MANAGEMENT OF THE UNCOMPLICATED PREGNANCY BEYOND 41+0 WEEKS' GESTATIONS: GRADE TABLES

GRADE TABLE 1: ROUTINE EARLY VS. SELECTIVE USE OF ULTRASOUND

Bibliography: Whitworth M, Bricker L, Mullan C. Ultrasound for fetal assessment in early pregnancy. Cochrane database Syst Rev [Internet]. 2015 Jul 14;(7):CD007058. Available from: http://www.ncbi.nlm.nih.gov/pubmed/26171896

Certainty assessment							Summary of findings				
Nº of participants (studies) Follow-up	Risk of bias	Inconsistency	Indirectness	Imprecision	Publication bias	Overall certainty of evidence	Study event rates (%)		Relative effect (95% CI)	Anticipated absolute effects	
							With selective US	With Early routine US		Risk with selective US	Risk difference with Early routine US
Induction for post-term pregnancies											
25516 (8 RCTs)	serious [a]	not serious	not serious	not serious	none	⨁⨁⨁◯ MODERATE	388/12696 (3.1%)	245/12820 (1.9%)	**RR 0.59** (0.42 to 0.83)	31 per 1,000	**13 fewer per 1,000** (from 18 fewer to 5 fewer)

CI: Confidence interval; **RR:** Risk ratio

Explanations

a. Risk of bias assessments from the Cochrane review "Ultrasound for fetal assessment" (2015) have been used. In these assessments, concerns about randomization and allocation concealment, blinding and data reporting have been identified.

GRADE TABLE 2: SWEEPING OF THE MEMBRANES VS. NO SWEEPING OF THE MEMBRANES

Bibliography: see below

Certainty assessment							Summary of findings				
							Study event rates (%)		Relative effect (95% CI)	Anticipated absolute effects	
№ of participants (studies) Follow-up	Risk of bias	Inconsistency	Indirectness	Imprecision	Publication bias	Overall certainty of evidence	With no membrane sweep	With Membrane sweep		Risk with no membrane sweep	Risk difference with Membrane sweep
Gestational age at delivery											
875 (4 RCTs)	not serious	not serious	not serious	not serious	none	⨁⨁⨁⨁ HIGH	424	451	-	The mean gestational age at delivery was **0**	MD **0.64 lower** (1.33 lower to 0.06 higher)
Time to onset of labour											
820 (5 RCTs)	serious [a]	not serious	not serious	not serious	none	⨁⨁⨁◯ MODERATE	405	415	-	The mean time to onset of labour was **0**	MD **0.97 lower** (1.47 lower to 0.46 lower)
Prelabour rupture of membranes											
2187 (11 RCTs)	not serious	not serious	not serious	not serious	publication bias strongly suspected [b]	⨁⨁⨁◯ MODERATE	161/1065 (15.1%)	205/1122 (18.3%)	**RR 1.21** (0.96 to 1.51)	151 per 1,000	**32 more per 1,000** (from 6 fewer to 77 more)
Spontaneous labour											
1588 (9 RCTs)	not serious	serious [c]	not serious	not serious	none	⨁⨁⨁◯ MODERATE	471/774 (60.9%)	565/814 (69.4%)	**RR 1.18** (1.04 to 1.34)	609 per 1,000	**110 more per 1,000** (from 24 more to 207 more)

Bibliography: see below

Certainty assessment							Summary of findings				
Chorioamnionitis											
922 (5 RCTs)	not serious	not serious	not serious	serious [d]	none	⨁⨁⨁◯ MODERATE	12/443 (2.7%)	20/479 (4.2%)	**RR 1.49** (0.74 to 3.00)	27 per 1,000	**13 more per 1,000** (from 7 fewer to 54 more)
Delivery >41 weeks											
1520 (9 RCTs)	not serious	not serious	not serious	not serious	none	⨁⨁⨁⨁ HIGH	147/744 (19.8%)	76/776 (9.8%)	**RR 0.53** (0.40 to 0.69)	198 per 1,000	**93 fewer per 1,000** (from 119 fewer to 61 fewer)
Delivery >42 weeks											
622 (3 RCTs)	not serious	not serious	not serious	serious [d]	none	⨁⨁⨁◯ MODERATE	18/297 (6.1%)	7/325 (2.2%)	**RR 0.43** (0.14 to 1.32)	61 per 1,000	**35 fewer per 1,000** (from 52 fewer to 19 more)

CI: Confidence interval; **MD:** Mean difference; **RR:** Risk ratio

Explanations

a. There was insufficient information regarding randomization and allocation concealment methods in two of these studies. In one study, date of induction was scheduled after participants were randomized, introducing the potential for additional bias.
b. Funnel plot shows publication bias is suspected;
c. Results from studies are inconsistent; I2 = 69%
d. There are a small number of events and a wide confidence interval that crosses the null.

Bibliography: Boulvain M, Fraser WD, Marcoux S, Fontaine JY, Bazin S, Pinault JJ, et al. Does sweeping of the membranes reduce the need for formal induction of labour? A randomised controlled trial. Br J Obstet Gynaecol. 1998 Jan;105(1):34–40.; Goldenberg M, Dulitzky M, Feldman B, Zolti M, Bider D. Stretching of the cervix and stripping of the membranes at term: a randomised controlled study. Eur J Obstet Gynecol Reprod Biol [Internet]. 1996 Jun;66(2):129–32. Available from: http://www.ncbi.nlm.nih.gov/pubmed/8735733; Parlakgumus HA, Yalcinkaya C, Haydardedeoglu B, Tarim E. The impact of sweeping the membranes on cervical length and labor: a randomized clinical trial. Ginekol Pol [Internet]. 2014 Sep;85(9):682–7. Available from: http://www.ncbi.nlm.nih.gov/pubmed/25322540; Salamalekis E, Vitoratos N, Kassanos D, Loghis C, Batalias L, Panayotopoulos N, et al. Sweeping of the membranes versus uterine stimulation by oxytocin in nulliparous women. Gynecol Obstet Investig. 2000;49(4):240–3.; Wiriyasirivaj B, Vutyavanich T, Ruangsri RA. A randomized controlled trial of membrane stripping at term to promote labor. Obstet Gynecol [Internet]. 1996 May;87(5 Pt 1):767–70. Available from: http://www.ncbi.nlm.nih.gov/pubmed/8677083; Cammu H, Haitsma V. Sweeping of the membranes at 39 weeks in nulliparous women: a randomised controlled trial. Br J Obstet Gynaecol. 1998 Jan;105(1):41–4.; Crane J, Bennett K, Young D, Windrim R, Kravitz H.

The effectiveness of sweeping membranes at term: a randomized trial. Obstet Gynecol [Internet]. 1997 Apr;89(4):586–90. Available from: http://www.ncbi.nlm.nih.gov/pubmed/9083317; Gupta R, Vasishta K, Sawhney H, Ray P. Safety and efficacy of stripping of membranes at term. Int J Gynaecol Obstet. 1998 Feb;60(2):115–21.; Hill MJ, McWilliams GD, Garcia-Sur D, Chen B, Munroe M, Hoeldtke NJ. The effect of membrane sweeping on prelabor rupture of membranes: a randomized controlled trial. Obstet Gynecol [Internet]. 2008 Jun;111(6):1313–9. Available from: http://www.ncbi.nlm.nih.gov/pubmed/18515514; Wong SF, Hui SK, Choi H, Ho LC. Does sweeping of membranes beyond 40 weeks reduce the need for formal induction of labour?[see comment]. BJOG An Int J Obstet Gynaecol. 2002 Jun;109(6):632–6.; Zamzami T, Al Senani N. The efficacy of membrane sweeping at term and effect on the duration of pregnancy: a randomized controlled trial. J Clin Gyncol Obs. 2014;3(1):30–4.; Yildirim G, Güngördük K, Karadağ OI, Aslan H, Turhan E, Ceylan Y. Membrane sweeping to induce labor in low-risk patients at term pregnancy: a randomised controlled trial. J Matern Fetal Neonatal Med [Internet]. 2010 Jul;23(7):681–7. Available from: http://www.ncbi.nlm.nih.gov/pubmed/19895357; el-Torkey M, Grant JM. Sweeping of the membranes is an effective method of induction of labour in prolonged pregnancy: a report of a randomized trial. Br J Obstet Gynaecol [Internet]. 1992 Jun;99(6):455–8. Available from: http://www.ncbi.nlm.nih.gov/pubmed/1637758; Dare FO, Oboro VO. The role of membrane stripping in prevention of post-term pregnancy: A randomised clinical trial in Ile-Ife, Nigeria. J Obstet Gynaecol. 2002;22(3):283–6.; Berghella V, Rogers RA, Lescale K. Stripping of membranes as a safe method to reduce prolonged pregnancies. Obstet Gynecol. 1996 Jun;87(6):927–31.; Ugwu EO, Obi SN, Iferikigwe ES, Dim CC, Ezugwu FO. Membrane stripping to prevent post-term pregnancy in Enugu, Nigeria: a randomized controlled trial. Arch Gynecol Obstet [Internet]. 2014 Jan;289(1):29–34. Available from: http://www.ncbi.nlm.nih.gov/pubmed/23764933; McColgin SW, Hampton HL, McCaul JF, Howard PR, Andrew ME, Morrison JC. Stripping membranes at term: can it safely reduce the incidence of post-term pregnancies? Obstet Gynecol [Internet]. 1990 Oct;76(4):678–80. Available from: http://www.ncbi.nlm.nih.gov/pubmed/2216203

GRADE TABLE 3: ACUPRESSURE VS. USUAL CARE

Bibliography: Mollart L, Skinner V, Foureur M. A feasibility randomised controlled trial of acupressure to assist spontaneous labour for primigravid women experiencing a post-date pregnancy. Midwifery [Internet]. 2016 May;36:21–7. Available from: http://www.ncbi.nlm.nih.gov/pubmed/27106940; Torkzahrani S, Mahmoudikohani F, Saatchi K, Sefidkar R, Banaei M. The effect of acupressure on the initiation of labor: A randomized controlled trial. Women Birth [Internet]. 2017 Feb;30(1):46–50. Available from: http://www.ncbi.nlm.nih.gov/pubmed/27444642

Certainty assessment							Summary of findings				
№ of participants (studies) Follow-up	Risk of bias	Inconsistency	Indirectness	Imprecision	Publication bias	Overall certainty of evidence	Study event rates (%)		Relative effect (95% CI)	Anticipated absolute effects	
							With Usual care	With Acupressure		Risk with Usual care	Risk difference with Acupressure
Mean gestational age at delivery											
44 (1 RCT)	not serious	not serious	not serious	serious [a]	none	⨁⨁⨁◯ MODERATE	22	22	-	The mean mean gestational age at delivery was **290.4** days	MD **0.2 days higher** (0.97 lower to 1.37 higher)
Time to birth											
100 (1 RCT)	not serious	not serious	not serious	serious [b]	none	⨁⨁⨁◯ MODERATE	50	50	-	The mean time to birth was **114.16** hours	MD **10.72 hours higher** (14.89 lower to 36.33 higher)
Spontaneous onset of labour											
44 (1 RCT)	not serious	not serious	not serious	serious [c]	none	⨁⨁⨁◯ MODERATE	9/22 (40.9%)	11/22 (50.0%)	**RR 1.22** (0.64 to 2.35)	409 per 1,000	**90 more per 1,000** (from 147 fewer to 552 more)

Bibliography: Mollart L, Skinner V, Foureur M. A feasibility randomised controlled trial of acupressure to assist spontaneous labour for primigravid women experiencing a post-date pregnancy. Midwifery [Internet]. 2016 May;36:21–7. Available from: http://www.ncbi.nlm.nih.gov/pubmed/27106940; Torkzahrani S, Mahmoudikohani F, Saatchi K, Sefidkar R, Banaei M. The effect of acupressure on the initiation of labor: A randomized controlled trial. Women Birth [Internet]. 2017 Feb;30(1):46–50. Available from: http://www.ncbi.nlm.nih.gov/pubmed/27444642

Certainty assessment							Summary of findings				
Spontaneous labour <48 hours											
100 (1 RCT)	not serious	not serious	not serious	serious [c]	none	⊕⊕⊕◯ MODERATE	11/50 (22.0%)	15/50 (30.0%)	**RR 1.36** (0.70 to 2.67)	220 per 1,000	**79 more per 1,000** (from 66 fewer to 367 more)
Spontaneous labour 49-96 hours											
100 (1 RCT)	not serious	not serious	not serious	serious [c]	none	⊕⊕⊕◯ MODERATE	12/50 (24.0%)	7/50 (14.0%)	**RR 0.58** (0.25 to 1.36)	240 per 1,000	**101 fewer per 1,000** (from 180 fewer to 86 more)

CI: Confidence interval; **MD:** Mean difference; **RR:** Risk ratio

Explanations

a. Clinically relevant: 1 day or 2 days could potentially influence whether or not someone gets an induction or not. Also, small sample size and confidence interval crosses the null and this is not a rare outcome.
b. Clinically relevant: depending on gestational age and labouring in hospital a difference of 14 hours less to 36 hours more could mean that an individual undergoes an induction or not. Small sample size, confidence interval is big, not a rare outcome.
c. This study had a small sample, few events and a wide confidence interval that crosses the null.

GRADE TABLE 4: ACUPUNCTURE VS. USUAL CARE

Bibliography: Neri I, Pignatti L, Fontanesi F, Facchinetti F. Acupuncture in Postdate Pregnancy Management. J Acupunct Meridian Stud [Internet]. 2018 Oct;11(5):332–6. Available from: http://www.ncbi.nlm.nih.gov/pubmed/29890286; Harper TC, Coeytaux RR, Chen W, Campbell K, Kaufman JS, Moise KJ, et al. A randomized controlled trial of acupuncture for initiation of labor in nulliparous women. J Matern Fetal Neonatal Med [Internet]. 2006 Aug;19(8):465–70. Available from: http://www.ncbi.nlm.nih.gov/pubmed/16966110; Asher GN, Coeytaux RR, Chen W, Reilly AC, Loh YL, Harper TC. Acupuncture to initiate labor (Acumoms 2): a randomized, sham-controlled clinical trial. J Matern Fetal Neonatal Med [Internet]. 2009 Oct;22(10):843–8. Available from: http://www.ncbi.nlm.nih.gov/pubmed/19526433

Certainty assessment							Summary of findings				
							Study event rates (%)			Anticipated absolute effects	
№ of participants (studies) Follow-up	Risk of bias	Inconsistency	Indirectness	Imprecision	Publication bias	Overall certainty of evidence	With Usual care	With Acupuncture/ Electro-Acupuncture	Relative effect (95% CI)	Risk with Usual care	Risk difference with Acupuncture/ Electro-Acupuncture
Time to birth											
101 (2 RCTs)	not serious	not serious	not serious	serious [a]	none	⨁⨁⨁◯ MODERATE	56	45	-	The mean time to birth was **0**	MD **0.43 lower** (1.85 lower to 1 higher)
Spontaneous delivery											
60 (1 RCT)	not serious	not serious	not serious	serious [a]	none	⨁⨁⨁◯ MODERATE	22/30 (73.3%)	20/30 (66.7%)	**RR 0.91** (0.65 to 1.27)	733 per 1,000	**66 fewer per 1,000** (from 257 fewer to 198 more)
Mean gestational age at delivery											

Bibliography: Neri I, Pignatti L, Fontanesi F, Facchinetti F. Acupuncture in Postdate Pregnancy Management. J Acupunct Meridian Stud [Internet]. 2018 Oct;11(5):332–6. Available from: http://www.ncbi.nlm.nih.gov/pubmed/29890286; Harper TC, Coeytaux RR, Chen W, Campbell K, Kaufman JS, Moise KJ, et al. A randomized controlled trial of acupuncture for initiation of labor in nulliparous women. J Matern Fetal Neonatal Med [Internet]. 2006 Aug;19(8):465–70. Available from: http://www.ncbi.nlm.nih.gov/pubmed/16966110; Asher GN, Coeytaux RR, Chen W, Reilly AC, Loh YL, Harper TC. Acupuncture to initiate labor (Acumoms 2): a randomized, sham-controlled clinical trial. J Matern Fetal Neonatal Med [Internet]. 2009 Oct;22(10):843–8. Available from: http://www.ncbi.nlm.nih.gov/pubmed/19526433

Certainty assessment							Summary of findings				
375 (1 observational study)	not serious	not serious	not serious	not serious	none	⊕⊕◯◯ LOW	263	112	-	The mean mean gestational age at delivery was **0** days	MD **2 days lower** (2.56 lower to 1.44 lower)

CI: Confidence interval; **MD:** Mean difference; **RR:** Risk ratio

Explanations

a. This study has a small sample size and a confidence interval that crosses the null.

GRADE TABLE 5: EVENING PRIMROSE OIL VS. PLACEBO

Bibliography: Kalati M, Kashanian M, Jahdi F, Naseri M, Haghani H, Sheikhansari N. Evening primrose oil and labour, is it effective? A randomised clinical trial. J Obstet Gynaecol [Internet]. 2018 May;38(4):488–92. Available from: http://www.ncbi.nlm.nih.gov/pubmed/29426270; Dove D, Johnson P. Oral evening primrose oil: its effect on length of pregnancy and selected intrapartum outcomes in low-risk nulliparous women. J Nurse Midwifery [Internet]. 1999;44(3):320–4. Available from: http://www.ncbi.nlm.nih.gov/pubmed/10380450

Certainty assessment							Summary of findings				
							Study event rates (%)			Anticipated absolute effects	
№ of participants (studies) Follow-up	Risk of bias	Inconsistency	Indirectness	Imprecision	Publication bias	Overall certainty of evidence	With placebo	With Evening primrose oil	Relative effect (95% CI)	Risk with placebo	Risk difference with Evening primrose oil
Time to birth											
80 (1 RCT)	serious [a]	not serious	not serious	not serious	none	⨁⨁⨁◯ MODERATE	40	40	-	The mean time to birth was **4.45** days	MD **0.06 days lower** (0.71 lower to 0.59 higher)
Mean gestational age at birth											
108 (1 observational study)	serious [b]	not serious	not serious	not serious	none	⨁◯◯◯ VERY LOW	54	54	-	The mean mean gestational age at birth was **279** days	MD **2.69 days higher** (0.02 lower to 5.4 higher)
Bishop score											

Bibliography: Kalati M, Kashanian M, Jahdi F, Naseri M, Haghani H, Sheikhansari N. Evening primrose oil and labour, is it effective? A randomised clinical trial. J Obstet Gynaecol [Internet]. 2018 May;38(4):488–92. Available from: http://www.ncbi.nlm.nih.gov/pubmed/29426270; Dove D, Johnson P. Oral evening primrose oil: its effect on length of pregnancy and selected intrapartum outcomes in low-risk nulliparous women. J Nurse Midwifery [Internet]. 1999;44(3):320–4. Available from: http://www.ncbi.nlm.nih.gov/pubmed/10380450

Certainty assessment							Summary of findings				
80 (1 RCT)	serious [a]	not serious	not serious	not serious	none	⊕⊕⊕◯ MODERATE	40	40	-	The mean bishop score was **4.35**	MD **0.75 lower** (1.66 lower to 0.16 higher)

CI: Confidence interval; **MD:** Mean difference

SExplanations

a. This study was downgraded for risk of bias as there was a significant loss to follow-up in both groups and these individuals were not included in an intention to treat analysis.
b. This study was downgraded for risk of bias as there were concerns about confounding variables.

GRADE TABLE 6: INDUCTION DURING THE 41ST WEEK VS. DURING THE 42ND WEEK

Bibliography: Gelisen O, Caliskan E, Dilbaz S, Ozdas E, Dilbaz B, Ozdas E, et al. Induction of labor with three different techniques at 41 weeks of gestation or spontaneous follow-up until 42 weeks in women with definitely unfavorable cervical scores. Eur J Obstet Gynecol Reprod Biol [Internet]. 2005 Jun 1;120(2):164–9. Available from: http://www.ncbi.nlm.nih.gov/pubmed/15925045; Hannah ME, Hannah WJ, Hellmann J, Hewson S, Milner R, Willan A. Induction of labor as compared with serial antenatal monitoring in post-term pregnancy. A randomized controlled trial. The Canadian Multicenter Post-term Pregnancy Trial Group. N Engl J Med [Internet]. 1992 Jun 11 [cited 2013 Oct 22];326(24):1587–92. Available from: http://www.ncbi.nlm.nih.gov/pubmed/1584259; Heimstad R, Skogvoll E, Mattsson LA, Johansen OJ, Eik-Nes SH, Salvesen KA. Induction of labor or serial antenatal fetal monitoring in postterm pregnancy: a randomized controlled trial. Obstet Gynecol. 2007 Mar;109(3):609–17.; Keulen JK, Bruinsma A, Kortekaas JC, van Dillen J, Bossuyt PM, Oudijk MA, et al. Induction of labour at 41 weeks versus expectant management until 42 weeks (INDEX): multicentre, randomised non-inferiority trial. BMJ [Internet]. 2019;364:l344. Available from: http://www.ncbi.nlm.nih.gov/pubmed/30786997; Sahraoui W, Hajji S, Bibi M, Nouira M, Essaidi H, Khairi H. [Management of pregnancies beyond forty-one week's gestation with an unfavorable cervix]. J Gynecol Obstet Biol Reprod (Paris). 2005 Sep;34(5):454–62.

Certainty assessment							Summary of findings				
№ of participants (studies) Follow-up	Risk of bias	Inconsistency	Indirectness	Imprecision	Publication bias	Overall certainty of evidence	Study event rates (%)		Relative effect (95% CI)	Anticipated absolute effects	
							With Induction at 42 weeks	With Induction at 41 weeks		Risk with Induction at 42 weeks	Risk difference with Induction at 41 weeks
Perinatal death											
9226 (6 RCTs)	serious [a]	not serious	not serious	not serious	none	⨁⨁⨁◯ MODERATE	13/4615 (0.3%)	1/4611 (0.0%)	**RR 0.26** (0.08 to 0.88)	3 per 1,000	**2 fewer per 1,000** (from 3 fewer to 0 fewer)
NICU											
9059 (5 RCTs)	serious [a]	not serious	not serious	not serious	none	⨁⨁⨁◯ MODERATE	386/4525 (8.5%)	324/4534 (7.1%)	**RR 0.83** (0.71 to 0.97)	85 per 1,000	**15 fewer per 1,000** (from 25 fewer to 3 fewer)
Meconium aspiration syndrome											
9212 (6 RCTs)	serious [a]	not serious	not serious	not serious	none	⨁⨁⨁◯ MODERATE	147/4602 (3.2%)	123/4610 (2.7%)	**RR 0.71** (0.47 to 1.07)	32 per 1,000	**9 fewer per 1,000** (from 17 fewer to 2 more)

Bibliography: Gelisen O, Caliskan E, Dilbaz S, Ozdas E, Dilbaz B, Ozdas E, et al. Induction of labor with three different techniques at 41 weeks of gestation or spontaneous follow-up until 42 weeks in women with definitely unfavorable cervical scores. Eur J Obstet Gynecol Reprod Biol [Internet]. 2005 Jun 1;120(2):164–9. Available from: http://www.ncbi.nlm.nih.gov/pubmed/15925045; Hannah ME, Hannah WJ, Hellmann J, Hewson S, Milner R, Willan A. Induction of labor as compared with serial antenatal monitoring in post-term pregnancy. A randomized controlled trial. The Canadian Multicenter Post-term Pregnancy Trial Group. N Engl J Med [Internet]. 1992 Jun 11 [cited 2013 Oct 22];326(24):1587–92. Available from: http://www.ncbi.nlm.nih.gov/pubmed/1584259; Heimstad R, Skogvoll E, Mattsson LA, Johansen OJ, Eik-Nes SH, Salvesen KA. Induction of labor or serial antenatal fetal monitoring in postterm pregnancy: a randomized controlled trial. Obstet Gynecol. 2007 Mar;109(3):609–17.; Keulen JK, Bruinsma A, Kortekaas JC, van Dillen J, Bossuyt PM, Oudijk MA, et al. Induction of labour at 41 weeks versus expectant management until 42 weeks (INDEX): multicentre, randomised non-inferiority trial. BMJ [Internet]. 2019;364:l344. Available from: http://www.ncbi.nlm.nih.gov/pubmed/30786997; Sahraoui W, Hajji S, Bibi M, Nouira M, Essaidi H, Khairi H. [Management of pregnancies beyond forty-one week's gestation with an unfavorable cervix]. J Gynecol Obstet Biol Reprod (Paris). 2005 Sep;34(5):454–62.

Certainty assessment							Summary of findings				
Caesarean section											
9226 (6 RCTs)	serious [a]	not serious	not serious	not serious	none	⊕⊕⊕◯ MODERATE	769/4615 (16.7%)	693/4611 (15.0%)	**RR 0.90** (0.82 to 0.99)	167 per 1,000	**17 fewer per 1,000** (from 30 fewer to 2 fewer)
Operative vaginal birth											
8476 (4 RCTs)	serious [a]	not serious	not serious	not serious	none	⊕⊕⊕◯ MODERATE	675/4240 (15.9%)	686/4236 (16.2%)	**RR 1.02** (0.93 to 1.12)	159 per 1,000	**3 more per 1,000** (from 11 fewer to 19 more)
Analgesia used											
4561 (2 RCTs)	not serious	not serious	not serious	not serious	none	⊕⊕⊕⊕ HIGH	900/2280 (39.5%)	994/2281 (43.6%)	**RR 1.10** (1.03 to 1.17)	395 per 1,000	**39 more per 1,000** (from 12 more to 67 more)
Postpartum haemorrhage											
5069 (3 RCTs)	not serious	not serious	not serious	not serious	none	⊕⊕⊕⊕ HIGH	250/2534 (9.9%)	251/2535 (9.9%)	**RR 1.00** (0.85 to 1.18)	99 per 1,000	**0 fewer per 1,000** (from 15 fewer to 18 more)

CI: Confidence interval; **RR:** Risk ratio

Explanations

a. Risk of bias, as assessed by the Cochrane review "Induction of labour for improving birth outcomes for women at or beyond term" were included here. Two new included studies (Keulen 2019 and Wennerholm 2019) were assessed with Cochrane Risk of Bias Tool 2.0. Risk of bias was rated serious due to missing information on randomization and/or allocation concealment methods. There was also concerns about selective reporting in the included studies, either due to missing information or missing data.

GRADE TABLE 7: INDUCTION DURING THE 42ND WEEK VS. BEYOND

Bibliography: Bergsjø P, Huang GD, Yu SQ, Gao ZZ, Bakketeig LS. Comparison of induced versus non-induced labor in post-term pregnancy. A randomized prospective study. Acta Obstet Gynecol Scand [Internet]. 1989;68(8):683–7. Available from: http://www.ncbi.nlm.nih.gov/pubmed/2698591; Herabutya Y, Prasertsawat PO, Tongyai T, Isarangura Na Ayudthya N. Prolonged pregnancy: the management dilemma. Int J Gynaecol Obstet [Internet]. 1992 Apr;37(4):253–8. Available from: http://www.ncbi.nlm.nih.gov/pubmed/1350540; Ocon L, Hurtado R, Coteron J, Zubiria A, Ramirez O, Garcia J. Prolonged pregnancy: procedure guidelines [Gestacion prolongada: pautas de actuacion]. Progresos Obstet y Ginecol. 1997;49(1):101–6.; Roach VJ, Rogers MS. Pregnancy outcome beyond 41 weeks gestation. Int J Gynaecol Obstet. 1997 Oct;59(1):19–24.; Witter FR, Weitz CM. A randomized trial of induction at 42 weeks gestation versus expectant management for postdates pregnancies. Am J Perinatol [Internet]. 1987 Jul;4(3):206–11. Available from: http://www.ncbi.nlm.nih.gov/pubmed/3300672

Certainty assessment							Summary of findings				
							Study event rates (%)			Anticipated absolute effects	
№ of participants (studies) Follow-up	Risk of bias	Inconsistency	Indirectness	Imprecision	Publication bias	Overall certainty of evidence	With Expectant Management	With Induction at 42 weeks	Relative effect (95% CI)	Risk with Expectant Management	Risk difference with Induction at 42 weeks
Perinatal death											
296 (2 RCTs)	serious [a]	not serious	not serious	serious [b]	none	⨁⨁◯◯ LOW	3/145 (2.1%)	1/151 (0.7%)	**RR 0.42** (0.06 to 2.80)	21 per 1,000	**12 fewer per 1,000** (from 19 fewer to 37 more)
NICU											
422 (3 RCTs)	serious [a]	serious [c]	not serious	serious [b]	none	⨁◯◯◯ VERY LOW	24/212 (11.3%)	23/210 (11.0%)	**RR 0.72** (0.16 to 3.35)	113 per 1,000	**32 fewer per 1,000** (from 95 fewer to 266 more)
Meconium aspiration syndrome											

Bibliography: Bergsjø P, Huang GD, Yu SQ, Gao ZZ, Bakketeig LS. Comparison of induced versus non-induced labor in post-term pregnancy. A randomized prospective study. Acta Obstet Gynecol Scand [Internet]. 1989;68(8):683–7. Available from: http://www.ncbi.nlm.nih.gov/pubmed/2698591; Herabutya Y, Prasertsawat PO, Tongyai T, Isarangura Na Ayudthya N. Prolonged pregnancy: the management dilemma. Int J Gynaecol Obstet [Internet]. 1992 Apr;37(4):253–8. Available from: http://www.ncbi.nlm.nih.gov/pubmed/1350540; Ocon L, Hurtado R, Coteron J, Zubiria A, Ramirez O, Garcia J. Prolonged pregnancy: procedure guidelines [Gestacion prolongada: pautas de actuacion]. Progresos Obstet y Ginecol. 1997;49(1):101–6.; Roach VJ, Rogers MS. Pregnancy outcome beyond 41 weeks gestation. Int J Gynaecol Obstet. 1997 Oct;59(1):19–24.; Witter FR, Weitz CM. A randomized trial of induction at 42 weeks gestation versus expectant management for postdates pregnancies. Am J Perinatol [Internet]. 1987 Jul;4(3):206–11. Available from: http://www.ncbi.nlm.nih.gov/pubmed/3300672

Certainty assessment							Summary of findings				
401 (2 RCTs)	serious [a]	not serious	not serious	serious [b]	none	⊕⊕◯◯ LOW	11/202 (5.4%)	6/199 (3.0%)	**RR 0.61** (0.18 to 2.04)	54 per 1,000	**21 fewer per 1,000** (from 45 fewer to 57 more)
Caesarean section											
810 (5 RCTs)	serious [a]	not serious	not serious	serious [b]	none	⊕⊕◯◯ LOW	111/403 (27.5%)	110/407 (27.0%)	**RR 0.97** (0.72 to 1.31)	275 per 1,000	**8 fewer per 1,000** (from 77 fewer to 85 more)
Operative vaginal delivery											
409 (3 RCTs)	serious [a]	not serious	not serious	serious [b]	none	⊕⊕◯◯ LOW	43/201 (21.4%)	42/208 (20.2%)	**RR 0.94** (0.65 to 1.38)	214 per 1,000	**13 fewer per 1,000** (from 75 fewer to 81 more)

CI: Confidence interval; **RR:** Risk ratio

Explanations

a. Risk of bias was rated serious as there was a lack of information about randomization and allocation concealment methods in these studies, as well as concerns about selective reporting.
b. Imprecision has been rated serious due to small sample sizes and large confidence intervals that cross the null.
c. Inconsistency has been rated serious as the two studies that contribute to the estimate of effect show conflicting results: one study favours the induction group and one study favours the control group. However, confidence intervals overlap so we are not overly concerned about inconsistency.

GRADE TABLE 8: ROUTINE VS. INDICATED SCAN AT 41 WEEKS

Bibliography: Lindqvist PG, Pettersson K, Morén A, Kublickas M, Nordström L. Routine ultrasound examination at 41 weeks of gestation and risk of post-term severe adverse fetal outcome: a retrospective evaluation of two units, within the same hospital, with different guidelines. BJOG [Internet]. 2014 Aug;121(9):1108–15; discussion 1116. Available from: http://www.ncbi.nlm.nih.gov/pubmed/24593288

Certainty assessment							Summary of findings				
							Study event rates (%)			Anticipated absolute effects	
№ of participants (studies) Follow-up	Risk of bias	Inconsistency	Indirectness	Imprecision	Publication bias	Overall certainty of evidence	With indicated scan	With Routine scan at 41 weeks	Relative effect (95% CI)	Risk with indicated scan	Risk difference with Routine scan at 41 weeks
Neonatal death											
4094 (1 observational study)	serious [a]	not serious	not serious	serious [b]	none	⨁◯◯◯ VERY LOW	9/2650 (0.3%)	3/1444 (0.2%)	**RR 0.61** (0.17 to 2.26)	3 per 1,000	**1 fewer per 1,000** (from 3 fewer to 4 more)

CI: Confidence interval; **RR:** Risk ratio

Explanations

a. Risk of bias was rated serious as there were significant differences in incidence of postdates pregnancies (65% higher) in the unit that used the indicated scan. It is unclear why the incidence rate was much higher.
b. Imprecision was rated serious as there was a wide confidence interval that crossed the null.

GRADE TABLE 9: MONITORING AT 40 WEEKS VS. ≥ 41 WEEKS

Bibliography: Mackeen AD, Edelson PK, Wisch S, Plante L, Weiner S. Antenatal testing in uncomplicated pregnancies: should testing be initiated after 40 or 41 weeks? J Perinat Med [Internet]. 2015 Mar;43(2):233–7. Available from: http://www.ncbi.nlm.nih.gov/pubmed/25014512

Certainty assessment							Summary of findings				
							Study event rates (%)			Anticipated absolute effects	
№ of participants (studies) Follow-up	Risk of bias	Inconsistency	Indirectness	Imprecision	Publication bias	Overall certainty of evidence	With >41 weeks	With Antenatal testing at 40 wks	Relative effect (95% CI)	Risk with >41 weeks	Risk difference with Antenatal testing at 40 wks
NICU											
1071 (1 observational study)	not serious	not serious	not serious	serious [a]	none	⊕◯◯◯ VERY LOW	7/244 (2.9%)	22/827 (2.7%)	**RR 0.93** (0.40 to 2.14)	29 per 1,000	**2 fewer per 1,000** (from 17 fewer to 33 more)

CI: Confidence interval; **RR:** Risk ratio

Explanations

a. Imprecision was rated serious due to small sample sizes and a large confidence interval that crosses the null.