Late Term and Post-term Pregnancy

Since 2013, The American College of Obstetricians and Gynecologists (ACOG) and the Society for Maternal-Fetal Medicine (SMFM) have been discouraging use of the general label "term pregnancy" and replacing it with a series of more specific labels: "early term," "full term," "late term," and "post-term."

The following represent the four new definitions of 'term' deliveries:

- Early Term: Between 37 weeks 0 days and 38 weeks 6 days
- Full Term: Between 39 weeks 0 days and 40 weeks 6 days
- Late Term: Between 41 weeks 0 days and 41 weeks 6 days
- Post-term: Between 42 weeks 0 days and beyond

Babies born between 39 weeks 0 days and 40 weeks 6 days gestation have the best health outcomes, compared with babies born before or after this period. This distinct time period is now referred to as "Full Term."

Why is My Pregnancy Going "Late Term" or "Post-term"?
In many situations, we just don't know. It is possible that our calculation of your dates are off. Women who are having their first pregnancy are much more likely to go overdue, as well as women who have gone overdue with previous babies. There may also be a genetic component: women who themselves went overdue as babies are more likely to carry their own babies longer. Many healthy women will carry a healthy baby past her due date and have an uncomplicated birth and postpartum. Every baby grows at a slightly different rate and becomes ready to be born at a different time. Only 2% of babies are born on their due date.

What are the risks of going "late term" or "Post-term"?
Incidence of stillbirth goes up a little every week after 37 weeks, but makes a bigger jump after 42 weeks. The risk of stillbirth at 42 weeks is 4 to 7 deaths per 1000 deliveries. By comparison, the risk of stillbirth or infant death in pregnancies between 37 and 42 weeks is 2 to 3 per 1000 deliveries. Other risks include, but are not limited to, aspiration of meconium (baby's own fecal matter), postmaturity syndrome, shoulder dystocia, and large body size. Risks to the mother include longer labor, increased risk of pelvic floor damage, and Cesarean birth, with all the risks inherent in Cesarean section, such as bleeding, infection, and damage to surrounding organs.

What are the risks of being induced?
There a few definitions around what "induction," might look like, but for the purposes of this informed choice document, we'll focus on hospital induction. If you are induced, you will likely have your cervix checked by your hospital care provider to assess for cervical ripening. How ripe your cervix is will depend on what the next step is – likely a medicinal or mechanical method to open your cervix, combined with a Pitocin drip to help your uterus contract. If you are induced, you may have a higher risk of Cesarean birth. You may be more likely to choose an epidural for pain management.

Are there natural induction methods?
Yes. But we respect these as having possible risks just as we respect hospital induction as having risks. Also, there is little data on whether they will work or not. Please let your midwife know if you plan or hope to do any natural induction techniques, as she can go over the risks with you and help you to apply these techniques in the safest way possible. Some options are: breast pump, sweeping the membranes, massage, acupuncture, the use of herbs or castor oil. Some of these techniques are more aggressive than others, which is why your midwife would like to have a discussion with you around them.

What is the treatment for late term and post-term pregnancy?
If you choose “expectant management” (the wait-and-see approach), you’ll continue to see your midwife on a weekly basis, and continue to nourish yourself with healthy, unprocessed foods and lots of water. Exercise gently, as long as your midwife feels this is safe. Get lots of rest. Your midwife will have recommended acupuncture for cervical ripening starting at 36 weeks, and you should continue this routine based on your acupuncturist’s recommendations. Your midwife is required to recommend to you two tests taken 72 hours apart, starting at 7-10 days overdue, to evaluate your baby’s wellbeing.

Auscultated Acceleration Test (AAT)
A 6 minute long test using a hand held doppler while your baby’s heart rate is counted in 5-second intervals and charted on a graph. Similar to the Non-Stress Test performed in the hospital, this test is looking for accelerations of the fetal heart rate with movement and/or stimulation and can be performed with your midwives in the clinic. If the AAT result is not optimal, your midwives will refer you for further fetal testing.

***Non-Stress Test* (NST)**
A 20-40 minute long test that involves placing monitors on your belly to evaluate your uterine activity, the baby’s heart rate, and your baby’s movement (you’ll also be given a buzzer to tell the machine when your baby has moved).

Biophysical Profile and Amniotic Fluid Index (BPP and AFI)
A biophysical profile looks at your baby on an ultrasound machine. They are measuring heart rate, muscle tone, movement, and breathing, as well as your level of amniotic fluid.

Is there anything else I should know?
At 42 weeks, your midwife will begin induction techniques of your choice or you may choose to transfer to the hospital for an induction. Your midwife is operating within Oregon law if she attends your birth at home up to 42 weeks and 6 days, however, the community standard among midwives in Oregon is to strongly recommend or require transfer of care for a hospital birth due to the increased risks. Glow Midwifery’s standard of care for post-term pregnancy is to transfer at 42 weeks unless onset of labor has begun either naturally, or by using natural induction methods.

I choose the following options for my late term or post-term pregnancy (please place initials next to your chosen statements):

_____ I choose to continue to wait for labor to begin spontaneously while monitoring my baby's wellbeing. I will plan with my midwife an NST, AAT and a BPP/AFI at the appropriate time. I understand that these tests are recommended every 72 hours or more for reassurance that my baby is healthy. I understand that the NST, AAT and BPP/AFI will not find all problems with a baby and cannot predict with 100% certainty that a baby will handle labor well, but are currently the best tools we have to predict a baby's well-being.

_____ I choose to continue to wait for labor to being spontaneously. I refuse the recommended NST, AAT and BPP/AFI recommended by the state of Oregon and my midwife. I understand that this may mean we have less information around my baby's wellbeing.

Additionally, please choose one of the following options:

_____ I choose to attempt a natural induction using techniques suggested by my midwives if onset of labor hasn't begun spontaneously by 42 weeks. I understand that if this attempt is unsuccessful, transfer to the hospital will be necessary for a medical induction.

_____ I would like to have my care transferred to the hospital for a medical induction if labor has not begun spontaneously by 42 weeks. My midwives may recommend a transfer sooner if any post-term testing is not optimal or if there are other concerns regarding fetal wellbeing.

Client's Name (please print):____

Client's Signature: ____ Date: __________________