

REFERRAL TO THE DEPARTMENT OF MATERNAL FETAL MEDICINE (MFM): FETAL INDICATIONS

This LOP is developed to guide clinical practice at the Royal Hospital for Women. Individual patient circumstances may mean that practice diverges from this LOP.

1. AIM

- To ensure best practice advice and support is available to a woman with significant fetal complications
- To allow a management plan to be developed within MFM, in consultation with the referring practitioner and the woman requiring ongoing fetal medicine care

2. PATIENT

- Pregnant woman at the Royal Hospital for Women:
 - with possible genetic, chromosomal, or structural fetal anomaly
 - requesting a diagnostic procedure (e.g. chorionic villus sampling)
 - with fetal growth restriction (FGR) as defined in table 1
 - with a complicated multiple pregnancy, monoamniotic twins, or higher order multiple pregnancy
 - with rhesus disease or other red cell or platelet alloimmune disease (antibodies)
 - following suspected exposure to an infectious agent known to have fetal sequelae e.g. as parvovirus, cytomegalovirus, toxoplasmosis, varicella zoster or rubella

3. STAFF

- Medical and midwifery staff
- Social Workers
- Sonographers
- Genetic Counsellors

4. EQUIPMENT

- Ultrasound machine

5. CLINICAL PRACTICE

- Refer any woman, at any gestation who fits the below criteria:

Table 1

First Trimester	<ul style="list-style-type: none"> • has abnormal fetal morphology at nuchal translucency ultrasound • requests a diagnostic/invasive procedure such as chronic villus sampling (CVS) or multi-fetal reduction • has a higher order multiple pregnancy, monoamniotic twins, or other twin pregnancy complication • has had a nuchal translucency measurement > 3.5mm • requires genetic counselling • has red cell antibodies that may cause haemolytic disease of the newborn • who requires or requests a second opinion
Second Trimester	<ul style="list-style-type: none"> • has an abnormal detected at fetal morphology ultrasound • requests a diagnostic/invasive procedure such as amniocentesis • has early onset FGR • has any severe fetal complication • has a complicated twin pregnancy, e.g. suspected twin to twin transfusion syndrome (TTTS), FGR[^], or anomaly • who requires or requests a second opinion
Third Trimester	<ul style="list-style-type: none"> • has a fetus with structural anomalies • requests a diagnostic/invasive procedure • has FGR[#] • has any severe fetal complication • who requires or requests a second opinion

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*Early FGR (<32 weeks) is defined as:

- Abdominal circumference (AC) or estimated fetal weight (EFW) <3rd centile; or
- umbilical artery absent end-diastolic flow; or
- AC or EFW <10th centile with uterine artery Pulsatility Index (PI) >95th centile or umbilical artery PI >95th centile¹

#Late FGR (>32 weeks) is defined as:

- AC/EFW <3rd centile or
- At least two of:
 - AC or EFW <10th centile
 - AC or EFW centile decrease of 50 centiles
 - Cerebroplacental ratio (CPR) <5th centile or umbilical artery PI >95th centile¹

^Selective fetal growth restriction in a twin pregnancy is defined as one fetus with an EFW <10th centile and the intertwin EFW discordance is >25%.²

- Complete the MFM referral form: [New MFM USS ref form.pdf \(nsw.gov.au\)](#)
- Fax a referral to the MFM department on 93826038. A written referral is required for all MFM reviews. The referral should include all the following documentation and be signed by a medical officer:
 - previous consultations
 - ultrasound reports
 - relevant pathology
 - maternal blood group
- Arrange routine referrals to MFM by contacting the hospital switchboard 93826111 and asking for 'fetus phone' Include all documentation as listed above
- Arrange urgent referrals requiring inpatient review by contacting the hospital switchboard 93826111 and asking to speak to the MFM fellow or the on-call MFM consultant. Include all documentation as listed above
- Inform woman that referral to the MFM team may include:
 - offer of an invasive procedure according to clinical need and woman's acceptance of same
 - liaising with relevant specialties, according to the fetal diagnosis. This may include consultation with a:
 - neonatologist,
 - medical imaging,
 - paediatric surgeon,
 - magnetic resonance imaging (MRI) radiologist,
 - geneticist,
 - paediatric cardiologist,
 - paediatric neurologist,
 - endocrinologist,
 - renal physician,
 - intensivist,
 - palliative care,
 - obstetric or other physician where there are maternal complications,
 - social work/mental health specialist, or
 - anaesthetist where there are relevant maternal co-morbidities
 - coordinating the timing of birth with the relevant team/s as the pregnancy advances
 - informing the birth unit, operating theatre, neonatal intensive care unit, Sydney Children's Hospital intensive care (ICU) where relevant with the timing of birth

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6. DOCUMENTATION

- MFM referral
- Medical record
- Antenatal Card
- NSW Register of Congenital Conditions

7. EDUCATIONAL NOTES

- Babies diagnosed antenatally on ultrasound with major structural congenital malformations likely to require surgery soon after birth should be delivered in an appropriate tertiary perinatal centre, adjacent to paediatric surgical services. Neonatal outcomes are improved for babies delivered in a tertiary facility with on-site paediatric surgery³

8. RELATED POLICIES / PROCEDURES / CLINICAL PRACTICE LOP

- Genetic Counselling: Reproductive Genetic Carrier Screening and Aneuploidy screening including the Non- Invasive Prenatal Screening (NIPS) test
- Monoamniotic Twins – Management
- High order multiple pregnancy – Antenatal Care
- Twin pregnancy - Antenatal Care
- NSW Health Prenatal Testing/Screening for Down Syndrome and Other Chromosomal Abnormalities PD2007_067
- Termination of Pregnancy – Framework
- Termination of Pregnancy (medical and surgical 1st, 2nd, 3rd Trimester) – Admission
- Framework for Termination of Pregnancy in New South Wales – Ministry of Health PD2021_018

9. RISK RATING

- Low

10. NATIONAL STANDARDS

- Governance for safety and quality in Health Service Organisation – Standard 1
- Partnering with Consumers – Standard 2
- Comprehensive Care – Standard 5

11. REFERENCES

1. ISUOG. ISUOG Practice Guidelines: diagnosis and management of small-for-gestational-age fetus and fetal growth restriction. *Ultrasound Obstet Gynecol* 2020, 56: 298-312.
2. ISUOG. ISUOG Practice Guidelines: role of ultrasound in twin pregnancy. *Ultrasound Obstet Gynecol* 2016, 47: 247-263.
3. Algert CS, Bowen JR, Hadfield RM, Olive EC, Morris JM, Roberts CL. Birth at hospitals with co-located paediatric units for infants with correctable birth defects. *ANZJOG* 2008; 48: 273-279.
4. Australasian Society of Infectious Diseases. Management of Perinatal infections, P Palasanthiran et al, 2014 Edition

REVISION & APPROVAL HISTORY

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