CLINICAL ASSESSMENTS IN LATE PREGNANCY

In late pregnancy, antenatal care becomes more frequent and includes planning and preparing for the birth. Recommendations are based on the evidence for interventions that aim to reduce the need for unnecessary induction of labour or unplanned caesarean section. Decisions about a woman’s care are made after considering the benefits and possible risks, always taking the woman’s preferences into account. When there is a higher risk of adverse outcomes, discussion with specialists (eg obstetrician, neonatologist, paediatrician) is required.

Fetal presentation (see Guideline Chapter 61)

Assessing fetal presentation

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<tr>
<th>Recommendation</th>
<th>Grade C</th>
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<td>Assess fetal presentation by abdominal palpation at 36 weeks or later, when presentation is likely to influence the plans for the birth.</td>
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How is non-cephalic presentation confirmed?

Suspected non-cephalic presentation after 36 weeks should be confirmed by an ultrasound assessment.

External cephalic version

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<th>Recommendation</th>
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<td>Offer external cephalic version (ECV) to women with uncomplicated singleton breech pregnancy after 37 weeks of gestation.</td>
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Consensus-based recommendation

Relative contraindications for ECV include a previous caesarean section, uterine anomaly, vaginal bleeding, ruptured membranes or labour, oligohydramnios (low amniotic fluid volume), placenta praevia and fetal anomalies or compromise.

Who should perform external cephalic version?

ECV should be performed by a health professional with appropriate expertise.

Discussing external cephalic version

- ECV involves a health professional using his or her hands on the woman’s abdomen to gently turn the baby
- ECV is successful in approximately half of women, with success more likely if medications are used to relax the uterus
- ECV is not appropriate in some situations (eg when there is vaginal bleeding, a low level of amniotic fluid or some fetal or uterine anomalies)
- ECV has low complication rates but should be carried out where there are facilities for emergency caesarean section
- If a woman chooses not to have ECV, or the procedure does not turn the baby or the baby returns to breech position, vaginal breech birth may still be possible depending on the individual situation

Practice summary

When: At around 36 weeks gestation

Who: Midwife; GP; obstetrician; Aboriginal and Torres Strait Islander Health Practitioner; Aboriginal and Torres Strait Islander Health Worker; multicultural health worker

- Discuss the risks associated with malpresentation: Explain that, while most babies turn to present with the crown of the head before labour, the birth process can be complicated if this does not occur.
- Discuss ECV with women with a breech baby: Explain that turning the baby before the birth reduces the need for caesarean section. Discuss the benefits and risks of the procedure and where it would take place.
- Discuss plans for the birth: Explain the risks and benefits associated with planned vaginal birth and caesarean section.
- Take a holistic approach: Encourage women to attend with family members to discuss plans for ECV and birthing options.
Prolonged pregnancy (see Guideline Chapter 62)

Options in prolonged pregnancy

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<th>Recommendation</th>
<th>Evidence-based recommendation</th>
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<td>Discuss options, including induction of labour, with a woman who is nearing prolonged pregnancy.</td>
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Discussing prolonged pregnancy

- Most women go into labour spontaneously by 42 weeks
- There are risks associated with pregnancies that last longer than 42 weeks
- Women with low-risk prolonged pregnancies may be offered membrane sweeping to ‘trigger’ labour
- Membrane sweeping involves the health professional separating the membranes from the cervix as part of a vaginal examination; it is safe but may cause discomfort and vaginal bleeding
- If pregnancy is prolonged, additional monitoring and management plans will be offered following specialist consultation, to reduce the risk of adverse outcomes
- It is very important to contact a health professional promptly if there are any concerns about decreased, absent or unusually increased fetal movements

Practice summary: prolonged pregnancy

**When:** At antenatal visits from 39 weeks onwards

**Who:** Midwife; GP; obstetrician; Aboriginal and Torres Strait Islander Health Practitioner; Aboriginal and Torres Strait Islander Health Worker; multicultural health worker

- Discuss the likelihood of prolonged pregnancy: Explain to the woman that pregnancy beyond 42 weeks is unlikely if dating is accurate.
- Discuss why interventions may be offered: Explain that the risk of complications increases from 42 weeks pregnancy. Decisions about management are made after considering the risks and benefits and taking the woman’s preferences into account.
- Discuss the need for fetal monitoring: Explain that increased fetal monitoring is necessary from 41 weeks, to ensure that there are no risks to the baby from the pregnancy continuing.
- Take a holistic approach: As well as the potential for women to experience anxiety if pregnancy is prolonged, consider practical difficulties (eg when the woman has travelled to give birth or arranged additional support around the estimated date of birth) and provide advice on relevant community supports (eg available financial assistance).