Fetal Growth Restriction FAQ's

Introduction

Improving detection of Fetal Growth Restriction (FGR) is an important strategy to reduce perinatal morbidity and mortality.

FGR is best defined as a fetus that has not reached its growth potential because of placental disfunction, with small for gestational age (SGA) referring to an infant with a birth weight of <10th centile.

Top tips for measuring symphseal fundal height (SFH)

1. Consistency is key. Measuring from fundus to symphysis allows two fixed points to measure fundal height. Using a standard technique reduces inter-observer variation.
2. For a fetus with a suspected non-longitudinal lie, continue to measure SFH. Measure from the highest upper point of the fundus, even if this is not in the midline.
3. A deviation of 3cm +/- gestation is an indication for ultrasound (USS) to check fetal growth.

Key considerations for USS

Routine USS for low risk women in the third trimester is not currently recommended as a screening tool for SGA/FGR. While the POP study reported that routine 36 week ultrasound improved the detection of SGA, it did not show significant benefit in improving clinical outcomes.

What is the role of dopplers in diagnosis & surveillance?
The cerebroplacental ratio (CPR) is the ratio of the fetal middle cerebral artery (MCA) pulsatility index (PU) to the umbilical artery PI. Gestation specific centiles are available for this ratio. A low CPR (<5th centile) is now generally accepted as an indicator for late FGR.

AFI or deepest pool?
Deepest pool reduces number of IOL for DVP with no change in outcome.

How is IVF a risk factor for FGR?

IVF and infertility are risk factors for placental dysfunction.

What role does a CTG have in the care of a baby with suspected SGA/FGR?

Continuous electronic fetal monitoring (CTG) is recommended during labour in all pregnancies suspected SGA/FGR

The role of CTG outside of labour (ie. antenatal surveillance CTGs) for women with SGA/FGR has not been well established. Practice should be governed by local consensus based clinical guidelines.

Further reading suggested: Cochrane antenatal CTG.

What is the role of Aspirin?

Low dose aspirin (LDA) reduces the risk of preterm preeclampsia in women assessed as high risk. For women assessed as high risk, LDA 100-150mg nocte is recommended.

There is a lack of evidence to support the use of LDA to prevent SGA/FGR.

REFERENCES

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