Hoped-for drop in childbirth deaths not happening

March 9 2010, By LAURAN NEERGAARD , AP Medical Writer

This Oct. 2007 family photo provided by Clare Johnson shows Linda Coale holding her son Benjamin in Crownsville, Md. Eleven days after her son Benjamin's birth by C-section, Linda Coale awoke in the middle of the night in pain, one leg badly swollen. Just as her doctor returned her phone call asking what to do, she dropped dead from a blood clot. (AP Photo/Family Photo)

(AP) -- Eleven days after her son Benjamin's birth by C-section, Linda Coale awoke in the middle of the night in pain, one leg badly swollen. Just as her doctor returned her phone call asking what to do, she dropped dead from a blood clot.

Pregnancy-related deaths like Coale's appear to have risen nationwide over the past decade, nearly tripling in the state with the most careful count - California. And while they're very rare - about 550 a year out of 4 million births nationally - they're nowhere near as rare as they should

be. The maternal mortality rate is four times higher than a goal the federal government set for this year.

"It's unacceptable," says Dr. Mark Chassin of The Joint Commission, the agency that accredits U.S. hospitals and which recently issued an alert to hospitals to take steps to protect mothers-to-be. "Maybe as many as half of these are preventable."

Two years after Coale's death near Annapolis, Md., her sister says topping that list should be warning women about signs of an emergency, like the clot called deep vein thrombosis, or DVT, that can kill if it breaks out of the leg and moves to the lung.

"All she wanted to do was have her own family, and when she finally gets that privilege, she's no longer with us," says Clare Johnson, who says her sister's only risk was being pregnant at age 35.

Maternal mortality gets little public attention in the U.S., aside from last year's worry over the swine flu that killed at least 28 pregnant women. Among the leading preventable causes are hemorrhage, DVT-caused pulmonary emboli and uncontrolled blood pressure.

It's not clear what's fueling the overall increase, although better counting is playing some role. But there are some suspects: A jump in cesarean deliveries that now account for almost a third of births. One in five pregnant women is obese, spurring high blood pressure and diabetes. More women are having babies in their late 30s and beyond.

"It can be a death here, a death there," says Dr. Elliott Main of the California Maternal Quality Care Collaborative, whose research is helping to uncover the rise. "Any one doctor or any one hospital hasn't really seen this change."

When he shows the statistics at medical meetings, "everybody sits up."

More startling, black women are at least three times more likely to die from pregnancy complications than white women, and research is too limited to tell why.

Then there are the near-misses. For every death, 50 additional women suffer serious complications of pregnancy or delivery, notes Dr. Jeffrey King of the University of Louisville, a spokesman for the American College of Obstetricians and Gynecologists.

At issue are deaths directly related to pregnancy or childbirth, up to 42 days after delivery. In 2006, the latest year for which data were available, there were 13.3 maternal deaths for every 100,000 births. A decade ago, the rate hovered around 7 - and by this year, the U.S. government had hoped to lower it to 3.3 deaths. California in 2006 charted 16.9 maternal deaths for every 100,000 births, up from a rate of 5.6 in 1996.

How pregnancy-related deaths are coded and counted changed during that time period, but Main says only about 30 percent of the increase may be due to that.

At the request of California health officials, Main is finishing an in-depth study of maternal deaths that already has prompted a project to reduce hemorrhage in 30 of the state's hospitals.

"Jumping on it early is very important," says Main, who worries that hospitals can lose track of bleeding that happens a bit at a time until "before you know it, you've bled a lot."

Among other safety steps:

-Seek early prenatal care to control underlying disorders and check for DVT risk. Pregnancy makes everyone's blood clot more easily. At extra risk are women who've already had a clot or whose relatives have, who are obese or who have varicose veins, says Dr. Geno Merli of Thomas Jefferson University Hospital. They may need blood-thinning medication.

C-sections, like any major surgery, also add to the risk.

Andrea Darling of Skillman, N.J., suffered a DVT in her first trimester in 2002 and endured months of treatment and anxiety before her son was born healthy. Darling already was being treated for a genetic clotting disorder but says patient education helped her take extra steps to avoid a C-section.

-Hospitals should consider using compression boots on C-section patients, says King. They help keep blood from settling in the lower legs.

-C-sections can be lifesaving but women should understand how to reduce their chances of needing one - because next pregnancies tend to end in C-section, too, and repeat C-sections increase hemorrhage risk. Coming to the hospital before you're properly dilated or seeking induction before the cervix is ready unnecessarily increases the C-section risk, Main says.

There often aren't clear explanations for these deaths, and Maryland's Clare Johnson tries not to wonder if anything could have saved her sister, because that's impossible to know.

Still, she urges better education about DVT as the family watches her nephew Benjamin, now 2, grow.

"He is truly our blessing in all this," Johnson says. "He's truly what gets

us through."

More information: Data from California Maternal Quality Care Collaborative: http://www.cmqcc.org/maternal-mortality