

Management of Late Term and Postterm Pregnancies

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DEFINITIONS

EARLY TERM: 37 0/7 – 38 6/7 weeks of gestation

FULL TERM: 39 0/7 – 40 6/7 weeks of gestation

LATE TERM: 41 0/7 – 41 6/7 weeks of gestation

POSTTERM: 42 0/7 weeks of gestation and beyond

BACKGROUND

One of the most important steps to decrease the incidence of late term and postterm pregnancies is to correctly establish a due date. The most accurate dating is achieved by early ultrasound in addition to the last menstrual period (LMP). As pregnancies progress, ultrasound is less reliable in establishing a due date and there are specific criteria regarding fetal size discrepancy depending on the weeks of gestation. In pregnancies dated by first trimester ultrasound examination, the prevalence of postterm pregnancy is about 2% and fewer inductions are performed for postterm pregnancy than in pregnancies dated by last menstrual period.

Postterm pregnancies are associated with increased maternal and neonatal complications. Neonatal complications include increased rates of NICU admission neonatal convulsion, meconium aspiration syndrome, fetal dysmaturity syndrome, and 5-minute APGAR scores less than 4. Maternal complications include increased rates of obstetric anal sphincter injuries (OASIS), intrauterine infection, postpartum hemorrhage, cesarean delivery. Another risk includes fetuses measuring large for gestational age (LGA), which can increase the risk for dysfunctional labor, shoulder dystocia, operative vaginal delivery, and cesarean delivery. Perinatal mortality (ie, stillbirths plus early neonatal deaths) at ≥ 42 0/7 weeks of gestation is twice that at term (4 to 7 versus 2 to 3 per 1000 deliveries). Maternal and neonatal morbidity is related, in part, to complications from fetal macrosomia.

Meta-analysis of 19 randomized trials showed routine labor induction at ≥ 41 weeks of gestation, was associated with a significantly lower rate of perinatal mortality than expectant management. The benefits of routine induction are modest, however, and depending on their values and preferences, some women may choose to be managed expectantly.

In women wishing to avoid pharmacologic agents for cervical ripening and induction, membrane sweeping (also called stripping the membranes) reduces the proportion of patients who remain undelivered at 42 0/7 weeks of gestation. This was illustrated in the de Miranda RCT which randomly assigned low-risk women at 41 0/7 weeks of gestation to membrane sweeping every 48 hours or expectant management up until 42 0/7 weeks. Improved outcomes without adverse effects were reported with a number needed to treat (NNT) of 6.

ANTEPARTUM MANAGEMENT

1. At 41 0/7 weeks of gestation, a review of the records is indicated to establish dates as well as possible. The patient can be categorized as having
 - a. Good dates: (evidence of ultrasound confirmation of pregnancy in the first or early second trimester) or
 - b.)Suboptimal dates: (implying ultrasound confirmation of pregnancy at or after 22 0/7 weeks of gestation)
2. Patients who are ≥ 41 0/7 weeks of gestation:

- a. Antenatal testing: NST twice weekly with amniotic fluid evaluation once weekly either in the radiology department or with an appropriately trained clinician. (Appendix 1)
Instructed in fetal kick counts with review of strict return precautions to OB triage.
3. In women wishing to avoid pharmacologic agents for cervical ripening and induction, membrane sweeping can be offered ≥ 39 0/7 weeks of gestation.
 - a. Clinical judgement and shared decision making should be used if the patient is positive for group B streptococcus bacteria.
4. Induction of labor should be discussed and offered at 41 0/7 weeks of gestation.
5. Induction of labor after 42 0/7 weeks and by 42 6/7 weeks of gestation is strongly recommended to decrease perinatal morbidity and mortality.
6. Recommendation for delivery for abnormal surveillance tests:
 - a. Non-reactive NST
 - b. Positive contraction stress test (CST)
 - c. Oligohydramnios
7. Management of suboptimally dated pregnancies
 - a. The timing of indicated delivery in a woman with a suboptimally dated pregnancy should be based on the best clinical estimate of gestational age.
 - b. Elective induction at 39 0/7 weeks gestation should not be offered.
 - c. Amniocentesis for fetal lung maturity is not recommended as a routine component of decision making when considering delivery in a woman with a suboptimally dated pregnancy.
 - d. A 32-week growth ultrasound should be completed. Although this follow-up examination is intended to support the working gestational age, interval fetal growth assessment potentially may detect cases of fetal growth restriction.
 - e. Given the a suboptimally dated pregnancy could actually be weeks further along than it is believed to be, antenatal fetal testing should be considered.
 - f. Late-term delivery is indicated at 41 weeks of gestation when gestational age is uncertain, using the best clinical estimate of gestational age.
 - g. In a patient with a suboptimally dated pregnancy and a prior low-transverse cesarean delivery who requests a repeat cesarean delivery, delivery is advised at 39 weeks of gestation using best clinical estimate of gestational age.

INTRAPARTUM MANAGEMENT

1. If fetus is measuring LGA, anticipate labor dysfunction, shoulder dystocia, and/or postpartum hemorrhage. Counsel the patient appropriately and discuss with the team.
2. Notify the pediatrics team as indicated per notification of pediatrician and pediatric nurse protocol.

APPENDIX 1

Technique for measuring the single deepest vertical pocket (SDVP) (also known as maximum vertical pocket [MVP], deepest vertical pocket [DVP], or largest vertical pocket [LVP]):

1. The operator should have previously received training on performing fluid assessments.
2. Ensure the ultrasound probe is clean.
3. Apply gel to the abdomen.

4. Use a curvilinear probe and orient it perpendicular to the floor. The indicator should be either towards the patient's right or patient's head.
5. Avoid excessive abdominal pressure.
 - a. Evaluate all four uterine quadrants. Once the largest pocket has been identified, measure the single deepest vertical pocket (SDVP). The pocket must be more than 1 cm wide.
 - b. Avoid measuring through the umbilical cord. Color flow may be useful to identify the umbilical cord. If present, the measurement should be taken from the top to the most superior aspect of the cord (not through or below the cord).
6. Print the photo and have it scanned into the patient's chart.
7. Normal values are a depth ≥ 2 cm and < 8 cm. Please reference the "Oligohydramnios" and "Polyhydramnios" Clinical Guidelines for further information. Although in a late term or postterm pregnancy, oligohydramnios diagnosis should lead to delivery.

REFERENCES

1. Definition of term pregnancy. Committee Opinion #579: American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2013;122:1139-40. (Reaffirmed 2017)
2. Management of late-term and postterm pregnancies. Practice Bulletin No, 146. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2014;124:390-6. (Reaffirmed 2024)
3. Antepartum fetal surveillance. ACOG Practice Bulletin No. 229. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2021;137:e116–27. (Reaffirmed 2024)
4. Ultrasound in pregnancy. Practice Bulletin No. 175. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2016;128:e241–56. (Reaffirmed 2025)
5. Management of suboptimally dated pregnancies. Committee Opinion No. 688. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2017;129:e29–32 (Reaffirmed 2024)
6. Methods for estimating the due date. Committee Opinion No. 700. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2017;129:e150–4. (Reaffirmed 2025)
7. Middleton P, Shepherd E, Morris J, Crowther CA, Gomersall JC. Induction of labour at or beyond 37 weeks' gestation. *Cochrane Database of Systematic Reviews* 2020, Issue 7. Art. No.: CD004945. DOI: 10.1002/14651858.CD004945.pub5.
8. Whitworth M, Bricker L, Mullan C Ultrasound for fetal assessment in early pregnancy. *Cochrane Database Syst Rev*. 2015 Jul 14;(7):CD007058. CD007058.pub3.
9. Sanchez-Ramos L, Olivier F, Delke I, Kaunitz AM. Labor induction versus expectant management for postterm pregnancies: a systematic review with meta-analysis. *Obstet Gynecol*. 2003;101(6):1312-8.
10. Rand L, Robinson JN, Economy KE, Norwitz ER. Post-term induction of labor revisited. *Obstet Gynecol*. 2000;96(5 Pt 1):779-83.
11. de Miranda E, van der Bom JG, Bonsel GJ, Bleker OP, Rosendaal FR. Membrane sweeping and prevention of post-term pregnancy in low-risk pregnancies: a randomised controlled trial. *BJOG*. 2006;113(4):402-8.
12. Magann EF, Chauhan SP, Washington W, et al. Ultrasound estimation of amniotic fluid volume using the largest vertical pocket containing umbilical cord: measure to or through the cord? *Ultrasound Obstet Gynecol*. 2002 Nov;20(5):464-7.

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