Complete Summary

GUIDELINE TITLE

Management of postterm pregnancy.

BIBLIOGRAPHIC SOURCE(S)

American College of Obstetricians and Gynecologists (ACOG). Management of postterm pregnancy. Washington (DC): American College of Obstetricians and Gynecologists (ACOG); 2004 Sep. 8 p. (ACOG practice bulletin; no. 55). [69 references]

GUIDELINE STATUS

This is the current release of the guideline.

This guideline updates a previous version: American College of Obstetricians and Gynecologists (ACOG). Management of postterm pregnancy. Washington (DC): American College of Obstetricians and Gynecologists; 1997 Oct. 6 p. (ACOG practice patterns; no. 6).

** REGULATORY ALERT **

FDA WARNING/REGULATORY ALERT

Note from the National Guideline Clearinghouse: This guideline references a drug(s) for which important revised regulatory information has been released.

- April 10, 2006, Mifeprex (mifepristone) and misoprostol: Update to March 17, 2006 notice (see below).
- March 17, 2006, Mifeprex (mifepristone) and misoprostol: Public Health Advisory to notify healthcare professionals of two additional deaths.
- July 19, 2005, Mifeprex (mifepristone) and misoprostol: Revised BOXED WARNING and WARNINGS sections of the Prescribing Information, the Medication Guide and Patient Agreement to inform healthcare professionals of four cases of septic deaths in the United States

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

Postterm pregnancy

GUIDELINE CATEGORY

Management

CLINICAL SPECIALTY

Obstetrics and Gynecology

INTENDED USERS

Physicians

GUIDELINE OBJECTIVE(S)

- To aid practitioners in making decisions about appropriate obstetric and gynecologic care
- To examine the evidence and provide recommendations about two management strategies for postterm pregnancy: antenatal surveillance and induction of labor

TARGET POPULATION

Pregnant women who have completed 42 weeks of gestation or are 14 days beyond the estimated delivery date

INTERVENTIONS AND PRACTICES CONSIDERED

1. Accurate assessment of gestational age (ultrasonographic validation)
2. Antenatal surveillance (nonstress testing, assessment of amniotic fluid volume estimation)
3. Assessment of cervical condition prior to labor induction
4. Induction of labor, including use of prostaglandin gels (dinoprostone or misoprostol)
5. Expectant management

MAJOR OUTCOMES CONSIDERED

- Maternal and perinatal morbidity and mortality

- Duration of labor (induction-to-delivery interval)
- Cesarean delivery rate among patients managed

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

The MEDLINE database, the Cochrane Library, and American College of Obstetricians and Gynecologists' own internal resources and documents were used to conduct a literature search to locate relevant articles published between January 1985 and April 2004. The search was restricted to articles published in the English language. Priority was given to articles reporting results of original research, although review articles and commentaries also were consulted. Abstracts of research presented at symposia and scientific conferences were not considered adequate for inclusion in this document. Guidelines published by organizations or institutions such as the National Institutes of Health and the American College of Obstetricians and Gynecologists were reviewed, and additional studies were located by reviewing bibliographies of identified articles.

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Studies were reviewed and evaluated for quality according to the method outlined by the U.S. Preventive Services Task Force:

I: Evidence obtained from at least one properly designed randomized controlled trial

II-1: Evidence obtained from well-designed controlled trials without randomization

II-2: Evidence obtained from well-designed cohort or case-control analytic studies, preferably from more than one center or research group

II-3: Evidence obtained from multiple time series with or without the intervention. Dramatic results in uncontrolled experiments could also be regarded as this type of evidence.

III: Opinions of respected authorities, based on clinical experience, descriptive studies, or reports of expert committees.

METHODS USED TO ANALYZE THE EVIDENCE

Review of Published Meta-Analyses
Systematic Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

Analysis of available evidence was given priority in formulating recommendations. When reliable research was not available, expert opinions from obstetrician–gynecologists were used. See also the "Rating Scheme for the Strength of Recommendations" field regarding Grade C recommendations.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Based on the highest level of evidence found in the data, recommendations are provided and graded according to the following categories:

Level A — Recommendations are based on good and consistent scientific evidence.

Level B — Recommendations are based on limited or inconsistent scientific evidence.

Level C — Recommendations are based primarily on consensus and expert opinion.

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Practice Bulletins are validated by two internal clinical review panels composed of practicing obstetrician-gynecologists generalists and sub-specialists. The final guidelines are also reviewed and approved by the American College of Obstetricians and Gynecologists (ACOG) Executive Board.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

The grades of evidence (I-III) and levels of recommendations (A-C) are defined at the end of the "Major Recommendations" field.

The following recommendations are based on good and consistent scientific evidence (Level A):

- Women with postterm gestations who have unfavorable cervices can either undergo labor induction or be managed expectantly.
- Prostaglandin can be used in postterm pregnancies to promote cervical ripening and induce labor.
- Delivery should be effected if there is evidence of fetal compromise or oligohydramnios.

The following recommendations are based primarily on consensus and expert opinion (Level C):

- Despite a lack of evidence that monitoring improves perinatal outcome, it is reasonable to initiate antenatal surveillance of postterm pregnancies between 41 weeks (287 days; estimated delivery date [EDD] +7 days) and 42 weeks (294 days; EDD +14 days) of gestation because of evidence that perinatal morbidity and mortality increase as gestational age advances.
- Many practitioners use twice-weekly testing with some evaluation of amniotic fluid volume beginning at 41 weeks of gestation. A nonstress test and amniotic fluid volume assessment (a modified biophysical profile [BPP]) should be adequate.
- Many authorities recommend prompt delivery in a postterm patient with a favorable cervix and no other complications.

Definitions:

Grades of Evidence:

I: Evidence obtained from at least 1 properly designed randomized controlled trial.

II-1: Evidence obtained from well-designed controlled trials without randomization.

II-2: Evidence obtained from well-designed cohort or case-control analytic studies, preferably from more than 1 center or research group.

II-3: Evidence obtained from multiple time series with or without the intervention. Dramatic results in uncontrolled experiments could also be regarded as this type of evidence.

III: Opinions of respected authorities, based on clinical experience, descriptive studies, or reports of expert committees.

Levels of Recommendation

Level A — Recommendations are based on good and consistent scientific evidence.

Level B — Recommendations are based on limited or inconsistent scientific evidence.

Level C — Recommendations are based primarily on consensus and expert opinion.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is identified and graded for each recommendation (see "Major Recommendations").

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Accurate assessment of gestational age and diagnosis of postterm gestation, as well as recognition and management of risk factors, may reduce the risk of adverse sequelae. Antenatal surveillance and induction of labor are 2 widely used strategies that theoretically may decrease the risk of an adverse fetal outcome.

POTENTIAL HARMS

- Overall, the medications (prostaglandin E_2 [PGE_2; dinoprostone] and PGE_1 [misoprostol]) were well tolerated with few reported side effects. Higher doses of PG (especially PGE_1) have been associated with an increased risk of uterine tachysystole and hyperstimulation leading to nonreassuring fetal testing results

- The risk of uterine rupture does not appear to increase substantially after 40 weeks of gestation, but the risk appears to be increased with labor induction with PG or pitocin regardless of gestational age.

QUALIFYING STATEMENTS

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These guidelines should not be construed as dictating an exclusive course of treatment or procedure. Variations in practice may be warranted based on the needs of the individual patient, resources, and limitations unique to the institution or type of practice.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

IMPLEMENTATION TOOLS

Patient Resources

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better
Staying Healthy

IOM DOMAIN

Effectiveness
Timeliness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

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ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

1997 Oct (revised 2004 Sep)

GUIDELINE DEVELOPER(S)

American College of Obstetricians and Gynecologists - Medical Specialty Society

SOURCE(S) OF FUNDING

American College of Obstetricians and Gynecologists

GUIDELINE COMMITTEE

American College of Obstetricians and Gynecologists (ACOG) Committee on Practice Bulletins-Obstetrics

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Not stated

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

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GUIDELINE AVAILABILITY

Electronic copies: Not available at this time.

Print copies: Available for purchase from the American College of Obstetricians and Gynecologists (ACOG) Distribution Center, PO Box 4500, Kearneysville, WV 25430-4500; telephone, 800-762-2264, ext. 192; e-mail: sales@acog.org. The ACOG Bookstore is available online at the ACOG Web site.

AVAILABILITY OF COMPANION DOCUMENTS

None available

PATIENT RESOURCES

The following is available:

- What to expect after your due date. Atlanta (GA): American College of Obstetricians and Gynecologists (ACOG); 2006.

Electronic copies: Available from the American College of Obstetricians and Gynecologists (ACOG) Web site.

Print copies: Available for purchase from the American College of Obstetricians and Gynecologists (ACOG) Distribution Center, PO Box 4500, Kearneysville, WV 25430-4500; telephone, 800-762-2264, ext. 192; e-mail: sales@acog.org. The ACOG Bookstore is available online at the ACOG Web site.

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NGC STATUS

This summary was completed by ECRI on April 14, 1999. The information was verified by the guideline developer on June 11, 1999. This NGC summary was updated by ECRI Institute on August 1, 2007. The updated information was verified by the guideline developer on September 10, 2007.

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