17th World Congress in Fetal Medicine

Palliative care in fetal medicine

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Objective

When faced with a diagnosis of a lethal abnormality, the majority of patients opt for termination of pregnancy. However, a smaller minority opt to continue with their pregnancy, and a suitable palliative care plan with a multidisciplinary approach is required in these cases to achieve the best possible outcome for these families.

Methods

Between January 2017 and January 2018 there were four pregnancies within our department with a suspected lethal abnormality where the parents opted not to have a termination of pregnancy. There were two cases of Trisomy 18, one case of hypoplastic left heart syndrome, and one case of a DCDA pregnancy with anencephaly in twin 2.

Results

The first case of Trisomy 18 had a constellation of abnormalities including radial hyperplasia, bilateral choroid plexus cysts, talipes of left foot and atrioventricular septal defect detected at anomaly scan. Karyotyping confirmed Trisomy 18. The couple were counselled regarding the likely outcome and a palliative delivery care plan was made which included intrapartum management. She attended in labour at 35+5 gestation and was found to have an abnormal CTG. The couple opted to have a Caesarean Section as it was important to them that everything possible was done for their baby. Although their baby passed away hours after being born, the couple were satisfied that this was the best possible outcome for them given the circumstances. The second case of Trisomy 18 had a large ventricular septal defect detected on scan. The couple attended for delivery planning where they expressed a desire to have an elective caesarean section due to a previous traumatic birth experience as well as to prevent any possibility of intrapartum fetal demise. Shortly after their delivery planning appointment however, there was an intrauterine fetal demise at 31 weeks gestation. The third case was a case of hypoplastic left heart syndrome for which the couple were aware that only palliative surgery could be offered. As they were committed to the pregnancy, they were referred to a tertiary unit for consideration of a Norwood procedure in the immediate newborn period. The fourth case was a DCDA twin pregnancy with anencephaly in twin 2. The couple were given the option to terminate the entire pregnancy or the affected twin or continue with the pregnancy. They were committed to carrying on with the twin pregnancy and were keen to consider organ donation of the anencephalic twin. An amniodrainage was done antenatally and she went on to deliver at 37 weeks via elective Caesarean Section and the twin with anencephaly passed away shortly after birth.

Conclusion

Palliative care remains an important aspect of fetal medicine. In patients who are committed to pregnancies with lethal abnormalities, careful antenatal counselling of the couple is required regarding the management of potential ante and intrapartum complications and the ethical considerations involved.