The term does not distinguish between those who have fetal growth restriction (FGR) i.e. those who have failed to reach their growth potential and those who are constitutionally small.

Not all fetuses with FGR will be SGA.

The definitions recommended with the Saving babies Lives Care bundle V2 are as below:

Definition of FGR in a previous pregnancy as a risk fac

Risk level	Risk factors	Recommendation
High	• Essential hypertension • Previous pregnancy with gestational hypertension / pre-eclampsia • Previous baby <10th centile • Stillbirth • Placental histology confirming placental dysfunction in a previous pregnancy • Type 1 or type 2 diabetes • Autoimmune disease (eg: systemic lupus erythematosus or antiphospholipid syndrome) • Chronic kidney disease • PappA <0.41	Recommend aspirin 150mg if the woman any of these high risk factors
Moderate	• • First pregnancy • Current smoker at booking • Are 40 years or older at booking • Pregnancy interval of more than 10 years • Body mass index (BMI) of 35kg/m² or more at first visit • Family history of preeclampsia in a first degree relative • Multiple pregnancy	Consider aspirin if the woman has two or more of these factors

3.2.2 Women without risk factors for SGA:

Both abdominal palpation and symphysis fundal height measurement (SFH) have limited accuracy to predict an SGA fetus.

However routine ultrasound in the third trimester has not been shown to improve outcome in low risk pregnancies and therefore measurement of SFH is used as a screening test in routine care.

In all women assessed as low risk at booking, measure the SFH at each antenatal visit from 24 weeks gestation.

The SFH measurement should be documented in the handheld notes and plotted on the personalised GROW growth chart.

Women unsuitable for monitoring by fundal height measurement

- Large fibroids (>5cm)
- BMI >35

These women require monitoring as per the GAP care pathway.

Indications for a growth scan (if the woman has not had one in the last 2 weeks) are:

- First SFH measurement below 10th centile
- Static growth: no increase in sequential measurements
- Slow growth: defined as serial SFHs with a trajectory less than the slope of the 10th centile

Carry out BP, urine dip and fetal movements.

A growth scan should be arranged within the next 2-3 working days.

3.2.4 Growth scan documentation

At the growth scan the sonographer should:

3.2.5e Incidental Doppler abnormality NOT SGA

- AC and EFW >10th centile
- Umbilical PI>95th centile (positive EDF) or MCA<10th (redistribution)

Sonographer:

Check biometry >10th centile and FM normal, ensure technically adequate measurement, repeat if necessary

Refer for consultant review in ANC on the day of the scan.

Midwife:

- Review the antenatal notes and history
- Ask about fetal movements
- Check BP and urine dip
- Perform a CTG if any concern about FM

Consultant:

If <36 weeks and no additional concern identified rescan in 1 week for Doppler with a review in ANC.

If >36 weeks - There is a need to consider timing of delivery (usually at 37 weeks) if persistent redistribution or UAPI>95th is confirmed.

A clear plan of management and follow up should be made.

3.2.5g

Absent or Reversed EDF in the umbilical artery

- Arrange computerised CTG (if more than 26 weeks)
- Urgent discussion and review by Consultant in ANC / On call consultant
- Consider in-utero transfer out if <28 weeks
- Reversed EDF deliver if >32 weeks
- Absent EDF deliver if >34

Between 24 – 36 weeks' gestation:

Timing of delivery for preterm SGA or FGR should be made by Consultant only

Consider referral to, or discussion with, Southampton FMU

Delivery will be determined by a combination of computerised CTG ,EFW and Dopplers, including CPR MoM

Steroids should be considered if delivery is anticipated < 35 weeks.

Magnesium sulphate should be considered (as per the preterm labour guideline), for all fetuses <34+0 weeks

More than 36 weeks arrange delivery

Mode of delivery will depend on the gestational age, condition of the fetus and suspected underlying cause and should be a consultant decision.

SGA is an indication for continuous CTG monitoring in labour and with any significant uterine activity during induction.

Consider sending the placenta for perinatal pathology.

For women who decline induction of labour or delivery after 39+0 weeks, counselling must include a discussion regarding evidence that there is no increase in risk for the baby or for the mother from delivery/induction at this gestation and that there is no evidence to determine how fetuses with SGA/FGR should be monitored if pregnancy continues.

Flow Chart for Management of Growth Scans

3.3 Potential complications / Risk Management

3.4 After care

4. Patient Information

5. Audit

5.1 Audit Indicators

5.2 Audit design

5.3 User Involvement

6. Evidence Base

6.1 Sources of information

1. NHS England Saving Babies Lives Care Bundle version 2 March 2019
2. Nice Hypertension in Pregnancy (2019)
3. RCOG greentop guideline: Small for Gestational Age No.31 February 2013
4. National Institute for Clinical Excellence. *Antenatal Care: Routine care for the healthy pregnant woman*.12; 2008

8. Version information

Version No.	Document owner and Post holder's title	Agreed at Maternity Governance	Final agreement	Description of Changes	Date on Microguide

	Advice from Dr Sian McDonnell Consultant Obstetrician, Ashford and St Foundation Trust				

Author Name and Date

Appendix One