

Autopsy study of maternal death in a tertiary care centre

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Abstract

Aims: The main objective is to study the gross pathology and microscopy of all organs in cases of maternal death, establish clinico-pathological correlation, to ascertain the exact cause of death and classify them into direct or indirect causes.

Settings and Design: Cross sectional study of all medical autopsies

Materials and Methods: A cross sectional study of all medical autopsies performed on deaths related to pregnancy at our tertiary care hospital over a period of four years. A total of 100 cases were studied. Maternal mortality autopsies where medico legal implications were involved or unnatural deaths not related to pregnancy were excluded from the study.

Statistical Analysis used: Nil

Results: The maximum no. of maternal deaths occurred in the age group 20-24 years (45%) followed by 30-34 years (19%). 62% of patients in our study were multigravidae. Majority of maternal deaths were seen in the postpartum period (75%). In the antepartum period maximum number of maternal deaths occurred in 3rd trimester (14%) Our study revealed majority of maternal deaths were due to indirect causes (76%), Pregnancy induced hypertension was the most common direct cause of death (9%). The majority of cases were due to infectious aetiology (45%), while the other indirect causes were sepsis (14%), coagulopathy (8%) and hemodynamic (8%).

Conclusion: The higher MMR in our study could be attributed to the fact that ours being a tertiary and referral care hospital, where patients are referred late and most of them are complicated cases and in serious condition at the time of admission. The low socioeconomic status of the patients, delay in referral and non-utilisation of the available antenatal care could be the major contributing factors.

Our study revealed majority of maternal deaths were due to indirect causes especially respiratory infections and hepatitis. Increased incidence of indirect causes reflect the present health care system. So adequate prenatal testing for these causes (infections), improving the nutritional status, sanitation can help in lowering the maternal mortality rate.

Keywords: Autopsy, Maternal death.

Introduction

Maternal death has serious implications on the family and the society.¹ Approximately 529,000 women die from pregnancy-related causes annually and almost all (99%) of these maternal deaths occur in developing nation. Every minute a woman dies during labour.² Maternal Mortality Rate (MMR) is a very sensitive index that reflects the quality of reproductive care provided to the pregnant women.¹ Maternal mortality rate is defined internationally, as the maternal death rate per 1, 00,000 live births.³ The autopsy studies would provide information on preventable causes of death, consequently leading to strategies for treatment and prevention of maternal morbidity.³ Hence this study was undertaken to evaluate the MMR in our tertiary care hospital and analyse the various causes of death and to study pathology in various organs.

Materials and Methods

We did a cross sectional study of all Medical autopsies performed on deaths related to pregnancy at Lokmanya Tilak Municipal Medical College Sion, Mumbai, tertiary care hospital over a period of four years from April 2011 to March 2015. The sample size

in the above period was 100 cases. Maternal mortality autopsies where medicolegal implications were involved or unnatural deaths not related to pregnancy were excluded from the study. All organs and tissues collected at autopsy and their gross pathology and microscopy was studied using H & E Stain and special stains whenever required. Clinical details were collected from Autopsy records and indoor papers.

Parameters studied were Gross pathology and Microscopy of all organs ascertaining the cause of death and Correlation with the clinical presentation and various haematological, biochemical and radiological investigations. In autopsies significant organ systems which were examined grossly in detail.

Results

Our study was carried out in a tertiary care hospital in the Department of Pathology over a period of four years from April 2011 to March 2015. Over these four years a total of 1714 autopsies were performed by our department, out of these 100 were maternal deaths and included in this study. Maternal mortality autopsies constituted 5.83% of the total autopsies.

There were 44604 live births and 332 maternal deaths over the period from April 2011 to March 2015. Thus the calculated maternal mortality rate in our present study in the above mentioned duration was 744 per 1 lakh live births.

The maximum no. of maternal deaths occurred in the age group 20-24 years (45%). The youngest maternal death occurred at the age of 18 years while the eldest death occurred in the age of 39 years. 62% of maternal deaths occurred in multigravidae. majority of maternal deaths were seen in the postpartum period (75%). In the antepartum period maximum number of maternal deaths occurred in 3rd trimester (14%), followed by 2nd trimester (7%) and 1st trimester (4%) 76% of patients died due to indirect causes and only 24% patients died due to direct causes.

Table 1. Distribution of maternal deaths due to direct causes (24 cases)

Direct cause	No. of cases
Pregnancy induced hypertension	09
Acute fatty liver of pregnancy	03
Abruptio placenta	03
Disseminated intravascular coagulation following IUFD	02
Ectopic pregnancy	02
Placenta praevia	02
Rupture of uterus	01
Vesicular mole	01
Puerperal sepsis	01
Total	24

Pregnancy induced Hypertension: We had nine cases of pregnancy induced hypertension. At autopsy the liver on cut surface showed extensive areas of necrosis. (Fig. 1)



Fig. 1

Acute Fatty Liver of Pregnancy: At autopsy fatty liver was seen. On histology all the three cases showed micro vesicular fatty changes in liver with chronic inflammatory infiltrate in the periportal area and hepatic lobule with Kupffer cell hyperplasia. (Fig. 2) The cause of death was ascertained as hepatocellular failure in all the cases.

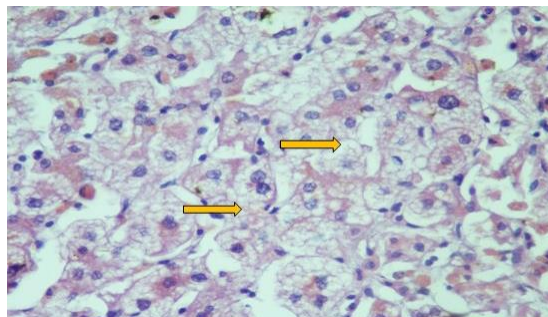


Fig. 2

Abruptio Placenta: There were three cases of abruptio placenta presented in the post-partum period and all were multigravidae.

Features of acute tubular necrosis were revealed on microscopy.

Placenta Praevia: At autopsy all organs were pale, liver showed macro vesicular fatty change and centrilobular necrosis. The cause of death in both the cases was hypovolemic shock following excessive bleeding in a case of placenta praevia.

Disseminated Intravascular Coagulation following Intrauterine Foetal Death: There were two multigravidae who presented in the 3rd trimester with intrauterine foetal death and pain in abdomen. At autopsy there were petechiae noted in the internal organs in the gastric mucosa, intestinal mucosa and capsule of liver. Histology revealed presence of fibrin thrombi in the renal and pulmonary microvasculature (Fig. 3).

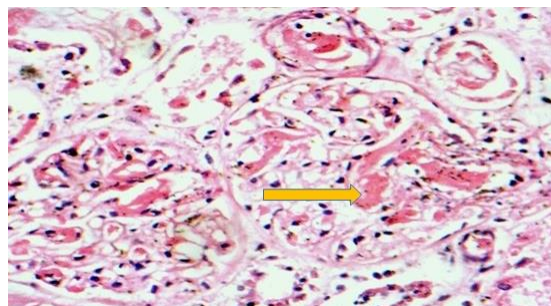


Fig. 3

Table 2. Distribution of maternal deaths due to indirect causes

Distribution of maternal deaths due to indirect causes	No. of cases
Infections	45
Sepsis	14
Coagulopathy	09
Hemodynamic causes	08
Total	76

Cerebral Infarct: Majority of the cases in this category were due to Dural venous thrombosis. All the four cases presented in postpartum period and were

multigravidae. At autopsy the superior sagittal sinuses showed beaded appearance and on cut opening showed thrombus. Two cases had associated cerebral infarcts and pin point haemorrhages in the right and left parietal lobes respectively (Fig. 4) one postpartum multigravida female died due to systemic thromboembolism embolism with coexisting pulmonary thromboembolism (Fig. 5) along with pulmonary infarct with splenic artery thrombosis with global splenic infarct.

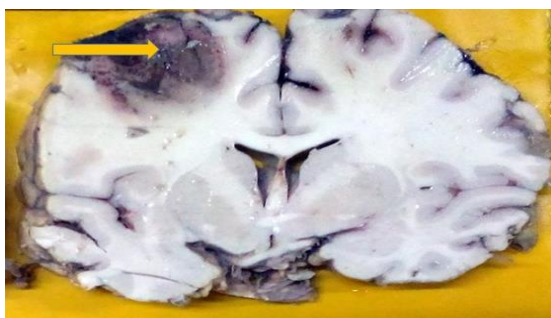


Fig. 4



Fig. 5

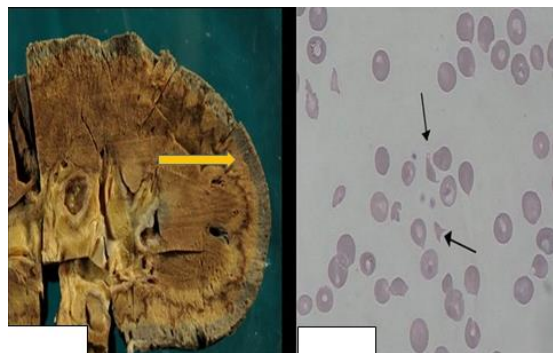


Fig. 6

Discussion

Our study was carried out in a tertiary care hospital in the Department of Pathology over a period of four years from April 2011 to March 2015. Over these four years a total of 1714 autopsies were performed by our department, Out of these 100 were maternal deaths and included in this study. Maternal mortality autopsies thus constituted 5.83% of the total autopsies.

The following table depicts the maternal mortality rate of our study in comparison to various national and international studies in tertiary care based institutes in both autopsy as well as clinical studies-

Table 3: Incidence of MMR

Authors	Maternal mortality rate per 1 lakh live birth
Panchabhai TS et al ^[45]	827
Jashnani KD et al ^[46]	1133
Nishu P et al ^{[47]*}	270.33
Zaman S et al ^{[48]*}	709.35
Walraven G et al ^{[49]*}	424
Present study	744

*Clinical studies

We observed that age of the patients in our present study ranged from 18 years to 39 years. Majority of the cases were in age group of 20-24 years (45%). Bardale RV et al⁵⁰ found the maximum number of maternal deaths in the age group 21-25 years (52.38%) similar to our study.

Influence of gravida on maternal mortality –

In our present study we found that the majority of maternal deaths occurred multigravidae (62%) which was similar to the study by Panchabhai TS et al⁴⁵ (62.45%). While in other studies by Nishu P et al⁴⁷

(49.48%), Puri A et al⁵¹ (51.53%) and Anandalakshmy PN et al⁵² (52.38%), there was an almost equal distribution amongst primigravidae and multigravidae.

Influence of gestational age on maternal mortality-

In our present study we observed that majority of maternal deaths were seen in the postpartum period (75%). In the antepartum period maximum number of maternal deaths occurred in 3rd trimester (14%), followed by 2nd trimester (7%) and 1st trimester (4%). In a study by Jashnani KD et al⁴⁶ postpartum deaths constituted 70% of maternal deaths and was comparable to our present study.⁵³

The following table depicts the comparison of direct and indirect causes of our present study with various national and international both autopsy as well as clinical studies-

Table 4: Distribution of direct and indirect causes

Author	Direct causes	Indirect causes
Jashnani K D et al ^[46] , n =89	38.2%	61.2%
Panchabhai TS et al ^[45] , n = 277	48.3%	51.7%
Fubara DS et al ^{[54]*} , n = 60	35%	65%
Puri A et al ^{[51]*} , n =72	55.39%	44.61%
Present study, n = 100	24%	76%

*clinical studies

The following table shows the various direct causes of maternal death in our present study and comparison with other studies

Table 5: Distribution of maternal deaths due to direct causes

Direct causes	Jashnani K D et al ^[46] , n =89	Panchabhai TS et al ^[45] , n = 277	Verma A et al ^{[55]*} n = 65	Surat Z et al ^{[48]*} n= 73	Present study n= 100
PIH	13.4%	14.44%	10.8%	28.7%	9%
AFLP	3.3%	2.53%			3%
Abruptio placenta		1.81%	10.2%	4%	3%
DIC f/g IUFD		2.17%			2%
Placenta praevia		0.71%	10.3%	3%	2%
Ectopic	1.1%		2.7%		2%
Rupture uterus	1.1%		4.1%		1%
Vesicular mole					1%
Puerperal sepsis	11.2%	5.78%	10.8%	9.5%	1%

*clinical studies

In the present study it was found that 9% of maternal deaths were due to pregnancy induced hypertension. Panchabhai TS et al⁴⁵ observed major cause of death in pregnancy induced hypertension to be DIC following sepsis. There incidence of cerebral edema and cerebral bleed was lower than us. Sawhney

H et al⁵⁶ analysed 69 maternal deaths due to eclampsia and found stroke (30.4%), cerebral bleed (31.8%), acute renal failure (34.8%) were the most common causes of death.

The following table depicts the distribution of various indirect causes of death by various studies and comparison with our present study.

Table 6: Indirect causes of death in pregnancy

Indirect causes	Jashnani K D et al ^[46] , n =89	Panchabhai TS et al ^[45] , n = 277	Verma A et al ^{[56]*} n = 65	Surat Z et al ^{[48]*} n= 73	Present study n=100
Acute hepatitis	41.5%	6.5%	4.6%		20%
Tuberculosis	2.2%	7.94%			10%
Pneumonia		0.72%			6%
Malaria	3.3%	2.17%			3%
Others	1.1%	4.07%			3%
Dengue					2%
Leptospirosis		1.08%			1%
Bronchopneumonia f/g sepsis		1.81%			15%
Acute pyelonephritis		2.89%			5%
Dural venous sinus thrombosis	1.1%	1.08%			4%
DIC					2%
Systemic Thromboembolism	1.1%				1%

Thrombotic microangiopathy					1%
Indirect causes	Jashnani K D et al ^[46] , n =89	Panchabhai TS et al ^[45] , n = 277	Verma A et al ^[56] n = 65	Surat Z et al ^[48] n= 73	Present study n=100
Dilated cardiomyopathy		0.72%			1%
Sickle cell anaemia	1.6%	1.72%			1%
Rheumatic heart disease	2.2%	7.58%		1.3%	1%

*clinical studies

In our present study, most common indirect cause of death in pregnancy was acute hepatitis (20%) followed by bronchopneumonia with sepsis (15%). Other indirect causes of death were tuberculosis (10%), pneumonia (6%), acute pyelonephritis (5%), dural venous sinus thrombosis (4%), malaria (3%), dengue (2%), DIC (2%), systemic thromboembolism (1%), thrombotic microangiopathy (1%), dilated cardiomyopathy (1%), sickle cell anemia (1%) and rheumatic heart disease (1%).

Jashnani KD et al⁴⁶ observed a high percentage of deaths due to acute hepatitis (41.5%) compared to our study (20%), while Panchabhai TS et al⁴⁵ and Verma A et al⁵⁶ found a lower incidence of acute hepatitis as an indirect cause of death compared to our study (20%) which was 6.5% and 4.6% respectively.

Panchabhai TS et al⁴⁵ found bronchopneumonia followed by sepsis as an indirect cause of death in 1.81% cases which was lower than our present study. (15%) and rheumatic heart disease in 7.58% cases which was higher than our present study (1%).

In our present study fulminant hepatitis was present in (20%) of the cases, other infections were tuberculosis in (10%), pneumonia (6%), malaria (3%), dengue (2%) and leptospirosis (1%) cases. Jashnani KD et al⁴⁶ found a higher incidence of maternal deaths due to fulminant hepatitis (41.5%) as compared to our study, while Menendez C et al⁶⁰ and Panchabhai TS et al⁴⁵ found fulminant hepatitis in 2.2% and 6.5% respectively.

Panchabhai TS et al⁴⁵ observed 7.9% maternal deaths due to tuberculosis which was comparable to our study, while Menendez C et al⁶⁰ and Jashnani KD et al⁴⁶ found lower incidence of 1.4% and 2.2% respectively.

We observed a lower incidence of malaria (3%) in comparison to study done by Menendez C et al⁶⁰ (10%). We did not observe any case of HIV in our present study.

Acute Hepatitis: Acute viral hepatitis constituted 20 cases (20%) of maternal deaths in our study, out of which 19 patients died due to hepatic failure and one died due to hepatic encephalopathy. Nagaria T et al⁶¹ studied acute viral hepatitis and observed hepatic encephalopathy as the most common cause of death (60%) followed by DIC (20%).

Khuroo and his colleagues noted a higher incidence of hepatitis E in pregnancy, eight times than in non-pregnant women, hepatitis was more than twice as common in 2nd trimester and 3rd trimester affected 22%

of pregnant women.⁶²

Anaemia: We had five maternal deaths (5%) due to severe anaemia with congestive cardiac failure. It has been estimated that 20% of maternal deaths in Africa can be attributed to anaemia.

Pituitary: We studied pituitary in all the cases and found pituitary necrosis in two cases (2%), and tubercular granuloma in one case (1%), while Jashnani KD et al⁴⁶ observed pituitary necrosis in 2 cases (2.24%) out of 89 cases. Sheehan's syndrome also known as postpartum anterior pituitary necrosis is caused due to ischemic necrosis due to blood loss and hypovolemic shock after child birth. Clinically the patient presents with postpartum haemorrhage, shock, headache, and diplopia.

Conclusion

The higher MMR in our study could be attributed to the fact that ours being a tertiary and referral care hospital, where patients are referred late and most of them are complicated cases and in serious condition at the time of admission. The low socioeconomic status of the patients, delay in referral and non-utilisation of the available antenatal care could be the major contributing factors.

Our study revealed majority of maternal deaths were due to indirect causes especially respiratory infections and hepatitis. Increased incidence of indirect causes reflect the present health care system. So adequate prenatal testing for these causes (infections), improving the nutritional status, sanitation can help in lowering the maternal mortality rate.

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