Suspected macrosomia alone is not an absolute contraindication to attempting vaginal birth after caesarean section (VBAC). Although success rates of VBAC decrease as newborn weight increases to 4000g or more, this effect does not decrease absolute VBAC success rate to less than 50% in women who have had a previous vaginal birth or previous VBAC [42, 47, 48]. There may be a higher risk of uterine rupture during labour after caesarean section with neonatal birth weights more than 4000g. The rates of rupture are highest in women with no prior history of vaginal birth and with increasing birth weight[42, 48]. However, the studies used actual birth weight as opposed to estimated fetal weight and hence, have limited applicability in making decisions regarding mode of delivery before labour[42]. Once again, the principles of SDM should be used when counselling women about their options for VBAC.

There is insufficient evidence to guide decision making for external cephalic version (ECV) in women with suspected macrosomia. There are no reported studies on the relationship between suspected macrosomia and success or failure of ECV. The principles of SDM should be used to guide discussion taking into consideration the full clinical picture.

4.4 Prevention of macrosomia

Interventions that have been shown to reduce the risk of macrosomia include

- Exercise during pregnancy
- Low glycemic diet in women with GDM
- Pre-pregnancy bariatric surgery in women with class 2 or class 3 obesity

A meta-analysis of 28 randomised clinical trials in 5322 women that compared standard care with supervised prenatal exercise found a decreased risk of macrosomia (OR 0.69; 95% CI 0.55 to 0.86) without an increase in small for gestational age babies or preterm birth[49]. A further meta-analysis of 15 high-quality randomi316(i)0.610352(316(i