

Nonmedically indicated early term delivery: Are your patients requesting it before 39 weeks?

➔ Despite widespread efforts to eradicate elective delivery before 39 weeks of gestation, patients continue to ask for it. How do you respond when they do?

Janelle Yates, Senior Editor

There's a serious push to end the practice of elective early term delivery once and for all. Not only has the American College of Obstetricians and Gynecologists (ACOG) teamed up with the March of Dimes to curtail nonmedically indicated deliveries between 37 and 39 weeks of gestation, but in April 2013, ACOG published a Committee Opinion on the issue, stating, in part:

Although there are specific indications for delivery before 39 weeks of gestation, a nonmedically indicated early term delivery is not appropriate...There are greater reported rates of morbidity and mortality among neonates and infants delivered during the early term period, compared with those delivered at 39 weeks and 40 weeks of gestation. The differences between 37 weeks of gestation and 39 weeks of gestation are consistent, larger, and statistically significant across multiple studies.¹

According to ACOG, **medically justified indications** for early term delivery include:

- complications of hypertension, including preeclampsia, eclampsia, and gestational hypertension
- history of myomectomy or classical cesarean delivery
- multiple gestation

- fetal growth restriction
- congenital malformation
- placenta previa, placenta accreta, or placental abruption
- oligohydramnios
- poorly controlled pregestational or gestational diabetes, or pregestational diabetes in combination with vascular disease
- chorioamnionitis
- premature rupture of membranes
- alloimmunization of pregnancy with suspected or known effects on the fetus.¹

Among the **nonmedically justified indications** for early term delivery are:

- maternal intolerance to late pregnancy
- previous complication of labor
- history of shoulder dystocia
- suspected fetal macrosomia
- history of rapid labor
- mother lives far from hospital.

Some physicians may consider a positive test for fetal lung maturity an indication for early term delivery as well, but ACOG very clearly states that this practice is unjustified.

"The rate of respiratory morbidity remains higher among neonates delivered during both the late-preterm and early term periods when compared with neonates delivered at 39 weeks of gestation," the ACOG Committee Opinion states. "However, because nonrespiratory morbidity also is increased, documentation of fetal pulmonary maturity does not justify early nonindicated delivery."¹

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ACOG also points out that, “at least one state Medicaid agency has stopped reimbursement for nonindicated deliveries before 39 weeks of gestation.”¹

Complications associated with early term delivery

Increased likelihood of admission to the neonatal intensive care unit (NICU).

Among infants delivered by nonmedically indicated cesarean, 17.8% of infants delivered at 37 to 38 weeks and 8% of those delivered at 38 to 39 weeks required NICU admission for an average of 4.5 days, compared with 4.6% of infants delivered at 39 weeks or beyond.²

Respiratory distress. Infants born at 37 weeks’ gestation have three times the risk of respiratory distress syndrome of infants born at 38 weeks, and infants born at 38 weeks have 7.5 times the rate of respiratory distress syndrome of infants born at 39 to 41 weeks.³ In addition, infants born at 37 to 38 weeks’ gestation have a significantly elevated risk of transient tachypnea of the newborn (TTN) and persistent pulmonary hypertension.³

When the infant is delivered by cesarean, the risk of respiratory morbidity is heightened further because cesarean delivery is an independent risk factor for such morbidity.³

In a cohort of consecutive women undergoing elective repeat cesarean delivery, Tita and colleagues found increased rates of adverse respiratory outcomes, need for mechanical ventilation, newborn sepsis, hypoglycemia, NICU admission, and hospitalization. These outcomes were increased by a factor of 1.8 to 4.2 for births at 37 weeks and by a factor of 1.3 to 2.1 for births at 38 weeks, compared with delivery at 39 weeks’ gestation.⁴

Cerebral palsy. In a Norwegian birth cohort of 1,682,441 singleton term births (no congenital anomalies) followed for a minimum of 4 and a maximum of 20 years, the rate of cerebral palsy was 2.3 times higher at 37 weeks and 1.5 times higher at 38 weeks than it was at 39 to 41 weeks of gestation.⁵

Neonatal mortality. The relative risk of neonatal mortality among infants born at 37 weeks’ gestation, compared with those

born at 39 weeks, is 2.3, and it is 1.4 among infants born at 38 weeks. ACOG notes, “these increased mortality rates need to be balanced against the ongoing risk of stillbirth from week to week in the early term pregnancy.”¹

Other morbidities. ACOG also lists pneumonia, hypoglycemia, and a 5-minute Apgar score of less than 7 as potential morbidities associated with early term delivery.¹

When patients ask for early term delivery

Although most clinicians are aware of the risks of nonmedically indicated early term delivery, many patients aren’t, and a significant number of patients request it.

In an effort to gauge the extent of patient requests for early term delivery, we polled the members of the OBG MANAGEMENT Virtual Board of Editors. More than 90% of respondents reported that their patients still request elective early term delivery. How often these requests are made varies from “rarely” to “daily,” with most respondents reporting requests once or twice per month.

The most common reason given for such a request: “They are just tired of being pregnant,” one VBE member reported.

Family logistics is another frequent justification.

“Our practice provides obstetric services to a large military population as well as a large geographic area,” said E. William McGrath Jr, MD, of Fernandina Beach, Florida. “Military deployment of a spouse and large travel distances are common reasons for induction requests prior to 39 weeks.”

How to manage patient requests for elective early term delivery

“We are careful to empathize with rather than criticize the patient and her family for the early delivery request,” Dr. McGrath explained. “Our providers cite ACOG guidelines, but we also mention the statements and policies of the March of Dimes, which disallows elective deliveries prior to 39 weeks. The March of Dimes has greater name recognition among the

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general public than ACOG does. We attempt to make the patient feel good about her request for early delivery, regardless of the reason—and help her feel even better about her decision to withdraw the request once she learns about the potential complications.”

“I tell all my patients that unless there is a maternal or fetal indication or a strong psychosocial indication, I will not induce them,” reported Sabina K. Cherian, MD, of Houston. “It is usually the multiparous patients who have had previous deliveries at earlier gestational ages who request these early inductions.”

“I tell patients that their due date is arbitrary and not an exact date in which we can guarantee that everything is OK,” said Brian Bernick, MD, of Boca Raton, Florida. Accordingly, “I advise them that their baby is not fully developed until at least 39 weeks. An early, unindicated induction puts both the baby and mother at risk. Lastly, I remind them that a healthy baby and mom are worth the wait.”

“I counsel my patients that even normal pregnancies with infants born at 37 to 38 weeks have a higher rate of complications, compared with those born at 39 weeks’

gestation, and that an earlier induction may also be more likely to lead to cesarean if the cervix is not yet favorable,” said Devin Namaky, MD, of Cincinnati, Ohio.

One simple response to a patient’s request for early term delivery?

It isn’t possible.

Increasing numbers of hospitals are establishing firm policies against elective early term delivery.

“Our hospital has a hard stop,” said Michael Kirwin, MD, of Freehold, New Jersey. “That makes it easy for me to tell the patient, ‘No.’”

References

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—Brian Bernick, MD

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