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PERINATAL MORTALITY RATE-HOSPITAL BASED STUDY

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In 1998 the Perinatal Mortality Study Group was established at Hacettepe University to determine the causes of perinatal mortality and to calculate perinatal mortality rates at this institution.The study group was constituted by the Department of Pediatrics, Units of Pediatric Pathology, Pediatric Cardiology, Pediatric Surgery, Genetics and Neonatology and the Department of Obstetrics and Gynecology, Perinatology Unit.At the end of every month, each case was discussed among the group including the autopsy results if available, and the cause of mortality was determined according to the Extended Wigglesworth Classification, by the consensus of the group members. Perinatal mortality rates at Hacettepe University were prospectively calculated. Perinatal mortality figures of two periods were compared .(1998-1999 and 2000-2001)

Total number of births over 500 grams was 3173 in the year period 1998 –1999 and 3013 in the year period 2000 - 2001. Perinatal mortality rate was 34,35/1000 in the period from 1/1/1998 to 31/12/1999 and 16,92 /1000 in the period from 1/1/2000 to 31/12/2001.

Among perinatal deaths, 61,46 % were intrauterine deaths and 38,54 % were early neonatal deaths in the period 1998-1999. In the period 2000- 2001, 58,83 % were inrauterine deaths and 40 % were early neonatal deaths.

In the period 1998-1999, 62,7 % of the deaths were < 1500 grams, and 46,7 % were between 500-1000 grams. The most common cause of death during this period was prematurity (Extended Wigglesworth Group III) (29,3%), followed by lethal congenital malformations (Group II) (26,6%) and macerated intrauterine deaths (Group I) (22,9%) Autopsy was available in 70,7% of the cases and micronecropsy was available in 12 %. Genetic studies were performed in 24 % of the cases and termination of pregnancy was carried out for fetal anomalies in 10,7 % of the cases.

In the period 2000-2001 72,54 % of the cases were < 1500 grams and 47,1 % of the cases were between 500- 1000 grams.The most common cause of death during this period was lethal congenital malformations (Group II) (31,4%), followed by macerated intrauterine deaths (Group I) (21,5%) and specific causes (Group V) (21,5%). Autopsy was available in 70,17 % of the cases and micronecropsy was obtained in 10,52 % of the cases. Twenty percent of the cases underwent genetic studies during pregnancy and termination of pregnancy was carried out in 19,29% of the cases.

Perinatal mortality rate has decreased at Hacettepe University during the last 2 years. Most common cause of mortality has changed from prematuriy to lethal congenital malformations in this period. Since our institution is a referral center, around 60% of the mortality is due to intrauterine deaths and around 30% of the deaths are due to lethal congenital malformations.

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BREECH DELIVERIES AND C/S

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Four to five percent of singleton pregnancies at term are complicated by breech presentation. Complications occur in about 60% of breech deliveries. Fetuses presented by the breech are at increased risk of birth injuries and hypoxia during vaginal delivery. The management of breech presentation is in a state of flux at the present time. Use of cesarean section is increasing. External version -even with the use of tocolytic agents for relaxation- is dangerous because its possible complications. In our practice vaginal delivery is preferred if the following criteria are completed: frank breech only, estimated fetal weight of 2500-3500g, adequate pelvimetry without hyperextended head, normal progression of labor, no evidence of fetal hypoxia with continous fetal monitoring, and the weight of the mother is under 90 kg. Vaginal frank breech delivery at term may be just as safe as cesarean section when careful selection criteria are used. If these criteria are not fulfilled, or the fetal monitoring cannot be performed, cesarean section is advisable. The increasing rate of cesarean section significantly lowered the perinatal morbidity and

mortality in developed countries in the past decades. In developing countries the operative background for cesarean section is not widely available. In these countries the attending personel need to be trained to perform breech deliveries to safely deliver these fetuses.

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POSTPARTUM HEMORRHAGE

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Postpartum hemorrhage is defined as excessive blood loss following delivery of the fetus. Bleeding might occur before, during or after the delivery of the placenta. As the consequence of increased blood volume in pregnancy and that of the hemodynamic changes occurring postpartum most patients can tolerate blood losses up to 1500 ml., provided that they are in good health and were not anemic before pregnancy. The diagnosis of postpartum hemorrhage is usually imprecise because for the wide range of blood loss following delivery encountered normally and the inaccuracy of the estimation of the amount of lost blood. The incidence of postpartum hemorrhage is approximately 5-10 % after vaginal delivery.
Postpartum hemorrhage is one of the leading causes of maternal mortality worldwide. Major causes of early postpartum hemorrhage are uterine atony, obstetric trauma, retained placental tissue, uterine inversion and coagulation defects. Causes of delayed postpartum bleeding include: uterine subinvolution, retained placental tissue, endometritis or placental polyp. As caesarean section rate increases in the well-developed areas of the world, dehiscence of the previous uterine scar may be an increasing cause of postpartum bleeding.
When the risk factors of postpartum hemorrhage are suspected or present, preventive measures should be instituted. Correction of anemia before delivery is a basic preventive measure to be instituted. Blood should be readily available in risk patients, like those with known placenta previa. Predelivery replacement of coagulation factors in patients with bleeding disorders should be managed. Prophylactic and proper use of oxytocic agents during and especially after delivery might decrease the risk of atony in the postpartum period.
Two basic principles govern the treatment of postpartum hemorrhage: the bleeding must be arrested and the blood volume must be restored as soon as possible. Successful management with a favorable outcome can be achieved only by correct identification of the cause of the bleeding and a very rapid decision-making at the same time. Wasting time might result in maternal death. Decrease in mortality rates can only be achieved in places where all the vital criteria of controlling serious postpartum hemorrhage meet, and a real teamwork is established.

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PERINATAL SCENARIO IN INDIA

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New born constetali the foundation of life. Healthy and sturdy baby are likely to evolve as physically and mentally strong adults. Healthy mother produce healthy baby. Female child must be accorded special status and attention. Current population of India is one billion plus.
National Literacy rate is 52% of Female literacy rate is 37.7%. Current perinatal scene in India are indeed dismal. Some Antenatal care of poor quality is received by 60 % of pregnant women. Only 24.5% of deliveries occur at health post and Hospitals. Among domicillary births, only 24.5% of deliveries are attended by trained traditional birth attendants. The current Neonatal and Perinatal mortality rate is 47 and 44 per thousand like births.
There is an excellent pyramid of MCH Services through the network of Sub Centers, Primary Health Centers District and States Hospitals for providing Health care services in rural area. 75% Population still leave in villages.