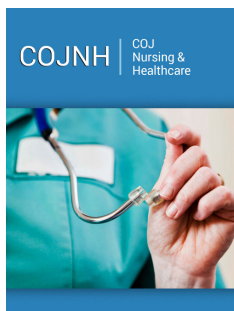


Fetal Growth Restrictions(FGR)

Nieves Capili*

Manila Central University, Philippines

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*Corresponding author: Nieves Capili,
Manila Central University, Philippines

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Opinion

Chew and Verna [1] give the basics to understand and manage Fetal Growth Restriction (FGR). Failure of the fetuses to attain full genetic growth potential is called Fetal Growth Restriction (FGR) affecting 3% to 7% of pregnancies based on diagnosis ultrasonography Estimated Fetal Weight (EFW) less than 10%ile of the Gestational Age(GA). EFW classifies FGR as either symmetrical or asymmetrical both of which depend on maternal conditions (hypertension, diabetes mellitus, sexually transmitted disease infection) and fetal genetic abnormalities like mosaicism. Poor and underdeveloped countries have higher rates of FGR, characterized by reduced body fat and muscle mass-pathophysiological conditions that retard nutrient transfer and organ development. Risk assessment when FGR shows low birth weight and abnormal physical features is supported by maternal history and physical examination.

The measurements of serial fundal weight and ultrasound aid in the diagnosis of FGR, excluding pregnancies that are misdated and cases of oligohydramnios. The management of FGR is at best when by ultrasound is detected at an early gestational age. Surveillance techniques like Doppler studies and CTG (cardiotocography) monitoring for heartbeat and uterine contractions best aid. The probable complications of the two FGR types vary- asymmetrical FGR has short-term complications like respiratory distress and far better outcomes than symmetrical FGR which is prone to long-term risks inclusive of neurodevelopmental issues and metabolic syndromes.

Mothers planning to give birth must be given proper education on pregnancy and must quit smoking, have a change in diet, and bed-rest in cases of high-risk pregnancies. Low-dose aspirin prophylaxis in the absence of preeclampsia is not advisable. Healthcare on FGR cases using an inter-professional term approach from delivery to post-discharge care is essential. Nutritional aids and communication with the mothers optimize patient outcomes. It is emphasized that healthcare professionals must have a clear understanding of maternal and neonatal care, and a good grasp of FGR's nature, treatment, and prevention to guide and educate pregnant mothers. The Society for Maternal-Fetal Medicine states that there is no treatment for FGR, but it can be managed to prevent post-natal complications and long-term effects on the life of the child.

Giving birth sooner by labor induction or caesarian delivery may be recommended in cases when pregnancy is likely to terminate in stillbirth. Early diagnostic tests including measurement of amniotic fluid, and amniocentesis for FGR can be added to ultrasound. Electronic fetal heart rate monitoring is a simple procedure that can be done weekly. A caveat is that not all fetuses that are small have FGR; there may be another health issue if it were not genetic. Prevention is best when the mother is given proper education on how to care for herself during pregnancy- taking a balanced diet, and regular consultation with the right healthcare professionals, especially when she has medications to take for other current health issues, like diabetes or hypertension.

Bed rest is not advisable in the management of FGR as the lack of activity may lead to bone demineralization, and musculoskeletal and cardiovascular deconditioning [2,3]. Tele-medicine Home-based management of high-risk pregnancies may not yet apply to FGR where management involves ultrasound, amniocentesis procedures, Doppler, and CTG monitoring [4]. However, a hybrid method with both in-person and telemedicine prenatal care models consistently FGR. Efforts to the promising benefits of incorporating telemedicine into prenatal care must be made [5].

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