FETAL BÜYÜME KISITLAMASI: DEĞERLENDİRME VE YÖNETİM

15. BÖLÜM

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GİRİŞ

Fetal büyüme kısıtlaması (FGR) ultrasonografi muayenesi iletespit edilir, doğum öncesi bakım, şüpheli tanıyı teyit etmeyi, FGR'nin nedenini ve ciddiyetini belirlemeyi, ebeveynleri bilgilendirmeyi, fetal büyümeyi ve iyilik halini yakından izlemeyi ve en uygun doğum zamanınıbelirlemeyi içerir. Anoploidi, konjenital malformasyonlar veya enfeksiyon gibi intrinsik fetal faktörlerden kaynaklanan FGR, genellikle herhangi bir müdahale ile iyileştirilemeyen korunan bir prognoz taşır. Uteroplasental yetmezlik ile ilgili FGR daha iyi bir prognoza sahiptir, ancak kötü perinatal sonuç riski artmaktadır.

Bu konu FGR ile komplike olan gebeliklerin değerlendirilmesi ve yönetimini tartışacaktır. FGR tanısı ve etkilenen bebeklerin sonuçları ayrı ayrı gözden geçirilir.

TERMİNOLOJİ:

Fetal büyüme kısıtlaması (FGR) terimi, tahmini ağırlığı gestasyonel yaşa göre 10. Persentil altında olan fetüsleri tahmin etmek için kullanılır. Gestasyonel yaşa göre küçük (SGA) terimi ise yalnızca doğum ağırlığı 10.persentil altında olan yenidoğanları tahmin eder.

PREVALANS:

Prevalans kullanılan tanı kriterlerine göre değişmektedir. Ancak fetal ağırlığın 10. Persentil altında olması en sık kullanılan tanım olmasına rağmen bu tanımlama fetusun bireysel büyüme potansiyelini dikkate almaz. Büyüme potansiyellerine ulaşmamış ve risk altında olan ancak göreceli olarak normal (10 persentil üzerinde) görülen fetüslerin tespit edilmemesine deyol açabilir. Diğer yandan, yapısal olarak küçük olup aslında büyüme potansiyeline ulaşmış bebeklerin de FGR tanısı almaları da söz konusu olabilir. Yenidoğan ve fetüslerin kendilerinden beklenen gelişime ulaşıp ulaşmadıklarını daha isabetli değerlendirmek amacıyla bireyselleştirilmiş büyüme standartlarını hesaplayan formüller geliştirilmiştir. Fakat bu karmaşık formülleri uygulamanın sonuçları iyileştirdiği gösterilememiştir (113).

İLK YAKLAŞIM:

Teşhis

FGR tanısı, belirli bir gebelik yaşı için gerçek ve beklenen sonografik biyometrik ölçümler arasındaki tutarsızlıklara dayanmaktadır. Geleneksel olarak, tekil büyüme eğrisine göre SGA(gebelik yaşına göre küçük bebek) 'lı bebek teşhisinde

ternal öykü veya fetal ultrason bulguları ile ilişkiliyse, en sık sitomegalovirüs veya toksoplazmozis olmak üzere seropozitiflik açısından maternal serum incelenir.

Doğum öncesi yönetim

- (1) fetal büyüme, (2) fetal davranış (biyofizikel profil [BPP] veya amniyon sıvısı hacminin değerlendirilmesi, nonstress testi) ve (3) fetal damarlardaki kan akım empedansı (Doppler velosimetri) 'nin seri ultrason değerlendirmesi; fetal değerlendirmenin temel unsurları ve gebelik yönetimi kararlarını yönlendirir. Amaç, utero ölümü ve yenidoğan morbiditesi açısından en yüksek risk altındaki fetusları tanımlamaktır ve bu nedenle erken doğumdan faydalanabilir. Sıklık, bulguların ciddiyetine ve muayenelerin fetal iyilik hali (haftada bir ile yedi kez) veya fetal büyümeyi (her iki ila dört haftada bir) izlemek için yapılıp yapılmadığına bağlıdır.
- Büyüme sınırlaması şüphesi olan gebeliklerin izlenmesi için umbilikal arterin Doppler velokimetrisini önerilmelidir (**Grade 1A**). Anormal Doppler ultrasonografi ile yönlendirilen doğum perinatal ölüm sıklığını azaltır. Normal Doppler bulguları güven vericidir ve bu nedenle potansiyel olarak erken doğum ve gereksiz preterm doğum sayısında azalma sağlar. Venöz dolaşımın Doppler değerlendirmesi, ileri preterm fetüste karar vermede ilave bilgi sağlayabilir, ancak araştırmaya devam edilmelidir.
- Doğumdan bir hafta önce 24-34. Gebelik haftaları arasında bir kez antenatal kortikosteroid tedavisi yapılmasını önerilir (**Grade 1A**) Doğum ve agresif yenidoğan müdahalesi planlanırsa erken uygulama belirtilir.Zamanlama, FGR şiddeti, Doppler bulguları, komorbid koşulları ve fetal durumdaki bozulma oranı gibi birçok faktöre dayanarak tahmin edilir.

Doğum

- Gestasyon yaşı, umbilikal arter Doppleri, BPP skoru, umblikal venöz Doppleri ve risk faktörlerinin varlığı veya yokluğu, uteroplasental yetmezlikvarlığı, aşağıdakileri içeren bir faktöre dayanarak büyümesi kısıtlı fetüsün doğumu planlanır.

Amaç, fetal olgunluğu ve büyümeyi en üst düzeye çıkarmakken, fetal veya neonatal mortalite ve kısa ve uzun vadeli morbidite risklerini en azaindirmektir. FGR ve normal BPP skorları veya nonstress testleri olan gebeler için) :

- Anormal duktus venosus Doppler: Bu gebeliği derhal doğurtulmalıdır.

32. gebelik haftasından önce doğum beklenen olgularda, nöroprotektif etki amaçlı magnezyum sülfat düşünülmelidir (113).

- Revers diastolik akım ≥32. gebelik haftası: Bu gebeliği derhal doğurtulmalıdır.
- Diastolik akımın yokluğu 34. gebelik haftası sonrası: Bu gebeliği derhal doğurtulmalıdır.
- Revers diastolik akım olan <32 haftalık gebelik öncesi veya diastolik akım olan<34 haftalık gebelik öncesi: Bu hastalarda, 32 haftaya kadar (eğer revers akım varsa) veya 34 haftaya (eğer akım yoksa) doğumu geciktirmek amacıyla günlük BPP skorlaması BPS normal kaldığı süreceyapılır. BPP veya duktus venöz Doppler anormal hale gelirse, bu gebelikler derhal doğurtulur.
- Azalan diastolik akım (pulsatilite indeksi yüzde 95 persentil üzerinde olan): Haftada iki kez bir BPP yapılmalı ve bu fetusları zamanında veya BPP'nin anormal hale gelmesiyle doğurtulmalı. Umbilikal arter akımıazalmasına neden olan oligohidramniyoz, preeklampsi veya hipertansiyon, böbrek yetmezliği, fetal büyüme durması, tahmini ağırlık <5 persentil altı,daha önce SGA lı bebek doğurma öyküsü gibi uteroplasental yetmezlik belirtileri varlığında 37 ile 38 haftalıkken doğum planlanmalıdır.
- Normal umbilikal arter doppler varlığında: Bu fetüsleri 39 ile 40 hafta arasında doğurtulmalıdır.

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