Inappropriate Use of the Terms Fetal Distress and Birth Asphyxia

ABSTRACT: The Committee on Obstetric Practice is concerned about the continued use of the term “fetal distress” as an antepartum or intrapartum diagnosis and the term “birth asphyxia” as a neonatal diagnosis. The Committee reaffirms that the term fetal distress is imprecise and nonspecific. The communication between clinicians caring for the woman and those caring for her neonate is best served by replacing the term fetal distress with “nonreassuring fetal status,” followed by a further description of findings (eg, repetitive variable decelerations, fetal tachycardia or bradycardia, late decelerations, or low biophysical profile). Also, the term birth asphyxia is a nonspecific diagnosis and should not be used.

The Committee on Obstetric Practice is concerned about the continued use of the term “fetal distress” as an antepartum or intrapartum diagnosis and the term “birth asphyxia” as a neonatal diagnosis. The Committee reaffirms that the term fetal distress is imprecise and nonspecific. The term has a low positive predictive value even in high-risk populations and often is associated with an infant who is in good condition at birth as determined by the Apgar score or umbilical cord blood gas analysis or both. The communication between clinicians caring for the woman and those caring for her neonate is best served by replacing the term fetal distress with “nonreassuring fetal status,” followed by a further description of findings (eg, repetitive variable decelerations, fetal tachycardia or bradycardia, late decelerations, or low biophysical profile). Whereas in the past, the term fetal distress generally referred to an ill fetus, nonreassuring fetal status describes the clinician’s interpretation of data regarding fetal status (ie, the clinician is not reassured by the findings). This term acknowledges the imprecision inherent in the interpretation of the data. Therefore, the diagnosis of nonreassuring fetal status can be consistent with the delivery of a vigorous neonate.

Because of the implications of the term fetal distress, its use may result in inappropriate actions, such as an unnecessarily urgent delivery under general anesthesia. Fetal heart rate patterns or auscultatory findings should be considered when the degree of urgency, mode of delivery, and type of anesthesia to be given are determined. Performing a cesarean delivery for a non-
reassuring fetal heart rate pattern does not necessarily preclude the use of regional anesthesia.

Since October 1, 1998, all inclusion terms except “metabolic acidemia” have been removed from the International Classification of Diseases code for fetal distress. The Committee believes that there should be uniformity in wording. The International Classification of Diseases, Ninth Revision, Clinical Modification code for fetal distress is based on fetal metabolic acidemia and excludes abnormal fetal acid–base balance, abnormality in fetal heart rate or rhythm, fetal bradycardia, fetal tachycardia, and meconium in liquor.

The term birth asphyxia is a nonspecific diagnosis and should not be used. The Committee strongly supports the criteria required to define an acute intrapartum hypoxic event sufficient to cause cerebral palsy, as modified by the ACOG Task Force on Neonatal Encephalopathy and Cerebral Palsy from the template provided by the International Cerebral Palsy Task Force (1) (Box 1).

### Criteria to Define an Acute Intrapartum Hypoxic Event as Sufficient to Cause Cerebral Palsy

1. **Essential criteria (must meet all four)**
   1. **Evidence of a metabolic acidosis in fetal umbilical cord arterial blood obtained at delivery (pH <7 and base deficit ≥12 mmol/L)**
   2. **Early onset of severe or moderate neonatal encephalopathy in infants born at 34 or more weeks of gestation**
   3. **Cerebral palsy of the spastic quadriplegic or dyskinetic type***
   4. **Exclusion of other identifiable etiologies, such as trauma, coagulation disorders, infectious conditions, or genetic disorders**

1. **Criteria that collectively suggest an intrapartum timing (within close proximity to labor and delivery, eg, 0–48 hours) but are nonspecific to asphyxial insults**
   1. **A sentinel (signal) hypoxic event occurring immediately before or during labor**
   2. **A sudden and sustained fetal bradycardia or the absence of fetal heart rate variability in the presence of persistent, late, or variable decelerations, usually after a hypoxic sentinel event when the pattern was previously normal**
   3. **Apgar scores of 0–3 beyond 5 minutes**
   4. **Onset of multisystem involvement within 72 hours of birth**
   5. **Early imaging study showing evidence of acute nonfocal cerebral abnormality**

*Spastic quadriplegia and, less commonly, dyskinetic cerebral palsy are the only types of cerebral palsy associated with acute hypoxic intrapartum events. Spastic quadriplegia is not specific to intrapartum hypoxia. Hemiparetic cerebral palsy, hemiplegic cerebral palsy, spastic diplegia, and ataxia are unlikely to result from acute intrapartum hypoxia (Nelson KB, Grether JK. Potentially asphyxiating conditions and spastic cerebral palsy in infants of normal birth weight. Am J Obstet Gynecol 1998;179:507–13.).


### References