CRITERIA FOR REFERRAL/TRANSFER TO CHRISTCHURCH WOMEN'S HOSPITAL FROM WEST COAST

INTRODUCTION

The vast majority of pēpi can be born on the West Coast, however, some antenatal fetal or maternal complications, will require a need to transfer or refer to Christchurch Women's Hospital (CWH) for review, ongoing antenatal care, or birth. This guideline outlines the potential clinical indications where referral or transfer should be considered. Transfer decisions will also need to consider other factors such as availability of a safe and timely transfer method.

LABOURING WOMEN

- < 37 weeks gestation (transfer as early as possible if in threatened or early preterm labour)
- ≥ 37 weeks with conditions which carry increased risk to mother or baby. These include but are not limited to the conditions listed below. The decision to transfer may be made in conjunction with the RG on call for paediatrics (who may in turn discuss with Neonatologist on call) as neonatal resource availability is a consideration.

If it is not an acute fetal concern in labour but a postnatal issue, follow any antenatal plans made by the Fetal Anomaly Advice Committee or MFM. Alternatively call the Neonatologist on call for advice.

CRITERIA FOR TRANSFER DURING PREGNANCY OR EARLY POSTNATAL

CRITERIA FOR ANTENATAL TRANSFER OR EARLY POSTNATAL TRANSFER

- Congenital antenatal abnormalities – follow the Fetal Anomaly Advice Committee plan.
- Multiple births – all twins irrespective of gestation or mode of birth.
- Antenatal or postnatal diagnosis of early or late onset FGR as defined by the National SGA Guidelines

ANTENATAL DIAGNOSIS	ANTENATAL DIAGNOSIS	POSTNATAL DIAGNOSIS
Early-onset FGR **Diagnosed <32^{+0} weeks' gestation**	**Late-onset FGR** **Diagnosed >32^{+0} weeks' gestation**	**FGR in the neonate**
EFW customised† or AC < 3rd centile **OR** UA with absent or reversed end-diastolic flow **OR** EFW customised† or AC < 10th centile PLUS one or more of the following: a) UA Doppler PI > 95th centile b) UtA Doppler mean PI > 95th centile or bilateral notching (perform only once at the time of diagnosis)	EFW customised† or AC < 3rd centile **OR** Two or more of the following: a) EFW customised† or AC <10th centile b) Slowing of fetal growth: • Decline in EFW or AC of > 30 centiles from 28^{+0} weeks' gestation onwards* c) Any of the following: • UA Doppler PI > 95th centile OR • CPR < 5th centile OR • UtA mean PI > 95th centile or bilateral notching (perform only once at the time of diagnosis)	Diagnose FGR in the neonate if one or more of the following criteria are met: a) Customised birthweight < 3rd centile)† b) Customised birthweight centile from 3 to <10† with two or more additional features: • BMI z-score < -1.3 • Length z-score < -1.3 • Skin or body fat z-score < -1.3 (where expertise and equipment allow) • Antenatal diagnosis of FGR • Major maternal risk factor/s for FGR • Evidence of placental insufficiency on histology c) Antenatal diagnosis of FGR and evidence of placental insufficiency (eg. abnormal Doppler studies), even if the customised birthweight centile is > 10 or more.

AC = fetal abdominal circumference; CPR = cerebroplacental ratio; EFW = estimated fetal weight; PI = pulsatility index; UA = umbilical artery; UtA = uterine artery.

*† Customised centiles for New Zealand Aotearoa are available online (https://nzaws.growservice.org/App/Account/Login) and are incorporated into the BadgerNet platform. *'if there is decline in EFW or AC of >30 centiles <28 weeks' gestation in the absence of early-onset FGR, consider another growth scan in 2-3 weeks.*

- Women with pregnancies complicated by moderate – to severe polyhydramnios should labour and birth at CWH (AFI > 30.1 cm and single pocket > 12) – due to potential undiagnosed congenital infection or anomaly.
- Risk of Neonatal Abstinence syndrome – from opiates (methadone, morphine codeine) and benzodiazepines. Follow Ngā Taonga Pēpi programme.
- Type 1 diabetics and Type 2 diabetics with poor blood sugar control with fetal effects on scan (macrosomia, acceleration in growth) and or maternal medical complications of diabetes.
- Those with gestational diabetes who in line with the Diabetes in pregnancy guideline need IOL/ birth prior to 39/40.
- All women who decline blood products who need operative birth or in their first pregnancy. All others need case review and discussion.
- Abnormal placentation: placenta praevia or suspected accreta, vasa praevia.

BMI

Due to anaesthetic risks, it is recommended that those women with a high BMI are referred to CWH:

- **> 45** at booking or at any time in pregnancy
- **BMI 40-45 with co-morbidities identified after anaesthetic and obstetric review**

See also Te Whatu Ora Te Tai o Poutini Criteria for Local Referral of Women with High BMI (Feb 2017)

- A fundal height is difficult and often unreliable in women with high BMI, therefore Te Whatu Ora Te Tai O Poutini recommends following GAP protocol, the National SGA guidelines, and Referral guidelines in measuring fundal height, using customized GROW charts, and referring for growth scans and Obstetric consultation.

REFERRAL CONSIDERATIONS

- Christchurch Women's Hospital has a Timing of Birth Assessment tool (TOBA) which along with the Induction of labour guidelines give an indication of when birth may be planned. These can be found on the maternity guidelines page on PRISM. It is worth considering these when you discuss transfer and potential timing of birth with pregnant people and their whanau.
- TOBA is also a good forum for second opinion re mode and timing of birth and meets twice a week. Decisions can be viewed on HCS following the meeting.