



Aneurin Bevan University Health Board

Management of Pregnancy with Large for Dates Fetus Guidelines

N.B. Staff should be discouraged from printing this document. This is to avoid the risk of out of date printed versions of the document. The Intranet should be referred to for the current version of the document.

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Introduction

Fetal macrosomia is associated with an increased risk of adverse maternal and neonatal outcomes. Such risks include shoulder dystocia, birth trauma to include clavicular fractures and Erb's palsy¹. For the mother this increases the risk of maternal post-partum haemorrhage, perineal trauma and 3rd /4th degree tears.

Fetal macrosomia appears to be associated with an increased risk of operative birth or caesarean section.

What is "large for gestational age" (LGA) or fetal macrosomia?

For this guideline we will discuss the LGA fetus, as the term fetal macrosomia relates to the birthweight of the neonate.

LGA thresholds:

- Symphysio-fundal height (SFH) >97TH centile for gestation
- Abdominal circumference (AC) >95th centile for gestation
- Estimated fetal weight (EFW) >90th centile for gestation

Policy Statement

Aims and Objectives

- Identify women at risk of having a macrosomic baby
- Reduce the need for unnecessary intervention and anxiety in women who are thought to be Large for gestational age
- Involve women in decision for earlier delivery in the event of a large for gestational age fetus on USS

Scope

All Doctors and midwives involved in the care of our obstetric population

Main Body

How do we manage women with LGA fetus?

Detected at >28 weeks gestation :

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- **SFH > 97th centile:** arrange USS for fetal biometry at next available slot: if EFW and AC <90th centile return to routine care , a repeat scan is not required if the growth velocity on SFH remains linear.

- **IF EFW or AC >95th centile**
 - o Check OGTT result if already performed
 - o If not had an OGTT and >28 weeks consider arranging a fasting blood sugar as OGTT is unreliable in 3rd trimester and HbA1c
 - If fasting reading is >5.6 or HbA1c > 42mmol/l refer to specialist midwife and diabetic clinic
 - o Arrange repeat USS at 38 weeks and ANC appointment at 38-39 weeks gestation to verify growth velocity and EFW.
 - o In all women – dietary advice to cut out sugars from diet until delivery (HAPO study showing direct correlation between maternal glucose and size of fetus in women without gestational diabetes)
 - o Consider individualised delivery plans depending on other risk factors specific to the woman (see below).

Delivery planning for EFW/ AC >90th centile at 36-40 weeks

- o A discussion with the women should take place ideally in ANC and the following should be addressed:

- o Inform the woman that there is an increased risk of shoulder dystocia (RR 0.60 CI 0.37-0.98) in LGA fetuses(1in 25), normal risk 1 in 150.

- o Inform women that the evidence from a RCT by Boulvain et al suggested that IOL at 37-38+6 weeks gestation reduces the risk of shoulder dystocia with no increase in c section rate (RR 0.32). Women should also be informed that neonatal outcomes are optimised and neonatal morbidity reduced if birth occurs >39 and 40+7 weeks gestation² as this avoids problems associated with immaturity of fetal organs.

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- Compared to expectant management there is no clear effect of induction of labour for suspected macrosomia on the risk of c-section (RR 0.91 CI 0.76-1.09) or instrumental delivery (RR 0.86 CI 0.65-1.13)
- The big baby trial suggests Erb's palsy is 1 in 10 in shoulder dystocia and clavicular fracture 1 in 10 shoulder dystocia.
- The Cochrane database suggests 60 women will need to be induced to prevent 1 fracture. Clavicular fractures, however, heal well without consequences and also occur in SVDs without shoulder dystocias.
- There is no difference in the level of brachial plexus injuries or Hypoxic ischaemic encephalopathy observed between early IOL and IOL after 40+7.
- IOL may be offered between 39 weeks and 40+7 weeks gestation following discussion with the patient's lead consultant.
- An EFW > 5000g in women without diabetes should prompt a discussion re mode of delivery and c section be considered (>4500g in women with diabetes).²
- Inform women that ultrasound estimation of fetal weight may be equivocal by approximately 15% either way.

Further Information Clinical Documents

No national evidence or standards

Audit

Review notes retrospectively to ensure

- SFH plotting and appropriate referral for USS
- Appropriate discussion has been documented between the woman and clinician re management of LFGA fetus at term

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- Audit timing of IOL for women with LFGA fetus and outcomes for mother and baby
- Appropriate referral for OGTT and / or fasting blood glucose levels /or HbA1C

Review

3 yearly unless new evidence first

References

1. King JR, Miller DA, Ouzounian 2012
2. American college 2013
3. Boulvain M, et al Induction of labour at or near term for suspected fetal macrosomia. Cochrane Database of systemic reviews 2016, Issue 5
4. Induction of labour for predicted macrosomia: study protocol for the 'Big Baby' randomised controlled trial (BMJ Open 2022;12)
5. Hyperglycaemia and Adverse Pregnancy Outcome (HAPO)-American Diabetic Association 2012Mar;35(3):574-580
6. Clinical Effectiveness Forum (CEF) on 30TH October 2023: CEF team discussed with obstetric lead and ABUHB maternity team and reviewed the guideline based on the current evidences.

Appendix One: Management of Pregnancy with Large for Dates Fetus

