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Midwifery Care for Pregnant Women with Late-Term Pregnancy

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Abstract:
Late-term pregnancy occurs at 41 weeks to 41 weeks and six days of gestation. It poses potential risks to both the mother and the fetus. Appropriate management is crucial for preventing morbidity and mortality. This study aims to analyze Midwifery Care for Pregnant Women with Late-Term Pregnancy. This study employs a case study design with a comprehensive midwifery care approach for one patient. Data collection was carried out using a combination of interviews, direct observation, physical examinations, and document review. The analysis followed the structured stages of the midwifery care process, which include assessment, diagnosis, implementation, and evaluation. The case study was conducted on Mrs. YS, who did not experience signs of labor and refused induction. The diagnosis was established as G3P1011 with a gestational age of 42-42 weeks and a late-term intrauterine live fetus. The intervention involved referring the patient to the hospital for a cesarean section. The evaluation showed that the C-section went well, and the mother and baby were in good health after delivery. This case study highlights the importance of early detection and appropriate decision-making when managing overdue pregnancies. Refusing induction poses a clinical challenge requiring an educational and collaborative approach to avoid increasing the risk of maternal and neonatal complications.

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INTRODUCTION

Postterm birth, defined as delivery beyond 42 weeks of gestation, and late-term pregnancy, encompassing gestational ages from 41 weeks and 0 days to 41 weeks and 6 days, are associated with heightened risks of adverse perinatal outcomes compared to term pregnancies (Singh et al., 2020). While late-term pregnancies often progress without severe complications, they are linked to increased rates of macrosomia, meconium-stained amniotic fluid, and fetal distress, which can compromise neonatal well-being (Ranjbar et al., 2023). Postterm pregnancies, however, pose a greater risk of stillbirth, neonatal death, and severe neonatal morbidities, including placental insufficiency, labor dystocia, meconium aspiration, and birth asphyxia (Nu et al., 2024). These complications underscore the critical need for timely intervention to mitigate risks to both mother and fetus.

Maternal complications also escalate in postterm pregnancies, with elevated rates of emergency cesarean sections (C-sections), postpartum hemorrhage, and prolonged labor (Latif & Aiken, 2024). The interplay between fetal and maternal risks necessitates careful monitoring and evidence-based management strategies to balance the benefits of prolonging pregnancy against potential harms. For instance, macrosomia—a common complication in postterm pregnancies—increases the likelihood of shoulder dystocia and birth trauma, further complicating vaginal delivery

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(Nu et al., 2024). Understanding these risks is essential for midwives and obstetricians to optimize care for women with prolonged gestations.

The etiology of postterm pregnancy remains incompletely understood, though genetic and physiological factors have been implicated. Conditions such as fetal anencephaly, placental sulfatase deficiency, and X-linked recessive inheritance patterns suggest a genetic predisposition (Bayraktar et al., 2022; Mitaol et al., 2023). Maternal characteristics, including nulliparity, a history of prior postterm pregnancy, and obesity, also contribute to prolonged gestation (Tegene et al., 2022). However, conflicting evidence exists regarding the role of fetal sex, with some studies identifying male fetuses as a risk factor. In contrast, others, such as Bayraktar et al. (2022), found no significant association.

The prevalence of postterm pregnancies is influenced by the methods used to determine gestational age. Clinical dating based solely on the last menstrual period (LMP) and physical examination often overestimates gestational age, leading to higher reported rates of postterm births. In contrast, first-trimester ultrasound dating improves accuracy and reduces the incidence of postterm pregnancies by approximately 50% (Saurabh, 2023). This highlights the importance of early pregnancy ultrasound in refining gestational age estimation and guiding clinical decision-making. Additionally, limited awareness among women and healthcare providers about the risks of prolonged pregnancy may contribute to delayed interventions.

Management strategies for postterm pregnancies prioritize reducing perinatal mortality and morbidity. Active management, including labor induction or elective C-section, is often recommended after 41 weeks to mitigate risks. However, evidence from a multi-country WHO analysis suggests that elective C-sections are associated with higher neonatal intensive care unit (NICU) admission rates compared to labor induction or expectant management (Saurabh, 2023; Abidin et al., 2022). This has shifted clinical guidelines toward prioritizing labor induction as a safer alternative, provided no immediate contraindications exist. Midwives are pivotal in counseling women about these options and ensuring informed decision-making.

Despite advancements in prenatal care, disparities in postterm pregnancy outcomes persist, particularly in low-resource settings where access to early ultrasound and timely interventions is limited. Socioeconomic factors, such as lower maternal education and inadequate antenatal care, further exacerbate risks (Tegene et al., 2022). Addressing these inequities requires a multifaceted approach, including community education, improved access to early pregnancy dating, and standardized protocols for monitoring and managing prolonged pregnancies.

Ultimately, the management of late-term and postterm pregnancies demands a nuanced understanding of risk factors, accurate gestational age assessment, and individualized care plans. As midwives are often the primary caregivers during pregnancy, their expertise in identifying high-risk cases, providing patient-centered counseling, and coordinating timely interventions is indispensable. Future research should focus on refining predictive models for postterm pregnancies, enhancing global access to early ultrasound, and evaluating long-term outcomes of management strategies to improve maternal and neonatal health worldwide.

STUDY DESIGN

This study utilized a case study design to explore comprehensive midwifery care for a single patient with prolonged gestation. Data collection was conducted through a multimodal approach, incorporating in-depth interviews with the patient, direct observation of clinical interactions, physical examinations, and review of medical records. The analysis followed the standardized stages of the midwifery care process: initial assessment of maternal and fetal health, formulation of a nursing

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diagnosis, implementation of evidence-based interventions, and evaluation of outcomes. The case focused on Mrs. YS, a 32-year-old woman with a gravidity and parity of G3P1011, who presented at 42 weeks of gestation without spontaneous labor onset and declined labor induction.

The patient was diagnosed with a late-term intrauterine live fetus at 42 weeks of gestation, confirmed via ultrasound dating in the first trimester. Given the absence of labor signs, refusal of induction, and escalating risks associated with prolonged pregnancy, the care plan prioritized maternal and fetal safety through timely referral for cesarean section. Interventions included continuous antenatal monitoring, patient education on risks of postterm pregnancy, and collaborative decision-making with obstetric specialists. Ethical approval for the study was obtained from the Ethics Committee of Poltekkes Kemenkes Malang, ensuring adherence to research integrity and patient confidentiality.

The case study methodology allowed for an in-depth exploration of midwifery decision-making in managing late-term pregnancies, emphasizing patient-centered care and clinical guidelines. Limitations included the single-subject design, which restricts generalizability, and reliance on retrospective medical record data. However, the structured application of the midwifery care process provided actionable insights into risk mitigation strategies for postterm pregnancies, highlighting the importance of interdisciplinary collaboration and informed consent in maternal healthcare.

PATIENT INFORMATION

Mrs. YS, 32 years old, G3P1011, was the subject of this case study. Her gestational age was 41-42 weeks. Gestational age was calculated by counting from the first day of the mother's last menstrual period, May 8, 2025.

CLINICAL FINDINGS

The results of the assessment revealed that the obstetric problem in this case is an overdue pregnancy. The researchers will describe the assessment results based on the stages of the midwifery process. Based on the results of a complete examination and the subjective data obtained, the mother did not experience signs of labor and refused induction. The following objective data was obtained: body weight, 55.7 kg; height, 155 cm; vital signs, blood pressure, 100/80 mmHg; breathing, 18x/min; pulse, 80x/min; fundus uteri height, 29 cm; fetal heart rate, 142x/min (regular); head presentation; no uterine contractions; and internal examination results, no opening. Based on the analysis of the obtained data, the obstetric diagnosis is G3P1011 at 41-42 weeks of gestation with a single, live, intrauterine fetus at term.

THERAPEUTIC INTERVENTION

The intervention performed was referring the patient to the hospital for a C-section. The results of the evaluation in this case were that Mrs. YS gave birth via C-section on February 26, 2026. After the C-section, the mother's general condition was good: compos mentis, blood pressure 110/70 mmHg, pulse 80x/min, respiratory rate 16x/min, and temperature 36.6°C. The newborn was in good condition, crying with intense redness, and had an APGAR score of 9-10. The birth weight was 2595 grams, the body length was 46 cm, and the head circumference was 33 cm. The mother's general condition was good on the fifth day postpartum (March 3, 2026). Her blood pressure was 110/70 mmHg, her pulse was 83 beats per minute, her respiratory rate was 16 breaths per minute, and her temperature was 36.8°C. There were no signs of infection in the surgical wound. Her bladder was

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empty, her TFU was good, and her height was two fingers above the symphysis. She had sanguinolenta lochia. The newborn's condition on day 5 was also good, with a weight of 2,600 grams and a length of 46 cm.

DISCUSSION

Regular uterine contractions induce the cervix to thin and dilate during labor, which leads to the ejection of the baby and associated products of conception (Das et al., 2023). In this case, the 32-year-old mother had no cervical opening and no uterine contractions, and she did not want to induce labor. While the exact etiology of post-term birth remains uncertain, several risk factors have been identified as contributing to its occurrence. These include maternal obesity, being nulliparous, and maternal age over 30 years, all of which have been linked to a heightened likelihood of post-term delivery (Kammies et al., 2022).

The obstetric diagnosis in this case is G3P1011 at 41-42 weeks of age with a late-term pregnancy. A range of terms, such as post-term, post-mature, late pregnancy, and postdates, are commonly used to describe pregnancies that extend to or beyond the estimated due date (EDD). However, the inconsistent use and lack of standardized definitions for these terms often result in clinical and terminological confusion. The American College of Obstetricians and Gynecologists (ACOG) has proposed a nomenclature that describes early term as pregnancies from 37 0/7 to 38 6/7 weeks of gestation, full term as pregnancies from 39 0/7 to 40 6/7 weeks, late term as pregnancies from 41 0/7 to 41 6/7 weeks, and postterm as pregnancies from 42 0/7 weeks of gestation onwards. The aim is to assign greater validity to births occurring at or after 37 weeks of gestation (Pallavee & Vishalakshi, 2023). Postterm pregnancy is significantly associated with increased risks of adverse perinatal outcomes, including oligohydramnios, meconium aspiration syndrome, perinatal asphyxia, and a higher frequency of neonatal intensive care unit (NICU) admissions. Moreover, the likelihood of C-sections is elevated in prolonged gestations. Timely recognition and appropriate clinical management, encompassing systematic evaluation and planned delivery, are crucial to minimizing maternal and fetal complications. Extending gestation beyond term is inadvisable, given the well-documented correlation with heightened perinatal mortality and maternal morbidity (Al-Genedy & Qushash, 2023).

In this case, the intervention is to refer the patient to the hospital for further evaluation and treatment. According to the Obstetric Indication List, patients with a gestational age greater than 294 days (more than 42 weeks) should be referred for further evaluation and treatment (Latif & Aiken, 2024). The intervention provided at the hospital is a cesarean section. Pregnancies that reach 42 weeks or more are associated with a very high rate of C-sections (Bhide, 2021; Sulistiorini et al., 2022). The American College of Obstetricians and Gynecologists (ACOG) recommends elective labor induction for low-risk nulliparous patients at 39 weeks and 0 days of gestation, and all at 42 weeks (Teal et al., 2021).

However, it is important to consider the risks associated with labor induction. Women who are induced are more likely to undergo a C-section than those who go into labor spontaneously. The risk of C-section delivery increases as gestational age increases from early to postterm among induced women, while remaining stable among those who experience spontaneous labor. One reason for the increased risk of C-section after labor induction is lower cervical dilation upon hospital admission, as well as higher rates of labor complications (Parasiliti et al., 2023). Other contributing intrapartum factors include dystocia, use of epidural analgesia, fetal intolerance to labor, and maternal request for a C-section during labor (Simões & Stilwell, 2021). Women who experienced irregular uterine contractions that remained five minutes apart or less, an indication of dysfunctional labor, were more

likely to undergo labor induction and ultimately cesarean delivery. In addition, certain maternal factors have been strongly associated with an elevated risk of C-section, including shorter maternal height, fetal macrosomia (birth weight exceeding 4,000 grams), pre-pregnancy obesity, maternal age of 30 years or older, and gestational weight gain surpassing the Institute of Medicine's recommended limits (Ramonienė et al., 2024).

While labor induction is commonly recommended to reduce the potential risks associated with post-term pregnancies, women who opt for expectant management or decline induction must receive respectful support and guidance from healthcare professionals throughout their decision-making process (Latif & Aiken, 2024). However, refusing labor induction in cases of post-term pregnancy has been associated with an increased risk of maternal and neonatal complications, as well as a significantly higher likelihood of undergoing a C-section (Blecher et al., 2020).

CONCLUSION

Spinal manipulation therapy, which chiropractic professionals often use, was found to be effective in reducing the risk of farmers experiencing low back pain. Research shows that spinal manipulation can help reduce pain, improve physical function, and speed up recovery compared to usual care. Therefore, it can be an effective option for low back pain management in farmers, helping them return to work faster, improve their posture, and enhance their quality of life.

The case of Mrs. YS's late-term pregnancy, with a gestational age of 41-42 weeks, shows the importance of appropriate, evidence-based treatment in preventing risks that can harm both mother and fetus. Although Mrs. YS refused induction of labor, referring her to a facility that could perform a C-section was an effective and lifesaving decision. The mother and baby's stable condition after delivery indicates the intervention's success. This study emphasizes the importance of educating pregnant women about the risks of an overdue pregnancy and the need for collaboration between health professionals and patients in clinical decision-making.

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CONFLICT OF INTEREST

There is no conflict of interest in this article.

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