PROLONGED PREGNANCY

This guideline and flowchart refers only to low risk uncomplicated pregnancies. Complicated cases should be individually managed in liaison with the team Consultant.

Woman presents with a prolonged pregnancy > 41 weeks with no plan for IOL.
1. Confirm Gestational age is correct
2. Provide leaflet on “Management of Prolonged Pregnancy” and discuss options

Any antenatal risk factors? e.g. ↑BP, APH, IUGR, PROM, ↓FM

Offer IOL

Was offer of IOL accepted?

Offer cervical assessment and membrane sweep

Was offer of cervical assessment & membranes sweep accepted?

Assess fetal well being twice weekly:
• USS
• CTG

Is:
• AFI >5,
• Fetus active and
• CTG reactive?

Following Resident Level 1 Registrar (or above) review, discharge home with:
• appointments for twice weekly fetal well being assessments
• appointments for weekly team clinic / FBC review.

Gain consent to perform:
• Bishops score
• Membranes sweep

Arrange IOL:
• at a mutually agreed time or
• ASAP if >41+3

Is planned IOL >41+3?

Discharge home with planned date for IOL

Inform Obstetric Registrar or higher
AIM

- Appropriate management of women with a pregnancy of more than 41 weeks gestation.

BACKGROUND INFORMATION

Prolonged pregnancy is defined as a pregnancy that has progressed beyond 42 weeks gestation\(^1\), although the terms prolonged pregnancy and post term pregnancy are interchanged depending on the author.\(^2\) Five to ten percent of all pregnancies are post term, although the rate is declining in Australia possibly due to different intervention strategies.\(^3\) Accurate assessment of gestational age is essential to prevent misdiagnosis of prolonged pregnancy. Male fetuses, genetic predisposition\(^4,5\), a history of a previous post term pregnancy, and obesity are all associated with increasing the risk for a prolonged pregnancy\(^5\).

Continuation of pregnancy beyond 41 weeks increases the risk of adverse outcomes for the woman and the fetus. When compared to birth at 40 weeks, perinatal mortality is 2-fold higher at 42 weeks and 5-7 fold higher at 43 and 44 weeks.\(^5\) Increased morbidity related to post term pregnancy includes risk of fetal distress, shoulder dystocia, labour dysfunction and obstetric trauma. Perinatal complications include meconium aspiration, asphyxia, fractured bones, peripheral nerve damage, pneumonia and sepsicaemia.\(^6\)

Current evidence does not support the use of acupuncture, homeopathy, herbal supplements, castor oil, hot baths, enemas or sexual intercourse to induce labour.\(^1\) Sweeping of the membranes can decrease the need for formal induction of labour by causing the release of endogenous prostaglandins, phospholipase A, oxytocin, and increasing the frequency of uterine contractions. The release of prostaglandins can last up to 6 hours.

KEY POINTS

1. A policy of offering labour induction at 41 to 42 completed weeks, compared to waiting for spontaneous labour indefinitely is associated with fewer perinatal deaths or risk for caesarean section, although the absolute risk is small.\(^7\)
2. The risk of stillbirth for women undelivered at 41 weeks gestation is about 0.1%,\(^8\) and the risk increases 2-fold by 42 weeks, and 5-7 fold by 43 to 44 weeks.\(^5\)
3. The estimated date of delivery (EDD) should be checked, as a common cause of considering a pregnancy to be prolonged is inaccurate dating.\(^5\)
4. Low risk antenatal women should be offered induction of labour (IOL) at 41 - 42 completed weeks, with information provided to them on the varying risks or perinatal death associated with different gestational time points, and for factors such as obesity or nulliparity.\(^7\)
5. At KEMH a women whose pregnancy continues past 41+3 weeks gestation should have fetal surveillance initiated which includes twice weekly ultrasound and CTG.
6. Membrane sweeping is associated with a reduction in need for formal induction particularly with multiparous women, increasing the rate of spontaneous labour, although it may increase the incidence of uncomplicated bleeding and pain for women.\(^1,9\)
7. At 41 weeks gestation all women should be provided with the KEMH information sheet 'Management of Prolonged Pregnancy'.

MANAGEMENT AT 41 WEEKS GESTATION

1. Confirm gestational age is correct:
   - A first trimester ultrasound EDD should be used in preference to the last menstrual period (LMP) if there is a difference of more than 5 days.\(^8,10\)
   - When there is a difference of more than 10 days between LMP and second trimester ultrasound EDD’s, the EDD should be adjusted to the second trimester ultrasound EDD.\(^10\)
When there is a first trimester and second trimester ultrasound available the ultrasound EDD should be determined by the first trimester scan.\textsuperscript{8,10} If the LMP was certain and regular, and \textbf{no ultrasounds} between 6 and 24 weeks of pregnancy, then use the LMP EDD. If \textbf{LMP uncertain or irregular}, and ultrasound performed between 6 – 24 weeks, then use ultrasound EDD.\textsuperscript{10}

2. Provide the woman with the KEMH leaflet ‘Management of Prolonged Pregnancy’. Document the leaflet has been given.

3. Initiate discussion regarding management options of prolonged pregnancy unless they have an induction booked before 41+3 weeks. The discussion should include:
   - Maternal and fetal risks (see point 4 below)
   - Options of management. Offer and book induction of labour (IOL) if the woman consents.
   - Fetal surveillance is recommended after 41+3 weeks gestation
   - The woman’s expectations and preferred options.

4. Assess whether any antenatal risk factors are present. If any of the following are present refer to the Obstetric Registrar or higher (Senior Registrar / Consultant) for review:
   - Increased blood pressure (↑BP)
   - History of antepartum haemorrhage
   - More than one attendance with reduced fetal movements (↓FM)
   - Intrauterine growth restriction (IUGR)
   - Significant medical conditions
   - Prelabour rupture of membranes (PROM).

5. If no risk factors, offer an IOL (with Bishops score +/- membrane sweep-unless contraindicated). If IOL is declined, offer cervical assessment and membrane sweep (unless contraindicated).
   - If a cervical examination is performed after 37 weeks gestation the woman may be offered ‘sweeping of the membranes’.\textsuperscript{1}
     - Offer nulliparous women membrane sweeping at around 40 and 41 weeks gestation.\textsuperscript{1}
     - Offer multiparous women membranes sweeping at around 41 weeks gestation.\textsuperscript{1}

6. Booking IOL:
   - If the woman is <41+3 weeks, then book IOL for mutually agreed time (if <41+3 weeks) and the woman can be discharged.
   - If the woman is >41+3 weeks, then arrange IOL for as soon as possible.

7. \textbf{Assess fetal wellbeing}: At KEMH the most acceptable means of fetal surveillance and recommended course of action for women should pregnancy continue beyond 41+3 weeks is:
   - Twice weekly CTG monitoring and
   - Twice weekly ultrasound examinations to measure amniotic fluid index (AFI).

8. Arrange Registrar (or higher) review of the CTG and ultrasound. If AFI >5, fetus active and CTG reactive then the woman can be discharged after review with appointments for twice weekly fetal wellbeing assessments, and weekly team clinic/FBC review.

\textbf{INTRAPARTUM}

During labour, continuous electronic fetal heart monitoring should be performed on all women with prolonged pregnancy after 42 weeks gestation.\textsuperscript{11} In the absence of other risk factors continuous fetal monitoring is not required prior to 42 weeks gestation unless labour is induced or unless multiple risk factors are present.\textsuperscript{11} See \textit{Clinical Guidelines, Labour and Birth Suite Quick Reference Guide for Intrapartum Fetal Surveillance}.
REFERENCES (STANDARDS)


National Standards – 1 Clinical Care is Guided by Current Best Practice
Legislation - Nil
Related Policies - Nil
Other related documents –

RESPONSIBILITY
Policy Sponsor Nursing & Midwifery Director OGCCU
Initial Endorsement April 2002
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