Postdates alone are not associated with poor pregnancy outcome. Extreme postdates or postdates in conjunction with poor fetal growth or developmental abnormalities do show an increased risk of stillbirth. But if growth restriction and birth defects are removed, there is no statistical increase in risk until a pregnancy reaches 42 weeks and no significant risk until past 43 weeks. The primary “evidence” of a sharp rise in stillbirth after 40 weeks—often misquoted as “double at 42 weeks and triple at 43 weeks”—seem to come from one study based on data collected in 1958. (1)
The first question one should ask is whether neonatal mortality statistics from the 1950’s should be compared to modern statistics, since labor anesthetics and forceps rates were very different. Early labor monitoring was scanty and prenatal monitoring not yet developed. The McClure-Brown report shows a rise in stillbirth from 10/1000 at 40 weeks to about 18/1000 at 42 weeks. Yes, that is nearly double. But think about those numbers. Even the beginning point is nearly ten times the modern mortality rate. Either modern delivery methods are vastly different or something is wrong with the data collection. This study should be updated by research conducted at least in this century! Modern statistics show an almost flat rate of stillbirth from 40 weeks to 42, with a slight rise at 43 weeks (all numbers being close to 1/1000). (2)

There is a creeping overreaction in dealing with postdate pregnancies. It is true that the stillbirth and fetal distress rates rise more sharply after 43 weeks, but it is also true that less than ten percent of babies born at 43 weeks suffer from postmaturity syndrome (over 90% show no signs). We should react to this rise by monitoring postdate pregnancies carefully and inducing if problems arise. But the rise in problems at 43 weeks does not imply a similar risk at 42 and 41 weeks. Postmaturity syndrome is a continuum. It becomes more likely as weeks progress past the due date but does not start on the due date. And the risks need to be compared to the risks of interventions. Induction, as already noted, is not risk free. In addition to the risks of prematurity, induced labors have higher rates of cesarean section, uterine rupture, cord prolapse, meconium aspiration, fetal distress, neonatal jaundice, maternal hemorrhage and even the rare but disastrous amniotic fluid embolism.

Large studies have shown that monitoring pregnancy while waiting for spontaneous labor results in fewer cesareans without any rise in stillbirth rate. One retrospective study of almost 1800 post term (past 42 weeks) pregnancies with reliable dates compared this group with a matched group delivering “on time” (between 37 and 41 weeks). The perinatal mortality was similar in both groups (0.56/1000 in the post term and 0.75/1000 in the on-times group). The rates of meconium, shoulder dystocia and cesarean were almost identical. The rates of fetal distress, instrumental delivery and low Apgar were actually lower in the postdate group than in the on-time group. (3) This is only one of several studies showing postdate pregnancies can be monitored safely until delivery or until indications arise for induction. Even the famous Canadian Multicenter Postterm Pregnancy Trial Group (Hannah) of 1700 postdate women showed no difference in perinatal outcome among women who were monitored past their due date, as compared with those who were induced at term. (4)

In some studies, post term births have shown a higher cesarean rate for suspected fetal...
distress. However, when a group of researchers conducted a case-matched review of nearly 300 postdate pregnancies, they concluded that the increased rate of obstetric and neonatal interventions “does not appear to be a result of underlying pathology associated with post-term pregnancy.” They suggest that “a lower threshold for clinical intervention in pregnancies perceived to be ‘at risk’ may be a significant contributing factor.” In other words, the perceived risk is greater than the actual risk and can become a self-fulfilling prophecy! When monitoring demonstrates the fetal growth, activity and amniotic fluid levels remain within expected norms, the baby can safely wait for spontaneous labor to begin. Spontaneous labor gives the greatest chance for vaginal birth, even though the baby may be slightly larger than if the mother were induced at 40 weeks.

**Preventing Prematurity**

Few medical treatments have been proven to truly prevent preterm birth. (Avoiding iatrogenic prematurity is most effective, of course!) Some of the most promising avenues are readily available to midwives, and we should share this research with our clients.

The following are some factors shown to be associated with preterm birth and some strategies for lowering the risks:

**Overwork, job fatigue, stress** Women in high-stress jobs or who work long hours on their feet have nearly three times the risk of preterm rupture of membranes leading to preterm birth. In a study of 3000 primips, those who worked in “high fatigue jobs” had a risk of preterm premature rupture of membranes (pPROM) of 7% compared to 2% for those who didn’t work outside the home. Although many women must work until the end of pregnancy, changing to less fatiguing jobs, if possible, will lower their risk of preterm birth.

**Poor nutrition in pregnancy, low weight gain** Low maternal weight gain is the single risk factor that crosses all racial and economic indicators. A woman with a low pregnancy weight and/or a low rate of gain before 20 weeks is at high risk for preterm birth. A balance of protein and carbohydrates provides the best nutrition. According to the Cochrane Database, restricted carbohydrate diets may raise the risk of preterm birth without having any effect on the incidence of macrosomia.
Vitamin C supplements Low levels of vitamin C have been implicated for several decades as contributors to prematurity and preterm rupture of membranes. In a study of 2064 pregnant women, those who had total vitamin C intakes of...