# Large for Gestational Age in Non-Diabetic Guideline

## Guideline information

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Clinical

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## Approval information

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Summary of document:
A guideline to promote consistent care and guidance for women for whom the fetus is expected to be large for the gestational age and where diabetes has been excluded.

Scope:
The guideline is applicable to all women and birthing people who access maternity services and aims to support midwives, obstetricians and other members of the multi-disciplinary team to provide consistent care to women when the fetus is expected to be large for the gestational age.
The guidance uses the term “woman” (pronouns she or her) to describe individuals whose sex assigned at birth was female, whether they identify as female, male or non-binary. It is important to acknowledge that it is not only people who identify as women for whom it is necessary to access women’s health and reproductive services. Therefore, this should include people who do not identify themselves as women but who are pregnant or have recently given birth. Obstetric and midwifery services and delivery of care must therefore be appropriate, inclusive and sensitive to the needs of those individuals whose gender identity does not align with the sex that they were assigned at birth.

To be read in conjunction with:
NICE Caesarean Birth (2020) NICE Inducing Labour (2021)
NICE Intrapartum care for women with existing medical conditions or obstetric complications and their babies (2019)

Owning group:
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Executive Director job title:
Sharon Daniel – Interim Director of Nursing, Quality and Patient Experience

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1.0 – New Guideline – 14.09.2017
2.0 – Guideline Update – 17.06.2022
3.0 – Updated – 26.09.2024

Keywords
Large for Gestational Age, Large for Dates

Glossary of terms
LGA – Large Gestational Age
SFH - Symphysis Fundal Height

# Contents

## Scope
The guideline is applicable to all women who access maternity services and aims to support midwives, obstetricians and other members of the multi-disciplinary team to provide consistent care to women when the fetus is identified to be large for the gestational age.

## Aim
The aim of this document is to:

- Consistent care planning for women who have a fetus who is considered large for gestational age.

## Objectives
The aim of this document will be achieved by the following objectives:

- This guideline sets out the care planning and management for non-diabetic women and birthing people where the fetus has been identified as being large for gestational age on ultrasound scan.

## Introduction
The number of large babies is on the increase. Over the last decade there has been a 1525% increase in many countries in the number of women giving birth to large infants. This trend has been attributed to increases in maternal height, body mass, gestational weight gain, diabetes, reduced cigarette smoking and changes in socio-demographic factors.

The definition of a macrosomic fetus or large for gestational age (LGA) fetus is ambiguous and varies across the literature. NICE (2021) state that fetal macrosomia describes a baby that is believed to be large for its gestational age, with an estimated fetal weight above the 95th percentile, at or after 36 weeks of pregnancy. Various ways have been used to define macrosomia over the years, including >4kg, >4.5 kg, or > 90th or 95th population based centile.

**To promote consistency in Hywel Dda University Health Board LGA wll refer to a baby over the 97$^{th}$ Centile on the USS in line with the All-Wales Maternity and Neonatal Guideline "All Wales Midwifery led Care Guideline"**

## Identification of Suspected Large for Gestational Age (LGA) by routine antenatal symphysis fundal height (SFH) measurement
Screening for impaired fetal growth is performed in all low risk pregnancies by plotting the SFH measurement onto GAP GROW chart

- If SFH is measured to be above 97$^{th}$ Centile refer for a growth scan.

## When estimated fetal weight (EFW) on growth scan is ≥97$^{th}$ centile

- If the scan shows the EFW >97$^{th}$ Centile, then Large for Gestational Age is diagnosed.

## When estimated fetal weight (EFW) on grown scan is <97$^{th}$ centile

- If The EFW is <97$^{th}$ Centile the woman continues her routine antenatal care.

## Ongoing Symphysis Fundal Height (SFH) Assessment when EFW on USS <97th centile

Plotting SFH measurements that remain above the 97th.

- If despite a normal scan and no evidence of GDM subsequent SFH measurements continues to plot above and **parallel** to the 97th centile, referral for another scan is **not** indicated

- If subsequently there is definite **increase** in the growth trajectory when plotted on the SFH chart please refer for repeat growth scan.

## Management of LGA

## Antenatal Care:

If growth is greater than 97th centile on the scan and/or increased Liquor Volume

- Refer to Consultant clinic.
- Arrange for GTT if not already done within 4 weeks.
- If Gestational Diabetes Mellitus (GDM) is confirmed refer to diabetes ANC (See Diabetes in pregnancy guidelines).
- Arrange a further growth scan by 37 weeks if there is more than 14 day interval between current scan and when woman will be 37 weeks ( e.g. scanned at 31weeks, so then request growth scan at 36+6 weeks) to facilitate discussions regarding choice of mode and place of birth.

## Counselling

Discuss with women without diabetes and with LGA

- Advise women with an EFW >97th centile that macrosomia (Birth Weight of >4.5kg) increases the chance of some birth complications, including shoulder dystocia and intrapartum related intervention such as caesarean birth.
- The accuracy of USS in estimating babies weight. The larger the baby the bigger the margin of error is Ultrasound scans have a 10% margin of error and a sensitivity of 50-60% for macrosomia.
- This means that the baby may be born normal weight and intervention might seem unnecessary.

The options for birth are:

- Expectant management,
- Induction of labour
- Caesarean birth (see the NICE guideline on caesarean birth)

Risks:

- There is uncertainty about the benefits and risks of induction of labour compared to expectant management, but:
- With induction of labour the risk of shoulder dystocia reduced compared with expectant management (7:1000 Vs 20:1000).

Rate of Shoulder Dystocia by Weight

- 5% (1:20).BW 4000-4250 g
- 9% (1:12) BW 4250-4500 g
- 14% (1:7) BW 4500-4750g
- 21% (1:5) BW 4750-5000g

- With induction of labour the risk of third- or fourth-degree perineal tears (linked to instrumental delivery, parity and fetal weight) is increased compared with expectant management (29:1000 Vs 6:1000).
- There is evidence that the risk of perinatal death, brachial plexus injuries in the baby, or the need for emergency caesarean birth is the same between the 2 options.
- Consideration should be given around the impact of induction on the woman's birth experience and on their baby
- Discuss the options for birth with the woman, taking into account her individual circumstances and her preferences, and respect her decision.

## Conservative Management

If woman choses a conservative approach antenatal care continues under consultant care. Advise birth in a consultant unit.

## Caesarean Birth

- If the woman opts for caesarean birth advise that in the absence of any other complications, a caesarean is recommended after 39/40

Discuss with the woman her options if she goes into labour prior to the planned caesarean date.

- Recommend Elective Caesarean if the EFW is ≥ 5 kg

After the initial consultation, advise the woman that if she wishes to discuss this further, she can be seen again in the ANC or by the consultant midwife if she prefers.

<u>Ensure that the consultation is clearly documented in the notes highlighting specific concerns or risks discussed.</u>

## Intrapartum Care:

## Place of Birth

- Recommend Birth in a Consultant Unit if the EFW is above 97$^{th}$ centile on ultrasound
- If a woman chooses to birth in another birth setting, explain the risk and benefits and respect the woman's choice /refer to consultant midwife.

## First Stage

- There is no evidence that continuous electronic monitoring provides any benefit compared to intermittent auscultation in women whose babies are large for gestational age. Therefore, the fetal heart should be monitored using intermittent auscultation.
- If there is a delay in first stage, a senior review including full assessment should happen before commencing Oxytocin for augmentation
- If wishes to have a water birth it is not contraindicated for LGA however, explain to the woman that if there are any concerns she might be asked to come out of the birthing pool.

## Second Stage

- Early recourse to caesarean birth if there is no descent of the presenting part.
- Instrumental assisted birth should be performed in theatre. Consultant should be informed and attend if required.
- Having a suspected LGA baby should not alter the management of second stage following the birth of the fetal head (i.e. waiting for restitution, waiting for next contraction, and attempting axial traction before declaring shoulders' dystocia).

## Third Stage

- Recommend active management of third stage in all birth settings.

## Special Considerations AC >95$^{th}$ centile

On growth scans if the AC is >95$^{th}$ centile arrange GTT (if less than 34 weeks and GTT has not been performed within the previous 4 weeks). Refer to consultant care regardless of the EFW for full assessment.

## Auditable Standards

- Evidence that the symphysis fundal height was accurately plotted and appropriate referral for USS.
- Appropriate discussion has been documented between the woman and clinician re management of large for gestational age fetus at term.
- GTT appropriately undertaken for women whose baby is noted to be LGA in the antenatal period.

## References

NICE August 2021 Antenatal Care NG201

NICE Sept 2017 Intrapartum Care NG235

NICE November 2021, Inducing Labour. NG207

NICE 2019 Intrapartum care for women with existing medical conditions or obstetric complications and their babies NG121

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