SASUOG

South African Society for Ultrasound in Obstetrics and Gynaecology

Best Practice Guideline for feedback by sonographers to referring clinicians

Background

Certain patients who have a routine scan by a sonographer may have histories or findings that require input from a medical practitioner with scanning or advanced fetal medicine expertise. This guideline indicates in which cases the sonographer should make this known to the referring clinician as the required input is out of scope of practice of a sonographer. The referring doctor will then decide whether he/she him/herself can deal with such specific issue, or whether the patient needs to be referred to a level III scanning unit.

When to provide feedback to the referring clinician

At 11-14 weeks: Patient to be urgently discussed with, or referred back to, the referring clinician as consultation with a fetal medicine expert may be urgent

- Screen high (>1:300) or intermediate (1:300 – 1:1 000) risk for the common trisomies following combined or NT screening;
- Nuchal translucency > 3.5mm;
- Suspected fetal anomaly incl. ascites or hydrops;
- Monochorionic twin pregnancy (if all is well at 11 – 14 weeks, referral at 16 weeks);
- Dichorionic twin pregnancy with clear discrepancy in fetal sizes;
- Specific maternal infections (Parvovirus B19, Rubella, Coxsackie, Toxoplasmosis, CMV);
- Family history of a first degree relative with a congenital defect or genetic disorder;
- Three or more first trimester miscarriages.
- Significant titers of anti-red cell antibodies

At 11-14 weeks: Suggest to the referring clinician that the detail scan (18-23 weeks) is rather booked with a medical practitioner than a sonographer

- Nuchal translucency > 95th centile;
- Abnormal ductus venosus flow;
- Chromosomal markers present i.e. single umbilical artery, polydactyly etc;
- Pre-existing metabolic disease (Diabetes, Phenylketonuria);
- Teratogen exposure (Retinoids, Phenytoin, Carbamazepine, Sodium valproate, Lithium carbonate, MTX);

- One or more second or third trimester losses (unless the cause is known and the risk will be managed by referring clinician).

At 18 – 22 weeks: Patient to be urgently discussed with, or referred back to, the referring clinician as consultation with a fetal medicine expert may be urgent

- Screen high (>1:300) or intermediate (1:300 – 1:1 000) for the common trisomies;
- Suspected fetal anomaly;
- Nuchal edema (> 6mm);
- Intra-fetal calcifications other than intracardiac echogenic focus;
- Echogenic bowel;
- Ventriculomegaly (> 10mm);
- Monochorionic twin pregnancy or unknown chorionicity;
- Dichorionic twin pregnancy with discordant growth > 20%;
- Placental abnormalities (hydropic, "jelly-like", "moth-eaten", tumour);
- Olighohydramnios (Deepest pool < 2cm);
- Polyhydramnios (Deepest pool > 8cm).

March 2019