Managing Post-Term Pregnancy

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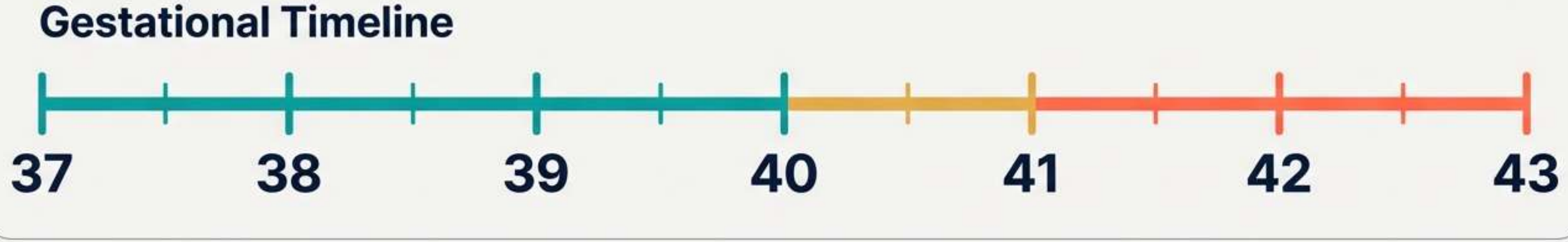


Post-term pregnancy officially begins at ≥ 42 weeks of gestation.

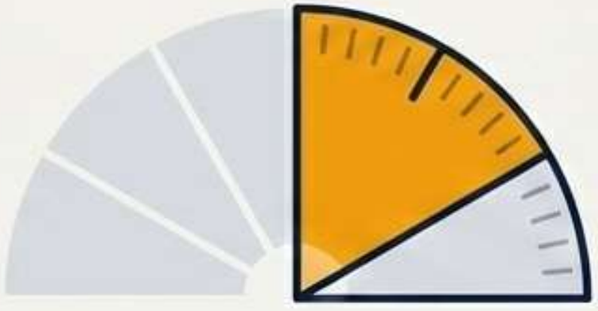
10%

Prevalence: Affects approximately 10% of all pregnancies.

Etiology: The exact aetiology of post-term pregnancy remains largely unknown.

Accurate dating is the absolute foundation of diagnosis and management.

The Clinical Reality



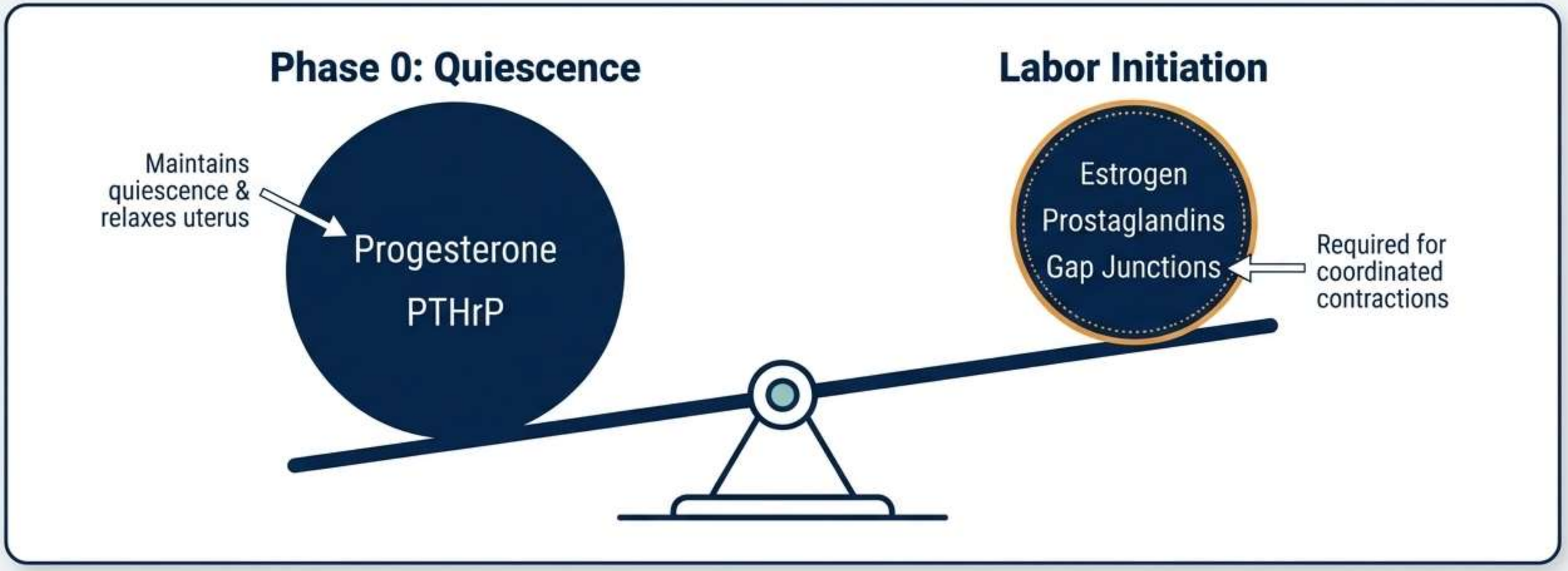
20-30% of all pregnancies present with uncertain dates, severely complicating the diagnosis of post-term pregnancy.

The Gold Standard

Diagnosis requires an early, first-trimester ultrasound estimation of **Crown-Rump Length (CRL).**

TAKEAWAY: Relying solely on the Last Menstrual Period (LMP) is insufficient for high-stakes late-term decision-making.

Prolonged gestation occurs when the uterus fails to exit Phase 0 quiescence.

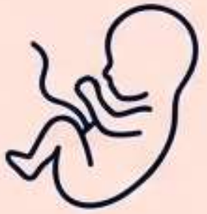


Synthesis: Until the hormonal balance tips to allow gap junction formation, coordinated uterine contractions cannot occur.

The clinical risks of post-term pregnancy affect both mother and fetus.

Maternal Risks

- Prolonged labor
- Increased risk of caesarean section
- Mechanical delivery problems



Fetal Risks

- Postmaturity syndrome
- Intrauterine hypoxia
- Meconium aspiration
- Fetal macrosomia
- Increased risk of stillbirth and perinatal death

Intensive fetal surveillance is required when extending into the post-term window.

Cardiotocography (CTG) / NST

Twice-weekly Non-Stress Test (NST). Must be performed at and after 42 weeks.

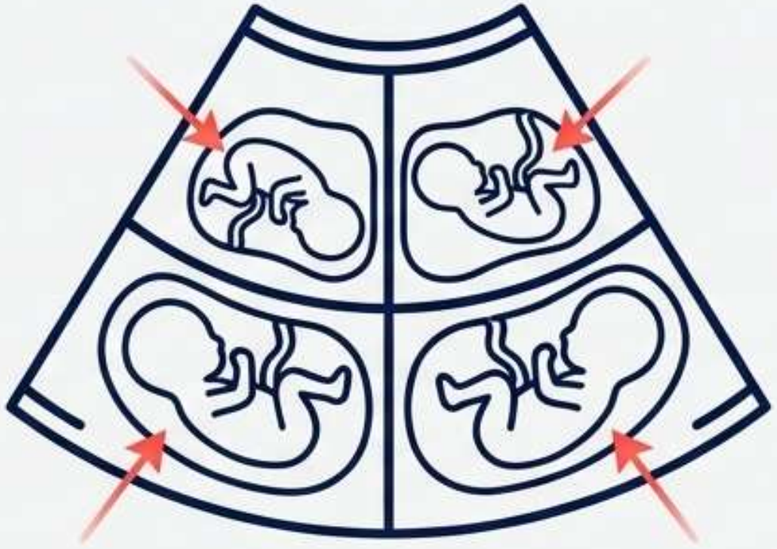
Amniotic Fluid Index (AFI)

Sum of vertical dimensions in four quadrants to detect oligohydramnios.

Fetal Movement

Patient-led fetal kick counts to self-monitor well-being.

Oligohydramnios is a definitive indicator for for immediate delivery.



AFI < 5

If there is any indication of oligohydramnios (AFI < 5), or if spontaneous fetal heart rate decelerations are found, delivery is indicated immediately.

Routine induction of labor is initiated between 41 and 42 weeks' gestation.

Step 1: 41 Weeks Reached

Firm gestational age confirmed.

Step 2: Cervical Assessment

Assess if the cervix is favorable.

Step 3: Action

Delivery should be initiated by the appropriate route regardless of other factors, due to increasing potential for perinatal morbidity and mortality.

Five clinical “Red Flags” that mandate immediate delivery post-dates.

	**Reduced Fluid:** Ultrasound confirms reduced amniotic fluid (AFI < 5).
	**Reduced Growth:** Fetal growth trajectories stall.
	**Reduced Movement:** Significant decrease in fetal movements.
	**Imperfect CTG:** Non-reassuring cardiotocography tracing.
	**Maternal Condition:** Mother is hypertensive or suffers from a significant medical condition.

Counseling the hesitant patient: Navigating the reality of post-term risks.

The Reality of Waiting

No test can guarantee 100% safety of the baby.

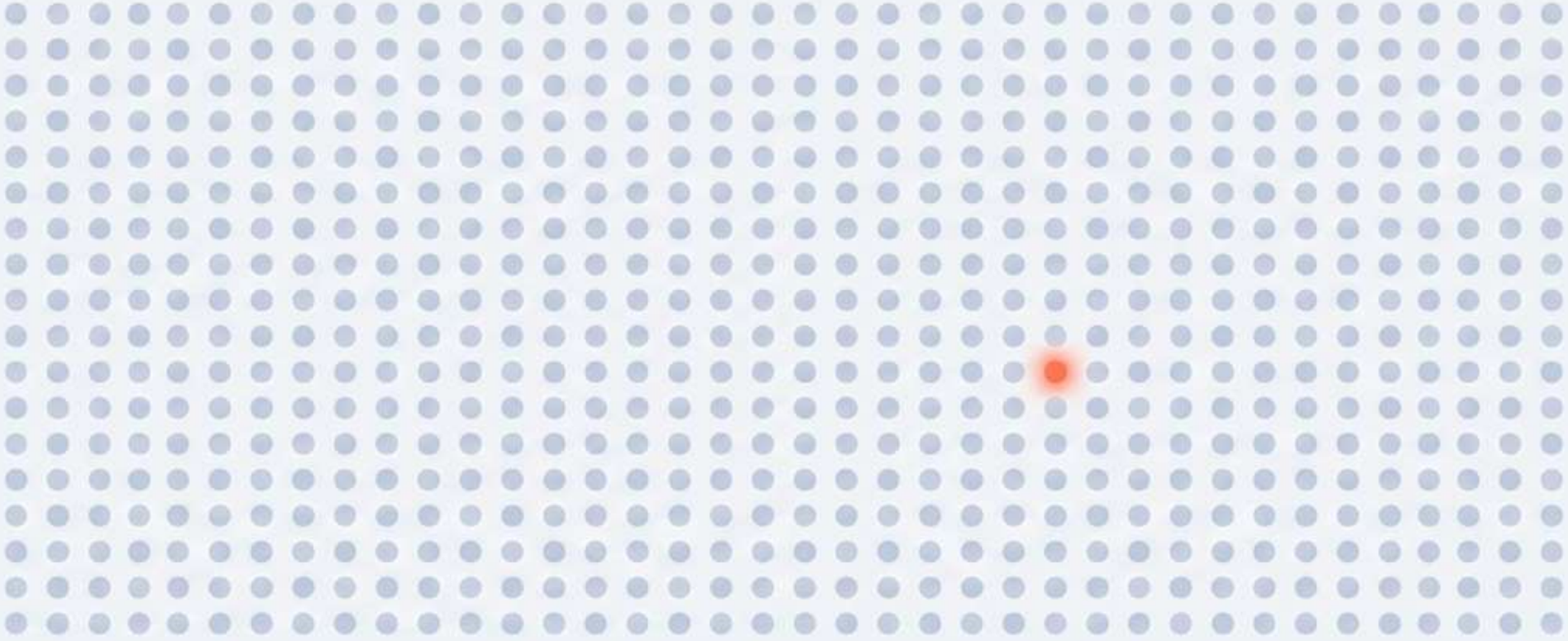
Perinatal mortality is increased at least twofold beyond 42 weeks.

The C-Section Myth

Induction between 41-42 weeks does NOT increase the rate of caesarean section compared to expectant management.

Waiting may actually increase C-section likelihood due to fetal compromise or the post-term uterus's reluctance to contract properly.

The statistical rationale: 300 to 400 inductions prevent one perinatal death



High-quality evidence shows that routine IOL at 41-42 weeks operates on a population-protection scale. We induce 300-400 pregnancies to reliably save one life that would have otherwise been lost to expectant management.

The Post-Term Management Pathway

Establish exact dates (1st Trimester CRL)

<41 Weeks

Await spontaneous labor; begin fetal kick counts

41–42 Weeks

Routine recommendation for Induction of Labor (IOL)

Refusal of IOL / Expectant Management

Initiate intensive bi-weekly NST and AFI monitoring

Override Protocol (Any Gestational Age ≥ 41): If AFI < 5, non-reassuring CTG, or maternal hypertension

IMMEDIATE DELIVERY