Clinical Practice Guideline Decreased Fetal Movements
Peninsula Care Goal Safe

Target Audience
- Registered Midwife
- Medical Officer
- Student Midwife/Medical Student (under the direct supervision of one of the above)

Purpose
This guideline is to identify the fetus at risk and provide guidance for the clinician in the appropriate assessment, investigation and management for this symptom.

Perceived decreased fetal movements is a common maternal symptom than can cause concern and anxiety. In the majority of cases there is no associated risk to the fetus, and normal movements resume, but in a small number of cases it can be an indicator of impaired fetal wellbeing that may require increased surveillance or delivery. It should be noted that the positive predictive value of perceived decreased fetal movements for fetal compromise is low at between 2% and 5%

Pregnant women usually start to feel movements at 18-20 weeks gestation, although multiparous women may feel them earlier than this. At this gestation, movements may not be felt as being regular or sustained. More sustained movements are usually felt from around 23 weeks.

This guideline is for women who are greater than 23 weeks gestation. Women under 24 weeks should be advised to see their regular care provider for fetal heart auscultation and reassurance.

Evidence to support the management of decreased fetal movements is limited by study numbers as adverse outcomes are rare, but the main aim of surveillance is to identify the fetus at risk of placental insufficiency. Of all the assessment modalities, umbilical artery doppler has been the most rigorously studied and has been shown to be associated with a reduction in perinatal deaths in high risk pregnancies.

Guideline
The Peninsula Health CPG has now been replaced with the Decreased Fetal Movements Guideline as part of the Safer Care Victoria Maternity eHandbook. Click on the link for the most up to date guideline:

Decreased Fetal Movements Guideline

Prevention

All maternity care providers are responsible for providing information to women about fetal movements, including actions to take in the event of decreased or absent fetal movement.

- Give all women the consumer information leaflet Your Baby's Movements Matter or direct women to the Movements Matter Video and Multiple Languages Information
- Provide written information at time of booking in to the hospital and again at 28 weeks.

- Emphasise the importance of maternal awareness of fetal movements at every pregnancy visit.
- Advise women to contact their maternity care provider if they have concerns about decreased or absent fetal movement; tell them not to wait until the next day to report their concerns.
- Maternal concern overrides any definition of DFM based on the number of movements felt.

Any woman reporting decreased fetal movements at 24/40 or more should be advised to immediately attend the Women's Health Unit for assessment.

For further management of decreased fetal movements see the **Maternity eHandbook** and the accompanying **flowchart.**

The management is summarised as follows:

Decreased fetal movements before 28 weeks

- **Decreased fetal movements between 24.0 and 27.6 weeks of gestation**: If a woman presents with DFM between 24.0 and 27.6 weeks of gestation, confirm the presence of a fetal heartbeat by auscultation with a Doppler handheld device.
- **If fetal movements have never been felt by 24 weeks of gestation, consider referring the woman to a specialist obstetrician.**

Decreased fetal movements at or after 28 weeks

- **Women who are concerned about DFM should be advised to:**
  contact the hospital or qualified maternity care provider immediately
  present within two hours for assessment if fetal movements are decreased or absent.
- **Women who are concerned about decreased fetal movements should NOT be advised to:**
  wait until the next day for assessment
  rest and monitor movements
  drink iced water or have something to eat.

Assessment of decreased fetal movements

Initial assessment

When a woman presents with DFM:

- the first priority is to confirm fetal heart immediately
- CTG should be performed within two hours of presentation
- if the presence of a fetal heart beat is not confirmed, arrange an urgent ultrasound scan to assess fetal cardiac activity.
- The fetal heartbeat needs to be differentiated from the maternal heartbeat.

Additional assessment

Take a complete history:

- Duration/pattern of DFM
- Maternal lifestyle issues (for example: exercise, smoking)
- Medication, alcohol or sedating drug use

- Abdominal pain
- Risk factors for stillbirth, such as diabetes, smoking, obesity, hypertension, IUGR, congenital malformation, poor obstetric history (complete list)

Ask questions:

- What is the duration of decreased fetal movements?
- How long since the woman last felt the baby move?
- Is this the first occasion of decreased fetal movements?

Baseline maternal observations:

- Temperature
- Pulse
- Blood pressure
- Respiratory rate and SpO2
- Urinalysis
- Conscious state

Abdominal palpation:

- Symphysis-fundal height measurement and assessment of fetal size and amniotic fluid level - is it appropriate for gestational age?
- Fetal lie and presentation
- Palpated movements
- Contractions
- Tension or guarding

CTG interpretation

Criteria for a normal antenatal CTG are:

- baseline of 110-160 bpm
- variability 6-25 bpm
- two accelerations - 15 bpm for 15 seconds - within 20 minutes
- no decelerations.

If the CTG does not meet criteria for a normal antenatal trace within 60 minutes, escalate to a more senior clinician.

If the **CTG is normal** and the woman is now happy with the fetal movements, fetal growth is clinically normal and there are no significant risk factors:

- reassure the woman and advise her to return if DFM recurs
- provide her with written information about expected fetal movements
- ensure she has a plan for ongoing antenatal care with a qualified maternity care provider
- document and sign related CTG forms as per local guidelines.

Ultrasound investigation

Consider an ultrasound assessment for amniotic fluid volume (AFI) and/or fetal biometry within 24 hours when:

- maternal perception of DFM persists, despite a normal CTG
- this is a second or subsequent presentation with DFM
- fetal growth restriction is suspected
- a bedside AFI is not normal
- there are other risk factors for stillbirth.

If an ultrasound is performed, assess fetal morphology if not done so previously. If the ultrasound is abnormal, manage the situation clinically. **Refer to flow chart.**

If a departmental ultrasound can not be arranged within the next 24hrs, the duty registrar or consultant is to perform an AFI in the interim, whilst the formal departmental ultrasound is being arranged.

Feto-maternal haemorrhage (FMH) investigation
Massive fetal to maternal haemorrhage (varying from >50 ml to >150 ml) has been demonstrated in approximately four per cent of stillbirths and in 0.04 per cent of neonatal deaths.
Other clinical signs of FMH include:

- uterine activity
- uterine tenderness
- vaginal bleeding.

Clinical risk factors do not reliably predict the likelihood of massive FMH and DFM may be the only history suggesting this possibility.
Consider testing for FMH where a CTG abnormality is detected in the presence of a normally grown fetus or other clinical features are suggestive of FMH.
If you are uncertain about the preferred mode of testing or capacity for testing in your service, consult with a specialist for further advice.

Optimal ongoing care

Care must be planned according to clinical findings and the woman's individual needs.

- Ensure the woman has a **clear plan** for ongoing care, including any need for:
  - admission, or outpatient follow up
  - repeat CTG
  - US examination
  - investigation for FMH
- Give all women information about the importance of fetal movements (Quick Links)
- Ensure the woman has the contact number for the health service.
- Advise women to contact their hospital or clinician if they have another episode of decreased fetal movements.
- If a woman has recurrent presentations with DFM, escalate care to a senior clinician.
- **Women who are concerned about decreased fetal movements should not wait until the next day for assessment of fetal wellbeing.**

Documentation

- Document full details of assessment and management in the woman's medical record and hand held record.
- Record the advice given about follow-up and where/when to present if the woman has another episode of DFM.
- Ensure documentation of CTG as per RANZCOG IFS **guideline**.

References:

Safer Care Victoria Maternity eHandbook: Decreased Fetal Movements, September 2017.

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Decreased Fetal Movements Flowchart. 2017 Safer Care Victoria.

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