TYGERBERG HOSPITAL

Department of Obstetrics and Gynaecology

PROTOCOL for Abnormal (RI>95th centile) Doppler (High Risk Clinic)

- Verify correct dating (history, first scan)
- Perform growth scan including liquor volume (deepest vertical pool DVP)
- Plot size and Doppler on graphs for correct gestation
- Advise on smoking, alcohol, etc.
- **These pregnancies are at risk of intra-uterine fetal death (IUFD), fetal distress in labour and preeclampsia (PE) - they CANNOT be referred back to an MOU or BANC clinic and belong in a High Risk Antenatal Clinic!**
- **Triage for registrar follow up at HRC**
- **Rule out PE weekly (**BP and urine check)
- **Once the baby is viable:**
    - Instruct mother on **daily kick count chart**
    - **Arrange twice weekly cardiotocography (CTG)**
    - **Doppler** weekly at Fetal Evaluation Clinic (FEC)
- In the absence of aggravating factors arrange **elective delivery at 36^0-36^6 weeks**
- **Delivery must be in a specialist hospital (Tygerberg).**
- **This finding is not a contra-indication to vaginal delivery but <u>requires continuous CTG monitoring throughout labour</u>**
- Any delivery before 36 weeks must be carefully thought through (correct GA, strong indication, repeated and confirmed abnormal observations etc) and antenatal steroids should be considered only if delivery is anticipated ≤34 weeks.
- Consider earlier delivery **if significant aggravating factors** develop (PE, DVP < 2cm or plateau of growth, persistent non-reactive CTG after 34 weeks) – this should always be a consultant decision and in the context of the current GA (discuss with fetal medicine if unclear)

Absent or reversed end diastolic flow on FEC Doppler: Refer to fetal medicine

AUTHORISED BY	Prof L Geerts
COMMITTEE RESPONSIBLE	L Geerts, DR Hall, G Theron, S Gebhardt
DATE REVISED	1 January 2016
DATE EFFECTIVE	15 February 2016
REVIEW DATE	15 February 2018