# **Decreased Fetal Movement (DFM) Care Pathway**

for women with singleton pregnancies from 28+0 weeks' gestation







## **INITIAL RESPONSE**

- All women who report a concern of decrease in strength and/or frequency of fetal movements should undergo immediate assessment.
- Presentation should not be delayed through efforts to stimulate the baby by food or drink, or by requesting women to phone back after a period of concentrating on fetal movements.

# If no fetal heart heard:

- Seek urgent obstetric review
- Confirm fetal death with ultrasound
- Manage as per Clinical Practice Guidelines for Care Around Stillbirth and Neonatal Death https://bit.ly/2WzoSnF

#### **CLINICAL ASSESSMENT**

- Listen to fetal heart by hand held or cardiotocography (CTG) Doppler.
- Detailed fetal movement history, ascertained from the woman.
- Clinical history and examination to assess for co-existing conditions and symptoms such as bleeding and pain.
- Risk factors for stillbirth should be identified. (see list)

Medical consultation is required in the presence of any concerning findings including pre-existing medical conditions

## **CARDIOTOCOGRAPHY (CTG)**

- Interpretation of antenatal CTG tracings should be in accordance with local guidelines.
- No further investigations are required for women if: (1) normal CTG and clinical assessment; and (2) no risk factors identified; and
   (3) first presentation for DFM; and (4) no maternal concerns of DFM at time of assessment.

If CTG findings are abnormal, seek urgent obstetric review.

## **FURTHER INVESTIGATION**

- **FMH testing** should be considered if clinical concerns (particularly with history of sustained or recurrent DFM).
- **Ultrasound** should be considered to assess for undetected fetal growth restriction (if no prior ultrasound in the past 2 weeks).
- Ultrasound assessment should include fetal biometry, estimated fetal weight, umbilical artery Doppler and amniotic fluid volume.
- The timing of ultrasound will depend on the woman's preferences, clinical urgency, presence of risk factors and service capability.

If ultrasound findings are abnormal or FMH results >1mL<sup>1</sup> seek obstetric review

#### Risk factors for stillbirth



- Maternal age >35 years
- Maternal smoking
- Overweight and obesity
- Nulliparity
- Assisted reproductive technology
- Alcohol and other drug use
- Aboriginal or Torres Strait Islander, Pacific, African and South Asian ethnicities
- No antenatal care
- Low education
- Low socioeconomic status
- Previous stillbirth
- Pre-existing diabetes
- Pre-existing hypertension
- Pre-eclampsia
- Small for gestational age (<10th centile)</li>
- Post term pregnancy (>41 weeks)

#### **BIRTH PLANNING**

- Individualise care, taking into consideration the woman's preferences ensuring informed shared decision- making around timing of birth.
- Where possible, birth should not be planned prior to 39 weeks' gestation unless clinically indicated.
- When returning to routine care: confirm the importance of reporting DFM and reassure the woman that she 'did the right thing' and not to hesitate to report any further concerns of DFM to her healthcare provider, even if it is on the same day.

\*If women have a concern of DFM prior to 28 weeks' gestation, they should be advised to contact their healthcare provider. There is currently insufficient evidence to inform the management of women who report DFM prior to 28 weeks' gestation.

1. Wylie BJ, D'Alton ME. Fetomaternal hemorrhage. Obstet Gynecol 2010; 115(5): 1039-51.

Disclaimer: This DFM Care Pathway is for general guidance only and is subject to a clinician's expert judgement. The DFM Care Pathway should not be relied on as a substitute for clinical advice.

# Safer Baby Bundle WORKING TOGETHER TO REDUCE STILLBIRTH

The Safer Baby Bundle resources are based on five key areas to support healthcare professionals with new strategies to help reduce stillbirths.









