HUTT maternity
Hutt Valley Maternity Care

HUTT VALLEY DHB

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Prolonged Pregnancy in Low Risk Women Policy

Hutt Maternity Policies provide guidance for the midwives and medical staff working in Hutt Maternity Services. Please discuss policies relevant to your care with your Lead Maternity Carer.

Purpose

- To identify the pregnancies that are prolonged, monitor the mother and baby appropriately while waiting for onset of labour or planning for induction of labour (IOL)
- To identify pregnancies that are showing signs of placental insufficiency and expedite delivery
- To reduce the number of unnecessary inductions of labour
- To reduce unnecessary interventions in healthy women and their pregnancies

Scope

- All obstetric staff employed by the Hutt Valley DHB
- All midwifery staff employed by the Hutt Valley DHB
- All Hutt Valley DHB maternity access agreement holders.

Definition

Prolonged pregnancy has been defined as 294 days and beyond (42+ weeks) (Bakketeig & Bergsjo (WHO), 1989; Roach & Rogers, 1997; Duff & Sinclair, 2000). 5 - 10% of pregnancies continue to at least 42 weeks gestation (Briscoe, Ngugen, Mencer, Gautam & Kalb, 2005). Simpson & Stanley (2011).

AFI - Amniotic Fluid Index
BP - Blood Pressure
CTG - Cardiotocograph
D/S - Delivery Suite
IOL - Induction of Labour
LMC - Lead Maternity Carer
LMP - Last menstrual period
MAU- Maternity Assessment Unit

Prerequisite

The management of a prolonged pregnancy proposed in this guideline is dependent on the continued health of the mother and baby.
Sure menstrual dates or an early dating scan (a scan that occurred within the first trimester) ensures certainty around prolonged pregnancy assessments and planning. If dates are uncertain then individualised management will be necessary (Briscoe et al, 2005; RCOG, 2001; Cochrane, 2006).

According to the referral guidelines (2012) code 4020 (Consultation): Midwives will refer in a timely manner for planned IOL by 42/40.

Induction of labour in a healthy woman and pregnancy should be scheduled in relation to the findings of the prolonged pregnancy assessment. If the pregnancy remains low risk then a recommendation should be made to consider induction after 41 weeks
For pregnancies that exceed 42 weeks gestation, increased fetal surveillance should be instituted.

Clinical Guideline
Information should be given to the woman regarding the management options of a prolonged pregnancy:
1) Expectant management – awaiting the spontaneous onset of labour
2) IOL - It should be clearly communicated that a pregnancy is not considered prolonged until the completion of 42 weeks of pregnancy (294 days) (Chua and Arulkumaran, 2000; Menticoglou & Hall, 2002; Bakketeig & Bergsjo (WHO), 1989; Roach & Rogers, 1997; Duff & Sinclair, 2000).

There should be some discussion about the risks associated with a prolonged pregnancy:
The risk of still birth at:
37 weeks gestation - 1:3000
42 weeks gestation - 3:3000
43 weeks gestation - 6:3000
(RCOG, 2001)

Expectant Management
- Maternal monitoring of fetal movements should be encouraged and any decreased or change in fetal movement noted and reported to the LMC (Gribben & James, 2005).
- Initial assessment by the LMC in the MAU or D/S at EDD plus 7 (or as practical) including CTG; BP; urinalysis, ultrasound scan including AFI / Biophysical profile (Briscoe et al, 2005) followed by review of findings and ultrasound with obstetrician on-call.
- Once the pregnancy exceeds 42 weeks gestation then daily CTG and weekly ultrasound scan including AFI or biophysical profile (BPP) (RCOG, 2001, evidence of benefit to support one form of monitoring over another is lacking but based on consensus /expert opinion, Briscoe et al, 2005).
- A modified BPP is considered normal if: reassuring CTG and an AFI of greater than 5. A BPP score of 8-10 is considered normal; 6 is borderline and 4 or less is abnormal (Briscoe et al, 2005).
- The option of IOL should be revisited at 42 (+0) weeks (Briscoe et al., 2005).

IOL at 41- 42 weeks
- Maternal monitoring of fetal movements should be encouraged and any decrease or change in fetal movement noted and reported to the LMC (Gribben & James, 2005).
- Initial assessment by LMC in the MAU or D/S at EDD plus 7 (or as practical) including CTG; BP; urinalysis, ultrasound scan including AFI / Biophysical profile

(Briscoe et al, 2005) followed by review of findings and ultrasound with obstetrician on-call.
- IOL organised with the consultant and Charge Midwife.
- Twice-weekly CTG monitoring from 41 weeks until IOL at 42 weeks.

Management plan for prolonged pregnancy

LMC:
- Discuss with the woman the choices and management options available when a pregnancy is prolonged.
- Discuss the process of the prolonged pregnancy assessment and the investigations that will be carried out.
- Gain informed consent from the woman for a prolonged pregnancy assessment and organise this with the consultant on call. Assess and carry out CTG and arrange ultrasound. This initial assessment would be expected to take place at 41+ weeks either on the MAU or D/S. Ensure all assessment findings are in the woman's notes along with CTG and ultrasound scan.
- Following the prolonged pregnancy assessment discuss a plan with the woman and obstetrician on call for expectant management or intervention by IOL at 42 weeks.
- Offer the woman a membrane sweep prior to formal induction of labour. This has been shown to reduce the numbers of women having to undergo formal IOL (Nice Guidelines).
- Offer pre-birth acupuncture. Pre-birth acupuncture from 37-38 weeks has also shown to reduce the need for medical induction (Betts & Lennox, 2006). Bookings for acupuncture clinic can be made through maternity reception on 8164.

37-38 weeks	Begin weekly pre-birth acupuncture for women to support physiological preparation for labour if requested. You will need to book ahead if you are planning to use the acupuncture clinic.
40-41weeks	Discussion with woman regarding proposed management plan for prolonged pregnancy. LMC to book a time in at either the MAU or D/S for CTG and discuss / arrange for a biophysical profile scan for 41 + weeks
41+ weeks	LMC to undertake CTG Consider membrane sweep Review of CTG, ultrasound scan by obstetrician on call and plan for expectant management or IOL if there are no concerns.
42 weeks	Induction of labour if the woman has not gone into spontaneous labour If the woman chooses not to be induced, then daily CTG and weekly scan until spontaneous labour occurs

Associated Policies

Acupuncture Policy
Induction of Labour Policy

References

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Informed Consent

The right of a consumer to make an informed choice and give informed consent, including the right to refuse medical treatment, is enshrined in law and in the Code of Health and Disability Consumers' Rights in New Zealand. This means that a woman can choose to decline treatment, referral to another practitioner, or transfer of clinical responsibility. If this occurs follow the process map on page 18 of the Referral Guidelines (Ministry of Health, 2012).