

A Note on Fetal Macrosomia

Nidhi Shah*

American Board of Pediatrics, Texas Tech University Health Sciences Center at Amarillo, USA

Editorial

The term “fetal macrosomia” is used to describe an infant who is much larger than average. A baby who is diagnosed as having fetal macrosomia weighs further than 8 pounds, 13 ounces (grams), any time of his or her gestational age. About 9% of babies worldwide weigh further than 8 pounds, 13 ounces. Pitfalls associated with fetal macrosomia increase greatly when birth weight is further than 9 pounds, 15 ounces (grams). Fetal macrosomia may complicate vaginal delivery and can put the baby at risk of injury during birth. Fetal macrosomia also puts the baby at increased risk of health problems after birth.

Symptoms

Dimension of fundal height during gestation. Fundal height open pop-up dialog box redundant amniotic fluid girding baby in the uterus (polyhydramnios). Polyhydramnios Open pop-up dialog box. Fetal macrosomia can be difficult to describe and diagnose during gestation. Signs and symptoms include large fundal height during antenatal visits, your health care provider might measure your fundal height the distance from the top of your uterus to your pubic bone. A larger than anticipated fundal height could be a sign of fetal macrosomia. Inordinate amniotic fluid (polyhydramnios) having too much amniotic fluid the fluid that surrounds and protects a baby during gestation might be a sign that your baby is larger than average. The amount of amniotic fluid reflects your baby's urine output, and a larger baby produces more urine. Some conditions that beget a baby to be larger might also increase his or her urine output [1].

Causes

Inherited factors and maternal conditions similar to obesity or diabetes can beget fetal macrosomia. Infrequently, a baby might have a medical condition that makes him or her grow quickly and larger. Occasionally it's unknown what causes a baby to be larger than average [2].

Threat factors

Numerous factors might increase the risk of fetal macrosomia some you can control, but others you can't [4].

For illustration

Maternal diabetes fetal macrosomia is more likely if you had diabetes before gestation (pre-gestational diabetes) or if you develop diabetes during gestation (gestational diabetes). Still, your baby is likely to have larger shoulders and lesser quantities of body fat than would a baby whose mother does not have diabetes, if your diabetes is not well controlled. A history of fetal macrosomia If you've preliminarily given birth to a large baby, you are at increased risk of having another large baby. Also, if you weighed further than 8 pounds, 13 ounces at birth, you are more likely to have a large baby. Maternal obesity fetal macrosomia is more likely if you are fat [5].

Inordinate weight gain during gestation Gaining too much weight during gestation increases the risk of fetal macrosomia. Former gravidity the risk of fetal macrosomia increases with each gestation. Up to the fifth gestation, the average birth weight for each

consecutive gestation generally increases by over to about 4 ounces (113 grams).

Having a boy Many babies generally weigh slightly further than female babies. Utmost babies who weigh further than 9 pounds, 15 ounces (grams) are male [6].

Overdue gestation if your gestation continues by further than two weeks past your due date, your baby is at increased risk of fetal macrosomia. Maternal age Women aged over 35 are more likely to have a baby diagnosed with fetal macrosomia [7].

Fetal macrosomia is more likely to be a result of maternal diabetes, obesity or weight gain during gestation than other causes. However, it's possible that your baby might have a rare medical condition that affects fetal growth, if these risk factors are not present and fetal macrosomia is suspected. Still, your health care provider might recommend antenatal individual tests and maybe a visit with a genetic counselor, depending on the test results, If a rare medical condition is suspected [8].

Complications

Fetal macrosomia poses health pitfalls for you and your baby both during gestation and after parturition.

Maternal pitfalls

Possible maternal complications of fetal macrosomia might include labor problems fetal macrosomia can beget a baby to come rammed in the birth canal (shoulder dystocia), sustain birth injuries, or bear the use of forceps or a vacuum device during delivery (operative vaginal delivery). Occasionally a C-Section is demanded [9].

Genital tract incisions during parturition, fetal macrosomia can beget a baby to injure the birth canal similar to by tearing vaginal muscles and the muscles between the vagina and the anus (perineal muscles). Bleeding after delivery fetal macrosomia increases the risk that your uterine muscles will not fully contract after you give birth (uterine atony). This can lead to potentially serious bleeding after delivery. Uterine rupture if you've had a previous C-Section or major uterine surgery, fetal macrosomia increases the risk of uterine rupture during labor a rare but serious complication in which the uterus gashes open along the scar line from the C-Section or other uterine surgery. An emergency C-Section is demanded to help life-threatening complications [10].

***Corresponding author:** Nidhi Shah, American Board of Pediatrics, Texas Tech University Health Sciences Center at Amarillo, USA, E-mail: nidhi.shah@hotmail.com

Received: 4-Apr-2022, Manuscript No: nnp-22-61224, **Editor assigned:** 5-Apr-2022, PreQC No: nnp-22-61224 (PQ), **Reviewed:** 11-Apr-2022, QC No: nnp-22-61224, **Revised:** 14-Apr-2022, Manuscript No: nnp-22-61224(R), **Published:** 21-Apr-2022, DOI: 10.4172/2572-4983.1000235

Citation: Shah N (2022) A Note on Fetal Macrosomia. Neonat Pediatr Med 8: 235.

Copyright: © 2022 Shah N. This is an open-access article distributed under the terms of the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original author and source are credited.

Acknowledgement

I would like to thank my Professor for his support and encouragement.

Conflict of Interests

The authors declare that they are no conflict of interest.

References

1. Shah Z, Chawla A, Patkar D, Pungaonkar S (2003) "MRI in kernicterus". *Australas Radiol* 47: 55-57.
2. Gómez M, Bielza C, Pozo FD, Rios Insua S (2007) "A graphical decision-theoretic model for neonatal jaundice". *Med Decis Making* 27: 250-265.
3. Gilmour, Susan M (2004) "Prolonged neonatal jaundice: When to worry and what to do". *Paediatr Child Health* 9: 700-704.
4. Duryea EL, Hawkins JS, McIntire DD, Casey BM, Leveno KJ (2014) A revised birth weight reference for the United States. *Obstet Gynecol* 124: 16-22.
5. Nesbitt TS, Gilbert WM, Herrchen B (1998) Shoulder dystocia and associated risk factors with macrosomic infants born in California. *Am J Obstet Gynecol* 179: 476-480.
6. Boulet SL, Alexander GR, Saliyu HM, Pass M (2003) Macrosomic births in the United States: determinants, outcomes, and proposed grades of risk. *Am J Obstet Gynecol* 188: 1372-1378.
7. Zhang X, Decker A, Platt RW, Kramer MS (2008) How big is too big? The perinatal consequences of fetal macrosomia. *Am J Obstet Gynecol* 198: 517.
8. Colletti JE, Kothari, S, Kothori S, Jackson DM, Kilgore KP, et al. (2007) "An emergency medicine approach to neonatal hyperbilirubinemia". *Emerg Med Clin North Am* 25: 1117-35.
9. Watchko JF (2006) "Hyperbilirubinemia and bilirubin toxicity in the late preterm infant". *Clin Perinatol* 33: 839-582.
10. Shah Z, Chawla A, Patkar D, Pungaonkar S (2003) "MRI in kernicterus". *Australas Radiol* 47: 55-57.