



Protracted Pregnancy: A Mini Review

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ABSTRACT

Increased antepartum and intrapartum foetal risk are associated with pregnancies that last longer than 42 weeks. Maternal risk may also be linked to post-term pregnancy, such as an increased possibility of an emergency Caesarean section delivery. Increased foetal growth and placental ageing contribute to the increased risk of severe perinatal outcomes associated with post-term pregnancy. Offering delivery is the most effective technique now available for managing the hazards associated with prolonged pregnancy.

Keywords: Pregnancy; Post-maturity; Post-term

INTRODUCTION

This is usually available from 41 weeks onwards, however the period varies up to 42 weeks depending on the location. Although giving induction of labour to treat post-term pregnancy is common and appears to reduce risk, women who choose expectant management or deny induction of labour should feel supported by healthcare professionals. Recent research suggests that inducing labour beyond 39 weeks in otherwise low-risk pregnancies is not associated with increased maternal or foetal risk, and may help to avoid Caesarean section [1-4]. In obstetrics, terminology is crucial for achieving a clear understanding of the risks connected with pregnancy problems. The terms 'prolonged pregnancy,' 'post-dates,' and 'post-term' are frequently interchanged, while they can also refer to other time periods. The phrase 'post-term' is the most well-defined and is most commonly used to describe any pregnancy that has lasted longer than 294 days. The Royal College of Obstetricians and Gynecologists (RCOG), the American College of Obstetricians and Gynecologists (ACOG), the World Health Organization (WHO), and the International Federation of Gynecology and Obstetrics (IFGO) have all agreed on this classification (FIGO).

The precision with which pregnancies are identified as post-term is another factor that has a substantial impact on the percentage of pregnancies labelled as post-term. When compared to populations where the due date is calculated based on the latest menstrual period, routine use of first trimester ultrasound reduces the overall incidence of post-term pregnancies. It is critical to precisely determine gestational age, ideally by measuring the crown-rump length between 10 and 13 weeks, in order to accurately identify pregnancies at risk of developing post-term and to initiate appropriate management conversations in a timely manner.

DISCUSSION

Post Pregnancy

While it is well known that post-term pregnancy is associated with greater maternal and foetal risk as compared to pregnancies that deliver before 42 weeks, the extent of these hazards in the research is highly variable. The risk of unfavourable perinatal outcomes rises gradually from w40 weeks onwards, rather than abruptly at 42 weeks, as the phrase "post-term pregnancy"

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suggests. The management measures to avert post-term pregnancy may also include dangers (for example induction of labour). As a result, specific counselling is required to decide the best course of action for each pregnancy, taking into account not just the danger posed by the pregnancy's duration but also the background risk posed by characteristics like parity [1,5].

These disparities in findings have sparked debate and confusion over how post-term pregnant women should be treated. As a result, it was vital to perform a critical evaluation of the literature. It has enabled the terminology and terminologies used to define post-term pregnancy to be clarified. Importantly, practise recommendations based on the best available research have been created, providing midwives with information to discuss with women.

Many kinds of contraception can now be started safely shortly after a pregnancy, and these will be discussed further below. If the mother is not exclusively breastfeeding, ovulation will continue, and she will be at risk of becoming pregnant by the 21st day after delivery or after the pregnancy has been terminated. There are numerous ways accessible, and it is critical that women are educated not only about the options available to them in their situation, but also on the effectiveness of these options [6].

Women are administered contraception at 6 weeks postpartum, according to traditional practise. Women are not sexually active until that time, and they are not likely to seek contraception choices until then, according to popular belief. However, research has shown that this is far from the truth, resulting in not only wasted opportunities to provide holistic health care, but also putting women at risk of unwanted pregnancies.

Epidemiology

The prevalence of post-term pregnancy varies based on the population. The rate of post-term pregnancy is influenced by the number of prim gravid women, the prevalence of obesity, the proportion of women with pregnancy problems, and the incidence of spontaneous preterm birth. Local management techniques such as the use of ultrasound for pregnancy dating, scheduled inductions of labour, and scheduled caesarean deliveries all have an impact on the rate of post-term births. To effectively identify a post-term pregnancy, an accurate measurement of gestational age is required. EDD calculations based on the first day of a patient's last normal menstrual period (LMP) are only accurate when the LMP is actually known rather than estimated, and when a woman's menstrual cycle is regular and predictable. The use of LMP to calculate gestational age in oligo-ovulatory women, defined as those whose menstrual cycles last more than 35 days or have less than eight menstrual cycles per year, can be inaccurate. The extended and frequently unpredictable length of the follicular cycle in these women causes gestational age to be exaggerated [7].

Etiology

It's still difficult to figure out what causes 'real' post-term pregnancies. Nulliparity and prior post-term pregnancy are two

common risk factors. Male foetuses have been linked to longer pregnancy times. Obesity has also been linked to increased pregnancy lengthening. Women with a low pre-pregnancy BMI, on the other hand, are more likely to birth preterm. The specific method by which BMI effects labour timing is uncertain, however changes in circulating oestrogen and progesterone levels may play a role [8].

Complications

Pregnancy beyond 41 weeks has been demonstrated to increase the likelihood of both the foetus and the mother suffering negative effects. For two reasons, risks have always been undervalued [9]. For starters, older studies were published before the widespread use of ultrasonography to determine gestational age; so many women with pregnancies that were not genuinely post-term were likely included. As a result of the misclassification bias, the complication rates linked with extended pregnancies will be underestimated.

CONCLUSION

The danger of routine induction of labour is lower than previously thought in the era of modern cervical ripening agents. Even with meticulous antenatal foetal screening, the risk of foetal mortality (stillbirth) is minimal in expectantly managed pregnancies. For all of these reasons, the authors advocate for routine induction of labour at 41 weeks for low-risk singleton pregnancies. The evidence for risk-based induction of labour at a younger gestational age is promising, but more research is needed before such an approach can be widely adopted.

CONFLICTS OF INTERESTS

There is no conflict of interest to declare.

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