NHS
Royal Berkshire
NHS Foundation Trust

Large for gestational age (LGA)

We are giving you this leaflet as we have identified that you may be having a baby that is bigger than average, sometimes referred to as large for gestational age (LGA). This leaflet will explain what this means, the chance of it causing complications and what this will mean for you care and birth.

What does this mean for me and my baby?

Large for gestational age means that based on the current rate of growth your baby is predicted to be 4kg or more by 40 weeks. Research has shown that 90% of those carrying a LGA baby will have a vaginal birth. However, there are known risks that you need to be aware of, in order to make informed decisions about your pregnancy and birth plan.

LGA babies are found in 9-13% of all births. The size of your baby can be down to genetics and the size of the biological parents. Risks begin to rise with increasing birthweight above 4.5kg. We know you are more likely to have LGA babies if you have had a LGA baby in the past, are diabetic including gestational diabetes or have a BMI of more than 30.

Possible complications for women which can happen with LGA births include:

- An increased chance of prolonged labour.
- Instrumental birth, such as Caesarean or assisted vaginal birth (forceps or ventouse).
- Perineal trauma (including episiotomy which is a surgical cut to the perineum at delivery made by the midwife or doctor and tears which can include more complicated 3rd and 4th degree tears).
- Postpartum haemorrhage (excess blood loss over 1 litre).
- Uterine rupture, although this is very, very rare, affecting fewer than 1 in 1000 LGA births.

Complications for the baby include an increased likelihood of:

- Shoulder dystocia – this is a rare complication where the head is born but there is difficulty delivering the baby's shoulders during a vaginal birth because the shoulders become temporarily stuck above the pubic bone, delaying the birth of the body). This requires emergency assistance to deliver the baby, which all staff are trained to identify and manage and are updated on a regular basis. Shoulder dystocia can be associated with damage to the baby's shoulders or arm (including nerve damage, such as brachial plexus injuries which can affect nerves of the shoulder, arm, forearm, hand and fingers, affecting 1 in 10 babies and is usually temporary, or rarely, bone fractures, which usually heal quickly and easily in babies). There is also a very rare risk of the baby not getting enough oxygen, known as fetal hypoxia, where the baby may suffer brain damage. However, most babies are not affected by shoulder dystocia.
- Hypoglycaemia (low blood sugar)
- Neonatal intensive care unit (Buscot Ward) admission.

How do you know I may have a larger than average baby?

It may be that your scans showed particularly above average measurements, or your midwife may have noticed an increase on your symphysis fundal height check which is performed from 24 weeks. This is when your midwife measures from your pubic bone to the top of your bump and plots this measurement on a growth chart in your notes. If on more than two occasions this measurement was above the 95th percentile or if there is a unexpected increase then your midwife will have referred you as having an LGA baby.

At this point we would invite to the hospital for a blood test to check for gestational diabetes and, if needed an ultrasound scan.

It is important to understand that estimating your baby's weight using ultrasound is always an estimation and it becomes harder to estimate this as your baby gets bigger, especially after 34 weeks. There can be a 20% difference, bigger or smaller than what is estimated. This could mean your baby is born at an average weight or is bigger or smaller than expected.

What does having an LGA baby mean for my birth plan?

You will have the opportunity to talk with an obstetrician (doctor specialising in pregnancy) about your birth plan and they can offer recommendations personalised to you. Sometimes an Induction of Labour (IOL) may be recommended, especially if you have gestational or pre-existing diabetes.

For non-diabetic women, evidence for IOL comes from a national group of experts using data from 1190 pregnancies and a comparison of outcomes between those undergoing IOL or waiting for spontaneous labour (expectant management) between 37-40 weeks. Compared to expectant management, those women who underwent IOL had;

- Small reduction in birthweight (178g).
- Fewer cases of shoulder dystocia.
- Fewer cases of fractures of babies' long bones – such as the humerus (upper arm) – although 60 women would need to be induced to prevent one fracture.

There was no difference in;

- The number of women undergoing Caesarean section or needing an instrumental birth.
- In the number of babies diagnosed with a brachial plexus injury or fetal hypoxia.

Evidence for whether IOL has any effect on perineal tears in unclear.

Further information

Another useful information sheet is on the RCOG website at https://www.rcog.org.uk/en/guidelines-research-services/guidelines/gtg42/.

To find out more about our Trust visit www.royalberkshire.nhs.uk

Please ask if you need this information in another language or format.

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