

Increased Nuchal Translucency (NT) on ultrasound in pregnancy (11 to 13⁺⁶ weeks)	
Type: Guideline	HDSS Certification Standard
Issued by: Maternity PPG Group	Version: 1.1
Applicable to: HVDHB Maternity	Contact person: CHOD O&G
Lead DHB: HVDHB	Level:

Hutt Maternity Policies provide guidance for the midwives and medical staff working in Hutt Maternity Services. Please discuss policies relevant to your care with your Lead Maternity Carer.

Purpose:

To provide clinical guidance for management of pregnant women with raised nuchal translucency on ultrasound at 11⁺⁰ to 13⁺⁶ weeks gestation.

Scope:

For the purposes of this document, staff will refer to:

All staff within Hutt Valley DHB. This includes staff not working in direct contact with patients/ consumers. Staff are taken to include anyone engaged in working to the Hutt Valley DHB. This may include but is not limited to:

- Employees irrespective of their length of service
- Agency workers
- Self-employed workers
- Volunteers
- Consultants
- Third party service providers, and any other individual or suppliers working in Hutt Maternity, including Lead Maternity Carers, personnel affiliated with third parties, contractors, temporary workers and volunteers
- Radiologists and ultrasonographers working in at community ultrasound providers
- Students

Definitions:

Increased nuchal translucency (NT) is >95th centile for gestation or ≥3.5mm (>99th centile) at 11+0 to 13+6 weeks gestation.

CVS Chorionic villus sampling

Echo Fetal echocardiography

MSS1 Maternal serum screening in first trimester

NIPT Non-invasive prenatal (cell-free DNA) testing

NT Nuchal translucency

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Causes:

Increased nuchal translucency is associated with chromosomal abnormalities. (NZMFM 2016)

Increased NT with a normal karyotype is also associated with a wide range of fetal defects, genetic syndrome and adverse outcomes. (ibid)

The risk of adverse outcome increases with increasing NT thickness. (ibid)

Aneuploidy (trisomy 21, trisomy 18 and 45XO Turner's syndrome are most common)

- Structural anomalies including: cardiac defects, diaphragmatic hernia, omphalocele and skeletal anomalies
- Predictive of future risk of twin-to-twin transfusion syndrome in monochorionic twins
- Congenital infection
- Genetic syndromes

Management

- Take a history including medical issues, past obstetric history and family history of genetic conditions / syndromes / structural anomalies.
- If only had NT scan, recommend MSS1 bloods.
- Refer urgently to Antenatal Clinic.
- Discuss findings and options: expectant management, NIPT, amniocentesis (or CVS if clinically appropriate).
- Care needs to offered in a non-judgemental manner, be focused on the pregnant person's individual circumstances, and their choices be fully supported.

Prognosis

NT at 11+0 to 13+6 weeks	Risk of adverse outcome e.g. chromosomal, structural, fetal death	% chance fetus will be normal with isolated NT and normal karyotype
< 3.5mm	5%	90%
3.5 – 4.4mm	30%	70%
4.5 – 5.4mm	50%	50%
5.5 – 6.4mm	80%	30%
≥ 6.5mm		15%

Persistent unexplained nuchal oedema at 18 to 20 weeks

- 10% chance of hydrops, perinatal death, genetic syndromes
- 3-5% chance of neurodevelopmental delay

Management Pathway

See Management plan in appendix 1.

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Related Documents:

Information to offer to pregnant people:

- [NZ MFM Network](#) Trisomy 21 (Down syndrome)
- [NZ MFM Network](#) Trisomy 18 (Edward syndrome)
- [NZ MFM Network Trisomy 13](#) (Patau syndrome)

References:

- Creasy & Resnik et al (ed). Creasy and Resnik's Maternal-Fetal Medicine: Principle and Practice, 7th Edition. 2014.
- Nicolaides, K. The 11-13+6 weeks scan. Fetal Medicine Foundation. 2004. [doi](#)
- New Zealand Maternal Fetal Medicine Network guideline: Increased nuchal translucency with normal karyotype. 2016. [doi](#)

Keywords for searching:

1. Nuchal Translucency
2. Ultrasound
3. NT scan
4. Down syndrome
5. Patau syndrome
6. Edward syndrome
7. Trisomy
8. MATY089
9. Pregnant

Informed Consent:

The right of a consumer to make an informed choice and give informed consent, including the right to refuse medical treatment, is enshrined in law and in the Code of Health and Disability Consumers' Rights in New Zealand. This means that a woman can choose to decline treatment, referral to another practitioner, or transfer of clinical responsibility. If this occurs follow the process map on page 18 of the Referral Guidelines (Ministry of Health, 2012).

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Tangata Whenua Statement:

The Women’s Health Service recognises the rights and responsibilities of Māori as tangata whenua and Treaty Partners. This allows and acknowledges the importance of cultural diversity in all aspects of our care and practice in Aotearoa New Zealand.

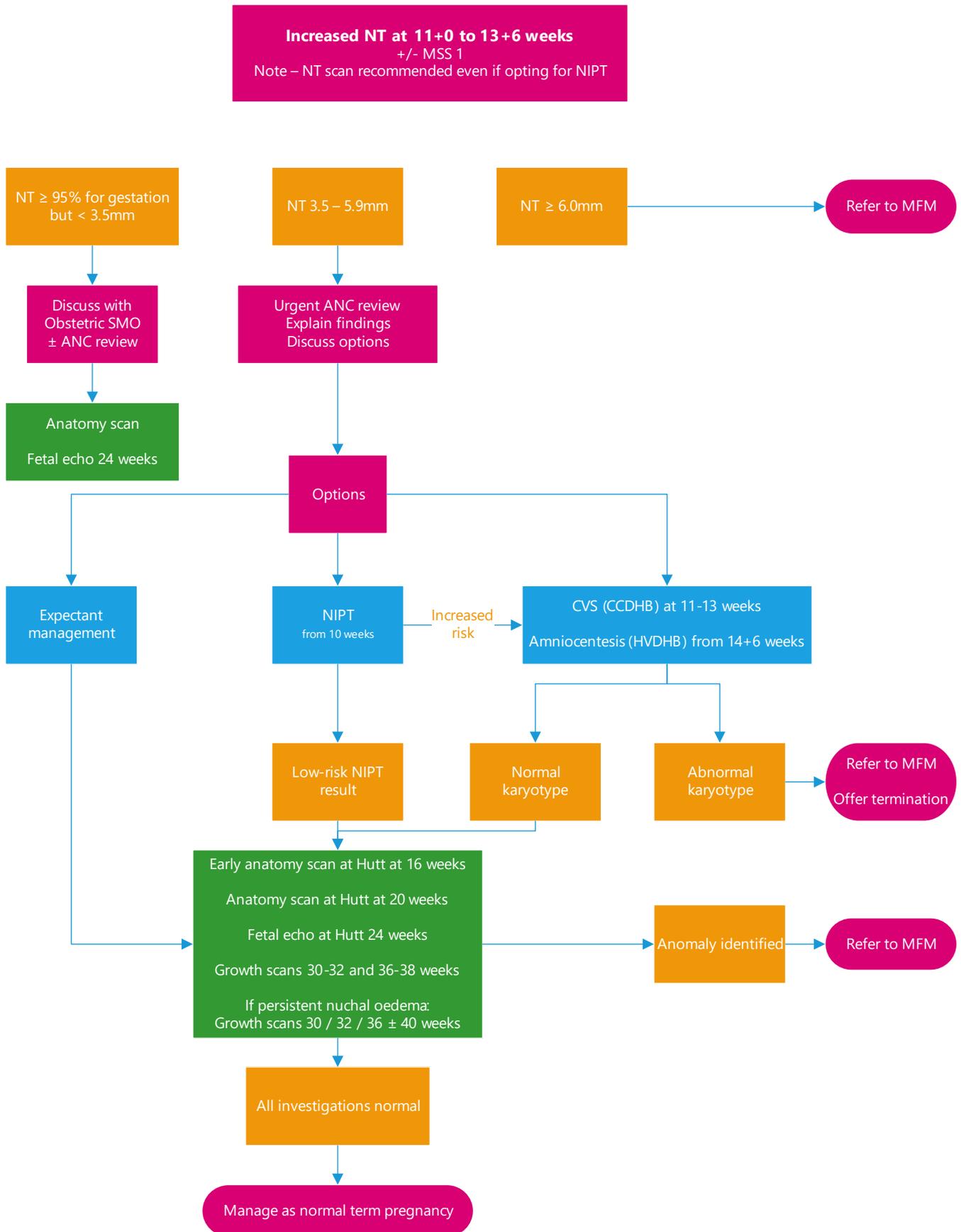
As stated in [Te Pae Amorangi](#) (Hutt Valley DHB Māori Health Strategy) 2018-2027, Hutt DHB as a Crown agency is committed to our role in maintaining active relationships with iwi, under Te Tiriti o Waitangi. This strategy recognises the established principles of Partnership, Participation and Protection and recognises steps towards the reviewed interpretation of Te Tiriti principles to date (from the [Wai 2575](#) claim into health). These are tino rangatiratanga, equity, active protection, partnership and options.

Attention in particular is drawn to:

- **Article one – Kāwanatanga:** actively engaging and working alongside with local iwi through the Hutt Valley [Māori Health Unit](#)
- **Article two – Tino Rangatiratanga:** Self-autonomy, self-determination; the responsibility to enable Māori to exercise their authority over their own health, determinants and definition of health
- **Article three – Ōritetanga:** equal health outcomes of peoples; ensuring that policy, guidelines or programmes do not further perpetuate any inequity
- **Article four (the ‘oral clause’) – Wairuatanga:** spirituality; thriving as Māori and the importance of health providers understanding health in te ao Māori (the Māori world), acknowledging the interconnectedness and inter-relationship of all living and non-living things.

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Appendix 1: Management of Increased Nuchal Translucency measurement



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