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)

- Midwife Manager
- 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
Evidence of very poor control with increasing macrosomia consider additional monitoring and earlier delivery		Individualise
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

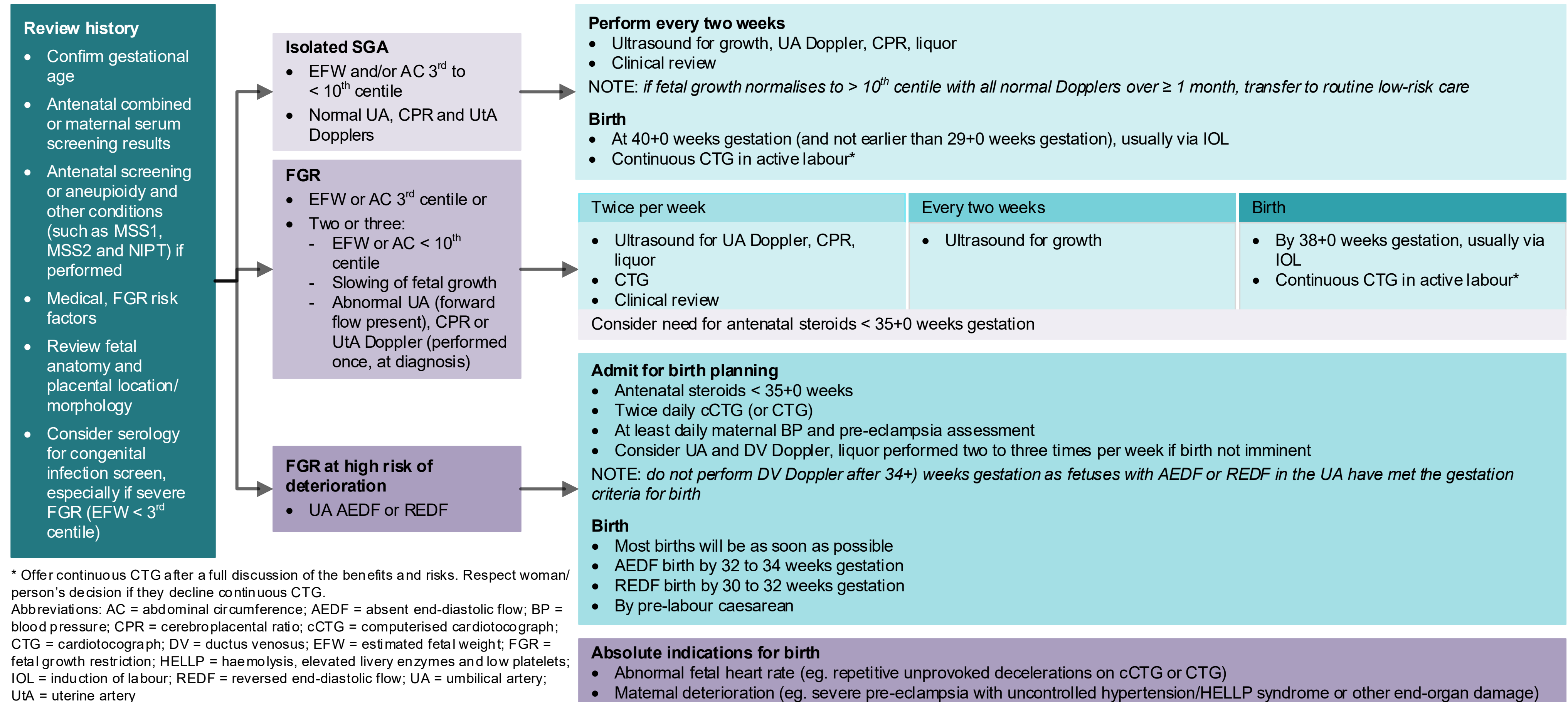
FETAL CONDITIONS

	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. • If booked beyond 41+1 weeks (either woman's request or CWH capacity issues) – offer the option of additional monitoring such AFI or CTG, although recognising there has been no clear benefit from studies that additional testing predicts late stillbirth.	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

SMALL FOR GESTATIONAL AGE (SGA) AND FETAL GROWTH RESTRICTION (FGR)

NZ SGA Guidelines: https://www.tewhatuora.govt.nz/publications/small-for-gestational-age-fetal-growth-restriction-guidelines

LATE SGA (>32 WEEKS) FLOW CHART FOR TIMING OF BIRTH RECOMMENDATIONS



* Offer continuous CTG after a full discussion of the benefits and risks. Respect woman/ person's decision if they decline continuous CTG.

Abbreviations: AC = abdominal circumference; AEDF = absent end-diastolic flow; BP = blood pressure; CPR = cerebroplacental ratio; cCTG = computerised cardiotocograph; CTG = cardiotocograph; DV = ductus venosus; EFW = estimated fetal weight; FGR = fetal growth restriction; HELLP = haemolysis, elevated livery enzymes and low platelets; IOL = induction of labour; REDF = reversed end-diastolic flow; UA = umbilical artery; UtA = uterine artery

Management of FGR should be individualised
Increased surveillance or expedited birth should occur if there are features of concern (eg. cessation of growth, oligohydramnios, repeated episodes or reduced movements).

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Any printed versions, including photocopies, may not reflect the latest version.

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.

https://www.tewhatuora.govt.nz/publications/small-for-gestational-age-fetal-growth-restriction-guidelines/

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

TOBA meetings are held on a Tuesday and Thursday morning each week at 0830.

Decisions regarding Timing of Birth will be entered onto HCS under the woman's NHI as a PROGRESS note on the same day.

This will include Date, Time and Gestation for Planned IOL. This timing can be changed if the clinical situation changes.

For any request that is outside the TOBA guideline and is difficult to individualise, further discussion with the referring clinician will occur.

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. NZ SGA Guidelines 2023
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.