



Research Article

Section: Obstetrics & Gynecology

Study on Post Dated Pregnancy: Its Maternal and Foetal Outcome

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HIGHLIGHTS

- Post-dated pregnancy increases maternal risks.
- Incidence ranges four to fourteen percent.
- Complications include distress and macrosomia.
- Study analyzed 106 post-dated cases.
- Early induction improves maternal-fetal outcomes.

Key Words:

Post-dated pregnancy
Maternal outcome
Maternal outcome
Induction of labor
Meconium aspiration syndrome

ABSTRACT

Introduction: Post-dated pregnancy, defined as a pregnancy extending beyond 40 weeks of gestation, is associated with increased maternal and fetal risks. The incidence ranges from 4% to 14%. Complications include meconium-stained liquor, oligohydramnios, fetal distress, macrosomia, shoulder dystocia, and increased rates of operative deliveries. This study aims to evaluate the maternal and fetal outcomes in post-dated pregnancies to guide better clinical management and reduce morbidity. **Materials & Methods:** This descriptive longitudinal study was conducted at the Department of Obstetrics and Gynecology, Tezpur Medical College, Assam, from 2023 to July 2024. A total of 106 pregnant women with gestational age between 40–42 weeks were included based on strict inclusion and exclusion criteria. Data were collected using clinical examination, ultrasonography, biophysical profiling, and monitoring tools. Mode of delivery, perinatal morbidity, and maternal complications were recorded. Statistical analysis was performed using SPSS version 23 with chi-square tests; $p < 0.05$ was considered significant. **Results:** Among the 106 patients, the majority were aged 20–25 years. Spontaneous vaginal delivery occurred in a significant proportion, while cesarean section was required in many cases due to fetal distress and failed induction. Maternal complications included perineal tears, postpartum hemorrhage, and prolonged labor. Fetal complications observed were low Apgar scores, meconium aspiration syndrome, NICU admission, and the need for neonatal resuscitation. A statistically significant correlation was found between gestational age and increased perinatal complications. **Conclusion:** Post-dated pregnancy poses significant maternal and fetal risks. Early identification and timely induction, coupled with vigilant intrapartum monitoring, can improve outcomes. Regular antenatal care and accurate dating using first-trimester ultrasound are essential in minimizing complications associated with post-dated pregnancies.

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INTRODUCTION

Term pregnancy is defined as the period that spans from three weeks before to two weeks after the expected date of delivery. In 2012, to enhance clarity and precision, professional bodies including the American College of Obstetricians and Gynaecologists (ACOG), the Society for Maternal-Fetal Medicine (SMFM), and other related organizations introduced refined classifications of term pregnancy. They replaced the singular term “term” with four distinct categories: early term, full term, late term, and post term. Early term refers to a pregnancy between 37 weeks and 38 weeks and 6 days of gestation. Full term denotes pregnancies from 39 weeks to 40 weeks and 6 days. Late term pregnancies fall between 41 weeks and 41 weeks and 6 days. Post term, on the other hand, is defined as a pregnancy that extends to or beyond 42 completed weeks of gestation, that is, 294 days or 14 days past the estimated date of delivery [1,2].

Pregnancy lasting 40 weeks or 280 days and beyond is commonly referred to as a post-dated pregnancy. The incidence of such pregnancies varies widely, ranging from 4% to 14% of all deliveries. Although not all post-dated pregnancies result in complications, the risk of adverse outcomes rises significantly with increasing gestational age, particularly beyond 42 weeks. Delayed delivery beyond 294 days is frequently associated with unfavorable outcomes for both mother and baby. Foetal complications may include meconium-stained liquor, meconium aspiration syndrome, oligohydramnios, macrosomia (big baby), birth injuries, neonatal sepsis, non-reassuring foetal heart rate patterns, and foetal distress during labor. Maternal complications often observed in post-dated pregnancies include cephalopelvic disproportion, cervical tears, labor dystocia, and postpartum hemorrhage. Furthermore, the incidence of operative delivery, especially cesarean section, is significantly higher in such cases [3-5].

The American College of Obstetricians and Gynaecologists recommends considering labor induction in pregnancies that progress beyond 42 weeks, provided the maternal and fetal conditions are favorable. However, there is currently no universal consensus on whether elective induction of labor should be initiated at 41 weeks (287 days) or expectant management should be continued until 41 weeks and 3 to 5 days (290–292 days). In the absence of definitive guidelines based on strong evidence, the decision must be individualized. It should consider both clinical assessments and the preferences of the patient, with appropriate counseling from the attending obstetrician. The shared decision-making process should weigh the potential benefits of earlier induction against the risks of prolonged gestation, all while addressing the emotional stress and clinical concerns of the patient [6,7]. It is noteworthy that in uncomplicated pregnancies, the lowest rates of adverse neonatal outcomes are observed when delivery occurs between 39 and 40

weeks of gestation. As gestation progresses beyond this period, the risk of complications such as placental insufficiency, umbilical cord compression, and fetal hypoxia increases, emphasizing the importance of timely intervention. The focus on managing post-dated pregnancy has become increasingly significant in recent years due to heightened awareness and advancements in fetal monitoring techniques. The role of ultrasonography, particularly in assessing amniotic fluid levels and detecting signs of placental aging or insufficiency, has become central in guiding clinical decisions. These sonographic evaluations enable better risk stratification and help in making informed choices regarding the timing and mode of delivery [8-10].

Despite technological advances, the management of post-dated pregnancy remains a subject of clinical debate. Some practitioners advocate for proactive induction policies to prevent complications, while others emphasize a more conservative, expectant approach if maternal and fetal well-being remains uncompromised. Ultimately, individualized care that integrates evidence-based practices, patient values, and vigilant monitoring is essential for optimizing both maternal and neonatal outcomes in post-dated pregnancies. As ongoing research continues to inform clinical protocols, the goal remains to strike a balance between timely delivery and avoiding unnecessary interventions [11,12].

The aim of this study is to determine the maternal and fetal outcomes among pregnant women with a gestational age between 40 and 42 weeks. Specifically, it seeks to estimate the proportion of women who undergo caesarean section within this group, analyze data on complications and adverse outcomes experienced by both mother and fetus during pregnancy and delivery, explore the correlations between maternal and fetal mortality and morbidity, and review the outcomes and risks associated with postdated pregnancies.

MATERIAL & METHODS

This descriptive longitudinal study was conducted at the Department of Obstetrics and Gynecology at Tejpur Medical College in Assam, India from 2023 to July 2024. Ethical approval has been obtained from the Ethical Approval Committee of Tejpur Medical College in Assam, India.

Study Population

The study population will consist of pregnant women attending TMCH, where approximately 8–10 eligible participants visit daily. Data will be collected over a period of 7 months (28 weeks)

with sampling conducted two days per week. These pairs of days will be randomly selected and may either follow a fixed or dynamic weekly schedule. On each data collection day, two eligible women will be selected using simple random sampling. Inclusion criteria include women aged 19 to 35 years with

singleton pregnancies at 40 weeks gestation, confirmed by a first-trimester scan or known LMP with regular cycles, and with cephalic presentation. Exclusion criteria include irregular cycles with unknown LMP, multiple gestations, congenital anomalies, systemic diseases, uterine anomalies, hypertensive disorders, post-cesarean pregnancies, Rh-negative status, antepartum hemorrhage, PROM, malpresentations, and intrauterine fetal death. A control group is not required for this study.

Data Analysis

Data related to socio-demographics, clinical features, and relevant parameters will be collected through interviews, clinical examinations, and laboratory investigations using a pre-designed data collection pro forma and analyzed using IBM SPSS version 23. Statistical tools such as the Chi-square test, Fisher's exact test, or Monte Carlo approximation will be applied as appropriate. The study was conducted after obtaining ethical clearance from the institutional ethics committee and

approval from SSUHS University, with informed consent from all participants.

RESULTS

In this study involving 106 patients, the age distribution revealed that the majority of participants were between 20 and 30 years of age, with 43.4% aged 20–25 years, 34% aged 26–30 years, followed by 14.15% aged 31–35 years, and only 8.5% were under 20 years. The mean age was 24.92 years with a standard deviation of 6.08. Majority of patients were primigravida, making up 63.2% of the sample. Among the 106 patients, 83.96% had received antenatal care while 16.04% had not.

Among the patients studied, 69.81% delivered between 40 weeks 1 day and 41 weeks, while 30.19% delivered between 41 weeks 1 day and 42 weeks. Among the 106 patients, 48.11% had vaginal deliveries, 40.57% underwent LSCS, and 11.32% had instrumental deliveries.

Table 1: Distribution of gestational age of the patients

Gestational Age Category	Number	Percentage (%)
41 weeks	74	69.81
42 weeks	32	30.19
Total	106	100

Table 2: Distribution of mode of delivery of the patients

Mode of Delivery	Number	Percentage (%)
Instrumental Delivery	12	11.32
Lscs	43	40.57
Vaginal Delivery	51	48.11
Total	106	100

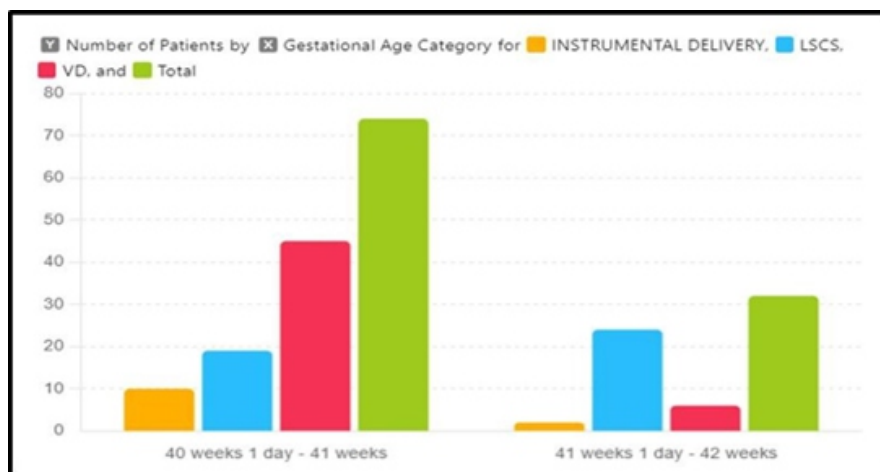


Figure 1: Peripheral smear (WBC) of patients with chronic kidney disease

Among patients delivering between 40 weeks 1 day and 41 weeks, vaginal delivery was most common (45 cases), while LSCS was predominant (24 cases) in those between 41 weeks 1 day and 42 weeks, indicating a shift toward surgical intervention with advancing gestational age.

Table 3: Distribution of Indication of C-section and Induction of Labour

Category	Subcategory	Number	Percentage (%)
Indication of LSCS	Fetal Distress	20	47.62
	Oligohydramnios	9	21.43
	Fetomaternal Disproportion	5	11.90
	Induction Failure	5	11.90
	Non-progress of Labour	2	4.76
	Obstructed Labour	1	2.38
	Total LSCS Cases	42	100
Induction of Labour	Yes	26	24.53
	No	80	75.47
Total Patients Analyzed		106	100

Among the 42 cesarean sections, fetal distress was the most common indication (47.62%), followed by oligohydramnios (21.43%), with other causes like fetomaternal disproportion and induction failure being less frequent. Additionally, among all 106 patients, 75.47% did not undergo labour induction, showing that natural onset of labour was significantly more common.

Table 4: Mode of delivery in patients with induction of labour

Mode Of Delivery	Number	Percentage (%)
Lscs	12	46.15
Vd	12	46.15
Instrumental Delivery	2	7.69

In this study involving 106 patients, the most common maternal complication observed was prolonged labour, affecting 16.04% of the cases, followed by perineal tears in 5.66%, postpartum haemorrhage (PPH) in 4.72%, and wound gaping in 1.89%, while no cases of shoulder dystocia were reported. Regarding neonatal outcomes, immediate resuscitation was required in 38.68% of newborns, and 25.47% were admitted to the NICU. An equal proportion (25.47%) had APGAR scores less than 7 at 5 minutes, while meconium aspiration syndrome was noted in 17.92% of the cases, and perinatal mortality occurred in 5.66% of the neonates. As for birth weights, the majority of neonates had weights between 2.500–2.999 kg (48.11%) and ≥ 3.000 kg (48.11%), while only 3.77% had low birth weights between 1.500–2.499 kg. The mean birth weight was approximately 2.95 kg with a standard deviation of 0.38 kg. Overall, the findings highlight the need for vigilant maternal monitoring to address prolonged labour and prompt neonatal care for issues like asphyxia and meconium aspiration. Among 106 neonates analyzed, 94.34% were discharged in good health, 4.72% died during hospitalization, and 0.94% were stillbirths.

Table 5: Mode of delivery in patients with induction of labour

Condition at Discharge	Number	Percentage (%)
Well	100	94.34
Died in hospital	5	4.72
Still Birth	1	0.94
Total	106	100.00

DISCUSSION

In the present study on post-dated pregnancies, the majority of patients were in the 20–30 year age group, with 43.4% falling between 20–25 years, 34% between 26–30 years, and 14.15% between 31–35 years. Only 8.5% of patients were under 20 years. This age distribution aligns with findings by Kandalgaonkar VP, et. al; 2019, who reported that 80.2% of women were aged 20–35 years, and Mohammed SA, et. al; 2019 reported 70.8% between 20–30 years. Similarly, Dobariya PV, et. al; 2017, and Akhtar P, et. al; 2014, observed that 69.05% and 72% of participants, respectively, were in the 20–30-year range, suggesting that this age group is commonly affected by post-dated pregnancies, although no direct correlation between age and post-dated pregnancy was observed [13-16].

Gestational age analysis in this study revealed that 69.81% of patients were between 40–41 weeks, and 30.19% were between 41–42 weeks. No patients beyond 42 weeks were included as it was part of the exclusion criteria. This is comparable to studies by Dobariya PV, et. al; 2017, where most patients were also between 40–41 weeks. Akhtar P, et. al; 2014, reported that 81% were in this gestational age group, while they found more patients between 41–42 weeks [15,16].

Regarding gravida status, 63.2% of patients in our study were primigravidas, and 36.8% were multigravidas. Similar findings were noted in studies by Mahapatro A & Samal S, 2015 (72%), Kandalgaonkar VP, et. al; 2019 (63.5%), and Francis S, 2015 (63.5%) [14,17,18]. On the contrary, studies by Marahatta R, et. al; 2009 and Naz F, et. al; 2006, reported higher numbers of multigravidas, suggesting that parity distribution in post-dated pregnancies may vary based on demographic differences [19,20].

In terms of delivery mode, 48.11% of patients had spontaneous vaginal deliveries, 19.6% were induced and delivered vaginally, 11.32% had instrumental deliveries, and 40.57% underwent LSCS. Among those delivering between 40 weeks 1 day and 41 weeks, the majority (60.8%) had vaginal births. However, for patients between 41 weeks 1 day and 42 weeks, LSCS rates rose to 75%, indicating an increased likelihood of operative delivery as gestation prolongs. Similar findings were reported by Kandalgaonkar VP, et. al; 2019 with 78.12% vaginal deliveries and 16.7% LSCS, where 68% delivered vaginally, 17% needed instrumental delivery, and 14% underwent LSCS [14]. Shinge N, et. al; 2013 found a cesarean rate of 37%, and Bhriegu R et. al; 2017 recorded 34% LSCS, with the remainder mostly vaginal [21,22].

Fetal distress emerged as the most common indication for cesarean delivery in this study (47.62%), followed by oligohydramnios (21.43%), fetomaternal disproportion and failed induction (11.90% each), and non-progress of labor (4.76%). This is consistent with other studies. For instance, Bhriegu R et. al; 2017 reported fetal distress in 23.5% and failed

Induction in 20.59% of cases, while kandalgaonkar vp, et. Al; 2019 also reported fetal distress (37.5%) and cephalopelvic disproportion (25%) as major indications [14,21].

At admission, 71.69% of patients were already in labor, and 28.3% were not. Among those not in labor, induction was done for 26 patients, with 12 delivering vaginally, 2 via instrumental means, and 12 requiring lscs. Comparatively, kandalgaonkar vp, et. Al; 2019 studied reported 57.3% not in labor at admission [14].

Maternal complications in our study included prolonged labor in 16.04%, perineal tears in 5.66%, postpartum hemorrhage in 4.72%, and wound gaping in 1.89%. No cases of shoulder dystocia were reported, likely due to the exclusion of macrosomic babies from vaginal delivery attempts. In contrast, bhriegu r et. Al; 2017 reported oligohydramnios in 17%, shoulder dystocia in 5%, and pph in 3% of cases. Patel n & modi p, et. Al; 2017, reported higher rates of protracted labor and perineal trauma (34.44% each) and pph in 20.47% [21,23]. The distribution of birth weight in this study showed that 48.11% of babies weighed 2.5–2.999 kg, and another 48.11% weighed 3 kg or more, with only 3.77% falling under 2.5 kg. The average birth weight was 2.95 kg. Kandalgaonkar vp, et. Al; 2019 studied reported 80.2% of babies weighed 2.5–3.5 kg, with a mean of 3.005 kg [14].

Neonatal outcomes indicated that 38.68% required immediate resuscitation, 25.47% had nicu admissions, and 25.47% had apgar scores <7 at 5 minutes. Meconium aspiration syndrome was observed in 17.92% of newborns. Similar complications were observed by kandalgaonkar vp, et. Al; 2019, who also noted high nicu admission rates and associations with meconium-stained liquor [14].

Perinatal mortality in the current study was 5.66%, with five neonatal deaths and one stillbirth. Most neonatal deaths were due to meconium aspiration syndrome, often among late referrals and unbooked cases. Akhtar p, et. Al; 2014, reported a mortality rate of 5.4%, and thakur reported 3% [16]. Kandalgaonkar vp, et. Al; 2019 reported a 1% neonatal mortality rate [14].

The study highlights the clinical significance of careful monitoring in post-dated pregnancies to reduce maternal and neonatal morbidity and mortality. Effective use of induction protocols, early detection of fetal distress, and timely operative interventions can improve outcomes in these high-risk pregnancies.

CONCLUSION

This study suggests that postdated pregnancies carry a higher risk of fetal and maternal complications, classifying them as high-risk. Early trimester sonography and reliable antepartum tests aid in identifying compromised fetuses. While inducing

labor at 40 weeks may reduce fetal risks, it raises maternal morbidity-especially in nulliparous women due to increased cesarean rates. Watchful waiting is safe for most with normal antepartum tests, but induction at 41 weeks is generally safer and more effective. Cervical ripening agents and fetal monitoring improve outcomes. Despite ongoing debate, further research is needed to optimize delivery timing and intervention strategies.

ABBREVIATIONS

SPSS: Statistical Package for the Social Sciences

NICU: Neonatal Intensive Care Unit

PPH: Postpartum Hemorrhage

CS: Cesarean Section

USG: Ultrasonography

LIMITATIONS & FUTURE PERSPECTIVES

The study was limited by its single-centre design, relatively small sample size, and short duration, which may restrict generalizability. Future research could focus on multicenter studies with larger cohorts to validate findings, evaluate long-term outcomes, and explore innovative diagnostic and management strategies for appendicular perforation, improving patient prognosis and reducing complications.

CLINICAL SIGNIFICANCE

Timely detection and management of acute appendicitis are crucial to prevent perforation, reducing morbidity and mortality. The study identifies high-risk groups, such as males and individuals at age extremes, highlighting the need for targeted preventive strategies and clinical vigilance. Delayed presentation significantly increases perforation risk, underscoring the importance of early healthcare access and awareness campaigns. Postoperative complications, including surgical site infections and prolonged ileus, emphasize the need for thorough preoperative risk assessment and tailored postoperative care. Recognizing the distal third of the appendix as the most common perforation site aids surgeons in effective intraoperative planning and management.

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AUTHOR CONTRIBUTIONS

All authors significantly contributed to the study conception and design, data acquisition, or data analysis and interpretation. They participated in drafting the manuscript or critically revising it for important intellectual content, consented to its submission to the current journal, provided final approval for the version to be published, and accepted responsibility for all aspects of the work. Additionally, all authors meet the authorship criteria

outlined by the International Committee of Medical Journal Editors (ICMJE) guidelines.

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CONFLICT OF INTEREST

Authors declared that there is no conflict of interest.

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ETHICAL APPROVAL & CONSENT TO PARTICIPATE

All necessary consent & approval was obtained by authors.

CONSENT FOR PUBLICATION

All necessary consent for publication was obtained by authors.

DATA AVAILABILITY

All data generated and analyzed are included within this research article. The datasets utilized and/or analyzed in this study can be obtained from the corresponding author upon a reasonable request.

USE OF ARTIFICIAL INTELLIGENCE (AI) & LARGE LANGUAGE MODEL (LLM)

The authors confirm that no AI & LLM tools were used in the writing or editing of the manuscript, and no images were altered or manipulated using AI & LLM.

PUBLISHER'S NOTE

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