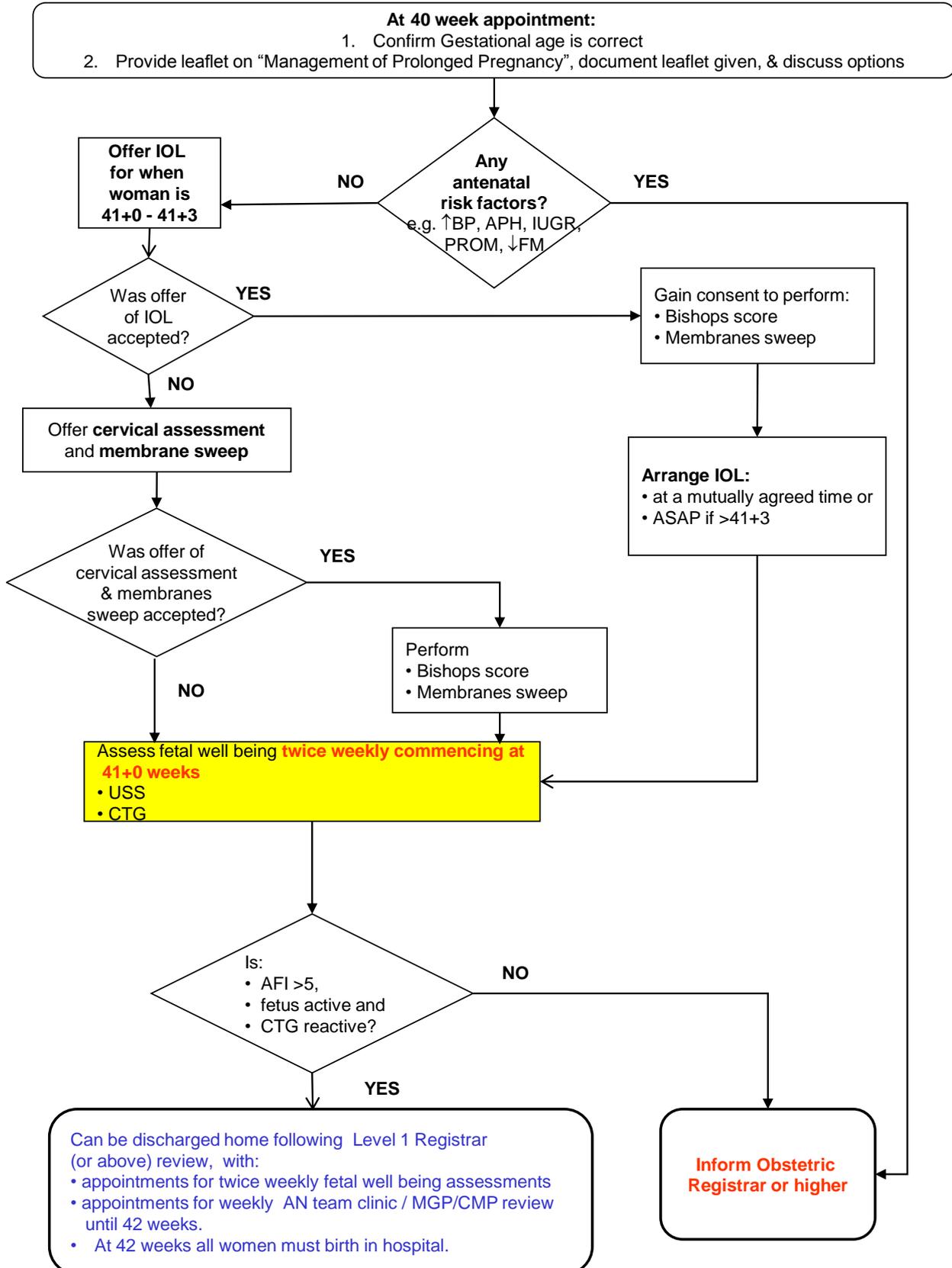




CLINICAL PRACTICE GUIDELINE

Pregnancy Beyond 41 weeks: management of

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## 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<sup>1</sup>, although the terms prolonged pregnancy and post term pregnancy are interchanged depending on the author.<sup>2</sup> 5-10% of all pregnancies are post term, although the rate is declining in Australia possibly due to different intervention strategies.<sup>3</sup> Accurate assessment of gestational age is essential to prevent misdiagnosis of prolonged pregnancy. Male fetuses, genetic predisposition<sup>4,5</sup>, a history of a previous post term pregnancy, and obesity are all associated with increasing the risk for a prolonged pregnancy<sup>5</sup>

The perinatal mortality rate at 40 weeks gestation approximately doubles by 42+0 weeks (2-3 deaths versus 4-7 deaths per 1000 births) and increases by 6 fold and higher at 43 weeks and beyond.<sup>13</sup>

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 septicaemia.<sup>6</sup>

Current evidence does not support the use of acupuncture, homeopathy, herbal supplements, castor oil, hot baths, enemas or sexual intercourse to induce labour.<sup>1</sup> 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. The estimated date of delivery (EDD) should be checked, as a common cause of considering a pregnancy to be prolonged is inaccurate dating.<sup>5</sup>
2. Low risk women should be offered IOL after 41+0 weeks gestation and depending on availability of places have their IOL booked to occur by 41+3 weeks gestation.
3. At 40 weeks gestation all women should be provided with the KEMH information sheet 'Management of Prolonged Pregnancy'. Document that the leaflet has been given. Discuss prolonged pregnancy, induction of labour and fetal monitoring required for pregnancies more than 41 weeks gestation.
4. Regular fetal surveillance should be offered to low risk women who chose expectant management after 41 weeks. While the literature suggests cardiotocography and Doppler have no significant benefit in predicting outcomes for pregnancies beyond 41+0 weeks, international guidelines recommend increased antenatal surveillance from 41+0 weeks. Consensus and expert opinion recommends twice weekly assessment of fetal welfare from 41+0 weeks gestation including as a minimum
  - ✓ The estimation of amniotic fluid volume to provide information regarding the placental function over the preceding week and

- ✓ The evaluation of the antenatal fetal heart rate pattern to provide information on the fetal condition at the point of time of testing.
- 5. 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.<sup>1,9</sup>
- 6. MGP and CMP women who labour spontaneously between 41 and 42 weeks gestation and have consented to ongoing fetal surveillance may continue to receive clinical care through these models including birthing in the Family Birth Centre or at home.
- 7. Women receiving care from the FBC/MGP or CMP must birth in hospital from 42 weeks gestation

## Management

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.<sup>8,10</sup>
  - 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.<sup>10</sup>
  - When there is a first trimester and second trimester ultrasound available the ultrasound EDD should be determined by the first trimester scan.<sup>8,10</sup>
  - If the LMP was certain and regular, and **no ultrasounds** between 6 and 24 weeks of pregnancy, then use the LMP EDD. If **LMP uncertain or irregular**, and ultrasound performed between 6 – 24 weeks, then use ultrasound EDD.<sup>10</sup>
2. At 40 weeks gestation initiate discussion regarding management options of pregnancy at 41 weeks gestation. The discussion should include:
  - Maternal and fetal risks (*see point 4 below*)
  - Options of management. Offer and book induction of labour (IOL) and document this.
  - Fetal surveillance is recommended after 41+0 weeks gestation
  - The woman's expectations and preferred options.
3. Assess whether any antenatal risk factors are present. If any of the following are present refer to the Obstetric Registrar or higher 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
  - Pre-labour rupture of membranes (PROM).
  - Maternal age  $\geq 40$  years and a first pregnancy
4. If no risk factors, offer an IOL (with Bishops score +/- membrane sweep-unless contraindicated).
  5. Booking IOL: it is recommended that IOL is not booked at a gestation  $> 41 + 3$  weeks
    - a. If the woman is  $<41+3$  weeks, then book IOL for mutually agreed time.
    - b. If the woman is  $>41+3$  weeks, then arrange IOL for as soon as possible.
  6. If IOL is declined, offer cervical assessment and membrane sweep (unless contraindicated).
  7. From 41 weeks gestation fetal wellbeing is to be assessed by:
    - a. Twice weekly CTG monitoring and
    - b. Twice weekly ultrasound examinations to measure amniotic fluid index (AFI).
    - c. The CTG and USS must be reviewed by a Registrar or above
  8. Arrange a follow up appointment at 42 weeks gestation with the clinic / MGP or CMP.
  9. At 42 weeks gestation all women must be referred to a specialist for ongoing care and birth management.

## Fetal Monitoring during Labour and Birth

In the absence of other risk factors continuous fetal monitoring is not required prior to 42 weeks gestation unless labour is induced or other risk factors are present.<sup>11</sup> See [Clinical Guidelines Quick Reference Guide for Intrapartum Fetal Surveillance](#)

During labour, continuous electronic fetal heart monitoring should be performed on all women with prolonged pregnancy after 42 weeks gestation.<sup>11</sup> .

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## Related WNHS policies, procedures and guidelines

Fetal Monitoring

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