Original Research Article

Role of Registration, Age, Parity, POG and Birth Weight in Fetal Distress and Neonatal Outcome

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Abstract
A prospective study was conducted at Kamla Nehru Hospital, I.G.M.C, Shimla on 100 women with one more signs of fetal distress like abnormal fetal movement perception by mother, meconium staining of amniotic fluid and fetal heart rate abnormality. Neonatal outcome was observed in relation to fetal distress at one and five minutes APGAR score. Neonates were found more asphyxiated in extremes of maternal age i.e. <20 years and >30 years, in unbooked cases, in primigravida and gravida>3 and with increasing period of gestation (POG). Neonatal outcome was poor in low birth weight babies.

Introduction
Every fetus has a potential risk of intrapartum hypoxia or birth injury and an optimum outcome can be concluded only at the end of labour. The aim is to detect at the earliest any associated risk factors like extremes of maternal age, post date or post term pregnancy, parity, booking status of the patient and expected neonatal birth weight which may adversely affect the neonatal outcome. Increased incidence of meconium stained amniotic fluid has been found associated with increased POG in different studies (Eden et al 1978\textsuperscript{1}, Usher et al 1988\textsuperscript{2}, Steer et al 1989\textsuperscript{3} and Katz and Bows 1992\textsuperscript{4}). Amniotic fluid volume was reduced in post term pregnancy and fetuses are more prone to hypoxia and more chances of meconium passage in uterus (Leveno et al 1984\textsuperscript{5}). The fetus of a prolonged pregnancy appears to be more at risk of hypoxia during labour and in post natal period compared with a fetus at term (Bakketig and Bergsjo 1989\textsuperscript{6}). The increased incidence of moderate to severe asphyxia in elderly patients is due to placental insufficiency which is a universally accepted fact. Cunningham and Leveno 1995\textsuperscript{7} studied 900 women over 35 years of age and concluded a significant increase in still birth and perinatal mortality in this age group. Early registration and regular antenatal checkup always detects fetuses and mother at risk at the earliest; minimising the intrapartum asphyxia and neonatal morbidity and mortality. Russ et al 1946\textsuperscript{8} concluded from his studies that in general primi para produces more asphyxiated babies than multi para. However the multi para (gravida $\geq$3) seems to have a greater tendency to be asphyxiated. Heavier fetus has reserve to withstand labour without alteration of fetal heart rate. Ciblis 1971\textsuperscript{9} concluded from his study that APGAR score was significantly better among heavier infants. The small fetuses had poor neonatal outcome.
Material and Methods
A prospective randomized study was conducted in the department of Obstetrics and Gynaecology at Kamla Nehru Hospital I.G.M.C, Shimla between July 2002-June 2003. Out of total delivery of 3912 during this period 100 patients of full term pregnancy in labour showing one or more clinical signs of fetal distress were selected for the study. Neonatal outcome was predicted on the basis of APGAR score at one and five minutes.

Selection of the Cases
Patients with full term (37-42 weeks) normal pregnancy with cephalic presentation in labour who had shown some alteration in fetal heart rate or rhythm, decrease or loss of fetal movements and meconium staining of amniotic liquor on spontaneous or artificial rupture of membrane were selected for the study. Pregnancy with antenatal complications like pregnancy induced hypertension, twin pregnancy, diabetes mellitus, severe anaemia, Rh incompatibility, ante partum haemorrhage and post maturity were excluded from the study. In all cases following observations were made and recorded in the case proforma. In each case a detailed obstetric and menstrual history was taken. Patients were asked about duration of labour pain, history of any bleeding or leakage per vaginum and color of liquor and any decrease or loss of fetal movements. A detailed general, physical, systemic and obstetrical examination was done and findings were noted.

Labour was monitored partographically. Out of 100 patients, 32 patients were monitored by cardiotocograph. Hb%, blood grouping and Rh typing and urine for albumin and sugar were done in each patient. Duration of first and second stage of labour recorded in cases on Normal Vaginal Delivery (NVD), low forcep delivery and in ventouse application. If delivery was not eminent and clinical monitoring showed ominous signs of fetal distress, patients were taken up for caesarean section. Umbilical cord was examined for its length, presence of knots and nicks, number of coils of cord encircling the neck and for number of umbilical vessels. Placenta was weighed and examined grossly for size, presence of infarcts, calcifications or any retroplacental clot. Neonates were examined for APGAR score at one and five minutes, birth weight, gestational age, any congenital malformation and meconium staining of cord, nails, skin and cornea and any evidence of meconium aspiration syndrome. According to APGAR score (Apger V. 1953) at one and five minutes neonates were classified into 3 categories:- 1. APGAR score: 7-10; healthy, no asphyxia. 2. APGAR score: 4-6; mild asphyxia. 3. APGAR score: 0-3; severe asphyxia and still birth. Asphyxiated babies were admitted to neonatal intensive care unit after primary resuscitative measures and followed up as long as the neonate was in hospital.

Statistics: Observations were recorded and analysed using Paired Students t-test.

Observations
Table 1 Relationship of Registration to Neonatal Outcome

<table>
<thead>
<tr>
<th>Registration</th>
<th>Total Cases</th>
<th>At one minute Apgar Group</th>
<th>At five minute Apgar Group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Group I</td>
<td>Group II</td>
</tr>
<tr>
<td>Booked</td>
<td>46</td>
<td>21(45.69%)</td>
<td>20(43.47%)</td>
</tr>
<tr>
<td>Unbooked</td>
<td>54</td>
<td>9(16.66%)</td>
<td>37(68.5%)</td>
</tr>
</tbody>
</table>

Paired student's t-test:
- Group I: t=1.84, p=0.207
- Group II: t=1.94, p=0.192
- Group III: t=1.98, p=0.187

In Table 1, 83.32% (45 patients) of unbooked patients had asphyxiated babies while only 54.33% (25 patients) of booked patients babies were asphyxiated at one minute APGAR.22.21%
(12 patients) of unbooked patients and 10.86% (5 patients) of booked patients had asphyxiated babies at five minutes APGAR. It was observed from the study that percentage of asphyxiated babies at 1 and 5 minutes APGAR score were more in unbooked cases.

**Table 2 Age Distribution and Relation to Neonatal Outcome**

<table>
<thead>
<tr>
<th>Age [Yrs]</th>
<th>Total</th>
<th>Group I</th>
<th>Group II</th>
<th>Group III</th>
<th>Group I</th>
<th>Group II</th>
<th>Group III</th>
</tr>
</thead>
<tbody>
<tr>
<td>15-20</td>
<td>8</td>
<td>2(25%)</td>
<td>4(50%)</td>
<td>1(12.5%)</td>
<td>3(37.5%)</td>
<td>4(50%)</td>
<td>11.25%</td>
</tr>
<tr>
<td>21-25</td>
<td>51</td>
<td>19(35.59%)</td>
<td>20(39.22%)</td>
<td>12(23.53%)</td>
<td>41(80.39%)</td>
<td>9(17.64%)</td>
<td>11.90%</td>
</tr>
<tr>
<td>26-30</td>
<td>30</td>
<td>9(30%)</td>
<td>18(60%)</td>
<td>3(10%)</td>
<td>29(96.66%)</td>
<td>6(13.33%)</td>
<td>0</td>
</tr>
<tr>
<td>&gt;30</td>
<td>11</td>
<td>3(27.27%)</td>
<td>8(72.73%)</td>
<td>0</td>
<td>10(90.90%)</td>
<td>1(9.09%)</td>
<td>0</td>
</tr>
</tbody>
</table>

Paired student’s t-test:
- Group I : t= -2.44, p=0.093
- Group II: t= 2.71, p=0.073
- Group III: t= 1.46, p=0.241

In Table 2, at one minute APGAR score 72.72% (8 patients) with >30 years of age, 69.98% (21 patients) between 26-30 years, 64.69% (33 patients) between 21-25 years and 75% (6 patients) between 15-20 years had asphyxiated babies. At 5 minute APGAR score, 62.5% (5 patients) between 15-20 years, 19.6% (10 patients) between 21-25 years and 9.09% (1 patient) >30 years of age group had asphyxiated babies. It was observed that in extremes of age i.e. <20 years and >30 years, incidence of asphyxiated babies were high. The best obstetric outcome was noted in age group 21-25 years at 1 minute and between 26-30 years at 5 minutes.

**Table 3 Parity Distribution and Relation to Neonatal Outcome**

Table 3 depicts; at 1 minute APGAR 100% (5 patients) babies were asphyxiated in gravida ≥ 4 while 66.06% (37 patients) in primigravida, 62.96% (17 patients) in second gravida and 66.66% (8 patients) in third gravida had asphyxiated babies. At 5 minutes APGAR score; 100% in gravida ≥4 (5 patients) and third gravid (12 patients) had healthy babies. Only 23.21% (13 patients) in primigravida and 14.18% (4 patients) of second gravid had asphyxiated babies. Hence it was observed that primigravida patients were more vulnerable to have asphyxiated babies both at 1 and 5 minutes in comparison to gravid 3 or more. It was statistically significant (p=0.029) in Group II.
Table 4 shows that at 1 minute APGAR 55.76% (29 patients) at POG 37-39 weeks, 56% (14 patients) at POG 39-40 weeks and 56.52% (13 patients) at POG 40-42 weeks had mild to moderately asphyxiated babies. 13.46% (7 patients) at 37-39 weeks, 16% (4 patients) between 39-40 weeks and 8.69% (2 patients) between 40-42 weeks had severely asphyxiated babies. At 5 minutes 13.45% (7 patients) between 37-39 weeks, 20% (5 patients) between 39-40 weeks and 21.73% (5 patients) between 40-42 weeks had mild to severely asphyxiated babies. It was observed that patients reported between 37-39 weeks has less number of asphyxiated babies as compare to 40-42 weeks gestation.

Table 5 shows, in upto 2 kg weight 60% (3 babies) at 1 minute and 20% (1 baby) at 5 minutes were mild to moderately asphyxiated. In 2.1-2.5kg weight 77.77% (21 babies) at 1 minute and 18.5% (5 babies) at 5 minutes were moderately to severely asphyxiated. In 2.62-3kg weight 23.53% (8 babies) at 1 minute and 88.24% (30 babies) at 5 minutes has APGAR score ≥7. In >3kg weight 58.81% (20 babies) at 1 minute and 20.59% (7 babies) at 5 minutes were asphyxiated. It was noticed that neonatal outcome was best in babies with birth weight between 2.6-3Kg groups. Neonatal outcome was poor in low birth weight babies. It was statistically significant (p=0.05).

Table 5 Neonatal Birth Weight-Distribution and Relation to Neonatal Outcome

<table>
<thead>
<tr>
<th>Birth weight</th>
<th>Total</th>
<th>Group I</th>
<th>Group II</th>
<th>Group III</th>
<th>Group I</th>
<th>Group II</th>
<th>Group III</th>
</tr>
</thead>
<tbody>
<tr>
<td>Up to 2 Kg</td>
<td>5</td>
<td>2(40%)</td>
<td>3(60%)</td>
<td>0</td>
<td>4(80%)</td>
<td>1(20%)</td>
<td>0</td>
</tr>
<tr>
<td>2.1 Kg to 2.5 Kg</td>
<td>27</td>
<td>6(22.22%)</td>
<td>16(59.26%)</td>
<td>5(18.51%)</td>
<td>22(81.48%)</td>
<td>4(14.81%)</td>
<td>1(3.70%)</td>
</tr>
<tr>
<td>2.6 Kg to 3 Kg</td>
<td>34</td>
<td>8(23.53%)</td>
<td>22(64.71%)</td>
<td>4(11.76%)</td>
<td>30(88.24%)</td>
<td>3(8.82%)</td>
<td>1(2.94%)</td>
</tr>
<tr>
<td>&gt;3 Kg</td>
<td>34</td>
<td>14(41.18%)</td>
<td>16(47.06%)</td>
<td>4(11.76%)</td>
<td>27(79.41%)</td>
<td>4(14.29%)</td>
<td>3(8.82%)</td>
</tr>
</tbody>
</table>

Paired student’s t-test:
- Group I: t=-3.16, p=0.05 (SIGNIFICANT)
- Group II: t=2.98, p=0.059
- Group III: t=2.91, p=0.062

Discussion

- Correlation of Registration with Neonatal Outcome:
  As depicted in Table 1, the number of asphyxiated babies were more in unbooked cases than booked one. This finding is consistent with the findings of Narula S (1992).  

- Age Distribution and Relation to Neonatal Outcome:
  As observed in Table 2, in extremes of age (15-20 years and >30 years) incidence of asphyxiated babies were high. These findings are consistent with the findings of Prasun et al (1986). Advancing maternal age had increased percentage of asphyxiated babies at 1 minute APGAR. These observations were consistent with the observations of Russ J.D. (1946) and Cunningham and Leveno.
In which they concluded that mothers with >35 years of age are at increased risk of poor neonatal outcome.

- **Parity Distribution and Relation to Neonatal Outcome:**
  As depicted in table 3, parity had shown a definite and a significant impact on neonatal outcome (p=0.029 in Group II). In primigravida 66.06% (37 patients) at 1 minute and 23.21% (13 patients) at 5 minutes had babies with moderate to severe birth asphyxia. 66.66% (8 patients) of gravidas 3 and 100% (5 patients) of gravidas ≥4 had moderate to severely asphyxiated babies at 1 minute. Above findings are consistent with the findings of Pradip et al (199513), Russ J.D et al (19468) in which they concluded that primi para produce more asphyxiated babies than do multi para. However the babies of multipara (gravida ≥3) seems to have a greater tendency to be asphyxiated.

- **Distribution of POG and Neonatal Outcome:**
  The presence of meconium is correlated best with gestational age as stated by Steer et al (19893). In the present study out of 100 patients, 78% (78 patients) had meconium stained amniotic liquor alone or with fetal heart rate abnormality. The percentage of meconium passage has increased considerably after 40 weeks of gestation in studies of Eden et al (19781), Usher et al (19882), Steer et al (19893), Katz and Bows (19924), Leveno et al (19845), and Bakketeig and Bergsjo (19896). The best neonatal outcome was observed between 37-39 weeks and worst between 40-42 weeks of gestation.

- **Neonatal Birth Weight-Distribution and Neonatal Outcome:**
  As depicted in Table 5, the best neonatal outcome was among birth weight of 2.6-3Kg group and neonatal outcome was poor in low birth weight babies. Among Group II of table 5, the relation of babies according to birth weight had nearly a significant value (p=0.059) at 1 and 5 minutes APGAR score. There was a statistically significant relation (p=0.05) among group I at 1 and 5 minutes APGAR score. So this study had denoted a betterment of APGAR score as birth weight increased consistent with the findings of Praun et al (198612) and Ciblis (19719).

**Conclusion**

It can be concluded from the study that neonates were found more asphyxiated in extremes of maternal age (<20 years and >30 years), in unbooked cases, in primigravida and gravida≥3, with increasing POG and in low birth weight babies (<2.5 Kg). So these parameters can also be looked after keenly to predict a good or bad neonatal outcome apart from labour accidents.

**Bibliography**