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**The American College of Obstetricians and Gynecologists Committee on Obstetric Practice
The Society for Maternal-Fetal Medicine**

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Medically Indicated Late-Preterm and Early-Term Deliveries

ABSTRACT: The neonatal risks of late preterm (34 0/7–36 6/7 weeks of gestation) and early-term (37 0/7–38 6/7 weeks of gestation) births are well established. However, there are a number of maternal, fetal, and placental complications in which either a late-preterm or early-term delivery is warranted. The timing of delivery in such cases must balance the maternal and newborn risks of late-preterm and early-term delivery with the risks of further continuation of pregnancy. Decisions regarding timing of delivery must be individualized. Amniocentesis for the determination of fetal lung maturity in well-dated pregnancies generally should not be used to guide the timing of delivery.

The American College of Obstetricians and Gynecologists and the Society for Maternal-Fetal Medicine have long discouraged nonindicated delivery before 39 weeks of gestation. The reason for this longstanding principle is that the neonatal risks of late-preterm (34 0/7–36 6/7 weeks of gestation) and early-term (37 0/7–38 6/7 weeks of gestation) births are well established. However, there are a number of maternal, fetal, and placental complications in which either a late-preterm or early-term delivery is warranted. The timing of delivery in such cases must balance the maternal and newborn risks of late-preterm and early-term delivery with the risks of further continuation of pregnancy. Recently, the Eunice Kennedy Shriver National Institute of Child Health and Human Development and the Society for Maternal-Fetal Medicine convened a workshop to address this issue by summarizing the available evidence and making recommendations (1). The evidence regarding timing of indicated delivery for most conditions is limited; therefore, these recommendations are based largely on expert consensus and relevant observational studies, and management should be individualized.

There are several important principles to consider in the timing of delivery. First, the decision making regarding timing of delivery is complex and must take into account relative maternal and newborn risks, prac-

tice environment, and patient preferences. Second, late-preterm or early-term deliveries may be warranted for either maternal or newborn benefit or both. In some cases, health care providers will need to weigh competing risks and benefits for mother and newborn; therefore, decisions regarding timing of delivery must be individualized. Additionally, recommendations such as these are dependent on accurate determination of gestational age.

Amniocentesis for the determination of fetal lung maturity in well-dated pregnancies generally should not be used to guide the timing of delivery. The reasons for this are multiple and interrelated. First, if there is a clear indication for a late-preterm or early-term delivery for either maternal or newborn benefit then delivery should occur regardless of such maturity testing. Conversely, if delivery could be safely delayed in the context of an immature lung profile result then no clear indication for a late-preterm or early-term delivery actually exists. Second, mature amniotic fluid indices are not necessarily reflective of maturity in organ systems other than the lungs.

Table 1 presents recommendations for the timing of delivery for a number of specific conditions. This list is not meant to be all-inclusive, but rather a compilation of indications commonly encountered in clinical practice. “General timing” describes the concept of whether a

Table 1: Recommendations for the Timing of Delivery When Conditions Complicate Pregnancy at or After 34 Weeks of Gestation ↵

Condition	General Timing	Suggested Specific Timing
Placental/uterine issues		
Placenta previa*	Late preterm/early term	36 0/7–37 6/7 weeks of gestation
Placenta previa with suspected accreta, increta, or percreta*	Late preterm	34 0/7–35 6/7 weeks of gestation
Prior classical cesarean	Late preterm/early term	36 0/7–37 6/7 weeks of gestation
Prior myomectomy	Early term/term (individualize)	37 0/7–38 6/7 weeks of gestation
Fetal issues		
Growth restriction (singleton)		
Otherwise uncomplicated, no concurrent findings	Early term/term	38 0/7–39 6/7 weeks of gestation
Concurrent conditions (oligohydramnios, abnormal Doppler studies, maternal co-morbidity [eg, preeclampsia, chronic hypertension])	Late preterm/early term	34 0/7–37 6/7 weeks of gestation
Growth restriction (twins)		
Di–Di twins with isolated fetal growth restriction	Late preterm/early term	36 0/7–37 6/7 weeks of gestation
Di–Di twins with concurrent condition abnormal Doppler studies, maternal co-morbidity [eg, preeclampsia, chronic hypertension])	Late preterm	32 0/7–34 6/7 weeks of gestation
Mo–Di twins with isolated fetal growth restriction	Late preterm	32 0/7–34 6/7 weeks of gestation
Multiple gestations		
Di–Di twins	Early term	38 0/7–38 6/7 weeks of gestation
Mo–Di twins	Late preterm/early term	34 0/7–37 6/7 weeks of gestation
Oligohydramnios	Late preterm/early term	36 0/7–37 6/7 weeks of gestation
Maternal issues		
Chronic hypertension		
Controlled on no medications	Early term/term	38 0/7–39 6/7 weeks of gestation
Controlled on medications	Early term/term	37 0/7–39 6/7 weeks of gestation
Difficult to control	Late preterm/early term	36 0/7–37 6/7 weeks of gestation
Gestational hypertension	Early term	37 0/7–38 6/7 weeks of gestation
Preeclampsia—severe	Late preterm	At diagnosis after 34 0/7 weeks of gestation
Preeclampsia—mild	Early term	At diagnosis after 37 0/7 weeks of gestation
Diabetes		
Pregestational well-controlled*	Late preterm, early term birth not indicated	
Pregestational with vascular complications	Early term/term	37 0/7–39 6/7 weeks of gestation
Pregestational, poorly controlled	Late preterm or early term	Individualized
Gestational—well controlled on diet or medications	Late preterm, early term birth not indicated	
Gestational—poorly controlled	Late preterm or early term	Individualized
Obstetric issues		
PPROM	Late preterm	34 0/7 weeks of gestation

Abbreviations: Di–Di, dichorionic–diamniotic; Mo–Di, monochorionic–diamniotic; PPRM, preterm premature rupture of membranes.

*Uncomplicated, thus no fetal growth restriction, superimposed preeclampsia, or other complication. If these are present, then the complicating conditions take precedence and earlier delivery may be indicated.

Modified from Spong CY, Mercer BM, D'Alton M, Kilpatrick S, Blackwell S, Saade G. Timing of indicated late-preterm and early-term birth. *Obstet Gynecol* 2011;118:323–33. [PubMed] [*Obstetrics & Gynecology*]

condition is appropriately managed with either a late-preterm or early-term delivery. “Suggested specific timing” refers to a more defined timing of delivery within the broader categories of late-preterm or early-term delivery. These are recommendations only and will need to be individualized and re-evaluated as new evidence becomes available.

References

1. Spong CY, Mercer BM, D’Alton M, Kilpatrick S, Blackwell S, Saade G. Timing of indicated late-preterm and early-term birth. *Obstet Gynecol* 2011;118:323–33. [[PubMed](#)] [[Obstetrics & Gynecology](#)] ↩

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