Polyhydramnios

This guidance does not override the individual responsibility of health professionals to make appropriate decision according to the circumstances of the individual patient in consultation with the patient and /or carer. Health care professionals must be prepared to justify any deviation from this guidance.

Introduction

Guideline for the management of all polyhydramnios identified on USS during pregnancy.

This guideline is for use by the following staff groups:

Obstetric Doctors and Midwives

Lead Clinician(s)

Rachel Duckett	Consultant Obstetrician
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Approved by *Maternity Governance Meeting* on:	19th September 2025
Approved by Medicines Safety Committee on:	N/A – No medicines
Review Date: This is the most current document and should be used until a revised version is in place	19th September 2028

Key amendments to this guideline

Date	Amendment	Approved by:
2nd February 2021	New guideline	MGM
May 2021	Appendix 1 minor amendment	MGM
4th June 2024	Document extended for another 12 months whilst under review	MGM
September 2025	Changes to Scanning requirements and OGTT recommendations	MGM

Inclusion statement

We recognise that although our policy uses words such as women/woman, not all birthing people or post-natal parents will identify as such. We encourage all staff to be welcoming of the diversity of our local population, be respectful of preferred language, pronouns, and adapt their communication appropriately. All staff should accommodate mothers and parents with individual needs or disabilities, whether they be physical or not visible, and adapt their care to support them with their pregnancy.

Ockenden Maternity Guidelines Assessment

Is there National Guidance Available for this guideline?	No
National Guidance used to inform guideline *e.g. NICE/RCOG*	N/A
Does the guideline follow National Guidance if available? *If no, what rationale has been used.*	
If no national guidance available or national guidance not followed, what evidence has been used to inform guideline.	Guidance adapted from Birmingham Women's hospital guidance. Local audit findings have reassured the changes to OGTT testing, scanning pathway and return to MLC.
Ratified at Maternity Guidelines Forum:	MGM 19/09/2025

Introduction

Polyhydramnios is defined as the accumulation of excessive amniotic fluid, this may be suspected clinically if the abdomen is tense and SFH is >3cm larger than expected. It is diagnosed using ultrasound as a deepest vertical pool (DVP) >8cm at any gestation. The deepest vertical pool measurement is defined as the largest visible cord- and limb-free pocket of amniotic fluid.

Further sub-categorisation to mild (DVP 8.1-11.9 cm), moderate (DVP 12-15.9 cm), and severe (DVP >/= 16cm) polyhydramnios may be of value with regard to the investigation and management.

The reported incidence is between 1-2% of pregnancies.

There is an association between the severity of the polyhydramnios and the risk of congenital anomaly. Severe polyhydramnios is associated with congenital anomaly in >70% cases, however in the absence of ultrasound differences the risk of congenital anomaly is much less(11%).

The amount of amniotic fluid volume present at any one time reflects a balance between the production and removal.

The factors affecting production are:

- Fetal urine production
- Secretions from the respiratory tract
- Oral secretions

The factors affecting removal are:

- Fetal swallowing
- Fluid dynamics across the membrane
- Intramembranous flow (i.e. Transfer across the placenta).

Abnormality in any of the above mechanisms leads to excessive accumulation of amniotic fluid.

There are various aetiologies, both maternal and fetal, these include congenital fetal anomalies, fetal aneuploidy, maternal diabetes or infection (see below).

Importantly >50% of cases remain idiopathic.

Box 1. Causes of polyhydramnios in a singleton pregnancy

Maternal

- Uncontrolled diabetes mellitus (pre-gestational and gestational)
- Rhesus and other blood group isoimmunisation leading to immune hydrops
- Drug exposure, e.g. lithium leading to fetal diabetes insipidus

Fetal

- Structural/congenital malformations (see Table 1)
- Chromosomal and genetic abnormalities, e.g. trisomies, Beckwith–Wiedemann syndrome, fetal akinesia–dyskinesia syndrome
- Congenital infections, e.g. toxoplasma, rubella, cytomegalovirus, and parvovirus
- Macrosomia
- Fetal tumours, e.g. teratomas, nephromas, neuroblastoma, and haemangiomas

Placental

- Tumours such as chorioangiomas and metastatic neuroblastoma

Unexplained

Table 1. Fetal structural abnormalities causing polyhydramnios in a singleton pregnancy

System affected	Condition
Central nervous system	Anencephaly
	Spina bifida
	Encephalocele
	Hydrocephalus
	Microcephaly
	Dandy–Walker malformation
Head and neck	Goitre, cystic hygroma, cleft palate
Respiratory system	Tracheal agenesis
	Congenital diaphragmatic hernia
	Congenital cystic adenomatoid malformation
	Bronchopulmonary sequestration
Gastrointestinal system	Esophageal atresia and tracheo-oesophageal fistula, duodenal and intestinal atresia
	Exomphalos
	Gastroschisis
Genitourinary system	Pelvi-uretric junction obstruction
	Bartter syndrome
Skeletal system	Lethal skeletal dysplasia
Cardiovascular system	Cardiac anomalies
Fetal tumours	Sacrococcygeal teratoma
Other	Immune and non-immune hydrops fetalis
	Fetal akinesia–dyskinesia syndrome

Objectives

The aim of this guideline is to make recommendations regarding the antenatal management of pregnancies where there is evidence of polyhydramnios. These recommendations include guidance on how often to perform ultrasound scans for liquor volume and umbilical artery Doppler and which patients need referral to the Fetal Medicine Department. It also includes guidance on who needs to have microbiology testing.

Policy Scope

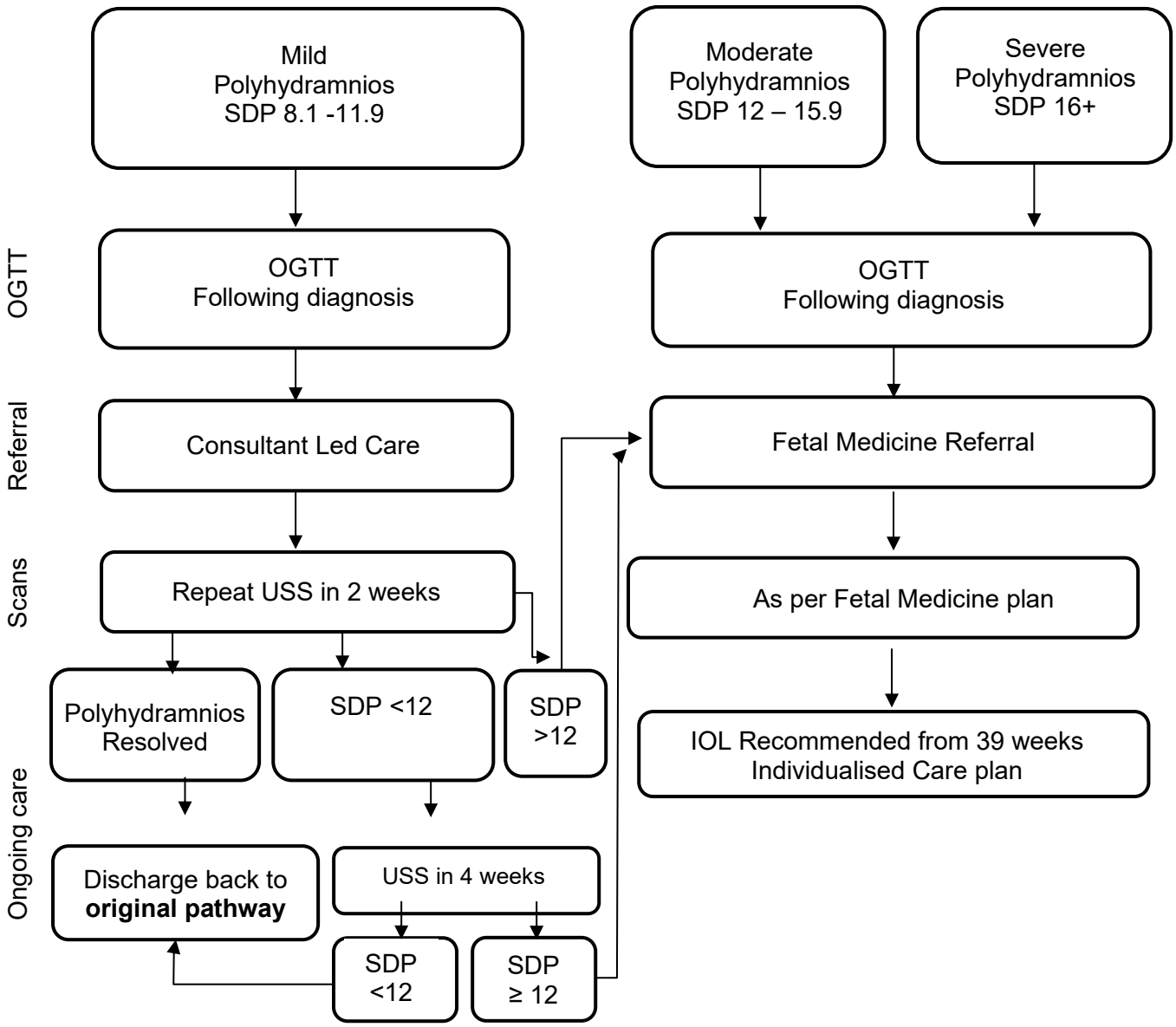
This policy addresses women with singleton pregnancies who have been diagnosed with polyhydramnios in their current pregnancy and gives recommendations as to their future management.

Management

- Transfer care of all women with diagnosed polyhydramnios to consultant-led care at the point of diagnosis.
- Women with resolved or persistent mild polyhydramnios can be referred to their original pathway (if MLC – suitable for MLU). Homebirth is not recommended due to the increased risk of cord prolapse in the event of SROM with polyhydramnios. Therefore, if a homebirth is requested thorough counselling should be undertaken as an outside of guidance homebirth. Please see Homebirth Guideline for further guidance.
- Women with moderate to severe polyhydramnios are not suitable for midwifery-led care, delivery in midwifery –led unit or homebirth.
- TORCH to be done only if suspected infection (scan findings such as echogenic bowel or maternal history of being unwell) or congenital anomalies.
- Perform GDM screening at the initial diagnosis of polyhydramnios. This does not need repeating for persistent polyhydramnios. If there are other signs such as macrosomia or persistent glycosuria, then discuss with consultant regarding need for repeat testing. Polyhydramnios alone is not an indication for repeat testing.
- Counsel women regarding risks of pre-term labour (PTL) and cord prolapse in the event of pre-term rupture of membranes (PROM).
- Women who contact triage with a PROM or PTL should be invited in immediately.
- Ensure a neonatal alert form has been completed, with as much detail as possible, if a referral to fetal medicine has been made as a NG tube may be required prior to the first feed and thorough neonatal check is indicated.
- Idiopathic polyhydramnios may resolve spontaneously, however there remains an increased risk of perinatal morbidity.
- Consider paired steroids for fetal lung maturation if considered high risk of PTL.
- Consideration can be made for IOL and should consider the full clinical picture:
    - Mild Polyhydramnios – Routine post-dates IOL (if referred to MLC)
    - Moderate-Severe Polyhydramnios – IOL recommended at 39 weeks following individualised care plan with fetal medicine team.
- (decision to be made by patients' obstetrician)
- Follow pathway below

Appendix 1 - Pathway for the management of Polyhydramnios

Management Flowchart



Monitoring

Page/ Section of Key Document	Key control:	Checks to be carried out to confirm compliance with the Policy:	How often the check will be carried out:	Responsible for carrying out the check:	Results of check reported to: *(Responsible for also ensuring actions are developed to address any areas of non-compliance)*	Frequency of reporting:
	WHAT?	**HOW?**	**WHEN?**	**WHO?**	**WHERE?**	**WHEN?**
	Scanning compliance	Local Audit	6 monthly	Obstetric Team	Maternity Audit Meeting	6 Monthly
	OGTT Compliance					
	Appropriate IOL					

Contribution List

This key document has been circulated to the following individuals for consultation;

Designation
Maternity Governance Meeting
Maternity Guidelines Committee

This key document has been circulated to the chair(s) of the following committee's / groups for comments;

Committee
Maternity Quality Governance Meeting

Supporting Document 2 – Financial Impact Assessment

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

	Title of document:	Yes/No
1.	Does the implementation of this document require any additional Capital resources	No
2.	Does the implementation of this document require additional revenue	No
3.	Does the implementation of this document require additional manpower	No
4.	Does the implementation of this document release any manpower costs through a change in practice	No
5.	Are there additional staff training costs associated with implementing this document which cannot be delivered through current training programmes or allocated training times for staff	No
	Other comments:	

If the response to any of the above is yes, please complete a business case and which is signed by your Finance Manager and Directorate Manager for consideration by the Accountable Director before progressing to the relevant committee for approval.