STANDARD OPERATING PROCEDURE

Management after a growth scan

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PURPOSE

To guide clinical management and care pathways following growth scans

OBJECTIVE

To standardise management following a growth scan to support appropriate clinical decision making and allow safe and timing escalation where growth parameters / fetal Doppler's are outside of normal limits

SCOPE

For all sonographers, midwives and doctors

AUDIT

Monitoring will be performed as part of the Maternity Safety Incentives and presented through the LMS Dashboard and local Maternity Governance.

1. Publication of SGA/FGR detection rates and percentage of babies born <3rd centile >37+6 weeks' gestation.
2. Ongoing case-note audit of <3rd centile babies not detected antenatally, to identify areas for future improvement (at least 20 cases per year, or all cases if less than 20 occur).
3. Monitoring of babies born >39+6 and <10th centile to provide an indication of detection rates and management of SGA babies.

Management following scan

If a scan is being requested at <3 weekly intervals, the case and indication for scan should be discussed with an ASPH FM consultant. If they are unavailable, this should be discussed with the consultant of the week or the patient's own consultant.

SGA (small for gestational age) AC <10th centile or EFW < 5-10th centile

FGR (fetal growth restriction) EFW less than the 5th centile

1.1 Normal scan

- Consistent growth velocity, AC and EFW above 10th centile, normal amniotic fluid volume (AFV) and fetal Doppler's.
- Woman should be reassured by the sonographer. She does NOT routinely need to see a doctor after each scan.
- Ensure appropriate FU arranged with MW as per AN care schedule

1.2 Large for gestational age >34 weeks

- AC or EFW>97th centile
- <36 weeks, arrange GTT. If GTT normal, FU in ANC to discuss timing of birth.
- >36 weeks, refer to diabetes clinic with a presumed diagnosis of GDM and manage as per diabetes guideline.

1.3 SGA - normal fetal Dopplers (less than 36+0 weeks)

- AC< 10th entile or EFW 3rd-10th centile
- Book fetal medicine scan in 14 days

Refer for review in Maternity Triage on the day of the scan. Midwife to:

- Review the antenatal notes and history
- Ask about fetal movements
- BP and urine dip

If there are no other concerns (normal FM, normal BP and urinalysis with an otherwise low risk pregnancy) then the midwife should:

- Give advice about reduced fetal movements
- Change to 'high risk' pathway, update the risk assessment on Badgernet
- Book Consultant ANC (named consultant based on Geographical area)

CTG monitoring in Maternity Triage should not be required for these women unless at the request of a consultant.

If after midwifery review there are other concerns (e.g. Reduced FM, High BP, proteinuria, other medical problems or poor obstetric history) the woman should be reviewed by the Maternity Triage Registrar or Consultant and an individual plan made.

1.4 SGA after 36 weeks' gestation:

All women need a medical review. The Tommy's App Timing of Birth Decision Support Tool will assist in the clinical decision making for timing of birth. If the plan for timing of birth is different to that recommended by the Tommys App, the rationale for this should be documented within BadgerNet.

Babies with an EFW 3rd-10th centile delivery should be initiated at 39+0 weeks (or earlier if there are additional concerns, for example abnormal Doppler's or reduced movement), even if there is normal growth velocity, normal AFV and Doppler's

Babies with an EFW 3rd-10th centile should be delivered at 37 weeks in the presence of abnormal fetal Doppler or additional clinical concern.

In an SGA fetus (EFW < 10th centile), IOL (if no contraindication) will normally be considered to achieve delivery by the EDD.

1.5 Normal growth. Incidental finding of oligohydramnios

- Normal growth. Reduced AFV (deepest pool < 2cm)

Refer for review in Maternity Triage on the day of the scan.

Midwife or Doctor to:

- Review the antenatal notes and history
- Ask about fetal movements
- Ask about a history of PROM
- Check observations: temperature / Pulse / BP
- Perform a speculum if the history suggestive of PROM

The woman should be reviewed by the Maternity Triage Registrar or consultant.

CTG monitoring should not be required for these women (unless they are diagnosed as having PROM) unless at the request of the consultant. If greater than 37 weeks' induction of labour should be recommended.

If pre-term, a rescan with a sonographer should be booked in 2 weeks.

1.6 Incidental Doppler abnormality NOT SGA

- AC and EFW >10th centile
- Umbilical PI>95th centile (positive EDF) or MCA<10th (redistribution)

Sonographer

Check biometry >10th centile and FM normal, ensure technically adequate measurement, repeat if necessary

Refer for review in Maternity Triage on the day of the scan.

Maternity Triage Midwife to:

- Review the antenatal notes and history
- Ask about fetal movements
- Check BP and urine dip
- Perform a cCTG if any concern about FM
- Maternity Triage Registrar review

If <36 week and no additional concern identified rescan in 1 week for Doppler with a review in ANC.

If >36 weeks - There is a need to consider timing of delivery (usually at 37+ weeks) if persistent redistribution or UAPI>95th is confirmed.

The Obstetric Registrar should review the entire clinical picture and discuss with the Consultant on call or fetal medicine if available. A clear plan of management and follow up should be made and documented within the Management Plan box on Badgernet

1.7 Abnormal Doppler or SGA less than 3rd centile

1.7.1 Absent or Reversed EDF in the umbilical artery

- Arrange computerised CTG (if more than 26 weeks)
- Urgent discussion and review by ASPH Fetal medicine or Tertiary Fetal medicine (St George's FMU)
- Reversed EDF deliver if >30 weeks
- Absent EDF deliver if >32 weeks

1.7.2 SGA and Umbilical PI>95th centile / MCA<10th (redistribution)

OR FGR- EFW<3rd centile

SGA and Umbilical PI>95th centile (PositiveDF) OR MCA<10th (redistribution) OR FGR- EFW<3rd centile

(NB if AC less than 3rd but EFW more than 3rd, follow the SGA amber scan advice above)

The clinical context **must** be taken into account in interpreting fetal growth and Doppler.

Refer for review in Maternity Triage on the day of the scan.

Maternity Triage Midwife to:

- Review the antenatal notes and history
- Ask about fetal movements
- Check BP and urine dip
- Perform a cCTG
- Arrange a same day Obstetric Registrar review

Arrange fetal medicine scan or Fetal Medicine Scan within 2-3 days

Between 24 – 36 weeks' gestation:

Timing of delivery for preterm SGA or FGR should be made by ASPH Fetal Medicine Consultants or tertiary fetal medicine if not available.

Delivery will be determined by a combination of computerised CTG and Doppler according to regional guidance

Steroids should be considered if delivery is anticipated < 36 weeks.

Magnesium sulphate should be administered (as per the preterm labour guideline), for all foetuses <34+0 weeks

More than 36 weeks – arrange delivery

Mode of delivery will depend on the gestational age, condition of the fetus and suspected underlying cause and should be a consultant decision. SGA is an indication for continuous CTG monitoring in labour and with any significant uterine activity during induction. Consider sending the placenta for perinatal pathology rather than ASPH

1.8 Flow Chart for Management of Growth Scans