POSTTERM PREGNANCY
DEFINITIONS

- infant with recognizable clinical feature indicating pathologically prolong pregnancy

- Post term or prolong pregnancy: >42 weeks (294 days) from LMP
INCIDENCE
4-14% (AVERAGE = 10%)

Recurrence

- if one previous postterm birth = 2
- if two previous postterm birth = 39%
- if mother had postterm the risk in daughter increased 2-3 fold
Perinatal mortality: Antepartum, intrapartum and neonatal death increases mostly intrapartum
MAJOR CAUSES

- Pregnancy Hypertension
- Prolong labor with CPD
- Unexplained anoxia
- Meconium aspiration
- Asphyxia
Early neonatal seizure:

Postterm = 5.4/1000
Term = 0.9/1000
Anencephaly → Adrenal hypoplasia

Lack of estrogen elevation

Prolonged pregnancy
POSTMATUREITY SYNDROME

Three stages:
1- Clear amniotic fluid
2- Green stained skin
3- Yellow-green skin discoloration
- Wrinkled, patchy peeling skin
- Long, thin body
- Open-eyed
- Unusually alert, old and worried-looking
- Wrinkling mostly on palms and soles
- Nails typically long

*Most of these are not growth restricted*
So:
- Many died
- Many are seriously ill
- Many are brain damaged

Due to:
- Birth Asphyxia
- Meconium aspiration

Incidence:
- 41-43 weeks: 10%
- At 44 week: 33%
Placental Dysfunction

- No degeneration or morphological change
- Placental apoptosis↑ (but clinical significance unclear)
- Cord plasma erythropoietin↑
  (Due to low fetal oxygenation)
FETAL DISTRESS AND Oligohydramnios

- Oligohydramnios
  - Cord compression

- Meconium in amniotic fluid
  - Meconium aspiration
MANAGEMENT

Interventions are indicated in prolonged pregnancy:
Which and when are controversial

41 or 42 weeks?

Induction or expectant management?
At 41 week:
- Induction if cervix is favorable
- Fetal testing if cervix is unfavorable
At 42 week:

- Induction if cervix is favorable

- Induction or fetal testing if is unfavorable
Cervical dilatation is an important prognostic factor for induction success.
**UNFAVORABLE CERVIX**

- PG gel can be used for cervical ripening

- Mifepristone (RU486) did not stimulated uterine activity

- Sweeping or stripping of membranes at 38-40 weeks decreased postterm pregnancy
Membranes stripping

- No change the risk of C/S
- No change in maternal and neonatal infection

*but could be*

- Painful
- Might provoke vaginal bleeding
- Irregular uterine contractions
Many clinician prefer to employ fetal testing to avoid induction
Fetal testing

- Fetal movement over 2 hour/each day
- NST 3 times/week
- Amniotic fluid volume 2-3 times/week

pocket < 3 cm is abnormal
When amniotic fluid is normal, no guarantee for fetal well being

But

When amniotic fluid is decreased, The fetal is at risk
If no vertical pocket > 2cm or AFI < 5 cm

Either delivery or close fetal surveillance
Doppler velocimetry was not recommended
in parkland hospital

42 completed wks

certain

42 completed wks

uncertain

1st induction

Oligohydramnios?

Fetal movement?

3 days later

2nd induction

Yes

No

weekly visit

induction of labor

3rd induction

versus C/S

Yes

No
INTERAPARTUM MANAGEMENT

- Admission as soon as suspected are in labor
- Electronic monitoring of fetal heart and contraction
- When to perform amniotomy is problematic

*Presence of thick meconium is worrisome*
Aspiration of thick meconium may cause severe pulmonary dysfunction and neonatal death

**SO:**

Suction the pharynx when head is delivered and before delivering of thorax
Identification of Thick Meconium:

When pregnant is remote from delivery

So:

C/S must be considered especially

If:

CPD or hypotonic, hypertonic dysfunction is evident
Some clinician avoid oxytocin use in this cases
Postterm fetus may be LGA and shoulder dystocia may develop