

CHAPTER VII

CONCLUSION

There are psychological and medicolegal reasons why postterm pregnancies will continue to engender anxiety. Because the loss of a fetus after the due date is more difficult to accept than one occurring earlier. The natural response is always to think of how unfortunate it is that the infant was not delivered earlier or followed more closely. Hence, the need that the postterm pregnancy must be affectively managed.

The fetus who remains in utero after the expected date of confinement is considered at increased risk. Problems are presented if one undertakes a policy of routine termination for all pregnancies that go beyond term. The consequence of such concern is increased monitoring of fetal well-being and often the induction of labor. The cesarean section rate is also increased postterm; this increase is usually attributed to failed induction of labor (Studd, J., 1985). It demonstrates that the routine termination for all pregnancies that go beyond term is not the effective management for postterm pregnancy.

At 42 weeks of gestation, the fetus has the risk of meconium-containing amniotic fluid before the onset of labor and intervention due to fetal distress during labor. It was demonstrated that the release of meconium into amniotic fluid by the fetus in vertex presentation is still a valid indicator of placental insufficiency and fetal hypoxia and is associated with perinatal mortality and birth asphyxia (Walker, J., 1954). Therefore, tests of fetal well-being are recommended to use at 42 weeks. The termination of pregnancy by Cesarean section is performed whenever the test is abnormal. The fetus at 42 weeks before the onset of labor also needs to be detected early the meconium staining of amniotic fluid by amnioscopy or amniocentesis. The labor should be induced in the patients with meconium-containing amniotic fluid with monitoring. In contrast, the gestation may be allowed to continue if the normality of the amniotic fluid is demonstrated. If the failure to visualize amniotic fluid for meconium staining occurs, the use of sonographic biometry and Doppler blood flow measurements are recommended.

At 43 weeks or more, the fetus has the risk of getting some more unfavorable fetal outcomes that are small for date, Clifford syndrome, low Apgar score. We recommend an extensive sonographic survey should be done to look for structural abnormalities. Anthropometric measurements should be made, including head and abdominal circumferences, biparietal diameter, femur length, and the

circumference's ratio of head/abdominal. A clinical and ultrasonic assessment of amniotic fluid volume also should be made. The Doppler fetal blood flow measurements are also recommended so as to predict the unfavorable fetal outcomes. The test of fetal well-being and amnioscopy or amniocentesis should be done or repeated if it had been performed before. The condition of cervix is assessed, and a decision is made as to whether to deliver the fetus. The postterm gravidas with a favorable cervix, induction of labor should be considered. The labor should be induced in the patients with reduction of the amniotic fluid volume. The special cases, pregnancy may be allowed to continue under close supervision in cases of placentofetal function tests are normal. Before induction of labor, assessment of the state of the cervix, maternal pelvis, fetal size and position are essential, and performance of an oxytocin challenge test (OCT) is advisable.

Throughout labor, spontaneous or induced, those fetuses who are postterm pregnancies should be monitored very closely for evidence of distress, including abnormalities of fetal heart rate and the presence of appreciable amounts of meconium in the amniotic fluid. Amniotomy performed during the first stage of labor have not been recommended. When the fetal head is not engaged to the maternal pelvis, extensive digital separation (membrane stripping) of the lower amniotic pole from the uterine wall is useful. The postterm fetus is at risk of

being born hypoxia and of having aspirated meconium into the lungs, thus compromising chances of successful ventilation. As soon as the head is delivered from the vagina, or from the uterus during a cesarean section, the mouth, pharynx, and nares should be aspirated quickly by the obstetrician. Moreover, it is essential that care for the newborn be provided immediately by someone who can skillfully clear the airway below the vocal cords, especially of meconium, and ventilate the infant is particularly susceptible to hypothermia and also may develop other metabolic derangements, especially serious hypoglycemia (Soothill and colleagues, 1987). Polycythemia and blood hyperviscosity occasionally may cause serious difficulty (Jones and Battaglia, 1977).

In summary, the major concern in postterm pregnancy remains the state of the fetus before the onset of labor. Problems that develop during labor can usually be effectively managed. In present study, the fetus in a postterm pregnancy has been found to be at higher risk than at term before the onset of labor and also during the labor. Neither routine induction of labor nor conservative watchful waiting can be advocated as a general rule for the management of the postterm gravidas; each case necessitates thorough individual assessment and attention.

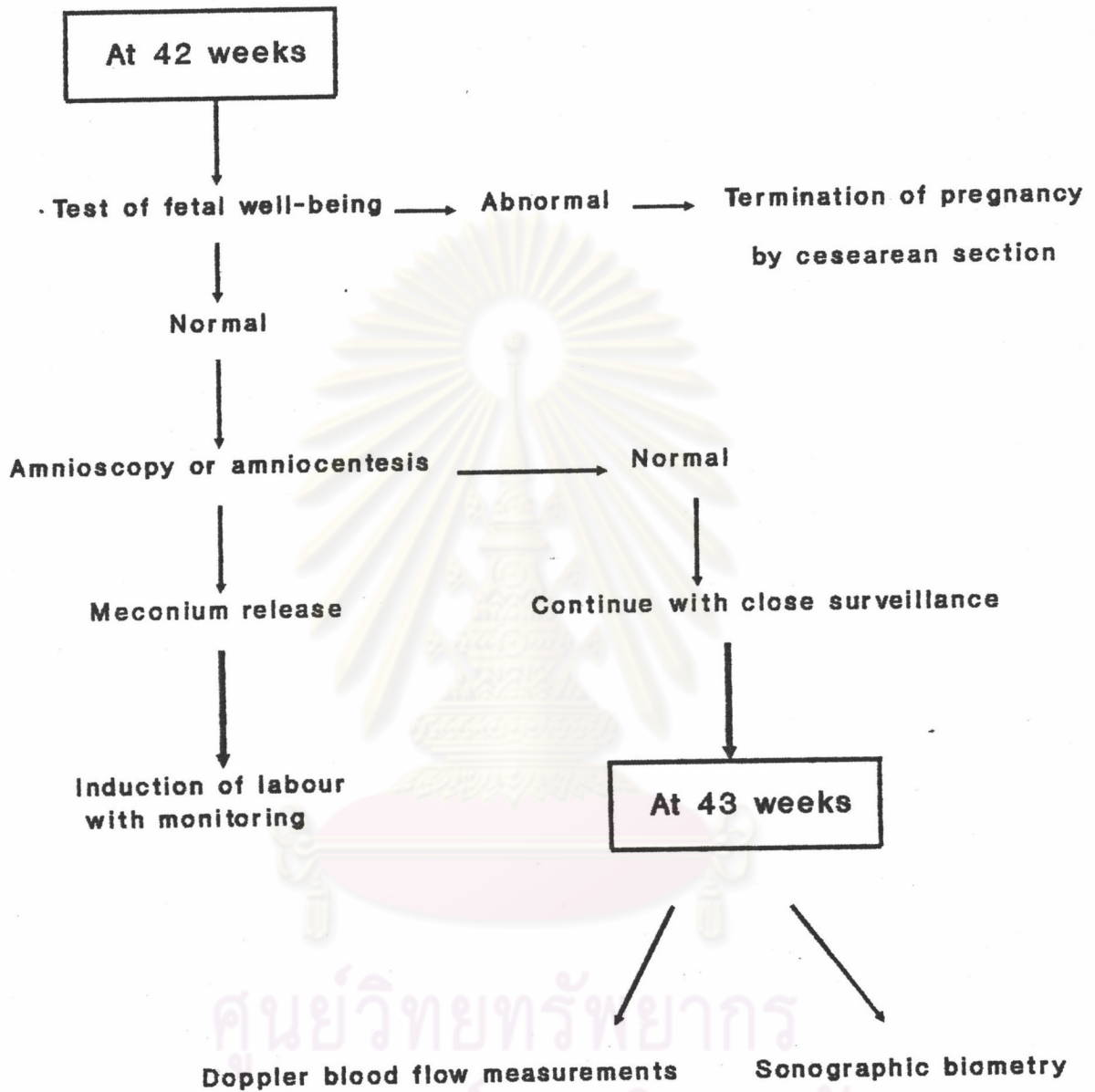


Figure 3. Management scheme