## PP-021 A comparative review of national and international guidelines on the diagnosis and management of fetal growth restriction

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**Objective:** The aim of this study was to review and compare the most recently published influential guidelines on the management of pregnancies complicated by fetal growth restriction, a frequent pregnancy complication and a major contributor of fetal and neonatal morbidity and mortality.

**Methods:** A descriptive review of guidelines from the American College of Obstetricians and Gynecologists, the Society for Maternal-Fetal Medicine, the International Federation of Gynecology and Obstetrics, the International Society of Ultrasound in Obstetrics and Gynecology, the Royal College of Obstetricians and Gynecologists, the Society of Obstetricians and Gynecologists of Canada, the Perinatal Society of Australia and New Zealand, the Royal College of Physicians of Ireland, the French College of Gynecologists and Obstetricians, and the German Society of Gynecology and Obstetrics on FGR was carried out.

**Results:** The definition of fetal growth restriction and small-for-gestational-age fetuses and the diagnostic criteria lack uniformity. On the contrary, all the reviewed guidelines highlight the importance of early universal risk stratification for fetal growth restriction to accordingly modify the surveillance protocols. It is unanimously recommended to evaluate low-risk pregnancies by serial symphysis fundal height measurement, while the high-risk ones warrant increased sonographic surveillance. After fetal growth restriction diagnosis, there is consensus that umbilical artery Doppler assessment is required to further guide management. Amniotic fluid volume evaluation is recommended by some medical societies. In case of early, severe or accompanied by structural abnormalities fetal growth restriction, most of the medical societies support the performance of prenatal diagnostic testing. There is also agreement regarding the importance of continuous fetal heart rate monitoring during labor, the optimal timing and mode of delivery, and the need for histopathological examination of the placenta after delivery. On the other hand, discrepancies were identified with regards to the frequency of fetal growth and Doppler velocimetry evaluation, although the majority of the reviewed guidelines recommend an average interval of 2 weeks, reduced to weekly or less when umbilical artery abnormalities are detected. In addition, inconsistency exists concerning the appropriate timing for corticosteroids and magnesium sulfate administration, the need of testing for congenital infections, as well as the administration of aspirin as a preventive measure. Cessation of smoking, alcohol consumption, and illicit drug use are proposed for fetal growth restriction prevention.

**Conclusion:** Fetal growth restriction is a clinical entity associated with numerous adverse antenatal and postnatal events mainly due to the lack of effective screening, prevention, and management policies and the absence of definitive cure apart from delivery. Therefore, it seems of insurmountable importance to develop and implement uniform international protocols for the early recognition, the adequate surveillance, and the optimal management of growth-restricted fetuses in order to ameliorate the perinatal outcomes of such pregnancies.

Keywords: Fetal growth restriction, intrauterine growth restriction, small for gestational age, guidelines, investigation, management, screening, diagnosis, prevention

## PP-022 A comprehensive review of major guidelines on postnatal care

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**Objective:** The aim of this study was to review and compare the most recently published influential guidelines on postnatal care practices, as the ongoing health care provision of both the mother and her offspring helps to timely identify and effectively manage any arising complications and therefore secure maternal and infant short- and long-term well-being.

**Methods:** A comprehensive review of guidelines from the American College of Obstetricians and Gynecologists, the World Health Organization, the National Institute for Health and Care Excellence, and the Public Health Agency of Canada regarding postnatal care was carried out.

**Results:** All the reviewed guidelines underline the

importance of postnatal health care provision, including home visits and midwifery services and the use of telemedicine for the facilitation of communication with the patient, and agree on the appropriate preparation for discharge and the discharge criteria. There is also agreement on the clinical aspects that should be evaluated at each postnatal visit, although discrepancies exist with regard to the contact schedule. In addition, there is consensus concerning the management of postnatal infections, perineal pain, fecal and urinary incontinence, and physical activity guidance. Clinicians should address mental health issues at each postnatal visit, according to all medical societies, but routine screening for depression is not recommended universally. As for the optimal interpregnancy interval, the American College of Obstetricians and Gynecologists recommends avoiding pregnancy for at least 6 months postpartum, whereas the National Institute for Health and Care Excellence recommends a 12-month interval. Discrepancies were identified with regards to the nutrition guidance, the recommended contraceptive methods, and the postpartum management of pregnancy complications. Of note, the World Health Organization is the only one to provide guidance regarding the prevention of specific infections during the postpartum period.

| | ACOG | WHO | NICE | PHAC |
|---|---|---|---|---|
| Clinical evaluation at the first 24 hours | Not discussed | Vaginal bleeding, fundal height, uterine tonus, temperature, heart rate. BP measurement shortly after birth and repeat after 6h. Urine void evaluation within 6h. | Bladder function with measurement of first void after birth. Woman's health assessment. | Assess physical and psychological well-being. Vital signs, uterine tone and condition of perineum, lochia, bladder and bowel function, breasts and nipples. Promote effective feeding. Hydration and nutrition |
| Discharge criteria | Not discussed | 24h after vaginal delivery. 1.Maternal and newborn well-being. 2. Parental and caregivers' skills and confidence for individual and newborn care. 3. Home environment and other factors affecting pp care and care-seeking behavior. | 1. Woman's health and bladder function, 2. Baby's health and meconium passing. 3. Feeding plan and observation of 1 successful feed. Inform about postnatal period available support. Discuss the timing. | Review test results and possible signs of postpartum complications. |
| Postnatal contact schedule | Individualize. Provide postnatal care plan with contact information and instructions about the timing of postnatal contacts. First contact at first 3w, following ongoing care until the comprehensive visit <12w. | Minimum 4 postnatal contacts. First within 24h for home delivery. At least 3 additional postnatal contacts between 48-72h, between 7-14 days and during week six. Individualize. | First midwife visit at 36h after transfer of care or after home birth. First HCP at 7-14 days after midwifery care. Comprehensive evaluation by GP at 6-8 weeks. | Provide postnatal care plan with contact information and instructions for the postnatal contacts. Follow-up visit at 24-72h after discharge. |

**Conclusion:** Although the puerperium is a critical period for the establishment of motherhood and the transition to primary care, postnatal care remains a relatively underserved aspect of maternity care. Therefore, it is crucial to develop consistent international strategies for the optimal care and support of women during this period to safely guide clinical practice and subsequently reduce maternal and neonatal morbidity.

Keywords: Postnatal care, postpartum care, puerperium, guidelines

## PP-023 A comparative review of national and international guidelines on the diagnosis and management of fetal growth restriction

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**Objective:** Evaluation of mutual influence of antiphospholipid syndrome and TORCH infection, as well as the inclusion of plasmapheresis in preconception preparation, on the course of pregnancy, its outcome and the birth of children with fetal growth restriction.

**Methods:** Three hundred and eighty patients were examined at the Family Planning and Reproduction Center of the Moscow Department of Health, Maternity Hospital No. 3, and Maternity Hospital No. 4 of the City Clinical Hospital named after. V.V. Vinogradova Moscow, Russian Federation. In 270 patients, based on laboratory criteria and anamnestic data, a diagnosis of "Primary antiphospholipid syndrome" was established. There are two key classes of antiphospholipid antibodies: lupus anticoagulant and antibodies (anticardiolipin, phosphatidylserine, phosphatidylcholine, phosphatidylethanolamine, phosphatidylic acid, β2-lycoprotein-1, annexin V). 270 examined patients were divided into three groups: Group I - 132 patients without signs of activation of TORCH infection with antiphospholipid syndrome. Group II - 138 patients - verified TORCH infection with antiphospholipidsyndrome. Group III - 110 patients with confirmed TORCH infection who did not have antiphospholipidantibodies. In order to identify the infectious process, monitor the dynamics of its development, the effectiveness of treatment and verify clinical and laboratory cure, we used the determination of antibodies of the IgG and IgM classes, their avidity,