

## History of Spontaneous Abortion, Fetal or Neonatal Loss

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### Definition/ cut-off value

A **spontaneous abortion** (SAB) is the spontaneous termination of a gestation at < 20 weeks gestation or < 500 grams.

**Fetal death** is the spontaneous termination of a gestation at  $\geq$  20 weeks.

**Neonatal death** is the death of an infant within 0-28 days of life.

Pregnant Women: any history of fetal or neonatal loss or 2 or more spontaneous abortions.

Breastfeeding: most recent pregnancy in which there was a multifetal gestation with one or more fetal or neonatal deaths but with one or more infants still living.

Non-Breastfeeding: most recent pregnancy.

Presence of condition diagnosed by a physician as self reported by applicant/participant/caregiver; or as reported or documented by a physician, or someone working under physician's orders.

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### Participant category and priority level

#### Category

#### Priority

Pregnant Women

I

Breastfeeding Women

I

Non-Breastfeeding Women

III

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### Justification

**Pregnancy:** Previous fetal and neonatal deaths are strongly associated with pre-term low birth weight (LBW) and small for gestational age (SGA) and the risk increases as the number of previous poor fetal outcomes goes up.

Spinnillo et al found that the risk for future small for gestational age outcomes increased two fold if a woman had 2 or more SAB. Adverse outcomes related to history of SAB include recurrent SAB, low birth weight (including preterm and small for gestational age infants), premature rupture of membranes, neural tube defects and major congenital malformations. Nutrients implicated in human and animal studies include energy, protein, folate, zinc, and vitamin A.

**Postpartum women:** A SAB has been implicated as an indicator of a possible neural tube defect in a subsequent pregnancy. Women who have just had a SAB or a fetal or neonatal death should be counseled to increase their folic acid intake and delay a subsequent pregnancy until nutrient stores can be replenished.

The extent to which nutritional interventions (dietary supplementation and counseling) can decrease risk for repeat poor pregnancy outcomes, depends upon the relative degree to which poor nutrition was implicated in each woman's previous poor pregnancy outcome. WIC Program clients receive

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**Justification (cont)**

foods and services that are relevant and related to ameliorating adverse pregnancy outcomes. Specifically, WIC food packages include good sources of implicated nutrients. Research confirms that dietary intake of nutrients provided by WIC foods improve indicators of nutrient status and/or fetal survival in humans and/or animals.

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**Clarifications/  
Guidelines**

Before assigning this risk code, be sure pregnancy outcome history is documented on the WIC-45, WIC-40, or WIC-41, whichever is appropriate.

**Elective or therapeutic abortions are not valid criteria for this risk code.**

Only spontaneous abortions – the spontaneous termination of a gestation before 20 weeks gestation or the loss of a fetus that weighs less than 500 grams – are included in this risk criterion. However, women who have had an elective or therapeutic abortion may be at nutritional risk, which must be precisely identified. Some other risk criteria that may apply include: risk code 332 – Closely spaced pregnancies, risk code 333 - High parity and young age, risk code 339 – Birth with nutrition-related birth defect (for women who have had a previous pregnancy). When using these risk criteria, proper documentation is required.

This risk code may be used in combination with risk code 311 – History of Preterm Delivery, and risk code 312 – History of Low Birth Weight, if the infant was born alive but death occurred within the first 28 days of life.

**Ectopic pregnancies** are included in this risk definition. If surgery was required, risk code 359 – Recent major surgery – may be used, unless laproscopic surgery was performed.

**Pregnant women:** The threshold for pregnant women is 2 SAB's because that has been associated with a two-fold increase in small for gestational age babies. A woman who becomes pregnant within 16 months after a SAB (her first) would qualify for risk code 332, Closely Spaced Pregnancies.

**Postpartum/Breastfeeding women:** Spontaneous abortions are specific to the “most recent” pregnancy because SAB's have been implicated as a indicator of a possible neural tube defect for a subsequent pregnancy. For breastfeeding woman, the most recent pregnancy must have been a multi-fetal pregnancy and the mother gave birth to at least one living infant. She is currently breastfeeding the surviving infant or infants.

**NOTE:** Self-reporting for “History of...” conditions should be treated in the same manner as self-reporting for current conditions requiring a physician's diagnosis, i.e., the applicant may report to the CA that she was diagnosed by a physician with a given condition at some point in the past. As with current conditions, self-diagnosis of a past condition should never be confused with self-reporting.

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**References**

1. Institute of Medicine: Nutrition During Pregnancy; National Academy Press; 1990; pp. 176-211.
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3. Carmi, R., et al. Spontaneous abortion-high risk factor for neural tube defects in subsequent pregnancy. Am J of Med Gen. 1994;51;93-97.
4. Paz, J. et al. Previous miscarriage and stillbirth as risk factors for other unfavorable outcomes in the next pregnancy. Bri J of Obstet Gyn. 1999 (October);808-812.
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6. Shapiro, S. LF Ross, and HS Levine: Relationship of Selected prenatal Factors to Pregnancy Outcome and Congenital Anomalies. Am J Public Health; February 1965; Vol. 55, No. 2; pp. 268-282.
7. Pre-term Labor; AGOG Technical Bulletin, No. 206; June 1995.
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