Preliminary Report

"Brought Dead" - cases of maternal mortality

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Abstract

Seven cases that were brought dead on the way to the hospital in 2057 BS (2000-2001 AD) have been presented in this study. Among seven, two cases were young primiparas, one was a grand multipara and four were between ages 20 – 25 years. Of these, one had post abortion complications, two were complicated by non-delivery and four had third stage complications. The information that the patient was dead on arrival to the hospital was received by the attendants in all cases with shock and disbelief so that it was very difficult to take proper history. An important point noted by this study was that only four maternal deaths occurred in the hospital and were recorded in the hospital statistics in that year, so that the number of deaths that occurred in transit to the hospital and were technically excluded from the hospital statistics exceeded the number of maternal deaths recorded in the hospital statistics. Another interesting point was that none of the seven women who expired on the way to the hospital were living at a distance greater than 15 Km from the hospital and yet had not attended antenatal clinic, implying that inadequate use of health services even in areas with relatively easy access to proper heath care is a major contributor to maternal death.

Maternal mortality rate is very high in Nepal. The government and other agencies working in the field of reproductive health are working hard to lower the mortality rates in the country.

Maternal mortality is defined as "the death of a woman while pregnant or within 42 days of the end of pregnancy irrespective of the duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes". [1]

Postpartum haemorrhage is the leading cause of maternal mortality in Nepal, accounting for 46% of deaths. Obstructed labour is the cause of death in16% of maternal mortality cases while complications of pregnancy induced hypertension and eclampsia account for 14% of maternal deaths. Puerperal sepsis is another important cause of maternal mortality accounting for 12% deaths.[2]

In Nepal, most deliveries are conducted at home due to multiple factors. Not having easy access to health care facilities is one main *cause for it. Because of multiple problems 67% of maternal mortality occurs at home*. ___Eleven percent of maternal deaths occur on the way to a health facility___ and only a further *11% of maternal deaths occur in health facility.* Ninety percent of the maternal deaths occur in a rural setting and 62% occur after delivery.[2]

In this context, it becomes important to note that statistics of maternal mortality gathered solely from health care institutions/facilities are misleading and only represent the tip of the iceberg. Even those cases of maternal deaths that die on the way to the hospital are not recorded in the hospital statistics, as those are not technically "hospital deaths".

Objective

The objective of this study is to analyze the cause of death in "brought dead" cases to the Maternity hospital during the period of one year 2000-2001A D (BS 2057). We hope thereby to highlight the importance and necessity of maintaining records of such cases in the hospital register so that these cases are not lost from the mortality statistics.

Study methods

The patients brought to casualty are seen by the doctor on duty in the Maternity hospital round the clock. A questionnaire directed at trying to find out the probable cause of death was administered to persons bringing the "bought dead" case.

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Separate records were kept of the patients being brought dead to the hospital. These records were kept as" **Brought dead"** to the hospital. These records were analyzed for the possible direct cause of death and factors directly of indirectly affecting the cause of death.

The study was carried out for the duration of one year, during which seven cases were brought dead to the hospital.

Results
Of the seven cases recorded, two were young primiparas, both aged 17 years, residing 10 to 15 km away from the hospital. The first had not delivered. There was history of vomiting at home five hours prior to reaching the Hospital. There was no history of seizures. The husband and brother-in-law to the hospital brought the case at 4:00AM and the body was oedematous on arrival. Aspiration of vomitus could have been a possible cause of death in this case.

The second case had delivered at home six hours prior to reaching the hospital. There was history of retained placenta and profuse bleeding following delivery. The husband and the mother of the deceased had brought this case. Post partum haemorrhage was thought to be the cause of death.

Four deaths were in the age group between 20 to 25 years. Out of these the first case was a 21 years old primi coming from 5 to 10 Km away from the Hospital. She was brought by her husband and had a retained placenta. The second case 22 years old primi with a history of spontaneous miscarriage at fifth month of pregnancy at home. Her brother brought her. The third case was primi aged 24 had delivered at home 5 hours prior to arrival at hospital and had been brought to the hospital by her brother for retained placenta. All these three young women probably died as a result of severe post partum haemorrhage leading to irreversible shock and death.

The fourth case was a 22 years old second gravida with previous history of LSCS coming from 8 Km away from the Hospital. The husband of the deceased who brought her gave history of severe vomiting for 6 hours followed by unconsciousness.

The seventh case brought dead was that of a 35 years old third gravida, also with retained placenta.

Hence, post partum haemorrhage due to retained placenta was the cause of death in five of the cases of maternal mortality brought dead to the hospital while in the other two the cause of death may have been due to severe pre-eclampsia leading to aspiration of vomitus. The lack of provision for autopsy in such cases makes it difficult to ascertain the exact cause of death.

Discussion
Seven cases of maternal mortality in which death occurred most probably during transit to the health centre have been presented. These cases were not attending antenatal care services despite having a well-equipped hospital relatively close to their residence. In spite of having a hospital close by with 24-hour availability of ambulance services, delivery was conducted at home and help was not taken in time.

A study conducted in Andhra Pradesh in India in 1984-85 which compared the data on maternal mortality obtained by conducting surveys in villages to the data obtained from hospital records also reported a similar finding of actual problem of maternal mortality far exceeding that seen from official records.[3] In that study, only half of the maternal deaths identified were noted in health facility records and under one third were recorded in primary health centre records. Another study in Laos found that among maternal deaths at home and home deliveries, 71% occurred to poor women and deaths on the way to the hospital involved 3% of poor women and 3% of rural women.[4] The situation in Nepal in this regard where the majority of the people are poor and live in remote villages is even worse with 90% deaths occurring in rural setting with 11% dying on the way to a health facility.

Conclusion
In order to reduce the maternal mortality in our country it is important not only to improve the availability of health care resource but also its acceptability. It is important to increase awareness among the general public as well as among primary level health care workers that every delivery is a potential "High risk" delivery, best conducted in a well equipped centre since fifteen percent of the deliveries may have life threatening complications. The value of bringing obstetric services to communities currently without them in reducing maternal mortality is unquestionable and has been shown to be of vital importance in developing countries like ours.[5] The knowledge of "Danger signs" during pregnancy and delivery among the women is very important.

There is also a need for maintaining records such cases in the hospital so that the statistics are not lost

and can be utilized to gauge the enormity of the problem and for development of appropriate plans and policies to improve on existing health care system.

Reduction of maternal mortality in developing countries is possible through elimination of unsafe abortion, active management of labour, appropriate management of pregnancy complications, and availability of adequate facilities. Safe motherhood requires the commitment of local people and local governments. The first step in a safe motherhood program is creating awareness among the political and economic elite. Governments are encouraged to shift resources from the military to housing, transportation, communications, education, and health during peace-times. Planning that includes proper roads, transportation, and communication facilities are important. Local professional associations, women's groups, and nongovernmental organizations are useful resources. Concerted efforts from many different agencies and all the people is required in order to achieve safe motherhood for all.[6]

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The figures above demonstrate LV aneurysm, which is a rare complication of myocardial infraction especially of anterior wall. It is found in 20-40%of cases and in most instances the aneurysm is of true type as in this case. The true aneurysm has wide neck, suspected in the presence of persistent ST segment elevation in ECG, is unlikely to occur after four to six weeks and it rarely ruptures. If the patient's ECG shows ST elevation beyond two weeks then the possibility of false aneurysm development is high which shows narrow neck in Echocardiography and is more likely to rupture. Systemic Embolisation is the most dreaded complication of true aneurysm for which patients are anticoagulated with warfarin keeping INR of 2.5 –3. LV aneurysectomy is the best treatment for the case.