Personal Paper

Stillbirth: a personal experience

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When our first child was stillborn on 13 February 1983 our worst fears were realised. We had both witnessed obstetric and paediatric disasters in our clinical careers and had friends who had lost children through malignant disease and the sudden infant death syndrome, so there was no immediate feeling of, "Why us?" We had even discussed how we would cope with a sick or malformed infant, and two nights before I went into hospital my husband dreamt that the baby would be stillborn. Having been brought up with a severely physically and mentally handicapped brother, I personally had no doubts that a dead child would be easier to accept than a brain damaged one, and when a scan confirmed that our baby had indeed died in utero the release of tension was so immense that I wanted to jump off the trolley and go home, only then realising that labour and childbirth were still to be endured. Like most mothers I could write a book about the rites of passage through antenatal clinic and labour ward but will confine myself to observing that I felt a real sense of achievement when my son was finally delivered, in spite of the macabre circumstances, and that I shall be eternally grateful for the miracle of epidural anaesthesia.

I was fortunate in having read recent articles on the management of perinatal death^{1,2} and had the presence of mind to ask for a photograph of Alasdair. A Polaroid camera was willingly produced from the special care baby unit, but the picture was so blurred that my husband raced home to fetch his own cameras. These photographs and slides have since become a great source of comfort and have enabled our parents to see their lost grandson. I was gently coaxed into holding him, and my initial revulsion disappeared on seeing that he was not damaged or deformed. Time passed all too quickly, and allowing him to be taken away to the mortuary was the hardest thing that I have ever had to do.

I was discharged home the following day, a merciful release after a night in a single room where the only sound was the crying of babies whom I could neither see nor comfort. Returning home without our own baby, dismantling the crib, and packing away the tiny useless garments were all predictably heart rending tasks, but we were sustained by the overwhelming support of our friends. Numb with shock, we drifted into a bizarre holiday mood and for a fortnight lived on a diet of wine and chocolates provided by well wishers.

I developed an irresistible urge to describe our ordeal in minute detail to anyone who would listen and have since discovered that this is a common reaction. As my husband returned to work my gloom deepened, the need to find an explanation for our misfortune increased, and I developed an intense desire to read everything ever written about the subject of stillbirth,

becoming exasperated at the apparent dearth of such literature in my local library and bookshops. I have since accumulated an extensive collection of books, medical articles, and newspaper cuttings, which has satisfied this extraordinary craving, but I would have appreciated something from the hospital, perhaps the pamphlet *The Loss Of Your Baby*,³ which might have soothed me in those frantic early days.

Service for perinatal casualties

My return to health was disappointingly slow, and although the discomforts of stitches and swollen breasts were a distraction from morbid reflections, I had several minor problems which I ignored once the midwives had completed their visits, resulting in my readmission to hospital after a month. Without the normal mother's passport of a baby to facilitate entry to the surgery or clinic it is surprisingly difficult to cry for help, and I should like to make a plea for hospitals to provide a service for the parents of perinatal casualties through which they could informally seek health advice and receive genetic, obstetric, and bereavement counselling—a one off postnatal consultation at six weeks is not enough. At first I suffered from attacks of panic and breathlessness in crowded places but quickly overcame these. Losing weight was a more intractable problem, and I thought ruefully of all the times I had been told, "You'll lose it soon enough once you're breast feeding."

Going back to work was a tremendous morale booster and my physical state immediately improved. I needed to know that I was still capable of doing a useful job and I am grateful to my colleagues for their tactful encouragement. We have received help from unexpected quarters and have found the most supportive people to be those who scarcely knew us before Alasdair's death. Perhaps we should not be surprised that our families and oldest friends have been less articulate—they too are grieving—but it is hard not to let a chance remark create barriers. We rapidly became immune to inquiries about the baby's health from those unaware of our history, but a statement like "I don't know how two doctors could have allowed their baby to die" is less easily forgotten.

Although already aware of the existence of the Stillbirth and Perinatal Death Association, I was determined to struggle along on my own and was vaguely mistrustful of self help organisations. In the fourth month, however, my inexorable depression reached the point where I knew I must overcome such prejudices and, contacting my local branch, I found what I so desperately needed, a group among whom I could ask questions and compare grievances without being a bore. I also gained an impression of two distinct types of women: those who had made a good recovery and were directing their compassion and skills towards helping others, and those who seemed to have been severely crippled by their loss. This discovery was both reassuring and chastening and strengthened my resolve to emulate the former species.

Looking back over these past months we can acknowledge

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many mistakes and particularly regret the blunder we made over the burial. My initial wish for a private funeral seemed a foolishly extravagant and self indulgent way of commemorating Alasdair so we opted for a free hospital burial, little realising that this meant consigning him to an anonymous, multiple grave. We chose not to attend the interment knowing that it would be too agonising, and when I later visited the cemetery I was unable to find any trace of his grave, merely being told by the attendant that it must be somewhere in the common ground. While in no way wishing to imply that we were coerced into this arrangement, I think that greater emphasis should be laid on the importance of making a rational decision in one's own time and that parents should be aware that although they can ask which cemetery their child is to be buried in, the grave itself may be unidentifiable.

Registration procedure

The experience of registering a stillbirth was also unexpectedly gruelling, the registrar's main preoccupation being whether we could prove that we were married. I was shocked to emerge from the office a few minutes later with nothing but a small receipt giving the hospital permission to proceed with the burial. I had misguidedly thought that we would be given the chance to name our baby and would receive a certificate to keep. I understand that the registration procedure in England and Wales has been modified since 1 April 1983 to take these factors into consideration and that the Scottish system is also under review—too late for us, but I am sure that it will be of great benefit of other parents.

We both want to be positive about our experiences and would like to help others in a similar plight. The current research interest in the psychological aftermath of perinatal morbidity is encouraging but makes it all the more distressing to come up against outmoded hospital customs. Local policy made it almost inevitable that I would be returned from the delivery suite to a ward full of babies, but we both feel strongly that it should have been possible to find me a bed elsewhere in the hospital, perhaps in the nearby gynaecological ward. As doctors we ought to be able to tackle the system from the inside but have so far found ourselves to be as impotent as our lay companions.

We are naturally very nervous about future pregnancies and, working as I do in a department of child psychiatry, I wonder about the emotional development of later children of bereaved parents. Tragedy has taught us many valuable lessons, not least the recognition of each other's strengths and weaknesses. It will always be sad to remember Alasdair's birthday so we have decided instead to celebrate the date of his conception and to rejoice in his brief but enlightening existence.

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Clinical curio: *Tribolium* Macleay (Coleoptera: Tenebrionidae) infestation in children

During November 1980 one of us (BBB) took part in the pathological investigation of several children in Lancaster after a minute black insect had been observed on the scalps of two young girls. The first girl, aged 4 years, had a scab on the scalp which was lifted by the mother, who observed the insect underneath the scab. Consequently, seven associated children were examined, and a further insect was noted in a second girl, aged 6 years. The two girls were playmates and were the only children of the group thus affected, although several (not the girl with the scab) had pediculus eggs (nits).

One of the insects was sent to YZE, who identified it as a species of *Tribolium* Macleay (Coleoptera: Tenebrionidae) and it was specifically identified as *T. destructor* Uyttenboogaart by DJ de CH. This species is a pest of stored products in the British Isles, although it is not as important a pest as the two other British species of *Tribolium*: *T. castaneum* (Herbst) and *T. confusum* Jacquelin du Val. It is, however, the species most commonly found in human habitations.¹

We could find no reference to the occurrence of *Tribolium* or any other Tenebrionid in man in the medical or entomological publications. Laurent, however, records the effects of the secretion of another Tenebrionid, *Blaps nitens* Cast, during routine handling in the laboratory²; the beetles were reported to eject their secretion on to the author when handled, causing a burning sensation on the nose and lips. Another species of *Blaps* *Fabricius*, *B. judaeorum* Miller, ejects a fluid that causes blisters on the skin. Although the vesicant properties of blister beetles of the family Meloidae have long been appreciated,^{3,4} the effects of the toxic secretions of the thoracic and abdominal glands of Tenebrionidae do not seem to be well documented in this regard. In his review of the medical importance of Coleoptera, Theodorides mentions Tenebrionidae only as intermediate hosts of helminths.⁵

The chemical composition of the odorous secretion of *Tribolium* species has been studied in some detail,⁶⁻¹⁰ and in all three British species it has been found to be mainly composed of quinones, whereas the secretion of Meloid beetles is cantharidin (C₁₀H₁₂O₄).⁵ Quinones are known to be carcinogenic, and a possible correlation between human malignancy and flour that has been contaminated by quinone secreting species of *Tribolium* has been suggested.¹¹ The secretion is highly toxic to the beetles themselves⁸ and is said to have bactericidal properties.⁹ The function of these secretions is presumably defensive.

To see if any harmful effects were produced by the beetle on the skin a single living specimen of *T. castaneum* was placed (ventral side

down) on YZE's left forearm and kept in position with sticky tape, the right arm acting as a control. After about an hour a mild irritating sensation was felt, which continued, but did not appreciably increase, during the next four hours, after which the beetle was removed and the arm examined. A slight depression was noted and the skin was raw. The injury healed within a day or two and no scar was left. This sort of injury is in sharp contrast to the fluid filled bullae caused by the cantharidin secreted by Meloids; in cases where severe vesiculation has occurred a noticeable scar is usually left.

Inquiries regarding the source of infection in the Lancaster children showed no association with stored products. The only positive finding was that all four parents concerned worked in the National Health Service. Any of them could therefore have acted as a vector with regard to one or both of the children, although if this were the case the infestation may have been more widespread than the two observed cases would suggest. We would like to thank Dr Lewis Davies of the Department of Zoology, University of Durham, for reading and commenting on the manuscript.—B B BEESON, consultant pathologist, Lancaster; D J DE COURCY HENSHAW, Waltham Abbey; Y Z ERZINCILIOGLU, zoologist, Durham.

Dr Beeson died last year before this curio was submitted.

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