

41-week Antenatal Visit

Dr Elizabeth McCarthy
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“First, check on maternal health, second, check on fetal health, and third, plan the next steps for the woman, with the woman.”



Transcribed directly from MOGCAST Episode 25. Listen here:

<https://open.spotify.com/show/6dtXQ6jLjAlI7lHtP71cYe?si=7671224caacc4f4a>

Hello, my name is Dr Elizabeth McCarthy, known as Liz, and I'm an obstetrician, subspecialist in maternal fetal medicine and have been heavily involved in teaching women's and newborn health at the University of Melbourne.

This podcast is about what happens in antenatal clinic for women at around 41 weeks or later in pregnancy. Are we there yet? The 10% of women who are still pregnant a week or longer after their expected date of delivery are often sick of hearing about other people's expectations that, haven't you had your baby yet? The reality is that no one fully understands what triggers human labour. If we knew this, we might be more successful in preventing both pre-term and post-term birth. But we can be sure that the 41-week pregnant woman is not prolonging her pregnancy in order to inconvenience other people.

The main tasks in caring for a woman attending antenatal clinic at 41 weeks or later are similar to an earlier pregnancy. First, check on maternal health, second, check on fetal health, and third, plan the next steps for the woman, with the woman. So the next steps sometimes include, one, offering a stretch and sweep, two, planning post-term monitoring, and three, planning labour induction. And I'll talk a little bit more about each of these soon.

So concerning the woman's health, check that she hasn't developed pregnancy complications, which would mean that the risks of continuing pregnancy outweigh those of interrupting the pregnancy. And when I say interrupt the pregnancy, I'm usually talking about labour induction. So examples are, if the woman has had an antepartum haemorrhage or pre-labour ruptured membranes or pregnancy induced hypertension or preeclampsia, then it's usually pretty straightforward to work with her to advise that labour induction is a safer way forward to just finish the pregnancy. Then we would do the routine physical examination checks you're all fairly familiar with, general examination for oedema, blood pressure, and point of care urinalysis.

Now, the second patient, the baby, the clinical assessment is, again, very similar to what you've done before. A conversation about fetal movements and then the obstetric abdominal examination, looking to see if fetal size is appropriate, if the head is the presenting part, and whether this is fixed in the pelvis.

So reduced fetal movements when a woman's already post-term might be sufficient reason to induce labour. If the fetus is clinically small, again, that might be a reason to prompt a discussion about labour induction sooner rather than later, with or without same-day testing with cardiotocography and ultrasound assessment for amniotic fluid.

So women have different views about what they would like to do if they're still pregnant at 41 weeks. Most women are prepared to be a mother, but exactly when, they may have different ideas. Some will have a strong desire to wait spontaneous onset of labour so that the baby chooses her own birthday. Conversely, other women prefer a planned birth. That may be for individual reasons such as arranging childcare, for paternity leave, or they're simply sick of the discomforts of late pregnancy.

The next step is similar to what you've done before, just checking on previous test results. But in terms of planning further testing, check with your local hospital guidance about post-term monitoring. In all hospitals, there will be something guiding to help us as clinicians exclude late-onset placental insufficiency.

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So a typical testing regime at the time of dictating would be second daily CTGs, the CTGs being a short-term test of placental health and an ultrasound assessment of amniotic fluid volume on the same day, which is a test for medium-term placental function. Most hospitals wouldn't recommend a growth scan when birth is going to be within a week anyway because birth weight of the newborn is by definition accurate, whereas the fetal weight estimates are an inaccuracy, which means it's not very clinically helpful to do a growth scan after 40 weeks. So if your hospital has a fetal monitoring unit or pregnancy day assessment unit, you'll probably find quite a few women attend there having post-term monitoring.

OK, then the question of a stretch and sweep. The woman's doctor or midwife might offer her this. What does this mean? It's shorthand for when that maternity practitioner inserts one or two gloved fingers into the woman's vagina to palpate the cervix, aiming to stretch. Here's the stretch bit. Stretch the cervical canal and sweep. What do they sweep? They sweep with their fingers the membranes, which are sitting somewhat attached over the lower uterine segment and internal cervical os. So stretch the cervix, sweep the membranes. Stretch and sweep.

You all know that examinations in general and particularly sensitive examinations such as stretch and sweep need a conversation beforehand to check that the woman consents to the examination which is proposed. The pros of having a stretch and sweep are, first, it can promote labour onset without medications, and second, the person doing the stretch and sweep can tell the woman about the woman's cervical ripeness or bishop score. And this information would be needed if there was going to be a labour induction because the technique of labour induction depends on if the woman's cervix is unripe with a low bishop score or ripe with a high bishop score.

Now, the cons of a stretch and sweep is that it can be uncomfortable. It's a sensitive examination and it will generate, in many cases a bit of mess, in terms of the mucus plug or show is dislodged, often with a little bit of blood. Women can distinguish a show, the mucus plug, from an antepartum haemorrhage because in colloquial terms, a show is like nasal mucus or snot with streaks of blood, whereas an antepartum haemorrhage is more like when blood flows from a cut finger.

So why do some women with otherwise uncomplicated pregnancies have labour induced between 41 and 42 weeks? This is primarily because stillbirth rates rise steadily with prolonged gestation and there's no strong evidence that waiting for spontaneous labour reliably reduces the risk of caesarean birth. While many post-term babies are healthy and well-grown, there are both small babies and large babies. Some have failing placentas and late onset fetal growth restriction and may have fetal distress in labour or tragically may go on to stillbirth.

At the other end of the extreme, other babies continue to grow to an extent that's called macrosomia. And for some macrosomic babies, the mechanics of birth get more and more challenging as the pregnancy goes on and these births can be complicated by obstructed labour or shoulder dystocia. So related to this, I do recommend listening or reviewing the podcasts on labour induction and caesarean section.

So that's the information I wanted to revise. So go ahead now with that information to antenatal clinic and pregnancy assessment units and learn from women who are still pregnant after their due date.

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Ask about the women's symptoms, but also their views, birth plans and priorities.

Listen to consent conversations about examinations such as stretch and sweep, about tests such as CTG and amniotic fluid ultrasound scans and about booked procedures such as labour induction and enjoy learning.

Bye.