# Protocol for small for gestational age (SGA) fetus with normal umbilical artery Doppler at the High Risk Clinic (HRC)

This protocol only applies when there is a SGA fetus at the Tygerberg High Risk Clinic [symphysis fundal growth (SF) <10$^{th}$ centile] with normal umbilical artery Doppler test at the Fetal Evaluation Clinic (FEC). SF <10$^{th}$ centile at community clinics will still be referred to their respective district hospital fetal evaluation clinics with management according to the provincial ultrasound policy.

- Verify correct dating (history, first scan)
- Perform HRC growth scan including liquor volume (deepest vertical pool DVP)
- Plot size and Doppler on graphs for correct gestation
  **If current EFW < P10 or HC/AC > P95 (or AC < P5 if head measurements difficult) for the correct gestation, manage further at HRC as below.**
  **If not SGA on ultrasound as above, <u>this protocol does not apply</u>**
  *(reference ranges: Salomon, Snijders, INTERGROWTH, <u>NOT Theron or Fenton</u>)*
- Advise on smoking, alcohol, etc.
- **These pregnancies are at risk of term IUFD (rarely preterm), fetal distress in labour and preeclampsia - they CANNOT be referred back to MOU or BANC and belong in a High Risk Antenatal Clinic!**
- **Rule out PE at least two-weekly**
- Once viable: Instruct mother on **daily kick count chart**
- **This finding is not a contra-indication to vaginal delivery but <u>requires continuous CTG monitoring throughout labour</u>**
- **Deliver no later than 40 weeks**

**SGA < 28 weeks:** Repeat HRC growth scan + FEC Doppler at 27-28 weeks

**SGA ≥28 weeks:**

- Repeat FEC Doppler 2 weekly and manage accordingly if it becomes abnormal
- **If EFW < P3 on diagnosis, Doppler remains normal and no PE:** Repeat HRC growth scan at **<u>34 weeks</u>**, incl. EFW, DVP
  - Adequate growth trend AND normal liquor AND reactive CTG – aim to deliver at 36$^{0}$-36$^{6}$ weeks
  - Clearly slowing growth trend OR reduced liquor (DVP < 2cm): perform CTG
    - CTG reactive – repeat CTG at 35 weeks - aim to deliver at 36 weeks
    - CTG non-reactive twice on same day – admit and consider delivery
- **If EFW P3-10 on diagnosis, Doppler remains normal and no PE**: Repeat HRC growth scan at **<u>36 weeks</u>**, incl. EFW, DVP

- If EFW at 36 weeks remains > P3 AND adequate growth trend AND normal liquor AND reactive CTG – aim to deliver at 40 weeks
- If EFW at 36 weeks is < P3 OR clearly slowing growth trend OR reduced liquor (DVP < 2cm): perform CTG
    - CTG reactive – repeat CTG at 37 weeks – aim to deliver at 38 weeks
    - CTG non-reactive twice on same day – admit and consider delivery

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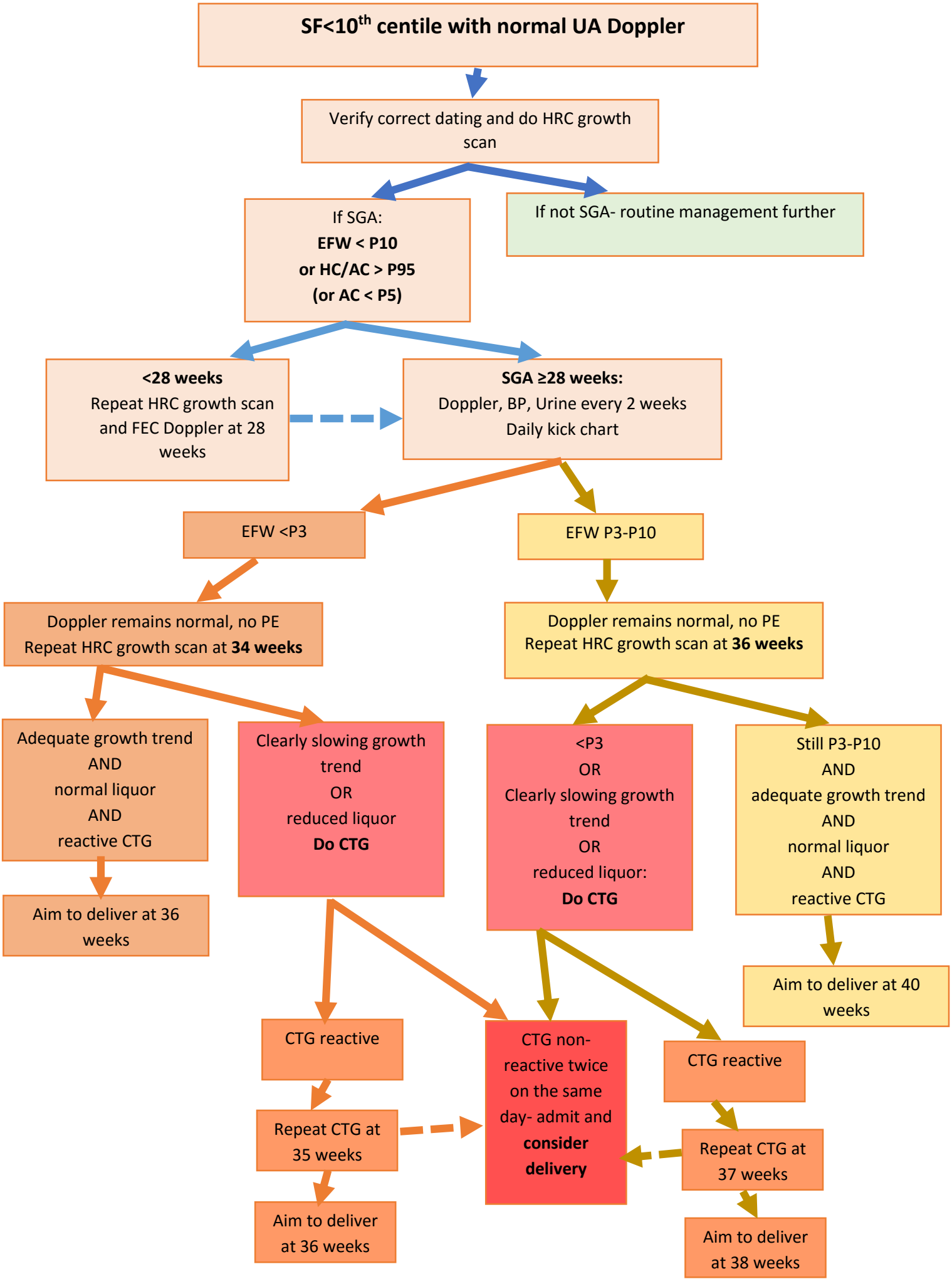
SF<10th centile with normal UA Doppler
Verify correct dating and do HRC growth scan
If SGA:
EFW < P10
or HC/AC > P95
(or AC < P5)
If not SGA- routine management further
<28 weeks
Repeat HRC growth scan and FEC Doppler at 28 weeks
SGA ≥28 weeks:
Doppler, BP, Urine every 2 weeks
Daily kick chart
EFW <P3
EFW P3-P10
Doppler remains normal, no PE
Repeat HRC growth scan at 34 weeks
Doppler remains normal, no PE
Repeat HRC growth scan at 36 weeks
Adequate growth trend
AND
normal liquor
AND
reactive CTG
Aim to deliver at 36 weeks
Clearly slowing growth trend
OR
reduced liquor
Do CTG
<P3
OR
Clearly slowing growth trend
OR
reduced liquor:
Do CTG
Still P3-P10
AND
adequate growth trend
AND
normal liquor
AND
reactive CTG
Aim to deliver at 40 weeks
CTG reactive
Repeat CTG at 35 weeks
Aim to deliver at 36 weeks
CTG non-reactive twice on the same day- admit and consider delivery
CTG reactive
Repeat CTG at 37 weeks
Aim to deliver at 38 weeks