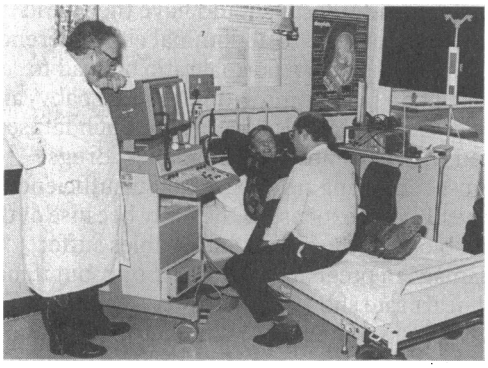
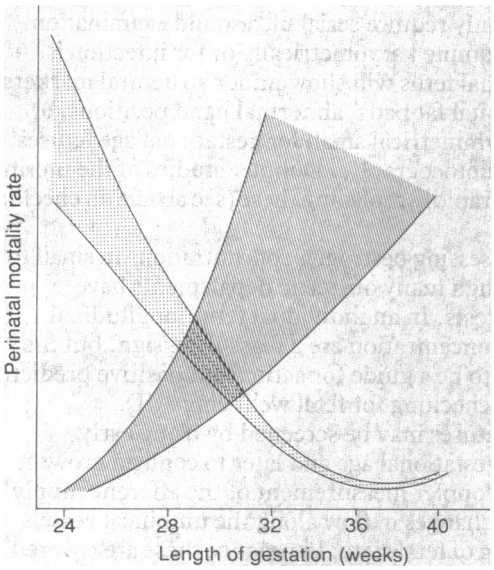


Corner of a fetal measurement laboratory.



The relative risks to a fetus of staying in the uterus on the wrong side of a poor placental bed perfusion system compared with the risks of being delivered too soon

In fetuses that are symmetrically small for gestational age correction and reversal of some of the causal factors might have helped, but it is too late to do this when the fetus is detectably small for gestational age. For example, curtailment of cigarette smoking should happen in early pregnancy. Such curtailment in the first 16 weeks allows fetuses to follow a normal growth pattern rather than that of growth retarded babies of smoking mothers.

The mother of a fetus that is small for gestational age should attend a hospital that has a capacity for more precise diagnosis and where special ultrasound and Doppler measurements are available. Many tertiary referral centres have a fetal measurement laboratory run on a day care basis. Women who live near large hospitals with such centres can still be outpatients while having full surveillance. If they live away from the centre, however, they may have to be transferred and become inpatients; this is the keystone of the in utero transfer system widespread in the United Kingdom. Probably a third of the women admitted as in utero transfers have fetuses that are small for gestational age as their indication for admission.

The double ultrasonographic surveillance of fetal growth and placental bed blood flow allows a more precise assessment to be made of fetal progress. Prospective frequent and regular consultations with the neonatal paediatrician who will be involved is essential. The fetus must be delivered at the most appropriate time by the most appropriate method. The time depends on weighing up the risks of keeping the fetus inside the uterus—that is, those of diminished placental bed perfusion—against the risks of being outside—that is, the risks of immaturity and survival in a good intensive care neonatal unit. The critical gestational age for these decisions is being pushed back all the time; now the worrying time for most obstetricians and neonatal paediatricians is 24-28 weeks. Once a pregnancy passes 30 weeks the concern is much less, although the respiratory distress syndrome can still cause illness after delivery.

Conclusions

The diagnosis, causes, and management of small for gestational age fetuses are all still uncertain. The best management is prevention

It must be remembered that the definitions of small for gestational age are used imprecisely and much that was thought to be known about its causation depended on data that were not mutually comparable. Until Doppler measurement the measures of fetal wellbeing were also inexact; even Doppler ultrasonography is not the last word on the subject. The ultimate management depends on avoiding trouble. Maybe we are overprotective of fetuses that are small for gestational age, but it is the best that we can do in 1991.

The figures showing the distribution of birth weight, the distribution of the length of gestation, the centiles of birth weight by length of gestation and date of the last menstrual period, and the centiles of birth weight by length of gestation and maternal smoking habit are reproduced by permission of Butterworth Heinemann from *British Births 1970* by R Chamberlain and G Chamberlain.

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Correction

ABC of Antenatal Care: Vaginal bleeding in early pregnancy—II

An error occurred in this article by Professor Geoffrey Chamberlain (18 May, p 1195). In the table of the symptoms and signs of ectopic pregnancy the symptoms of unruptured and ruptured ectopic pregnancy are transposed. The table should read that the symptoms of an unruptured ectopic pregnancy have a gradual onset and consist of a dull ache over days and that those of a ruptured ectopic pregnancy have a sudden onset and consist of severe pain over minutes (and not vice versa as published).