Fetal growth restriction clinical practice guidelines: systematic review

Marina **Piergianni** [*], Martina **Mercaldi**, Danilo Italo Pio **Buca**, Francesca **Di Sebastiano**, Marco **Liberati**, Francesco **D'Antonio**

Center For High-Risk Pregnancy and Fetal Care, Department of Obstetrics and Gynecology, University of Chieti, Chieti, Italy.

DOI: 10.36129/jog.2022.S27

Objective. To systematically identify and critically assess the quality of clinical practice guidelines.

Materials and Methods. Medline, Embase, Google Scholar, Scopus and ISI Web of Science databases were searched to identify all relevant CPGs on the management of pregnancies complicated by FGR. The risk of bias and quality assessment of the CPGs included were performed using AGREE II tool.

Results. The definition of FGR: 22.2 of CPS adopted the Delphi consensus, 55.6% an estimated EFW/AC < 10th centile, 11.1 an EFW/AC < 5th centile, one CPG defined FGR as an arrest or a shift in the rate of growth measured longitudinally. 55.5% recommended the customized growth charts. In case of AEDF/REDF in the umbilical artery: 11.1% recommended assessment every 24-48 h, 44.4% every 48-72 h, 1 CPG recommended assessment 1-2 times per week. In case of FGR with mild abnormalities in the UA, middle cerebral artery or cerebroplacental ratio or presence of FGR without Doppler abnormalities: one CPG recommended delivery at 34-37 weeks, one at 37, one at 36-37 weeks, while 6 CPGs did not report any recommendation. In case of FGR with AEDF in the UA: 44.4% recommended delivery by 32 weeks, 44.4% by 34 weeks, while one CPG generically recommended delivery before 37 weeks of gestation. In case of REDF: 44.4% suggested considering delivery by 30 weeks, 33.3% by 32 and one CPG by 34 weeks of gestation.

Conclusions. There is significant heterogeneity in the management of pregnancies complicated by FGR in published CPGs.