

Understanding your options for delivery of a large for gestational age (LGA) baby

Other formats

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- 01392 402093 (for Mid Devon, East Devon and Exeter services)
- 01271 314090 (for North Devon services)
- rduh.pals@nhs.net



This leaflet guides you through your next steps after a scan has suggested your baby is growing larger than expected for this stage of pregnancy.

This is quite common, and we're here to support you and help you understand what it means for you and your baby.

If you have any questions after reading this, you can talk them through with your midwife or one of the doctors — we're always here to listen and help.

What does large for gestational age mean?

A large for gestational age (LGA) baby is a baby who is predicted to be either:

- Over 4kg (nearly 9lb) at 40 weeks (on your due date)
- On or above the 97th centile

QUESTION

What is a centile?

When we measure your baby, we measure three things:

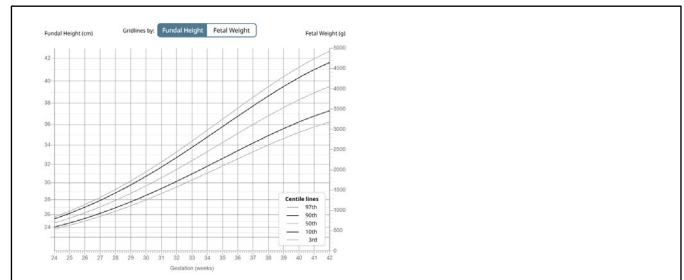
- **Head size, tummy size, size of the thigh bone (femur)**

We combine these measurements to give us your baby's estimated fetal weight (EFW), and then we use the EFW of your baby and your height and weight to work out centiles.

If we imagined 100 women who are the same height and weight as you, and each of them had a baby, those babies would all be different shapes, sizes, and weights. If we lined them up from the smallest (number 1) to the heaviest (number 100), we could see where your baby might fit in that line.

An LGA baby is a baby who is above number 97 (above the 97th centile).

Above the top line in your growth chart.



Is the Ultrasound scan accurate?

It's important to remember that while most scans do a good job of estimating your baby's size, sometimes babies are born smaller or larger than predicted. This can happen if the baby's position made the scan more difficult. Overall, scans are reliable and remain the best tool we have for estimating your baby's birth weight.

Why are some babies large for gestational age?

The most common causes are:

- Genetics (bigger parents will have bigger babies)
- Raised maternal BMI
- Pre-existing Diabetes
- Gestational Diabetes (if you are found to have an LGA baby before 30 weeks you may be referred for a test for gestational diabetes)
- Previous LGA baby
- Post-dates (if you are beyond 40 weeks)

What are the risks if my baby is predicted to be LGA?

Most babies who are larger than average are born vaginally without any problems. However, there are some risks that can be higher when a larger baby is born vaginally.

Risks to mum

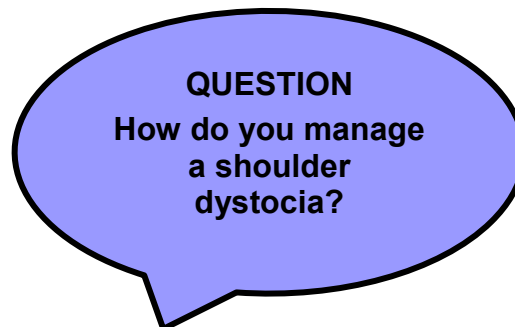
Increased likelihood of:

- A longer Labour
- Instrumental delivery (forceps or vacuum assisted – sometimes called a ventouse delivery)
- Episiotomy (small cut to the perineum to aid delivery of the baby)
- 3rd or 4th degree tear (a tear that involves the muscle around your back passage)
- Post-partum haemorrhage (bleeding after delivery)

Risks to baby

Increased likelihood of:

- **Shoulder Dystocia** (after the baby's head is delivered, the baby's shoulders become wedged behind the mother's pelvic bone, preventing the rest of the body from being delivered) – occurs in 1 in 200 births and can lead to other complications such as:
 - Bone and/or nerve injury
 - Hypoxic brain injury (where there is a lack of oxygen delivery to the baby's brain during delivery)
 - Admission to the neonatal ICU



A shoulder dystocia is an emergency situation, but one that the medical team is trained to handle quickly and safely.

- First, the doctor or midwife will call more team members into the room. *Everyone has a role, and **help is called early to keep things as safe as possible.***
- You'll be asked not to push for a moment while the team uses special manoeuvres to help deliver your baby safely. The first is called the **McRoberts manoeuvre** (see picture).

The **McRoberts' manoeuvre alone is successful in about 90% of cases.**

That means most babies stuck with shoulder dystocia are delivered **without needing further procedures.**

If McRoberts doesn't work, the team has **other safe techniques**:

- They may ask you to go onto your hands and knees (if possible).
- They may gently reach inside to move the baby's shoulders.

These steps are rarely needed — and only used if necessary.

The McRoberts Maneuver:

Your legs will be lifted up and bent tightly toward your chest.

This helps to open up your pelvis and can free the baby's shoulders.

You'll be supported while this is done - you don't have to move yourself.



What are my options?

If your baby is estimated to be LGA, it's important to understand your options and the possible risks and benefits of each option.

- Option one: expectant management (no intervention)
- Option two: induction of labour
- Option three: caesarean section (C-section)

As we have said, most babies who are LGA are born vaginally without any problems. Vaginal birth avoids surgery and allows for faster recovery, but there is a slightly higher chance of shoulder dystocia and its associated complications. Inducing labour can help prevent further growth of a large baby, but it may increase the likelihood of interventions.

A planned caesarean avoids the risk of shoulder dystocia, but it is major surgery with longer recovery and potential complications.

Option 1. Expectant Management

Choosing no intervention means you will wait for natural labour to begin on its own without any medical procedures to start or speed up the process.

This is a very reasonable option to consider, especially if you have delivered an LGA baby vaginally before.

Potential benefits:

- Avoids the risks associated with medical interventions such as induction

Risks and considerations:

- There is a risk of a prolonged or difficult labour due to a larger baby
- There is a higher risk of shoulder dystocia if you wait for spontaneous labour compared to women who opt for an induction of labour
- There is an increased risk of emergency caesarean compared to women who opt for an induction of labour
- There may be increased risk of birth injury to the baby or mum

What else to consider:

- A stretch and sweep is an alternative low intervention option to an induction of labour.

A doctor or midwife examines the vagina to feel for the position of the cervix (the opening of the womb) to gently 'stretch' it and 'sweep' their finger around the inside of the opening to help start labour and reduce the need for an induction.

If it works, you can expect to go into labour within 48 hours. If it does not work, it can be repeated two or three times over the next few days.

Option 2. Induction of Labour

Inducing labour involves medical intervention to start the labour process before it begins naturally. This is usually carried out from 38 weeks onwards (sometimes earlier if your baby is measuring particularly large for gestational age).

This may involve methods such as a prostaglandin pessary or physical methods such as a balloon catheter which take 24-48 hours to work. You then move to the labour ward to have your waters artificially broken and then if your contractions don't become strong enough on their own, you start an oxytocin infusion to help get good, strong regular contractions.



Potential benefits:

- Reduces the risk of experiencing a longer, complicated labour due to a large baby
- Helps to avoid the risks of waiting too long and having a baby that becomes even larger, which might increase delivery complications such as shoulder dystocia and its associated risks

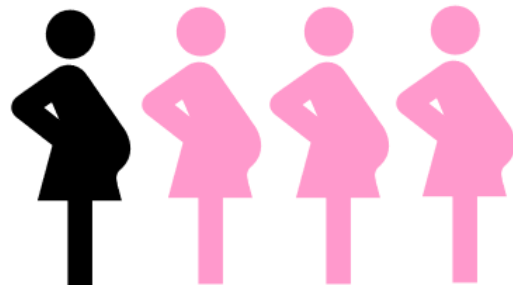
Risks and considerations:

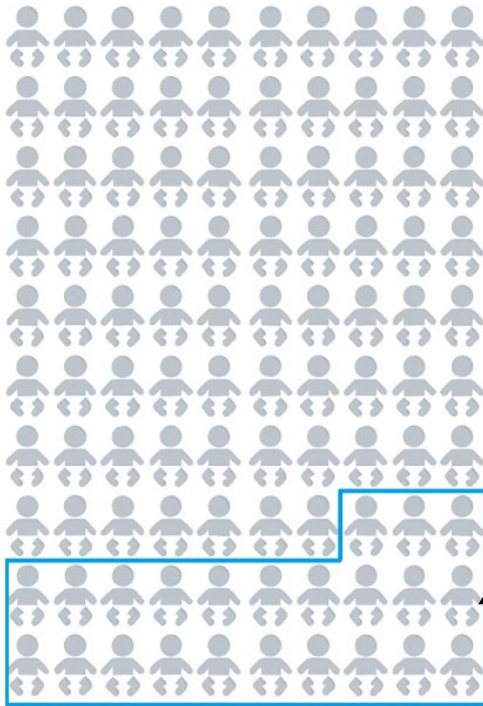
- Your choice of place of birth will be limited, as you may be recommended interventions that are not available for a home birth or in a midwife-led Birth Centre
- Induction can be a long process (from having the pessary or balloon, to waiting for your waters to be broken and then having sometimes up to 24 hours on the oxytocin infusion)
- An induction of labour requires an increased level of fetal monitoring
- You may be less likely to be able to use a birthing pool (if you require intravenous oxytocin)
- There is a risk of needing a caesarean section for three reasons:
 - Unsuccessful induction (despite our interventions – your body does not go into labour)
 - Fetal distress (some babies do tolerate the hormone infusion well, so we continuously monitor your baby's heart rate while using oxytocin)
 - Maternal request to stop the induction process
- An induced labour may be more painful than a spontaneous labour
- There's a small risk of uterine rupture, especially if you have had a previous C-section (where a previous caesarean scar opens up during labour)

QUESTION

If I'm induced, what's the likelihood I'll give birth vaginally?

About 3 in 4 women who are induced go on to have a vaginal birth





Or to explain it another way, if 100 women are induced, around 59 give birth vaginally without assistance, 18 have an instrumental birth to help deliver their baby either by forceps or a ventouse cup, and **23 will have babies born by caesarean**

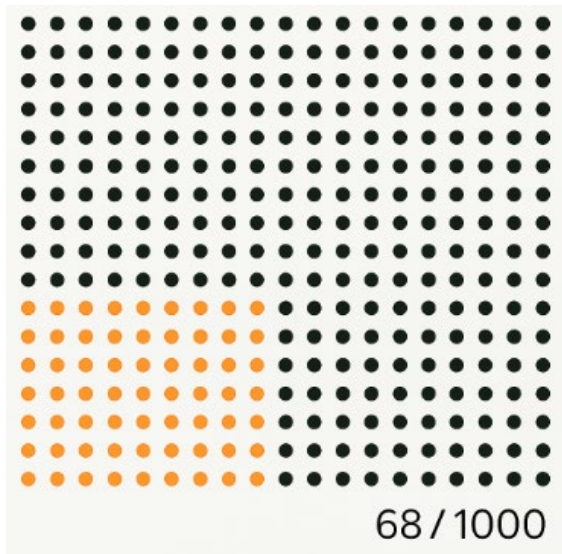
QUESTION
How effective is an induction of labour at reducing the risk of shoulder dystocia?

Studies consistently show that when labour is induced, it lowers the chance of shoulder dystocia in LGA babies, so it's one way to help make delivery of an LGA baby safer.

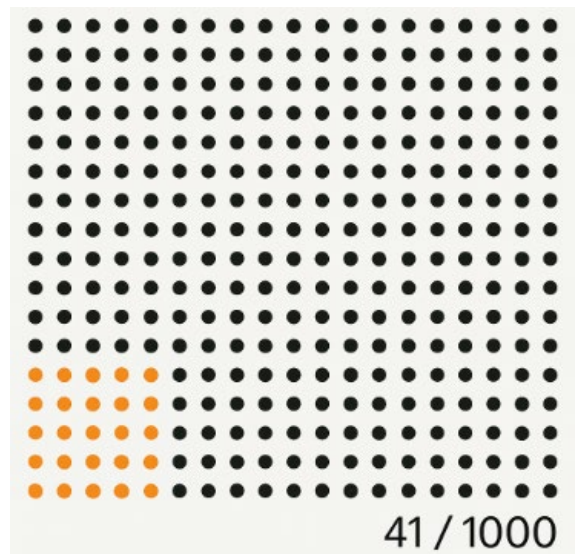
In the diagrams below, each dot represents a woman giving birth: the black dots are those who delivered without shoulder dystocia, and the yellow dots are those whose delivery was complicated by shoulder dystocia.

Out of every 1,000 women who wait for labor to start on its own, about 68 will experience shoulder dystocia. If labor is induced, that number goes down to about 41 out of 1,000.

Await spontaneous labour



Induction of labour



QUESTION
What is the big baby trial?

You may have heard of a recent UK trial called ‘the big baby trial’ which involved almost 3000 women with predicted LGA babies to look at whether inducing labour at 38⁰–38⁴ weeks reduces the risk of shoulder dystocia.

The results showed that:

- All women with LGA babies have a risk of shoulder dystocia at all gestations
- There is a slightly higher risk of shoulder dystocia if you wait for spontaneous labour
- There is no difference in outcomes for babies if you have an induction or if you wait for spontaneous labour
- Earlier delivery reduced the need for emergency caesarean section
- Earlier delivery did not increase the risk of tearing

Option 3. Caesarean Section

A caesarean section is a surgical procedure where the baby is delivered through an incision made in the abdomen and uterus. This is usually carried out during the 39th week of pregnancy and you would be informed of the exact date of your caesarean close to the time. (In rare cases planned caesareans are carried out in our emergency theatre and so can be subject to last-minute changes).

Potential benefits:

- Can be planned ahead of time and reduce uncertainty.
- May avoid complications like shoulder dystocia or birth injuries.

Risks and considerations:

- Major surgery with a longer recovery time.
- Increased risk of infections, blood loss, and blood clots.
- Longer hospital stay and recovery time.
- Potential complications in future pregnancies (e.g., uterine rupture, placenta issues)
- Increased risk of admission to the special care baby unit for breathing support

Which option is best for me and my baby?

Deciding how to approach the birth of a predicted LGA baby can feel overwhelming, and it's important to remember that there isn't always a single "right" choice.

It can help to reflect on the factors that matter most to you so you can make a choice that feels right for both you and your baby. Take your time, ask questions, and explore all your options.

	Not Important	Neutral	Very Important
Avoiding major abdominal surgery			
Shorter Recovery time			
Having labour start naturally			
Reducing risk of shoulder dystocia and its associated complications			

You don't need to decide immediately, and it's completely okay if you revisit your decision later and choose a different path.



PALS

The Patient Advice and Liaison Service (PALS) ensures that the NHS listens to patients, relatives, carers and friends, answers questions and resolves concerns as quickly as possible. If you have a query or concern, please contact PALS:

- 01392 402093 (for Mid Devon, East Devon and Exeter services)
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