GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Bae Abertawe
Swansea Bay University Health Board

Antenatal counselling proforma for Estimated Fetal Weight (EFW) via Ultrasound scan is ≥97th centile with normal GDM screen and otherwise uncomplicated pregnancy

Use for women who would otherwise meet the criteria for Midwifery Led Care (MLC).

Name & Hospital Number:_____ Date:_____	
Situation	Estimated fetal weight (EFW) ≥97th on USS, with no other obstetric or medical complications. Antenatal counselling and discussion
Background	**Gravida ___Parity___ BMI:_____at booking. EDD:_____** Medical history Obstetric history USS – EFW _____Centile GDM Screen: _____VTE score:_____ Findings of abdominal palpation if relevant

Discussion	**Reason for discussion: - EFW over 97th centile on USS.** The definitions of 'Large for Gestational Age' (LGA) fetus, macrosomia, or fetal overgrowth is widely debated. According, to the National Institute for Clinical Excellence (NICE, 2021) fetal macrosomia describes a fetus that is believed to be large for its' gestational age, with an Estimated Fetal Weight (EFW) above the >95th centile, at or after 36 weeks of pregnancy. The Royal college of Obstetricians and Gynaecologists (RCOG, 2012) identify macrosomia as an EFW greater than >4.5kg, with this cut off limit appearing to have the strongest association in terms of fetal outcomes. <u>Ultrasound scan accuracy</u> Despite ultrasound being the most accurate way to assess fetal growth, there are still inaccuracies in EFW by ultrasound leading to a commonly accepted error margin of 15%, which may be larger with LGA babies. It is important to inform women of the potential estimation error when discussing birth options for LGA (McMurrugh, Viera & Sankaran, 2024). The findings of the 'Big Baby' study, as well as its limitations, provide information that can be communicated to pregnant women with a suspected LGA fetus, to assist them in making choices about mode and timing of their delivery. First, they should be made aware that ultrasound assessed fetal weight is an estimate only, with substantial margins of error. Second, the potential short-term and long-term risks and benefits should be discussed with regard to the different delivery pathways. Third, our study supports previous reports that, compared with delivery at 39 weeks' gestation or later, earlier delivery can reduce the risk of shoulder dystocia.8,10 However, this benefit can be reached without needing to induce before 38 weeks' gestation, and without affecting neonatal outcome including need for phototherapy. We also showed that induction of labour, although associated with an extra half day in hospital pre-delivery, can lead to a reduction in operative deliveries. These findings provide essential information for maternal choices regarding the timing and mode of delivery, including expectant care, induction of labour, or elective caesarean section (Gardosi et al, 2025) **It is therefore paramount to reassure women that most babies weighing up to 4.5kg are born vaginally with no complications.**

Risks associated with LGA

There are associated adverse maternal and neonatal outcomes from birthing an LGA baby. Including:

- The need for a caesarean birth.
- Postpartum haemorrhage.
- Third-and fourth-degree tears.
- Shoulder dystocia.
- Low Apgar scores.
- Hypoglycaemia.
- Admission to Neonatal intensive care unit.
- Severe neonatal morbidity and perinatal mortality.

(McMurrgh, Viera & Sankaran, 2024).

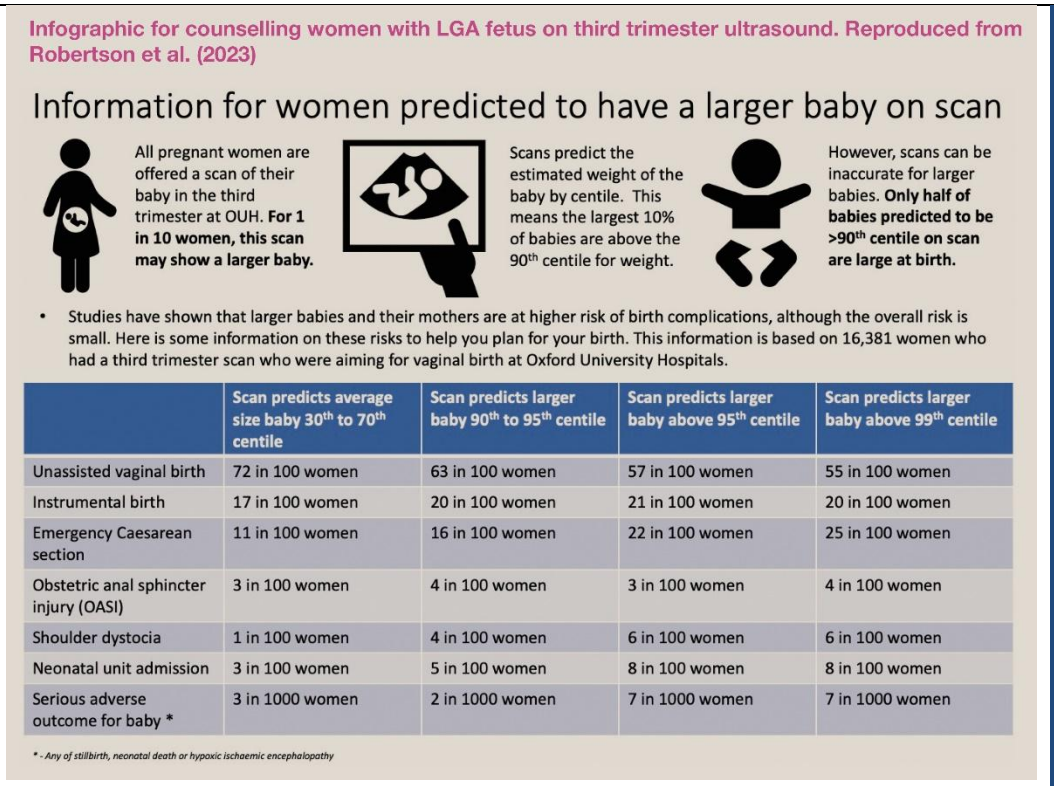
NICE Inducing labour Guidelines (2021)

Risks and benefits of induction of labour (IOL) compared to expectant management for suspected fetal macrosomia (in women without diabetes).

Outcome	Induction of labour	Expectant management	Risk difference
Shoulder dystocia	410 per 10,000 babies	680 per 10,000 babies	270 per 10,000 babies
Third-or fourth-degree tears	260 per 10,000 women	69 per 10,000 women	191 per 10,000 women

Adapted from guideline (NG207)

Infographic for counselling women with LGA fetus on third trimester ultrasound. Reproduced from Robertson et al. (2023)



	Scan predicts average size baby 30th to 70th centile	Scan predicts larger baby 90th to 95th centile	Scan predicts larger baby above 95th centile	Scan predicts larger baby above 99th centile
Unassisted vaginal birth	72 in 100 women	63 in 100 women	57 in 100 women	55 in 100 women
Instrumental birth	17 in 100 women	20 in 100 women	21 in 100 women	20 in 100 women
Emergency Caesarean section	11 in 100 women	16 in 100 women	22 in 100 women	25 in 100 women
Obstetric anal sphincter injury (OASI)	3 in 100 women	4 in 100 women	3 in 100 women	4 in 100 women
Shoulder dystocia	1 in 100 women	4 in 100 women	6 in 100 women	6 in 100 women
Neonatal unit admission	3 in 100 women	5 in 100 women	8 in 100 women	8 in 100 women
Serious adverse outcome for baby *	3 in 1000 women	2 in 1000 women	7 in 1000 women	7 in 1000 women

* - Any of stillbirth, neonatal death or hypoxic ischaemic encephalopathy

NICE (2021) recommends that women with a suspected LGA (>95th centile) fetus are offered options of expectant management, induction of labour and caesarean birth.

Induction of labour

A Cochrane review demonstrated that induction of labour at term reduces the risk of shoulder dystocia/birthweight/neonatal fracture in cases that are estimated to weigh more than 4000g (Boulvain, 2016). The Royal College of Obstetricians and Gynaecologists (RCOG) does not currently recommend induction of labour for women with a suspected macrosomic fetus in the absence of diabetes (RCOG, 2012).

NICE state 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 appears to be reduced compared with expectant management
- with induction of labour the risk of third- or fourth-degree perineal tears is increased compared with expectant management

- 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
- they will also need to consider the impact of induction on their birth experience and on their baby.

Discuss the options for birth with the woman, taking into account their individual circumstances and their preferences, and respect their decision. Support recruitment into clinical trials, if available (NICE, 2021).

Caesarean birth

The (RCOG), Green-top Guideline No 42, the management of shoulder dystocia was issued in 2012. They recommended that elective caesarean section should be considered for women and birthing person with diabetes or gestational diabetes where EFW >4.5 kg in an attempt to reduce morbidity. It has been estimated that 443 diabetic women with babies >4.5 kg would need to have caesarean in order to prevent **one** permanent brachial plexus injury. In non-diabetic pregnant women with a EFW >5 kg, the number needed to treat rises to 3695 hence this **not** been a recommendation **(See caesarean birth information sheet)**

Care in labour

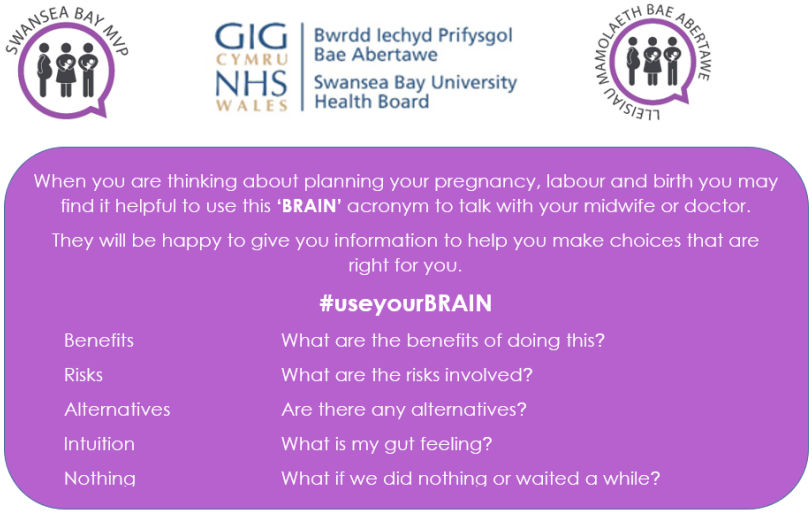
Outcomes from birthing in a midwifery led environment for healthy women with uncomplicated pregnancies from Birthplace (2011) discussed.

Models of care and access to facilities in each birth setting discussed and understood. Transfer times from;

- The Bay Birth Centre is currently_____ minutes.
- Neath Port Talbot Birth Centre currently _____ minutes.

	• Home birth- Welsh Ambulance aim to attend within 8 minutes in 65% of cases where the transfer is an emergency. Most transfers are for none-urgent reasons.
Plan	Opting for: Routine midwifery led care ☐ OR referred to obstetrician for further discussion ☐ Planning to birth (location) – _____ According to the All-Wales place of birth assessment criteria an EFW via USS >97th centile with normal GDM screen and otherwise uncomplicated pregnancy requires an individual assessment and Intrapartum care-planning. After an individual discussion and assessment, the woman may be suitable to give birth in a midwife-led setting. These discussions are completed around 36/40 and should be revisited and re-evaluated at every antenatal contact as the pregnancy progresses. Following the above guidance an LGA fetus (outside of maternal diabetes)is **not** at higher risk of intrapartum hypoxia and is therefore eligible for Intermittent Intelligent Auscultation (IIA) regardless of chosen place of birth, in line with the IA guideline Water immersion during labour and water birth are **not** contraindicated when there is suspected LGA fetus. However, explain to the woman that any concerns emerge that they may be asked to exit the birth pool. Any delay in the 1st stage or second stage of labour requires full holistic assessment and referral to obstetric services as required. *Assessment for suitability of birth setting should be made at each Antenatal contact. Reassessed:

Date	Gestation	Birth choice setting	Sign



Complete the BRAIN form in conjunction with the woman ensuring she has an informed choice in her decision making.

Use **BRAIN** to make decisions that feel right for you and your baby

There are many choices and decisions to make as your pregnancy progresses. Should I have antenatal tests? Should I plan a pool birth or a caesarean birth? Should I have my labour induced?

Sometimes a course of action is presented as a given but you always have choices. The tool provides a logical approach to talking through all options with your doctor and midwife

What is the decision/care being considered?

.....

How long do I have to make this decision? .....

Benefits What are the benefits of making this decision?

.....

Risks What are the risks associated with this decision?

.....

Alternatives Are there any alternatives?

.....

Intuition How do I feel? What does my 'gut' tell me?

.....

Nothing What if I decide to do nothing/wait and see? What happens next?

.....

Form Completed By:

_____

Staff

Stamp:

Date: _____

***to be filed at the front of the woman's records.**