The Royal HOSPITAL FOR WOMEN

CLINICAL BUSINESS RULE

CLINICAL POLICIES, PROCEDURES & GUIDELINES

Approved by Quality and Safety Committee
September 2022

POSTDATES – MANAGEMENT OF PREGNANCY BEYOND 41 WEEKS GESTATION

This CBR is developed to guide clinical practice at the Royal Hospital for Women. Individual patient circumstances may mean that practice diverges from this CBR.

1. AIM
- Appropriate management of a pregnant woman beyond 41 weeks gestation

2. PATIENT
- Woman under the age of 40 with an uncomplicated singleton pregnancy exceeding 41 weeks

3. STAFF
- Midwives and medical staff
- Student midwives

4. EQUIPMENT
- Cardiotocograph (CTG) Machine
- Doppler

5. CLINICAL PRACTICE
- Discuss and reconfirm estimated due date as per RHW Estimating Due Date Clinical Business Rule (CBR)
- Discuss option with woman of cervical membrane sweep to encourage spontaneous labour
- Inform woman that membrane sweeping is usually offered at 40-41 weeks gestation, however, can be offered/attempted once to twice weekly from 38 weeks gestation (Royal Hospital for Women (RHW) Sweeping Membranes to Encourage Spontaneous Labour CBR)
- Discuss induction of labour process and possible date with woman at antenatal visit closest to 40 weeks gestation
- Review individual risk factors and explain rationale for recommending induction of labour from 41 weeks gestation, emphasising that the overall background risk of stillbirth is low (see educational notes for stillbirth risk factors as per safer baby bundle[12])
- Give woman the information brochure '41-42 weeks Information about your birth options' and 'Induction of Labour' (available from P drive patient information folder)
- Recommend induction of labour (IOL) for a woman with no risk factors from 40+8 weeks gestation and no later than 42+0 weeks gestation
- Perform vaginal examination with consent to determine Bishop's Score. Membrane sweep can be performed at the same time with the woman's consent
- Book IOL by calling birth unit and giving required details
- Call antenatal ward to book bed for previous day if cervical preparation is required
- Recommend twice weekly CTG from 40+7 weeks gestation
- Recommend Amniotic Fluid Index (AFI) from 40+7 weeks gestation Arrange in office hours). This may be performed by an appropriate clinician as a bedside USS. If deepest pocket < 2cm or AFI less than 8cm recommend formal USS
- Discuss with the woman the limitations of CTG and AFI surveillance
- Recommend IOL if oligohydramnios (AFI ≤5cms or deepest pocket ≤2cm on formal ultrasound scan) or evidence of fetal compromise
- Discuss with the woman the importance of her ongoing awareness of fetal movement patterns and that she should call the hospital if there is a change in the fetal movements

Expectant Management ≥ 42 Weeks Gestation
- Arrange obstetric consultation (prior to 41+6 weeks gestation) to plan ongoing management for the woman who has declined IOL and chooses to await spontaneous labour after 42+0 weeks gestation

- Arrange ongoing fetal surveillance after 42 weeks gestation as follows:
  - twice weekly ultrasound scan, and
  - three times a week CTG
- Advise woman that birth is recommended to occur in the birthing unit, not the low-risk birth rooms
- Recommend continuous electronic fetal monitoring if gestational age ≥42 weeks at time of birth

6. DOCUMENTATION

- Antenatal card
- Medical record

7. EDUCATIONAL NOTES

- Timing of membrane sweeps is controversial in low-risk women. A randomized controlled trial recommends sweeping of membranes from 41 weeks every 48 hours until labour occurs. In this study, serial sweeping of membranes from 41 weeks decreased most pregnancies reaching 42 weeks [5]
- Women should be recommended induction of labour from 40+8 weeks gestation, as the present evidence reports a decrease in perinatal mortality without increased risk of caesarean section[1]
- A Cochrane review of 22 trials included 9,383 women[2] showed that compared with a policy of expectant management, a policy of labour induction showed:
  - Fewer (all-cause) perinatal deaths (Relative Risk (RR)=0.31, 95% CI 0.12 to 0.88; 17 trials, 7,407 women)
  - One perinatal death in the labour induction policy group compared with 13 perinatal deaths in the expectant management group.
  - The number needed to treat to benefit (NNTB) with induction of labour to prevent one perinatal death was 410 (95% CI 322 to 1492).
  - Fewer babies with meconium aspiration syndrome (RR 0.50, 95% CI 0.34 to 0.73; 8 trials, 2,371 infants)
  - Fewer caesarean sections (RR 0.89, 95% CI 0.81 to 0.97; 21 trials of 8,749 women)
- A Cochrane review of 22 trials[4] (2,797 women) assessing membrane sweeping to induce labour, of which 20 compared sweeping of membranes with no treatment, showed that sweeping of the membranes, performed as a general policy in women from 38 weeks, was associated with reduced duration of pregnancy and reduced frequency of pregnancy continuing beyond 41 weeks (relative risk RR 0.59, 95% confidence interval (CI) 0.46 to 0.74) and 42 weeks (RR 0.28, 95% CI 0.15 to 0.50). To avoid one formal induction of labour, sweeping of membranes must be performed in eight women (number needed to treat (NNT) = 8)[4]
- The SWEPIS[13] study found that IOL at 41 weeks in low-risk pregnancies was associated with decreased risk perinatal mortality when compared to expectant management and IOL at 42 weeks. However, it showed no significant difference in other neonatal outcomes or caesarean delivery with either group
- NICE Guidelines[6] recommends that:
  - induction should be offered any time from 41 weeks
  - membrane sweeping reduces the need for 'post-dates' induction
- In summary recommendation from the above evidence:
  - after 41 completed weeks of gestation, if the dates are certain, women should be offered elective delivery
  - if the cervix is unfavourable, preparation should be undertaken
  - if expectant management is chosen, assessment of fetal wellbeing should be initiated
- The Ministry of Health guideline on *Management of pregnancy Beyond 41 weeks Gestation* states that, whilst 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 cited in these guidelines recommended twice weekly assessment of fetal welfare from 41+0 weeks gestation including as a minimum:
  - The estimation of amniotic fluid volume to provide valuable 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
- The Safer Baby Bundle identifies the following risk factors for stillbirth [12]:
  - Previous stillbirth
  - Known or suspected small for gestational age (SGA) i.e. <10th centile
  - Antepartum haemorrhage
  - Hypertension/preeclampsia
  - Pre-existing diabetes or hypertension
  - Maternal body mass index (BMI) >30
  - Maternal age >35 years
  - Nulliparity

- Pregnancy achieved with assisted reproductive technology
- Post-term pregnancy (> 41 weeks)
- Rhesus isoimmunisation
- Aboriginal or Torres Strait Islander, African, and South Asian ethnicities
- Smoking, illicit drug use
- No antenatal care

8. RELATED POLICIES / PROCEDURES / CLINICAL PRACTICE LOP/BUSINESS RULES

- Induction of labour for women with a post-dates low risk pregnancy
- Fetal Movements - Identification and Management of Reduced Patterns
- Fetal Heart Rate Monitoring – Maternity – MoH GL2018/025
- Obesity and weight gain in Pregnancy, labour and postpartum
- Fetal Growth Assessment (Clinical) in Pregnancy
- Estimating due date (EDD)
- Sweeping Membranes to Encourage Spontaneous labour
- Prostaglandin Administration for cervical preparation
- Cervical Catheterisation for Mechanical Cervical Preparation
- Advanced Maternal Age (AMA) and Outcomes
- Maternity Management of pregnancy beyond 41 weeks Gestation MoH GL2014_015
- Care Pathway for Women Concerned About Fetal Movements MoH GL2021_019
- Australian Commission on Safety and Quality in Health Care - Clinical Care Standard – Stillbirth prevention and bereavement care (currently under consultation)

9. RISK RATING

- Low

10. NATIONAL STANDARDS

- Standard 2 – Partnering with Consumers
- Standard 5 – Comprehensive Care
- Standard 6 – Communication for Safety
- Standard 8 – Recognising and Responding to Acute Deterioration

11. REFERENCES

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randomised, superiority trial. BMJ. 2019 Nov 20;367: l6131. doi: 10.1136/bmj. l6131. PMID: 31748223; PMCID: PMC6939660.

REVISION & APPROVAL HISTORY

Maternity Services CBR committee endorsed 22/8/2022
Replaced – *Induction of Labour for Women with a Post-dates Low Risk Pregnancy*
Approved Quality & Patient Safety Committee 20/6/13
Endorsed Maternity Services LOPs group June 2013
Reviewed April 2013
Approved RHW Quality Council 16/5/05
Endorsed Maternity Services Clinical Committee 19/4/05 (addition to point 2 following RCA Oct 2009)
Replaced – *Postdates management of women with a low-risk pregnancy*
Approved Quality Council 17/5/04

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