

with CRL at 7 weeks GA ($\beta -1.17$, $p=0.001$; $\beta -1.68$, $p<0.001$) and at 9 weeks GA ($\beta -1.30$, $p=0.010$; $\beta -1.44$, $p=0.001$), but no significant association with CRL at 11 weeks GA was found. UtA-PI and UtA-RI at 9 weeks GA were negatively associated with CRL at 9 weeks GA ($\beta -2.25$, $p<0.001$; $\beta -1.78$, $p<0.001$) and CRL at 11 weeks GA ($\beta -2.45$, $p<0.001$; $\beta -2.03$, $p<0.001$). At 11 weeks GA, both indices were negatively associated with CRL at 11 weeks GA ($\beta -1.89$, $p=0.001$; $\beta -1.20$, $p<0.001$). The UtA-PI and UtA-RI assessed at 11 weeks GA, were associated with an decreased odds with ongoing pregnancy (respectively OR 0.36, $p=0.002$; OR 0.052, $p=0.001$).

Conclusions: These preliminary results suggest that higher first-trimester uterine artery Doppler indices are associated with reduced first-trimester embryonic growth, and decreased odds of ongoing pregnancy. Further analyses are needed to conform these findings and assess clinical relevance.

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Placental location and the accuracy of sonographic estimated fetal weight: large retrospective cohort study

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Objectives: To evaluate the effect of placental location on the accuracy of sonographic estimated fetal weight (EFW) and its clinical relevance across gestation.

Methods: This retrospective cohort study included singleton pregnancies delivering at a tertiary center between 2012–2020. Cases with EFW calculated by the Hadlock 4 formula within 14 days prior to delivery were included. Placental location was classified as anterior or posterior; other locations were excluded due to small sample size. Accuracy was assessed by percent error and deviations >15%, with analyses stratified by gestational age.

Results: A total of 19,295 pregnancies were included (50.4% anterior, 41.9% posterior). Baseline characteristics were largely comparable. EFW strongly correlated with birth weight ($r=0.93$, $p<0.001$), with minimal bias (mean error 0.48%). Mean percent error was 1.34% in posterior and -0.23% in anterior placentas ($p<0.001$), indicating slight overestimation with anterior placentation. Errors >15% occurred in 4.25% of cases. Overall rates were similar, but anterior placentas showed more marked underestimation (4.14% vs 2.55%, $p<0.001$), reflecting differences in error distribution. No differences were observed before 32 weeks, while significant effects emerged thereafter ($p<0.001$).

Conclusions: Placental location affects the pattern of error in sonographic fetal weight estimation, especially in late gestation. Anterior placentation shows slight overestimation with more frequent marked underestimation. However, given the small differences and strong agreement with birth weight, this effect is not clinically meaningful.

Supporting information can be found in the online version of this abstract

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Optimal timing of delivery in suspected late growth restricted fetuses at term: are 37 and 39 weeks valid cut-offs?

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Objectives: Optimal timing of delivery in late fetal growth restriction (FGR) at term is unknown. This prospective study aims to assess the impact of arbitrary cut-offs for delivery at late vs early term in FGR fetuses.

Methods: Singleton pregnancies at $\geq 32+0$ weeks with suspected late FGR (estimated weight <10th centile or 50-centile abdominal circumference drop or abnormal fetal Dopplers) were included at UCLH (London, UK). Fetuses with high-risk FGR ultrasound features (estimated weight <3rd centile, abnormal umbilical artery Doppler or cerebro-placental ratio, abnormal 36-week uterine artery Dopplers) were delivered at 37 weeks, whereas the remaining low-risk fetuses were delivered after 39 weeks. Some women delivered later or earlier due maternal choice, protocol deviation or pregnancy complications. We planned a per-protocol analysis comparing late vs early term groups by gestational week at delivery: late vs early high-risk FGR (≥ 38 vs 37^{+0} - 37^{+6}); and late vs early low-risk FGR (≥ 39 vs 37^{+0} - 38^{+6}). The primary outcome was a composite of severe adverse outcomes: perinatal death, encephalopathy and resuscitation at birth. The secondary outcome was a composite of mild adverse outcomes (neonatal unit admission, hypothermia and hypoglycemia).

Results: 1103 neonates were included (2018-2022). There was no significant difference in severe adverse outcome between late vs early groups (7 vs 7%, OR: 1.0, 95% CI: 0.42-2.46, $p=0.97$ in late vs early high-risk; 6 vs 4%, aOR: 0.7, 95% CI: 0.34-1.4, $p=0.33$ in late vs early low risk). There were no perinatal deaths in the low-risk cohort. The mild adverse neonatal composite was lower in late vs early high-risk (41 vs 57%, OR: 0.53, 95% CI: 0.34-0.84, $p<0.01$) and late vs early low-risk (30 vs 40%, aOR: 0.61, 95% CI: 0.44-0.85, $p<0.01$) cohorts.

Conclusions: Early term birth can cause harm when arbitrary cut-offs are used. When appropriately risk stratified there is benefit in continuing pregnancies at low risk of placental insufficiency to 39 weeks.

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Association of cerebroplacental ratio with adverse neonatal outcomes in late small-for-gestational-age fetuses

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Objectives: To evaluate the association between abnormal cerebroplacental ratio (CPR) and adverse neonatal outcomes in late small-for-gestational-age (SGA) fetuses.

Methods: This retrospective cohort included SGA fetuses from 2019-2025 at a regional perinatal center serving an inner-city, high-risk population. Late SGA was defined as abdominal circumference or estimated fetal weight between the 3rd-10th percentiles with normal umbilical artery pulsatility index (PI) after 32 weeks. Abnormal CPR was defined as middle cerebral artery to umbilical artery PI ratio <5th percentile. Groups with normal vs abnormal CPR were compared.

The primary outcome was a composite of adverse neonatal outcomes (arterial cord pH ≤ 7.05 , 1-minute Apgar <7, NICU admission >24 hours, respiratory distress syndrome, intraventricular hemorrhage, necrotizing enterocolitis, or neonatal death). Secondary outcomes were preeclampsia and SGA at birth (<10th percentile). Multivariable logistic regression adjusted for confounders.

Results: 543 pregnancies met inclusion criteria: 417 (76.8%) with normal CPR and 126 (23.2%) with abnormal CPR. Maternal