Decreased fetal movements (DFM) – finding the balance

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To the editor,

We wish to thank Saunders and Griffin for their interest in our guideline.¹ While stillbirth is becoming increasingly recognised as an important public health issue, it remains a devastating outcome, not only for the parents and family who experience the loss, but also for their healthcare providers.²

Unfortunately, an increased focus on stillbirth has not yet been matched with evidence to improve its prediction and prevention. Decreased fetal movements (DFM) from 28 weeks gestation is a worrying symptom reported by 10-15% of pregnant women.³ DFM may represent a change in fetal activity in response to a specific underlying cause such as fetal growth restriction, placental dysfunction, foeto-maternal haemorrhage or fetal abnormality. The risk of stillbirth associated with DFM is increased across all gestational age groups after 28 weeks gestation.⁴ Despite evidence demonstrating a strong association between DFM and stillbirth, the majority of women reporting DFM will have a healthy baby.³

Surveys across Australia and New Zealand have demonstrated a wide variation in practice in response to the symptom of DFM.³ The guideline⁵ was developed in response to this variation and a call from women and clinicians to standardise care.

Our current tools for the assessment of fetal health have recognised limitations and any expectation that all stillbirths are preventable is unrealistic. Balancing a rational approach to the investigation and care of women who present with DFM challenges us to be mindful of the consequences of intervention in situations where there is no demonstrable underlying pathology. It is also important to acknowledge that following the birth of a stillborn baby, information may be revealed about the cause that was not identified, or possibly, not identifiable antenatally.

While we (and others) are actively seeking answers to better inform the management of women who report DFM, we should remember that the symptom of DFM is not a diagnosis of impending fetal death and, in the majority of cases, presents an opportunity to investigate further and provide reassurance to continue a pregnancy rather than resorting to early delivery out of fear.

We agree with the authors of the AFFIRM trial that until further data from current studies (My Baby's Movements in Australia and Mindfetalness in Sweden) and the planned individual participant data meta-analysis are forthcoming, current practices around responding to maternal concern of DFM

should remain unchanged.⁶ How clinicians ultimately respond to concerns of DFM has an important influence in determining the outcome for a pregnancy.

References

1. Daly LM, Gardener G, Bowring V, et al. Care of pregnant women with decreased fetal movements: update of a clinical practice guideline for Australia and New Zealand. *Aust N Z J Obstet Gynaecol* 2018; 58: 463–468.
2. Heazell AEP, Siassakos D, Blencowe H, et al. Stillbirths: economic and psychosocial consequences. *Lancet* 2016; 387(10018): 604–616.
3. Flenady V, MacPhail J, Gardener G, et al. Detection and management of decreased fetal movements in Australia and New Zealand: a survey of obstetric practice. *Aust N Z J Obstet Gynaecol* 2009; 49(4): 358–363.
4. Stacey T, Thompson JMD, Mitchell EA et al. Maternal perception of fetal activity and late stillbirth risk: findings from the Auckland stillbirth study. *Birth* 2011; 38(4): 311–316.
5. Gardener G, Daly L, Bowring V, et al. Clinical practice guideline for the care of women with decreased fetal movements. Brisbane, Australia: Centre of Research Excellence in Stillbirth, 2017.
6. Norman JE, Heazell AEP, Rodriguez A, et al. Awareness of fetal movements and care package to reduce fetal mortality (AFFIRM): a stepped wedge, cluster-randomised trial. *Lancet* 2018; 392(10158): 1629–1638.