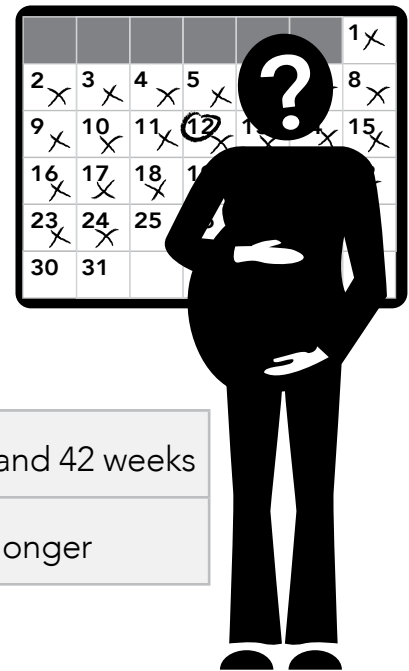


# When your pregnancy goes past your due date

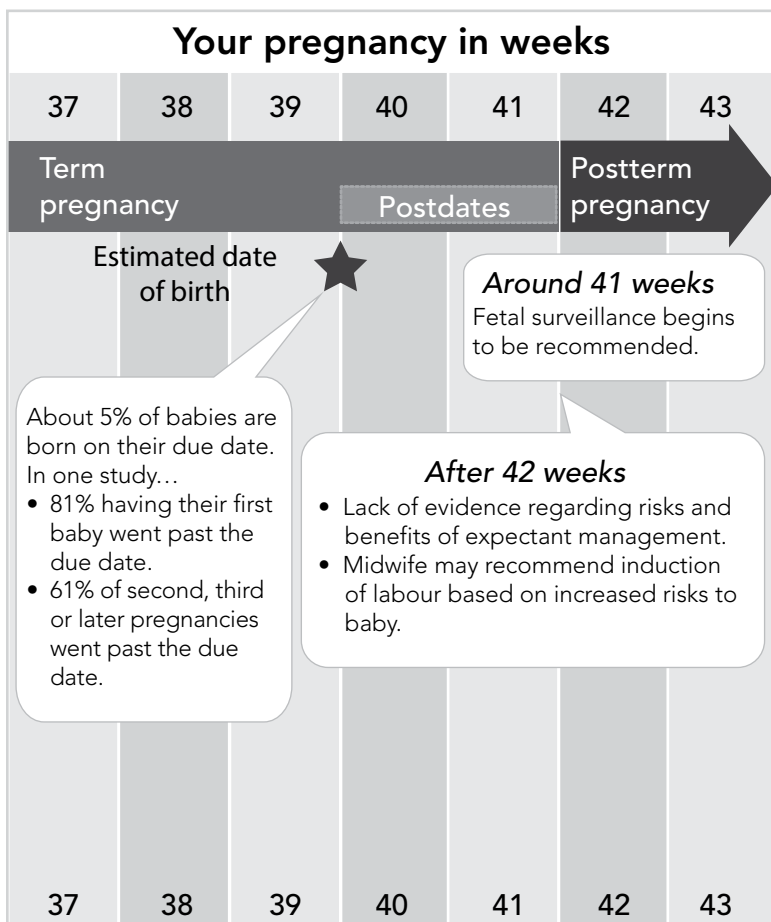
The length of a pregnancy is thought to be about 280 days, or 40 weeks. It is not unusual for pregnancies to last longer than 40 weeks. Anywhere between 37 and 42 weeks is considered a term pregnancy. A pregnancy that lasts longer than 40 weeks may be called a postdates, postterm or prolonged pregnancy.



<b>Postdates pregnancy</b>	A pregnancy that lasts between 40 and 42 weeks
<b>Postterm pregnancy</b>	A pregnancy that lasts 42 weeks or longer

## What is an estimated due date?

It's important to keep in mind that estimated due dates are just that – they're best guesses based on the information available (such as the date of your last menstrual period or the results of an ultrasound). Only about 5 in 100 people give birth on their due date.



Your estimated due date may have a lot of emotional significance to you, your partner, and your family and friends. Expectations for your baby's arrival may be high, and you may feel frustrated if your baby doesn't arrive on time.

Your estimated due date is also significant to your midwives because it helps them assess whether your baby's growth is on track.

## How often do pregnancies last longer than 40 weeks?

It's not clear exactly how many people experience postdates pregnancy. That's because different methods are used to estimate pregnancy length and different terms are used to describe pregnancies that last longer than 40 weeks. You are especially likely to go past your due date in your first pregnancy.

This document provides client-friendly information based on the Association of Ontario Midwives' Clinical Practice Guideline No. 10: Management of the Uncomplicated Pregnancy Beyond 41+0 Weeks' Gestation. It is designed to help you better understand some of the considerations and choices you may face while receiving care from your midwife. It is not intended to replace the informed choice discussions that you and your midwife will have. If you have any questions, concerns or ideas after reading over this document, please share them with your midwife.

## Why do we pay attention to a postdates pregnancy?

Most babies are born healthy, regardless of whether they arrive at term or later. However, there are certain risks that begin to increase after about 41 weeks of pregnancy, rising even higher after 42 weeks of pregnancy.

- In general, babies born after 41 weeks are at an increased risk of dying before or during labour (stillbirth) or soon after birth.
- When pregnancy lasts longer than 41 weeks there is an increased risk of problems arising in labour for which a caesarean section may be required.
- Babies born at 41 weeks and later are more likely to release a sticky poo called meconium into the uterus. Meconium usually isn't a problem, but if your baby breathes meconium into their lungs they can develop serious breathing problems (meconium aspiration syndrome). Babies who breathe meconium into their lungs receive care in a nursery or newborn intensive care unit (NICU). Most babies with meconium aspiration syndrome recover quickly.
- Babies born at 41 weeks and later are more likely to require the care of specialists and be admitted to the neonatal intensive care unit (NICU).

### Risk of stillbirth or death in the first week of the baby's life

40 weeks	About 3 in 1000
41 weeks	About 1 in 1000
42 weeks	About 5 in 1000

### Risk of meconium aspiration syndrome

40 weeks	About 3 in 1000
41 weeks	About 5 in 1000
42 weeks	About 5 in 1000

It's important to keep in mind that most postdates pregnancies are NOT associated with major or long-term complications. While the risk of certain complications is higher, the overall risk is still low. It's also difficult to predict whether you or your baby will develop problems as a result of postdates pregnancy.

## What might happen if your pregnancy is postdates?

You might feel impatient. You, your partner, and your family and friends may have made preparations for your baby's arrival. You might be excited to meet the new member of your family. You may also feel physically uncomfortable – your back might ache and you may have a hard time getting comfortable enough to sleep.

Your midwife may recommend increased monitoring of your baby's well-being. Monitoring activities that your midwife may offer include:

- Counting how often your baby kicks during a specific time period.
- A period of monitoring your baby's heart rate using continuous fetal monitoring, called a non-stress test.
- Using ultrasound to measure:
  - » the amount of water (amniotic fluid) surrounding your baby.
  - » the baby's movements, muscle tone, practice breathing movements and amount of water around the baby, assigning a score for each measurement (this is called a biophysical profile).
  - » your baby's growth.

In some situations, you may be offered the option of induction of labour. This is when labour is artificially started by one or more of these methods:

- Giving you synthetic prostaglandin by inserting a gel, tablet or pessary (like a tampon) into your vagina. Prostaglandin is a hormone that softens the cervix so it dilates more easily. In some cases prostaglandin will also cause the uterus to contract.
- Using an intravenous drip (a needle in your arm) to administer a synthetic version of oxytocin, another hormone that stimulates the uterus to contract.

- Rupturing your membranes or “breaking your waters” by making a small hole in the amniotic sac surrounding your baby in the uterus. This will often encourage the uterus to contract.

Because some methods of induction take place in a hospital (prostaglandin gel, oxytocin), undergoing induction of labour may limit your options for where you give birth. Many midwives will offer herbs, homeopathic remedies, acupuncture, castor oil, nipple stimulation, or stretch and sweep (see below) for those who are interested in natural alternatives to induction.

The alternative to induction of labour is called **expectant management**. This is when you wait for labour to start while undergoing regular monitoring of your baby’s wellbeing. If monitoring (for example, ultrasound) suggests that your baby is not continuing to thrive in your uterus, induction of labour may be recommended.

## What else may help you to go into labour?

There are other methods that are thought to encourage labour naturally. One that midwives frequently offer their clients is called stretch and sweep or sweeping the membranes. Your midwives will use their fingers to examine your vagina and assess your cervix. Depending on the degree of change to your cervix, your midwives will stretch your cervix open (stretch) and pass their fingers between the inside of your cervix and the bag of waters that holds your baby (sweep). This may feel slightly uncomfortable – you may even find it painful. Research suggests that stretch and sweep shortens the time before the baby’s birth by an average of 3 days.

Other methods used to start labour include castor oil, acupuncture, homeopathy, naturopathic and herbal remedies. Little research has been done to establish how well these methods work or to test the ideal circumstances for their use. Please check with your midwives if you are interested in these alternative methods of starting labour.

## Induction of labour compared to expectant management

One way that has been proposed to reduce the potential risks of postdates pregnancy is to induce labour once all pregnancies reach a certain point – for example, 41 or 42 weeks. Some research suggests that a policy of labour induction can reduce the already small risk that your baby will die during labour or afterwards. One problem with this approach is that hundreds or thousands of people will require induction in order to prevent a small number of serious injuries or deaths. Plus, the medical interventions used to stimulate labour and birth sometimes have their own risks:

- If your labour is induced you may be more likely to need a caesarean section or an assisted vaginal delivery (with forceps or vacuum).
- If your labour is induced your baby may be more likely to have breathing problems or require admission to a neonatal intensive care unit.

Ultimately, there is little good-quality research to suggest that one option offers clear advantages over the other. What this means is that decisions about whether to choose induction of labour or expectant management can be difficult to make.

As long as your baby is healthy and well-positioned for labour, your chances of having a normal and uncomplicated birth may be highest if you wait until 42 weeks for your labour to begin on its own. Monitoring of your baby’s well-being in the meantime will help ensure that your baby continues to do well and will help your midwife determine whether or not induction may be advisable. If monitoring suggests that your baby is no longer thriving in your uterus, choosing to undergo an induction of labour before more serious problems develop may offer the best chance for a normal and uncomplicated birth.

