T
reating mild gestational diabetes lowered the risks of fetal overgrowth, shoulder dystocia, cesarean delivery, and gestational hypertension; as well as decreasing maternal weight gain, based on a study of almost 1,000 women. However, treating mild gestational diabetes did not improve the composite primary outcome of neonatal mortality, hypoglycemia, hyperbilirubinemia, hyperinsulinemia, and birth trauma in a multicenter, randomized clinical trial designed to establish whether such treatment reduced perinatal and obstetric complications.

“The findings from our trial confirm a modest benefit from the identification and treatment of women with mild carbohydrate intolerance during pregnancy,” said Dr. Mark B. Landon and his associates in the National Institute of Child Health and Human Development Maternal-Fetal Medicine Units Network.

Some Fetal Ultrasound Findings May Not Require Follow-Up

BY SHERRY BOSCHERT

San Francisco — Putting reassuring wording in a pregnant patient’s chart may alleviate worry for the mother after a fetal ultrasound shows an isolated choroid plexus cyst or isolated echogenic intracardiac focus, Dr. Mary E. Norton said.

Neither of these findings is cause for ultrasound follow-up or amniocentesis if the mother has no other risk factors for chromosomal abnormalities, Dr. Norton explained at a confer ence on antepartum and intrapartum management sponsored by the University of California, San Francisco. They do, however, cause anxiety or fear in many patients, studies suggest. It’s hard for mothers to get over the idea of a cyst in the fetal brain when they hear that it is marginally associated with chromosomal abnormalities, for example, despite physician counseling that isolated choroid plexus cysts are not associated with Down syndrome and resolve in essentially all cases, she said.

How can clinicians ensure an adequate assessment when a choroid plexus cyst is identified without instilling unnecessary anxiety for the mother? Scheduling multiple visits and ultrasounds and meetings with genetic counselors is not the way to go, said Dr. Norton, professor of obstetrics and gynecology at the University of California, San Francisco.

At her institutions, when clinicians perform a fetal ultrasound identify a choroid plexus cyst, they get extra, careful images of the heart and hands at that time to check for abnormalities. If this is not done on the level I ultrasound, clinicians should consider getting a level II ultrasound for these patients, she suggested. If no other abnormalities are seen and results of any other screening (such as a triple screen) suggest that the woman is at low risk for chromosomal abnormalities, the following wording goes in her chart: “An isolated choroid plexus cyst was identified. While this finding has been associated with fetal chromosome abnormalities, no other major or minor anomalies were identified in this fetus. In the absence of other risk factors, this finding most commonly represents a normal variant and no further evaluation is recommended.”

The same wording is used after a fetal ultrasound identifies isolated echogenic intracardiac focus, inserting this phrase in place of “choroid plexus cyst.”

“These patients don’t need to have an echocardiogram to evaluate the fetal heart,” because this finding is not associated with congenital heart defects, she said. “They’re not pathologic in and of themselves, but they do have a small association with an increased risk of chromosomal abnormalities.”

This can raise anxiety unnecessarily in a woman with no other risk factors for abnormalities, but putting the reassuring wording in the chart can help them reframe their risk, Dr. Norton said.

Closer management is needed for fetal ultrasound findings with borderliner significance, such as renal pelvis ectasia, or findings that have the potential for significant abnormality (echogenic bowel or mild ventriculomegaly), she added.

In more than 90% of cases, fetal pelvics is a normal finding representing a physiological response to maternal progesterone. In a small percentage of cases, however, it can represent obstruction of the ureteropelvic junction or reflux that may have important implications after birth.

The risk for Down syndrome may be marginally increased with isolated pelvicsia, and amniocentesis is not warranted unless other risk factors are present, she noted.

Studies suggest that ultrasound follow-up is reasonably sensitive and specific if the pelvicsi measures less than 4 mm in pregnancies before 20 weeks’ gestation, less than 7 mm between 20 and 30 weeks’ gestation, or less than 10 mm from 30 weeks to term, Dr. Norton said.

There’s no need for monthly ultrasounds, but schedule a repeat ultrasound in the middle of the third trimester to rule out progression of the pelvicsia and determine the need for postnatal follow-up, she said.

If the findings persist in the third trimester, wait at least 10 days after delivery for postnatal follow-up so the fetal volume status can adjust from prenatal to postnatal status. In the past, prophylactic antibiotics were given to the newborn during these 10 days in case the findings represented reflux, but it is unclear whether antibiotics are necessary. “That’s a pediatric urologic decision,” she noted.

Of the two more concerning findings, echogenic bowel has been associated with trisomies, cystic fibrosis, viral infection, intrauterine growth restriction (IUGR), and fetal demise.

“Echogenic bowel is a tricky one because we see it in many cases that ultimately go on to have a completely normal outcome, and we never know why it was there,” she said.

Dr. Norton advised careful evaluation and follow-up. Get cystic fibrosis screening if it hasn’t already been done, and do maternal or fetal testing for cytomegalo virus, she said.

“We do offer amniocentesis for karyotyping,” although it’s unclear whether this is warranted in women who are otherwise low risk, she said. Get a follow-up ultrasound to evaluate the bowel and fetal growth in the third trimester. “The risk of IUGR is not inconsequential,” she warned.

Mild ventriculomegaly, in which fetal cerebral ventricles measure 10-15 mm, usually involves normal variants, especially when the ventricles are in the smaller end of that range. Rare cases may represent obstructive hydrocephalus, intracranial hypertension, or be markers for other underlying CNS pathology.

Order a level II ultrasound and get a fetal MRI, which can clearly show developments of the fetal brain and CNS findings not seen on ultrasound. “We do order MRI, although the precise utility of that, I would acknowledge, is still under investigation,” Dr. Norton said.

Because ventriculomegaly is associated with chromosomal abnormalities or infectious disease in a small number of cases, perform postnatal imaging for hydrocephalus or-plus toxoplasmosis.

Dr. Norton said that she has no conflicts of interest related to her presentation.