produced earlier. Thomas, Peabody, Turnier, et al (2000) concluded that intrauterine growth measured by head circumference, birth weight, and length varies according to race and gender. These researchers also found that altitude did not seem to significantly affect birth weight, as has been suggested by other authors. It is recommended that readers access and use the most current intrauterine growth chart specific to the referent population being evaluated.

Classification of infants at birth by both birth weight and gestational age provides a more satisfactory method for predicting mortality risks and providing guidelines for management of the neonate than estimating gestational age or birth weight alone. The infant's birth weight, length, and head circumference are plotted on standardized graphs that identify normal values for gestational age (for birth weight see Fig. 7-1, *B*). Infants whose weight is **appropriate for gestational age (AGA)** (between the 10th and 90th percentiles) can be presumed to have grown at a normal rate regardless of the time of birth—preterm, term, or postterm. Infants who are **large for gestational age (LGA)** (above the 90th percentile) can be presumed to have grown at an accelerated rate during fetal life; **small for gestational age (SGA)** infants (below the 10th percentile) can be assumed to have intrauterine growth restriction or delay.

When gestational age is determined according to a standardized gestational age scale such as the NBS, the newborn will fall into one of the following nine possible categories for birth weight and gestational age: AGA—term, preterm, postterm; SGA—term, preterm, postterm; LGA—term, preterm, postterm. Fig. 7-2 illustrates the disparity between birth weights of three preterm infants of the same gestational age, 32 weeks. Birth weight and gestational age both influence morbidity and mortality; the lower the birth weight and gestational age, the higher the morbidity and mortality.