American Journal of Obstetrics and Gynecology

Founded in 1920

volume 185 *number* 3 SEPTEMBER 2001

CLINICAL OPINION

Perinatal hospice

Nathan J. Hoeldtke, MD,[a] and Byron C. Calhoun, MD[b]

Honolulu, Hawaii, and Tacoma, Washington

When the prenatal diagnosis of a lethal fetal anomaly has been established, some patients choose to continue their pregnancy. Currently, there is a paucity of medical literature addressing the specific management of families in this unique circumstance. We propose a model of care that incorporates the strengths of prenatal diagnosis, perinatal grief management, and hospice care to address the needs of these families. We discuss the identification of candidates for this form of care; the multidisciplinary team approach; and the aspects of antepartum, intrapartum, and postpartum care. Finally, we discuss some barriers that might need to be overcome when attempting to implement perinatal hospice care. (Am J Obstet Gynecol 2001;185:525-9.)

Key words: Perinatal hospice, perinatal grief, lethal anomaly, prenatal diagnosis

Congenital anomalies are now the leading cause of death through the first year of life.[1] Many congenital defects, such as anencephaly or bilateral renal agenesis, are lethal conditions that may be diagnosed during the antenatal period. Generally, when a diagnosis of a lethal anomaly has been established, parents are confronted with 2 options: termination of the pregnancy or expectant management, "letting nature take its course." Although much has been written about the management of those choosing termination of pregnancy under these circumstances, there is little in the medical literature to specifically guide clinicians caring for families choosing to continue these pregnancies.

We believe that the strengths of 3 medical and social advances of the past 4 decades can be integrated in an organized program to comprehensively and effectively address the needs of these families. These advances include the capability for accurate prenatal diagnosis, a new understanding and appreciation of perinatal grief, and the advent of modern hospice care. Uniting key features of these disciplines and applying them to the care of these families results in a model that we refer to as *perinatal hospice.*

From the Department of Obstetrics and Gynecology, Tripler Army Medical Center,[a] and the Department of Obstetrics and Gynecology, Madigan Army Medical Center.[b]

The opinions or assertions contained herein are the private views of the authors and are not to be construed as official or reflecting the views of the Department of the Army or the Department of Defense.

Received for publication October 5, 2000; revised February 20, 2001; accepted March 30, 2001.

Reprint requests: Nathan J. Hoeldtke, MD, Department of Obstetrics and Gynecology, Tripler Army Medical Center, Honolulu, HI 96859.

6/1/116093

doi:10.1067/mob.2001.116093

The current situation

Prenatal diagnosis of fetal pathology was virtually impossible before the last half of the 20th century. The first prenatal diagnosis of a significant congenital anomaly was the sonographic diagnosis of anencephaly, reported in 1964.[2] This was followed by the prenatal diagnosis of a fetal karyotype abnormality in 1968.[3] Subsequently, the revolutions in diagnostic imaging and molecular genetics have resulted in a rapidly expanding roster of conditions that can be detected in the prenatal period. New uses for maternal serum analyte screening and the increased application of routine prenatal sonography ensure that many cases of fetuses with lethal conditions will continue to be uncovered during the prenatal period. Accumulated experience and refinements in diagnostic technique are also enabling better prognostication about the severity of many prenatal diagnoses, including those with potentially lethal consequences.

Unfortunately, despite some hopeful advances in fetal therapy, the ability to accurately diagnose a fetal condi-