Original Recommendation [2010]	Updated Recommendation [2021]	Explanation of Change(s)
Gestational dating		
1. Inform clients that when EDB information is available from both LMP and ultrasound measurements, an EDB based on ultrasound dating prior to 24 weeks is less likely to result in a postterm pregnancy. (II-2-B)	1. Midwives should offer clients an ultrasound before 24 weeks, optimally in the first trimester, to obtain the most accurate estimate of gestational age. Review the following as part of an informed choice discussion with clients: • Ultrasound dating will not prevent a pregnancy from progressing beyond its due date, but it decreases the chance that the pregnancy will be inaccurately classified as postdates. • First-trimester ultrasound provides the most accurate estimate of gestational age. • For clients who are late to care, an ultrasound estimate of gestational age during the second or third trimester may still be more accurate than an estimate of gestational age determined by LMP alone. [2021] **Strong recommendation; moderate certainty of evidence** *This recommendation recognizes that an accurate estimate of gestational age allows for optimal decision-making on managing a postdates pregnancy, and it may reduce the need for unnecessary intervention.*	Recommendation remains largely consistent with original, with additional emphasis on the effectiveness of a first trimester ultrasound for gestational dating. Bullet points include considerations for those who arrive late to care. • RCT evidence (2004) shows effectiveness of first trimester over second trimester ultrasound for dating • Observational literature supports these findings and also indicates that second and third trimester US may reduce the number of pregnancies categorized as postterm, compared with LMP alone

2. For clients who choose not to have ultrasound, taking as accurate a menstrual history as possible is recommended to give a more precise estimate of pregnancy length. Obtain as much menstrual and fertility information as possible from the client. Corroborate or reassess estimated dates based on physical assessments. (III-A)	2. For clients who choose not to have an ultrasound, take the most accurate menstrual history possible to obtain a more precise estimate of pregnancy length. Corroborate or reassess estimated dates based on physical assessments. Review the following with clients: • First day of last menstrual period • Average cycle length • Ovulation date, implantation date or conception date, if known [2021] **Good practice statement** *This good practice statement recognizes the client as the primary decision-maker and acknowledges that some clients may prefer not to have an ultrasound.*	Following GRADE methodology, this recommendation is now considered as a Good Practice Statement. • Good practice statements in this CPG represent guidance that the WG deemed important but that were not appropriate for formal ratings of certainty of evidence. Good practice statements are made when the Committee is confident that the action has net benefit to the client and that sensible alternatives do not exist.
Interventions to promote spontaneous labour		
3. Offer sweeping of membranes, when appropriate, beginning between 38 and 41 weeks, to reduce the rate of postterm pregnancy and the need for induction. (I-A)	3. Midwives should discuss the risks and benefits of membrane sweeping and offer it between 38 and 41 weeks' gestation to promote the spontaneous onset of labour and reduce the risk of pregnancy progressing beyond 41 weeks. [2021] **Strong recommendation; moderate certainty of evidence** *This recommendation recognizes midwives' commitment to physiologic birth and low-intervention approaches to promote spontaneous labour.*	Language changes only; no change required to recommendation.

Summary statement No recommendations on either using or not using evening primrose oil, acupuncture or homeopathy can be made due to the absence of good quality research and subsequent lack of evidence regarding efficacy. These approaches may be offered as part of a range of alternatives, including conventional therapies, discussing the risks and benefits of each as well as any research gaps.	4. There is insufficient evidence to support the use of acupuncture, acupressure, evening primrose oil or homeopathy for the prevention of postdates pregnancies. • Research evidence on these interventions is limited, although no harms have been noted. [2021] **No recommendation:** ***very low certainty to moderate certainty of evidence***	In keeping with GRADE methodology, this Summary Statement has now been categorized as No Recommendation. • No recommendation: CPG Committee has deemed that there is insufficient evidence available to make a recommendation about the intervention. • Acupressure has been added to the list of interventions addressed, as this was identified as an intervention of interest by midwives.
Induction vs. Expectant Management		
4. Prior to 41+0 weeks' gestation, discuss the risks and benefits of induction of labour between 41 and 42 weeks' gestation and offer induction by 42+0 weeks' gestation. (II-2-A)	5. For pregnancies at 41 weeks' gestation, midwives should offer IOL between 41+0 and 42+0 weeks. • Prior to 41 weeks, discuss the risks and benefits of IOL between 41 and 42 weeks. • Offer clients with uncomplicated postdates pregnancies full support in choices that allow them to maximize their chances of spontaneous labour, including supporting their decision to choose expectant management up to and beyond 41+0 weeks' gestation.	Recommendation remains consistent; aspects of informed choice discussion are now included as bullet points (Recommendations #5 and 6 in the original CPG are now included here).

	• For clients who choose expectant management after 42 weeks, discuss that evidence suggests that perinatal morbidity and mortality increase with gestational age, although absolute risks remain low. [2021] **Strong recommendation:** ***moderate certainty of evidence*** *This recommendation recognizes the client as the primary decision-maker, as well as the evidence that induction during the 41st week (41+0 to 41+6) reduces perinatal mortality, although the absolute risks of perinatal death during this time remain low*	
5**. Inform clients that the absolute risk of perinatal death from 40+0 weeks to 41+0 weeks to 42+0 weeks' gestational age changes;** currently available research is not of high quality and has not established an optimal time for induction. Therefore, clients with uncomplicated postdates pregnancies should be offered full support in choices that will allow them to enter spontaneous labour. A policy of expectant management to 42+0 weeks following an informed choice discussion is the most appropriate strategy for	Included as part of Recommendation above.	This recommendation is now part of the larger recommendation on IOL (Recommendation #5), as it speaks to informed choice discussions on IOL for pregnancies beyond 41 weeks.

clients who wish to maximize their chance of normal birth. (II-2-A)		
6. For clients choosing expectant management beyond 42+0 weeks, discuss the lack of clear evidence on which to base a recommendation regarding expectant management other than a trend towards increasing perinatal morbidity and mortality with increasing gestational age (II-2-A)	Included as part of Recommendation above.	This recommendation is now part of the larger recommendation on IOL (Recommendation #5), as it speaks to informed choice discussions on IOL for pregnancies beyond 41 weeks.
	NEW: Summary statement Midwifery management of postdates induction has excellent outcomes for clients. There is no difference in rates of caesarean section and neonatal morbidity and mortality when compared with obstetrical care, and there are lower rates of assisted vaginal delivery and episiotomy for nulliparous clients. Both multiparous and nulliparous clients are less likely to use pharmaceutical pain relief. Provided that midwives have the knowledge, skills, experience and community-based health infrastructure to do so, midwifery management of postdates induction is appropriate. [new 2021]	This summary statement has been included in order to support Midwifery Management of Induction. • Summary statements: CPG Committee has deemed a recommendation unnecessary according to standards of care.
Fetal Surveillance		

7. For clients choosing expectant management of pregnancy at and beyond 41+0 weeks' gestation, offer ultrasound twice weekly, starting between 41 and 42 weeks and continuing until delivery to assess fetal well-being and amniotic fluid volume. (II-2-A)	6. For those choosing expectant management, offer ultrasound twice weekly, starting between 41 and 42 weeks and continuing until birth to assess fetal well-being. • For ultrasound assessments, BPP, AFI or maximum fluid pool depth can be used according to the care provider and community standards. • In communities where ultrasound is unavailable, NST may be offered. [2021] **Strong recommendation:** ***very low certainty*** *This recommendation recognizes the limited direct evidence on the optimal method and timing of fetal surveillance. It also recognizes indirect evidence showing that fetal surveillance is effective, as well as community standards of offering ultrasound twice weekly where available.*	Recommendation remains consistent, with additional considerations for communities where ultrasound is not available.