Dear client,

Your due date has passed ... what now? Wait until your child decides to be born or opt for an induced labour? Both options are possible. It is important to make a well-considered decision that suits you.
The information about pros and cons are listed in this ‘decision aid’ with population diagrams, to help you make a well informed decision.

Definition
Post term pregnancy (overdue) is at 42+0 weeks of pregnancy.

Postdates pregnancy (nearly overdue) is the period between 41+0 weeks and 41+6 weeks of pregnancy.

What is it about?
Post term pregnancy can be a risk factor for a poorer health outcome for the baby and also for the mortality of the baby. This has to do with the blood flow in the placenta, which gradually decreases, due to which the amount of amniotic fluid can also decrease. For this reason, the advice in the Netherlands, is not to let the pregnancy last longer than 42 weeks and to induce labour at 41+6.

Also in **postdates pregnancy**, there may be less blood flow to the placenta and decreased amniotic fluid, which may affect the health outcome of the baby.

Postdates pregnancy
After reading this ‘decision aid', after having had a conversation with your midwife or gynaecologist about the advantages and disadvantages of being pregnant for longer than 41 weeks, the pros and cons of an induced labour, you can make a well informed decision:

- Induce labour from a gestation period of 41 weeks.

- Await a spontaneous start of labour up to 42 weeks.

Inducing labour from 41 weeks:
If you choose to induce labour, you will be referred to a gynaecologist. In the hospital, they will discuss with you how the delivery will be induced. The method of induction depends on the ripening of your cervix at the start of the induction. For detailed information we refer to the flyer “inducing labour” of the hospital of your choice.

If your cervix is already sufficiently mature, and there are no other risk factors for which you are in care of the gynaecologist, your own midwife can break the membranes either at home or in the hospital (as an outpatient). After this we will wait a few hours to see if you have spontaneous contractions. If there are no or insufficient contractions, you will be referred to the gynaecologist and the delivery is continued in hospital. Usually with the help of intravenous medication to induce the contraction.

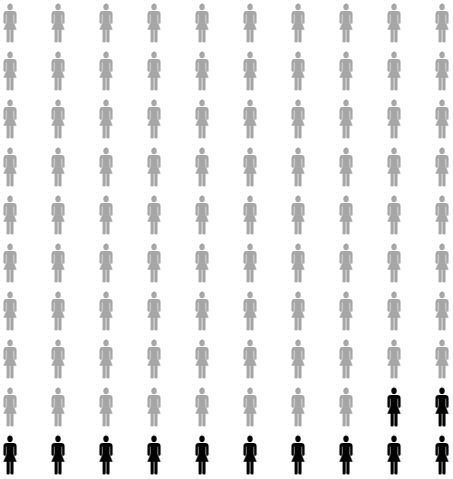
Await a spontaneous start of labour up to 42 weeks:
If you decide to wait for a spontaneous start of labour, we will schedule two extra check-ups in the hospital with the gynaecologist to keep an extra eye on the condition of the baby during this period. During these checks, an ultrasound and a heart registration will be made of the baby. If these checks are fine, you can await the spontaneous start of labour.

‘Decision aid’
Below you will find an overview of the most important pros and cons to help you make your choice. These data are based on medical research in low-risk pregnancies. These are pregnancies in the care of midwives, just like yours.

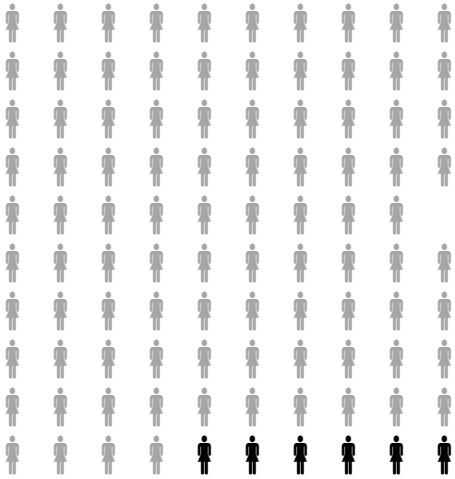
Inducing labour versus not inducing

In general, you see greater disadvantages of inducing labour the earlier in pregnancy you induce labour. Several disadvantages (such as excessive bleeding after birth (haemorrhage) and total ruptures) are therefore less common when inducing labour in the postdates or post term pregnancy.

How often is the uterus overstimulated?

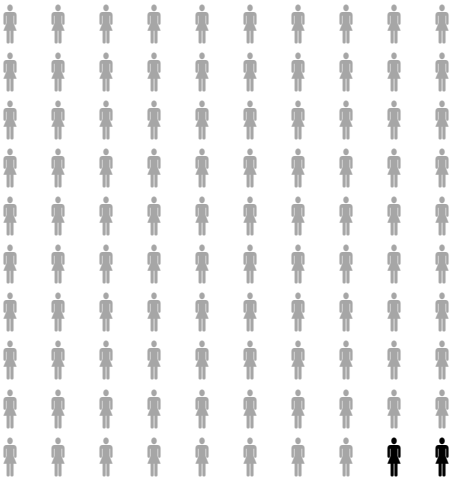


With induction:
12 in 100 women
(12%)

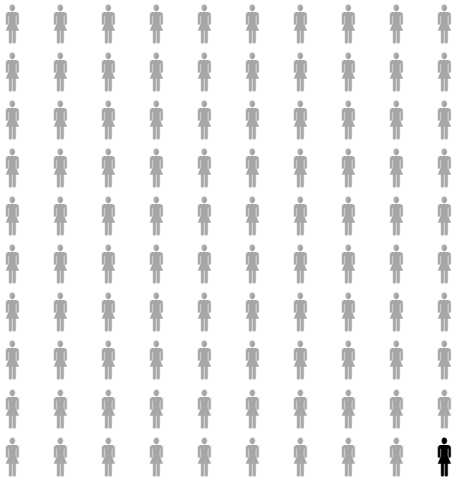


Without oxytocine:
6 in 100 women
(6%)

How often does blood loss of more than 1.5 litres occur or is a blood transfusion required?

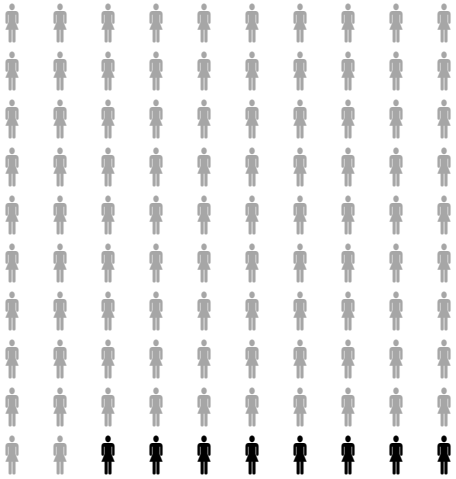


Induced labor:
2 in 100 women
(1,9%)

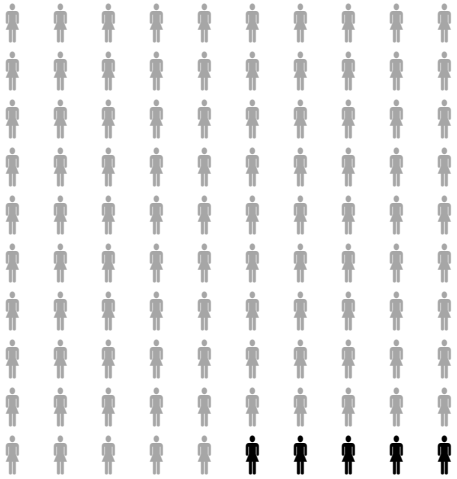


Spontaneous labor:
1 in 100 women
(0,9%)

How often does a total rupture occur when women give birth to their first child?

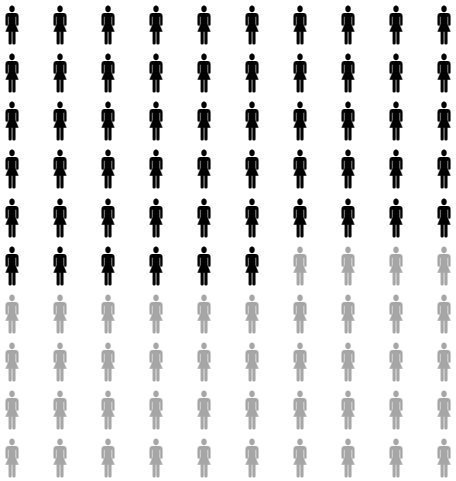


Induced labor:
8 in 100 women
(8%)

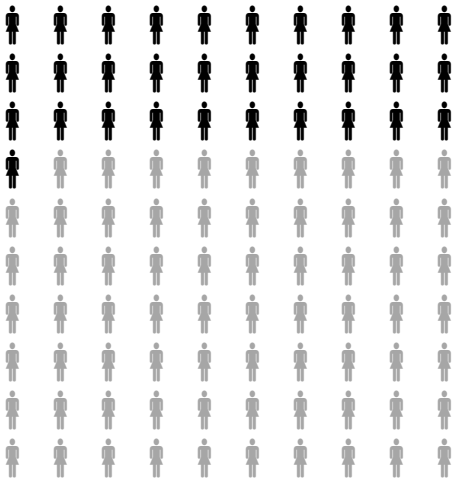


Spontaneous labor:
5 in 100 women
(5%)

How often does a woman need medical pain relief during childbirth?

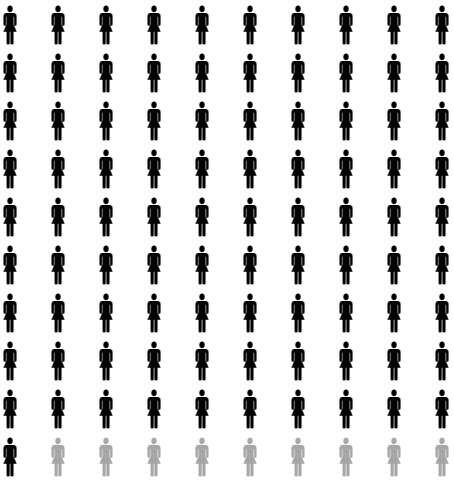


Induced labor:
56 in 100 women
(56%)

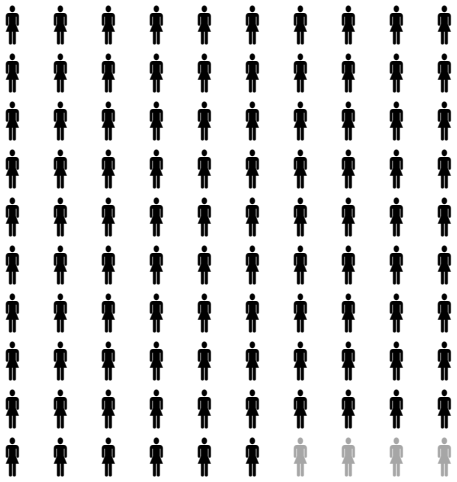


Spontaneous labor:
31 in 100 women
(31%)

How often do women have a positive delivery experience?

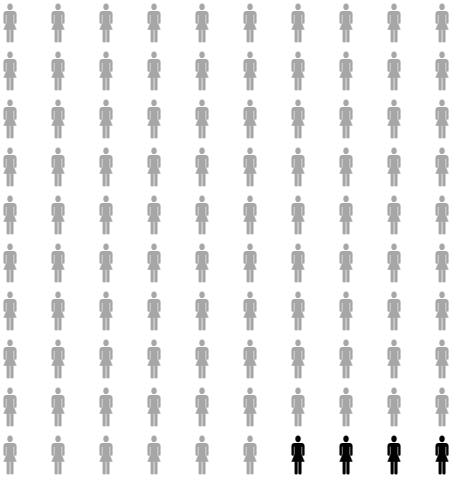


Induced labor:
91 in 100 women
(91%)

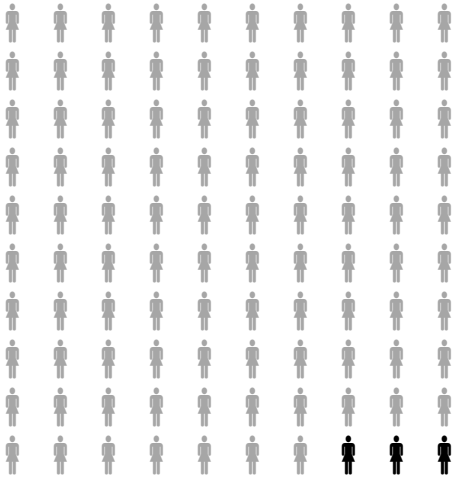


Spontaneous labor:
96 in 100 women
(96%)

How often does severe jaundice (hyperbilirubinemia) occur in a child?

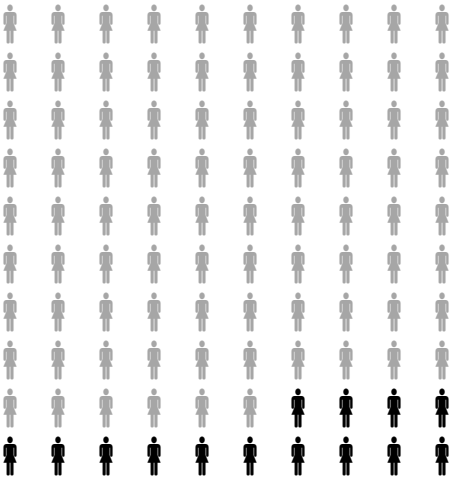


Induced labor:
4 in 100 women
(3,6%)

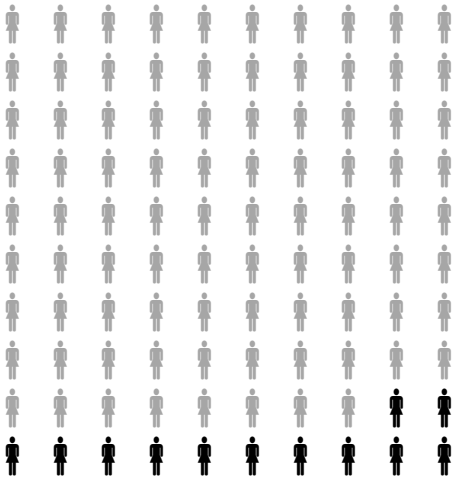


Spontaneous labor:
3 in 100 women
(2,9%)

How often does a child suffer from respiratory infections up to the age of 5?



Induced labor:
14 in 100 women
(14%)

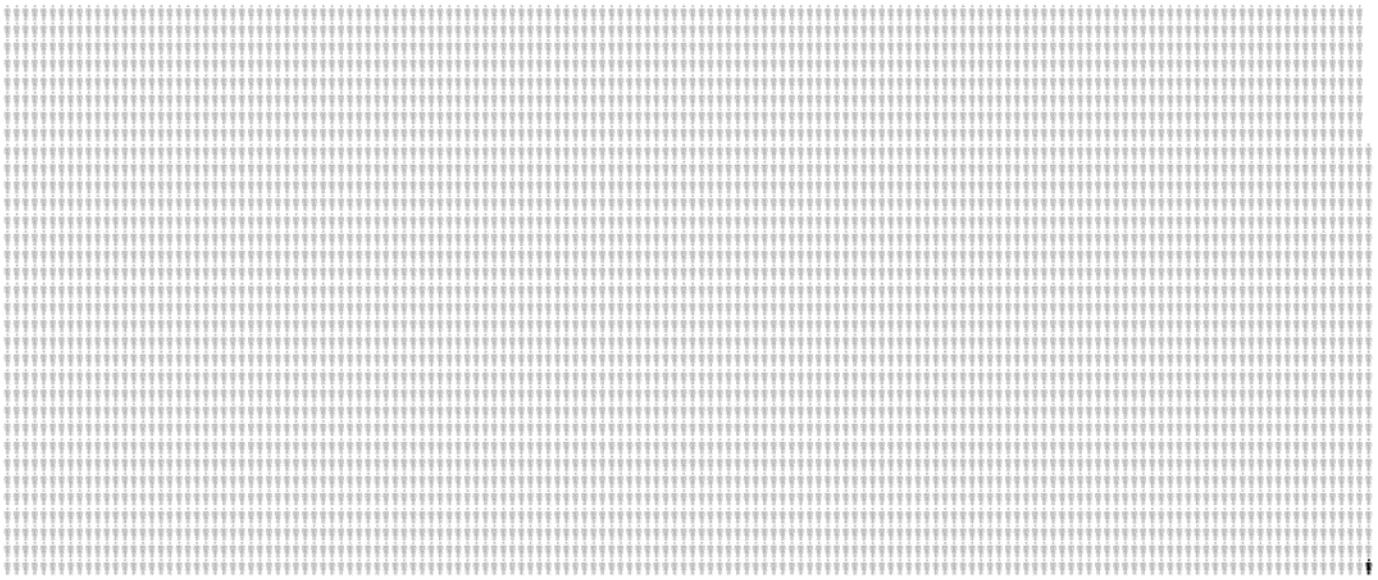


Spontaneous labor:
12 in 100 women
(12%)

Intrauterine death (the death of the baby in the womb) by gestational age

Number of intrauterine deaths in that week of pregnancy, in the group of women who are still pregnant that week. (Perined data from 2012-2018).
The data of week 39 is left out, because the number of intrauterine deaths is too low to show: 0,01%. This means 0,5 intrauterine death per 5.000 women.

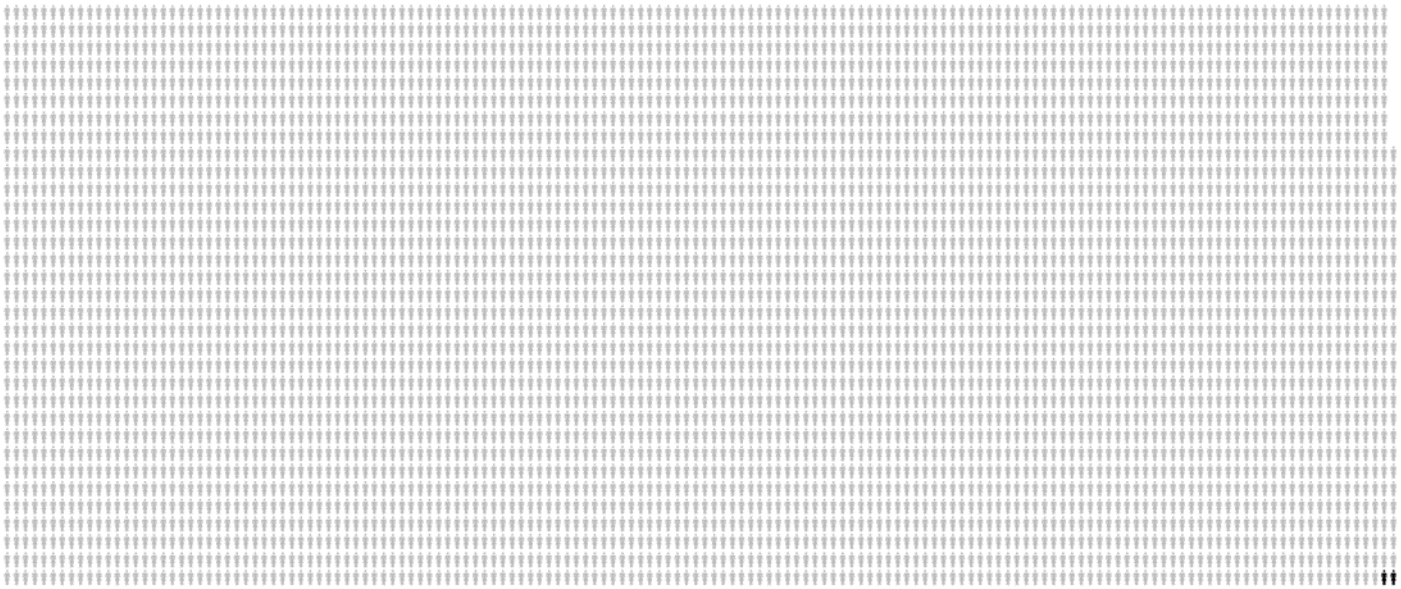
*What is the risk of an intrauterine death at **week 40**?*



Out of 5.000 women:
1 baby dies
4.999 babies are born alive

0,02%

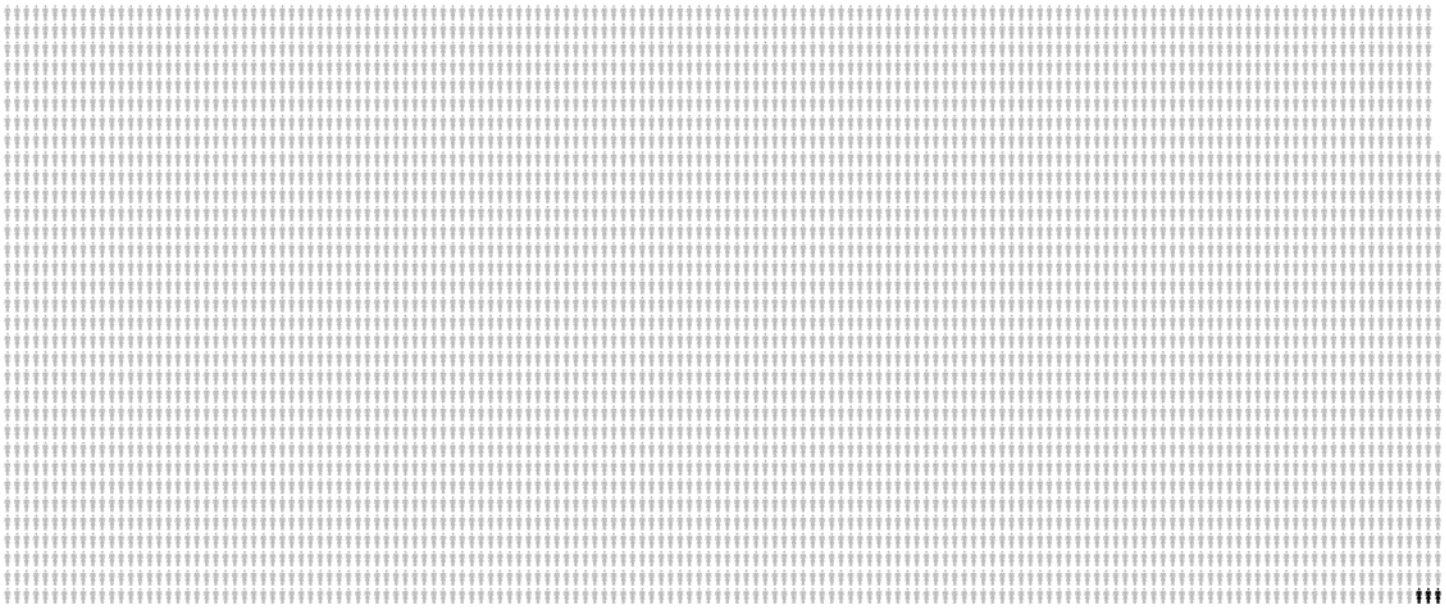
*What is the risk of an intrauterine death at **week 41**?*



Of 5.000 women:
2 babies die
4.998 babies are born alive

0,04%

*What is the risk of an intrauterine death at **week 42**?*

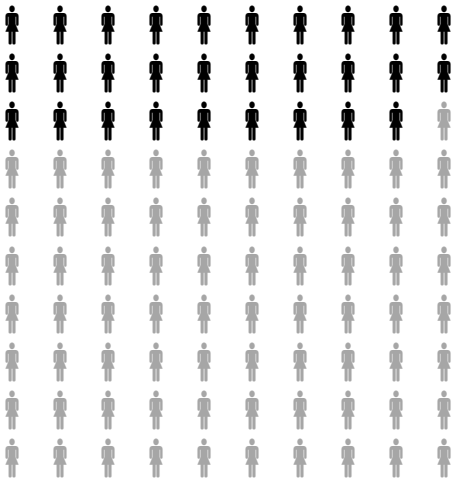


Out of 5.000 women:
3 babies die
4.997 babies are born alive

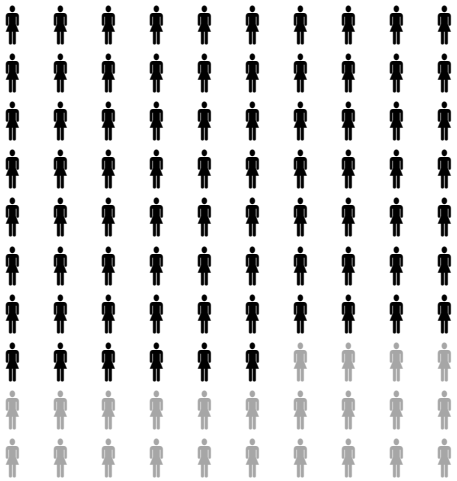
0,06%

Induce labour or await at 41 or 42 weeks (Index-study)

How often labour starts spontaneously?

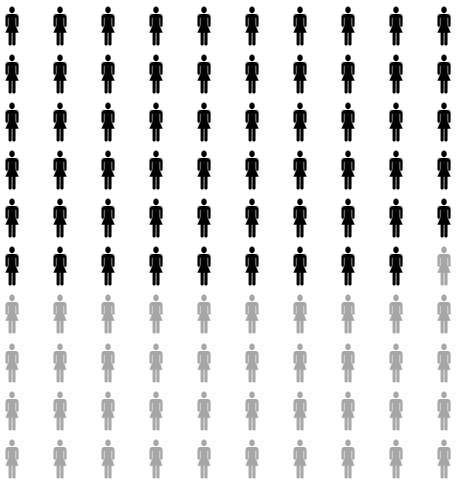


Induced at 41 weeks:
29 in 100 women
(29%)

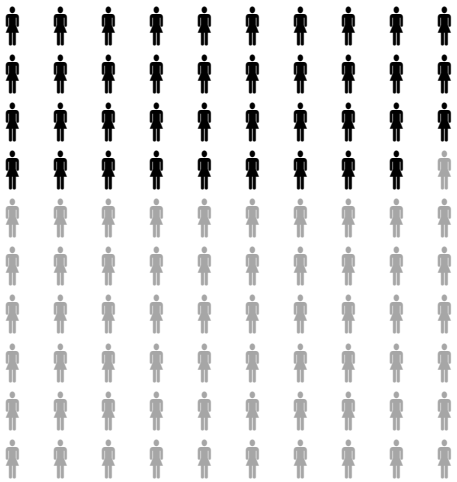


Await until 42 weeks:
74 in 100 women
(74%)

How often will oxytocin (medical stimulation) be administered during labour?

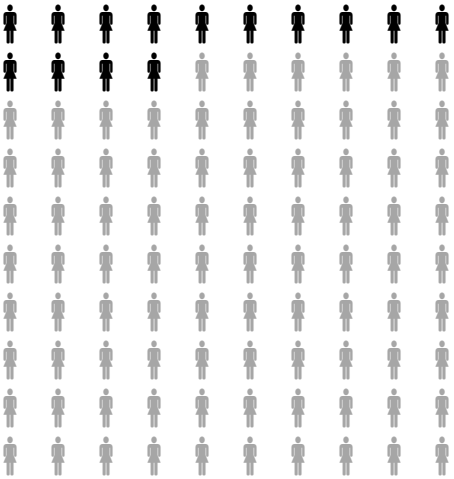


Induced at 41 weeks:
59 in 100 women
(59%)

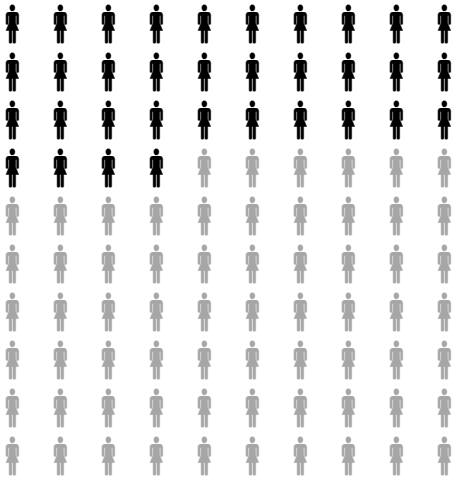


Await until 42 weeks:
39 in 100 women
(39%)

How often is the delivery supervised by your own midwife?

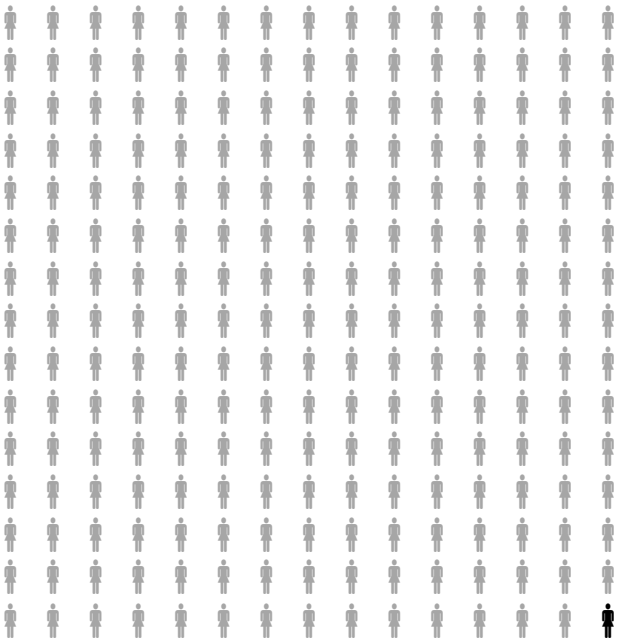


Induced at 41 weeks:
14 in 100 women
(14%)



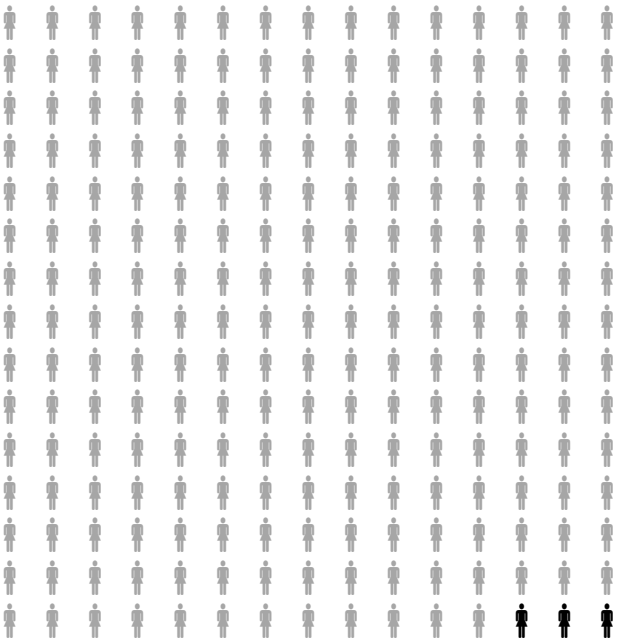
Await until 42 weeks:
34 in 100 women
(34%)

How often did an adverse outcome occur for the child in the INDEX study?
Adverse outcome: perinatal mortality, Apgar score <4, meconium aspiration, brachial plexus lesion, intracranial haemorrhage, or NICU admission.



Induced at 41 weeks: **0,4%**
1 in 225 adverse outcome
224 in 225 no adverse outcome

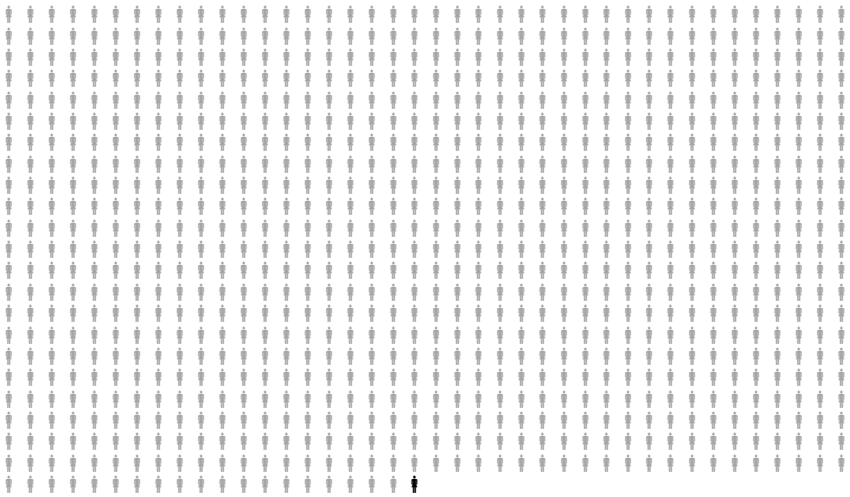
p = 0.06



Await until 42 weeks: 1,3%
3 in 225 adverse outcome
222 in 225 no adverse outcome

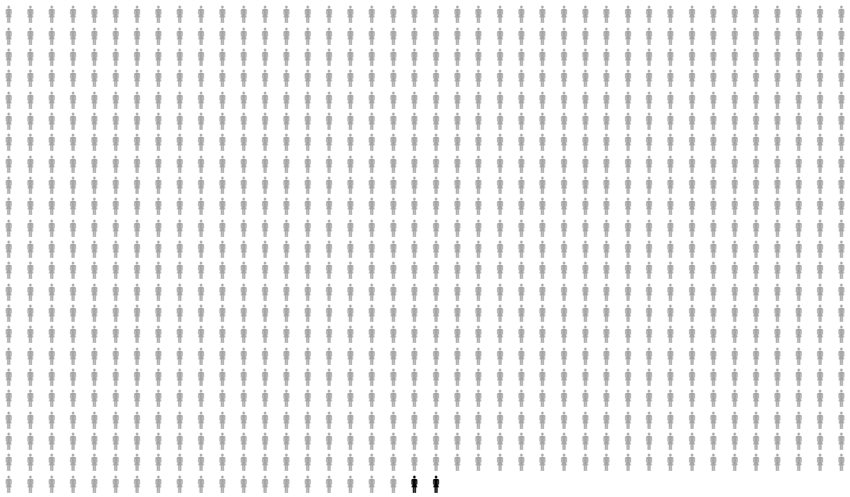
Composite adverse outcome measure: no significant difference (p = 0.06). Apgar score <4 shown, due to international consensus that Apgar score <7 has insufficient predictive value.

How often did a child die in the INDEX study (perinatal mortality)?
The study was not large enough to show a difference in mortality. The numbers are thus influenced by chance



Induced at 41 weeks: 0,1%
1 in 900 died
899 in 900 were born alive

p = 1.00



Await until 42 weeks: 0,2%
2 in 901 died
899 in 901 were born alive

	Await until 42 weeks	Induce at 41 weeks
Health of baby	Most babies are born healthy. The chance of the baby dying is <1% There is no difference in the number of infections in the new-born. There is no difference in Apgar scores <7 after 5 minutes. Long-term effects, such as the effects on the general health of the new-born, have not been studied.	
Health of mother	There is no difference in the number of caesarean sections, medically assisted deliveries, amount of blood loss during delivery, occurrence of ruptures or shoulder dystocia (difficult birth of the baby's shoulders).	
Pain relief	If pain relief is required, your midwife will refer you to the hospital. The chance that you need pain relief is lower with a spontaneous birth.	In general, induced labour has a longer duration than spontaneous labour. Therefore, pain relief is more often required.
Place of birth	In principle, at home or in hospital (outpatient) in the care of your own midwife. If the delivery does not proceed normally, the midwife will refer you to the gynaecologist. If you were already medical and under the care of the gynaecologist, you have a clinical delivery in the hospital.	In principle, in the hospital (clinically) in the care of the gynaecologist. If there is already sufficient dilation to break membranes, an induction can also be started at home or in hospital (outpatient). If the delivery proceeds normally, it can be in the care of your own midwife.
Check-ups during the delivery	During a delivery (at home or on an outpatient basis) in the care of your own midwife, the progress of the delivery is monitored by means of internal examinations. The baby's condition is monitored by regular listening to the heart frequency. If the delivery does not proceed normally, the midwife will transfer care to the gynaecologist. All deliveries from 42 weeks onwards take place in hospital (clinically) under the care of the gynaecologist.	During a delivery in the care of your own midwife, the progress of the delivery is monitored by means of internal examinations. The baby's condition is monitored through regular listening to the heart frequency. In the case of a delivery in the care of the gynaecologist, the progress is monitored by means of internal examinations. In addition, you have an IV drip and the baby is monitored with a continuous heart film. This can potentially lead to less freedom of movement.
Length of time	A spontaneous delivery with a normal course takes an average of 12 hours. During a spontaneous delivery, there is also a chance that an IV drip is required with contraction inducers, if the delivery is not progressing sufficiently. The delivery then becomes clinical. If you have given birth vaginally before, it is expected that both an induced and a spontaneous labour will be quicker than the previous birth.	The duration of induced labour is highly dependent on the maturity of the cervix at the start of induction. If the cervix is not mature, it usually takes at least 24 hours to ripen the cervix before the membranes can be ruptured. After the membranes have been ruptured, the delivery takes an average of 12 hours. If you have given birth vaginally before, it is expected that both an induced and a spontaneous labour will be quicker than the previous birth.
Experience	A spontaneous delivery, in the care of the midwife or the gynaecologist, generally has a smoother course, whereby the women in labour feel more in control. This can contribute to a positive experience of giving birth .	Waiting for the start of labour, with loss of control and adaptation to hospital protocol can sometimes lead to a negative experience. Good communication and joint decision-making before and during childbirth prevents this in most cases.
Psyche mother	There is still uncertainty about whether medical contraction inducers influence the psyche of the mother.	
Breastfeeding	There is still uncertainty about whether medical contraction inducers influence breastfeeding.	

Sources:
Wetenschappelijk reactie over nadelen van een inleiding met oxytocine. KNOV 2019. Zie https://www.knov.nl/vakkennis-en-wetenschap/tekstpagina/867-2/wetenschappelijk-adviseurs/hoofdstuk/1226/wetenschappelijk-adviseurs/
NB Gebaseerd op verschillende studies. Zie voor een volledig overzicht van de nadelen de website van de KNOV.
Seijmonsbergen-Schermers AE, Peters LL, Goodarzi B, Bekker M, Prins M, Stapert M et al. Which level of risk justifies routine induction of labor for healthy women? Sexual & Reproductive Healthcare; In Press. DOI: https://doi.org/10.1016/j.srhc.2019.100479.
Keulen JKJ, Bruinsma A, Kortekaas JC, et al. Induction of labour at 41 weeks versus expectant management until 42 weeks (INDEX): multicentre, randomised non-inferiority trial. BMJ. 2019;364:l344.
'Keuze hulp' Zizobrabant.nl

Population charts author: Anna Seijmonsbergen-Schermers January 2022