Seattle Children's Indications for Fetal Echo Referral

CONSIDER EARLY FETAL ECHO: Available at Seattle Prenatal Center only **(between 14 to 17+6 weeks + f/u echo at 20-22 weeks to complete anatomy)**
CHD in 1st degree relative to fetus with complex congenital heart disease (ie. Single ventricle, heterotaxy, etc.)
Fetal Karyotype Abnormality
DEFINITIVE FETAL ECHO INDICATIONS **(estimated risk ≥ 3%)** **Standard Timing 18-22 weeks (after anatomy scan): See exceptions below***
Pregestational Diabetes
Diabetes in first trimester
Uncontrolled phenylketonuria (preconception level >10mg)
SSA/SSB positive **timing: fetal echos btw. 16-28 weeks q 2 weeks. Between 16-18 weeks, functional cardiac assessment + PR interval only; assess anatomy after 18 weeks*
Fetal Rhythm abnormalities **timing: whenever referral comes in even if before 18 weeks*
Maternal 1st Trimester Medications (ACE inhibitors, Retinoic Acid, NSAIDs 3rd trimester)
1st trimester Rubella infection
Maternal Parvo, Coxsackie, Adenovirus, Cytomegalovirus
Congenital Heart Disease in 1st degree relative to fetus
Fetal Karyotype Abnormality
IVF (in-vitro fertilization) if provider or patient concerns
Cardiac Anomaly identified via ultrasound
Unable to clear heart on ultrasound
Extracardiac Anomaly identified via ultrasound *fetal echocardiogram should be performed in all fetuses with identified extracardiac abnormalities unless the specific anomaly is known to confer low risk (like isolated cleft lip) and has been well demonstrated by other testing (including obstetric scan that includes normal 4-chamber and outflow tract views) to be isolated. Examples below:* • Omphalocele • Duodenal Atresia • Congenital Diaphragmatic Hernia • Central Nervous Malformations • Genitourinary Malformation • Neural Tube Defect • AVM's and Vein of Galen • CPAMS/Lung Masses Rhabdomyomias • SCTs • Mild Isolated Micrognathia w/ normal anatomy: ECHO Not needed • Severe Micrognathia with EXIT planned: Needs ECHO • Micrognathia with heart NWS: Needs ECHO
Increased Nuchal Translucency 3.5mm or greater
Monochorionic Twins
Absent Ductus Venosus
Hydrops or effusions

***Note: Printed copies are for reference only. Always refer to the electronic version.**

CONSIDER FETAL ECHO - DISCUSS WITH REFERRING PROVIDERS + PATIENT (estimated risk 2-3%) Standard Timing 18-22 weeks (after anatomy scan)
Maternal Medication: Vitamin A, Paroxetine, NSAIDS 1st + 2nd trimester
Increased Nuchal Translucency 3.0 to 3.5 mm

FETAL ECHO NOT INDICATED (estimated risk ≤ 1%) Standard Timing 18-22 weeks (after anatomy scan)
Gestational Diabetes
Maternal medications (SSRIs, Coumadin, Anticonvulsants, Lithium,)
Maternal infection (other than those listed above)
Maternal Obesity (BMI > 30)
2nd degree or greater (to the fetus) of congenital heart disease
Family History of patent foramen ovale, patent ductus arteriosus
Previous child with T21, T18, T13, 22q + heart anomaly
Family history of hypertrophic cardiomyopathy, Marfans, Ehler-Danlos
Nuchal transluceny less than 3.0 mm
Single Umbilical artery (ie. 2 vessel cord) or abnormal placenta)
In vitro fertilization with normal cardiac views on anatomy scan