LIMITED 2nd/3rd TRIMESTER OBSTETRICAL ULTRASOUND PROTOCOL

GESTATIONAL AGE: For pregnancies ≥14wks

BILLING CODE:

UOBL- ***(76815) Only one UOBL can be charged per visit even for multiple pregnancies.***

PREP: No prep

DESCRIPTION: This exam should be used for any exam that does not meet the image criteria of an anatomy or follow up exam. Biometry is not required but may be included in a UOBL. Examples:

- **AFI only**
- **Limited evaluations of placenta for location**
- **Determination of fetal presentation**
- **Following up abnormal anatomy or anatomy not seen on prior seen on a prior UW ultrasound, regardless if biometry was included, should use code UOBF (76816*)***
- **If we have not seen the patient for an anatomy ultrasound and the order is for limited anatomy, a growth ultrasound or Dopplers, contact the ordering provider to have them change the order to an anatomy ultrasound.**

**** See separate protocols for Emergent Fetal Well Being Assessment, Pregnancy Loss, Basic and Detailed Anatomy, OB Follow Up exams and specialty OB exams.**

DATING: As a routine, use the date provided by the clinician or patient's known LMP. Working EDD in EPIC should be used if more than one date is provided. Use AIUM and ACOG dating criteria if dating is unknown. Guidelines for redating based on ultrasound can be found here

IMAGES TO OBTAIN

Additional images may be requested as needed in addition to the basic requirements listed below.

MATERNAL STRUCTURES

UTERUS ***if indicated***

- Follow up fibroids if previously seen.
- New or incidental findings should also be imaged.

ADNEXA AND OVARIES: ***if indicated***

- Follow up cysts or masses if previously seen.
- New or incidental findings should also be imaged.

MATERNAL STRUCTURES continued…

CERVIX:

TRANSABDOMINAL IMAGING

- To be measured transabdominally on all pregnancies less than 24 weeks GA. Normal cervical length is greater than 3.0 cm before 24 weeks.
- Color image of the LUS to assess for vasa previa.
- If you suspect vessels are present, or are unable to see the cervix without fetal parts obscuring the area, a transvaginal imaging study should be performed.

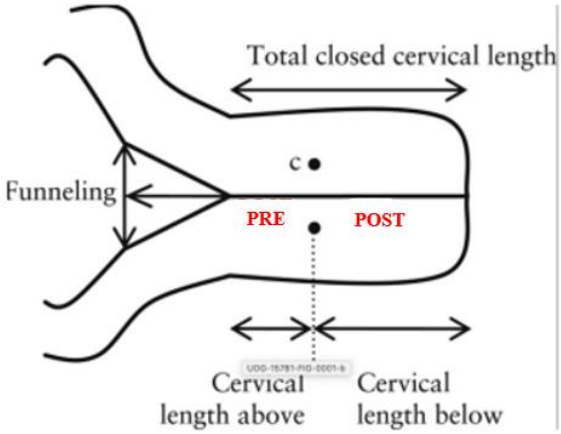
TRANSVAGINAL IMAGING

STERILE OR BACTERIOSTATIC GEL PACKS AND SINGLE USE COVERS TO BE USED FOR ALL TRANSVAGINAL IMAGING.

******Verbal consent to be obtained from the patient for transvaginal imaging. Documentation of consent to be included in report. If a male sonographer is doing the scan, there will need to be a female chaperone present for the transvaginal or translabial portion of the exam.***

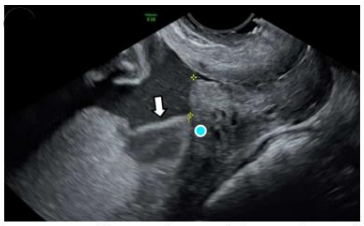
- If the cervix appears shortened or funneled before 24 weeks, or if a cervical length is specifically requested, a transvaginal ultrasound should be performed. *(A translabial study can be done in place of transvaginal imaging in cases of PPROM, bulging membranes or patient request/refusal of TV.)* The following should be documented-
- Total cervical length
- Closed length of cervix
- Open length of funneling if present. Greater than 50% open length of cervix is associated with higher risk of preterm delivery.
- Assess whether the cervix is dynamic by observing for changes for at least 2 minutes. Images should be taken at the beginning and end of this period to document the time spent. If the cervix is dynamic, report the shortest closed cervical length.
- Color image of the LUS to assess for vasa previa.
- Sample any vessels seen within 2cm of the cervical os with spectral Doppler to see if they are arterial or venous. If it is an arterial vessel, be sure to also include heart rate measurements to differentiate the fetal blood vessels from maternal vessels by comparing their respective heart rates.

- Transvaginal ultrasound is not needed to evaluate the cervix after 24 weeks. If you find a short or dilated cervix transabdominally during an ultrasound exam, contact the referring provider and inform them of the findings. If the referring provider cannot be contacted, call triage nurse or L&D.
- For cerclage evaluation: Take 2D images, as well as cine sweeps, of the cervix showing suture in transverse and sagittal. Measure the total cervical length AND closed cervical length from stitch to external os. Do not apply fundal pressure or Valsalva with patients that have a cerclage.



PLACENTA:

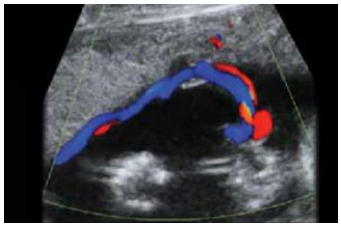
- Document location of placenta in sagittal and transverse.
- Show thickness and echotexture.
- If venous lakes are present, include a color image and a 2D cine clip showing the slow flow movement within.
- Assess for a bi-lobed placenta or succenturiate lobe. If present, document location of connecting vascular supply to the primary placental lobe.
- Assess relationship of placental edge to the internal cervical os to rule out placenta previa.
- Measure the distance from the inferior most portion of the placental tissue if it appears to be low lying. Also include a measurement from the edge of the placental sinus if one is present. A placenta should be described as low lying if it is less than 2 cm from the cervical os, or less than 1.1 cm from the placental sinus.
- Cine clip of any abnormality.
- If accreta is suspected, see additional images needed in separate PAS protocol.



Measurement from a placental sinus to internal os.

PLACENTAL CORD ORIGIN *if previously marginal or velamentous*:

- Document the placental cord origin in transverse and sagittal planes using color Doppler and show the vessels of the cord separating into the placenta. To rule out a velamentous cord origin, the cord should be shown clearly coming out from the placenta, not just coursing along the surface.
- Measure the distance from the cord origin to the edge of the placenta if it appears near the edge. A marginal cord origin is defined as less than 2 cm from placental edge.



FETAL POSITION:

- Document fetal position.

FETAL HEART RATE:

- Measure fetal heart rate with M-Mode. Normal range is 110 – 170 bpm. If the fetal heart rate is above or below, refer to Urgent OB Contact List to contact charge nurse or L&D. If being scanned at an outpatient clinic, contact the referring provider or on call the OB staff for further instructions.

FETAL ANATOMY:

- Stomach
- Bladder
- Kidneys – Sagittal and transverse views. Include length measurements.
- 4 chamber view of heart

AMNIOTIC FLUID VOLUME:

- 20-24 weeks: AFI evaluation should be done using MVP. If abnormal, obtain a four quadrant AFI.
- After 24 weeks, or if it appears abnormal before 24 weeks: Evaluation should be done using a four quadrant AFI
- For multiple gestations (twins, triplets, etc): Always measure the MVP unless Mono/mono gestation, then use four quadrant measurements.
- Fluid pockets measured should be greater than 1cm in width.

AMNIOTIC FLUID INDEX 4 quadrant

<5cm	Oligohydramnios
5-24 cm	Normal
≥ 24 cm	Polyhydramnios

MVP and TWINS single largest pocket

<2 cm	Oligohydramnios
2-8 cm	Normal
≥ 8 cm	Polyhydramnios

LIMITED OB IMAGE LIST

MINIMUM IMAGES REQUIRED	MODE
GENERAL	
Placenta Sag -*check if low lying or previa*	2D
Placenta Trans	2D
Cord Origin if previously marginal or velamentous	2D/Color
FHR	M-mode
Presentation	2D
AFI (MVP for 20-24wks, 4 quad >24wks)	2D+
CVX <24wks	2D+
LUS w color	Color
ANATOMY	

4CH	2D
STOMACH	2D
KIDNEYS trv and sag	2D
BLADDER	2D

LIMITED OB PROTOCOL HISTORY

	Date	Changes made	By whom
Created	5/1/2022		Renee Betit Fitzgerald
Changed	5/5/2023	Cerclage image was incorrect. Pre and Post labels revised. Removed Placenta Accreta section – see specialized protocol	OB Protocol meeting 4/27/23 Dighe, Cheng, Ma, Hitti, Shaun, Renee, Dalene
Added	4/17/2024	Image Lists	Renee Betit Fitzgerald
Added	10/15/2024	If the cervix is contracted on transvaginal imaging, wait at least 2 minutes for the contraction to pass. Document an image at the beginning of scanning and after 2 minutes to verify this was done.	Renee Betit Fitzgerald
Added	1/23/2025	Added AFI MVP for 20-24wks, do 4 quad if abnormal.	Combined Protocol Meeting MFM/RAD Attendees: 1/23/25 E Cheng, M Dighe, K Ma, M Richley, S Swati, C Cheng, S Bornemeier, B Marion, R Betit Fitzgerald, P Thompson
Added	2/12/2025	Added: **CERVIX** - A translabial study can be done in place of transvaginal imaging in cases of PPROM, bulging membranes or patient request/refusal of TV. -Assess whether the cervix is dynamic by observing for changes for at least 2 minutes. -Color image of the LUS to assess for vasa previa. -Sample any vessels seen within 2cm of the cervical os with spectral Doppler to see if they are arterial or venous. If it is an arterial vessel, be sure to also include a HR measurement to differentiate the fetal blood vessels from maternal vessels by comparing their respective heart rates.	Manjiri Dighe Renee Betit Fitzgerald
Added	2/12/2025	**PLACENTA**	Manjiri Dighe Renee Betit Fitzgerald

		-If venous lakes are present, include a color image and a 2D cine clip showing the slow flow movement within. -Assess for a bi-lobed placenta or succenturiate lobe. If present, document location of connecting vascular supply to the primary placental lobe. -Document the placental cord origin in transverse and sagittal planes using color Doppler and show the vessels of the cord separating into the placenta. To rule out a velamentous cord origin, the cord should be shown clearly coming out from the placenta, not just coursing along the surface.	
Updated	7/10/2025	Description of exam updated	Amie Hollard Renee Betit Fitzgerald
Updated	9/16/2025	If we have not seen the patient for an anatomy ultrasound and the order is for limited anatomy, a growth ultrasound or Dopplers, contact the ordering provider to have them change the order to an anatomy ultrasound.	MFM division physicians