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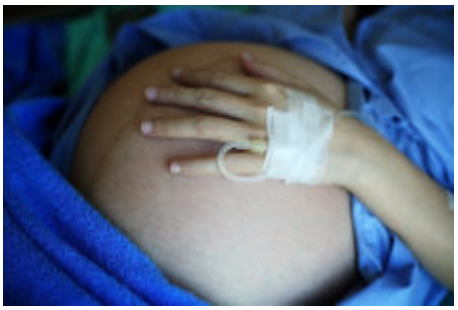
Pregnancy-Related Deaths Rising, But Why?

By Krystal Alexander — August 24, 2016



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The Centers for Disease Control and Prevention (CDC) [1] defines a pregnancy-related death as follows: The death of a woman while pregnant or within 1 year of pregnancy termination—regardless of the duration or site of the pregnancy—from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes.

The CDC began national surveillance of the issue in 1986. Since then there has been a steady increase in the number of reported pregnancy-related deaths up to 2012 (last reported data), from 7.2 deaths per 100,000 live births to 15.9 deaths per 100,000 respectively. The highest mortality ratio was seen in 2009, and then again in 2011, with 17.8 pregnancy-related deaths per 100,000 live births. The increase on its own may not turn heads, but in a global context, it depicts a slowly growing problem when compared to [2] figures from other developed countries. And even more worrisome, experts have been unable to clearly identify the overall cause for the increase.

Along with the rise in pregnancy-related deaths, there has been the predominance of chronic lifestyle diseases among women of childbearing age. Increasing numbers of women now enter pregnancy with a preexisting cardiovascular issue, which may or may not be adequately controlled or treated. Most commonly this includes hypertension, diabetes, obesity, and chronic heart disease. This situation is reflected in statistics that show cardiovascular diseases accounted for 14.7 percent of pregnancy-related deaths within the US from 2011-2012. Additionally, cardiomyopathy and hypertensive disorders of pregnancy accounted for 10.8 and 7.6 percent respectively, during the same time period.

The problem is perpetuated and facilitated by the excellent quality of care these patients are offered through specialty and high risk obstetric clinics and hospital services. Instead of placing the focus on preventive medicine and prenatal counseling, we have thrown our resources and expertise toward serving an unhealthy female population in an attempt to carry a fetus to term in less than acceptable circumstances. What we should be doing is offering prenatal counseling to all women of childbearing age prior to conception. While I respect women's rights, there is an ethical conundrum that exists when a poorly controlled diabetic or a morbidly obese woman presents to an antenatal clinic. The level of care and attention her case requires is considerably greater than

that for a non-diabetic, non-obese woman. The reasonably anticipated complications, for both mother and baby, are numerous. The need for operative intervention for delivery must be discussed, and as with any surgical intervention, the risk of morbidity and mortality increases.

By no means am I advocating for (or against) abortion. But I think there is a conversation to be had with regards to the moral responsibility a physician bears to educate his/her patient on how a pregnancy can exacerbate an underlying condition. These patients may not always comprehend the risks they subject themselves to. A pathologist I once worked with considered pregnancy to be a pathological state by virtue of the myriad of physiologic changes that occur. At the time I thought he was joking. But in retrospect, it's a valid argument. When the body already has to cope with an underlying chronic condition, its resilience is tested if a fetus is added to the equation.

The US healthcare system is remarkable. So remarkable that it appears we are now biting off more than we can chew, figuratively speaking. It seems our egos have grown just as much as the waistlines of those women of childbearing age. We assume that our robust healthcare system, our practice of evidence based medicine, and the collective experience of our best physicians have made us into an entity capable of handling anything. However, bowing out when the situation calls for it is as admirable as knowing when to take on a challenge. The physicians who take calculated risks, and not just any risk, are the ones who likely can best contribute to this dialogue. These include the specialists who recognize not just their own strengths and weaknesses, but are also acutely aware of the shortcomings of the healthcare infrastructure they work within. And from a public healthcare standpoint, the shortcoming appears to be that overall we are dealing with a baseline unhealthy population. When we begin to adequately address these chronic lifestyle diseases and cardiac conditions prior to pregnancy, I would hazard a guess that the statistics will change.
