1/31/19 njm

Expectant Management of Indicated Deliveries

When labor is induced, cervical status has an impact on the duration of induction and the likelihood of vaginal delivery. If the cervical status is unfavorable, a ripening process is generally employed prior to induction to shorten the duration of induction and maximize the possibility of vaginal delivery.

Although cervical status at induction provides insight into the chance of cesarean delivery, it does not completely predict whether avoiding labor induction and managing the patient expectantly will result in a higher chance of vaginal delivery. An unfavorable cervix generally has been defined as a Bishop score of 6 or less in most randomized trials.

The 'unripe' cervix

The following principles / practices apply to TOLACs and actually to all cervical ripening:

If the patient's cervix is not ripe, then there is no need to start the cervical ripening at the very stroke of midnight on the day the patient just become 37 0/7, 38 0/7, 39 0/7, etc… for the vast majority of indications. If you look at many of the indications for delivery - a range is given e. g., 40-41 wks, etc….

Please don't set up the expectation with the patient that she will get a cervical ripening started at the very millisecond of first day that the guideline says we could start (if she had a favorable cervix)
If her cervix is not ripe, then she may not get started until the last day of that week, or later in some cases. If you have a question as to whether you should delay to the end of the 'range' of dates, please consult an OB/GYN or MFM

This may involve a little of the 'art of medicine'
….you may clearly state a 'range' of the dates…but the patient hears only the first day of that 'range'….so you then need to tactfully reinforce the 'range' of dates concept so that the patient (and her family) are not dealing with the unexpected when they show up in OBT and get the bad news that her cervix is completely unripe - and the patient and her family both say she has never heard of such a concept as a 'range' of dates.

Medical Conditions

Various medical conditions can be expectantly managed in pregnancy if certain reassuring criteria are met. Expectant management should be re-evaluated on a frequent basis and has been shown to increase median gestational by 7 days in hypertensive disorders. (Range 2-35 days)

Expectant management would be based on the assumption that certain conditions are not present. These conditions would include:

Abruptio placenta

Growth restriction

Non-reassuring fetal status

Oligohydramnios

Severe preeclampsia features

Labor

Rupture of membranes

Vaginal bleeding

Management

Evaluate the patient during the EGA range provided in Table 1. If the Bishop's score is 6 or less, then consider membrane stripping and the following.

Hypertension

2x / wk NST and BP check

Weekly Amniotic Fluid evaluation

CBC, CMP q 72 hrs

Re-evaluate cervical exam in at least one week

If the patient's Bishop's score is 7 or greater, then proceed toward delivery.

If Bishop score is 6 or less, then repeat above cycle x one week.

Diabetes

1.) Known adequate control

2x / wk NST

Weekly Amniotic Fluid evaluation

Re-evaluate cervical exam in at least one week

If the patient's Bishop's score is 7 or greater, then proceed toward delivery.

If Bishop score is 6 or less, then repeat above cycle x one week.

Cholestasis, non-severe

Weekly NST / Amniotic Fluid evaluation

Re-evaluate cervical exam in at least one week

If the patient's Bishop's score is 7 or greater, then proceed toward delivery.

If Bishop score is 6 or less, then repeat above cycle x one week.

Table 1

	EGA range for onset cervical ripening
Chronic hypertension	
-Controlled on no medications	39 0/7–39 6/7 weeks
-Controlled on medications	39 0/7–39 6/7 weeks
Gestational hypertension	37 0/7–38 6/7 weeks
Preeclampsia, non-severe features	Case by case basis > 37 weeks
Cholestasis, non-severe	39 0/7–39 6/7 weeks
DM /GDM adequate control	39 0/7–39 6/7 weeks
Others	Case by case basis

References:

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Revised 1/31/19njm
Approved 5/14/18 njm