Induction at 41 Weeks May Avert Complications

BY MICHELE G. SULLIVAN   Mid-Atlantic Bureau

RIVIERA MAYA, MEXICO — Routine induction of labor at 41 weeks is safe for women with low-risk singleton pregnancies and may decrease the risk of postterm pregnancy complications for both mother and baby, Dr. Errol Norwitz said at a meeting on obstetrics, gynecology, perinatal medicine, neonatology, and the law.

“This would affect 30% of low-risk deliveries and 10%-15% of all deliveries, so this is a big management shift,” said Dr. Norwitz, director of maternal-fetal medicine at Yale-New Haven Hospital, Conn. “It would definitely affect your practice.”

But such a change would be both cost effective and safer for mother and baby, he asserted. Recent data suggest that routine induction of labor in these women is safer than previously thought, with little or no impact on cesarean delivery rates, and that the risks of postterm birth are greater than previously thought.

Stillbirth is the greatest risk for the postterm fetus, with a fourfold increase at 43 weeks and a sevenfold increase by 44 weeks, compared with 40 weeks. Newer studies have identified other problems as well, including fetal macrosomia, meconium staining, “fetal distress,” and uteroplacental insufficiency. Neonatal encephalopathy is also a risk, with a 10-fold increase at 42 weeks, compared with 38 weeks.

But the mother is also at risk, Dr. Norwitz said. “This is an underappreciated problem. Shoulder dystocia is much more common, as is severe perineal injury, with third- and fourth-degree tears. There is also an increased risk of postpartum hemorrhage.”

In 1997, the American College of Obstetricians and Gynecologists recommended induction of labor after 43 weeks for low-risk pregnancies, but the current guidelines, issued in 2004, don’t offer specific recommendations. This omission is possibly the result of concerns that labor induction is associated with an increase in the incidence of cesarean deliveries—an association that may never be conclusively proved or disproved, Dr. Norwitz said. “It would take a randomized controlled trial of 150,000 post-term pregnancies to really answer this question, and I don’t think we’re going to get that. We have to appreciate that the literature in this area is limited.”

The best source of data is a 2000 Cochrane Database review, which included 26 trials of various size and quality (Cochrane Database Syst. Rev. 2000;2:CD000170). Those of highest quality, Dr. Norwitz said, were two randomized controlled trials of 108 (1992) and 440 (1994) pregnancies, and a Canadian trial of almost 3,500 conducted in 1992. Both 1992 trials showed a significant decrease in cesarean rates among pregnancies induced at 41 weeks, while the 1984 study showed no significant difference in cesarean rates between the two groups. The review also concluded that routine induction of labor after 41 weeks appeared to reduce perimortem mortality.

“It appears that in multiparas women and nulliparas with a favorable cervical exam, routine induction at 41 weeks doesn’t carry an increased risk of a C-section,” Dr. Norwitz said. ”But in nullips with an unfavorable cervix, we might see the rate increase slightly. For these women, we must weigh the risk of preventing postterm complications to mom and baby with the risks of a cesarean delivery.”

Dr. Norwitz offered an algorithm for managing postterm, low-risk, singleton pregnancies:

About 50% of all pregnancies reach the 40th week. At this time, discuss the option of induction and check the cervix, but do not institute fetal surveillance. About half of the group will deliver spontaneously within the next week. For the remaining patients, offer either induction of labor or expectant management at 41 weeks.

For the women who elect continued expectant management, discuss the risks of continuing the pregnancy beyond 41 weeks and document the discussion. Institute some method of fetal surveillance to assess the baby’s condition.

“None single test has ever been shown to be better than another, with the exception of Doppler velocimetry alone—that has not been shown to be adequately sensitive” Dr. Norwitz said. “Most of us do twice weekly fetal testing, and one of these assessments should include an estimation of amniotic fluid volume.”

Most of these women will give birth by 42 weeks, leaving only 3%-4% of pregnancies to continue into the 43rd week. At this time, induction of labor should routinely be recommended because the increased risk of stillbirth is significant, he said.

Most women who choose induction at 41 weeks will deliver successfully, but some inductions will fail. Those women can be admitted for rupture of membranes and oxytocin, or sent home and brought back for a repeat induction in 2-3 days if the fetal testing is reassuring, Dr. Norwitz said.

Fish Oil Supplements May Benefit Infants’ Eye-Hand Coordination

BY JONATHAN GARDNER   London Bureau

High doses of fish oil supplements in pregnant women improve eye and hand coordination in their babies at age 2½ years, according to a new study. The researchers said the small size of their sample size limits their ability to answer this question, and they don’t think they’re going to get that. They have to appreciate that the literature in this area is limited.

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Uterine Myomas in Pregnancy Increase Risk of Complications

LAS VEGAS — Uterine myomas in pregnancy are significantly associated with pregnancy complications, including first- and second trimester miscarriage, malpresentation of the baby at delivery, and preterm labor, Dr. Radwan Assaad reported at the annual meeting of the American Association of Gynecologic Laparoscopists.

In addition, “a cesarean delivery in the presence of a low anterior myoma is associated with a high incidence of postpartum hemorrhage,” said Dr. Assaad of Wayne State University, Detroit.

Findings from previous studies have linked uterine myomas to pregnancy complications including preterm labor, placental abruption, and postpartum hemorrhage. To further study the effect of uterine myomas on pregnancy complications, Dr. Assaad and colleagues reviewed data from 155 women who were diagnosed with myomas during pregnancy. Overall, 49% of the women had vaginal deliveries, and 55% cesarean deliveries. Malpresentation at delivery (the most common complication) occurred in 22% of the patients. Of these, 16.8% were breech, 3.9% were transverse, and 1.3% were oblique. Other complications included growth restriction (17.4%), preterm labor (17.4%), and premature rupture of membranes (16.1%). In addition, 7.7% of the women had first-trimester miscarriages and 5.8% had second-trimester miscarriages.

Overall, the risk of postpartum hemorrhage was 27.3% among women who had cesarean deliveries, compared with only 2.6% among women who had vaginal deliveries. Notably, a low-lying anterior fibroid was associated with an eightfold risk of postpartum hemorrhage. Overall, the rate of first-trimester miscarriages and 5.8% had second-trimester miscarriages.

Currently, the risk of postpartum hemorrhage was defined as an estimated blood loss of more than 500 cc during a vaginal delivery and more than 1,000 cc during a cesarean delivery. Myomectomies (which have been shown to reduce the risk of miscarriage in women with fibroids) were performed in 9% of the women who had cesarean deliveries, and the myomectomies were not associated with an increased risk of postpartum hemorrhage in these patients, Dr. Assaad said.

—Heidi Splete