

History of Spontaneous Abortion, Fetal or Neonatal Loss

Definition/ cut-off value

A spontaneous abortion (SAB) is the spontaneous termination of a gestation at < 20 weeks gestation or < 500 grams

Fetal death is the spontaneous termination of a gestation at ≥ 20 weeks

Neonatal death is the death of an infant within 0-28 days of life.

Pregnant women: any history of fetal or neonatal death or 2 or more spontaneous abortions.

Breastfeeding women: most recent pregnancy in which there was a multifetal gestation with one or more fetal or neonatal deaths but with one or more infants still living

Non-Breastfeeding: most recent pregnancy

Presence of condition diagnosed by a physician as self reported by applicant/participant/caregiver; or as reported or documented by a physician, or someone working under physician's orders.

Participant category and priority level

Category

Priority

Pregnant Women

I

Breastfeeding Women

I

Non-Breastfeeding Women

III, IV, V, or VI

Justification

Pregnancy:

Previous fetal and neonatal deaths are strongly associated with preterm low birth weight (LBW) and small for gestational age (SGA) and the risk increases as the number of previous poor fetal outcomes goes up.

Spinnillo et al found that the risk for future small for gestational age outcomes increased two fold if a woman had 2 or more SAB. Adverse outcomes related to history of SAB include recurrent SAB, low birth weight (including preterm and small for gestational age infants), premature rupture of membranes, neural tube defects and major congenital malformations. Nutrients implicated in human and animal studies include energy, protein, folate, zinc, and vitamin A.

Postpartum women:

A SAB has been implicated as an indicator of a possible neural tube defect in a subsequent pregnancy. Women who have just had a SAB or a fetal or neonatal death should be counseled to increase their folic acid intake and delay a subsequent pregnancy until nutrient stores can be replenished.

The extent to which nutritional interventions (dietary supplementation and counseling) can decrease the risk for repeat poor pregnancy outcomes, depends upon the relative degree to which poor nutrition was implicated in each woman's previous poor pregnancy outcome. WIC Program clients receive foods and services that are relevant and related to ameliorating adverse pregnancy outcomes. Specifically, WIC food packages include good sources of implicated nutrients. Research confirms that dietary intake of nutrients provided by WIC foods improve indicators of nutrient status and/or fetal survival in humans and/or animals.

References

1. American College of Obstetricians and Gynecologists. Preterm Labor. Technical Bulletin 206. Washington, DC: ACOG, 1995.
 2. Carmi R, Gohar J, Meizner I, Katz M. Spontaneous abortion--high risk factor for neural tube defects in subsequent pregnancy [see comments]. *Am.J.Med.Genet.* 1994;51:93-7.
 3. Institute of Medicine, Committee to Study the Prevention of Low Birth Weight. Preventing low birth weight. National Academy Press, Washington, D.C.; 1985.
 4. Institute of Medicine. Nutrition during pregnancy. National Academy Press, Washington, D.C.; 1990.
 5. Kramer MS. Intrauterine growth and gestational duration determinants. *Pediatrics* 1987;80:502-11.
 6. Paz JE, Otano L, Gadow EC, Castilla EE. Previous miscarriage and stillbirth as risk factors for other unfavourable outcomes in the next pregnancy. *Br.J.Obstet.Gynecol.* 1992;99:808-12.
 7. Shapiro S, Ross LF, Levine HS. Relationship of selected prenatal factors to pregnancy outcome and congenital anomalies. *Am.J.Public Health* 1965;55;2:268-282.
-

8. Spinillo A, Capuzzo E, Piazzzi G, Nicola S, Colonna L, Iasci A. Maternal high-risk factors and severity of growth deficit in small for gestational age infants. *Early Hum.Dev.* 1994;38:35-43.
 9. Thorn DH. Spontaneous abortion and subsequent adverse birth outcomes. *Am.J.Obstet.Gyn.* 1992;111-6.
-

Clarification

NOTE: A woman who becomes pregnant within 16 months after a SAB (her first) would qualify for risk #332, Closely Spaced Pregnancies.

Self-reporting for “History of...” conditions should be treated in the same manner as self-reporting for current conditions requiring a physicians diagnosis, i.e., the applicant may report to the CPA that s/he was diagnosed by a physician with a given condition at some point in the past. As with current conditions, self-diagnosis of a past condition should never be confused with self-reporting.
