrospective study of 344 unbooked women with intrauterine fetal death who presented at the labour ward of the University of Port Harcourt Teaching Hospital between January 1, 2011 and December 31, 2015. Data was obtained from their case/theater records and ward registers, encoded into a spreadsheet and analyzed using SPSS 22.0. Results were presented as means, rates and proportions. Associations between variables were assessed using students t-test and Pearson's correlation. Differences were considered statistically significant at $p < 0.05$. There were 12,421 deliveries. Of these, 10,136 (81.6%) received antenatal care while 2,285 (18.4%) did not. There was a total of 1,313 perinatal deaths, giving a perinatal mortality rate of 60.9/1000 births in unbooked patients and 18.4/1000 births in booked patients ($p < 0.01$). Majority 149 (43.3%) of the IUFDF occurred below 37 weeks gestation and 123 (35.8%) at term. Intrauterine fetal death occurred prior to presentation in 320 (93%) of the patients. This was statistically significant at $p < 0.01$. Most of the women were referred from traditional birth attendants and religious institutions. Hypertensive disorders, abruption placentae, obstructed labour, prolonged pregnancy and Prolonged Rupture of Membranes (PROM) with chorioamnionitis were the most common complications associated with intrauterine fetal death. The leading cause of IUFDF were hypertensive disorders, abruption placentae and obstructed labour. Women should be encouraged to register for antenatal care and deliver in health facilities with skilled attendants.

Corresponding Author:

Terhemen Kasso

Department of Obstetrics and Gynaecology, University of Port Harcourt Teaching Hospital, Rivers State, Justina Omoikhefe Alegbeleye, Nigeria

Page No.: 6-10

Volume: 15, Issue 2, 2020

ISSN: 1816-3319

International Journal of Tropical Medicine

Copy Right: Medwell Publications

INTRODUCTION

The World Health Organization (WHO) defines stillbirth as death of a fetus before the complete expulsion or extraction from its mother of a product of conception weighing at least 1000 g and occurring after 28 completed weeks of gestation or having at least 35 cm body length which is indicated by the fact that after such separation, the fetus does not show any evidence of life. The definition of stillbirth using gestational age or birth weight varies in different countries. This makes the comparison of stillbirth rates difficult. However, the definition recommended by the WHO for international comparison is a baby born with no signs of life at or after 28 weeks of gestation^[1,2]. Intrauterine fetal death can be devastating both to the mother and the attending obstetrician. The hope of every expectant mother is to deliver a live healthy baby and any deviation from that could be agonizing. An estimated 2.6 million stillbirths occur annually with 98% in the low-income and middle-income countries^[3]. Stillbirth rates vary in different countries. It is lowest in Finland with the rate of 2 per 1000 births, high in Pakistan and Nigeria with stillbirth rates of 47 and 42 per 1000 births, respectively. It also varies within countries with India having a range of 20-66 per 1000 births in different states^[2]. In Nigeria, the perinatal mortality rate varies in different regions and centers, ranging from 39-130/1000 live births^[4-6]. Half of all stillbirths (1.3 million) occur during labour and delivery^[7], especially in developing countries. Majority of these intrapartum deaths are due to avoidable causes. In the developed world, stillbirths are largely antepartum with no obvious cause^[8]. Causes of intrauterine fetal death include maternal infections (malaria, syphilis, human immunodeficiency virus), metabolic abnormalities like diabetes and thyroid dysfunction^[9] also hypertension, obesity, rhesus isoimmunization. Fetal causes include congenital abnormalities, intrauterine growth restriction, with some placental and umbilical causes (placenta abruption, cord accidents) contributing to it^[10]. Stillbirth is a subset of perinatal mortality and a major contributor of over 50% of perinatal mortality in developing countries^[11,12]. It is an important indicator of the quality of antenatal care and obstetric care during labour and delivery^[13]. Perinatal mortality is defined as the total number of late fetal deaths (stillbirths) and deaths within the first week of life (early neonatal deaths) per 1000 total births^[14]. It is one of the important vital statistics that is used to measure the quality of maternal and fetal care of any nation and this also has a direct relationship with a nation's socioeconomic advancement^[15]. Nigeria has high rates of stillbirths (42 per 1000 total births) worldwide^[2] as well as perinatal mortality rates which vary between different centers from 39-133 per 1000 total births^[4,5,16,17]. In developing countries, maternal illiteracy

and lack of antenatal care are usually responsible for most of the factors that lead to stillbirths. The unbooked patient is more at risk of having intrauterine fetal death and other pregnancy complications^[18]. They do not access antenatal care because of poverty, illiteracy, ignorance, traditional/cultural/religious beliefs or low status of women in the society. These group of patients usually have prolonged hospital stay with increased cost of treatment^[18]. The causes of stillbirths and perinatal mortality are however, similar and are also mostly preventable. There are no recent studies in our center addressing this important issue. This study therefore sets out to determine the prevalence of intrauterine fetal death and identify the associated risk factors among the unbooked patients seen in our hospital. Such knowledge will be useful in developing strategies to prevent IUFDs.

MATERIALS AND METHODS

This was a retrospective cohort study of 756 unbooked women with IUFD who presented to the labour ward of the department of Obstetrics and Gynaecology, University of Port Harcourt Teaching Hospital (UPTH) between January 1, 2011 and December 31, 2015. Data was collected from patient's case notes, labour ward and theatre registers. Information collected included socio-demographic characteristics, place of referral, mode of delivery, maternal complications. Ethical approval was obtained from the ethical review board of UPTH. The data collected was coded and entered into a spread sheet using SPSS Version 22.0 for windows® which was also used for analysis. Results are presented as means with standard deviations, rates and proportions. Associations between variables were assessed using students t-test. Differences were considered statistically significant at $p < 0.05$.

RESULTS AND DISCUSSION

In the period under review, there were a total of 12,421 deliveries. Of this, 10,136 (81.6%) were booked while 2285 (18.4%) were unbooked. There was a total of 985 still births, giving a still birth rate of 80.5 per 1000 births. There were a total of 1,313 perinatal deaths, giving a perinatal mortality rate of 105.8 per 1000 births. Still births comprised 75% of all perinatal deaths (985 of 1313). There was significantly more still births among the unbooked parturients (330.8 per 1000 births) than the booked parturients (22.6 per 1000 births). Three hundred and forty-four (344) unbooked women had intrauterine fetal deaths. About half of them (170) had no form of antenatal care while 174 had some form of antenatal care but defaulted. The mean age was 28.7 ± 4.8 years. The mean parity was 1.5 ± 1.68 . Table 1 shows the sociodemographic characteristics of the parturients.

Table 1: Socio-demographic characteristics

| Characteristics | Number | Percentage |
|---------------------------|------------|------------|
| Age (mean±SD) | 28.67±4.76 | |
| ≤19 | 5 | 1.5 |
| 20-29 | 199 | 57.8 |
| 30-39 | 132 | 38.4 |
| 40-49 | 8 | 2.3 |
| Parity (mean±SD) | 1.50 ±1.68 | |
| 0 | 125 | 36.3 |
| 1 | 90 | 26.2 |
| 2 | 42 | 12.2 |
| 3 | 42 | 12.2 |
| 4 | 22 | 6.4 |
| ≥5 | 23 | 6.7 |
| Educational status | | |
| No formal education | 30 | 8.7 |
| Primary | 36 | 10.5 |
| Secondary | 210 | 61.1 |
| Tertiary | 68 | 19.8 |
| Occupation | | |
| Housewives | 116 | 33.7 |
| Civil servants | 92 | 26.7 |
| Traders/business women | 84 | 24.4 |
| Students | 29 | 8.4 |
| Teachers | 18 | 5.2 |
| Health workers | 5 | 1.5 |
| Marital status | | |
| Married | 335 | 97.4 |
| Single | 9 | 2.6 |

Majority of the women [210 (61.1%)] had secondary education, however, there was no significant correlation between education or occupation and the occurrence of intrauterine fetal death (Pearson's correlation = 0.0043). A weak negative correlation between parity and the occurrence of intrauterine fetal death (Pearson's correlation = -0.13) was observed. About a third of the women 123 (35.8%) presented at term (37 weeks or more) with labour complications while 149 (43.3%) were preterm presentations and 40 (11.6%) presented at an unknown gestational age. Intrauterine fetal death occurred prior to presentation in 320 (93%) of the patients. This was statistically significant at $p < 0.01$. Table 2 shows that 167 (48.5%) women were referred from faith-based institutions while 47 (13.7%) came from traditional birth attendants. Majority 216 (62.5%) had spontaneous vaginal deliveries while 85 (24.7%) had emergency caesarean sections and 15 women (4.4%) had hysterectomies. This is shown in Table 3. Majority of the babies 206 (59.9%) were of normal weight while 94 (27.3%) were low birth weight babies. About two-third (60%) of the babies were macerated stillbirths while 40% (145) were fresh stillbirths. Table 4 shows the maternal complications on admission. Severe preeclampsia/eclampsia 55(15.9), abruptio placentae 50(14.5%), obstructed labour 35(10.2%), prolonged pregnancy 27(7.9%), Prolonged Rupture of Membranes (PROM) and chorioamnionitis 25(7.3%) were the most common maternal complications associated with intrauterine fetal deaths.

The definition of stillbirth varies in different countries. However, in this study, it was taken as a baby

Table 2: Place of referral

| Characteristics | Number | Percentage |
|------------------------------|--------|------------|
| Faith based institutions | 167 | 48.5 |
| Traditional birth attendants | 47 | 13.7 |
| Private clinics | 39 | 11.3 |
| Health centers | 34 | 9.90 |
| Self-referral | 28 | 8.10 |
| Maternity homes | 20 | 5.80 |
| RSUTH | 6 | 1.70 |
| General Hospital | 3 | 0.90 |

Table 3: Mode of delivery

| Characteristics | Number | Percentage |
|-------------------------------------|--------|------------|
| Spontaneous Vertex delivery | 216 | 62.8 |
| Emergency caesarean section | 85 | 24.7 |
| Exploratory laparotomy | 13 | 3.80 |
| Exploratory laparotomy+Hysterectomy | 11 | 3.20 |
| Assisted vaginal breech delivery | 7 | 2.00 |
| Instrumental delivery | 7 | 2.00 |
| Caesarean hysterectomy | 4 | 1.20 |
| Destructive operation | 1 | 0.30 |

Table 4: Maternal complications on admission

| Complication | Number | Percentage |
|-------------------------------|--------|------------|
| Abruptio placenta | 50 | 14.5 |
| Severe preeclampsia/Eclampsia | 55 | 15.9 |
| Obstructed labour | 35 | 10.2 |
| Prolonged pregnancy | 27 | 7.9 |
| PROM with Chorioamnionitis | 25 | 7.3 |
| Placenta praevia | 9 | 2.6 |
| Uterine rupture | 8 | 2.4 |
| Hypertension in pregnancy | 7 | 2.0 |
| RVD in pregnancy | 6 | 1.7 |
| Malaria | 5 | 1.5 |
| Breech presentation | 5 | 1.5 |
| Retained 2nd twin | 5 | 1.5 |
| Severe anaemia | 4 | 1.2 |
| Impacted transverse lie | 4 | 1.2 |
| Others* | 99 | 28.8 |

Others = Anaencephaly, hydrocephalus, Cord prolapse, gestational diabetes mellitus, prolonged labour, shoulder dystocia

born with no signs of life after 28 weeks of gestation. Still birth rate also varies in different countries and in some countries between regions. The stillbirth rate in this study was 80.5 per 1000 births with most occurring in the unbooked women. This is high compared to a study conducted in Saudi Arabia where the stillbirth rate was 10 per 1000 deliveries^[8]. It is also higher than what was obtained in India (29.2 per 1000 live births)^[1] Abakaliki, South-Eastern Nigeria (41.4 per 1000 births)^[19] and Katsina, Northern Nigeria (46.9 per 1000 deliveries)^[20]. A study in Orlu, South-Eastern Nigeria reported a higher rate (180 per 1000 births) than what was observed in this study^[21]. Majority of the women presented at a gestational age ≥ 37 weeks with intrapartum complications which is the time most intrauterine fetal death occur in developing countries as opposed to developed countries. The stillbirths occurred prior to presentation in 93% of patients which was statistically significant. This indicates late presentation to the health facility in the advent of complications. The same trend was observed in a study

carried out in Benin city where perinatal mortality rate in the unbooked patients was about eight times that of the booked patients^[22]. Similar findings were reported in South-Eastern Nigeria where majority of the stillbirths occurred in unbooked patients^[19]. Majority of the women were referred late from faith based institutions and traditional birth attendants indicating lack of antenatal care in these patients. This was also reported in India where 43.3% of stillbirth cases were referred cases^[1]. A study done in Lagos, South-Western Nigeria also reported lack of antenatal care amongst other risk factors^[23]. Good quality antenatal care was observed in Ghana to significantly decrease the odds of delivering a stillborn^[24]. A large number of them had vaginal deliveries as was also observed in other studies^[1, 21]. The risk factors for Intrauterine Fetal Death (IUFD) in this study varied from preeclampsia/eclampsia accounting for most of the cases, followed by abruptio placentae and obstructed labour. A previous study carried out in Uyo, Southern Nigeria also reported preeclampsia/eclampsia accounting for most cases of IUFD^[25]. Prolonged pregnancy and obstructed labour as contributing factors further show lack of antenatal care and delivery with skilled birth attendants. Many of the babies were macerated indicating that the fetal deaths occurred more than 24 h prior to presentation. This was also observed in previous studies in Jos and Orlu^[21, 26]. This is because of delay in decision making by most of our women to utilize a health facility even in emergency situations. The study in India however reported a greater number of fresh still births which is contrary to the findings in this study^[1]. This may be due to early health seeking behaviour in such a place. We observed more stillbirths in women aged 20-29 years in this study as opposed to other studies where older women were more affected^[27, 28]. Most of the women had secondary and tertiary education but still did not register for antenatal care in any health facility or registered but defaulted. These women preferred to patronize faith-based institutions and traditional birth attendants reflecting how religion and culture can affect women's health seeking behaviour in our environment irrespective of their educational status.

CONCLUSION

Pregnant women who do not register for antenatal care are more predisposed to having adverse pregnancy outcomes. This is further worsened when there is no skilled birth attendance at deliveries. The risk factors identified are largely preventable and can be detected early during antenatal care and appropriately managed. Also, creating awareness about the dangers of lack of antenatal care is pertinent, women should be encouraged to register early for antenatal care and deliver in health facilities with skilled birth attendants.

REFERENCES

01. Divya, B., U.A. Nayak and O.V.A. Swarup, 2015. A study of intrauterine foetal death in a tertiary care hospital. *Int. J. Reprod. Contraception Obstetrics Gynecology*, 4: 2028-2031.
02. Lawn, J.E., H. Blencowe, R. Pattinson, S. Cousens and R. Kumar, 2011. Stillbirths: Where? When? Why? How to make the data count?. *Lancet*, 377: 1448-1463.
03. Stanton, C., J.E. Lawn, H. Rahman, K. Wilczynska-Ketende and K. Hill, 2006. Stillbirth rates: Delivering estimates in 190 countries. *Lancet*, 367: 1487-1494.
04. Adimora, G.N. and I.O. Odetunde, 2007. Perinatal mortality in University of Nigeria Teaching Hospital Enugu at the end of the last millennium. *Niger. J. Clin. Pract.*, 10: 19-23.
05. Federal Ministry of Health, 2008. National demographic and health survey. Perinatal Mortality, Federal Ministry of Health, Nigeria.
06. Kuti, O., E.O. Orji and I.O. Ogunlola, 2003. Analysis of perinatal mortality in a Nigerian teaching hospital. *J. Obstetrics Gynaecology*, 23: 512-514.
07. De Bernis, L., M.V. Kinney, W. Stones, P.T. Hoop-Bender and D. Vivio *et al.*, 2016. Stillbirths: Ending preventable deaths by 2030. *Lancet*, 387: 703-716.
08. Archibong, E.I., A.A. Sobande and A.A. Asindi, 2003. Antenatal intrauterine fetal death: A prospective study in a tertiary hospital in South-Western Saudi Arabia. *J. Obstetrics Gynaecology*, 23: 170-173.
09. Incerpi, M.H., D.A. Miller, R. Samadi, R.H. Settlege and T.M. Goodwin, 1998. Stillbirth evaluation: What tests are needed? *Am. J. Obstet. Gynecol.*, 178: 1121-1125.
10. Faye-Petersen, O.M., D.A. Guinn and K.D. Wenstrom, 1999. Value of perinatal autopsy. *Obstetrics Gynecology*, 94: 915-920.
11. McClure, E.M., M. Nalubamba-Phiri and R.L. Goldenberg, 2006. Stillbirth in developing countries. *Int. J. Gynecology Obstetrics*, 94: 82-90.
12. Obed, S.A., 2002. Intrauterine Fetal Death. In: *Comprehensive Obstetrics in the Tropics*, Kwawukume, E.Y. and E.E. Emuveyan (Eds.). Accra Asante and Hittscher Printing Press Ltd, Accra, Ghana, pp: 193-197.
13. Kambarami, R.A., 2002. Levels and risk factors for mortality in infants with birth weights between 500 and 1,800 grams in a developing country: A hospital based study. *Cent. Afr. J. Med.*, 48: 133-136.
14. Dubowitz, L.M., V. Dubowitz and C. Goldberg, 1970. Clinical assessment of gestational age in the newborn infants. *J. Pediatr.*, 77: 1-10.

15. Fawole, A.O., A. Shah, O. Tongo, K. Dara and A.M. El-Ladan *et al.*, 2011. Determinants of perinatal mortality in Nigeria. *Int. J. Gynecology Obstetrics*, 114: 37-42.
16. Ibekwe, P.C., H.U. Ugboma, N. Onyire and U. Muoneke, 2011. Perinatal mortality in southern Nigeria; less than half a decade to the millennium developmental goals. *Ann. Med. Health Sci. Res.*, 1: 215-222.
17. Igberase, G.O., 2014. Perinatal mortality in a rural referral hospital in the Niger Delta, Nigeria. *Afr. J. Med. Health Sci.*, 13: 47-50.
18. Fabamwo, A., D. Akinola and O. Mojinyinola, 2010. The tragic consequences of unsupervised pregnancies among patients referred to a tertiary maternity unit in Lagos, South West Nigeria. *Internet J. Trop. Med.*, Vol. 7,
19. Agbata, A.T., J.N. Eze, C.I. Ukaegbe and B.N. Odio, 2017. A 4-year retrospective review of stillbirths at the federal teaching hospital, Abakaliki, Southeast Nigeria. *Afr. J. Med. Health Sci.*, 16: 19-24.
20. Suleiman, B.M., H.M. Ibrahim and N. Abdulkarim, 2015. Determinants of stillbirths in Katsina, Nigeria: A hospital-based study. *Pediatr. Rep.*, Vol. 7, 10.4081/pr.2015.5615
21. Okeudo, C., B.U. Ezem and E.E. Ojiyi, 2012. Stillbirth rate in a teaching hospital in South Eastern Nigeria: A silent tragedy. *Ann. Med. Health Sci. Res.*, 2: 176-179.
22. Bobzom, D.N. and J.A. Unuigbo, 1996. Stillbirths and perinatal mortality at the University of Benin Teaching Hospital, Nigeria. *J. Obstetrics Gynaecology*, 16: 159-162.
23. Olusanya, B.O. and O.A. Solanke, 2009. Predictors of term stillbirths in an inner-city maternity hospital in Lagos, Nigeria. *Acta Obstetrica Gynecologica Scandinavica*, 88: 1243-1251.
24. Afulani, P.A., 2016. Determinants of stillbirths in Ghana: Does quality of antenatal care matter?. *BMC. Pregnancy Childbirth*, Vol. 16, 10.1186/s12884-016-0925-9
25. Emaebong, A., 2017. A ten year analysis of intrauterine fetal death: An age-matched case control study at a general hospital in Sub-Saharan Africa. *Evo J. Public Health*, 2: 12-18.
26. Mutihir, J.T. and P.O. Eka, 2011. Stillbirths at the Jos University teaching hospital: Incidence, risk and etiological factors. *Niger. J. Clin. Pract.*, 14: 14-18.
27. Chuwa, F.S., A.H. Mwanamsangu, B.G. Brown, S.E. Msuya and E.E. Senkoro *et al.*, 2017. Maternal and fetal risk factors for stillbirth in northern Tanzania: A registry-based retrospective cohort study. *PloS One*, Vol. 12,
28. Bahtiyar, M.O., E.F. Funai, V. Rosenberg, E. Norwitz, H. Lipkind, C. Buhimschi and J.A. Copel, 2008. Stillbirth at term in women of advanced maternal age in the United States: When could the antenatal testing be initiated?. *Am. J. Perinatology*, 25: 301-304.