

EARLY ONSET FGR AND REVIEW OF OUTCOMES FROM SGA CLINICS IN UHB

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•Introduction:-

- Small fetuses are divided into normal(constitutional small), non-placenta mediated growth restriction(e.g. structural, or chromosomal anomaly, fetal infections and placenta mediated growth restriction(placental dysfunction).
- All women should be assessed at booking for risk factors for FGR to identify those who require increased surveillance.
- Defining FGR and thus diagnosing it in a current pregnancy is challenging because of the need to determine growth potential.

•Objective:-

We had looked at the outcomes of early onset FGR referred to fetal medicine

•Methodology :-

- It was Prospective study from period of March 2023 to Aug 2023.
- Cases were identified from SGA clinic lists (Oceano, Clinical Portal, Viewpoint) with inclusion criteria of Singleton pregnancies seen in SGA clinic < 32 weeks , No known structural abnormality or chromosomal or genetic difference, EFW <3rdcentile with/without abnormal dopplers.
- Clinical details and notes were collected from BadgerNet, Viewpoint and clinical portal for babies if anything was picked up later.

RESULTS

- Total number of patients picked up were 109, among them 79% were identified with risk factors for SGA. Major risk factors we had identified were Prev SGA with 68%, Smoker 20% and others included Low PAPPA 8% and Advanced Maternal age 4%. No specific target timeframe but usually once referred pt is seen in 7- 10 days. Sometimes in 2 weeks to sync with the growth evaluation. Out of 98 (seen within 15 days 89%), some others were already in FM due to some other reasons=26 and 1 pt was seen in rainbow clinic.Out of 11 (after 15 days 10.09%)(1 had incomplete referral and rest had made FM referral twice. Regarding chromosomal screening combined test was done in 66%, Quad test was in 18% and 1 had both Quad and Nipt test. Normal uterine artery doppler seen in 44% ,18% had abnormal doppler while 37% had no uterine artery doppler. All patients underwent CMV and Toxoplasma screening as per the trust guidelines however only 2 were CMV IgM +ve. One patient had low level of CMW igM of uncertain significance, non-specific reactivity .2nd patient had low levels of CMW igM in the absence of High CMW igG avidity. suggestive of that the infection occurred >3months prior. this does not indicate and acute infection.
- Regarding MOD 52% had c section and 43% had NVB.30% has pretern <37 weeks while 70% managed to be delivered above 37 weeks. Regarding Neonatal outcome 96% had good Apgar score and 30.9% had Neonatal admission among them most common cause was jaundice with 56%.

Conclusion :-

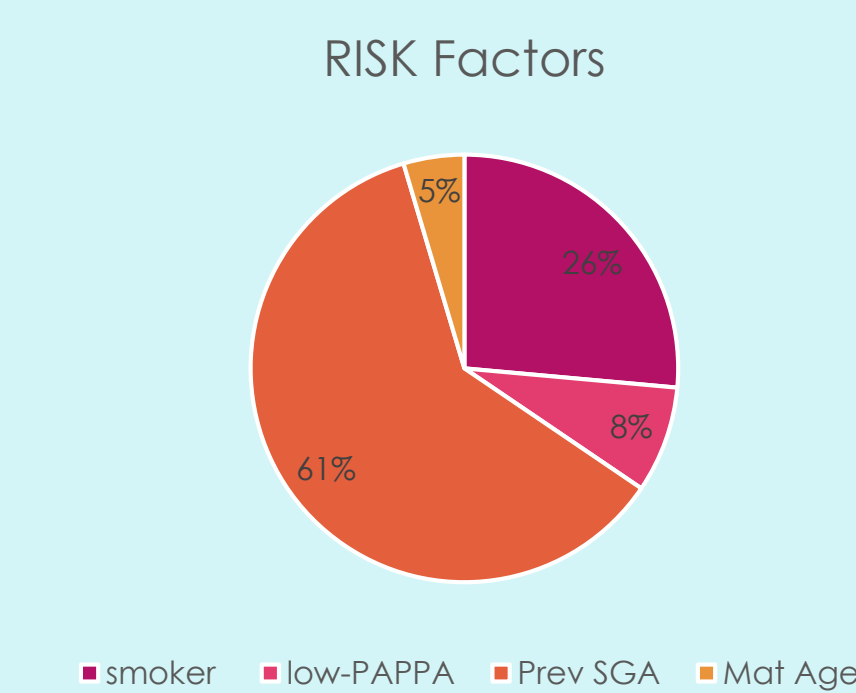
The SGA clinic at UHB has demonstrated good compliance with the recommended standards. Given the national pressure on Fetal Medicine services due to staffing crises and the demands of various national programs, we have found this model of care to be safe, effective, and sustainable. It has become a model that many units aspire to adopt. Additionally, it exemplifies a culture of teaching, training, teamwork, and self-reliance. Fetal infections are responsible for up to 5% of SGA fetuses. The most common pathogens are reported to be cytomegalovirus (CMV), toxoplasmosis, malaria and syphilis, although a multicentre study found no association between congenital toxoplasmosis and incidence of a SGA infant

INFECTIOUS STATUS/ TORCH SCREENING

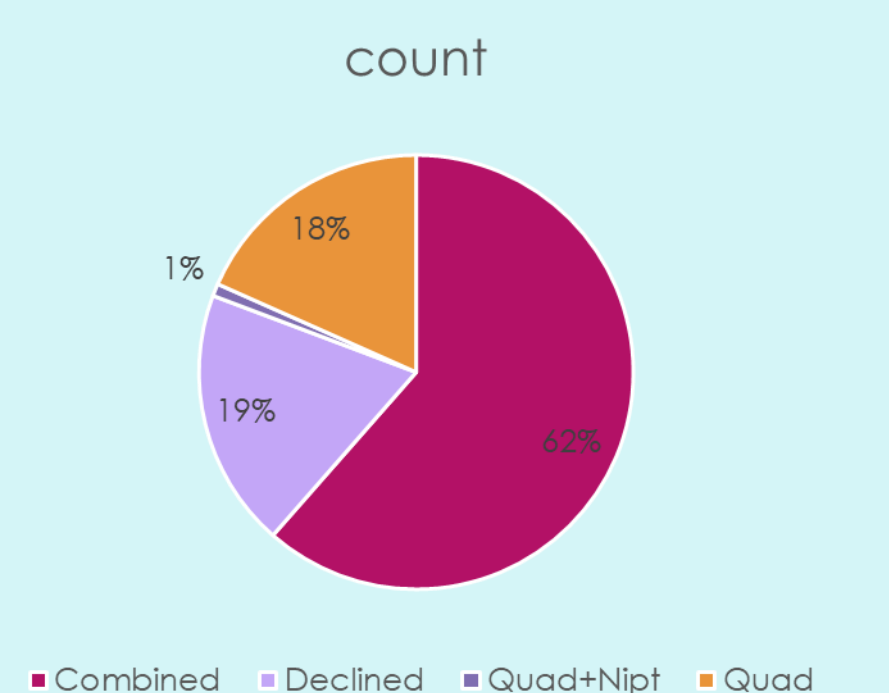


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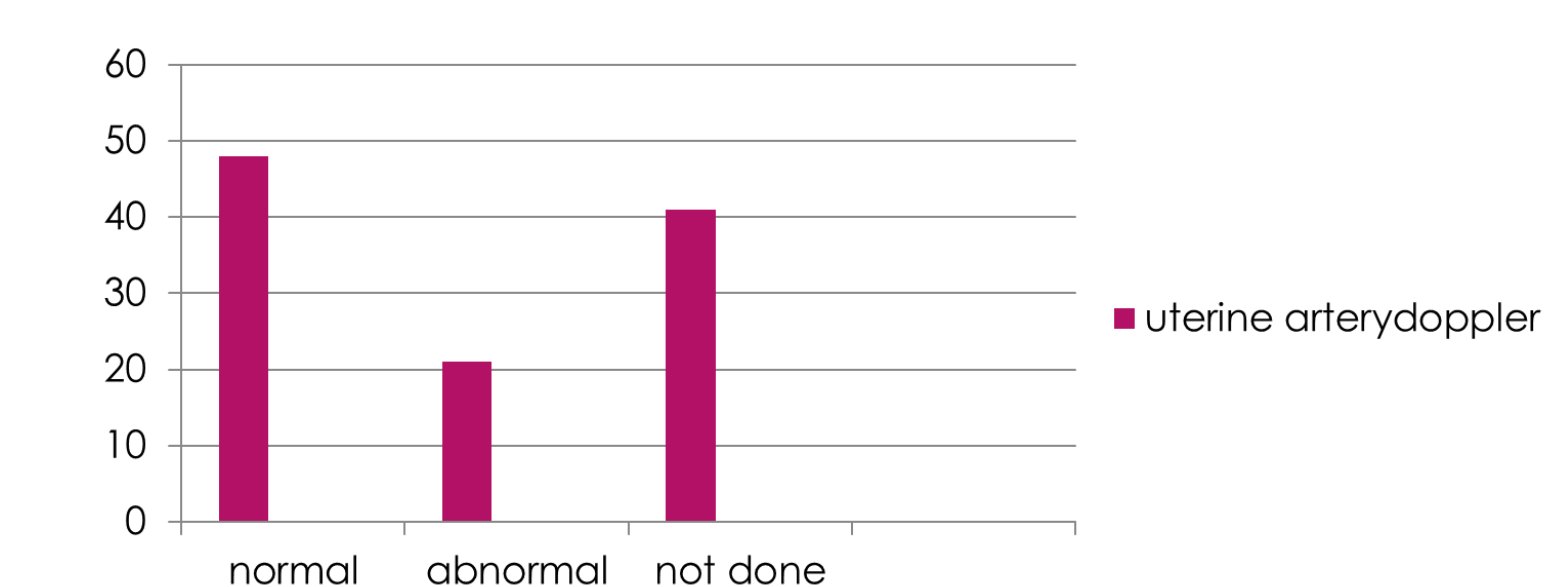
Risk factors



COUNT OF Combined/Quad/NIPT



Uterine artery Doppler



Interval between referral and first fetal medicine Appointment.

