IDA-TALLINNA KESKHAIGLA

AS Ida-Tallinna Keskhaigla
Ravi 18, 10138 Tallinn
Rg-kood 10822068
Tel 666 1900
E-post info@itk.ee
www.itk.ee

Intrauterine Fetal Death

The purpose of this leaflet is to provide basic information on the causes and treatment of intrauterine fetal death, also known as stillbirth. Intrauterine fetal death is defined as the death of a fetus after the 22nd week of pregnancy, before the onset of childbirth. This occurs in approximately one in every 200 pregnancies. The exact treatment for each case is specific to the individual and depends on the woman's particular health circumstances.

Why does it happen?

In about a third of cases, the cause of death cannot be determined, and this can also occur during a normal pregnancy.

There are a number of conditions that can cause or contribute to fetal death in the womb:

- Infection
- preeclampsia
- placental detachment
- placental developmental disorder
- the mother having diabetes, kidney disease, high blood pressure, or other chronic disease
- maternal overweight or obesity
- the mother's age (under 15 and over 35 years)
- maternal smoking, alcohol or drug use
- fetal developmental disorder
- a problem with the umbilical cord, such as a knot or the twisting of the umbilical cord around parts of the body of the fetus
- multiple pregnancy

There are no pregnancy tests or studies that can reliably predict fetal death.

Fetal death is confirmed by doppler and ultrasound examinations in the absence of fetal heart tones. After death has been detected, it may still feel as if the fetus is moving – this is due to the fetus floating freely in the surrounding amniotic fluid.

Method of childbirth

For the majority of women who do not induce childbirth, the onset of childbirth occurs spontaneously within 1–3 weeks. However, this does increase the risks to the woman's health, especially with regard to coagulation disorders. If the mother has co-morbidities, such as preeclampsia or an increase in blood pressure during pregnancy, it is not practical to wait for natural childbirth to begin.

The induction of childbirth is required immediately in the event of sepsis, preeclampsia, placental abruption or the water breaking.

A vaginal birth is preferable. Compared to a caesarean section, it has several advantages:

- Fewer health risks for women
- Faster healing after childbirth and an earlier return home
- Faster recovery
- Lower risk in future pregnancies

In the event of intrauterine fetal death, a caesarean section is the least recommended method of delivery due to the associated risks.

If a woman has previously undergone a caesarean section and there are no contraindications, vaginal childbirth is preferred. This decision is made on a case-by-case basis, taking into account the risks.

For a vaginal birth to be possible, it may be necessary to induce labour. There are different methods of doing this, such as administering misoprostol and/or mifepristone, breaking the water or amniotomy. Another method is to place a balloon catheter in the cervical canal to open it. The method chosen depends on the maturity of the cervix. The induction of labour can occur quickly, but it can also take several days.

Vaginal childbirth is led by a midwife, and can be attended by both a chosen companion and a birth supporter. If necessary, a gynaecologist is also present during childbirth. In certain special situations, vaginal childbirth may result in a vacuum extraction or caesarean section should a condition arise that places the health of the mother at risk.

Although we want to give you ample time to adapt to the situation, certain conditions, such as severe preeclampsia, coagulation disorders and infection, require an urgent decision on when and how to give birth.

Postpartum period

Giving birth to a stillborn baby is an emotionally difficult process.

After giving birth, we advise you to spend time with the child. If you do not wish to do so, please let the midwife know. If you wish, it is also possible to save mementos from the fetus, such as hair, or hand impressions.

After childbirth, milk is produced in the breasts. To prevent this we will give you cabergoline. In addition, cold compresses and pain therapy can also be used.

Various patient information materials on the postpartum regimen and self-care are available on our website.

To determine the cause of death, an autopsy must be performed on the fetus. The hospital will issue you a death certificate for the child and a statement detailing the cause of perinatal death. At the request of the family, it is possible to include the child's first and last name on these documents. A social worker from the Women's Clinic will help you with these arrangements. Afterwards, it is possible to either cremate or bury the fetus.

Psychological support is available at the hospital upon referral from a clinical psychologist or an outpatient pregnancy crisis counsellor.

Further studies

Tests and examinations before or after childbirth:

- mother’s blood test to detect signs of preeclampsia, infection, liver or kidney problems, and diabetes mellitus
- mother’s blood test to detect clotting problems (thrombophilia and antiphospholipid syndrome). These tests sometimes need to be performed repeatedly, as results obtained during pregnancy and immediately after childbirth may be inaccurate
- bacterial culture from the cervix, placenta, and fetus
- genetic examination of the fetus, if necessary
- placental study

Follow-up

After the examinations, the results of which may take several months to arrive, an appointment with a doctor is arranged. Regardless of the method of delivery, remember that an emergency visit to the Women’s Clinic of East Tallinn Central Hospital is required in case of severe abdominal pain, bleeding, or a fever above 38 °C.

Risk of recurrence

The risk of repeated intrauterine fetal death in subsequent pregnancies depends primarily on the specific cause of death. In general, each subsequent pregnancy carries a higher risk, with the risk of repeated intrauterine fetal death being four to five times greater. Subsequent pregnancies may require more intensive monitoring and earlier termination.

It is recommended that families plan for the next pregnancy when they are psychologically ready for it. This is highly individual and requires the support of both a doctor and a psychologist. The general recommendation is to avoid further pregnancies for at least 6 months after a vaginal delivery and at least 1 year after a caesarean section.

It is important to remember that most women who have experienced intrauterine fetal death will go on to have healthy babies in the future.

ITK1285

Approved by the decision of the Medical and Nursing Care Quality Commission of *Aktsiaselts Ida-Tallinna Keskhaigla* on 01.October 2025 (Protocol No. 2.2-8/5-25)