

## Referral and Management of Large for Gestational Age Fetuses or Polyhydramnios

### A Guideline recommended:

<b>For use in:</b>	Maternity Services
<b>By:</b>	Midwives, Obstetricians and Ultrasonographers
<b>For:</b>	Pregnant women
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<b>If Yes - does the strategy/policy deviate from the recommendations of NICE? If so why?</b>	Guideline written to reflect resources available within the Trust

This guideline has been approved by the Trust's Clinical Guidelines Assessment Panel as an aid to the diagnosis and management of relevant patients and clinical circumstances. Not every patient or situation fits neatly into a standard guideline scenario and the guideline must be interpreted and applied in practice in the light of prevailing clinical circumstances, the diagnostic and treatment options available and the professional judgement, knowledge and expertise of relevant clinicians. It is advised that the rationale for any departure from relevant guidance should be documented in the patient's case notes. The Trust's guidelines are made publicly available as part of the collective endeavour to continuously improve the quality of healthcare through sharing medical experience and knowledge. The Trust accepts no responsibility for any misunderstanding or misapplication of this document.

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## Version and Document Control:

Version Number	Date of Update	Change Description	Author
8	25/09/2020	Flowchart removed.	Rosie Goodsell Martin Cameron Richard Smith

## This is a Controlled Document

Printed copies of this document may not be up to date. Please check the hospital intranet for the latest version and destroy all previous versions.

## Broad Recommendations

This guideline is relevant to all healthcare professionals involved in the care of pregnant women including Midwives, General Practitioners, Obstetricians and Sonographers. This guideline addresses:

- When to refer to ultrasound for scanning of large for gestational age fetuses
- Management of large for gestational age fetuses
- Management of polyhydramnios

## Definitions

BMI	Body mass index
EDD	Estimated date of delivery
EFW	Estimated Fetal Weight
FHM	Fundal Height Measurement
LGA	Large for Gestational Age
OGTT	Oral Glucose Tolerance Test
Sonographer	Practitioner qualified to perform growth scans

Centile Lines are the lines of growth on the customised growth chart where EFW and FHM are marked. The 10<sup>th</sup>, 50<sup>th</sup> and 90<sup>th</sup> are marked in bold.

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## Referral to Ultrasound for GROWTH Scans

- Excessive growth or accelerated growth where the growth is steeper than any curve on the chart as this may be indicative of polyhydramnios.
- A first measurement above the 90th centile **IS** an indication for a growth scan. If the estimated weight on USS is >90<sup>th</sup> centile, **THEN** a POGTT should be done (unless already performed and abnormal). If POGTT normal, then an ANC appointment with a scan at 38 weeks should be made – serial scans is not required in this case.

## Referral following a growth scan

### 1. EFW above 90th centile (or significantly increased growth velocity):

Guidance on who to perform POGTTs is in the trust guideline on diagnosis and management of gestational diabetes [Trustdocs Id: 844](#). It depends if patients has pre-pregnancy risk factors for GDM and whether they have had previous POGTTs.

## Suspected polyhydramnios

A history of sudden increase in fundal height with the clinical impression of polyhydramnios. Polyhydramnios can result in excessive fetal mobility, fetal parts difficult to feel. Refer to antenatal clinic at any gestation and refer to ultrasound.

### If polyhydramnios is confirmed, consider causes:-

1. Idiopathic
2. Maternal (gestational diabetes, GDM)
3. Fetal (tracheo-oesophageal fistula [TOF] – may be absent stomach on ultrasound, although presence of stomach does not exclude diagnosis).

Guidance on who to perform POGTTs is in the trust guideline on diagnosis and management of gestational diabetes [Trustdocs Id: 844](#). It depends if patients has pre-pregnancy risk factors for GDM and whether they have had previous POGTTs.

If TOF suspected by absent stomach (and after GDM excluded) consider referral to fetal medicine as there is around 50% chance of other abnormalities and 5% association with aneuploidy.

Paediatric alerts do not need to be sent for isolated mild polyhydramnios.

For severe polyhydramnios at less than 34 weeks gestation it may be appropriate to discuss with one of the fetal medicine consultants about merits of amniodrainage.

## Fetal Macrosomia from 38 weeks

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There is some evidence that macrosomic fetuses are at increased risk of shoulder dystocia. The NICE 2008 guideline for induction of labour does not recommend IOL for fetal macrosomia but more recent evidence suggest that IOL may reduce the risk of shoulder dystocia, without increasing the risk of caesarian delivery (relative risk [RR] 0.32, 95% CI 0.15–0.71;  $p=0.004$ ). The risks and benefits of IOL must be discussed with the woman.

Hence IOL at term can be offered for fetal macrosomia from the consultant ANC if the EFW on USS is above the 90th centile. Timing of this needs to be discussed with the woman and should include a discussion about the risk of shoulder dystocia at different fetal weights rather than simply centiles. An estimate of risks at different weights is:

- 5% (1 in 20) in birthweight of 4000 – 4250g (8lb 13oz to 9lb 6oz)
- 9% (1 in 12) in birthweight of 4250 – 4500g (9lb 6oz to 9lb 15oz)
- 14% (1 in 7) in birthweight 4500 – 4750g (9lb 15oz to 10lb 7oz)
- 21% (1 in 5) in birthweight 4750g – 5000g (10lb 7oz to 11lb) (Nesbitt1998)

Using this information, it would be reasonable to offer induction when the EFW is predicted to be around 4kg.

If woman declines IOL and wants to consider expectant management repeat scan in 2 weeks to reassess growth. If size increases beyond 5000g arrange discussion of mode of delivery.

All women with a baby >90<sup>th</sup> centile between 35+0 and 38+0 should be offered entry to the Big Baby Trial.

### Following birth

The attending midwife at delivery should generate the birth centile and plot the birthweight on the GROW chart. This is for audit purposes only. The birthweight must be checked against the WHO charts (Robertson's charts) to determine risk of hypoglycaemia. (This must be according to **completed** weeks of pregnancy.) Babies <3<sup>rd</sup> centile on these charts must be referred to the neonatologist for a management plan, and the hypoglycaemia guideline commenced. Trust Guideline for the Management of Hypoglycaemia in Preterm Infants [Trustdocs Id: 1196](#).

### Polyhydramnios

If polyhydramnios is present, a naso gastric tube should be passed before the baby is fed to exclude trachea oesophageal fistula (TOF)

### Monitoring and review

- Compliance of staff training annually will be undertaken by the trust training department.

### Summary of development and consultation process undertaken before registration and dissemination

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This guideline was written by the author on behalf of the Obstetrics & Gynaecology Directorate, Maternity Guidelines Committee, which has seen and approved its content.

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## Distribution list / dissemination method

Clinical Midwifery Managers, Community team leaders, Midwives, Obstetricians, Sonographers via Hospital Intranet.

## References / source documents

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[www.pi.nhs.uk/growth/example.htm](http://www.pi.nhs.uk/growth/example.htm) Recommendations for Fundal Height Measurement.

### Guidelines

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<https://www.england.nhs.uk/publication/saving-babies-lives-version-two-a-care-bundle-for-reducing-perinatal-mortality/>