

# Pre-eclampsia and hypertension in pregnancy

[Recommendations 1.2.23 to 1.2.28](#)

## Why the committee made the recommendations

Guidance on risk assessment and risk reduction for pre-eclampsia is covered by the [NICE guideline on hypertension in pregnancy](#). Although the guideline implies that pregnant women will be routinely tested for proteinuria, it does not explicitly recommend this. Therefore, the committee agreed that, in line with current practice, urine testing for proteinuria should be offered at every routine face-to-face appointment.

There was little evidence on the setting and technique for monitoring blood pressure during pregnancy, so the committee made the recommendations based on their knowledge and experience and existing NICE guidance. The committee were aware that the [British and Irish Hypertension Society lists blood pressure measurement devices validated for use in pregnancy](#). This has also been noted in the [NICE guideline on hypertension in adults](#).

The committee agreed that monitoring blood pressure and testing for proteinuria at every routine face-to-face antenatal appointment enables hypertension and pre-eclampsia to be identified and treated early, which is important because they can have severe consequences.

Guidance on care for pregnant women with gestational or chronic hypertension is covered by the NICE guideline on hypertension in pregnancy.

## How the recommendations might affect practice

The recommendation reflects current practice and no change in practice is expected.

[Return to recommendations](#)

# Monitoring fetal growth and wellbeing

[Recommendations 1.2.29 to 1.2.35](#)

## Why the committee made the recommendations

Risk assessment starting in early pregnancy enables increased monitoring of babies who are at an increased risk of fetal growth restriction, which is associated with fetal morbidity and mortality. The committee were aware of available risk assessment tools, such as those in the [Royal College of Obstetricians and Gynaecologists' guideline on the investigation and management of the small-for-gestational-age fetus](#) or the [NHS saving babies' lives care bundle version 2](#).

Evidence showed that ultrasound scans and symphysis fundal height measurement do not accurately predict a baby being born small or large for gestational age. However, the committee agreed that the current routine practice of using symphysis fundal height measurement to monitor fetal growth should be used, because it is a simple and low-cost intervention and can alert to further investigations when concerns arise about the baby being either larger or smaller than expected for gestational age. When the symphysis fundal height measurement is large for gestational age, ultrasound scans could be used to assess the size of the baby and the volume of amniotic fluid. Small-for-gestational-age babies are at an increased risk of perinatal mortality and morbidity; therefore, when this is suspected, further investigations should be done to monitor the growth and wellbeing of the baby, taking into consideration the full clinical picture.

The committee were aware that many women may request routine ultrasound scans in late pregnancy, but available evidence showed no benefit from routine ultrasound in late pregnancy (from 28 weeks) for uncomplicated singleton pregnancies. However, the absence of effect found in the evidence does not mean that there is definitely no effect. There was also no evidence on maternal anxiety in relation to routine ultrasound scanning. The committee were in favour of research on this in the future; however, a research recommendation was not prioritised because there is a good amount of evidence on other key outcomes.

The committee were aware that cases of stillbirth have been linked to reduced fetal movements. Therefore, structured fetal movement awareness packages have been trialled. Evidence on the use of a [structured fetal movement awareness package](#), such as the one described in the UK trial Awareness of fetal movements and care package to reduce fetal mortality (AFFIRM), did not detect a reduction in stillbirths or perinatal mortality but did find that there were more interventions at birth, including more caesarean births and inductions of labour, and fewer spontaneous vaginal births. Another study from Sweden compared giving a leaflet to pregnant women teaching them a method of being aware of

fetal movements, with usual care. No clinically important benefits or harms were detected, including no difference in perinatal mortality, although there was a small, but statistically significant, reduction in births after 41+6 weeks and fewer caesarean births. Health economic evaluation did not establish cost effectiveness for either of these structured awareness packages.

Although the available evidence did not support the use of structured packages, the committee agreed that fetal movements should be discussed routinely and women's concerns should be taken seriously. The committee agreed that there is no agreed definition of normal fetal movements. Discussing the topic of babies' movements in the womb and how they change throughout the pregnancy can help women recognise changes to their own baby's movement patterns. When there are concerns, an assessment of the woman's wellbeing and the baby's wellbeing and size should be done.

## How the recommendations might affect practice

The recommendations on fetal growth monitoring largely reflect current practice, although in some maternity units it is common to offer women with uncomplicated singleton pregnancies ultrasound scans after 28 weeks to monitor the baby, so there might be a change of practice for these units and some potential cost savings. On the other hand, there may be some more scans due to suspected large for gestational age.

Current practice for managing reduced fetal movements is to follow the [NHS saving babies' lives care bundle version 2](#). The recommendations in this guideline similarly emphasise the importance of recognising and reporting concerns on fetal movements and acting on those concerns by assessing the woman and the baby.

[Return to recommendations](#)

## Breech presentation

[Recommendations 1.2.36 to 1.2.38](#)

## Why the committee made the recommendations

There was not enough evidence to support routine ultrasound at 36+0 weeks to 39+0 weeks to identify breech presentation, so the committee did not change the current

standard practice of offering abdominal palpation with selective ultrasound when breech is suspected.

Because of the lack of evidence, the committee made a [research recommendation to compare routine ultrasound scans from 36+0 weeks with selective ultrasound scans](#).

In the case of breech presentation, the committee agreed that a discussion about the different options and their potential benefits, harms and implications is needed to ensure an informed decision. External cephalic version is standard practice for managing breech presentation in uncomplicated singleton pregnancies at or after 36+0 weeks. Head-down vaginal birth is preferred by many women and the evidence suggests that external cephalic version is an effective way to achieve this.

## How the recommendations might affect practice

The recommendations reflect current clinical practice and no change in practice is expected.

[Return to recommendations](#)

## Communication – key principles

[Recommendations 1.3.1 to 1.3.6](#)

### Why the committee made the recommendations

The committee agreed that the key principles of care in the antenatal period are to listen to women and be responsive to their needs, in line with the findings of the [Ockenden report on maternity services at the Shrewsbury and Telford hospital NHS trust](#), and to enable women to make informed decisions about their care, in line with the [Montgomery ruling](#). The committee emphasised that women should be supported in their decision making even when their preferences and values differ from those of the healthcare professionals.

The evidence did not show a particular benefit from any one specific approach to giving information, although 1 study found that supplementing information provided face-to-face with online information increased knowledge. The committee based the recommendations

on their knowledge and experience.

The committee agreed that information should meet the needs of the woman, for example, taking into account any language barriers, learning disabilities or other needs. Most antenatal care information is given in a one-to-one or couple discussion. Offering other formats to supplement this can help improve understanding and engagement, including written materials and group discussions in antenatal classes or, in some cases, group antenatal appointments.

There was evidence that women value information that is relevant to their own circumstances. The committee agreed that healthcare professionals should explore the level and accuracy of the woman's (and her partner's) existing knowledge and understanding of the topic. The committee discussed the importance of allowing sufficient time for discussions.

## **How the recommendations might affect practice**

The recommendations largely reflect current practice.

[Return to recommendations](#)

## **Information about antenatal care**

[Recommendations 1.3.7 to 1.3.19](#)

### **Why the committee made the recommendations**

The committee agreed, based on the evidence and their knowledge and experience, that if women are given information about antenatal care, their schedule of appointments and what happens at different appointments and stages of pregnancy, they are more likely to be engaged, follow advice and share their concerns with healthcare professionals.

There was no evidence identified to inform the timing of information provision, but the committee agreed that it is important to have a staged approach and cover topics relevant to each stage of pregnancy.

The first antenatal (booking) appointment is an opportunity to discuss and share