PATIENT EDUCATION

The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

Pregnancy • EP069

When Pregnancy Goes Past Your Due Date

Waiting for the birth of a child can be both an exciting and anxious time, especially if your pregnancy goes past the due date. The average length of pregnancy is 280 days, or 40 weeks, counted from the first day of your ***last menstrual period (LMP)****. A pregnancy that lasts 41 weeks up to 42 weeks is called "late term." A pregnancy that lasts longer than 42 weeks is called "postterm."*

This pamphlet explains

- *how your due date is set*
- *causes of postterm pregnancy*
- *risks of postterm pregnancy*
- *tests that check fetal well-being*
- *when labor induction is recommended*

Your Due Date

The date your baby is due—your ***estimated due date (EDD)***—is calculated from the first day of your LMP. The EDD is used as a guide for checking your pregnancy's progress and tracking the growth of the ***fetus***. It is only an estimate of when your baby will be born (see box "How to Estimate Your Due Date"). Keep in mind that only 1 in 20 women (5%) gives birth on her EDD.

An ***ultrasound exam*** often is used to confirm the due date calculated from your LMP. In general, the earlier you have an ultrasound, the more accurate it is in confirming a due date. Your ***obstetrician–gynecologist (ob-gyn)*** will evaluate the dating from your ultrasound and compare it with your due date based on your LMP. Once a due date has been selected, it does not change, no matter how many additional ultrasound exams you may have during your pregnancy.

Causes of Postterm Pregnancy

The causes of postterm pregnancy are unknown, but there are several factors that may increase your chances

How to Estimate Your Due Date

Here is one way to calculate your due date:

1. Take the date that your last menstrual period started.
2. Add 7 days.
3. Count back 3 months.

Example: The first day of your last menstrual period was January 1. Add 7 days to get January 8. Then count back 3 months. Your due date is October 8.

of having a postterm pregnancy. These factors include the following:

- This is your first baby.
- You are carrying a male fetus.
- You have had a prior postterm pregnancy.
- You are obese.

Risks of Postterm Pregnancy

The health risks for you and your fetus may increase if a pregnancy is late term or postterm, but problems occur in only a small number of postterm pregnancies. Most women who give birth after their due dates have uncomplicated labor and give birth to healthy babies.

The most serious concern of a postterm pregnancy is an increased risk of ***stillbirth***. Postterm babies tend to have lower ***Apgar scores*** at birth than babies born before 42 weeks. They also are more likely to need special care in a ***neonatal intensive care unit (NICU)***. Additional problems that can affect the fetus or newborn include the following:

- ***Amniotic fluid*** problems—The fluid that cushions the fetus in the ***uterus*** may decrease in a late-term or postterm pregnancy. This can cause the ***umbilical cord*** to become compressed, which restricts the flow of ***oxygen*** to the fetus.
- ***Postmaturity syndrome***—This syndrome occurs in 10–20% of babies who are born past their due dates. Babies with this syndrome may have peeling skin, overly long fingernails, and decreased stores of fat. Before birth, the fetus may pass ***meconium*** in the uterus and may be born with meconium staining the amniotic fluid, skin, or umbilical cord. If meconium is passed, it may get into the lungs of the fetus through the amniotic fluid. This can cause serious breathing problems after birth.
- ***Macrosomia***—A late-term or postterm fetus can gain a lot of weight. If the fetus is estimated to weigh 9–10 pounds, this condition is called macrosomia. Macrosomia may lead to problems during labor and delivery that increase the chances of an ***assisted vaginal delivery*** or ***cesarean delivery***.

There are risks to your health as well. There is a higher chance of infection and ***postpartum hemorrhage*** when your pregnancy goes past your due date. There also is a higher risk of severe tears in the area between the vagina and the anus.

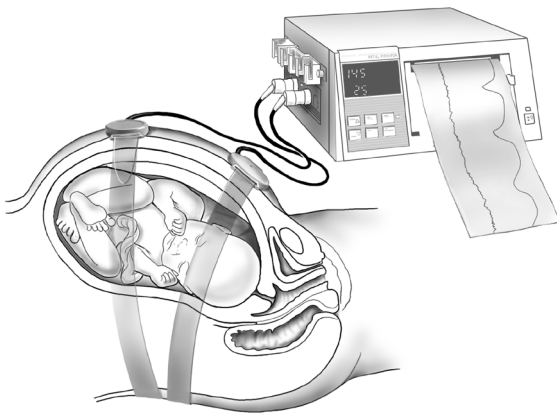
Tests for Fetal Well-Being

When a fetus is not born by the due date, tests may help your ob-gyn or other health care professional check the fetus's condition. No test can give 100% assurance. These tests cannot always find a problem even if one exists, or the results may show that there may be a problem when there is none. A pregnancy between 40 weeks and 41 weeks of gestation does not necessarily require testing, but at 41 weeks your ob-gyn or other health care professional may recommend testing.

Tests of fetal well-being use ***electronic fetal monitoring*** and sometimes ultrasound. During electronic fetal monitoring, two belts are placed around your abdomen to hold sensors. These sensors measure fetal heart rate and the frequency of uterine contractions. These tests are done in your ob-gyn or other health care professional's office or a hospital. Tests may include the following:

- Nonstress test (NST)—This test measures the fetus's heart rate for a specific period of time, usually 20 minutes. Results of the NST are noted as reactive (reassuring) or nonreactive (nonreassuring). A nonreactive result does not necessarily mean that the fetus is not healthy. Nonreactive nonstress test results often are followed by other tests to give more information.
- Biophysical profile (BPP)—This test involves monitoring the fetal heart rate as well as an ultrasound exam. It checks the fetal heart rate, breathing, movement, and muscle tone. The amount of amniotic fluid also is

Electronic Fetal Monitoring



Electronic fetal monitoring is used to perform the nonstress test, the biophysical profile, and the contraction stress test. Two belts are placed around the mother's abdomen to hold sensors that measure fetal heart rate and the frequency of uterine contractions.

assessed. A modified BPP checks the fetal heart rate and amniotic fluid level.

- Contraction stress test (CST)—The CST assesses how the fetus's heart rate changes when the uterus contracts. To make your uterus contract mildly, you may be asked to rub your nipples through your clothing or you may be given ***oxytocin*** through an intravenous (IV) tube in your arm. Results are noted as reassuring or nonreassuring. Results also can be equivocal (the results are not clear) or unsatisfactory (there were not enough contractions to produce a meaningful result).

These tests may be done weekly or twice weekly beginning at 41 weeks of pregnancy. If a test result is nonreassuring, you may need to repeat the same test or have a different test. In some cases, delivery may be recommended.

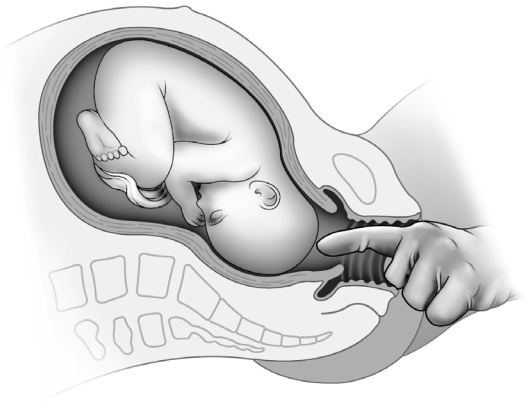
Labor Induction

Labor induction may be recommended if your pregnancy reaches 41 weeks. Induction is started using medications or other methods. To induce labor, your ***cervix*** needs to have started softening in preparation for delivery. This is called ***cervical ripening***. Medications or other methods may be used to start this process. Labor may be induced using one of the following methods:

- Stripping or sweeping the amniotic membranes—Your ob-gyn or other health care professional sweeps a gloved finger over the thin membranes that connect the ***amniotic sac*** to the wall of your uterus. The cervix needs to be dilated 1–3 cm for this procedure to be considered. This procedure may start labor within 48 hours. It can cause some discomfort and vaginal bleeding.
- Rupturing the amniotic sac—Your ob-gyn or other health care professional makes a small hole in the amniotic sac to release the fluid ("breaking the waters"). The cervix needs to be dilated 1–3 cm and the fetus's head needs to be in close contact with the cervix for this procedure to be considered. Most women go into labor within hours of their water breaking. If labor does not occur, another method may be used to start your labor.
- Oxytocin—Oxytocin is made in your body and causes the uterus to contract. A drug form of oxytocin can be given through an IV tube in your arm. The dosage may be slowly increased over time and is carefully monitored.
- Prostaglandin analogs—These are medications placed in your vagina to start cervical ripening.
- Cervical ripening balloon—Your ob-gyn or other health care professional may place a small balloon-like device in your cervix to mechanically dilate it and help start labor.

Each method of labor induction carries some risks. These risks may include changes in fetal heart rate, infection, and contractions of the uterus that are too strong. You and your fetus will be monitored throughout the process. Another possibility is that labor induction may not work. The method used to induce labor may need to be repeated. In some cases, you may need to have an assisted vaginal delivery or a cesarean delivery.

Stripping Amniotic Membranes



Your ob-gyn or other health care professional may sweep a gloved finger over the thin membranes that connect the amniotic sac to the wall of your uterus. This procedure may help start labor.

Finally…

Most babies born after their due dates are healthy. Tests of fetal well-being and close monitoring during the last weeks of pregnancy can help reduce the risks for you and your fetus. You and your ob-gyn or other health care professional will decide on the best course of action if your pregnancy is late term or postterm.

Glossary

Amniotic Fluid: Water in the sac surrounding the fetus in the mother's uterus.

Amniotic Sac: Fluid-filled sac in the mother's uterus in which the fetus develops.

Apgar Score: A measurement of a baby's response to birth and life on its own, taken 1 minute and 5 minutes after birth.

Assisted Vaginal Delivery: Vaginal delivery of a baby performed with the use of forceps or vacuum.

Cervical Ripening: The process by which the cervix softens in preparation for labor.

Cervix: The lower, narrow end of the uterus at the top of the vagina.

Cesarean Delivery: Delivery of a baby through incisions made in the mother's abdomen and uterus.

Electronic Fetal Monitoring: A method in which electronic instruments are used to record the heartbeat of the fetus and contractions of the mother's uterus.

Estimated Due Date (EDD): The estimated date that a baby will be born.

Fetus: The stage of prenatal development that starts 8 weeks after fertilization and lasts until the end of pregnancy.

Last Menstrual Period (LMP): The date of the first day of the last menstrual period before pregnancy that is used to estimate the date of delivery.

Macrosomia: A condition in which a fetus is estimated to weigh between 9 pounds and 10 pounds.

Meconium: A greenish substance that builds up in the bowels of a growing fetus. If meconium is passed, it may get into the lungs of the fetus through the amniotic fluid. This can cause serious breathing problems.

Menstrual Cycle: The monthly process of changes that occur to prepare a woman's body for possible pregnancy. A menstrual cycle is defined from the first day of menstrual bleeding of one cycle to the first day of menstrual bleeding of the next cycle.

Neonatal Intensive Care Unit (NICU): A specialized area of a hospital in which ill newborns receive complex medical care.

Obstetrician–Gynecologist (Ob-Gyn): A physician with special skills, training, and education in women's health.

Oxygen: A gas that is necessary to sustain life.

Oxytocin: A hormone used to help bring on contractions of the uterus.

Postmaturity Syndrome: A condition in which a postterm fetus is born with a long and lean body, an alert look on the face, lots of hair, long fingernails, and thin wrinkled skin.

Postpartum Hemorrhage: Heavy bleeding that occurs after delivery of a baby and placenta.

Stillbirth: Delivery of a dead baby.

Ultrasound Exam: A test in which sound waves are used to examine the fetus.

Umbilical Cord: A cord-like structure containing blood vessels that connects the fetus to the placenta.

Uterus: A muscular organ located in the female pelvis that contains and nourishes the developing fetus during pregnancy.

This Patient Education Pamphlet was developed by the American College of Obstetricians and Gynecologists. Designed as an aid to patients, it sets forth current information and opinions on subjects related to women's health. The average readability level of the series, based on the Fry formula, is grade 6–8. The Suitability Assessment of Materials (SAM) instrument rates the pamphlets as "superior." To ensure the information is current and accurate, the pamphlets are reviewed every 18 months. The information in this pamphlet does not dictate an exclusive course of treatment or procedure to be followed and should not be construed as excluding other acceptable methods of practice. Variations, taking into account the needs of the individual patient, resources, and limitations unique to the institution or type of practice, may be appropriate.

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