

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)

predicts late stillbiltil.	
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

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

Perform every two weeks **Review history** Ultrasound for growth, UA Doppler, CPR, liquor Isolated SGA Confirm gestational · Clinical review EFW and/or AC 3rd to age NOTE: if fetal growth normalises to > 10th centile with all normal Dopplers over ≥ 1 month, transfer to routine low-risk care < 10th centile Antenatal combined Normal UA. CPR and UtA Birth or maternal serum Dopplers At 40+0 weeks gestation (and not earlier than 29+0 weeks gestation), usually via IOL screening results Continuous CTG in active labour* Antenatal screening **FGR** or aneupioidy and EFW or AC 3rd centile or Every two weeks Twice per week Birth other conditions Two or three: (such as MSS1 Ultrasound for UA Doppler, CPR. Ultrasound for growth • By 38+0 weeks gestation, usually via - EFW or AC < 10th MSS2 and NIPT) if liquor centile performed CTG · Continuous CTG in active labour* Slowing of fetal growth Medical, FGR risk · Clinical review Abnormal UA (forward factors flow present), CPR or Consider need for antenatal steroids < 35+0 weeks gestation UtA Doppler (performed Review fetal once, at diagnosis) anatomy and Admit for birth planning placental location/ Antenatal steroids < 35+0 weeks morphology Twice daily cCTG (or CTG) • At least daily maternal BP and pre-eclampsia assessment Consider serology . Consider UA and DV Doppler, liquor performed two to three times per week if birth not imminent for congenital FGR at high risk of infection screen, NOTE: do not perform DV Doppler after 34+) weeks gestation as fetuses with AEDF or REDF in the UA have met the gestation deterioration

UA AFDF or RFDF

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

· AEDF birth by 32 to 34 weeks gestation

- · Most births will be as soon as possible
- REDF birth by 30 to 32 weeks gestation
- By pre-labour caesarean

criteria for birth

Birth

Absolute indications for birth

- Abnormal fetal heart rate (eq. repetitive unprovoked decelerations on cCTG or CTG)
- Maternal deterioration (eg. severe pre-eclampsia with uncontrolled hypertension/HELLP syndrome or other end-organ damage)

Management of FGR should be individualised

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

especially if severe

FGR (EFW < 3rd

centile)

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



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
- 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.