Frimley Health
NHS Foundation Trust

Identification and management of fetal growth restriction

Key Points

- The aim of antenatal diagnosis and appropriate management of fetal growth restriction (FGR) is to reduce perinatal mortality and morbidity, primarily by optimising the timing of delivery of the affected fetus.
- The use of customised growth charts is a first line screening tool towards detection of FGR

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Abbreviations

ANC	Antenatal clinic
BMI	Body mass index
DAU	Day assessment unit
EDD	Estimated date of delivery
EFW	estimated fetal weight
FGR	Fetal growth restriction
FH	Fundal height
MAC	Maternity assessment centre
SGA	Small for gestational age
UAD	Uterine artery Doppler

Contents

INTRODUCTION

The small for gestational age (SGA) fetus is not a diagnosis, but a heterogeneous condition with multiple causes, including incorrect dating, constitutionally small fetus, fetal growth restriction (FGR) secondary to placental insufficiency and fetal abnormality. However, distinctions between normal and pathologic growth often cannot reliably be made in the antenatal period because of current technical limitations.

Small for gestational age (SGA) is when the estimated fetal weight (EFW) <10th centile). Fetal growth restriction (FGR) is where a fetus fails to reach its growth potential. These are 2 distinct entities. Although SGA babies are at increased risk of FGR compared to appropriately grown fetuses, fetuses <3rd centile are far more likely to be FGR than fetuses between 3rd – 10th centile. Many babies growing consistently along the 3rd – 10th centile will be normal.

The aim of antenatal diagnosis and appropriate management of fetal growth restriction (FGR) is to reduce perinatal mortality and morbidity, primarily by optimising the timing of delivery of the affected fetus.

The use of customised growth charts is a first line screening tool towards detection of FGR.

SCOPE

This guideline is relevant to all healthcare professionals involved in the care of pregnant women including midwives, general practitioners, obstetricians and sonographers.

This guideline addresses:

- Use and production of a customised growth chart
- Booking risk assessment
- When and how to measure fundal height using a standardised technique
- When to refer to ultrasound for a growth scan
- Serial growth scans for women at high risk of fetal growth restriction
- Management of pregnancy with SGA so that those babies with FGR are identified from those that are normal constitutionally small babies.
- Identification of babies with FGR above the 10th centile who demonstrate reduced growth velocity

OBJECTIVES

a. To ensure that there is accurate fetal surveillance, through risk assessment and standardised fundal height measurements of low risk women and appropriate fetal growth scans for women with identified risk factors.

b. To ensure that serial fundal height measurements are plotted correctly on customised growth charts.

c. Where growth problems are suspected from fundal height measurements, referral for a growth scan and appropriate further investigations to assess fetal well-being should be undertaken as soon as possible and within three working days.

d. Where a problem has been identified following a scan, referral is indicated to an obstetrician for discussion and agreement of an appropriate management plan, to be seen as soon as possible.

ROLES AND RESPONSIBILITIES

- **To risk assess at booking, during pregnancy and arrange serial growth scanning if high risk of fetal growth problems or if fundal height measurements not accurate (e.g., raised BMI):**

- Midwives, Obstetricians, GPs

- **To generate customised growth charts:**

Customised growth charts are to be generated via the GROW 2.0 app at the booking appointment. EDD must be changed after the 12 week ultrasound scan if required. GROW 2.0 can be accessed via: https://uk.growapp.org/

Late bookers and transfers from other trusts should have a chart generated at the time they book / present, unless they already have one generated from their previous trust.

To undertake fundal height measurements and plot on customised charts:

- All antenatal care providers (midwives, obstetricians, and GPs)

- **To measure fetal biometry, calculate EFW and plot on customised charts:**

Sonographers, appropriately trained obstetric medical staff (normally fetal medicine doctors)

CLINICAL CONTENT

Customised Growth Charts

The charts are used to plot both fundal height measurements obtained during clinical examination and EFW following an ultrasound examination. They are customised to each individual taking into account the height, weight, ethnicity, and parity of the woman. Birth weights of previous children need to be inputted to identify previous problems with growth as a birth weight centile is calculated, but this does not affect the centiles produced. Those generating charts should check birth weight centiles of previous babies to ensure those below the 10th centile are identified and referred to a consultant obstetrician for growth scans and shared care.

Measuring fundal height (FH)

Who to measure

Women who are suitable for serial fundal height measurements and are identified as being on the low risk pathway for fetal growth surveillance should have serial fundal height measurements undertaken as a primary screening test for fetal wellbeing. These should commence from 26-28 weeks gestation.

In cases where the measurements can be inaccurate, e.g., multiple pregnancy, BMI>35, fibroids and significant uterine anomalies (See algorithm), do not measure fundal height and refer to consultant obstetric clinic for individualised management plan and serial growth scans.
All women on a high or moderate risk pathway should be referred for consultant led care and reviewed for serial growth scans (See flow diagram, below). If suitable for Fundal height measurements, women on a moderate or high risk pathway, where serial scans commence from 32 weeks, fundal height measurements should be performed 2-3 weekly from 26-28 weeks but ceased once ultrasound surveillance is commenced.

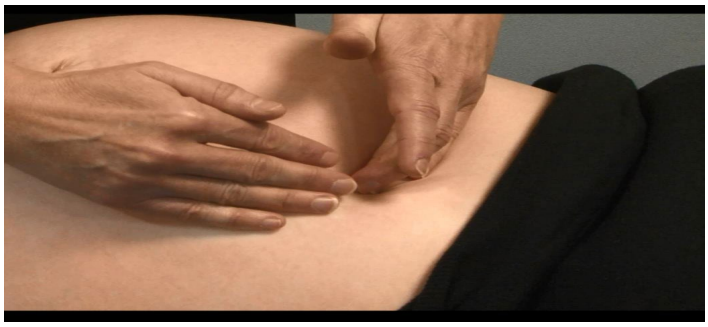
How to measure

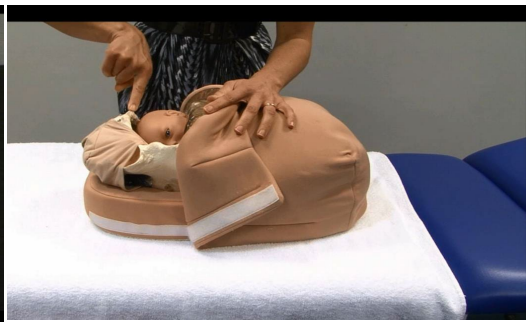
The fundal height measurement should be performed with the mother in semi-recumbent position at a 45 degree angle, with an empty bladder and the uterus relaxed and non- contracting. It is recommended that the clinician uses both hands to perform an abdominal palpation, identifies the highest point of the uterine fundus then leaves one hand on the fundus. A non-elastic tape-measure, starting at zero, is placed on the uterine fundus – at the highest point (which may or may not be in the midline). The tape measure should then be drawn down to the top of the symphysis pubis and the number read to the first decimal point (e.g.32.6cms). To reduce the possibility of bias, the tape measure should be used with the cm side hidden, and the measurement should be taken once only.

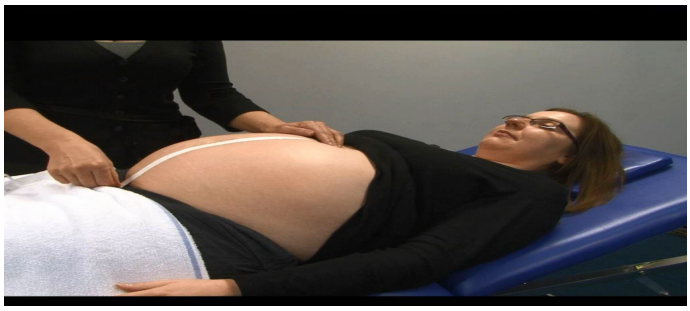
The result should be recorded to the first decimal point on the customised growth chart and the value plotted via GROW 2.0. The method for measuring fundal height is explained below the customised growth chart to support standardised practice.

For women on a low risk pathway for fetal growth surveillance, Serial fundal height measurements should be carried out by **a GAP competency assessed professional,** 2-3 weekly from 26-28 weeks gestation until **delivery.**

Women should cease fundal height measurements if moved onto a scan surveillance pathway.







REFERRAL TO ULTRASOUND

Indications for a growth scan are:

- First fundal height measurement below 10th centile (26-28 weeks)
- Static growth: no increase in **sequential measurements**
- Slow growth: plot not following expected trajectory in downwards direction
- Excessive growth: plot not following expected trajectory in an upward direction

Note that a first measurement above the 90th centile is NOT an indication for a growth scan. A scan would however be indicated if there was a clinical suspicion of polyhydramnios or there was excessive growth on subsequent measurements. (refer to guideline on large for gestational age)

Requests for a growth scan should be made via EPR. Where there are concerns around fetal growth, a scan appointment should be made within 72 hours (including weekends and bank holidays).

The sonographer will discharge back to established care if the scan is normal. If there are concerns regarding the scan, the sonographer will make the referral according to the Growth Scan Pathway - Visual Aid.

The gestation is under 36 weeks and umbilical artery Doppler PI and amniotic fluid is normal. The mother reports normal fetal movements

OR
The gestation is over 36 weeks and both the umbilical artery and middle cerebral artery are normal.

In the term SGA fetus with normal umbilical artery Doppler but an abnormal middle cerebral artery Doppler (below 5th centile) arrangements for delivery should be made as these have a moderate predictive value for acidosis at birth.

Serial growth scans for those at high and moderate risk of growth restriction (See algorithm below)

Some women will be at increased risk of developing fetal growth restriction because of risk factors in the current pregnancy, past medical history or past obstetric history. All women should be assessed at booking for risk factors to identify those who need increased surveillance. Women who fall into these categories will need referral to a consultant obstetrician or maternal fetal medicine specialist. The consultant-led team will arrange for serial scans and follow up in ANC as required.

Women on a moderate risk pathway or high risk pathway where serial scans commence at 32 weeks must have the fundal height measurement performed and plotted from 26-28 weeks.(See section: 'Who to Measure' above). A Referral for US scan must be made If concerns identified.

Pregnancy associated plasma protein A (PAPP-A) is a hormone that is produced by the placenta in pregnancy. It is one of two hormones that are measured during the 12week combined screening test.
Studies have shown that low PAPP-A may contribute to fetal growth restriction.
Women who consent to combined screening will have their Papp-A measured as part of the screening test . Women who decline screening or complete quadruple screening will not have their Papp- A measured.

Low PappA <0.4mom.
In this trust the screening team will identify all women with a low Pappa A level <0.4mom. These women will be sent information advising them to commence low dose Aspirin. The screening team will then request for uterine artery dopplers to be added to the anomaly scan request.
Appendix 1: sent to women with their combined screening result (appendix 1)

REFERRALS FOLLOWING A GROWTH SCAN – REFER TO GUIDANCE ON PATHWAY BELOW

These referrals will be made by the sonographer once the growth scan has been completed and the EFW plotted on the customised growth chart.

- If the EFW plots between the 10th and 90th centile and is following the centile curve, and the liquor volume is normal, the woman will be asked to attend her next antenatal appointment as planned (this should already have been confirmed with the woman by the referring carer). A referral to DAU / MAC is not required.

- **If the EFW does not plot within the 10th and 90th centile or is not following a centile curve, or there are concerns regarding the liquor volume or umbilical artery Doppler, then the following referrals should be made.**

EFW above 90th centile (or significantly increased growth velocity)

Refer to Large for gestational age (LGA) guideline.

EFW below 10th centile or reduced growth velocity, normal liquor volume, normal umbilical artery Doppler

For obstetric review following the growth scan.

Fetuses between 3rd – 10th centile will often be constitutionally small and therefore not at increased risk of stillbirth. Care of such fetuses should be individualised and the risk assessment can include Doppler investigations, the presence of any other high risk features for example, recurrent reduced fetal movements, and the mother's wishes. In the absence of any high risk features, delivery or the initiation of induction of labour should be considered at 39+0 weeks. Birth should be achieved by 39+6 weeks. Other risk factors should be present for birth to be recommended prior to 39 weeks.

Suboptimal fetal growth:
When assessing fetal growth, a pattern of slowing growth velocity (i.e., a downward trend in the percentile) indicates an increased risk of morbidity and stillbirth and should necessitate review. This review should include assessment of all fetal biometry measurements since the anomaly scan to identify potentially erroneous single measurements and also the presence or absence of other risk factors for FGR. Particular attention should be paid to a downward trend in abdominal circumference growth velocity.

In fetuses with declining growth velocity and EFW >10th centile the risk of stillbirth from late onset FGR should be balanced against the risk of late preterm delivery. Delivery should be planned from 37+0 weeks unless other risk factors are present. Risk factors that should trigger review of timing of birth are: reduced fetal movements, any umbilical artery or middle cerebral artery Doppler abnormality, cCTG that does not meet criteria, maternal hypertensive disease, abnormal sFlt1: PlGF ratio/free PlGF or reduced liquor volume. Opinion on timing of birth for these infants should be made by a senior obstetrician and in consultation with fetal medicine where possible.

Ongoing surveillance for fetuses below 10th centile or suboptimal growth must be referred to a named consultant and for follow up in ANC for ongoing care.

EFW below 3rd centile or reduced growth velocity with oligohydramnios and/or abnormal umbilical artery Doppler and/or abnormal middle cerebral artery Doppler

For immediate obstetric /fetal medicine review.

All management decisions should be discussed and agreed with the mother. This discussion should include risks and benefits to enable mothers to make an informed choice. In the cases of fetuses <3rd centile and with no other concerning features, initiation of labour and/or delivery should occur at 37+0 weeks and no later than 37+6 weeks gestation. Delivery <37+0 weeks can be considered with senior obstetric input that may include fetal medicine advice, particularly if there are additional concerning features, but these risks must be balanced against the increased risks to the infant of delivery at earlier gestations. Discussions must include parents at all stages.

If FGR is identified prior to 34 weeks, referral to fetal medicine is required.

Uterine Artery dopplers

Early onset FGR is rare (~0.5%). The majority of cases are associated with abnormal uterine artery Doppler indices or already present estimated fetal weight (EFW) <10th centile in the early third trimester. Uterine artery Doppler can be used in the second trimester (20 – 24 weeks alongside routine fetal anomaly scan) in high risk women to determine their risk for placental dysfunction and therefore risk for pregnancy induced hypertensive disorders or early onset FGR. If the uterine artery Doppler pulsatility index is normal (mean ≤95th centile) the risk of these disorders is low and thus serial scanning for fetal biometry can be commenced in the third trimester.

Women who have high risk factors for FGR, require uterine artery dopplers to be performed. These will be performed at the anomaly scan. This needs to be requested via EPR at the point of requesting the 20 week anomaly scan. The result of the uterine artery dopplers will determine when serial ultrasound surveillance will commence (See algorithm).

Women at moderate risk of FGR do not require uterine artery Doppler assessment but are still at risk of later onset FGR so require serial ultrasound assessment of fetal growth from 32 weeks.

Ongoing surveillance for fetal growth should be performed at intervals of no less than 14 days, with optimum assessment for growth velocity being 21 – 28 days. For the vast majority of pregnancies in the moderate risk category or in those unsuitable for SFH measurements, an interval of four weeks is appropriate. For women in the high risk category the scan interval should be confirmed following the first assessment for fetal growth.

Ultrasound surveillance of fetal biometry should continue until delivery in women at high or moderate risk of fetal growth restriction or unsuitable for fundal height measurements.

Post birth:
Birth weight centile must be generated via the GROW App at birth. This must then be documented in EPR.

AUDITABLE STANDARDS

- Use of customised growth chart
- On going “missed case” audit

MONITORING COMPLIANCE

This guideline will be subject to three yearly audit and results presented to the department clinical audit meeting. Action plans will be monitored at the quarterly department clinical governance meeting. The audit midwife takes responsibility for initiating and reporting the audit.

COMMUNICATION

If there are communication issues (e.g., English as a second language, learning difficulties, blindness/partial sightedness, deafness) staff will take appropriate measures to ensure the patient (and her partner, if appropriate) understand the actions and rationale behind them.

EQUALITY IMPACT ASSESSMENT

This guideline has been analysed for impact on equality and does not have an adverse impact on any protected characteristic.

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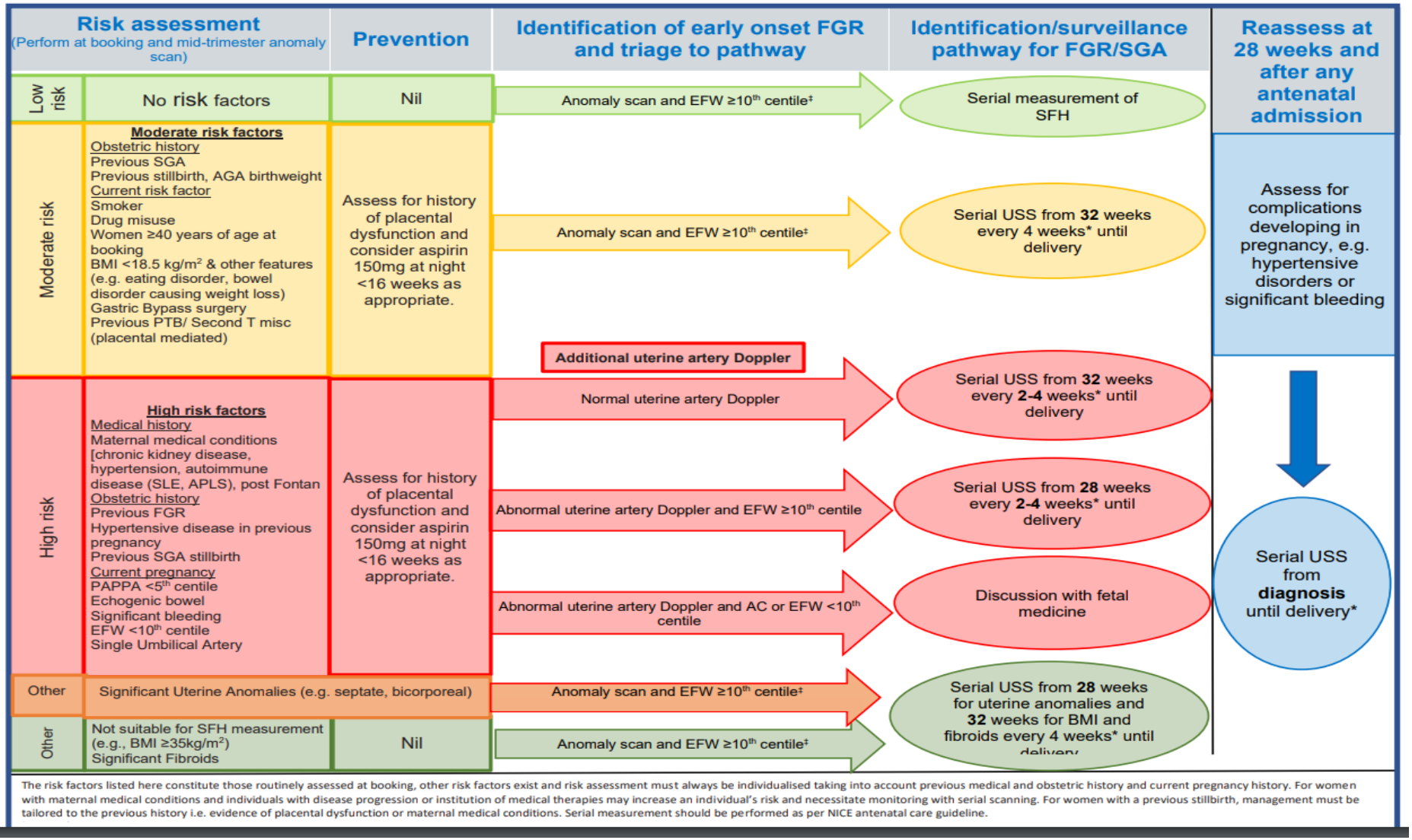
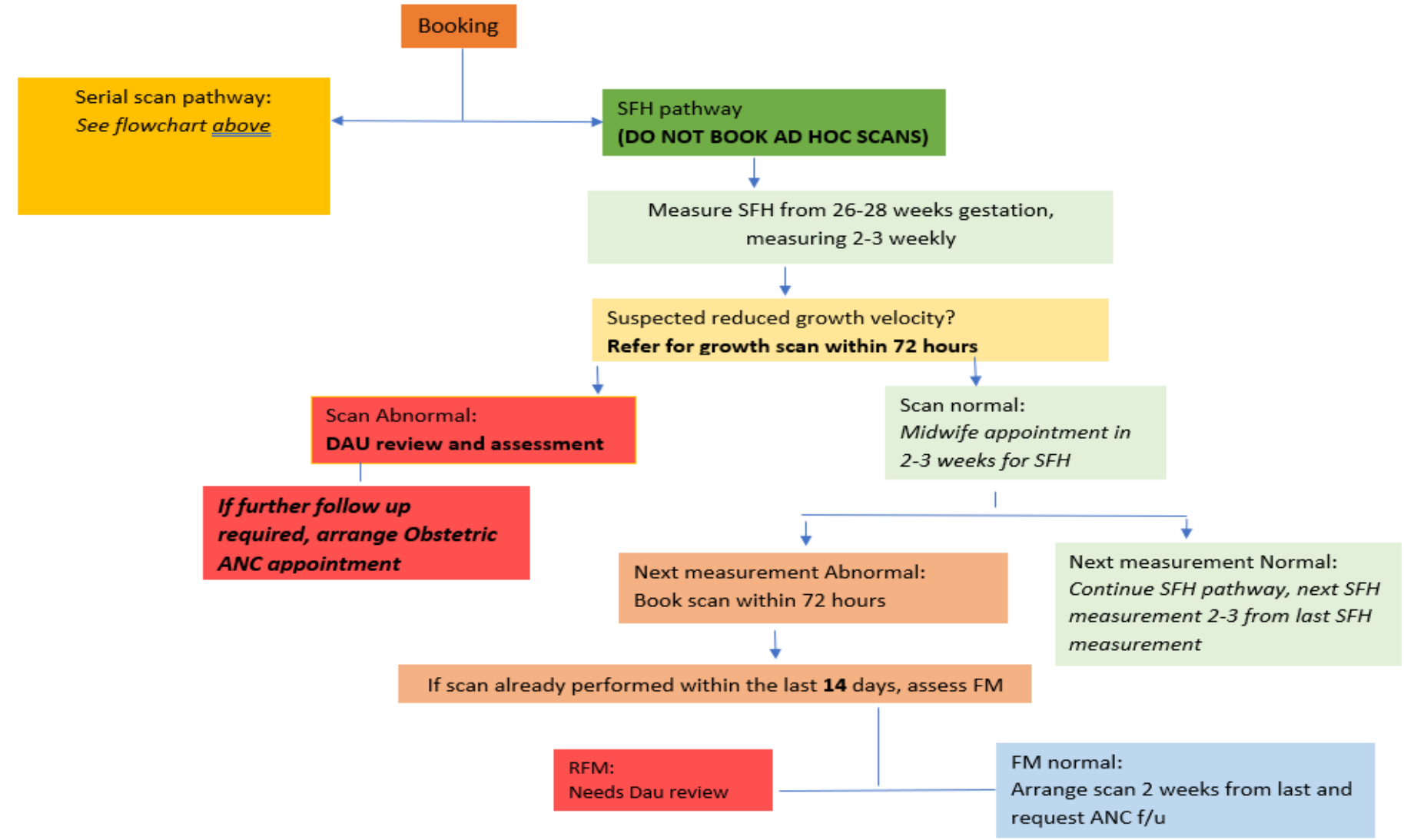
Risk assessment and surveillance for FGR



NB: Women who are on a moderate risk pathway or high risk pathway who are commencing serial scans from 32 weeks require SFH measurement at 26-28 weeks. Referral to be made for those who's initial plot is below the 10th centile.

Guidance on SFH pathway


Booking
Serial scan pathway:
See flowchart above
SFH pathway
(DO NOT BOOK AD HOC SCANS)
Measure SFH from 26-28 weeks gestation, measuring 2-3 weekly
Suspected reduced growth velocity?
Refer for growth scan within 72 hours
Scan Abnormal:
DAU review and assessment
If further follow up required, arrange Obstetric ANC appointment
Scan normal:
Midwife appointment in 2-3 weeks for SFH
Next measurement Abnormal:
Book scan within 72 hours
Next measurement Normal:
Continue SFH pathway, next SFH measurement 2-3 from last SFH measurement
If scan already performed within the last 14 days, assess FM
RFM:
Needs Dau review
FM normal:
Arrange scan 2 weeks from last and request ANC f/u

Appendix 1: Letter sent to women with their combined screening result

NHS
Frimley Health
NHS Foundation Trust

Antenatal Screening Telephone No:
Frimley Park 0300 6136989
Wexham Park 0300 6153301

Date

Enclosed is your combined screening result for Down's syndrome, Edward's and Patau's syndrome (Trisomy 21, 18 and 13 respectively). If you have any questions about your result, please contact the screening team at the hospital where you have chosen to give birth (Frimley or Wexham) on the telephone number above.

The combined screening test, performed around 12 weeks of pregnancy, is mainly used to screen for the more common chromosomal abnormalities. The blood test element checks two substances that originate in the placenta. One of these substances is called PAPP-A (pregnancy associated plasma protein-A).

Why am I being sent this letter?

We are sending you this letter because the level of PAPP-A in your blood for this pregnancy has shown a lower level than normal. As a precaution, we like to monitor the growth of babies with extra ultrasound scans, where a low PAPP-A level has been found.

What is PAPP-A?

Research studies have shown that a lower PAPP-A level result **might** be associated with a low birth weight baby. A low PAPP-A level is one below 0.40 MoMs, where a MoM is the multiple of the median. This is just a statistical way of describing a result compared with the average.

Do I need to do anything now?

In addition to us monitoring the growth of your baby, we would advise that if you are not already taking it you **should start to take a low dose aspirin 150mg once daily** until the birth of your baby. Research (Ref: AJOG.orgSystematicReviewsFeb2017) has shown that women who take low dose aspirin can reduce their chance of having a low birth weight baby. The greatest benefit is seen in women who start taking aspirin daily before 16 weeks of pregnancy. Don't worry if you are already more than 16 weeks as we know that there is still some benefit if it is started later in the pregnancy. Please contact your community Midwife if you have problems obtaining the Aspirin.

When will I have the growth scans?

An additional test will be carried out at your 20 week scan called uterine artery dopplers. This will determine whether your next scan is at 28 weeks or 32 weeks and the frequency of further growth scans.
If you have been booked for Consultant led care, please discuss this letter with the hospital doctor to ensure they are fully aware so all appropriate follow up appointments are arranged.

What other monitoring is available?

At every appointment with either your midwife or doctor, your blood pressure will be measured, and your urine checked for protein.

Every pregnant woman should have a customised GROW chart. This will be produced by your community midwife at your booking appointment. You will have regular growth scans 2-4 weekly.

Findings of the scan will be plotted on this chart and will show if your baby is growing as expected. If there are any concerns, scan department will ensure you are reviewed by one of the obstetric doctors.

Who can I speak to if I need further information?

You are welcome to phone one of the antenatal screening midwives if you have any queries or concerns on 03006136989 (Frimley Park Hospital) or 03006153301 (Wexham Park Hospital).

As your pregnancy progresses you will start to feel regular movements. If you have any concerns about your baby's movements, please contact the hospital you have booked to have your baby.
01276 604527 (Frimley Park Hospital) or 0300 6154520 (Wexham Park Hospital).

Receiving the news that you have low PAPP-A levels may cause anxiety but please be assured that the majority of babies will have normal growth. For those babies that are found to be small you will have the reassurance of close surveillance. If we are concerned about your baby's growth, we may occasionally recommend to deliver your baby earlier than your due date. This will of course be discussed with you if relevant.

For a translation of this leaflet or for accessing this information in another format:

Please contact (PALS) the Patient Advice and Liaison Service on:

Frimley Park Hospital
Telephone: 0300 613 6530
Email: fhft.palsfrimleypark@nhs.net

Wexham Park & Heatherwood Hospitals
Telephone: 0300 615 3365
Email: fhft.palswexhampark@nhs.net

Frimley Park Hospital	**Heatherwood Hospital**	**Wexham Park Hospital**
Portsmouth Road, Frimley, Surrey, GU16 7UJ	Brook Avenue, Ascot, Berkshire, SL5 7GB	Wexham, Slough, Berkshire, SL2 4HL
Hospital switchboard: 0300 614 5000		**Website:** www.fhft.nhs.uk

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Growth Scan Pathway - Visual Aid

EFW on GROW 2.0 (black dot), normal Doppler and liquor.	• if referred as urgent scan: back to scheduled care. • if on Serial scan pathway: Review in ANC - growth scan in 4 weeks.
Accelerated growth < 90th centile on GROW 2.0 (red dot), normal Doppler and liquor.	• if referred as urgent scan: Refer for GTT/BM monitoring-->if negative no further scan. • if on Serial scan pathway: Review in ANC - book GTT/BM monitoring- growth scan in 4 weeks.
LGA > 90th centile on GROW 2.0 (red dot), normal Doppler and liquor.	• if referred as urgent scan: Refer for GTT/BM monitoring --> if negative book growth scan and ANC @ 36-37 weeks (scan will be performed at 36/37, if no scan in the last 4 weeks). • if on serial scan pathway: Review in ANC - growth scan in 4 weeks
Polyhydramnios (DVP) normal growth, normal Doppler: **Mild 10 to 12.9cms** **Moderate 13 to 14.9cms** **Severe >=15cms**	• Mild: Refer for GTT - growth scan in 3 weeks with ANC. • Moderate: immediate obs review, for GTT/BM monitoring and TORCH - growth scan in 3 weeks with ANC. • Severe: Imediate obs review, for GTT/ BM monitoring ,TORCH. Obs team to discuss with fetal medicine lead*.
Oligohydramnios (DVP <2cm) normal EFW on GROW 2.0, normal Doppler	• if referred as urgent scan: Immediate obs review (?SROM) and Refer for growth scan in 2 weeeks with ANC. • if on serial scan pathway: Immediate obs review (?SROM) and book ANC with growth scan in 2 weeks. • Anhydramnios - immediate obs review (?SROM) Obs team to discuss with fetal medicine lead*.
Abnormal umbilical artery Doppler, (raised PI >95th) normal growth growth 2.0, and normal liquor.	• if referred as urgent scan: Book Doppler and liquor in 1 week, growth scan in 2 weeks with ANC • if on serial scan pathway: Review in ANC - Doppler and liquor 1 week, growth scan 2 weeks with ANC.
Reduced EFW growth velocity on GROW 2.0 (red dot) above the 10th centile, normal Doppler , normal liquor.	• if referred as urgent scan: Refer for growth scan in 2 weeks with ANC. • if on serial scan pathway: Review in ANC - book further growth scan in 2 weeks with ANC review.
SGA EFW < 10 th =/>3 rd centile on GROW 2.0, normal liquor, normal Doppler.	• if referred as urgent scan: book for 1 week Doppler and liquor, 2 week growth scan with ANC review. Immediate obs review if this is a new finding post 36 weeks. • if on serial scan pathway: Review in ANC - If new finding, Doppler and liquor 1 week, growth scan 2 weeks with ANC review. Further scans 2-4 weekly depending on clinical picture and gestation.
>34 weeks - FGR EFW <3 rd centile on GROW 2.0 or AC <3 rd on Chitty Astraia graph.	• if referred as urgent scan: If this is a new finding - immediate obs review. • if on serial scan pathway: If new finding, review in ANC if on same day, or arrange immediate obs review . • In the presence of reduced liquor and/or abnormal Doppler, depending on gestation, Obs team to discuss with fetal medicine lead* or plan for delivery.
< 34 weeks - FGR EFW <3rd centile on GROW 2.0 or AC <3rd Chitty Astraia graph.	• if referred as urgent scan: Immediate obs review to make a referral to screening team to schedule fetal medicine appointment. • if on serial scan pathway: Review in ANC if same day, or arrange immediate obs review to make a referral to screening team to schedule fetal medicine appointment.
Reduced EFW growth velocity on GROW 2.0 (red dot), in the presence of oligohydramnios and/ or abnormal Doppler.	• if referred as urgent scan: arrange immediate obs review. Depending on gestation, plan delivery or make referral to screening team to schedule fetal medicine appointment. • if on serial scan pathway: Review in ANC if same day arrange immediate obs review. Depending on gestation, plan delivery or make referral to screening team to schedule fetal medicine appointment.
Absent or reversed EDF in umbilical artery.	• if referred as urgent scan: arrange immediate obs review. Depending on gestation, plan delivery or make referral to screening team to schedule fetal medicine appointment. • if on serial scan pathway: Review in ANC if same day, or arrange immediate obs review. Depending on gestation, plan delivery or make referral to screening team to schedule fetal medicine appointment.

. **Recommended serial scan pathway following an urgent scan. With findings of normal growth, liquor and Doppler, the next scan is indicated in 4 weeks.**

Gestation of urgent scan.	Gestation of the next serial scan.		
28	32	36	40
29	33	37	
30	34	38	
31	35	39	
32		36	40
33		37	
34		38	
35		39	
36			40
37			
38			
39			
40			

Notes for clinicians reviewing, requesting and reporting growth scans

- If the most recent EFW or SFH plots red on GROW 2.0 but the growth velocity is documented as 'normal' in the review box on GROW 2.0, it is normal growth. A plot may stay red on GAP but not need an action.
- If an urgent growth scan is performed and there is normal growth, Doppler and liquor, the ultrasound department will liaise with ANC to reschedule the next routine growth scan, according to the above table.
- If the obstetric team don't ensure that each scan request includes a full and correct clinical indication for ultrasound, which stipulates the correct timeframe for the subsequent scan, in line with the visual aid; the request may be rejected during vetting.
- If GDM, BP or autoimmune disease is medicated and/or poorly controlled, 2 weekly growth scans may be indicated after 34 weeks (even with normal growth, Doppler and liquor) to help inform decisions surrounding management of delivery. The obstetric team must ensure that this is clear in the clinical indication on the scan request.
- If there is a new finding of HC or FL <3rd centile on a growth scan, the obstetric team to discuss this with FM lead.
- If a fetal medicine scan has been requested for a patient on a serial scan pathway the screening team will liaise with ANC to reschedule the next serial growth scan.
- If there is a finding of FGR, the only acceptable further surveillance for the obstetric team to request through the ultrasound department is once weekly Dopplers, twice weekly growth scan. If any further surveillance is required such as twice weekly Doppler, it is a fetal medicine scan pathway, and the referral should go through the antenatal screening team.
- *Discussions with fetal medicine leads should be direct (not through AN screening team) and should be documented in EPIC.

Full version control record

Version:	4.3
Guidelines Lead(s):	V Shirol, A Deans, A Roberts, N Rose-Stone D Frew, R Edwards
Contributor(s):	K Franks, Antenatal and newborn screening lead midwife
Lead Director / Chief of Service:	Miss Anne Deans
Library check completed:	N/A
Ratified at:	Chair's action approval by Bal Sagoo (CoS, O&G) and Emma Luhr (DoM) on 25/10/2025
Date Issued:	20/10/2025
Review Date:	March 2026
Pharmaceutical dosing advice and formulary compliance checked by:	N/A
Key words:	Fetal growth restriction, customised growth charts, symphysis fundal height

This guideline has been registered with the trust. However, clinical guidelines are guidelines only. The interpretation and application of clinical guidelines will remain the responsibility of the individual clinician. If in doubt, contact a senior colleague or expert. Caution is advised when using guidelines after the review date.

This guideline is for use in Frimley Health Trust hospitals only. Any use outside this location will not be supported by the Trust and will be at the risk of the individual using it.

Version Control Sheet

Version	Date	Guideline Lead(s)	Status	Comment
1.0	December 2015	V Shirol, A Deans, A Roberts	Final	Implement of GAP
2.0	September 2017	V Shirol, A Deans, A Roberts, S.Coxon	Final	Updated to include WPH
3.0	June 2020	V Shirol, A Deans, A Roberts, S Coxon, Nicola Rose-Stone, Duncan Frew	Final	Approved at OGCGC 22.06.2020, also minor change approved as Chair's action by CoS A. Deans (06.10.20) and prior to publishing on p7 (from plotting in whole centimetres to the nearest half).
3.1	July 2021	V Shirol, A Deans, A Roberts, S Coxon, N Rose-Stone, D Frew	Interim	Papp A letters added to appendix section as per K Franks. Chair's action by CoS A. Deans 5/8/2021
4.0	March 2023	N. Rose-Stone, R. Edwards, A. Roberts	Final	Guideline and FGR risk assessment updated, Chair's action (interim CoS B.Sagoo, 20.03.2023) and Obstetric Clinical Governance Committee 28.03.23

4.1	July 2023	N. Rose-Stone, R. Edwards, A. Roberts	Interim	Addition of guidance on SFG pathway, implemented following the tragic passing of Molly B who was born sleeping on 13th May 2023 Ratified by Obstetric Clinical Governance Committee 28.07.23
4.2	October 2023	N. Rose-Stone	Interim	Risk assessment and surveillance updated with UAD, aligned with SBL3, Chair's action approval by Anne Deans (CoS O&G) and Emma Luhr (DoM) on 26.10.2023
4.3	October 2025	N.Rose-Stone	Interim	Minor amendments to wording and visual aid added. Chairs action approved Bal Sagoo (CoS O&G) and Emma Luhr (DOM) on 20/10/25