Large for Gestational Age in Non-Diabetic Guideline

Guideline information

Guideline number: 623

Classification:
Clinical

Supersedes:
Previous Version

Local Safety Standard for Invasive Procedures (LOCSSIP) reference:
N/A

National Safety Standards for Invasive Procedures (NatSSIPs) standards:
N/A

Version number:
2.0

Date of Equality Impact Assessment:
Detail date of EqIA

Approval information

Approved by: Maternity Written Documentation Review Group

Date of approval:
17/06/2022

Date made active:
26/07/2022

Review date:
17/06/2025

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 and birthing people when the fetus is expected to be large for the gestational age.

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)

Patient information:
N/A

Owning group:
Obstetric Written Documentation Review Group
17/06/2022

Executive Director job title:
Mandy Rayani – Director of Nursing, Quality and Patient Experience

Reviews and updates:
1.0 – New Guideline – 14.09.2017
2.0 – Guideline Update – 17.06.2022

Keywords
Large for Gestational Age, Large for Dates

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

Contents

Guideline information 1
Approval information 1
Scope 4
Aim 4
Objectives 4
Introduction 4
Identification 4
Management 5
Special Considerations 7
Auditable Standards 7
References 7

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 and birthing people when the fetus is expected to be large for the gestational age.

Aim

The aim of this document is to:

- Consistent care planning for women and birthing people who have a fetus who is considered large for gestational age.
- The guideline is only applicable for women and birthing people.

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. The Perinatal institute recommend using >90th customised GROW centile, based on recent studies that have shown that customised centiles improve the identification of macrosomia that is associated with pathological outcome (GAP/grow).

To promote consistency in Hywel Dda University Health Board LGA will refer to a baby over the 90th Centile on the USS

Identification

Fundal height measurements are an inaccurate way of estimating fetal size. They are influenced by the maternal size, amount of amniotic fluid, status of the bladder, pelvic masses (e.g. fibroids), fetal position and many other factors.

If SFH is measured to be above 97th Centile the woman should be offered a growth scan.

If the scan shows the EFW >90th Centile then LGA is diagnosed. If The EFW is <90th Centile the woman continues her routine antenatal care.

Further assessments will be by SFH and are expected to follow the same centile (>97th) without the need for further scans.

Management

Antenatal Care:

Referral

If growth is greater than 90th centile on the scan and/or increased Liquor Volume

- Refer to Consultant clinic.
- Arrange for GTT if not already done within 4 weeks.

If GDM is confirmed refer to diabetes ANC (See Diabetes in pregnancy guidelines).

Counselling

Discuss with women without diabetes and with LGA

1. 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.
2. 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** or **caesarean birth** (see the NICE guideline on caesarean birth)
- 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 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.

- Consider should be given around the impact of induction on their 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.

Discuss the options for birth with the woman, taking into account her individual circumstances and her preferences, and respect her decision.

If the woman opts for Conservative Management

Antenatal care continues as normal (can be referred back to MW care if no other risk factors)

If the woman opts for IOL
The timing of the IOL should be agreed between the woman and her consultant depending of the **estimated fetal weight, the woman's concerns, and the centile, and vaginal assessment.**
However, recommendation is IOL not before 37/40.
Manage as per IOL guidelines.

If the woman opts for Caesarean Birth
Advise the woman 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.

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

Intrapartum Care:

Place of Birth
- Explain to the woman all the different birth settings available (Home, MLU, Consultant Unit).
- Recommend birth in Consultant Unit if the EFW is above 97th centile on the USS.
- 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.
- Water birth 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.
- If there is a delay in first stage, a senior review including full assessment should happen before commencing Oxytocin for augmentation

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

On growth scans if the AC is >95th centile 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

The Obstetrician & Gynaecologist (TOG) 2010 TOG release : Management of large babies in non-diabetic women , Aye SS, Miller V, Saxena S, Farhan M. Management of large-for-gestational-age pregnancy in non-diabetic women. The Obstetrician & Gynaecologist 2010;12:250-256.

NICE August 2021 Antenatal Care NG201

NICE Sept 2017 Intrapartum Care CG190

NICE November 2021, Inducing Labour. NG170

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

1. Adam, S, Lombaard, H. A. D, Zyl, D.G. van. Are we missing at-risk babies? Comparison of customised growth charts v. standard population charts in a diabetic population. South Afr. J. Obstet. Gynaecol. 2014; 20, 88–90.
2. Cha, H.H, Kim, J.Y, Choi, S.J, Oh, S.Y, Roh, C.R, Kim, J.H. Can a customized standard for large for gestational age identify women at risk of operative delivery and shoulder dystocia? J. Perinat. Med. 2012; 40, 5, 483-488.
3. RCOG GTG 42 Shoulder Dystocia; and "Antenatal and intrapartum prediction of shoulder dystocia" Gupta et al. European Journal of Obstetrics & Gynecology . 2010 Aug;151(2):134-9.
4. Nesbitt TS, Gilbert WM, Herrchen B. Shoulder dystocia and associated risk factors with macrosomic infants born in California. *Am J Obstet Gynecol*. 1998;179(2):476-480.