

Stillbirth

(Courtesy of March of Dimes Resource Center)

When fetal death occurs after 20 weeks of pregnancy, it is called stillbirth. These tragic deaths occur in about 1 in 160 pregnancies (1). Most stillbirths occur before labor begins. The pregnant woman may suspect that something is wrong if the fetus suddenly stops moving around and kicking. A small number of stillbirths occur during labor and delivery.

How is fetal death diagnosed?

An ultrasound examination (a test that uses sound waves to take a picture of the fetus) can confirm that the fetus has died by showing that the fetus's heart has stopped beating. It sometimes can help explain why the fetus died. The health care provider also can do some blood tests on the woman to help determine why the fetus died.

How is the pregnant woman treated?

The health care provider discusses options for delivering the fetus. Some women may need to deliver immediately for medical reasons.

However, many couples can decide when they want to deliver the fetus. Some choose to wait until the woman goes into labor. Labor usually starts within two weeks after the fetus dies. Waiting for labor generally poses little risk to a woman's health. If labor has not begun after two weeks, providers recommend inducing labor because there is a small risk of developing dangerous blood clots after this time.

Most couples choose to have labor induced soon after they learn of their baby's death. If the woman's cervix has not begun to dilate in preparation for labor, the provider may use vaginal medicine to help prepare her cervix. She is then treated with the hormone oxytocin (also called Pitocin), which is given through a vein. Oxytocin stimulates uterine contractions. Generally, a woman does not need a cesarean unless she develops problems with labor and delivery.

What tests are done after the fetus is delivered?

After delivery, the fetus, placenta and umbilical cord are examined carefully to help determine why the fetus died. The provider often recommends an autopsy and tests to diagnose common chromosomal problems. In some cases, the provider recommends tests for specific disorders or various infections.

In up to half of all cases, these tests cannot determine the cause of stillbirth (2). However, information from these tests often is useful in helping couples plan a future pregnancy, even if the cause of the stillbirth remains unknown.

What are the causes of stillbirth?

There are a number of known causes of stillbirth. Sometimes more than one of these causes may contribute to the baby's death. Common causes include:

- **Birth defects:** About 15 to 20 percent of stillborn babies have one or more birth defects (1). At least, 20 percent of these have chromosomal disorders, such as Down syndrome (1). Others have other birth defects resulting from genetic, environmental or unknown causes.
- **Placental problems:** Placental problems cause about 25 percent of stillbirths (3). One of the most common placental problems is placental abruption. In this condition, the placenta peels away, partly to almost completely, from the uterine wall before delivery. It results in heavy bleeding that can threaten the life of mother and baby. Sometimes it can cause the fetus to die from lack of oxygen. Women who smoke cigarettes or use cocaine during pregnancy are at increased risk of placental abruption.
- **Poor fetal growth:** Fetuses who are growing too slowly are at increased risk of stillbirth. About 40 percent of

stillborn babies have poor growth (2). Women who smoke cigarettes or have high blood pressure are at increased risk of having a baby that grows too slowly. An ultrasound examination during pregnancy can show that the fetus is growing poorly, allowing health care providers to carefully monitor the pregnancy.

- **Infections:** Infections involving the mother, fetus or placenta appear to cause about 10 to 25 percent of stillbirths (4, 5). Infections are an important cause of fetal deaths before 28 weeks of pregnancy (4). Some infections may cause no symptoms in the pregnant woman. These include genital and urinary tract infections and certain viruses, such as fifth disease (parvovirus infection). These infections may go undiagnosed until they cause serious complications, such as fetal death or preterm birth (before 37 completed weeks of pregnancy).
- **Chronic health conditions in the pregnant woman:** About 10 percent of stillbirths are related to chronic health conditions in the mother, such as high blood pressure, diabetes, kidney disease and thrombophilias (blood clotting disorders) (5). These conditions may contribute to poor fetal growth or placental abruption. Pregnancy-induced forms of high blood pressure (such as preeclampsia) also may increase the risk, especially when they recur in a second or later pregnancy (6).
- **Umbilical cord accidents:** Accidents involving the umbilical cord may contribute to about 2 to 4 percent of stillbirths (3). These include a knot in the cord or abnormal placement of the cord into the placenta. These can deprive the fetus of oxygen.

Other causes of stillbirth include trauma (such as car accidents), postdate pregnancy (a pregnancy that lasts longer than 42 weeks), Rh disease (an incompatibility between the blood of mother and baby), and lack of oxygen (asphyxia) during a difficult delivery. These causes are uncommon.

Certain risk factors also are associated with stillbirth. Some of these include (1, 4, 5):

- Maternal age over 35
- Maternal obesity
- Multiple gestation (twins or more)
- African-American ancestry

A recent study found that African-American women had a two-fold increased risk of stillbirth compared to white women (7). It is not known why African-American women are at higher risk. The risk for Hispanic women was similar to that of non-Hispanic white women (7).

Can stillbirths be prevented?

Since the 1950s, stillbirths have declined dramatically. The decline is largely due to better treatment of certain conditions, such as maternal high blood pressure and diabetes, which can increase the risk of stillbirth. Today, women with well-controlled diabetes and high blood pressure face little increased risk of stillbirth.

Rh disease was an important cause of stillbirth until the 1960s. Now it usually can be prevented by giving an Rh-negative woman an injection of immune globulin at 28 weeks of pregnancy and again after the birth of an Rh-positive baby.

Women with high-risk pregnancies (including those with high blood pressure and diabetes) are carefully monitored during late pregnancy, usually starting by about 32 weeks. Tests that monitor the fetal heart rate often can tell if the fetus is in trouble. This can allow treatment, sometimes including early delivery, which can be lifesaving.

Health care providers often suggest that high-risk pregnant women do a daily “kick count” starting around 28 weeks of pregnancy. One approach is to record how long it takes a fetus to make ten movements. It is reassuring if a fetus makes ten movements within two hours. If a woman counts fewer than ten kicks in two hours, or if she feels that the baby is moving less than usual, she should contact her health care provider. Her provider may recommend tests, such as fetal heart rate monitoring and

ultrasound. For more information, see [Kicks Count!](#) from First Candle.

Pregnant women should report any vaginal bleeding to their health care provider immediately. Vaginal bleeding during the second half of pregnancy can be a sign of placental abruption. Often, a prompt cesarean delivery can save the baby.

Providers carefully monitor women who have had a stillbirth in a previous pregnancy for any signs of fetal difficulties. This can help assure that all necessary steps can be taken to prevent another fetal death.

What can a woman do to reduce her risk of stillbirth?

Women should have a [preconception visit](#) with their health care provider. This visit allows the provider to identify and treat conditions, such as diabetes and high blood pressure, before pregnancy to reduce the risks of problems during pregnancy. This visit also is a good time to discuss all prescription, over-the-counter and herbal medications with their provider because some medications can pose a risk to the fetus.

Obesity may increase a woman's risk of stillbirth (1, 5). Women who are obese should consider losing weight before they attempt to conceive. Their health care provider can discuss their ideal weight and how they can achieve it. A woman should never try to lose weight during pregnancy. However, women who are obese should not gain as much weight during pregnancy as women who are not overweight. Guidelines from the Institute of Medicine recommend that obese pregnant women limit their gain to 11 to 20 pounds, compared to 25 to 35 pounds for women who start pregnancy at a normal weight (8).

Women should not smoke, drink alcohol or use street drugs during pregnancy. All of these can increase the risk of stillbirth and other pregnancy complications.

What is the risk of stillbirth happening again in another pregnancy?

Parents who have had a stillbirth often are worried about this tragedy happening again. The risk is low for most couples, though the risk is higher than for couples who have not had a stillbirth. For example, chromosomal birth defects, placental problems and cord accidents are unlikely to occur again in another pregnancy (3).

However, the risk for having another stillbirth may be higher if a maternal health condition (such as diabetes) or a genetic disorder caused the previous stillbirth. In such cases, the couple may benefit from [genetic counseling](#). A genetic counselor can advise the couple about the risk of stillbirth or other pregnancy complications in another pregnancy.

Any couple who has had a stillbirth should discuss their risk of stillbirth with their health care provider before getting pregnant again. In some cases, the woman and her health care provider can take steps to reduce her risk in another pregnancy. For example, if a woman has diabetes or high blood pressure, she can get the condition under good control before she tries to conceive.

Does the March of Dimes support research on stillbirth?

The causes of stillbirth often are the same as the causes of birth defects, preterm birth and infant death. The March of Dimes supports many grants on genetic abnormalities, placental problems, maternal illnesses (including high blood pressure) and fetal infections, all of which can contribute to stillbirth and other adverse pregnancy outcomes. The ultimate goal of these grants is to develop new ways to prevent and treat these disorders, so they do not result in stillbirth, birth defects or other pregnancy complications.

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