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Wharton’s jelly absence: a possible cause of stillbirth

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ABSTRACT

The umbilical cord is a structure that provides vascular flow between the fetus and the placenta. It contains two arteries and one vein, which are surrounded and supported by gelatinous tissue known as Wharton’s jelly. There are many umbilical cord abnormalities that are related to the prognosis of fetus survival and birth weight. The authors report a case of umbilical cord constriction due to the localized absence of Wharton’s jelly, which was undiagnosed antenatally and had a fatal outcome. A review of the association between the absence of Wharton’s jelly and an unfavorable pregnancy outcome was undertaken.

Keywords: Umbilical Cord; Wharton Jelly; Stillbirth.

CASE REPORT

A male stillborn fetus was delivered at 33 weeks and 4 days of gestational age through a vaginal birth, which was the second pregnancy of a 32-year-old woman. The mother had a history of a previous ectopic pregnancy and left salpingectomy, plus type II diabetes mellitus and arterial hypertension—the latter two without medical control. The woman stopped feeling the fetal movements 6 hours before hospital admission. An ultrasound examination diagnosed intrauterine fetal demise, and the labor was induced with misoprostol.

AUTOPSY FINDINGS

On gross examination, the placenta measured 15.0 × 14.0 cm in diameters, corresponding to an area of 164 square centimeters (–1.4 z score and 1 percentile, small for gestational age)² 2.5 cm of mean thickness (3.0 z score and 99 percentile, large for gestational age)² and weighed 425.0 g (1.1 z score and 87 percentile, adequate for gestational age).² The insertion of the umbilical...
At microscopy, absence of Wharton’s jelly was evidenced in the constricted segment. (Figures 2B and 2C).

DISCUSSION

The umbilical cord—the fetal lifeline—is a structure that connects the fetus to the placenta, and is crucial for fetal development. It is composed of two arteries and one vein and is cushioned by a special type of mucous connective tissue known as Wharton’s jelly. At birth, the average diameter and circumference of the umbilical cord in a normal-term infant is 1.5 cm and 3.6 cm, respectively.²,³ Wharton’s jelly seems to have the function of the adventitia layer, which is lacking in the umbilical cord, and binds and encases the umbilical vessels. Wharton’s jelly is an amorphous substance, which is rich in glycosaminoglycans, proteoglycans, and...
predominantly hyaluronic acid. It is surrounded by myofibroblasts, which are mesenchymal cells with the characteristics of both fibroblasts and smooth-muscle cells. Myofibroblasts have both fibrogenesis and contractile functions and produce increasing amounts of type I, II, and V collagen fibrils during the pregnancy, giving Wharton’s jelly elastic and contractile properties as well as microfibrils. Hyaluronic acid is the most common glycosaminoglycan—a hydrophilic component of Wharton’s jelly that absorbs water and electrolytes. Umbilical cord elasticity confers resistance to external pressure, and acts as a physical buffer in the regulation of fetoplacental blood circulation and umbilical vessels. It has been speculated that the cells of Wharton’s jelly may participate in the regulation of umbilical blood flow. In some cases, the reduction in fetal growth could be directly associated with Wharton’s jelly decrement, leading to hypoplasia of the umbilical vessels. If Wharton’s jelly is poorly developed, or if the vessels remain unprotected, they become more prone to compression.

The sonographic umbilical cord diameter and area increase as a function of gestational age until the 32nd week of pregnancy. After that, a reduction in the diameter of the umbilical cord can be observed due to the water content of Wharton’s jelly at the end of the pregnancy. Over a 1 year period, Proctor et al. studied 497 umbilical cords of gestational ages ranging from 18 weeks to 41 weeks. They found that the umbilical cord diameter increases as the gestational age progresses until 28 weeks when it reaches a plateau at approximately 1.0 cm. These findings are in agreement with the antenatal ultrasound assessment of the umbilical cord that describes an increase in diameter with gestational age until the third trimester. Using Proctor’s nomogram, they identified and classified the umbilical cord diameter as thin (< 10th percentile), average (10th–90th percentile) and thick (> 90th percentile), and concluded that the umbilical cord components were responsible for the diameter variation. According to this standard, the cord of the present case was a thick one. Their findings show that a significant increase in the vessel area (specifically an increase in the umbilical artery wall area) is responsible for a thick umbilical cord diameter, while a significant decrease in Wharton’s jelly area is responsible for a thin umbilical cord diameter.

Pathologic studies and case reports demonstrated that a thin umbilical cord is associated with oligohydramnios, fetal distress, and adverse pregnancy outcome. Silver et al. reported that in post-term pregnancies, the umbilical cord diameter is smaller in patients with oligohydramnios compared with normal amniotic fluid. In addition, these authors found a higher incidence of antepartum variable decelerations in patients with a small umbilical cord diameter compared with those with a normal umbilical cord. Raio et al. found an association between the presence of a thin umbilical cord and the delivery of an infant who is small for its gestational age. Proctor et al. showed that there was a relationship between the umbilical cord diameter and gross placental pathologic features. A thin umbilical cord was associated with low placental weight percentile, a single umbilical artery, and a marginal umbilical cord insertion.

Marked reductions in the diameter of the umbilical cord may be referred to as constrictions, stricture, torsion, and coarctation. When present,
they are frequently found close to the fetal insertion site, as was observed in our case. They are more prevalent in long cords and marked coiled cords. In these cases, the obstruction of blood flow occurs by the same mechanism as with excessive coiling. None morphological evidence of fetoplacental vascular obstruction was observed in the present case. Some authors suggested that it is either a primary deficiency of Wharton’s jelly, or is due to a secondary phenomenon caused by a gradual decrease in Wharton’s jelly at the fetal end of the cord. It has been suggested that the umbilical cord constriction could be due to a degeneration of Wharton’s jelly around the vessels, since normal development of the vessel would not be possible in the absence of embryonal mesenchyme, although no mucoid or degenerative changes were demonstrated. Other possible physiopathologic mechanisms for this anomaly could be an incomplete fusion of the amniotic covering and the mesenchyme of the umbilical cord during early development, or a hypoplasia of this amniotic covering with a secondary loss of Wharton’s jelly. In 1961, Bergman, Lundin and Malmstrom described the first case in which a segment of the umbilical arteries were devoid of their Wharton’s jelly covering. The most common complication of this anomaly results in fetal demise, but cord constrictions have also been implicated in fetal growth restriction and fetal intolerance to labor; in the present case, fetal weight was adequate for gestation age.

A different umbilical cord anomaly related to the lack of Wharton’s jelly is known as insertio funiculi furcata. In those cases, the insertion site is normal, but as the cord vessels lose the Wharton’s jelly their vessels become separated before reaching the placental surface. In a velamentous insertion, the umbilical cord is inserted into the membranes and the umbilical vessels remain unprotected for some distance before reaching the placenta. An increased incidence of fetal distress and perinatal mortality has been described in association with both velamentous insertion and insertio funiculi furcata.

Baergen describes four cases of stillbirth and umbilical cord constriction. In all the four cases, the absence of Wharton’s jelly around the umbilical cord arteries described so far were associated with acute fetal distress and perinatal death, and this may have been due to compression of the unprotected vessels. According to Baergen, this is consistent with animal studies in which fetal lambs that were subjected to intermittent partial chord occlusion develop cerebral necrosis and serious fetal neurologic damage. Chronic partial obstruction can also lead to fetal growth restriction. Abnormally coiled cords, abnormally short or long cords, velamentous cord insertions, constrictions, true knots, cord entanglement, and cord prolapse have all been associated with an increased risk of fetal demise, neurologic injury, or abnormal development outcome. In the present case, we observe a thick and under to normal coiled cord.

Filiz et al. investigated the relationship between the amount of Wharton’s jelly and its protective role in umbilical cord vessels, and hence, on fetal growth. Their study enrolled 299 women and concluded that the “quality” and characteristics of Wharton’s jelly were both important in its protective role. Abnormal situations, such as a decrease in the hyaluronic acid content of Wharton’s jelly and Wharton’s jelly fibrosis, may affect the mechanical characteristics of the cord, which leads to impaired fetal circulation, anoxia, and fetal death.

CONCLUSION

The changes in the quantity or quality of Wharton’s jelly affects the diameter of the umbilical cord and the hemodynamics of its vessels, leading to impaired fetal blood flow and consequently low weight gain and fetal demise. The constriction in the umbilical cord due to the absence of Wharton’s jelly, which was seen in our case, much probably was the cause of fetal death since the autopsy did not show any malformations or other disorders. We highlight the need to study the umbilical cords in all cases of stillbirth.

REFERENCES


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