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Opinion

Should the recommendation against maternal rest in fetal growth restriction be revisited?

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Introduction

Current professional guidelines from both the Society for Maternal–Fetal Medicine (SMFM) and the American College of Obstetricians and Gynecologists (ACOG) recommend against maternal activity restriction for the management of fetal growth restriction (FGR)[1–3]. In Consult Series #52, the SMFM specifically recommends against the use of activity restriction for *in-utero* treatment of FGR (GRADE 1B)[1], while the more general Consult Series #50 on activity restriction in obstetrics suggests against activity restriction for the management of FGR, preterm prelabor rupture of membranes and hypertensive disease of pregnancy (GRADE 2B)[2]. The ACOG Practice Bulletin No. 227 echoes this position[3]. In this Opinion, we argue that these recommendations rest on a critically flawed evidentiary foundation and that emerging data on the physiological effects of maternal left lateral rest on uteroplacental perfusion warrant a reappraisal of this recommendation.

The evidentiary basis for current guidelines is insufficient

The SMFM and ACOG recommendations against maternal activity restriction in FGR derive from a single randomized controlled trial (RCT) by Laurin and Persson in 1987[4], evaluated in the Cochrane systematic review of Say *et al.*[5]. While systematic reviews and RCTs are appropriately placed at the apex of the evidence hierarchy, the quality of the underlying evidence should be scrutinized. The RCT of Laurin and Persson contains several critical design limitations that constrain its ability to determine whether maternal rest improves fetal growth in pregnancies affected by FGR.

Absence of a true control group

The RCT compared hospital bed rest with outpatient management, in which women were taken off work but their daily activities at home were otherwise unrestricted. Both study arms therefore entailed some reduction in usual activity[4,5]. No normal-activity control group was included. Consequently, the RCT compared two intensities of activity restriction rather than testing bed rest against unrestricted normal activity. It is therefore not possible to determine from these data whether bed rest confers benefit relative to standard ambulatory care.

Lack of specificity regarding positional instruction

The RCT required only that hospital bed rest be applied for approximately 22 hours per day, with rest at home permitted during weekends, rather than resuming normal activity. However, there was no further guidance regarding how this rest should be conducted[4]. This omission is physiologically critical. Studies have demonstrated that the left lateral recumbent position augments maternal cardiac output and uterine perfusion relative to the supine position[6–10], whereas the supine position in late pregnancy results in partial compression of the inferior vena cava and aorta by the gravid uterus, reducing venous return, cardiac output and uteroplacental blood flow[11–14]. In a recent prospective, cross-sectional study by DeVore *et al.*[10], comprising 300 pregnancies between 10 and 39 weeks' gestation, this phenomenon was quantified directly using non-invasive brachial-cuff pulse-wave analysis that compared the supine position with the left lateral position and reported significantly lower total peripheral vascular resistance (764 *vs* 871 dynes × s/cm^5; $P < 0.001$), lower mean arterial pressure (76 *vs* 87 mmHg; $P < 0.001$) and higher stroke volume (101 *vs* 96 mL; $P = 0.005$) associated with the left lateral position, while cardiac output was preserved. Because cardiac output was maintained despite the reduction in afterload, the net effect of adopting the left lateral position is enhanced end-organ perfusion, which is the precise hemodynamic change that would be expected to support fetal growth. Without instructions regarding preferential resting positions, any benefit conferred by maternal inactivity in the 1987 RCT could have been negated, or even reversed, by prolonged supine positioning during the bed-rest interval.

Inadequate statistical power

With only 107 participants enrolled and 79% remaining in their originally allocated group[4], the study was severely underpowered. The authors of the Cochrane review themselves acknowledged that the small sample size may have been insufficient to detect clinically meaningful differences between groups[5]. No formal power calculation or sample size justification was reported.

Baseline imbalances and limited outcome measures

The Cochrane review[5] reported similar mean estimated fetal weight (EFW) deviation at enrolment between

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groups: −21.7% for the bed-rest group *vs* −20.7% for the ambulatory group; the corresponding difference in birth-weight deviation (−19.7% *vs* −20.6%) was also non-significant ($P = 0.63$). Because both groups were comparably growth-restricted at entry and this small between-group difference was not statistically significant, this does not by itself indicate a failure of randomization. However, the trial's small size limited the ability to confirm that the groups were truly balanced at baseline. Moreover, although the trial protocol specified ultrasound assessment of fetal growth every 2 weeks, the published outcome analysis reported only birth weight, Apgar scores, umbilical cord pH and operative delivery rate; interval growth velocity, the primary mechanism by which maternal rest would theoretically exert benefit, was not analyzed as an outcome measure[4,5].

Misinterpretation of insufficient evidence

The Cochrane review concluded that there is not enough evidence to evaluate the use of a policy of bed rest in hospital for suspected impaired fetal growth: a statement of insufficient evidence, rather than evidence of ineffectiveness[5]. Despite this important distinction, both SMFM and ACOG translated the findings of this single underpowered and methodologically limited RCT into recommendations against bed rest. The rationale for these recommendations appears to derive primarily from the known harms of prolonged inpatient bed rest (thromboembolism, deconditioning, maternal psychological distress and financial costs), rather than from definitive evidence of lack of benefit of positional rest *per se*[2]. Importantly, the harms cited in the SMFM Consult Series #50 pertain specifically to prolonged inpatient confinement, rather than to the outpatient, time-limited, position-specific intervention at issue in more recent observational work. It should be noted that Laurin and Persson reported a more definitive conclusion than did the subsequent Cochrane review, stating in their abstract that hospital bed rest was 'not beneficial, either to fetal growth or to pregnancy outcome'[4]. The authors nonetheless limited the generalizability of this conclusion to moderately growth-restricted pregnancies, noting that most included fetuses had a weight deviation of only −1 to −2 SD, and that only a minority deviated more than −3 SD; the trial was therefore not designed or powered to address more severely growth-restricted phenotypes[4].

Independent corroborating evidence for activity restriction

An independent line of evidence not previously considered in the SMFM or ACOG guidelines is provided in the study of Vasapollo *et al.*[15]. In this prospective case–control study of 30 normotensive pregnant women with elevated total vascular resistance enrolled between 27 and 29 weeks' gestation, maternal physical activity restriction significantly reduced peripheral vascular resistance and was associated with improved fetal growth trajectories. This finding directly supports the hypothesis that reducing maternal activity can alter maternal–fetal hemodynamics in a clinically meaningful way, and that doing so improves fetal growth in at-risk pregnancies.

Emerging evidence: effect of left lateral maternal rest on fetal growth

DeVore *et al.* have previously published four studies examining the effect of prescribed left lateral maternal rest on fetal growth, each employing different criteria to define abnormal growth[16–19]. All four studies drew from the same cohort of 265 fetuses (or subsets thereof) and demonstrated consistent improvement following 2 weeks of maternal rest. Table 1 summarizes the findings across the four studies. The observed improvements in fetal growth following maternal left lateral rest are most plausibly attributable to enhanced blood flow to the uterus and placenta. The consistency of these findings across four analytically independent definitions of abnormal growth strengthens the case for a genuine physiological effect rather than a definitional or statistical artifact.

Physiological plausibility: improved uteroplacental blood flow as the most likely explanation

MRI evidence for enhanced uteroplacental perfusion

Magnetic resonance imaging (MRI) studies have provided direct evidence for enhanced uteroplacental blood flow, the physiological mechanism believed to underlie the improvement in fetal growth observed following maternal rest. Couper *et al.*[20] demonstrated that in late gestation, compared with the left lateral position, the supine position is associated with a 6.2% reduction in oxygen delivery to the fetus and an 11% reduction in fetal umbilical venous blood flow, although only the reduction in oxygen delivery reached statistical significance. Jani *et al.*[21] subsequently showed that, compared with appropriately growing fetuses, FGR fetuses derive proportionally greater benefit from maternal left lateral positioning, owing to their already compromised baseline oxygenation and placental reserve. Clinically, the abdominal circumference (AC) (the biometric parameter most sensitive to nutritional status and placental function) showed the most dramatic improvement following maternal left lateral rest in this series, consistent with the hypothesis of improved nutrient delivery via enhanced uteroplacental perfusion.

Direct non-invasive hemodynamic measurement of the positional effect

The abovementioned MRI findings are complemented in other studies by direct non-invasive hemodynamic measurements obtained across gestation. In their prospective, cross-sectional study of 300 pregnancies, DeVore *et al.*[10] found that the maternal left lateral position produced significantly lower peripheral vascular resistance and mean arterial pressure and higher stroke volume than did the supine or sitting positions, with

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Table 1 Summary of studies examining fetal growth improvement following left lateral maternal rest

Study	*Definition of FGR*	*Sample size* (n)	*Improvement rate after 2 weeks of left lateral maternal rest*	*Expected spontaneous improvement rate* (Controls)*
DeVore (2025)[16]	EFW < 10th percentile after prior EFW > 10th percentile	265	75% (199/265) returned to EFW > 10th percentile	12–19% in internal controls
DeVore (2025)[17]	Delphi consensus criteria for FGR or SGA[26]	265 (148 FGR; 117 SGA)	Median EFW percentile rose from 6 to 18 ($P < 0.001$); EFW returned to >10th percentile in 70% of FGR and 82% of SGA fetuses	No separate control group
DeVore (2025)[18]	Growth velocity deceleration (four definitions)	265	64–79% improvement across definitions	No separate control group
DeVore (2025)[19]	EFW < 10th percentile with concomitant AC growth velocity < 10th percentile (all had prior EFW > 10th percentile)	104	AC growth velocity > 10th percentile in 94% of fetuses; HC growth velocity from 71% to 81% of fetuses > 10th percentile; FL growth velocity from 46% to 83% of fetuses > 10th percentile	No separate control group; by design, AC growth velocity was >10th percentile in 0% of fetuses before rest (an inclusion criterion)

Only first author is given for each study. All four studies drew from the same cohort of 265 fetuses (or subsets thereof). *Expected spontaneous improvement rate in the Prospective Observational Trial to Optimise Paediatric Health in Intrauterine Growth Restriction (PORTO) study was 17%. In the PORTO study[27], fetal growth restriction (FGR) was defined as an estimated fetal weight (EFW) < 10th percentile. AC, abdominal circumference; FL, femur length; HC, head circumference; SGA, small-for-gestational age.

cardiac output preserved, a combination that implies enhanced uteroplacental perfusion. These findings extend the MRI-based observations of Couper *et al.*[20] and Jani *et al.*[21] by providing a scalable, clinically practical method for confirming the hemodynamic response to positional intervention, and by quantifying the magnitude of the effect across a broad gestational-age range. The convergence of MRI and non-invasive pressure-wave evidence supports a coherent mechanistic account: the left lateral position produces a favorable hemodynamic phenotype of reduced vascular resistance with preserved flow, which translates into measurably greater oxygen and nutrient delivery to the fetus.

Convergent evidence from sleep-position epidemiology

The physiological mechanism is further supported by a large body of epidemiological evidence that the maternal supine sleep position in late pregnancy is associated with reduced birth weight and an increased risk of late stillbirth. The individual participant data meta-analysis of Cronin *et al.*[22] demonstrated that sleep onset in the supine position is an independent risk factor for late stillbirth, with no significant interaction with fetal vulnerability indicators. A secondary analysis by Anderson *et al.*[23] showed that women at ≥ 28 weeks' gestation who usually adopted the supine position at sleep onset delivered infants with a significantly lower mean birth weight compared with those who adopted a non-supine position (3410 g *vs* 3554 g; $P < 0.05$). Additional case–control evidence from the studies of Heazell *et al.*[24] and Gordon *et al.*[25] supports the same directional effect. Taken together with the MRI physiology observations and the direct hemodynamic measurements, these findings converge on a coherent mechanism: supine positioning impairs uteroplacental perfusion, while left lateral positioning preserves and enhances it, and the magnitude of this effect is clinically relevant at the population level.

Consistency across multiple definitions of abnormal growth

The improvement rates across the four studies of prescribed left lateral maternal rest[16–19] presented in Table 1 were remarkably consistent (64–94%), regardless of whether abnormal growth was defined by a simple EFW threshold, Delphi consensus criteria incorporating Doppler findings[26], growth velocity deceleration or combined EFW and AC velocity criteria[16–19]. This consistency argues against the findings being an artifact of any single definitional framework. If measurement error or regression to the mean were the primary explanations, one would expect differential improvement rates depending on the stringency of the inclusion criteria; yet, the rates remained similar across all four studies.

Improvement in growth velocity

The fourth study in the series by DeVore *et al.* is particularly compelling because it demonstrated improvement in growth velocity (a rate of change) rather than merely percentile crossing at a single time point[19]. In this study, by design, the AC growth velocity was < 10th percentile in 100% of included fetuses at the time of diagnosis of an EFW < 10th percentile. Following 2 weeks of maternal rest in the left lateral position, 94% of fetuses demonstrated a growth velocity > 10th percentile. In addition, the head circumference growth velocity

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improved from 71% to 81% of fetuses > 10th percentile, and femur length growth velocity improved from 46% to 83% of fetuses > 10th percentile. Growth velocity is inherently less susceptible to regression to the mean than are single-point percentile measurements because it requires sustained improvement across two sequential time points. The magnitude of the AC velocity change is difficult to attribute to measurement error alone.

Magnitude of effect exceeds spontaneous improvement

The Prospective Observational Trial to Optimise Paediatric Health in Intrauterine Growth Restriction (PORTO) multicenter study of Cody *et al.*[27] established that approximately 17% of fetuses diagnosed with FGR spontaneously outgrow their diagnosis without intervention. The control groups in the series of DeVore *et al.* showed spontaneous improvement rates of 12–19%, consistent with the PORTO findings[16]. In contrast, the bed rest groups demonstrated improvement rates of 64–94%, representing a 4- to 5-fold increase over the expected rate of spontaneous improvement. An effect of this magnitude demands an explanation beyond statistical artifact.

Selection of a reversible phenotype

A critical and deliberate design element across all four studies of DeVore *et al.* is that all included fetuses had previously demonstrated an EFW > 10th percentile before declining below it[16]. This selection criterion enriches the study population for fetuses with reversible growth deceleration rather than fixed placental pathology, constitutionally normal growth potential that was temporarily compromised, and intact placental reserve capacity amenable to augmented perfusion. This is a clinically rational strategy for identifying the population most likely to benefit from an intervention that improves blood flow. Fetuses with severe early-onset FGR and fetuses with absent or reversed end-diastolic flow would not be expected to respond similarly, and we make no claim herein that maternal rest should replace or delay delivery in such cases.

Terminology matters: 'bed rest' is not a single intervention

Based largely on one Cochrane review[5] published around 30 years ago, comprising a single RCT of 107 women[4], which is therefore underpowered to demonstrate benefit and lacks methodological specifics, recent management guidelines have uniformly admonished against bed rest for the management of FGR. The approach applied in the four studies of DeVore *et al.*[16–19] was designed explicitly to improve fetal growth by augmenting uteroplacental perfusion through maternal left lateral positioning, and the observed positive results are supported by the independent data of Vasapollo *et al.*[15], the MRI physiology observations of Couper *et al.*[20] and Jani *et al.*[21], and direct non-invasive hemodynamic measurements across 300 pregnancies[10]. Given the mechanistic coherence and the consistency of effect across multiple definitions of abnormal growth, it seems unreasonable to summarily interdict the use of position-specific, time-limited outpatient rest in selected cases of FGR.

To many clinicians and patients, the term 'bed rest' connotes strict, continuous, inpatient bed confinement, an intervention which is indeed associated with thromboembolism, bone loss and psychological distress[2], and which differs substantially from the outpatient, intermittent, position-specific rest evaluated in these four studies[16–19]. To avoid this conflation, we recommend that the term 'bed rest' be accompanied by specifics regarding duration, setting (inpatient *vs* outpatient) and maternal position. The intervention supported by emerging data is specifically outpatient, time-limited left lateral recumbent rest during waking hours, not continuous inpatient confinement.

A call for rigorous prospective investigation

In light of the foregoing analysis, we contend that the current recommendation against maternal rest for FGR is not supported by high-quality evidence of ineffectiveness, but rather is assumed due to the absence of adequate evidence of either benefit or harm specific to this intervention. The distinction between absence of evidence and evidence of absence is not merely semantic; it has direct clinical implications for a condition that affects up to 10% of pregnancies[1,3] and for which few effective interventions exist.

The consistency of improvement across four studies employing analytically independent definitions of abnormal growth, the dramatic improvement in growth-velocity parameters, the magnitude of effect (4- to 5-fold above expected spontaneous improvement), the independent corroboration by the findings of Vasapollo *et al.*[15] and the convergent sleep-position epidemiology[22–25] all collectively support the hypothesis that left lateral maternal rest genuinely improves fetal growth in a subset of FGR fetuses. The physiological mechanism of improved uteroplacental blood flow, substantiated by MRI data[20,21] and direct non-invasive hemodynamic measurement[10], provides a biologically plausible explanation.

We therefore advocate a properly designed, multicenter RCT to determine definitively whether periods of left lateral maternal rest should be incorporated into the clinical management of select cases of FGR. Such a RCT should incorporate: (1) a true normal-activity control group rather than two intensities of activity restriction; (2) blinded sonographic assessment of fetal biometry; (3) objective compliance monitoring, supplemented by non-invasive brachial-cuff hemodynamic assessment[10] to quantify the physiological response to the intervention; (4) stratification by gestational age at diagnosis, severity of FGR and umbilical artery Doppler status as well as umbilical venous blood flow; (5) formal *a-priori* power calculations based on clinically meaningful differences in interval growth velocity; and (6) neonatal outcome

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data, including birth weight, gestational age at delivery, admission to neonatal intensive care unit and composite neonatal morbidity. Until such evidence is available, we believe that the blanket recommendation against maternal rest in cases of FGR warrants reconsideration. Our opinion is summarized in Videoclip S1.

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SUPPORTING INFORMATION ON THE INTERNET

The following supporting information may be found in the online version of this article:

Videoclip S1 Narrated summary of the authors' argument for reconsidering the recommendation against maternal rest in fetal growth restriction, outlining the methodological limitations of the Laurin and Persson randomized controlled trial[4], the physiological rationale for left lateral maternal rest, and the observational evidence of improved fetal growth across four studies[16–19].

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