



Procedure for the management of large for gestational age fetus

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Section Headings

1.0 Introduction

The detection and planning for birth of the large for gestational age (LGA) fetus is an area of importance. Evidence is increasing for the necessity of guidelines to manage these women and the fetus in order to decrease the risk of shoulder dystocia and complex labours and birth. This guideline outlines the care of these women.

2.0 Objective

The purpose of this guideline is to outline a structured and standardised approach to the management of the large for gestational age fetus (LGA).

This includes:

- The identification of LGA fetus using fundal height measurements and individualised growth charts
- The counselling of women with the LGA fetus
- The management of the LGA fetus

3.0 Scope

This guideline applies to all medical and midwifery staff working on the maternity unit.

4.0 Main body of the document

Definitions

Macrosomia - is a newborn with an excessive birth weight (> 4000g or greater than the 90th percentile for a given gestational age)

Large for gestational age (LGA) - refers to suspected macrosomia in pregnancy.

The thresholds used to define LGA antenatally are:

- Estimated fetal weight (EFW) > 90th centile
- Abdominal circumference (AC) > 95th centile

Early term gestation - is defined as 37 and 38 weeks.

Background Information

Fetal macrosomia is associated with an increased risk of perinatal morbidity and mortality. Intrapartum maternal and perinatal complications include prolonged labour, difficult birth, operative vaginal delivery, caesarean delivery, postpartum haemorrhage, vaginal lacerations, shoulder dystocia with brachial palsy and asphyxia, as well as facial nerve palsy.

Indications for a growth scan/referral

If consecutive Symphysis-Fundal Height (SFH) measurements are above the 90th centile but continue to follow the slope of the curve on the customised growth chart, no action is required.

If there is a sudden significant rise in the SFH, an ultrasound scan and appointment should be made with the antenatal clinic to investigate for LGA and/or polyhydramnios.

If LGA is detected < 36 weeks, a follow up scan and clinic appointment should be arranged at 37-38 weeks to enable appropriate counselling and planning for delivery.

Glucose tolerance test (GTT)

If the EFW is > 90th centile and/or the AC > 95th centile, a glucose tolerance test should be performed as soon as possible.

If a GTT has been performed at an earlier gestation, any decision regarding a repeat test should be made by a registrar or consultant.

If the GTT is positive, refer to specialist diabetic midwife and transfer care to medical disorders antenatal clinic.

Planning delivery for a fetus with EFW > 90th centile / AC > 95th centile at 36-40 weeks

The timing of delivery, options and maternal wishes should all be considered as part of the plan.

It is important to explain the challenges and limitations of ultrasound and EFW.

Advise women of the risks including the risk of shoulder dystocia.

Routine caesarean delivery is not uniformly recommended but should be discussed with the patient and this discussion should be documented in the notes.

Consider offering a membrane sweep from 37 weeks. Clearly communicate this plan to the community midwife in the patient's handheld notes.

Earlier induction >38 weeks should be considered:

- Inform women that induction of labour does not increase the risk of caesarean section or instrumental delivery and improves the likelihood of spontaneous vaginal delivery.
- Earlier induction of labour also results in lower mean birthweight, and fewer birth fractures and shoulder dystocia.
- These benefits should be balanced against the effects of early-term induction of labour. Prior to 39 weeks gestation, induction of labour or operative delivery is associated with a small increased risk in perinatal morbidity and neurodevelopmental delay.
- The woman should be informed of the small increased risk of perineal trauma.
- Women with an EFW above 5kg should be offered a caesarean section because the risk of shoulder dystocia is 15%.

5.0 Roles and responsibilities

Midwives/Support staff

Have a responsibility to monitor fetal growth and refer if deviations in the fetal growth pattern are suspected.

Obstetricians

Have a responsibility to develop management plans for women where LGA is identified

6.0 Associated documents and references

1. ER Margo-Malosso et al. Induction of labour for suspected macrosomia at term in non-diabetic women: a systematic review and meta-analysis of randomized controlled trials. *BJOG* 2017; 124: 414-42
2. Induction of labour at or near term for suspected fetal macrosomia. *Cochrane* 2016
3. ACOG Practice Bulletin No 173: Fetal macrosomia. *Obstet Gynaecol* 2016; 128: e 195-209



4. Boulvain M et al. Induction of labour versus expectant management for large-for-date fetuses: a randomised controlled trial. *Lancet*, 2015. 385(9987): p. 2600-5
5. NHS England. Saving Babies' Lives Care Bundle Version 2. March 2019

7.0 Training and resources

Training will be given as documented in the Maternity Training Needs Analysis. This is updated on an annual basis.

8.0 Monitoring and audit

This section should describe how the author intends to monitor and/or audit the document to ensure it is fit for purpose and being implemented.

The Table below helps to focus the author on the monitoring requirements and must be used for all Trust Approved Documents. Assistance can be obtained from the Clinical Governance and Compliance Manager.

Minimum requirement to be monitored	Process for monitoring e.g. audit	Responsible individual/ group/ committee	Frequency of monitoring	Responsible individual/ group/ committee for review of results	Responsible individual/ group/ committee for development of action plan	Responsible individual/group/ committee for monitoring of action plan and Implementation

9.0 Equality and Diversity

The Trust is committed to an environment that promotes equality and embraces diversity in its performance as an employer and service provider. It will adhere to legal and performance requirements and will mainstream equality, diversity and inclusion principles through its policies, procedures and processes. This procedure should be implemented with due regard to this commitment.

To ensure that the implementation of this procedure does not have an adverse impact in response to the requirements of the Equality Act 2010 this policy has been screened for relevance during the policy development process and a full equality impact assessment is conducted where necessary prior to consultation. The Trust will take remedial action when necessary to address any unexpected or unwarranted disparities and monitor practice to ensure that this policy is fairly implemented.

This procedure can be made available in alternative formats on request including large print, Braille, moon, audio, and different languages. To arrange this please refer to the Trust translation and interpretation policy in the first instance.

The Trust will make reasonable adjustments to accommodate any employee/patient with particular equality, diversity and inclusion requirements in implementing this procedure. This may include accessibility of meeting/appointment venues, providing translation, arranging an interpreter to attend appointments/meetings, extending policy timeframes to enable translation to be undertaken, or assistance with formulating any written statements.

9.1 Recording and Monitoring of Equality & Diversity

The Trust understands the business case for equality, diversity and inclusion and will make sure that this is translated into practice. Accordingly, all procedures will be monitored to ensure their effectiveness.

Monitoring information will be collated, analysed and published on an annual basis as part of Equality Delivery System. The monitoring will cover the nine protected characteristics and will meet statutory employment duties under the Equality Act 2010. Where adverse impact is identified through the monitoring process the Trust will investigate and take corrective action to mitigate and prevent any negative impact.



Appendix 1

Rapid Equality Impact Assessment Form

For Clinical Policies or Procedures only

See Guidance for advice on completing this assessment.

Please use the guidance provided and give particular consideration to the needs of people with protected characteristics age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, sex race, religion or belief and sexual orientation.

Department:		CBU/Area/ward/	
Title of Person(s) completing this form:		New or Existing Policy/Procedure	
Title of Policy/Procedure being assessed:		Implementation Date:	
1. What is the main purpose (aim/objective) of this policy/procedure?	Who does the proposed policy/procedure affect Staff <input type="checkbox"/> Patients <input type="checkbox"/> Carers <input type="checkbox"/> Public <input type="checkbox"/>		

2	Will the proposal have any impact on discrimination, equality of opportunity or relations between groups? If so what?	Yes	No
3.	Will there be a positive benefit to the users or workforce as a result of the proposed work? If so what?	Yes	No
4.	Will the users or workforce be disadvantaged as a result of the proposed work? If so, how?	Yes	No

If you are unsure of your answers or have answered yes to any of the above you should refer to the guidance for information on each of the protected groups and complete the Impact Assessment found on page 34 of the guidance. If the answer is yes to questions 2 or 4 then please complete the impact assessment form found on page 34 of the guidance.

When is the next review? Please note review should be immediately on any amendments to your clinical policy or procedure

1 Year	2 year	3Year
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Appendix 2**Glossary of terms (if required)**

AC – Abdominal circumference

EFW – Estimated fetal weight

GTT – Glucose tolerance test

LGA – Large for gestational age

Appendix 3 (must always be the last appendix)

Maintain a record of the document history, reviews and key changes made (including versions and dates)

Version	Date	Comments	Author
1			

Review Process Prior to Ratification:

Name of Group/Department/Committee	Date



Trust Approved Documents (policies, clinical guidelines and procedures)

Approval Form

Please complete the following information and attach to your document when submitting a policy, clinical guideline or procedure for approval.

Document type (policy, clinical guideline or procedure) Detail any section headings that have been removed from the template and the reason for this	SOP
Document title	Management of the Large for Gestational Age Fetus
Document author (Job title and team)	Mona Fawzy Labour Ward Lead Consultant
New or reviewed document	Reviewed
List staff groups/departments consulted with during document development (including BFS, & any other stakeholders)	
If this document deviates from published national guidance please state the reasons for this and the impact this may have on patient safety (include relevant risk ID).	
Approval recommended by (meeting and dates):	WB&G 21/10/22 CBU3 B&G 02/11/22
Date of next review (maximum 3 years)	02/11/2025
Key words for search criteria on intranet	LGA
Key messages for staff (consider changes from previous versions and any impact on patient safety)	
I confirm that this is the <u>FINAL</u> version of this document	Name: Molly Claydon Designation: governance Support co-ordinator

FOR COMPLETION BY THE CLINICAL GOVERNANCE TEAM

Approved by (group/committee): CBU3 Business and Governance
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