Can brain impairment be detected by in utero behavioural patterns?

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Abstract
Fetal behavioural patterns were examined to test whether they could be used to localise sites of brain damage antenatally. Decreased fetal movement, persistent non-reactive fetal heart rate (FHR) pattern, and/or central nervous system malformation were used as indicators of possible neurological impairment. Ten fetuses tested in this way underwent further ultrasound examination observing movement of the extremities, chest wall (breathing), and eye and mouth, and active/quiet FHR patterns. Eight of these 10 fetuses were found on postnatal examination to have a brain impairment. The fetuses having potential in utero brain impairment were divided into four groups: those with (1) lesion sites at, or caudal to, the pons-medulla that were specifically identified by fetal behaviour, (2) diffuse lesions in the brain which, although resulting in abnormal behaviour, could not be localised by this behaviour, (3) lesions localised in the cerebral hemisphere(s) but with no abnormal behaviour, and (4) temporally abnormal behaviour in utero, finally changing over to a normal pattern with no neonatal neurological abnormality. A screening system for the antenatal assessment of brain impairment is thus proposed.

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In recent years increasing emphasis has been placed on perinatal origins of brain injury in the case of neurologically impaired infants.1-4 Authors have questioned the causal relationship between birth asphyxia and cerebral palsy.1 5 6 Ellis et al reported that of 89 infants who died within one neonatal week, 25% had prenatal brain damage.1 Naeye et al provided strong evidence that most examples of cerebral palsy were not the result of perinatal asphyxial events in full term infants, but rather the consequence of, usually preventable, prenatal intraterrine problems.6 The Neurological Collaborative Perinatal Project of the National Institute of Neurological and Communicative Disorders and Stroke reported that birth asphyxia accounted for only 6% of all cases of cerebral palsy.5

Over the past decade, the assessment of in utero behavioural development has been facilitated by the real time ultrasound observation of fetal movements, such as those of the eyes, extremities (arms and legs), breathing, and mouthing.7-13

We previously reported three fetuses without central nervous system malformations, who had abnormal behavioural patterns in utero; the neonates were subsequently found to have brain damage.14

We have extended our observations to other fetuses by assessing the correlation between intrauterine behavioural patterns and neonatal outcome and determining the extent to which lesion sites in the developing fetal brain could be localised at term. An attempt was also made to initiate an antenatal screening system, to discriminate those fetuses with compromised central nervous system function from the general population.

Methods
FETAL POPULATION
A total of 1426 singleton full term fetuses, of between 37 and 41 weeks of gestation, were studied during the three year period from January 1988 to February 1991 in the Maternity and Perinatal Care Unit, Kyushu University Hospital.

PRENATAL CARE SYSTEM
Standard systematic prenatal care was scheduled at intervals of four weeks until 28 weeks, then once every two weeks until the 36th week, and weekly thereafter.15 At each visit fetal anatomy, growth, and amniotic fluid pocket measurements were evaluated using real time ultrasound.16 At 30 weeks or more of gestation, all fetuses underwent fetal heart rate (FHR) monitoring for 30–120 minutes, using a cardiotocograph (Toitu MT-810).

INDICATIONS OF POSSIBLE FETAL BRAIN FUNCTION IMPAIRMENT
Fetuses exhibiting any of the following were considered to have potential in utero brain function impairment.

(1) Decrease or lack of fetal movement
A decrease or lack of fetal movement was defined as the mother reporting fewer fetal...
movements than three per 12 hours or experiencing a complete cessation of fetal movement for the same time period.  

(2) Persistent non-reactive FHR pattern

The FHR patterns were categorised by the criteria of Rochard et al. Abnormal FHR patterns were defined as abnormal FHR variability of 6 bpm or more, presence of decelerations, or at least two FHR accelerations concurrent with fetal movement. A 'non-reactive' FHR pattern consisted of heart rate ranging between 120 and 160 beats per minute (bpm), a baseline FHR variability of 6 bpm or more, absence of decelerations, and at least two FHR accelerations concurrent with fetal movement. A 'non-reactive' FHR pattern occurred in 1–2 days. The ultrasound image was stored by video cassette recorder (Sony model V0-9600), together with the simultaneous recording of video frame codes using a frame code generator (Sony model FCG-700). FHR recordings were made 1–3 times a day.

To assess whether brain impairment occurred prenatally, we defined six different behavioural patterns as indicators:

(1) Movement of extremities

We observed movement in all four extremities in the fetus, for 60 minutes continuously, and defined this movement to be normal when at least one episode of motion, involving extension, flexion, external and internal rotation or abduction and adduction of all extremities occurred.

(2) Breathing movement

Fetal thoracic and abdominal wall movements were observed using a longitudinal scan in the median plane. One breathing movement was defined as the synchronous movements of the chest wall (inward), the abdominal wall (outward), and diaphragm (downward), followed by their return to the resting positions. According to the report of Patrick et al no apnoeic intervals were greater than 120 minutes at 34 weeks' gestation onwards. We therefore considered breathing movement as absent when it was not detected for more than 120 minutes' observation by ultrasound.
the presence or absence of eye movement, respectively (fig 1). The 25–75% ranges for the duration of eye movement and no eye movement periods were 2–30 and 2–25 minutes, respectively. Alternation of eye movement and no eye movement periods was considered to be abnormal when the duration of eye movement and/or no eye movement was out of these ranges.

(4) Eye movement pattern: rapid eye movements and slow eye movements
While replaying the video tapes using the slow motion and frame freezing modes, we measured the duration of each eye movement unit, in seconds, by subtracting the frame code at the onset from that at the end of each eye movement unit (fig 2). Rapid eye movements and slow eye movements were defined as those having durations of less than, and equal to or more than the critical value of 0–76 seconds, respectively, according to our previous report. The state of rapid eye movement coexisting with slow eye movements was considered to be the normal eye movement pattern.

(5) Concurrence of regular mouthing with the no eye movement period
Both mouthing movements and eye movements were observed simultaneously on one ultrasound image for 60–90 minutes. We defined one unit of mouthing movement as that action where the mouth opened and returned to a closed position. The interval between two consecutive occurrences of mouthing movement was used as a variable.
Concurrence of regular mouthing movement with the no eye movement period was considered normal when repetitive mouthing movements were observed at a regular interval of 300–600 msec during the no eye movement phase (fig 3).

(6) Active and quiet phases of FHR pattern
Following the criteria of Timor-Tritsch et al, active and quiet FHR patterns are defined as increased long term FHR variability with high baseline heart rate, and decreased long term FHR variability, with low baseline heart rate, respectively. In human fetuses at term, active and quiet phases were reported to last for 30–50 and 20–40 minutes, respectively. When several alternations between active and quiet FHR patterns are observed during an observation period of 120–180 minutes, the active and quiet FHR pattern was considered to be normal.

ASSESSMENT OF BRAIN IMPAIRMENT AFTER BIRTH
In this study, in order to confirm the existence of brain impairment, all infants underwent a neurological examination on the 28th neonatal day. In the event any abnormal findings were noted, various neurological tests were made, including physical examination,
Table 2 Correlation between fetal behavioural patterns and postnatal findings

<table>
<thead>
<tr>
<th>Fetal behavioural patterns</th>
<th>Case No. of extremities</th>
<th>Movement No: Breathing movement</th>
<th>EM/NEM period alteration</th>
<th>Eye movement pattern</th>
<th>Regular Mouthing</th>
<th>Accelerating FHR pattern</th>
<th>Postnatal diagnosis</th>
<th>Lesion location and distribution</th>
<th>Age</th>
<th>Neurological sign</th>
</tr>
</thead>
<tbody>
<tr>
<td>1* Absent</td>
<td>Present</td>
<td>Normal</td>
<td>Present</td>
<td>Present</td>
<td>Present</td>
<td>Present</td>
<td>Spinal cord haemorrhage</td>
<td>Spinal cord (C5–6)</td>
<td>20 months</td>
<td>Quadriplegia, sensory disturbance</td>
</tr>
<tr>
<td>2* Present</td>
<td>Absent</td>
<td>Absent</td>
<td>Present  ‡</td>
<td>Present</td>
<td>Absent</td>
<td>Absent</td>
<td>Möbius’ syndrome with central hypo-ventilation</td>
<td>Pons-medulla</td>
<td>3 years</td>
<td>No spontaneous respiration, mental retardation</td>
</tr>
<tr>
<td>3* Present</td>
<td>Present</td>
<td>Normal</td>
<td>Absent</td>
<td>Present</td>
<td>Absent</td>
<td>Absent</td>
<td>Undetermined</td>
<td>Cerebral white matter, diffuse Cerebral hemisphere, diffuse, brainstem, cerebellum</td>
<td>3 years</td>
<td>Mental retardation cerebral palsy</td>
</tr>
<tr>
<td>4 Present</td>
<td>Present</td>
<td>Disproportional</td>
<td>Present</td>
<td>Present</td>
<td>Absent</td>
<td>Absent</td>
<td>Neuronal migration abnormality, hydrocephalus, cerebellar hypoplasia</td>
<td>Diffuse</td>
<td>27 months</td>
<td>Mental retardation cerebral palsy, epilepsy</td>
</tr>
<tr>
<td>5 Present</td>
<td>Present</td>
<td>Absent</td>
<td>Absent  ‡</td>
<td>Absent</td>
<td>Absent</td>
<td>Absent</td>
<td>Hydrocephaly (alobar)</td>
<td>Right frontal lobe</td>
<td>Died shortly after birth</td>
<td>8 months</td>
</tr>
<tr>
<td>6 Present</td>
<td>Present</td>
<td>Normal</td>
<td>Present</td>
<td>Present</td>
<td>Present</td>
<td>Present</td>
<td>Arachnoid cyst</td>
<td>Right quadrigeminal cister to intrahemispheric fissure</td>
<td>7 months</td>
<td>Not noted</td>
</tr>
<tr>
<td>7 Present</td>
<td>Present</td>
<td>Normal</td>
<td>Present</td>
<td>Present</td>
<td>Present</td>
<td>Present</td>
<td>Hydrocephalus, Encephalocele</td>
<td>Occipital lobe</td>
<td>Not noted</td>
<td></td>
</tr>
<tr>
<td>8 Present</td>
<td>Present</td>
<td>Absent-normal</td>
<td>Present</td>
<td>Absent</td>
<td>Absent-normal</td>
<td>Present</td>
<td>Normal</td>
<td>None</td>
<td>7 months</td>
<td>Not noted</td>
</tr>
<tr>
<td>9 Present</td>
<td>Present</td>
<td>Absent-normal</td>
<td>Present</td>
<td>Absent</td>
<td>Absent-normal</td>
<td>Present</td>
<td>Normal</td>
<td>None</td>
<td>1 month</td>
<td>Not noted</td>
</tr>
</tbody>
</table>

EM/NEM = eye movement/no eye movement.
*Previously reported.14
‡Rapid eye movement and slow eye movement.
†Undeterminable because of lack of EM/NEM alteration.

Results

Table 2 shows the summary of the 10 cases with regard to the correlation between the prenatal behavioural patterns and postnatal findings.

In case 1, despite a normal breathing pattern, no movements in any of the four extremities were observed. In case 2, a lack of breathing movement was noted repeatedly, together with the abnormal finding that the alternation of eye movement and no eye movement periods was undiscriminating. In case 3, the concurrence of regular mouthing with the no eye movement period was not observed. Details of cases 1–3 have been described elsewhere.14 In case 4, although alternating eye movement and no eye movement periods were noted, the duration of these periods was abnormally disproportional, at 23–72 minutes (longer than normal range) and 2–10 minutes (shorter than normal range), respectively. The findings in case 5 demonstrated that only sporadic eye movements existed and, therefore, we could not determine either eye movement/no eye movement period alternation or regular mouthing movements concurrent with the no eye movement period. This case also showed a persistent non-reactive FHR pattern. Repeated ultrasonography revealed that the abnormal patterns observed in cases 1–5 were persistent. After birth, functional and/or morphological central nervous system abnormalities were detected in cases 1–5, of which, cases 1 and 2 had localised lesions in the spinal cord (C5–C6) and the pons-medulla, respectively, and cases 3–5 were diagnosed as having diffusely spread lesions in the brain.

Cases 6, 7, and 8 showed entirely normal behavioural patterns. Postnatally, however, these cases were found to have localised lesions in the cerebral hemisphere.

In cases 9 and 10, the first extensive examination showed abnormal behavioural patterns in eye movement/no eye movement period alternation and eye movement pattern (rapid/slow eye movement), respectively. However, these findings changed to normal patterns from the second observation onwards. Postnatal physical examinations indicated no neurological abnormalities.

Discussion

In the present study we focused on detecting brain impairment occurring in utero. Therefore, the neurological outcome was assessed during the early neonatal period in order to avoid the influencing factors acquired during extrauterine life. Accordingly, there may have been some cases that were evaluated as normal at birth but showed mental retardation and/or cerebral palsy a few years later.

The six indicators observed in this study were all considered to be functionally mature, in normal fetuses, from 35–36 weeks’ gestation onwards.15–10 12 13 19 20 22 All cases studied here were within this gestational period, and in eight of the 10 cases suspected as having possible central nervous system impairment, abnormal behavioural patterns were detected repeatedly in every ultrasound examination, providing evidence of existing lesions in the central nervous system during intrauterine life. The remaining two cases, which indicated abnormal patterns in alteration of...
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A clinical system capable of detecting a functional impairment of the central nervous system, in utero, should fulfill the following conditions: it should (1) require only a short observation time, (2) be applicable to all fetuses, (3) have a high sensitivity for identifying brain impairment, and (4) require no special training for the examination. As for the screening system in this study, 20–25 minutes is required to examine each patient, which makes it feasible in daily obstetric practice. In the present study, we selected the following three findings: a lack of or decrease in fetal movement, fetal central nervous system malformation, and abnormal FHR pattern as pointers for examining central nervous system dysfunction.

One case with Möbius’ syndrome showed a persistent non-reactive FHR pattern with no signs of fetal distress at 35 weeks of gestation onwards, but had typical fetal distress during delivery leading to vacuum extraction. This fact suggests that the persistent non-reactive pattern, observed in this case, did not indicate hypoxia, but reflected functional impairment of the control centre of fetal heart rate (described elsewhere in detail14).

In order to discern effectively brain dysfunction in utero, any diagnostic system must contain three elements: a screening procedure for the general population, high detection rate of cases with in utero brain function impairment, and follow up confirmation of impairment after birth. Although the application of fetal behaviour in assessing brain impairment is still in the early stages, in this study, we used this as a prototype for a diagnostic system and could demonstrate its usefulness in clinical practice, especially in cases having underlying neural abnormality without accompanying discernible morphological changes by the current method. However, if we apply the extensive evaluation programme presented in this study to population screening, enormous time will be required to detect abnormal findings as it takes 60–120 minutes to test for each behavioural indicator. To solve this problem and complete the system, after the original accumulation of data from this pilot programme, it is essential to revise the indications of the central nervous system impairment to include maternal mental retardation, birth weight at and below 2000 g and/or breech presentation, which are reported to be predictors of cerebral palsy. Also crucial is the development of an extensive behavioural examination in order to verify brain function more precisely.

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