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MATERNAL-NEWBORN

Postterm Gestation

Pregnancy ≥ 42 Weeks · Placental Insufficiency · Dysmaturity Syndrome

SOURCE TRANSPARENCY

This topic was not in the uploaded personal notes. Content derived from standard nursing references: *Saunders Comprehensive Review for NCLEX-RN (2026)*, *ATI Maternal Newborn Nursing*, *Lowdermilk's Maternity & Women's Health Care*, ACOG Practice Bulletin No. 146 (Management of Late-Term and Postterm Pregnancies), and AWHONN Perinatal Nursing Standards.

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Definition / Overview

Pregnancy that extends beyond the expected due date, classified by completed weeks from the last menstrual period (LMP). Accurate dating — ideally confirmed by first-trimester ultrasound — is essential.

FULL TERM
39 0/7 – 40 6/7
Optimal gestational range

LATE TERM
41 0/7 – 41 6/7
Begin surveillance

POSTTERM
≥ 42 0/7
294+ days from LMP

INCIDENCE
5–10%
Of all pregnancies

Why it matters: Risk of perinatal mortality *doubles* at 42 weeks and is up to 4× higher at 43 weeks compared to term. Increased risk of stillbirth, meconium aspiration, macrosomia, shoulder dystocia, and cesarean birth.

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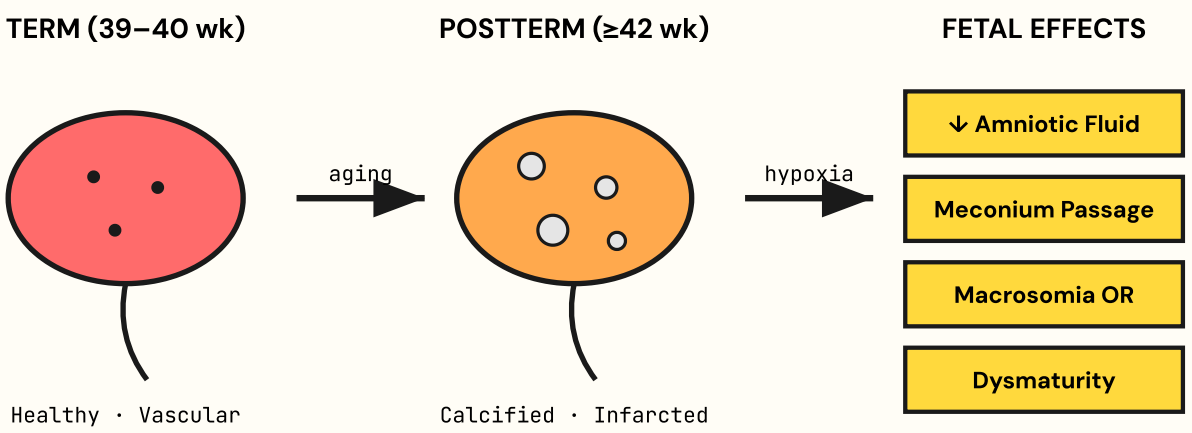
Pathophysiology

1. Pregnancy continues past 42 weeks → **placenta begins to age** (calcification, infarction, fibrosis).
2. Aging placenta → **↓ uteroplacental perfusion** → ↓ O_2 + nutrient delivery to fetus.
3. ↓ Renal perfusion in fetus → **↓ fetal urine output** → **oligohydramnios** (AFI < 5 cm) → cord compression risk.
4. Fetal hypoxia + gut maturity → **passage of meconium in utero** → meconium-stained amniotic fluid → aspiration risk.
5. Two possible outcomes: (A) **Macrosomia** (continued growth if placenta still functioning) OR (B) **Dysmaturity Syndrome** (wasting if placental failure).



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Signs & Symptoms

🤰 Maternal

- Pregnancy duration ≥ 42 weeks from LMP
- Fundal height larger than dates (if macrosomia)
- OR maternal weight loss (placental failure)
- Decreased fetal movement reports
- Reduced amniotic fluid on ultrasound (AFI < 5)
- Possible meconium-stained fluid on ROM
- Unfavorable cervix common (low Bishop score)

👶 Newborn (Dysmaturity Syndrome)

- **Long, thin body** — loss of subQ fat
- **Dry, cracked, peeling, leathery skin**
- Long fingernails & toenails
- Abundant scalp hair
- Meconium-stained skin / nails / cord
- Wide-eyed, alert appearance ("old man baby")
- Loss of vernix & lanugo
- Hypoglycemia, hypothermia, polycythemia

🚨 RED FLAGS — Report Immediately

- **Decreased fetal movement** — fewer than 10 kicks in 2 hours
- **Meconium-stained amniotic fluid** — especially thick/particulate
- **Late or recurrent variable decelerations** on EFM (uteroplacental insufficiency / cord compression)
- **Oligohydramnios** — AFI < 5 cm or single deepest pocket < 2 cm
- **Absent end-diastolic flow** on umbilical artery Doppler
- **Non-reactive NST** or biophysical profile (BPP) ≤ 4

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Priority Nursing Interventions

Antepartum Surveillance

- ✓ **Assess** accurate gestational dating (first-trimester US is gold standard)
- ✓ **Teach** daily fetal kick counts: 10 movements in 2 hours
- ✓ **Monitor** with NST 1–2× weekly starting at 41 weeks
- ✓ **Perform** weekly BPP and AFI assessment
- ✓ **Assess** Bishop score to determine readiness for induction
- ✓ **Prepare** client for induction at 41–42 weeks per ACOG guidelines

Intrapartum (Airway · Breathing · Circulation)

- ✓ **Apply** continuous external fetal monitoring (EFM)
- ✓ **Position** in lateral (left side preferred) to maximize placental perfusion
- ✓ **Administer** O_2 8–10 L/min via non-rebreather for non-reassuring FHR
- ✓ **Discontinue** oxytocin immediately if tachysystole or late decels occur
- ✓ **Prepare** for amnioinfusion if thick meconium & variable decels
- ✓ **Anticipate** possible operative or cesarean delivery
- ✓ **Notify** NRP-trained team for delivery attendance

Newborn Care

- ✓ **Assess** infant tone, breathing, HR *first* — vigorous infants do NOT need routine suctioning even with meconium (per current NRP)
- ✓ **Suction** below the cords (intubation + suction) ONLY if non-vigorous and meconium-stained
- ✓ **Maintain** thermoregulation — radiant warmer (↓ subQ fat = poor thermoregulation)
- ✓ **Monitor** blood glucose every 30–60 min until stable (risk of hypoglycemia)
- ✓ **Assess** for birth trauma — shoulder dystocia, clavicle fracture, brachial plexus injury
- ✓ **Initiate** early feeding to prevent hypoglycemia

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Pharmacology

DRUG / CLASS	MECHANISM	SIDE EFFECTS	NURSING CONSIDERATIONS
Misoprostol (Cytotec) *PGE_1 analog*	Cervical ripening; softens & effaces cervix; induces contractions	Tachysystole, uterine rupture, N/V, diarrhea, fever	**CONTRAINDICATED with prior C-section** (rupture risk). Place in posterior fornix. Monitor FHR & contractions q15–30 min.
Dinoprostone (Cervidil insert / Prepidil gel) *PGE_2*	Cervical ripening; softens cervix; mild uterine stimulation	Tachysystole, hypotension, headache, fever, GI upset	Insert vaginally; client supine 30 min after. **Remove insert immediately** if tachysystole or fetal distress. Has retrieval string.
Oxytocin (Pitocin) *Posterior pituitary hormone*	Stimulates uterine contractions; induction/augmentation of labor	Tachysystole, uterine rupture, FHR decels, water intoxication, hypotension	IV piggyback via pump only. Titrate q30–60 min. **STOP for: >5 contractions/10 min, late decels, non-reassuring FHR.** Always have Mg sulfate / terbutaline available.
Terbutaline (Brethine) *β_2 agonist · tocolytic*	Relaxes uterine smooth muscle; reverses tachysystole	Maternal tachycardia, tremors, hyperglycemia, pulmonary edema	SubQ rescue dose for uterine tachysystole. Monitor maternal HR — hold if >120 bpm.

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NCLEX Test Traps

Meconium-stained fluid at delivery

✕ TRAP
Routinely suction every infant on the perineum

✓ RIGHT
Assess infant **tone, cry, breathing first**. Suction below cords ONLY if non-vigorous.

Oxytocin running, late decels appear

✕ TRAP
Notify HCP first, then continue infusion

✓ RIGHT
STOP oxytocin first, reposition left, O_2, IV bolus, THEN notify HCP.

Client with prior C-section, postterm

✕ TRAP
Administer misoprostol to ripen cervix

✓ RIGHT
Misoprostol is contraindicated — uterine rupture risk. Use mechanical ripening or scheduled C-section.

Mother reports ↓ fetal movement at 41 wk

✕ TRAP
Reassure her it's normal late in pregnancy

✓ RIGHT
Have her come in immediately for NST/BPP. Decreased movement = red flag.

Postterm vs late-term confusion

✕ TRAP
41 weeks = postterm pregnancy

✓ RIGHT
41 weeks = **late-term**. Postterm = **≥ 42 0/7 weeks**.

Postterm newborn glucose check

✕ TRAP
Wait for symptoms before checking

✓ RIGHT
Check glucose within 30–60 min of birth — depleted glycogen stores = hypoglycemia risk.

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Patient Education

Accurate Dating

First-trimester ultrasound provides the most reliable due date. Know your dating method.

Daily Kick Counts

Count fetal movements daily. Goal: **10 movements in 2 hours**. Report fewer immediately.

When to Call

Decreased movement, ROM, bleeding, severe headache, decreased urination, contractions.

Attend All Testing

Twice-weekly NST and weekly BPP/AFI after 41 weeks are essential — do not skip.

Induction Discussion

Induction typically offered at 41 weeks, recommended by 42 weeks. Discuss risks & benefits with HCP.

Newborn Expectations

Baby may have peeling skin, long nails, or appear thin — these are expected findings, not abnormal.

Increased Risk Awareness

Higher chance of induction, C-section, and NICU stay. Pack hospital bag by 39 weeks.

Hydration

Adequate maternal hydration supports amniotic fluid volume. Aim for 8–10 glasses daily.

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Memory Boosters

WRINKLED

The postterm newborn looks like a little old person

- **W** — **Wasted** appearance — loss of subQ fat
- **R** — **Reduced** amniotic fluid (oligohydramnios)
- **I** — **Increased** meconium passage
- **N** — **Nails** long (fingers & toes)
- **K** — **Knowing**, alert, wide-eyed look
- **L** — **Leathery**, dry, cracked, peeling skin
- **E** — **Excess** scalp hair
- **D** — **Decreased** glucose & temperature

Quick Associations

- **≥ 42 weeks = PROBLEM.** Postterm cutoff is 42 0/7. Anything 41 = late-term.
- **Bishop ≥ 8 = ready to induce.** Lower scores → cervical ripening needed first.
- **AFI < 5 = Oh No.** "O" for Oligohydramnios = low fluid = cord compression risk.
- **Misoprostol + prior C-section = NEVER.** Uterine rupture is the boards answer.
- **STOP Pit first** for tachysystole or late decels — before O_2, before reposition, before HCP call.
- **10 in 2.** 10 fetal movements in 2 hours = adequate.
- **Vigorous baby + mec = no suction.** NRP 2020+ guideline. Assess tone first.
- **"Old man baby"** visual cue: long nails, dry skin, alert eyes, lots of hair, thin = dysmaturity.

NCJMM CLINICAL JUDGMENT

Six-Step Clinical Judgment Scenario

SCENARIO: *A 32-year-old G2P1 at 41 6/7 weeks gestation is admitted for induction of labor. History: previous vaginal delivery. Vitals: BP 118/74, HR 88, T 98.6°F. Cervix 2 cm/50%/-1 station, Bishop score 5. NST reactive. AFI = 4.8 cm. Misoprostol 25 mcg placed intravaginally 2 hours ago. Nurse now notes 6 contractions in 10 minutes with a recurrent late deceleration pattern. FHR baseline 165 bpm with minimal variability. Client reports strong, "back-to-back" contractions.*

STEP 1 · RECOGNIZE CUES

What's relevant?

Postterm (41 6/7), low AFI (4.8 — oligohydramnios), tachysystole (6 ctx/10 min), recurrent late decels, tachycardia (FHR 165), minimal variability, misoprostol on board.

STEP 2 · ANALYZE CUES

What does it mean?

Tachysystole from misoprostol is causing uteroplacental insufficiency. Late decels + minimal variability = Category III tracing. Oligohydramnios worsens the picture. Fetal hypoxia in progress.

STEP 3 · PRIORITIZE HYPOTHESIS

What's the top concern?

#1: Uteroplacental insufficiency / fetal hypoxia from prostaglandin-induced tachysystole. Risk of fetal acidemia → stillbirth if not corrected.

STEP 4 · GENERATE SOLUTIONS

What can be done?

Intrauterine resuscitation: remove misoprostol (if retrievable), reposition L lateral, O_2 10 L NRB, IV LR bolus, stop any uterotonics, consider terbutaline 0.25 mg SubQ rescue, notify HCP, prepare for possible C-section.

STEP 5 · TAKE ACTION

What to do FIRST?

Reposition client to left lateral and apply O_2 at 10 L via non-rebreather — immediate intrauterine resuscitation. Simultaneously stop any oxytocin if running, call HCP, prepare terbutaline rescue per order.

STEP 6 · EVALUATE OUTCOMES

Did it work?

Reassess in 5–10 min: FHR returns to baseline 120–150, variability improves (moderate), decels resolve, contractions space to ≤ 5/10 min. If no improvement → emergent C-section.