



When Pregnancy Goes Past Your Due Date

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What is the due date?

The date your baby is due—your **estimated due date (EDD)**—is calculated from the first day of your last menstrual period (LMP). The EDD is used as a guide for checking your pregnancy's progress and tracking the growth of the **fetus**.

How is the due date determined?

An **ultrasound exam** often is used to confirm the due date. Your **obstetrician–gynecologist (ob-gyn)** will evaluate the dating from your ultrasound exam and compare it with your due date based on your LMP. Once a due date has been selected, it does not change no matter how many additional ultrasound exams you may have during your pregnancy.

What is postterm pregnancy?

The average length of pregnancy is 280 days, or 40 weeks, counted from the first day of your LMP. A pregnancy that lasts 41 weeks up to 42 weeks is called “late term.” A pregnancy that lasts longer than 42 weeks is called “postterm.”

What causes a postterm pregnancy?

The causes of postterm pregnancy are unknown, but there are several factors that may increase your chances of having a postterm pregnancy. These factors include the following:

- This is your first baby.
- You are carrying a male fetus.
- You have had a prior postterm pregnancy.
- You are obese.

What are the risks associated with postterm pregnancy?

The health risks for you and your fetus may increase if a pregnancy is late term or postterm, but problems occur in only a small number of postterm pregnancies. Most women who give birth after their due dates have uncomplicated labor and give birth to healthy babies. Risks associated with postterm pregnancy include the following:

- **Stillbirth**
- **Macrosomia**
- **Postmaturity syndrome**
- **Meconium** in the lungs of the fetus, which can cause serious breathing problems after birth
- Decreased **amniotic fluid**, which can cause the **umbilical cord** to pinch and restrict the flow of **oxygen** to the fetus

Other risks include an increased chance of an **assisted vaginal delivery** or **cesarean delivery**. There also is a higher chance of infection and **postpartum hemorrhage** when your pregnancy goes past your due date.

When should I have testing in a postterm pregnancy?

A pregnancy between 40 weeks and 41 weeks of gestation does not necessarily require testing, but at 41 weeks your ob-gyn or other health care professional may recommend testing. These tests may be done weekly or twice weekly. The same test may need to be repeated or a different test may need to be done. In some cases, delivery may be recommended.

What is electronic fetal monitoring?

Tests of fetal well-being use electronic fetal monitoring and sometimes an ultrasound exam. During electronic fetal monitoring, two belts are placed around your abdomen to hold sensors. These sensors measure fetal heart rate and the frequency of uterine contractions.

What is a nonstress test?

The nonstress test (NST) measures the fetus's heart rate for a specific period of time, usually 20 minutes. Results of the NST are noted as reactive (reassuring) or nonreactive (nonreassuring). A nonreactive result does not necessarily mean that the fetus is not healthy. Nonreactive nonstress test results often are followed by other tests to give more information.

What is a biophysical profile?

A biophysical profile (BPP) involves monitoring the fetal heart rate as well as an ultrasound exam. It checks the fetal heart rate, breathing, movement, and muscle tone. The amount of amniotic fluid also is assessed.

What is a contraction stress test?

A contraction stress test (CST) assesses how the fetus's heart rate changes when the **uterus** contracts. To make your uterus contract mildly, you may be given **oxytocin** through an intravenous (IV) tube in your arm. Results are noted as reassuring or nonreassuring. Results also can be equivocal (the results are not clear) or unsatisfactory (there were not enough contractions to produce a meaningful result).

What is labor induction?

Labor induction may be recommended if your pregnancy reaches 41 weeks. Induction is started using medications or other methods. To induce labor, your **cervix** needs to have started softening in preparation for delivery. This is called **cervical ripening**. Medications or other methods may be used to start this process.

How is labor induced?

Methods for inducing labor may include the following:

- Stripping or sweeping the amniotic membranes—Your ob-gyn or other health care professional sweeps a gloved finger over the thin membranes that connect the **amniotic sac** to the wall of your uterus.
- Rupturing the amniotic sac—Your ob-gyn or other health care professional makes a small hole in the amniotic sac to release the fluid (“breaking the waters”).
- Oxytocin—A drug form of oxytocin can be given through an IV tube in your arm. This will cause the uterus to contract. The dosage may be slowly increased over time and is carefully monitored.
- Prostaglandin analogs—These are medications placed in your vagina to start cervical ripening.
- Cervical ripening balloon—Your ob-gyn or other health care professional may place a small balloon-like device in your cervix to mechanically dilate it and help start labor.

What are the risks of labor induction?

The risks of labor induction may include changes in fetal heart rate, infection, and contractions of the uterus that are too strong. You and your fetus will be monitored throughout the process. Another possibility is that labor induction may not work. The method used to induce labor may need to be repeated. In some cases, you may need to have an assisted vaginal delivery or a cesarean delivery.

Glossary

Amniotic Fluid: Water in the sac surrounding the fetus in the mother's uterus.

Amniotic Sac: Fluid-filled sac in the mother's uterus in which the fetus develops.

Assisted Vaginal Delivery: Vaginal delivery of a baby performed with the use of forceps or vacuum.

Cervical Ripening: The process by which the cervix softens in preparation for labor.

Cervix: The lower, narrow end of the uterus at the top of the vagina.

Cesarean Delivery: Delivery of a baby through incisions made in the mother's abdomen and uterus.

Estimated Due Date (EDD): The estimated date that a baby will be born.

Fetus: The stage of prenatal development that starts 8 weeks after fertilization and lasts until the end of pregnancy.

Macrosomia: A condition in which a fetus is estimated to weigh between 9 pounds and 10 pounds.

Meconium: A greenish substance that builds up in the bowels of a growing fetus. If meconium is passed, it may get into the lungs of the fetus through the amniotic fluid. This can cause serious breathing problems.

Obstetrician–Gynecologist (Ob-Gyn): A physician with special skills, training, and education in women's health.

Oxygen: A gas that is necessary to sustain life.

Oxytocin: A hormone used to help bring on contractions of the uterus.

Postmaturity Syndrome: A condition in which a postterm fetus is born with a long and lean body, an alert look on the face, lots of hair, long fingernails, and thin wrinkled skin.

Postpartum Hemorrhage: Heavy bleeding that occurs after delivery of a baby and placenta.

Stillbirth: Delivery of a dead baby.

Ultrasound Exam: A test in which sound waves are used to examine the fetus.

Umbilical Cord: A cord-like structure containing blood vessels that connects the fetus to the placenta.

Uterus: A muscular organ located in the female pelvis that contains and nourishes the developing fetus during pregnancy.

If you have further questions, contact your obstetrician–gynecologist.

FAQ069: Designed as an aid to patients, this document sets forth current information and opinions related to women's health. The information does not dictate an exclusive course of treatment or procedure to be followed and should not be construed as excluding other acceptable methods of practice. Variations, taking into account the needs of the individual patient, resources, and limitations unique to the institution or type of practice, may be appropriate.

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