Book

A bonfire of the tape measures

Were an obstetrician of the 1960s to be catapulted into a modern antenatal clinic, there is much that would alarm and astonish him. But in our approach to screening women at low risk of complications leading to stillbirth he would find reassuring familiarity in a maelstrom of change. In the same world where personalised medicine has the promise of targeting treatments to patients' individual genotypes, where imaging procedures combine detailed co-investigation of structure and function, and where humanised monoclonal antibodies can "take down" a signalling protein with the accuracy of a sniper, the primary diagnostic tool of a national screening programme to identify the compromised human fetus remains the tape measure.

An army of midwives charts the distance from the pubic symphysis to the uterine fundus in many high-income countries. In the UK, this was the sole positive recommendation of the National Institute for Health and Clinical Excellence (NICE) for the assessment of fetal wellbeing in low-risk women in their 21st-century *Guideline on Antenatal Care*. Thus it is hardly surprising that current rates of death of potentially viable fetuses are similar to the rates of death of mothers in the 19th century. The distraught and bewildered parents of stillborn babies come to terms with an outcome that affects one pregnancy in 200 (beyond 23 weeks of gestation); yet this event will often never have previously been mentioned in a conversation with any health professional. I quote a parent, bereaved in late 2010: "If stillbirth really is ten times as common as cot death, we cannot be the only ones who had bought three sleep positioners but had never once considered the possibility of stillbirth".

So perhaps the challenge for any new book on the subject is the extent to which it can elaborate a convincing strategy to reduce the population burden of stillbirth. As an account of the current state of the field, *Stillbirth: Prediction, Prevention and Management* is an excellent contribution. It takes a systematic approach working from epidemiology to aetiology, through to clinical management. There is little overlap between chapters; the only significant case is between the chapter on stillbirth epidemiology in high-income countries and that on demographics and exposures. However, all chapters are by acknowledged experts in the field who present clear, thorough, and succinct accounts of their subjects. This book would be a useful reference for a range of health professionals working in obstetrics, looking for further information on a topic that has been relatively neglected.

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The presentation of this material represents a foundation on which to consider the problem of stillbirth. This book will inform a reader on the nature and scope of the problem and on the risk factors and circumstances of many losses, and also provide information on the approach to the bereaved parents. But if there is an omission, it is perhaps an analysis of why we have failed to be as successful in reducing rates of stillbirth compared with neonatal death. In the UK, for example, the most recent Centre for Maternal and Child Enquiries report on perinatal mortality recorded an 18% decline in neonatal deaths from 2000 to 2008 compared with a 5·5% decline in stillbirth rates. Progress on stillbirth depends on identifying the critical gaps in knowledge to allow construction of the public health programme that will be required to have a more significant impact. Most stillbirths in high-income countries occur to women who are low risk. The recommended approach to screening low-risk women is not simply a manifestation of nasty nihilism by NICE. It reflects the absence of any strong evidence anywhere that we can screen a low-risk population using any method and reduce perinatal mortality. Is this because our ultrasonic and biochemical tools are useless at predicting risk? Is this because we can predict risk but we cannot modify it? How good are the trials that sought to reduce perinatal mortality using routine ultrasound (biometry and Doppler)? The evidence assembled in *Stillbirth* forms the basis for developing a research agenda, the ultimate goal of which, in the UK, is a bonfire of the tape measures of the nation's midwives and obstetricians.

Yet perhaps one culprit has escaped full prosecution in this book. In the absence of infection or congenital abnormality, most stillbirths can be attributed to some form of placental dysfunction. Despite an excellent chapter on the pathology of the placenta and umbilical cord, I am not sure that this investigation of stillbirth quite puts the sick placenta in the frame. This evasive killer is caught red-handed in cases of abruption and it is repeatedly questioned in cases of pre-eclampsia and growth restriction. But I am not sure that the pieces are put together. In my opinion, our ability to reduce significantly the population burden of stillbirths will depend on inter-agency cooperation to locate dysfunctional placentas, place them under surveillance, and intervene before it is too late.

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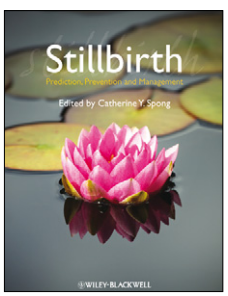

Stillbirth: Prediction, Prevention and Management
Catherine Y Spong, ed.
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