OBSTETRICS AND GYNAECOLOGY
CLINICAL PRACTICE GUIDELINE

Labour and birth: Planned birth timing

(indications and gestations for booking inductions and caesareans)

Scope (Staff):	WNHS Obstetrics and Gynaecology Directorate staff
Scope (Area):	Obstetrics and Gynaecology Directorate clinical areas at KEMH and OPH

This document should be read in conjunction with this Disclaimer

Contents

Introduction

Initiatives to reduce unnecessary elective early births: Birth before 39 weeks may have serious outcomes for the child.[1] The statement by the Australian Preterm Birth Prevention Alliance draws attention to recent research suggesting that "birth before 39 weeks of pregnancy may have important consequences in later life, including behavioural and learning problems in school aged children".[1]

Recommendations [2023]:

- The timing of planned birth should be delayed to 39 weeks or later, in women without additional risks.[1, 2]
- Individualise decisions through partnership between the pregnant woman and health care providers, considering risk of stillbirth against risk of harm in childhood.[1]

Induction of labour (IOL) or Caesarean birth may be indicated when the available evidence suggests benefits of birth to the mother or fetus outweigh the potential risks of continuing the pregnancy. There remains no one point in time that suits every woman, and decisions around optimal timing of births are multifactorial.

Indications for planned birth

- For recommendations and considerations for gestations of planned birth, refer to Appendix: Safe timing of birth
- Timing of elective birth may be altered to meet the anticipated postnatal medical needs of the neonate, in the context of availability of paediatric specialist expertise.

Planning: IOL

Consent

A shared decision-making approach should be used to inform the consent discussion with the woman. Discuss and document:

- Indication
- Maternal and/or fetal benefit and risk
- Individual circumstances
- Method(s) of IOL
- Recommended fetal monitoring
- Pain relief options
- Options if IOL is unsuccessful, declined or if expectant management is preferred

Contraindications

- Placenta praevia (including if distance of <20mm from the internal cervical os on transvaginal assessment in third trimester)
- Vasa praevia
- Malpresentation including transverse lie, compound presentation, and oblique lie
- Known cephalopelvic disproportion
- Acute fetal compromise
- Cord presentation or prolapse
- Active genital herpes
- HIV positive women
- Maternal refusal

Assessment

1. Review maternal history. Confirm gestation and check for contraindications for IOL.
2. Perform abdominal palpation (confirm presentation, lie, position and engagement)
3. Assess fetal wellbeing
4. Assess cervix and document the Bishop score

Assessment of the cervix - Bishop score

The Bishop score is used to determine method for IOL at commencement of IOL.

Score	0	1	2
Station	-3cm	-2cm	-1/-0cm
Dilation	0 cm	1 -2 cm	3-4 cm
Length	3 cm	2 cm	1 cm
Consistency	Firm	Medium	Soft
Position	Posterior	Mid	Anterior

Generally, a score of 8 or more indicates a cervix is ready to dilate, and is associated with a high chance of spontaneous labour and responsiveness to induction interventions.[3]

Methods of IOL

Bishop score ≤ 6	Bishops score ≥ 7
1. Transcervical catheter 2. Prostaglandins (PG) including: a. PG- E_2 gel b. Cervidil	1. Artificial rupture of membranes (ARM) 2. Oxytocin infusion

Refer to IOL: Methods guideline (available to WA Health staff through HealthPoint).

Delayed induction: Management

- An updated medical management plan is to be documented in the clinical file, including any need for fetal (or maternal) assessment.

Planning: Caesarean birth

When planning of birth indicates that Caesarean birth is medically recommended, follow the elective caesarean, pre-admission and preparation sections within the Caesarean Birth guideline.

At OPH, see also Osborne Park Hospital WNS: Caesarean Section- Elective (OPH)

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Related policies

Medicines and Poisons Act 2014

Related WNHS policies, procedures and guidelines

WNHS Clinical Guidelines:

Obstetrics and Gynaecology (see also links to specific guideline conditions within appendix):

- Caesarean Birth
- Labour and Birth guidelines

Osborne Park Hospital WNS: Caesarean Section- Elective (OPH)

Perioperative Services (available to WA Health staff through HealthPoint):

- Complex Surgical Care in Perioperative Patients
- Elective Surgery

WNHS policy: Elective Surgery List Management

Useful resources and related forms

The University of Sydney:

- Consumer information: Every Week Counts (external website)
- Healthcare professionals: Every Week Counts: Healthcare professionals (external website)

The Safer Baby Bundle (external website): Timing of Birth

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Version history

Version number	Date	Summary
1	July 2023	• New guideline created with content relating to booking an induction moved to this guideline from the IOL guideline. • Statements and recommendations relating to prevention of preterm birth added. The timing of planned birth should be delayed to 39 weeks or later, in women without additional risks. Added appendix with table of indications for planned birth with suggested gestations. • Individualise decisions through partnership between the pregnant woman and health care providers, considering risk of stillbirth against risk of harm in childhood. • New considerations for earlier birth in women of South Asian ethnicity

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Appendix: Safe timing of birth

Indications that commonly prompt birth before 39 weeks

Note- This is not an exhaustive list. The Australian Preterm Birth Prevention Alliance recommends decisions on timing of birth should be made with consideration for the overall individual clinical scenario and available evidence, through shared decision making with pregnant women and their support persons.[1]

Condition	Consensus	Evidence
Age (advanced maternal)	In light of the increased risk of late stillbirth in women aged 40 or over, initiate shared decision-making regarding birth from **39+0 weeks** in the absence of an indication for an earlier birth. See also p18 of Antenatal Care Schedule guideline for fetal surveillance	4-6
Alloimmunisation - see related Blood Group and Antibody guideline for general screening and management	If titres of an antibody known to cause haemolytic disease of the fetus and newborn (HDFN) **other than** Kell are stable at < 1:32, initiate shared decision-making regarding birth from **38+0 weeks**. This recommendation does not apply if the fetus is believed to be negative for the antigen in question on the basis of cfDNA or paternal testing. If the titre of an antibody known to cause HDFN is 1:32 or greater, or anti-Kell antibodies are present, management decisions including timing of birth should be made by a fetal medicine service.	7
Cholestasis - see also guideline for general management	If total bile acids <100 µmol/L, initiate shared decision-making regarding birth from **38+0 weeks** based on bile acid concentration, other risk factors, and discussion with the patient. Given the higher stillbirth risk with total bile acids >100 µmol/L, very close surveillance and birth from **37+0 weeks** should be discussed, with a low threshold for preterm delivery for stillbirth prevention. Plan for early delivery with maternal morbidity (jaundice and/or severely deranged transaminases), or in the setting of suspected fetal compromise.	8
Diabetes – see also guideline for general management		
Pre-existing diabetes	Initiate shared decision-making regarding birth from **38+0 weeks** if well controlled. Discuss birth from **37+0 weeks** only in select cases (e.g. significantly unstable BSLs or fetal growth restriction). Counselling needed regarding risks/benefits of vaginal birth if high risk of shoulder dystocia. Avoid preterm delivery for diabetes alone.	9
Gestational diabetes mellitus (GDM)	If diet controlled and no other perinatal concerns, management should be in accordance with usual maternity care for women without diabetes. If insulin is required but control of blood sugar levels is good and fetal growth is within the normal range, initiate shared decision-making regarding birth from **39+0 weeks**. Management for women with suboptimal glycaemic control or other complications needs to be individualised, with the aim to achieve **38+0 weeks** where safe to do so.	10

Fetal		
Fetal growth restriction (EFW / AC <10%) -see guideline for general management [EFW- estimated fetal weight; AC- Abdominal circumference]	**In FGR suspected on ultrasound at or near term**, close biophysical monitoring and shared decision-making for birth from **38+0 weeks** should be initiated. Consider that accurate biometric measurements are difficult to achieve at late gestations, and that UA PI and MCA PI are often poor guides of pathology at term. The evidence to support cerebroplacental ratio(CPR) for decision-making remains unclear. **In FGR suspected preterm on serial biometry** with persistently normal UA PI, MCA PI, AFI and fetal movements, initiate shared decision-making regarding birth from **38+0 weeks** with close monitoring (ultrasound, CTG). If UA PI is increased but positive end-diastolic flow is present, initiate shared decision-making regarding birth from **37+0 weeks**. Earlier birth based on other Doppler abnormalities needs to be individualised, ideally with input from a fetal medicine service.	11-14
Fetal macrosomia (suspected) * (ultrasound EFW +/- AC ≥95th centile for gestation)	IOL for suspected fetal macrosomia may reduce the risk of shoulder dystocia and neonatal fractures. The evidence base is limited and heterogeneous, however, and the accuracy of antenatal ultrasound in predicting neonatal macrosomia is poor. For this reason, management needs to be individualised, using shared decision-making that incorporates other risk factors for macrosomia (e.g. clinically large fetus, increased maternal BMI). In the absence of diabetes, it is reasonable to consider birth in women with suspected fetal macrosomia from **39+0 weeks**. See also RANZCOG Macrosomia guideline (external website) *Note- EFW not taken as a single predictor and other factors including previous birth weight and maternal factors are considered.	15, 16
Hypertensive disorders- see 'H' medical and midwifery guidelines for general management		
Pre-eclampsia	Expectant management where safe before **34+0 weeks**. From **34+0 to 37+6 weeks**, close surveillance with plan for early birth if evidence of maternal or fetal compromise (severe disease). In asymptomatic well women with good blood pressure control and no features of severe disease, initiate shared decision-making regarding birth from **38+0 weeks**.	17, 18
Isolated hypertension (pre-existing or gestational)	For women with well controlled, stable, uncomplicated hypertension, initiate shared decision-making regarding birth from **39+0 weeks** to avoid worsening of disease. Earlier birth should be considered on an individualised basis in the context of suboptimal control of blood pressure or other complications.	
In-vitro fertilisation (IVF)- (pregnancies resulting from)	There are no good data to guide the timing of birth for women with otherwise uncomplicated pregnancies conceived through in-vitro fertilisation. A proportion of women with IVF pregnancies will develop one of the conditions listed above, and should receive care appropriate to that condition. In the absence of an indication for an earlier birth, the earliest gestation at which elective birth should be considered is **39+0 weeks**.	19

Obesity (maternal)- see guideline for general management	The risk of stillbirth in women with a body mass index **(BMI) of ≥ 50** kg/m2 is significantly increased after 38 weeks. Shared decision-making should be initiated for such women regarding birth from **38+0 weeks**. Lesser degrees of obesity are associated with a less pronounced increase in the risk of stillbirth. There is a lack of high-level evidence to guide the care of women with BMIs of 30 – 49 kg/m2, and management needs to be individualised. Birth from **39+0 weeks** may be considered in this population following counselling.	20
Placental: site disorders or adherence (see guideline for general care)	Elective **CS** for **asymptomatic placenta praevia from 38+0 weeks**. Elective **CS** for **asymptomatic placenta accreta spectrum from 35+0 weeks**. Elective **CS** for **asymptomatic** women with **vasa praevia** from **36+0 weeks.**	21-24
Preterm prelabour rupture of membranes - see guideline for general management	**Before 34 weeks**, expectant management with antibiotic therapy. Deliver with any signs of maternal or fetal compromise. **Between 34+0 and 36+6 weeks** with no signs of chorioamnionitis, discuss risks with woman but aim cautious expectant management with antibiotic coverage regardless of GBS status. Close monitoring and low threshold to deliver if evidence of chorioamnionitis or fetal compromise. Initiate shared decision-making regarding birth from **37+0 weeks** if no concerns prior.	25

Acknowledgment of source: Australian Preterm Birth Prevention Alliance (2022). Promoting safe timing of birth through prevention or delay of iatrogenic preterm and early term birth.

Prolonged pregnancy

Prolonged pregnancy- see guideline for general management	Low risk women should be offered IOL from **41+0 weeks** and have their IOL booked to occur **by 41+3 weeks**. Low risk women of South Asian ethnicity- from **40+0 weeks**	Australian Government Department of Health and Aged Care. Part J: Clinical assessments in late pregnancy: Prolonged pregnancy. 2022. In: Pregnancy care guidelines [Internet]. The average length of pregnancy may be earlier (39 weeks) in women of South Asian ethnicity (e.g. Bangladesh, Bhutan, India, Iran, Maldives, Nepal, Pakistan, Sri Lanka), compared to women born in Australia and New Zealand (40 weeks), and this has implications for late pregnancy monitoring and birth planning.

Maternal request

Maternal request for early birth, without medical indication, is not recommended at WNHS as it does not align with the Australian Preterm Prevention Alliance principles for 'Promoting safe timing of birth through prevention or delay or iatrogenic preterm and early term birth'.