Ultrasonic Fetal

Weight & Acute Birth Wt.

Original Article Correlation Between Ultrasonic Estimated Fetal Weight and Acute Birth Weight of Neonate in Pakistan

Zafar Tanveer Ahmed¹, Saima Ameer², Nighat Haroon Khan², Saira Bilal², Madeeha Tanveer Khan² and Fareeha Tanveer²

ABSTRACT

Objective: To study the A mutual relationship Ultrasonic value fetal weight and acute birth weight of neonate in Pakistan.

Study Design: Observational study

Place and Duration of Study: This study was conducted at the Radiology Department of Lahore General Hospital, Lahore and Idris Teaching Hospital Sialkot from Jan 2019 to July 2019.

Materials and Methods: The patients of 37th week of gestation and over were added in the study to compare the acute the weight of a baby and Ultrasonography estimated weight of the fetus. Total 282 pregnant ladies with no complication history were sorted for the study as a sample. The history medical examination and ultrasonic examination were considered in every patient. The informed consent was also taken from every pregnant woman. The permission of the ethical committee was also considered.

Results: The advancement in technology has helped to improve public health in reducing the risk of mortality in women and in neonates. The study reveals that there is no significant difference between the value of the weight of a baby calculated in Ultrasonography and the real weight delivered at birth time.

Conclusion: It can be concluded from the results that the ultrasound is a safe and good predictor of birth weight and its readings and results can help in important decision by the gynecologist for safer delivery.

Key Words: Correlation, Ultrasonic, value of baby weight, real baby weight, neonate

Citation of article: Ahmed ZT, Ameer S, Khan NH, Bilal S, Khan MT, Tanveer F. Correlation Between Ultrasonic Estimated Fetal Weight and Acute Birth Weight of Neonate in Pakistan. Med Forum 2020;31(6):12-16.

INTRODUCTION

The evaluation of fetal development is a basic part of pre-birth care, empowering recognizable proof of babies in danger of death of a fetus.¹ identification of both baby development limitation and enormous for pregnancy age embryos is basic to design suitable welfare.² FGR, alluding to hatchlings with a weight of a baby plotting underneath the tenth percentile, is the single most grounded chance fetal death.³ LGA embryos, those with a weight of a baby more prominent than the ninety percent,² are in danger of the shoulders are stuck and subsequently expanded crisis cesarean segment values.²

Following the presentation of reexamined FGR the board principle1 to lessen fetal death value,⁴ medical imaging assessment of baby development has become

^{1.} Department of Radiology Sialkot, Medical College, Sialkot.
 ^{2.} Department of Radiology, Lahore General Hospital Lahore.

Correspondence: Dr. Zafar Tanveer Ahmed, Assistant Professor of Radiology Sialkot Medical College Sialkot. Contact No: 03338611766 Email: zafar.tanveer66@gmail.com

Received:	January, 2020
Accepted:	March, 2020
Printed:	June, 2020

all the more generally carry out.¹ Betweens different evaluations, a medical imaging development check joins the exhibition of 3 baby statistical analysis estimations — head boundary (HC), stomach outline (AC) and The distance from the head of the femur to its distal end⁵ clearly defined norms and tourist spots needed for every estimation are specified by the National Health Service Fetal Anomaly Screening Programme,⁶ to guarantee exactness and reproduction and decrease both between and intra-administrator inconstancy. The parietal bones distance across (BP D) estimation of the baby head was recently acted in inclination to the HC, however this training is currently viewed as obsolete in the UK, as per the British Medical Ultrasound Society (BMUS).⁵

While verifiably the 3baby statistical analysis estimations (HC, AC, FL) taken during the sweep were drawn on singular populace a drawing that shows information in a simple way,^{5,7–9} the estimations are currently joined to compute an expected baby weight (EFW),¹ drawn on a redid development diagram (CGC).¹⁰ The CGC was first brought into training longer than 10 years prior, however has gotten generally used during the last five years.¹⁰ CGCs are customized to consolidate mother sacred qualities, containing weight list Basal Metabolic index and state of belonging to social group, to anticipate the ideal

baby development bend for an each pregnancy.¹⁰ as a result, any divergence in development is probably going to speak to the science of the causes and effects of diseases, as opposed to physiological difference.¹⁰

Generous study has explored the most exact equation for ascertaining.¹¹⁻¹³ between late years, formulas adjusted to explicit populaces, for instance two pregnancies or large body hatchlings, and those fusing have length, breadth, and depth (3D) medical imaging have been assessed, however they are until to turn out to be medically established.¹³ As such, in ebb and flow United Kingdom medical practice, the RCOG 1 and BMUS advocate the utilization of the *locking* the doors 14; a relapse techni 9ue consolidating every one of the 3 boundary.⁵ Although most proof backings formulae fusing each of the three parameters,¹⁵⁻¹⁷ the alternating current estimation much delicate each marker of unusual baby growth.^{18,19}

In two thousand five, an orderly survey evaluating the precision of medical imaging EFW found the *locking* the doors 14 created the littlest deliberate mean mistakes on a typical baby population.¹¹ When this proof was fortified in future,¹² enormous arbitrary blunder continues to exist.^{16,20} Most altogether, estimation of EFW utilizing medical imaging is for the most part overestimated, particularly in the number of inhabitants in little fetuses,^{12,20} raising concerns in regards to rate of obstetric intervention.^{21,22} When thinking about the administration of conveyance, EFW ought to be exact to inside five percent, however ten percent is satisfactory,^{11,23} therefore limiting irregular blunder level needed.^{11,15}

The point of this audit was to survey the current exactness of medical imaging computation of EFW, distinguishing much predictable education while building up the key factors at present influencing precision.

MATERIALS AND METHODS

An observational study was conducted at the Radiology Department of Lahore General Hospital, Lahore and Idris Teaching Hospital Sialkot from Jan 2019 to July 2019. The patients of 37th week of gestation and over were added in the study to compare the acute baby weight and Ultrasonography estimated weight of the fetus. Total 282 pregnant ladies with no complication history were sorted for the study as a sample. The history, medical examination and ultrasonic examination were considered in every patient.

RESULTS

The selected sample size was 282 pregnant ladies which include both the primipara and multipara. The distribution of both groups is shown in the table 1 below. It is clear that primipara includes 42.5% of the selected sample and multipara includes 57 percent of the sample.

Table No.1: Primipara statistics for actual andestimated birth weight

Weight	Sample N	Percentage
Primipara	120	0.425(42%)
Multipara	162	0.574(57%)
Total	282	100 (100%)

Following table 2 describe the pattern of ultrasonic birth weight and neonatal birth weight of both primipara and multipara. Baby weight less than 2.5 kg is considered low birth weight which may be because of many internal and external factors. From the table 2 it is clear that the majority of the neonate lies in the range of normal baby weight that is from 2.5 kg to 3.5 kg which cumulatively includes 71 % in multipara and 85 % in the primipara group. It is obvious that the new born weight increases as the weight on estimated sonographic reports increases.

Table No.2: Pattern of ultrasonic birth weight and neonatal birth weight of both primipara and multipara

Sr#	Weight	Multipara		Primipara	
		Estimated	New born	Estimated	New born
		baby weight	weight	baby	weight
				weight	
1	2.0-	25(15%)	24(14.8%)	20(17%)	18((15%)
	2.5 kg				
2	2.5-3.0	51(31%)	50(30.8%)	40(33%)	39((32.5%)
	kg				
3	3.0-	65((40%)	64(39.5%)	45(37%)	45(37%)
	3.5 kg				
4	3.5 kg	20(12%)	0	15((12.5)	14(11.7%)
	-4 kg				
5	Above	1(0.6%)	0	0	
	4 Kg				

 Table No.3: Correlation of real birth weight with estimated birth weight

	on on one			
Weight	Real birth	Estimated	Correlation	P-Value
	weight	birth	coefficient	
		weight		
Low baby				
weight	2288g+38g	2284g+36g	0.965	0.486
Less than				
2500 g				
Normal				
weight	3545g+46g	3535g+37g	0.947	0.465
2500g-				
4000 g				
М				
acrosomia	4314g+44g	4344g+5	0.874	0.2173
Above		1g		
4000 g				

Med. Forum, Vol. 31, No. 6

Table 3 is about the estimated weight of the fetus in comparison to real birth weight of the neonate in the grams. The table also shows the positive correlation of coefficient with the estimated birth weight and real birth weight. P value was also less than 0.05 which shows no significant difference in the both real and calculated weight of the baby.

It means there is no visible difference in the value weight and the real baby weight in the case of primipara deliveries. Accurate measurement of fetal weight helps the obstetrician for the vital delivery decision.

DISCUSSION

Ultrasound computation of baby weight is regularly favorable an estimate in contrast with real weight.^{16,18} When the technique is dependable, trust in the precision of the figuring left blocked by arbitrary mistake; exactness is essentially identified with the equation used and no of consolidated as well as dynamic ones.^{15,17}

The locking the doors¹⁴ created the most reliable way methodical blunder & least irregular mistake over each of the seven examinations. At the point when the outcomes were pooled, the recipe created a MPE inside the five percent value of precision looked for in medical use,^{11,23} showing an better than something in exactness when the past formal assessment.¹¹ The adjustment of the investigations was, nonetheless, identified with the precision of the outcomes just, with no thought of test or populace findings,²⁵ restricting size the noteworthiness of the outcomes. The reliable exact outcomes for such evaluation were gotten by Rashid, however this investigation had the littlest example size (n = seventy three) and information were gathered from the Bangladesh populace just, lessening the force and conclusions.^{11,18} Nevertheless, it must be viewed as that babies from such populace are unavoidably less,¹ in this way featuring the viability of the locking the doors¹⁴ while computing the EFW of little embryos, a worry brought up in past study.^{12,20}

The United Kingdom concentrate by Anderson et al, created the most elevated value of mistake for the locking the doors.¹⁴ Even though the examination was distributed in two thousand seven, the information are old; gathered from checks acted in two thousand. In the most recent ten years, there have been huge improvements in both medical imaging hardware and use,⁵ and along these lines, such outcomes few possessions portrayal of recent precision.

The exactness of medical imaging count of EFW was most elevated in the way that consolidated each of the 3 baby as well as dynamic ones; supporting past written works.¹⁶

June, 2020 Learn more A formula,¹⁴ two different techniques were

surveyed that joined every one of the three estimations al. Ott et Furthermore, Combs et al; both created valid outcomes (Equivalent discoveries were procured in a past review¹⁹ for the Combs et al. recipe, be that as it may, such technique is volumetric instead of the ordinarily utilized relapse condition, and has not been broadly surveyed, along these lines the dependability of the strategy remains indeterminate.^{11,19} The Ott et al. recipe was just surveyed in one examination inside this literature, and however the outcomes were showing signs of future success, past distributed writing represents huge inconsistency.²⁰

Strategies fusing the biometric parameters just, carry out ineffectively, with enormous arbitrary mistakes¹⁵, The Hadlock et al equation was the most correct,²⁰ however irregular blunder values left considerably upper than those delivered by the Learn more A formula,¹⁴ reverberating past values.^{11,20} estimated fetal weight dependent on the biometric parameters just, is especially uncommon in delivering health care, as a solid FL estimation can ordinarily be acquired all through the time period extending from the 28th week of gestation until delivery.

Standard only the Fetal size and age estimations were amazingly conflicting, to some degree worried as this technique is all the more every now and again utilized near the end incubation, when an exact estimation of the baby head is regularly limited by its profound situation inside the pelvis of mother. Greatest altogether, over the seven added investigations, arbitrary mistake values of all findings consolidating two measurable factors were perseveringly upper than the Learn more A formula.¹⁴

Such creators propose a scope of formulae ought to be used in delivering health care by doctors, and a particular technique ought to be picked subordinate upon the fetal populace being assessed.²⁴

The rest of the well springs of mistake distinguished were administrator centered; absence of experience, lacking preparing and review lacking sufficient enhancement of the medical imaging.³ Such discoveries are obvious in the present ultrasound atmosphere; in the United Kingdom, lacking sufficient enrollment and maintenance of ultrasounds experts has brought about expanded work of organization staff, with brief period assigned to maintain review and skill. Both the United Kingdom Association of Sonographers and the Royal College of x-ray specialist, look at review as a condition that, either temporarily or permanently,

impedes mission accomplishment in supporting and holding aptitudes and advancement, to empower skilled delivering health care and arrangement of a special medical imaging administration.

Neither investigations showed that picture standard impacted the precision of medical imaging, a important finding obvious in the past survey performed by Dudley.¹¹ During the most recent ten years there have been considerable innovative progressions in medical imaging hardware, & the presentation of both symphonious and complex imaging has demonstrated profoundly compelling on picture difference and goals, empowering progressively exact arrangement of an instrument for measuring external or internal dimensions when measurement of the anatomic segments of the fetus by ultrasound estimations. Notwithstanding this, the rising degrees of heftiness inside the mother populace to accept, as expanding body mass index inconveniently influences medical imaging picture slandered; careful and target translation of medical imaging discoveries is fundamental, guaranteeing fitting restrictions are recognized.²⁵

CONCLUSION

It can be concluded tram the results that the ultrasound is a safe and good predictor of birth weight and its readings and results can help in important decision by the gynecologist for safer delivery.

Author's Contribution:

Concept & Design of Study:	Zafar Tanveer Ahmed
Drafting:	Saima Ameer, Nighat
	Haroon Khan
Data Analysis:	Saira Bilal, Madeeha
	Tanveer Khan, Fareeha
	Tanveer
Revisiting Critically:	Zafar Tanveer Ahmed,
	Saima Ameer
Final Approval of version:	Zafar Tanveer Ahmed

Conflict of Interest: The study has no conflict of interest to declare by any author.

REFERENCES

- 1. Maya Z. Maternal mortality in Nigeria; an indicator of women's status, March 18, 2014.
- 2. CIA World Fact Book 2013.Nigeria infant mortality rate, March 19, 2014.
- MacKenzie AP, Stephenson CD, FunaiEF. Prenatal sonographic assessment of fetal weight, March 15, 2014.
- Shittu AS, Kuti O, Orji EO, Makinde NO, Ogunniyi SO, AyoolaOO, Sule SS. Clinical versus sonographic estimation of fetal weight in southwest Nigeria. J Health Popul Nutr 2007;25(1):14–23.

- 5. Palmer PES. Manual of diagnostic ultrasound. Geneva: World Health Organization: Obstetrics; 1995p.236–244.
- American Pregnancy Association, author. Cephalopelvic disproportion (CPD), March 19, 2014.
- MacGregor S, Sabbagha R. Assessment of gestational age by ultrasound. Glob Libr Women's Med 2008 doi: 10.3843/GLOWM.10206. (ISSN: 1756-2228)
- Henriksen T. the macroscopic fetus: a challenge in current obstetrics. Acta Obstet Gynecol Scand 2008;87(2):134–145.
- 9. Nahum GG, Smith CV. Estimation of fetal weight, February20, 2013.
- Mohammedbeigi A, Farhadifar F, Soufi-zadeh N, Mohammadsalehi N, Rezaiee M, Aghaei M. Fetal macrosomia: risk factors, maternal and perinatal outcome. Ann Med Health Sci Res 2013;394: 546–550.
- Sanders RC, Minner NS. Uncertain dates, elective Caesarian section, late registrants. In: Sanders RC, Winter TC III, editors. Clinical sonography: a practical guide. 4th ed. Philadelphia: Lippincott, Williams and Wilkins; 2007.p.407–421.
- 12. Predanic M, Pernic SC. Sonographic Assessment of the Umbilical Cord. The Ultrasound review of obstet and Gynecol 2005;4(20):105–110.
- 13. Hendrix NW, Grady CS, Chauhan SP. Clinical versus sonographic estimates of birth weight in term of parturients: a randomized clinical trial. J Reprod Med 2000;45:317–322.
- 14. Chattergee MS, Izquierdo LA, Nevils B, Gilson GJ, Barada C. fetal foot: evaluation of gestational age, August 8, 2013.
- 15. BossakWS, SpellacyWN. Accuracy of estimating fetal weight by abdominal palpation. J Reprod Med 1972;9:58–60.
- Ojwang S, Ouko BC. Prediction of fetal weight in utero by fundal height/girth measurements. J Obstet Gynecol East Central Afr 1984;3:111.
- 17. Titapant V, Chawanpaiboon S, Mingmitpatanakul K. A comparison of clinical and ultrasound estimation of fetal weight. J Med Assoc Thai 2001;84:1251–1257.
- Mehdizadeh A, Alaghehbandan R, Horsan H. Comparison of clinical versus ultrasound estimation of fetal weight. Am J Perinatol 2000;17:233–236.
- 19. Combs CA, Rosenn B, Miodovnik M, Siddiqi TA. Sonographic estimation of fetal weight and macrosomia: is there an optimum formula to predict diabetic fetal macrosomia? J Matern Fetal Med 2000;9(1):55–61.

- 20. Hadlock FP, Harrist RB, carpenter RJ, Deter RL, Park SK. Sonographic estimation of fetal weight: the value of femur length in addition to head and abdomen measurement. Radiol 2004;150:535.
- 21. Firoozabadi RD, Ghasemi N, Firoozabadi MD. Sonographic fetal weight estimation using femoral length: Honorvar equation. Ann Saudi Med 2007;27:179–182.
- 22. Chien PF, Owen P, Khan KS. Validity of ultrasound estimation of fetal weight. Obstet Gynecol 2000;95(6 pt 1):856–860.
- 23. Venkat A, Chinnaiya A, Gopal M, Monglli JM. Sonographic estimation in a Southeast Asian population. J Obstet Gynaecol Res 2001;27(5): 275–279.
- 24. Kurmanavicus J, Burkhardt T, wiser J, Huch R. Ultrasonographic fetal weight estimation: accuracy of formulas and accuracy of examiners by weight from 500 to 5000g. J Perinat Med 2004;32(2): 155–161.
- 25. Ibukun AO, Olatona FA, OridotaES, Okafor IP, Onajole AT. Knowledge and uptake of communitybased health insurance scheme among residents of Olwora, Lagos. J Clin Sci 2013;10(2):8–12.