Fetal Abnormality Policy

Every client who attends Window to the Womb must have a diagnostic well-being check as prescribed by our protocols, undertaken by a trained and qualified sonographer. They will also receive a fetal well-being report which records the key observations made by their sonographer during their scan. This is our promise.

Window to the Womb have professional standards and a DUTY OF CARE to all our clients; if our sonographers observe any ultrasound findings consistent with an anomaly they will:

1. Inform the client in a caring, honest and professional manner
2. Write a detailed medical report dealing with the findings
3. Submit the report following the referral 'Pathways' agreed with the local NHS Fetal Medicine Unit or Early Pregnancy Unit

When an anomaly is suspected by a Sonographer the following process should be followed closely:

1. The sonographer should discretely inform the scan assistant that the ultrasound findings are atypical
2. In Window to the Womb the scan assistant should only stop the video recording once the sonographer has completed all observations.
3. The sonographer should gather as much diagnostic information as reasonably achievable to aid in any future diagnosis.
4. Once the scan is concluded the sonographer should inform the client of their ultrasound findings. It is not expected nor suggested that a sonographer should assume or discuss any potential diagnosis, this is the role of a Doctor, and therefore a referral to the appropriate department in the NHS should be made.
5. It is at the client's discretion as to whom remains in the scan room while any discussion takes place regarding the ultrasound results. If required, the scan assistant should arrange for the wider family and specifically any children to leave the scan room and be looked after elsewhere in the clinic.
6. Any discussion regarding ultrasound results must take place either in the scan room or where applicable, a quiet room by the sonographer. Clients should not leave the clinic until they are fully informed of any ultrasound findings. In the rare instance that a second opinion is required by the Window to the Womb clinical lead panel this should be explained to the client and they should be advised timelines for their results. If the ultrasound results are atypical and the clinical lead panel are unavailable within a reasonable time period, the sonographer should refer the client to the appropriate department in the NHS for a second opinion.

Sonographers employed at WTTW and firstScan clinics must complete all scans in accordance with the local Scan Room Protocols, taking into consideration guidance from the Fetal Anomaly Screening Programme, The National Institute for Health and Care

Excellence. Ultrasound scans are often completed at a gestation different to NHS scans. As such, the detection rate of abnormalities may be reduced. The time to complete a scan also varies, which again will have an impact on the detection of certain anomalies. In particular, serious cardiac anomalies require a number of specialised views of the heart and the great vessels which cannot be achieved in the timeframe of a Window to the Womb scan.

The Fetal Anomaly Screening Programme handbook sets out the conditions screened for as a minimum by the NHS along with detection rates at 10 to 14 weeks and 18^{+0} to 20^{+6} weeks. Anomalies identified at WTTW that should be referred to NHS include the following:

1. No fetal heartbeat present at any gestational age.
2. Oligohydramnios (SDP* < 20mm) or Polyhydramnios (SDP* > 80mm).
3. Cysts in the abdomen or chest at any gestational age. Size and position should be documented.
4. Dilated renal pelvises, multicystic kidneys, grossly enlarged urinary bladder.
5. Abnormal situs and size of the heart.
6. Fetal ascites/oedema (fluid retention).
7. Cleft lip or undetected talipes in the third trimester.
8. Echogenic bowel. The echogenicity of this should be greater than that of bone.
9. Following the FASP anomaly scan where a low lying placenta was not revealed, but now appears low lying.
10. Subjectively grossly thickened NT (this should not be measured as not DQASS)

**SDP – Single Deepest (Cord Free) Pool*

Summary of anomalies which should/could be detected during WTTW scans 16 weeks to 40 weeks and at firstScan clinics 6 weeks to 15^{+6} weeks.

6 weeks to 10 weeks:

Miscarriage (missed, inevitable, incomplete, complete)	1:4 pregnancies
Ectopic pregnancy	1-2% of pregnancies
Molar pregnancy	1-3: 1,000 pregnancies
Conjoined twins	1:50,000 pregnancies

10 to 14 weeks:

Acrania/exencephaly/anencephaly	Gastroschisis	Absent Limbs
Alobar holoprosencephaly	Omphalocele (12+ Weeks)	Megacystis
Cystic hygroma		

14 to 40 weeks:

Same as 10 to 14 weeks with the addition of:

Open spina bifida - (reduced detection rate at 14 to 20 weeks)
Cleft lip - (reduced detection rate at 14 to 20 weeks)
Diaphragmatic hernia
Bilateral renal agenesis
Atypical cardiac situs / size

- The sonographer should complete the appropriate Referral Form in full and should follow the procedure detailed below (dependent upon gestational age).

Referral Process

In pregnancies of 6 to 15^{+6} weeks, (firstScan clinic):

If an Ectopic pregnancy is either suspected or confirmed, the emergency protocol must be implemented, rather than the steps below.

1. The Clinic Manager should contact the local Early Pregnancy Unit (EPU) or Fetal Medicine Unit (FMU) as documented in each clinic's referral process.
2. Where the EPU or FMU are unavailable (out of hours) the client should be advised of the timeframe to expect contact before leaving the clinic. The client should be advised not to attend the Emergency Department unless symptoms change.
3. The findings will be documented in a detailed scan report produced by the sonographer which should then be given to the client along with a referral letter to take to their appointment.
4. The sonographer should make it clear that they would be prepared to discuss their observations with the client's medical team if required.

In pregnancies >16 weeks (Window to the Womb clinic):

1. Intrauterine Fetal Demise (IUFD) requires referral to the Labour Suite (CLS) or Maternity Triage Unit (MTU) as documented in the clinic referral process.
2. In the case of any ultrasound findings consistent with a fetal anomaly, the client requires referral to the Fetal Medicine Unit (FMU) or appropriate department.
3. Once the sonographer has explained the ultrasound results, a copy of the Well-being Report, and the referral letter should be given to the client.
4. Include copies of the referral letter with the Wellbeing Report in the clinic files.
5. The sonographer should make it clear that they would be prepared to discuss their observations with the client's medical team if required.

6. The family MUST be given time to deal with the news that they have just received. It is the responsibility of the Scan Assistant to communicate with reception to manage the future appointments and communicate with families waiting in the clinic.
7. The Registered Manager must be notified of the detail of the referral and it must be included on the clinic's referral log.

In any situation when the clinic is not able to complete a referral:

If the EPU or FMU cannot be contacted, the clinic has 2 options:

1. If the scan was completed at a time when the hospital ward is not manned (weekends or evenings), the clinic should try to re-contact the hospital on the next working day to arrange an appointment and should then advise the woman directly.
2. If it is impossible to contact the EPU or FMU at the woman's local hospital, the clinic has the option to contact the woman's GP to make an appointment for her.
3. In either of the above instances the client must be kept informed of timelines.

Our primary responsibilities in any of these circumstances are:

1. Honesty and candour
2. Care and compassion
3. Effective communication
4. Remaining calm and professional

Pathway referrals

The referral contact details for each of the local hospitals are available in each clinic.

Further reading:

NHS Screening Programmes - Fetal Anomaly Screening Programme handbook, August 2018. Obstetric & Gynaecological Ultrasound. How, Why and When. Fourth Edition. Trish Chudleigh, Alison Smith and Sonia Cumming. Pub: Elsevier, 2017.

Authors:	Reviewed by:	Next review due:
J Clewes A Walton	D Stothart	
Date: 04/03/2020	Date: 04/03/2020	Date: 03/03/2021

Appendix 1: Reasons for Referral WTTW (For Display)

16 to 40 Weeks		
Anomaly	**Notes**	**Referral to**
IUFD	Intrauterine Fetal Demise	CLS
Polyhydramnios	Single deepest cord free pool >80mm	FMU/ANC/SC
Oligohydramnios	Single deepest cord free pool <20mm	FMU/ANC/SC
Breech Presentation	After 36 Weeks	FMU/ANC/SC
Undiagnosed Low-lying Placenta	After 34 Weeks	FMU/ANC/SC
Suspected Small for Gestational Age (SGA)	On or below 10th centile	FMU/ANC/SC
Suspected Large for Gestational Age (LGA)	On or above 95th centile	FMU/ANC/SC
Suspected Fetal Abnormality		FMU/ANC/SC

Key

CLS – Labour Suite

FMU – Fetal Medicine Unit

ANC – Antenatal Clinic

SC – Screening Coordinator

Please refer according to agreed NHS pathways.
Please see Scan Room Protocols & Fetal Abnormality Policy for full details.

Appendix 2: Normal variants (For Display)

16 to 40 Weeks		
Anomaly	**Notes**	**Referral to**
CPC's (Choroid plexus cysts)	No need to document or refer	
Echogenic foci in the heart	No need to document or refer	
Increased nuchal fold on the suboccipitobregmatic view	No need to document or refer	
Two vessel cord	No need to document or refer	
Echogenic bowel	Refer if brighter than bone	FMU/ANC/SC
Dilated renal pelvis	16 – 20weeks - Greater than 7mm - refer	FMU/ANC/SC
Dilated renal pelvis	24 – 40weeks - Greater than 10mm - refer	FMU/ANC/SC
Dilated Cisterna Magna in third trimester	From posterior aspect of vermis to internal aspect of skull vault	No referral unless greater than 10mm
Enlarged CSP	Greater than 6mm in third trimester	
Ventriculomegaly	If the posterior horn of the lateral ventricle appears subjectively dilated	No referral unless greater than 10mm
Nuchal fold	If it appears subjectively larger than 6mm & screening previously declined by the client	Refer for second opinion

Key

CLS – Labour Suite

FMU – Fetal Medicine Unit

ANC – Antenatal Clinic

SC – Screening Coordinator

Please refer according to agreed NHS pathways.
Please see Scan Room Protocols & Fetal Abnormality Policy for full details.

Appendix 3: Reasons for Referral firstScan (For Display)

Reasons for Referral to NHS
Intrauterine Fetal Demise (IUFD)
Ectopic Pregnancy Follow Emergency Policy
Pregnancy of Unknown Location (PUL) No confirmed gestation sac with yolk sac and/or embryo
Inconclusive Scan (PUV) Gestation sac >25mm
Confirmed Miscarriage CRL > 7mm No Fetal Heartbeat
Suspicion of Molar Pregnancy
Suspected Fetal Abnormality See Fetal Abnormality Policy

Ultrasound Findings Documented But Not Requiring Referral to NHS
Inconclusive Scan Gestation Sac <25mm
Gestation Sac with live embryo/fetus with a Sub-chorionic haemorrhage noted adjacent to the sac
Scan showing two or more sacs with one live embryo/fetus and a second non-viable sac
Physiological herniation of fetal bowel
Gestation sac with live embryo/fetus with Chorionic bump
Gestation sac with live embryo with a slow FH seen – (No documentation required)

Please refer according to agreed NHS pathways.
Please see Scan Room Protocols & Fetal Abnormality Policy for full details.