TIMING OF BIRTH FOR SPECIFIC OBSTETRIC INDICATIONS (TOBA)

OVERRIDING PRINCIPLE: AIM FOR > 39+0 FOR IOL AND ELECTIVE CS

- If required before 39 weeks gestation state reasons in the IOL or Elective CS proforma. (Recommended timings of birth for obstetric indications listed below.)
- Requests will be reviewed in the TOBA meeting (Tuesdays and Thursdays 08:30) and if it is felt delivery could be safely deferred, or in some cases brought forward, the clinician will be informed, and the patient offered a date accordingly.

TIMING OF BIRTH ASSESSMENT TEAM (TOBA)

- Birthing Suite Lead Midwife – or representative
- Obstetrician – at least one rep to attend
- Neonatologist – one rep to attend

MATERNAL CONDITIONS

		TIMING OF BIRTH
GDM – diet controlled		41 weeks
GDM – metformin or insulin well controlled		40 weeks
Type 2 DM – good control		39-40 weeks
Type 2 DM – poor control		38-39 weeks
Type 1 DM		38-39 weeks
Previous classical CS/high risk surgical incisions (attempting to avoid labour)		38-39 weeks
Placenta praevia		38 weeks
Complex placenta praevia with recurrent bleed		individualised management
PET (moderate to severe)		37 weeks or individualise
PET (mild)		38-39 weeks
Mild PIH/chronic hypertension well controlled		38-40 weeks
Obstetric Cholestasis	Bile salts < 40	40 weeks
	Bile salts > 40 or worsening liver function	38 weeks
	Bile salts > 100 or ALT > 200	individualised management

FETAL CONDITIONS

	TIMING OF BIRTH
Post-dates Inform woman of the benefits of IOL at 41+0/41+1 based on high-quality research evidence. If the woman chooses: • Induction at 41+0/41+1 – request IOL at 40+0 with plan for IOL date 41+0/41+1. This will be booked without need for any additional fetal surveillance. • To wait beyond 41+1 – offer additional fetal monitoring from 41+0/40 (such as growth scan with AFI, and twice-weekly CTG) and review decision for timing of delivery if any concern for fetal wellbeing.	41-42 weeks (to reduce stillbirth)
SROM without signs of infection	37 weeks
SROM with signs of infection	Individualise
DCDA twins	37-38 weeks
MCDA twins	36-37 weeks
MCMA twins	32-33 weeks
Vasa praevia (other risk factors for PTL)	36 weeks (individualised management for signs of preterm labour/bleeding)
Significant RBC antibodies, no sign fetal anaemia	37-38 weeks
Structural abnormalities	39-40 or individualised

FETAL GROWTH RESTRICTION (FGR)

	TIMING OF BIRTH
Fetal growth restriction (FGR) late onset > 32/40	38 weeks

FGR defined as:

- *AC or EFW < 3rd centile –or–*
- *Cust EFW < 10th + abnormal UA or MCA/CPR Doppler* –or–*
- *AC or Cust EFW crossing centile > 30% + abnormal UA or MCA/CPR Doppler**

*MCA/CPR Doppler < 5th centile needs to be measured more than once as carries poor reproducibility. Repeat MCA/CPR measurement in 2-3 days if significant concerns, or repeat 1 week if less so, to determine if persistent.

MONITORING FGR

After referral and initial assessment – DAU antenatal monitoring schedule with one to twice-weekly CTG, scan AFI, MCA and UA Doppler, maternal BP and movements. Increase frequency/ clinical review/plan for delivery if significant concerns.

Only plan earlier gestation for birth if FGR (above criteria) PLUS significant additional concerns. For example:

- AC less than 3rd centile with reduced interval growth
- Abnormal UA Doppler >> 95th centile
- Abnormal CTG
- Maternal PET

SMALL FOR GESTATIONAL AGE (SGA)

	TIMING OF BIRTH
Small for gestational age (SGA)	39-40 weeks

SGA defined as:

- *AC < 10th centile or Cust EFW < 10th + normal UA, MCA/CPR Doppler*
- *Normal interval growth*

MONITORING SGA

After referral and initial assessment – DAU with two-weekly growth, AFI and Dopplers. Increase to weekly AFI and Dopplers with 37 week gestation or any other concerns.

LARGE FOR GESTATIONAL AGE (LGA) WITHOUT EVIDENCE GDM

The NZ national guideline supports expectant management for suspected macrosomia in the absence of other obstetric concerns. Given the insufficient evidence we therefore recommend timing of birth no earlier than 40 weeks gestation.

PLEASE SUBMIT IOL or LSCS request with as much information as possible on the forms

REFERENCES

1. Ministry of Health – Indication of Labour in Aotearoa New Zealand, *Clinical Practice Guideline,* 2019.
2. ISUOG Practice Guidelines: Diagnosis and Management of SGA Fetus and Growth Restriction, *Ultrasound Obstet Gynecol* 2020;56:298-312.
3. SGA Detection and Management – *ADHB Guideline* 2020.
4. NZMFM Network SGA, 2014 (due to be updated).
5. Ovadia et al., URSO in Intrahepatic Cholestasis of Pregnancy; An individualised Data Analysis. *Lancet Gastro Hepatology*, 2021.
6. SWEPIS – Swedish Post-Term Induction Study. BMJ 2019;367.

PLEASE NOTE

This document is designed as a guidance for recommendations on timing of birth at Christchurch Women's Hospital with the aim to provide some consistency for the medical staff making these decisions after clinical referral.

This document provides a timing of birth framework following review of the evidence base. However, individualisation will always be required for complex cases.

The information within this document does not replace the consultation and discussion process with women, and therefore LMCs should still refer women according to the usual clinical criteria.