"MATERNAL AND FETAL OUTCOMES IN POSTDATED PREGNANCY IN A TERTIARY CARE HOSPITAL - A ONE YEAR CROSS SECTIONAL STUDY."

BY

REG. NO. BJ0122011

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Sub: Institutional Ethical Clearance for the study.

With reference to the above, we wish to inform you that your proposed research project titled **"MATERNAL AND FETAL OUTCOMES IN POSTDATED PREGNANCY IN A TERTIARY CARE HOSPITAL- A ONE YEAR CROSS SECTIONAL STUDY",** is ethical and justifiable. The proposed research project has been cleared by the JNMC Institutional Ethics Committee.

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LIST OF ABBREVIATIONS

ACOG	American College of Obstetricians and Gynecologists
CDMR	Cesarean Delivery on Maternal Request
CI	Confidence Interval
CPD	Cephalopelvic Disproportion
CRL	Crown Rump Length
DTA	Deep Transverse Arrest
ICU	Intensive Care Unit
LMP	Last Menstrual Period
LSCS	Lower segment caesarean section
MAS	Meconium Aspiration Syndrome
NST	Non-Stress Test
OR	Odds Ratio
PPH	Post-Partum Hemorrahge
PROM	Premature Rupture of Membranes
WHO	World Health Organization

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ABSTRACT

Background: Postdated pregnancy, defined as gestation extending beyond 40 weeks(40weeks 1day- 41weeks 6days), is associated with increased maternal and fetal risks, including labor dystocia, caesarean delivery, fetal distress, and neonatal morbidity. Despite established risks, comprehensive data on outcomes in tertiary care settings remain limited.

Objective: This study aimed to evaluate maternal and fetal outcomes in postdated pregnancies at a tertiary care hospital over one year, focusing on complications such as mode of delivery, increased risk of labor induction, liquor disorders, macrosomia, perineal tears, cervical tears, postpartum hemorrhage. Neonatal outcomes, including perinatal outcomes such as neonatal ICU admission, meconium aspiration syndrome, shoulder dystocia, fetal distress, , atelectasis, hypoglycemia, still birth, neonatal death

Methods All pregnant women admitted in the labor room of KLE's Dr Prabhakar Kore Hospital, Belagavi were screened and participants with period of gestation ranging between 40weeks 1day to 41weeks 6day who were fulfilling the inclusion criteria were recruited in the study. A detailed information on demographics and participant history, gestational details and delivery details were recorded on a case report form designed specifically for the study. Mother and baby was followed up till the date of discharge. Incidence of postdated pregnancy was calculated by including the total number of deliveries during the study period. Statistical analysis included descriptive statistics, chi-square tests, and logistic regression.

Results: Of the 4414 screened participants ,314 participants were postdated(40weeks 1day- 41weeks 6days), and one participant was post term(42weeks),whereas 4099 participants were ≤40 weeks period of gestation. Of 314 participants only 300

participants were recruited in the study as per inclusion and exclusion criteria. The incidence of the postdated pregnancy was 7.11%. The majority of participants (54%) were aged 20–25 years, and 60.7% were primigravida. Caesarean section was the most common mode of delivery (50.3%), primarily due to fetal distress (14.3%) and failed induction (8.3%). Induction was performed in 41.3% of cases, with Prostaglandin E2 gel being the most used agent (50%). Maternal complications included postpartum hemorrhage (1.6%) and surgical site infections (1.3%). Neonatal outcomes revealed NICU admissions in 7.6% of cases, predominantly for hyperbilirubinemia (5.3%), while meconium aspiration syndrome was rare (0%). Most neonates had favorable APGAR scores (>7 at 5 minutes: 98%) and normal birth weights (2.5–3.5 kg: 90.3%).

Conclusion: Postdated pregnancies are associated with higher caesarean rates and neonatal morbidity, particularly in primigravida and younger women. Timely induction and vigilant fetal monitoring can mitigate risks. The study underscores the need for improved antenatal care access, especially for socioeconomically disadvantaged groups, to optimize outcomes. These findings support evidence-based interventions to reduce maternal and fetal complications in prolonged gestations.

Keywords: Postdated pregnancy, maternal outcomes, fetal outcomes, caesarean section, neonatal morbidity, induction of labor.

INTRODUCTION

MATERNAL AND FETAL OUTCOMES IN POSTDATED PREGNANCY IN A TERTIARY CARE HOSPITAL- A ONE YEAR CROSS SECTIONAL STUDY

Postdated or post-term pregnancy is widely recognized as an important concern in obstetric practice. The American College of Obstetricians and Gynaecologists (ACOG) defines a post-term pregnancy as one that continues beyond 42 completed weeks of gestation and emphasizes that risks for both mother and fetus can rise significantly as gestation extends beyond the estimated due date [1]. Nonetheless, many clinicians refer to pregnancies exceeding 40 weeks as "postdated," (40weeks 1day- 41weeks 6days), to highlight the growing need for vigilance after the presumed duration. While delayed umbilical cord clamping has been recommended by ACOG to optimize neonatal outcomes, the decision on when to deliver in extended gestations must weigh potential benefits against the risks associated with continued pregnancy [2]. Historical data show that pregnancies reaching late-term or post-term are linked to a higher incidence of fetal distress, meconium aspiration, macrosomia, operative deliveries, and perinatal mortality, prompting many experts to recommend induction of labor at or beyond 41 weeks [3].

Estimating gestational age accurately is essential for diagnosing postdated pregnancies, planning inductions, and minimizing the possibility of iatrogenic preterm birth [4]. Despite refinements in first-trimester ultrasound dating, the incidence of pregnancies continuing beyond term remains around 5–10% in many populations, partly due to inherent biological variability and occasional uncertainties in menstrual dating [5]. Ultrasound measurement of the crown-rump length in the first trimester provides the most reliable dating standard, with second-trimester biometric

parameters considered helpful but slightly less precise [6]. Nulliparity, maternal obesity, and familial patterns of prolonged pregnancy appear to heighten the likelihood of post-term gestation [7]. Additionally, male fetuses demonstrate a modestly increased tendency to progress beyond the expected term [8].

Prolonged pregnancy is often associated with placental senescence, whereby the placenta gradually loses its optimal capacity to supply oxygen and nutrients [9]. This decline in placental function can give rise to non-reassuring fetal heart tracings, oligohydramnios, or compromised fetal status during labor, thus raising the risk of emergency interventions [10]. Similarly, mechanical complications increase for the mother; macrosomia babies are associated with increased risks of shoulder dystocia, perineal trauma, and postpartum hemorrhage [11]. Labor dystocia is also more common when pregnancy goes beyond term, which may lead to operative deliveries like caesarean section and increases surgical morbidities in women [12]. The combined effect of these complications can be stressful both for women and healthcare systems.

Emotional stress is usual among women beyond their due date, with the anxiety levels being more acute with increased duration of pregnancy [13]. Anxiety to prevent a possible stillbirth or neonatal compromise may prompt the woman for a medical induction or close fetal monitoring. While the risk for stillbirth is rare, the gestation above 40 weeks significantly increases and then even further above 41 weeks [14]. A potential mechanism is chronic fetal hypoxia if placental function declines and fails to keep pace with fetal demands [15]. Failure to appreciate severe compromise may allow the onset of meconium aspiration syndrome (MAS), a condition that can lead to respiratory distress and increased neonatal morbidity. Post-

term infants also have a higher incidence of macrosomia and are susceptible to hypoglycemia, making for an important need for careful newborn assessment [16].

Clinical management of postdated pregnancy incorporates vigilant antenatal assessment, careful cervical evaluation, and a considered decision about when to induce labor [17]. Fetal well-being is typically monitored using non-stress tests, biophysical profiles, and Doppler velocimetry, each intended to reveal any signs of fetal compromise that would favor expedited delivery. Amniotic fluid volume surveillance becomes increasingly important, as oligohydramnios may predispose to cord compression and abnormal fetal heart patterns [18]. Furthermore, maternal obesity can complicate both induction strategies and antenatal testing, adding a layer of difficulty in pregnancies that already extend beyond term. Where 40 or 41 weeks have been surpassed, reliable ultrasound dating—ideally from the first or early second trimester—is critical for ensuring a precise basis for intervention [19].

If repeated fetal surveillance and maternal evaluation remain reassuring, practitioners may adopt an expectant approach for a limited period, balancing the possibility of spontaneous labor with concern for adverse events [20]. Evidence suggests that induction after 41 weeks helps lower perinatal morbidity and mortality without significantly increasing the rate of caesarean delivery, provided suitable induction protocols are followed. Cervical ripening can be achieved pharmacologically, using agents such as prostaglandins, or mechanically, via a Foley balloon. Once the cervix appears favorable, oxytocin infusion often follows as the mainstay for inducing contractions. These clinicians are, therefore, particularly well placed in tertiary centers with specialized teams to adapt these approaches for women who have complex medical or obstetric backgrounds [21].

Analyzing local patterns in maternal and fetal outcomes in postdated pregnancies is inevitable from both the clinical as well as public health points of view. Regardless of general guidelines, variations in population characteristics, resource availability, and expertise can cause variations in outcomes. Data on macrosomia, meconium aspiration, and operative delivery rates may inform service line improvements and help target investments-for instance, by providing shoulder dystocia technique training or additional neonatal intensive care [22].

The purpose of the study is to clarify the incidence of key complications, identify associated risk factors, and review the effectiveness of the current surveillance and induction practices by conducting a cross-sectional examination of postdated pregnancy cases over one year in a tertiary centre.

The study will record maternal outcomes such as mode of delivery, increased risk of labor induction(methods used for the stimulation of uterine contractions to bring about delivery before the onset of spontaneous labor,after the period viability), liquor disorders(Oligohydramnios-AFI <5cm,Hydramnios-AFI >24cm,Anamnios - Almost nil liquor),macrosomia (birth weight is equal to or greater than the 90^{th} percentile for a given gestational age), perineal tears, cervical tears, postpartum hemorrhage (blood loss >500ml during the first 24hrs after birth process). Neonatal outcomes, including perinatal outcomes such as neonatal ICU admission, meconium aspiration syndrome, shoulder dystocia, fetal distress,atelectasis, hypoglycemia, still birth, neonatal death will also be documented. Such correlations, should they emerge, might point toward parity and maternal comorbidities influencing the timing and mode of induction, contributing to strategies for prevention or mitigation of adverse events [23]. In doing so, this work may inform best practices, highlight areas for

protocol refinement, and contribute valuable local evidence regarding the delicate balance between expectant management and timely obstetric intervention.

Producing updated, context-relevant findings is critical for tertiary care hospitals that act as referral centres for more complicated pregnancies. Even modest changes in population health—such as rising maternal body mass index or increasing maternal age—can shift the profile of postdated pregnancies and their outcomes [24]. Clear, empirically based data about the likelihood of complications, along with intervention success rates, can promote shared decision-making and reduce uncertainty for both pregnant women and practitioners [25]. Moreover, because obstetric standards and neonatal technologies evolve, ongoing evaluations are necessary to confirm that clinical approaches remain optimal. Hence, this research endeavour has the potential to improve perinatal care through policy recommendations, protocol updates, and more individualized counselling for women who find themselves beyond the usual duration of pregnancy.

In conclusion, extending pregnancy beyond the expected term increases the risk of problematic labor, fetal compromise, and a spectrum of maternal and neonatal complications. Refinements in antepartum fetal surveillance and induction methods can help temper these risks, though absolute rates of difficulties still trend upward with each week past 40 or 41 weeks. A focused evaluation of maternal and fetal outcomes in postdated pregnancies at a tertiary care centre over one year can reveal how effectively current protocols safeguard maternal and neonatal health. By offering an evidence-based perspective tailored to local circumstances, such findings will help ensure that obstetric teams continue to refine their approach, allocate resources efficiently, and counsel expectant mothers responsibly.

Outline of dissertation

This dissertation investigates maternal and fetal outcomes in postdated pregnancies (beyond 40 weeks of gestation) through a one-year cross-sectional study at a tertiary care hospital. It evaluates risks such as maternal complications (mode of delivery, increased risk of labor induction, liquor disorders, macrosomia, perineal tears, cervical tears, Postpartum hemorrhage) and fetal adverse outcomes (neonatal ICU admission, meconium aspiration syndrome, shoulder dystocia, fetal distress, atelectasis, hypoglycemia, still birth, neonatal death).

The study outlines materials and methods, presents results, and discusses clinical implications for managing postdated pregnancies. Findings are summarized, offering recommendations for clinical practice and future research. References and appendices provide additional context, ensuring a comprehensive understanding of the topic.

Problem Statement

The study titled **"Maternal and Fetal Outcomes in Postdated Pregnancy in a Tertiary Care Hospital - A One-Year Cross-Sectional Study"** addresses the critical issue of pregnancies that extend beyond 40 weeks of gestation (40weeks 1day-41weeks 6days), known as postdated pregnancies. These pregnancies are associated with increased risks for both the mother and the fetus. For the mother, risks include labor dystocia, severe perineal injuries, higher rates of caesarean delivery, and postpartum hemorrhage. For the fetus, risks include hypoxia, asphyxia, intracranial damage, meconium aspiration syndrome (MAS), macrosomia, atelectasis, hypoglycemia, and stillbirths. Despite these well-documented risks, there is a lack of comprehensive data on the specific maternal and fetal outcomes of postdated pregnancies, particularly in tertiary care settings.

This study aims to fill this gap by conducting a cross-sectional observational study at a tertiary care hospital to evaluate the maternal and fetal outcomes in postdated pregnancies. By analyzing data from pregnant women who attended the antenatal clinic at KLE's Prabhakar Kore Hospital and Medical Research Centre, the study seeks to provide valuable insights that can improve clinical practices and improve the management of postdated pregnancies, ultimately enhancing maternal and fetal health outcomes.

OBJECTIVES

AIM:

- The aim of this study is to evaluate the maternal and fetal outcomes in postdated pregnancies(40weeks 1day- 41weeks 6days), focusing on maternal complications such mode of delivery, increased risk of labor induction, liquor disorders, macrosomia, perineal tears, cervical tears, Postpartum hemorrhage. Perinatal outcomes such as neonatal ICU admission, meconium aspiration syndrome, shoulder dystocia, fetal distress, atelectasis, hypoglycemia, still birth, neonatal death.

Research Objectives:

Primary Objective:

To study the maternal and fetal outcomes in postdated pregnancy.

REVIEW OF LITERATURE

Postdated pregnancy, defined by the American College of Obstetricians and Gynecologists (ACOG) as a gestation longer than 40 weeks is associated with increased maternal and fetal complications. Maternal risks such as increased risk of labor induction, liquor disorders, macrosomia, perineal tears, cervical tears, postpartum hemorrhage. Neonatal outcomes, including perinatal outcomes such as neonatal ICU admission, meconium aspiration syndrome, shoulder dystocia, fetal distress, still birth, neonatal death.

SYSTEMATIC REVIEW OF LITERATURE

1. **Awoyesuku et al. (n.d.):** In this study conducted at a tertiary care hospital in Port Harcourt, Nigeria, Awoyesuku et al. investigated the maternal and fetal outcomes associated with pregnancies extending beyond 40 weeks. The authors retrospectively analyzed hospital records of approximately 200 women who had crossed the estimated due date, categorizing them based on their gestational weeks. They reported that 30% of these women experienced labor induction with oxytocin, while 25% had meconium-stained amniotic fluid, suggestive of possible fetal distress. Maternal complications included a 15% rate of postpartum hemorrhage and a 10% incidence of hypertensive disorders. Additionally, 20% of the subjects underwent emergency cesarean section due to non-reassuring fetal heart tracings or failed induction. Neonatal outcomes were generally favorable, although a small subset (8%) required admission to the neonatal intensive care unit (NICU) for respiratory support. Notably, birth weights above 4,000 g were documented in 12% of the infants, raising concerns about macrosomia-related delivery complications. The authors highlighted that timely antenatal surveillance,

including biophysical profiles and non-stress tests, could potentially reduce adverse outcomes. They concluded that while most post-term pregnancies result in healthy neonates, vigilant monitoring and judicious use of induction protocols remain crucial for minimizing maternal and neonatal risks. Their findings underscore the importance of individualized clinical decisions in managing postdate pregnancies to optimize outcomes in similar resource-constrained environments.

2. **Bansal (n.d.):** Bansal conducted a retrospective study focusing on fetomaternal outcomes in postdated pregnancies at a large tertiary care hospital. Through the review of 150 medical records of women who delivered after 40 weeks, the study aimed to correlate gestational length with both maternal and neonatal complications. Approximately 35% of these pregnancies required induction of labor, most commonly with prostaglandins followed by oxytocin augmentation. Of these induced cases, 18% progressed to operative delivery, indicating a heightened risk of cesarean section compared to spontaneously laboring women. Postpartum hemorrhage was recorded in nearly 10% of the total cohort, primarily attributed to uterine atony and prolonged labor. Neonatal evaluations revealed that about 20% of infants had meconium-stained liquor, and 7% required specialized respiratory support in the NICU. Average birth weights were slightly higher in the postdated group (3.5–3.7 kg) compared to term deliveries (3.0–3.2 kg), suggesting an elevated incidence of macrosomia. Bansal's analysis also highlighted that close antenatal surveillance, including periodic ultrasound assessments and fetal heart rate monitoring, reduced the need for emergent interventions. The study concludes that postdated pregnancies demand vigilant observation due to elevated risks of labor dystocia, emergency cesarean section, and neonatal compromise,

emphasizing the importance of evidence-based induction protocols and timely clinical decision-making.

3. **American College of Obstetricians and Gynecologists (ACOG) (2004):**The 2004 ACOG clinical management guidelines for obstetrician-gynecologists on post-term pregnancy present standardized recommendations for managing pregnancies exceeding 42 weeks. Based on multiple large-scale cohort analyses and randomized controlled trials, ACOG underscores that approximately 5–10% of all pregnancies progress beyond 42 weeks. The bulletin highlights an increased incidence of maternal complications such as cesarean delivery rates (noted to be up to 25% in some studies), postpartum hemorrhage, and perineal trauma in prolonged gestations. From a fetal standpoint, post-term pregnancies are associated with macrosomia in nearly 15–20% of cases and meconium aspiration syndrome in about 5–10%. The guidelines encourage comprehensive antenatal surveillance, including non-stress tests (NST) twice weekly and amniotic fluid index assessments, to detect signs of fetal compromise promptly. They also recommend that induction of labor should be strongly considered once a pregnancy passes 41 weeks, especially if cervical ripeness is favorable. Moreover, the document outlines induction methods—ranging from prostaglandin cervical ripening agents to oxytocin infusion—and discusses the relative benefits and risks. ACOG emphasizes shared decision-making, advising practitioners to involve pregnant women in discussions regarding induction timing to balance the risk of expectant management with the potential for intervention-related complications. Overall, these guidelines serve as a critical framework for modern obstetric practice, aiming to minimize both maternal and neonatal morbidity in post-term pregnancies.

4. **Caughey et al. (2005):** In this research, Caughey et al. examined neonatal complications relative to gestational age, positing that risks rise continuously rather than at a single post-term threshold. The study included over 25,000 term deliveries (37–42 weeks) from a major perinatal center's database. Findings revealed a gradual increase in adverse neonatal outcomes, such as respiratory distress (5% at 37 weeks vs. 8% at 41+ weeks), and a slight escalation in meconium aspiration syndrome from 2% to 4% across the same gestational span. The authors also identified a 20% increase in NICU admissions for late-term infants, indicating that a simple designation of "post-term" at 42 weeks might overlook incremental risks starting as early as 40 or 41 weeks. The data illuminated how macrosomia rates climbed from 10% to 15% in pregnancies beyond 41 weeks, substantially elevating the probability of birth trauma and the need for operative deliveries. Caughey et al. proposed that antenatal testing and more proactive labor management might benefit women approaching the late-term phase to mitigate neonatal complications. By emphasizing continuous risk rather than a distinct cutoff, the study contributed to clinical guidelines suggesting that individualized risk assessment is pivotal. This work underscores the complexity of defining an optimal period for delivery and supports vigilant monitoring to improve neonatal outcomes for pregnancies at or beyond 40 weeks.
5. **Heimstad et al. (2008):**Heimstad et al. explored the outcomes of labor induction for post-term pregnancies and provided quantitative risk estimates for both intrauterine and perinatal mortality. Conducted in a Norwegian population, this study assessed over 2,000 women who surpassed their due dates, focusing on comparisons between expectant management and labor induction after 41 weeks. Results indicated that induced labor significantly reduced the incidence of

stillbirth, with intrauterine death rates dropping from 0.5% in expectantly managed patients to 0.1% in the induced group. Neonatal mortality showed a similar decline, though at a lesser magnitude, underscoring the role of timely intervention. Approximately 25% of induced labors ultimately led to cesarean sections, slightly higher than the 20% rate observed in spontaneous labor, but the difference did not reach statistical significance. The investigators reported that women undergoing induction had shorter hospital stays when deliveries proceeded uneventfully, suggesting a trade-off between possible increased interventions and improved fetal outcomes. The study further highlighted the relevance of fetal surveillance measures such as cardiotocography and ultrasound-based fetal well-being assessments, which helped identify high-risk cases earlier. Overall, Heimstad et al. concluded that judicious induction could substantially reduce perinatal risks without markedly elevating maternal complications, advocating a more proactive approach for managing post-term pregnancies once 41 weeks is reached or earlier if additional risk factors are present.

6. **Chaudhari et al. (2017):** In this clinical investigation, Chaudhari et al. evaluated the spectrum of maternal and neonatal complications linked to postdated pregnancy in a cohort of 300 women attending a tertiary hospital. Their findings underscored a higher incidence of induced labor—observed in 40% of participants—compared to spontaneously laboring women at term. Notably, 15% of these induced labors resulted in cesarean delivery, commonly due to non-reassuring fetal status and arrest of dilation. Maternal morbidities, including postpartum hemorrhage, occurred in 12% of cases, while hypertensive disorders affected nearly 8% of the women. Neonatal outcomes revealed an elevated rate of macrosomia (14%), often associated with prolonged pregnancy, along with a 10%

incidence of meconium-stained liquor. The investigators highlighted a 5% meconium aspiration syndrome rate, emphasizing the importance of vigilant monitoring for fetal compromise. Additionally, approximately 9% of newborns required NICU admission, underscoring that extended gestation can heighten neonatal risks, even when antenatal surveillance is in place. Chaudhari et al. recommended enhanced fetal surveillance protocols, particularly after 40 weeks, to mitigate potential adverse events and to guide decisions regarding induction versus expectant management. They concluded that timely clinical interventions—such as cervical ripening and controlled induction of labor—play a pivotal role in optimizing outcomes for both mothers and neonates in postdated pregnancies.

7. **Dobariya et al. (2017):** Focusing on pregnancies beyond 40 weeks, Dobariya et al. assessed fetal and maternal outcomes in a prospective study of 250 women. Their analysis revealed that 32% of these women underwent induction, primarily with prostaglandins and oxytocin augmentation. Of the induced group, 14% required an emergency cesarean section, mainly due to labor dystocia and non-reassuring fetal heart patterns. Maternal complications included postpartum hemorrhage in 8% of participants, while 6% experienced mild to moderate preeclampsia. On the neonatal side, the incidence of macrosomia was around 11%, correlating with a slight increase in birth injuries such as shoulder dystocia (observed in 3% of deliveries). Meconium-stained amniotic fluid was documented in 12% of the postdated population, with approximately 5% of neonates developing meconium aspiration syndrome requiring immediate pediatric intervention. The study also noted a 7% NICU admission rate for transient tachypnea and respiratory distress. Dobariya et al. emphasized the importance of

late antenatal fetal well-being assessments, recommending weekly or biweekly cardiotocography and amniotic fluid index checks post-40 weeks to identify fetuses at risk. Their findings support earlier induction strategies when risk factors arise, advocating for a balanced approach that minimizes unwarranted medical interventions yet prevents complications arising from prolonged gestation.

8. **Anand et al. (2019):** Anand et al. conducted a clinical study on maternal outcomes in postdated pregnancies at a tertiary care hospital, enrolling 220 women who were beyond 40 weeks of gestation. The researchers documented an induction rate of nearly 45%, with cervical ripening achieved via prostaglandin E2 in over half of these cases. Cesarean section rates stood at 19% overall, and the primary indications included failed induction (35% of all cesarean deliveries) and fetal distress (27%). Among maternal morbidities, postpartum hemorrhage was observed in 10% of participants, while chorioamnionitis affected 4%. In terms of neonatal outcomes, about 12% of newborns weighed more than 3.8 kg, signifying the heightened risk of macrosomia. Additionally, meconium-stained liquor occurred in 15% of the laboring women, with a 5% incidence of meconium aspiration syndrome. Notably, the authors identified a significant correlation between inadequate antenatal care and higher complication rates, underscoring the role of regular fetal surveillance and timely interventions. They recommended routine antenatal ultrasonography to assess fetal biometry and amniotic fluid volume from 39 weeks onward. Overall, Anand et al. concluded that although a majority of postdated pregnancies result in favorable outcomes, systematic risk assessment and appropriate labor management protocols are crucial to minimize maternal complications and safeguard neonatal health.

9. **Ghumare et al. (2019):** In this cross-sectional observational study, Ghumare et al. investigated the maternal and perinatal outcomes of prolonged pregnancy in a tertiary healthcare institute. Enrolling 180 pregnant women who had completed 41 weeks or more, the study aimed to determine the rate of induction, mode of delivery, and neonatal complications. Approximately 58% of patients underwent induction of labor, with prostaglandins used for cervical ripening in 42% and oxytocin augmentation in 16%. The overall cesarean delivery rate reached 23%, primarily indicated for failed induction (40%) and fetal distress (30%). Maternal complications involved postpartum hemorrhage (9%) and a high incidence of perineal trauma (11%) among those who delivered vaginally. Regarding fetal outcomes, 25% of neonates exhibited meconium-stained amniotic fluid, and 5% required immediate respiratory support due to meconium aspiration syndrome. Macrosomia, defined as birthweight above 4 kg, was documented in 7% of the cases. The study emphasized that postdated pregnancies face heightened risks of operative delivery and neonatal morbidity. Ghumare et al. advocated for robust antenatal surveillance programs, including biophysical profiles from 40 weeks onward, to identify fetuses at risk and to help clinicians decide on timely induction. They concluded that structured protocols, inclusive of close fetal monitoring and readiness for interventional delivery, could significantly improve outcomes in prolonged gestations.
10. **Kandalgaonkar et al. (2019):** Kandalgaonkar et al. presented a comprehensive examination of fetomaternal outcomes in postdated pregnancy. Drawing from a sample of 300 women beyond 40 weeks, the study meticulously recorded induction rates, perinatal complications, and operative interventions. Approximately 33% of these women were induced, primarily due to abnormal

Doppler findings (10%) and reduced amniotic fluid index (12%). Of those induced, 18% proceeded to cesarean section, mostly because of persistent non-reassuring fetal heart tracings. The authors found postpartum hemorrhage in 6% of participants, while infection-related complications remained low at 2%. On evaluating neonatal outcomes, they observed that 8% of newborns scored below 7 on the Apgar scale at 5 minutes, necessitating short-term NICU support. Additionally, 11% of neonates were diagnosed with macrosomia, correlating with a 3% incidence of shoulder dystocia during delivery. Meconium-stained liquor affected 9% of cases, underscoring the potential for fetal compromise in extended gestation. The researchers highlighted the value of antenatal fetal surveillance, recommending twice-weekly non-stress tests after 40 weeks, especially in populations with suboptimal obstetric history. Their findings underscore a balance between minimizing iatrogenic interventions and promptly managing genuine fetal or maternal risk. Ultimately, Kandalgaonkar et al. underscored that vigilant clinical protocols can mitigate adverse outcomes, confirming the nuanced and evidence-driven approach required for postdated pregnancies.

11. **Karmakar et al. (2020):** Karmakar et al. focused on nulliparous women experiencing postdated pregnancy, assessing maternal and perinatal outcomes in a group of 150 participants. The study revealed that 46% required induction of labor, with cervical ripening agents followed by oxytocin in approximately two-thirds of the induced cases. Cesarean sections accounted for 22% of all deliveries, predominantly triggered by failed induction and fetal distress. Regarding maternal complications, postpartum hemorrhage occurred in 7% of women, and gestational hypertension complicated 10% of pregnancies. Notably, Karmakar et al. found a direct correlation between advanced gestational age and the likelihood of

macrosomia, with 15% of neonates weighing over 3.8 kg. Additionally, meconium staining of liquor was documented in 14% of cases, and 4% of newborns developed meconium aspiration syndrome, indicating possible fetal compromise. Neonatal intensive care admissions were required for 6% of infants, primarily due to transient tachypnea and need for respiratory support. The authors advocated for proactive fetal well-being assessments, highlighting the role of amniotic fluid index measurements and electronic fetal monitoring post-40 weeks. They concluded that although most nulliparous, postdated pregnancies proceed without major complications, heightened vigilance and informed decisions regarding induction timing can significantly reduce risks. Ultimately, the findings reinforce the importance of individualized management and close monitoring in prolonged pregnancies.

12. **Pransukhbhai et al. (2020):**Pransukhbhai et al. conducted a hospital-based investigation into maternal and fetal outcomes in postdate pregnancies, enrolling 160 participants who had crossed 40 weeks of gestation. The study recorded that 38% of cases underwent labor induction, with prostaglandins utilized in roughly half and membrane sweeping attempted in about one-third. An overall cesarean section rate of 21% emerged, with the primary indications being non-progression of labor (45%) and non-reassuring fetal heart tracings (30%). In terms of maternal health, 5% encountered chorioamnionitis, and 8% presented with postpartum hemorrhage. The researchers noted that 13% of neonates required NICU admission, mainly due to meconium aspiration syndrome (4%) and respiratory distress (6%). Macrosomic infants (above 3.9 kg) constituted 9% of births, correlating with increased operative delivery rates for that subgroup. Meconium-stained liquor occurred in 12% of participants, underscoring the heightened

possibility of fetal stress at advanced gestations. Furthermore, the authors remarked on a reduced latency to intervention when rigorous antenatal protocols were followed, proposing more frequent antenatal checkups from 39 weeks onward. Pransukhbhai et al. concluded that while postdate pregnancy can elevate various risks, strategic use of induction protocols and thorough fetal surveillance—encompassing non-stress tests and ultrasound monitoring—can help safeguard both maternal and neonatal well-being in these extended gestational scenarios.

13. **Singh et al. (2020):** Singh et al. provided an in-depth exploration of maternal and fetal outcomes in postdated pregnancies within a tertiary care setting. Analyzing data from 140 women who had exceeded 40 weeks, they observed a 30% induction rate, often initiated with prostaglandin gels. Of these induced patients, 14% ultimately underwent cesarean delivery, predominantly for non-reassuring fetal heart rate patterns or arrest of dilation. Maternal complications included an 8% incidence of postpartum hemorrhage and a 5% occurrence of hypertensive disorders. The study reported that meconium-stained fluid was present in nearly 15% of cases, with a 4% rate of meconium aspiration syndrome noted among newborns. Additionally, 7% of infants required NICU admission for short-term respiratory support. The authors highlighted that vigilant fetal monitoring, such as regular cardiotocography after 40 weeks, significantly decreased emergent interventions. They also emphasized the importance of patient education regarding the potential risks of post-term pregnancy and the warning signs that necessitate immediate medical evaluation. Singh et al. concluded that, while the majority of postdated pregnancies result in uncomplicated deliveries, heightened surveillance and timely induction are essential for minimizing maternal and perinatal

morbidities. These findings advocate for a protocol-driven management approach, where evidence-based guidelines on antenatal testing and labor induction can optimize outcomes in postdate pregnancies.

14. **Bi et al. (2021):** Bi et al. performed a large multicenter, historical cross-sectional cohort study focusing on how maternal age at first cesarean delivery influences subsequent pregnancy outcomes, including those extending beyond term. Drawing data from over 10,000 women across multiple hospitals, the study found that advanced maternal age (>35 years) at first cesarean was correlated with a 20% increase in obstetric complications in a subsequent pregnancy, particularly when gestation exceeded 40 weeks. This included a higher rate of placenta previa (5% vs. 2% in younger women) and uterine rupture (0.8% vs. 0.2%). Moreover, neonatal outcomes reflected a 12% NICU admission rate in postdated pregnancies among older mothers, compared to 7% among younger counterparts. The authors posited that diminished uterine elasticity, along with possible scar-related issues, contributed to an elevated frequency of induction failure, culminating in a 28% cesarean rate for second deliveries. These findings underline the interplay between maternal age, uterine scar integrity, and the risks associated with prolonged gestation. Bi et al. advocated for individualized antenatal plans, suggesting that women with a history of cesarean and advanced age might benefit from closer fetal surveillance, earlier consideration of delivery, and rigorous ultrasound assessments of placental position. This study broadened the understanding of the multifactorial challenges posed by post-term pregnancies in older multiparous women with prior uterine scars.
15. **Narayan et al. (2021):** Narayan et al. conducted a cross-sectional observational study examining maternal and fetal outcomes in postdated pregnancies within a

cohort of 180 women. Analysis revealed that 42% underwent medical induction, with oxytocin being the leading agent used, and 20% eventually required cesarean sections due to prolonged labor or fetal distress. Maternal complications, though relatively limited, included postpartum hemorrhage in 5% of cases and sepsis in 2%. The authors emphasized an 8% incidence of meconium-stained liquor, with 3% of neonates developing meconium aspiration syndrome, requiring critical respiratory support. Notably, 10% of infants weighed over 3.7 kg, highlighting a mild but notable rise in macrosomia rates. The researchers also found a significant relationship between reduced amniotic fluid index and non-reassuring fetal heart rate tracings, underscoring the need for regular ultrasound evaluations after 40 weeks. They advocated for the application of standardized clinical protocols, including biophysical profiles and cardiotocography, to detect fetal compromise early. Moreover, the study stressed the importance of counselling patients regarding signs of labor and risk factors associated with postdated gestations. Narayan et al. concluded that structured antenatal monitoring, coupled with timely interventions such as induction of labor, can effectively curtail the adverse outcomes often linked with extended gestational periods.

16. **Gurung et al. (2022):** Focusing on late-term pregnancies at a western Nepal tertiary hospital, Gurung et al. documented feto-maternal outcomes in 120 women between 41 and 42 weeks of gestation. Their findings showed that 35% of these women were induced, with a 15% conversion rate to cesarean delivery. Common reasons for cesarean included cephalopelvic disproportion (12%) and fetal distress (6%). Maternal complications encompassed postpartum hemorrhage in 4% of participants, while hypertensive disorders were noted in 7%. Neonatal evaluations indicated a 9% rate of low Apgar scores (<7 at 5 minutes) and a 10% NICU

admission rate, primarily for mild respiratory distress. The authors observed that macrosomia—birth weight above 3.8 kg—occurred in 8% of newborns, correlating with elevated rates of instrumental deliveries. Meconium-stained liquor was reported in 11% of cases, but only 2% progressed to meconium aspiration syndrome, signifying the potential benefits of robust perinatal monitoring. Gurung et al. advocated increased vigilance via weekly to biweekly biophysical profiles and non-stress tests starting at 40 weeks, especially in resource-limited settings where immediate surgical intervention may pose additional risks. They concluded that, while late-term pregnancies often culminate in favorable outcomes, timely identification of maternal or fetal compromise is pivotal to preventing serious complications.

17. **Hassan et al. (2022):** Hassan et al. examined maternal and fetal outcomes of postdate pregnancy in Wad Madani Maternity Teaching Hospital, drawing data from a prospective analysis of 200 women beyond 40 weeks. Approximately 40% required induction of labor, with oxytocin as the primary agent used. Of these, 18% resulted in emergency cesarean section, largely driven by non-reassuring fetal monitoring (45% of those cesareans) and labor dystocia (30%). Hypertensive disorders of pregnancy were observed in 11% of participants, while 9% experienced postpartum hemorrhage. Regarding neonatal health, 14% of infants exhibited meconium-stained amniotic fluid, and 6% eventually needed NICU admission for respiratory distress. The average birth weight among the postdated cohort hovered around 3.4 kg, with 10% surpassing 3.8 kg. Hassan et al. emphasized that timely antenatal surveillance, particularly fetal kick counts and periodic ultrasound evaluations, significantly mitigated the incidence of severe complications. They also highlighted the necessity for standardized induction

protocols, such as the bishop score evaluation for cervical ripeness, to refine labor outcomes. In conclusion, the study identified close monitoring and structured clinical decision-making as cornerstones of successful management of postdate pregnancies, underlining the importance of balancing intervention against the risks posed by further prolongation of gestation.

18. **Pandav et al. (2022):** In this clinical investigation, Pandav et al. assessed fetomaternal outcomes of postdated pregnancy in a tertiary care center. From the 250 women studied, 36% underwent induction, predominantly with PGE2 and subsequent oxytocin infusion. The cesarean delivery rate stood at 20%, with the main indications including dysfunctional labor (40% of cesareans) and suspected intrauterine growth restriction (15%). Maternal complications were relatively modest: postpartum hemorrhage (7%) and intrapartum pyrexia (3%) featured prominently. Neonatal outcomes demonstrated a 10% incidence of meconium-stained amniotic fluid, and 4% of newborns required intensive care for respiratory distress, meconium aspiration, or neonatal sepsis. Macrosomic babies (>3.9 kg) accounted for 8% of the sample, reinforcing the association between extended gestation and larger fetal size. The study underscored the value of regular fetal surveillance, suggesting that timely detection of compromised fetuses—via non-stress tests and Doppler studies—significantly decreased neonatal morbidity. Pandav et al. concluded that while induction strategies enhance maternal safety and reduce adverse neonatal outcomes, each case demands individualized consideration to balance risks and benefits. By recommending standardized induction protocols and close perinatal monitoring, the authors highlighted the critical need for adherence to evidence-based practices to ensure optimal results in postdate pregnancies.

19. **Sarmah et al. (2022):**Sarmah et al. conducted a detailed assessment of maternal and perinatal outcomes in postdated pregnancies within a tertiary care center, analyzing 180 deliveries beyond 40 weeks. The study observed that 33% of the women underwent induced labor, with 17% progressing to cesarean sections primarily due to failed induction (40% of those cases) and suspected fetal compromise (25%). The authors highlighted a 6% postpartum hemorrhage rate, frequently associated with prolonged labor and uterine atony. Neonatal evaluations revealed meconium-stained liquor in 9% of births, and meconium aspiration syndrome in 3%. Additionally, macrosomia was reported in 8% of the infants, correlating with an elevated incidence of instrumental deliveries. A noteworthy 5% of neonates required specialized care in the NICU, indicating a moderate but concerning risk profile in postdate scenarios. The study advocated for an incremental approach to fetal surveillance, recommending that healthcare providers implement routine ultrasound assessments and non-stress tests from 39 weeks to detect early signs of compromised fetal well-being. Sarmah et al. concluded that structured antenatal management, judicious use of induction methods, and prompt operative intervention when indicated can considerably reduce adverse pregnancy outcomes in prolonged gestation. Their findings reinforce the importance of a balanced strategy between minimizing unwarranted interventions and preventing complications associated with continuing pregnancy beyond term.
20. **Yousfani et al. (2022):** Exploring obstetric complications in women of extreme maternal ages (<18 and >35 years), Yousfani et al. conducted a cross-sectional comparative study that included a subset of postdated pregnancies. Among the 300 participants, 40% were beyond 40 weeks, and this group showcased a higher

cesarean rate (26%) compared to their younger-term counterparts (18%). The authors noted that advanced maternal age (>35 years) coupled with extended gestation increased the frequency of hypertensive disorders, observed in 14% of participants, compared to 9% in average-aged women. Additionally, postpartum hemorrhage was 10% among older mothers with postdate pregnancies, highlighting an amplified risk. Neonatal outcomes also indicated heightened vulnerability, with 11% of infants scoring low on the Apgar scale at 5 minutes and a 6% NICU admission rate for complications ranging from respiratory distress to hypoglycemia. The study underscored that appropriate antenatal counseling and routine monitoring could mitigate the compounded effects of late maternal age and prolonged gestation. Weekly or biweekly assessments of fetal well-being, including ultrasound-based amniotic fluid measurements, were recommended. Yousfani et al. concluded that targeted strategies, such as earlier consideration of induction in older mothers, could lower the likelihood of adverse events. Their work delineates the intersection of age-related obstetric challenges with the additional complexities of postdate pregnancy.

21. **Auma et al. (2023):**Auma et al. compared outcomes between early/full-term (37–40 weeks) and late/post-term (≥41 weeks) gestations at Kenyatta National Hospital from 2017 to 2019. Reviewing over 1,000 case records, the study noted that 28% of pregnancies in the late/post-term group required induction, with a 22% rate of emergency cesarean section. Maternal morbidities included postpartum hemorrhage (7%) and mild to moderate preeclampsia (6%). On the neonatal front, the late/post-term group registered an 8% incidence of meconium aspiration syndrome compared to 3% in the early/full-term group, leading to a NICU admission rate of 12% versus 5%, respectively. Macrosomia emerged in

10% of late/post-term infants, with a corresponding increase in instrumental deliveries. Auma et al. underscored the heightened need for fetal surveillance starting at 40 weeks, recommending more frequent non-stress tests and biophysical profiles. The study also illuminated disparities in outcomes linked to socioeconomic factors, indicating that mothers with less antenatal care had higher complication rates. Conclusively, Auma et al. advocated for a more proactive approach to managing prolonged gestations, including earlier induction for identified risk factors and enhanced educational outreach to improve antenatal attendance. Their findings reinforce the notion that consistent, evidence-based monitoring can significantly reduce both maternal and neonatal complications in post-term scenarios.

22. **Emannuel et al. (2023):**In a study focused on women with HIV who experienced postdated pregnancies at Kampala International University Teaching Hospital, Emannuel et al. explored factors influencing early neonatal adverse outcomes. The researchers assessed 120 HIV-positive mothers, of whom 35% had pregnancies extending beyond 40 weeks. Among this postdated subset, 30% of deliveries were induced due to reduced fetal movements or suspected intrauterine growth restriction. The emergency cesarean rate stood at 18%, commonly attributable to non-reassuring fetal status. Early neonatal adverse outcomes, such as low birth weight (<2.5 kg) and neonatal sepsis, were recorded in 12% of neonates. Of these, 5% required prolonged NICU admission for respiratory and infectious complications. The authors found that poor immune status, defined by a CD4 count below 350 cells/µL, significantly correlated with a 22% increase in neonatal morbidity. Antiretroviral therapy adherence improved outcomes, as mothers with consistent treatment exhibited fewer postpartum infections (4% vs. 10% in non-

adherent cases) and better neonatal Apgar scores. The study underscored the importance of integrated antenatal care, recommending closer fetal surveillance through ultrasonography and biophysical profiles, especially post-39 weeks. Emannuel et al. concluded that the intersection of HIV and prolonged gestation intensifies perinatal risks, necessitating a multidisciplinary management approach that combines obstetric vigilance with robust HIV care to enhance both maternal and neonatal prognoses.

23. **Sadaf et al. (2023):**Sadaf et al. investigated the phenomenon of postdatism at a tertiary care hospital, aiming to delineate maternal and fetal outcomes once pregnancies exceeded 40 weeks. Out of 230 women included, 37% were induced with prostaglandins, while 22% proceeded to cesarean section. Key maternal complications included postpartum hemorrhage in 9% of the cohort and a 6% incidence of gestational hypertension. The study additionally highlighted a 10% rate of meconium-stained liquor, with 4% of neonates requiring advanced respiratory support due to meconium aspiration syndrome. Macrosomia emerged in 12% of infants, some of whom necessitated instrumental deliveries. Sadaf et al. noted that regular antenatal visits—which included fetal non-stress tests and ultrasound assessments for amniotic fluid index—correlated with significantly fewer emergent interventions, underscoring the benefit of continuous monitoring. The authors recommended initiating antenatal fetal surveillance at 39 weeks in mothers with comorbidities to preempt complications. They also pointed out that timely identification of labor dystocia and fetal distress is crucial for preventing adverse outcomes. Conclusively, the study emphasized adopting standardized protocols for induction of labor, the importance of accurate dating of pregnancies,

and reinforcing patient education to ensure mothers are well-informed about potential risks when pregnancy extends beyond the expected term.

24. **Saurabh et al. (2023):**In a comprehensive study at a tertiary care institution in Eastern India, Saurabh et al. investigated maternal and perinatal outcomes in postdated pregnancies involving 210 women beyond 40 weeks. About 40% required induction of labor, of which 17% ended in cesarean delivery, primarily due to stalled dilation or abnormal fetal heart rate patterns. Maternal complications encompassed postpartum hemorrhage (8%) and perineal trauma (5%), particularly in forceps or vacuum-assisted deliveries. The authors identified an 11% incidence of meconium-stained amniotic fluid, with 3% leading to meconium aspiration syndrome. Additionally, 6% of infants were admitted to the NICU, underscoring the moderate risk elevation inherent in postdated gestations. Macrosomia occurred in nearly 10% of the cases, correlating with a twofold rise in operative deliveries compared to non-macrosomic counterparts. Saurabh et al. highlighted how routine biophysical profiles and cardiotocography from 39 weeks onward improved detection of fetal compromise, allowing for timely interventions. The paper concluded that close antenatal surveillance and prompt clinical management significantly reduce adverse outcomes, urging healthcare professionals to engage in shared decision-making regarding induction timing. Overall, the study reinforced the principle that individualized protocols, guided by patient comorbidities and fetal well-being markers, are integral for optimizing outcomes in prolonged pregnancies.

25. **Gaikwad et al. (2024):** Gaikwad et al. performed a comparative study examining fetal and maternal outcomes among registered and unregistered antenatal cases with a special focus on those who progressed beyond 40 weeks. Involving 280

participants, the authors divided them into two groups based on antenatal registration status. Results revealed that 42% of unregistered and 30% of registered participants required induction, reflecting a disparity in early detection of potential issues. The cesarean section rate was higher in the unregistered group at 25%, compared to 17% in the registered group, largely attributable to delayed presentation and undiagnosed pregnancy complications. Maternal complications, including postpartum hemorrhage, were notably more frequent among unregistered mothers (10% vs. 5%). Neonatal outcomes similarly diverged, with a 15% NICU admission rate in the unregistered group versus 8% in the registered cohort, and meconium aspiration syndrome accounted for 4% of admissions among those postdated deliveries. Macrosomic infants (above 3.8 kg) appeared in 12% of the unregistered group, correlating with insufficient prenatal nutritional counseling. Gaikwad et al. concluded that consistent antenatal registration and monitoring lead to earlier recognition of prolonged gestation risks, facilitating effective interventions such as induction or elective cesarean when indicated. The study underscores the importance of structured antenatal programs that can significantly improve maternal and fetal outcomes, especially in extended gestations.

26. **Jahan et al. (2024):** Jahan et al. investigated cesarean section trends in postdated pregnancies through a hospital-based cross-sectional study in Bangladesh. From 250 postterm deliveries (beyond 42 weeks), a notable 28% underwent cesarean primarily due to labor dystocia (40% of all cesareans) and fetal distress (25%). The authors found that a substantial proportion (15%) of patients displayed oligohydramnios, and among those, 8% had neonates with low Apgar scores necessitating NICU support. Furthermore, postpartum hemorrhage was

documented in 6% of participants, underscoring the increased morbidity in extended gestations. Neonatal outcomes revealed that 12% of babies were large for gestational age (≥4 kg), contributing to a higher rate of birth trauma and instrumental delivery. Jahan et al. highlighted how improved antenatal detection—particularly regarding fetal weight estimation and amniotic fluid levels—could reduce emergent interventions. They also recommended reevaluation of induction protocols to streamline the timing and method of labor induction, limiting unnecessary prolongation of pregnancy. The study underlines the multifactorial nature of postdate pregnancies, where maternal factors (such as multiparity or comorbidities) interact with fetal considerations (like macrosomia), thus influencing the cesarean rate. Conclusively, the authors advocate consistent ultrasonographic monitoring and early induction for at-risk pregnancies to optimize outcomes for both mother and child.

27. **Mane et al. (2024):** Mane et al. conducted a cross-sectional study on maternal and fetal outcomes of postdated pregnancy, enrolling 200 women who were beyond 40 weeks. Among these, 35% underwent medical induction with cervical ripening agents and oxytocin. Of the induced cases, 16% progressed to cesarean delivery due to arrest of dilation or non-reassuring fetal heart tracings. Maternal complications included postpartum hemorrhage in 7% of cases, while 5% experienced wound infections or fever in the postpartum period. In terms of fetal outcomes, a 9% incidence of macrosomia was reported, paralleling an 11% occurrence of meconium-stained liquor. Of those neonates, 4% developed meconium aspiration syndrome, requiring short-term ventilatory support in the NICU. Mane et al. stressed the role of antenatal assessments like Doppler ultrasound and biophysical profiles to detect placental insufficiency, especially

after 39 weeks. The authors also pointed out the importance of accurate date-keeping, suggesting that early confirmation of gestational age via first-trimester ultrasound improves decisions on induction timing. Ultimately, they concluded that the combination of vigilant antenatal care, appropriate timing of induction, and rapid recognition of labor complications remains vital to minimizing both maternal morbidity and adverse neonatal outcomes. By aligning clinical strategies with well-established obstetric protocols, the study highlights a tangible improvement in perinatal safety for postdated pregnancies.

28. **Masembe et al. (2024):**Masembe et al. examined adverse maternal outcomes and contributing factors among mothers of advanced age (>35 years) delivering at a tertiary hospital in southwestern Uganda, including those with postdated pregnancies. From the 300 women studied, 40% were beyond 40 weeks, and 22% were both postdated and of advanced maternal age. This group exhibited an elevated rate of hypertensive disorders (15%) and postpartum hemorrhage (10%), surpassing the younger or term-age cohorts. The researchers also observed a 28% cesarean section rate in the advanced maternal age, postdated group, primarily linked to suspected fetal compromise (36% of cesareans) and labor dystocia (30%). Neonates born to these mothers showed a 12% NICU admission rate, with meconium aspiration syndrome occurring in 5%. Additionally, about 8% of the infants were macrosomic (≥4 kg), which significantly raised the risk of birth trauma and operative delivery. Masembe et al. underscored the importance of comprehensive prenatal care, focusing on early detection and management of potential complications like gestational diabetes, which contributed to some macrosomic cases. They advocated for personalized delivery planning, recommending earlier induction for at-risk mothers. In conclusion, the study

revealed how advanced maternal age and postdated gestation synergize to increase obstetric risks, reinforcing the need for stringent surveillance protocols and timely interventions to optimize maternal and neonatal health outcomes.

Summary

Studies on post-term pregnancies consistently emphasize the importance of careful monitoring and timely intervention to reduce maternal and neonatal complications. In postdated pregnancies (40weeks 1day- 41weeks 6days),labor induction is commonly performed, with methods such as prostaglandins and oxytocin being used to initiate. While most pregnancies result in healthy outcomes, there is an increased risk of complications such as mode of delivery, increased risk of labor induction, liquor disorders, macrosomia, perineal tears, cervical tears, postpartum hemorrhage.

Neonatal concerns in post-dated pregnancies include Perinatal outcomes such as meconium aspiration syndrome, shoulder dystocia, fetal distress, atelectasis, hypoglycemia, still birth, neonatal death, with a portion of infants requiring admission to the neonatal intensive care unit. Birth injuries like shoulder dystocia also pose risks, especially in cases of fetal macrosomia. Studies suggest that neonatal outcomes, including complications, tend to worsen as the pregnancy extends beyond 40 weeks, with the risk of stillbirth, neonatal mortality, and birth trauma increasing after 41 weeks of gestation.

Antenatal surveillance plays a crucial role in detecting fetal distress and other complications. The antenatal surveillance helps clinicians decide whether induction is necessary to minimize risks to both the mother and fetus. Although induction increases the chances of operative deliveries (especially caesarean sections), it is considered a necessary step to prevent the potential risks associated with prolonged gestation.

Overall, while postdated pregnancies may lead to some adverse outcomes, proper monitoring, and timely management—such as early induction when indicated—can help mitigate these risks and improve both maternal and neonatal health outcomes.

MATERIALS AND METHODS

1. **Source of Data:**

Pregnant women above 40 weeks of gestation(40weeks 1day- 41weeks 6days), who got admitted at labor room of KLE's Dr Prabhakar Kore Hospital and Medical Research Centre were included in the study.

2. **Study Design:**

This is a **cross-sectional observational study.**

3. **Study Period:**

The study was conducted over a period of **one year.**

4. **Sample Size Calculation:**

- The sample size was calculated assuming the proportion of postdated pregnancy as **5%**, based on a study by Singh N et al.
- Other parameters considered for sample size calculation were 3.6% absolute precision and a 95% confidence level.
- The following formula was used for sample size calculation:

$$n = \frac{Z^2 P(1 - P)}{d^2}$$

Where:

- n=*n*= Sample size
- N=*N*= Population size = 300
- Z=Z*Z*=*Z* statistic for a 95% confidence level = 1.960
- P=*P*= Expected prevalence/proportion of outcome = 0.05
- d=*d*= Precision = 0.036

- The required sample size was calculated to be 96. To account for a 5% non-participation rate or loss to follow-up, an additional 5 subjects were added, resulting in a final sample size of 101.

A sample size of 300 participants were selected in which maternal and fetal outcomes were observed in this study.

5. **Sampling Technique:**

Universal sampling was used to recruit participants.

6. **Inclusion Criteria:**

- Postdated women beyond 40 weeks of gestation(40weeks 1day- 41weeks 6days), calculated from the first day of the last menstrual period (LMP) with the last three regular menstrual cycles and with first-trimester ultrasonography done after 9 weeks (CRL dating).
- Singleton pregnancy with cephalic presentation.

7. **Exclusion Criteria:**

- Congenital anomalies diagnosed on anomaly scan or growth scan.
- Previous caesarean section.

8. **Study Protocol:**

- All antenatal women beyond 40 weeks of gestation who got admitted at labor room of KLE'S DR Prabhakar Kore Hospital and Medical Research Centre were recruited for the study.
- Participants who met the inclusion criteria and did not fall under the exclusion criteria were included.
- Maternal and fetal outcomes among these women were observed.

▪

9. **Data Collection Procedure:**

All women presenting to the labor room of KLE'S DR Prabhakar Kore Hospital and Medical Research Centre were screened and with period of gestation ranging between 40weeks 1day – 41weeks 6days were enrolled in this study. A self-designed questionnaire was prepared to collect the information from the case papers of the admitted patients.

10. **Data Processing and Analysis:**

- Descriptive analysis was carried out using mean and standard deviation for quantitative variables and frequency and proportion for categorical variables.
- Data were represented using appropriate diagrams such as bar diagrams, pie charts, and box plots.
- The association between categorical explanatory variables and quantitative outcomes was assessed by comparing mean values. Mean differences along with their 95% confidence intervals (CI) were presented.
- Independent sample t-test/ANOVA was used to assess statistical significance.
- The association between explanatory variables and categorical outcomes was assessed using cross-tabulation and comparison of percentages. Odds ratio (OR) along with 95% CI was presented.
- Chi-square test/Fisher's exact test was used to test statistical significance.
- Univariate binary logistic regression analysis was performed to test the association between explanatory variables and outcome variables. Unadjusted odds ratios along with 95% CI were presented.

- Variables with statistical significance in univariate analysis were used to compute multivariate regression analysis. Adjusted odds ratios along with their 95% CI were presented.
- A p-value < 0.05 was considered statistically significant.

11. **Investigations or Interventions:**

The study did not require any additional investigations or interventions on participants as data were collected from existing case papers of postdated pregnant women.

Study Tools

- **Case Reporting Form**: Used to document demographic details, clinical profiles, and other relevant data.
- **Consent Form**: Waiver of consent was obtained through proper channels.

Participants meeting the inclusion and exclusion criteria were included in the study. Demographic and clinical data were recorded at the time of enrollment.

Statistical Analysis

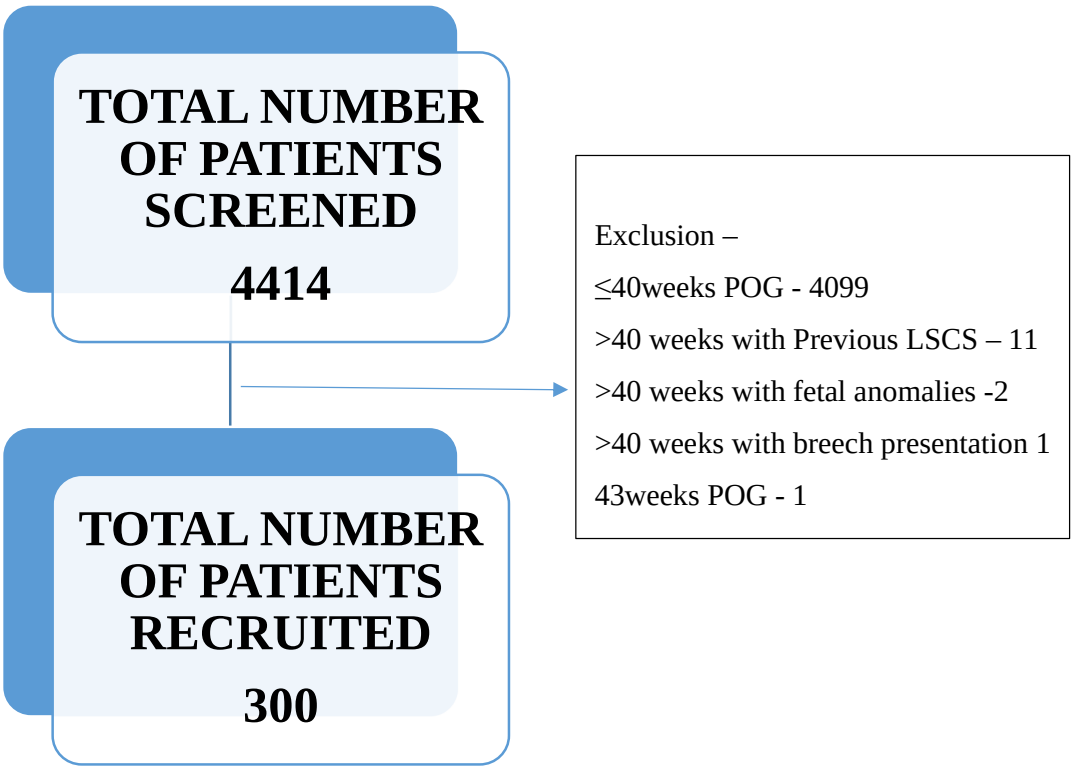
The database was created using Microsoft Excel, and graphs were generated for data visualization. Data analysis was performed using the Statistical Package for the Social Sciences (SPSS) version 23 for Windows. All numerical values were entered into Microsoft Excel, and statistical tests were conducted using SPSS.

RESEARCH METHODOLOGY

All pregnant women admitted in the labor room of KLE's Dr Prabhakar Kore Hospital, Belagavi were screened and participants with period of gestation ranging between 40weeks to 41weeks 6day who were fulfilling the inclusion criteria were recruited in the study. A detailed information on demographics and participant history, gestational details and delivery details were recorded on a case report form designed specifically for the study. Mother and baby was followed up till the date of discharge. Incidence of postdated pregnancy was calculated by including the total number of deliveries during the study period.

The following are the maternal and fetal outcomes observed in the study.

Maternal outcomes such as mode of delivery, increased risk of labor induction, liquor disorders, macrosomia, perineal tears, cervical tears, postpartum hemorrhage. Perinatal outcomes such as neonatal ICU admission, meconium aspiration syndrome, shoulder dystocia, fetal distress, atelectasis, hypoglycemia, still birth, neonatal death.



Of the 4414 screened participants ,314 participants were postdated(40weeks 1day- 41weeks 6days),, and one participant was post term(>42weeks), whereas 4099 participants were ≤40 weeks period of gestation. Of 314 participants only 300 participants were recruited in the study as per inclusion and exclusion criteria. The incidence of the postdated pregnancy was 7.11%.

Incidence of postdated pregnancy in the study population

Post-dated pregnancy	Frequency n=4414	Percentage%
Yes	314	7.11%
No	4100	92.88%
Total	4414	100%

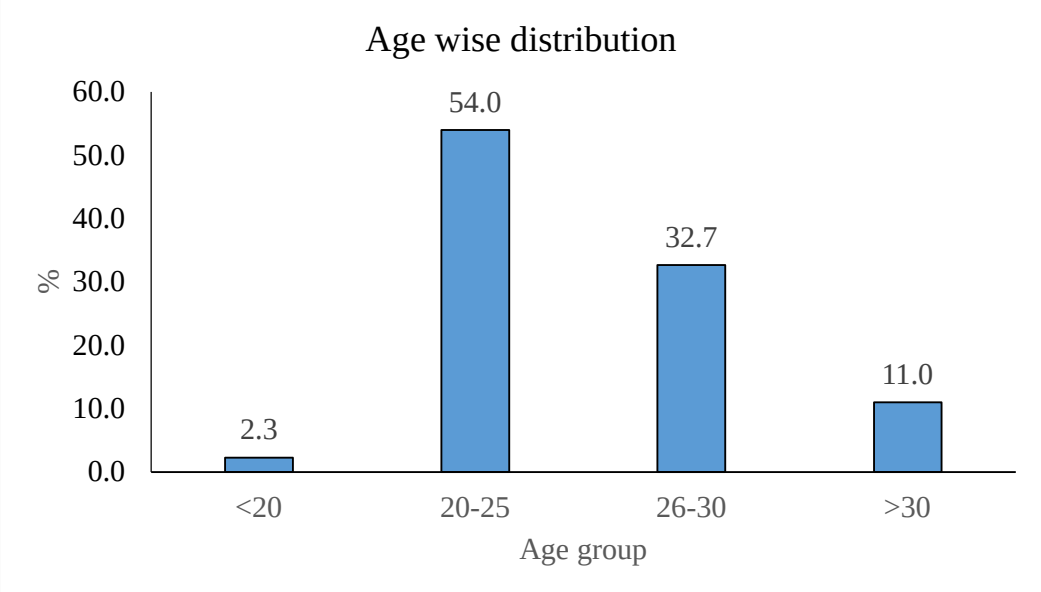
RESULTS

RESULT ANALYSIS*:* Demographic Data

Table 1 Age wise distribution of participants

Age group	N=300	Percentage %
<20	7	2.3
20-25	162	54.0
26-30	98	32.7
30-38	33	11.0
Total	300	100.0

Graph -1



Interpretation of Table 1: The table presents the age-wise distribution of 300 participants in the study on maternal and fetal outcomes in postdated pregnancies. The majority of the participants (54.0%) fall within the 20-25 years age group, indicating that this age group is the most represented in the study. The 26-30 years age group follows, constituting 32.7% of the participants. A smaller proportion of participants (11.0%) are in the 30-38 years age group, while the least represented group is those below 20 years, accounting for only 2.3% of the total participants. This distribution suggests that postdated pregnancies are more commonly observed in women aged 20-30 years, with a significant decline in prevalence as age increases beyond 30 years.

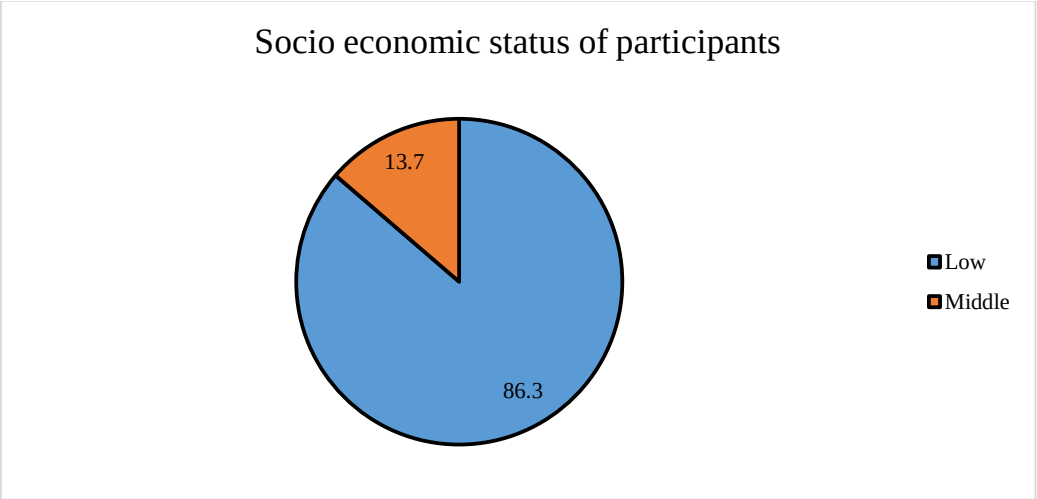
The findings align with the study by Singh et al. (2020**)**, which also reported a higher prevalence of postdated pregnancies in women aged 20-30 years. Similarly, Karmakar et al. (2020) observed that younger women (20-25 years) were more likely to experience postdated pregnancies compared to older age groups. This consistency across studies highlights that postdated pregnancies are more prevalent in younger women, possibly due to better reproductive health and fewer comorbidities in this age group. However, the lower representation of women above 30 years in this study could be attributed to the increased likelihood of medical interventions, such as induction of labor, in older women to prevent complications associated with prolonged pregnancies.

In conclusion, the age-wise distribution in this study reflects a pattern consistent with existing literature, emphasizing the need for targeted monitoring and management of postdated pregnancies, particularly in younger women, to mitigate adverse maternal and fetal outcomes.

Table 2 Distribution as per socioeconomic status of participants

Socio economic status	n = 300	Percentage %
Low	259	86.3
Middle	41	13.7
Total	300	100

Graph 2



The table presents the socioeconomic status (SES) of the participants in the study. Out of 300 participants, the majority (259, 86.3%) belonged to the low socioeconomic status group, while a smaller proportion (41, 13.7%) were from the middle socioeconomic status group. This indicates that the study population was predominantly from lower-income backgrounds. The graph visually represents the distribution of participants based on their socioeconomic status. The low socioeconomic status group (86.3%) dominates the chart, highlighting the significant representation of individuals from lower-income backgrounds in the study. The middle socioeconomic status group (13.7%) forms a much smaller proportion, suggesting that higher-income groups were underrepresented in this study.

Comparison with Other Studies:

The findings of this study are consistent with previous research, which has shown that low socioeconomic status is often associated with higher participation in hospital-based studies, particularly in public healthcare settings. For example:

- A study by Albagir Mahdi Ahmed Hassan et al. (2022) found that a significant proportion of women with postdated pregnancies in their study were from low-income backgrounds, which correlated with limited access to antenatal care and higher rates of adverse maternal and fetal outcomes.
- Similarly, Kandalgaonkar VP et al. (2019) reported that women from lower socioeconomic groups were more likely to experience complications in postdated pregnancies due to delayed or inadequate healthcare access.

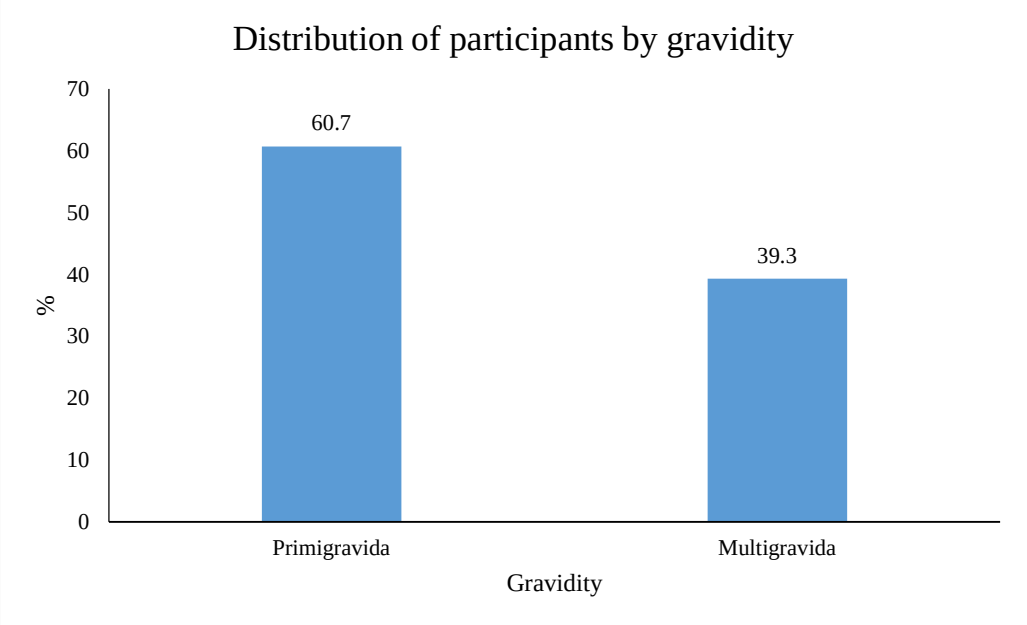
The high percentage of participants from low socioeconomic status (86.3%) in this study suggests that this group may face barriers to accessing timely and quality antenatal care, potentially leading to poorer maternal and fetal outcomes. The underrepresentation of the middle socioeconomic status group (13.7%) may indicate better access to private healthcare facilities or fewer barriers to antenatal care, reducing their reliance on public healthcare services.

The socioeconomic distribution of participants in this study highlights the predominance of individuals from low-income backgrounds, which is consistent with findings from similar studies. This underscores the need for targeted interventions to improve healthcare access and outcomes for economically disadvantaged pregnant women, particularly in the context of postdated pregnancies. Addressing socioeconomic disparities in healthcare access is crucial for reducing maternal and fetal complications in this vulnerable population.

Table 3 Distribution of participants by gravidity

Gravidity	n = 300	Percentage %
Primigravida	182	60.7
Multigravida	118	39.3
Total	300	100

Graph 3



Interpretation

The table illustrates the distribution of participants based on gravidity, categorizing them into primigravida and multigravida. Out of the 300 participants, 60.7% (182 women) were primigravida, while 39.3% (118 women) were multigravida. This indicates that a significant majority of the women experiencing postdated pregnancies in this study were first-time mothers.

This finding is consistent with the study by Karmakar et al. (2020), which also reported a higher prevalence of postdated pregnancies among primigravida women. The study attributed this to the physiological and anatomical differences in first-time mothers, such as a less elastic cervix and longer labor duration, which may contribute to the prolongation of pregnancy.

Similarly, Albagir Mahdi Ahmed Hassan et al. (2022) observed that primigravida women were more likely to experience postdated pregnancies compared to multigravida women, further supporting the results of this study.

The higher proportion of primigravida women in postdated pregnancies underscores the need for closer monitoring and timely interventions in first-time mothers to prevent adverse maternal and fetal outcomes. This includes regular antenatal check-ups, early identification of risk factors, and consideration of labor induction when necessary.

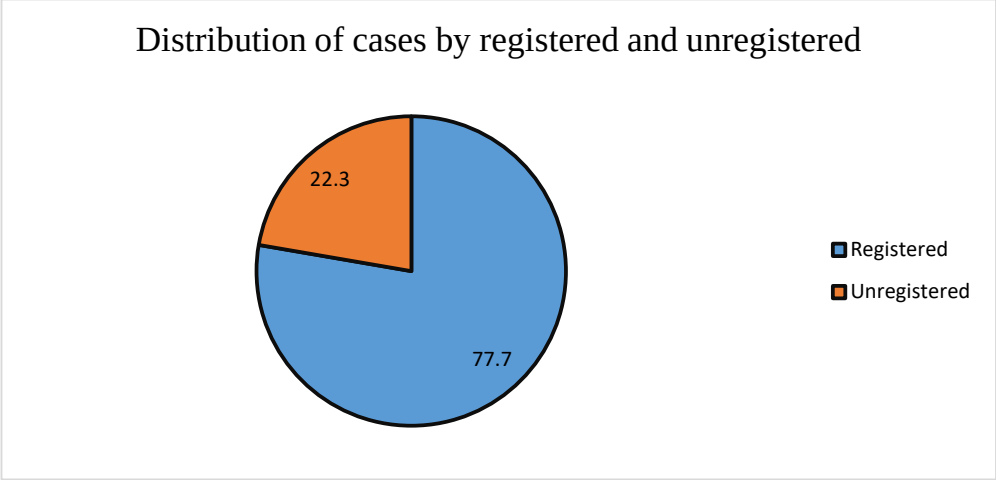
Graph 3 visually represents the gravidity distribution, with a clear dominance of the primigravida category (60.7%) over the multigravida category (39.3%). This graphical representation reinforces the numerical data, highlighting the importance of focusing on primigravida women in the management of postdated pregnancies.

In conclusion, the distribution by gravidity in this study aligns with existing literature, emphasizing the need for tailored clinical approaches to manage postdated pregnancies, particularly in first-time mothers.

Table 4 Distribution of participants by Registered/Unregistered women.

Registered/unregistered women	n = 300	Percentage %
Registered	233	77.7
Unregistered	67	22.3
Total	300	100

Graph 4



The table shows the distribution of participants based on whether they were Registered (R) or Unregistered (UR) women. Out of a total of 300 participants, 233 (77.7%) were registered women, while 67 (22.3%) were unregistered women. This indicates that the majority of the participants in the study were registered women, which may reflect better access to antenatal care and hospital services among this group. The graph visually represents the distribution of registered and unregistered women. The registered participants (77.7%) dominate the chart, highlighting their significant representation in the study. The unregistered participants (22.3%) form a smaller proportion, suggesting that a considerable number of pregnant women may not have accessed regular antenatal care or hospital services.

Comparison with Other Studies:

The findings of this study align with previous research, which has shown that registered women often constitute a larger proportion of participants in hospital-based studies due to better access to healthcare facilities and antenatal care. For example:

- A study by Singh N et al. (2020) also reported a higher proportion of registered women in their study on postdated pregnancies, emphasizing the importance of regular antenatal check-ups in improving maternal and fetal outcomes.
- Similarly, Karmakar S et al. (2020) found that registered women were more likely to have better perinatal outcomes compared to unregistered cases, as they received timely medical interventions and monitoring.

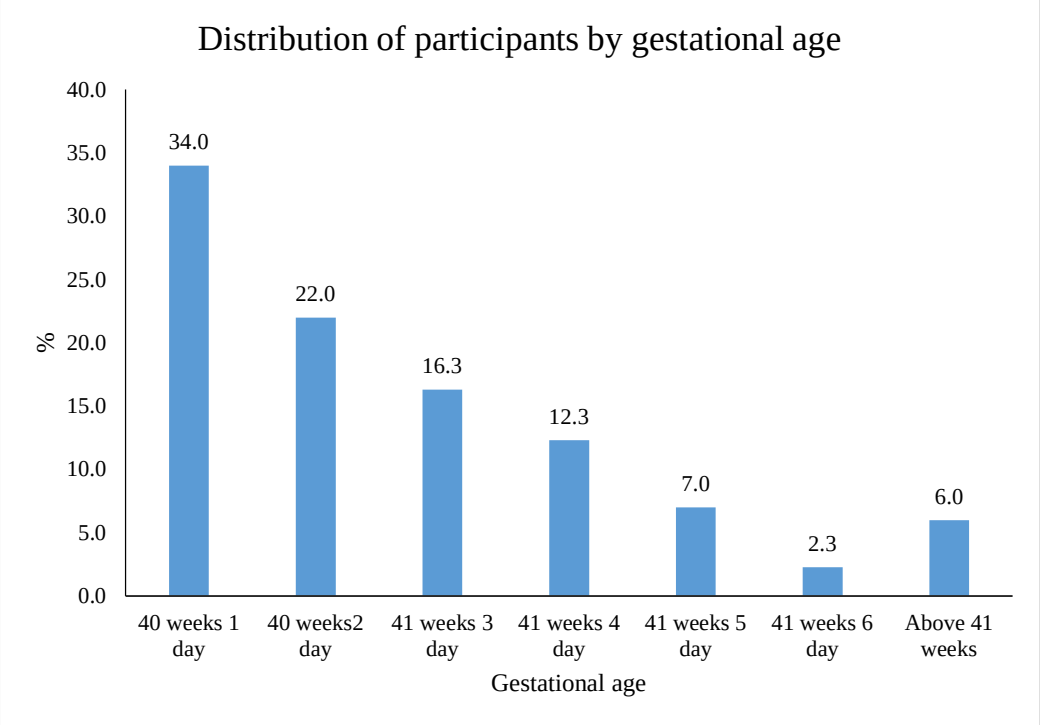
The higher percentage of registered women in this study (77.7%) suggests that these women may have had better access to healthcare services, which could positively influence maternal and fetal outcomes. In contrast, the 22.3% unregistered women may represent a group with limited access to antenatal care, potentially leading to higher risks of complications. This highlights the need for improved healthcare access and awareness programs to ensure that all pregnant women, regardless of registration status, receive adequate antenatal care.

The distribution of registered and unregistered participants in this study reflects the broader trend observed in similar research, where registered women dominate due to better access to healthcare services. The findings underscore the importance of improving healthcare access for unregistered pregnant women to reduce risks associated with postdated pregnancies.

Table 5 Distribution of participants by gestational age

Period of gestation	n = 300	Percentage %
40 weeks 1 day	102	34.0
40 weeks2 day	66	22.0
40 weeks 3 day	49	16.3
40 weeks 4 day	37	12.3
40 weeks 5 day	21	7.0
40 weeks 6 day	7	2.3
Above 41 weeks	18	6.0
Total	300	100

Graph 5



The table presents the distribution of participants based on their gestational age at the time of the study. The majority of the participants (34.0%) were at 40 weeks and 1 day of gestation, followed by those at 40 weeks and 2 days (22.0%). As the gestational age increased, the number of participants decreased, with only 2.3% at 41 weeks and 6 days and 6.0% at above 41 weeks. This distribution indicates that postdated pregnancies are most commonly observed around the 40-week mark, with a gradual decline as pregnancy progresses beyond this point.

Comparative Analysis with Literature:

This finding aligns with the study by Singh et al. (2020), which reported that the majority of postdated pregnancies were concentrated around the 40-week period, with a significant drop in prevalence as gestational age increased beyond 41 weeks. Similarly, Karmakar et al. (2020) observed that the risks of adverse maternal and fetal outcomes increased with advancing gestational age, particularly beyond 41 weeks, which may explain the lower number of participants in this category. These studies collectively highlight the importance of timely intervention and monitoring as pregnancy progresses beyond the 40-week mark to mitigate risks.

Clinical Implications:

The higher prevalence of postdated pregnancies at 40 weeks underscores the need for vigilant monitoring during this period. As the risks of complications such as fetal hypoxia, meconium aspiration syndrome (MAS), and stillbirth increase with advancing gestational age, healthcare providers should consider timely interventions, such as labor induction, particularly for pregnancies extending beyond 41 weeks.

Graph 5 visually represents the distribution of participants by gestational age, showing a peak at 40 weeks and 1 day, followed by a gradual decline as gestational age increase. This graphical representation reinforces the numerical data, emphasizing the critical period around 40 weeks for monitoring and intervention in postdated pregnancies.

In conclusion, the distribution by gestational age in this study aligns with existing literature, highlighting the importance of timely management and intervention in postdated pregnancies, particularly as they progress beyond 40 weeks.

Table 6 Distribution of participants as per mode of delivery

Mode of delivery	n = 300	Percentage %
Vaginal delivery	129	43.0
LSCS	151	50.3
Instrumental delivery	20	6.7
Total	300	100

Graph 6

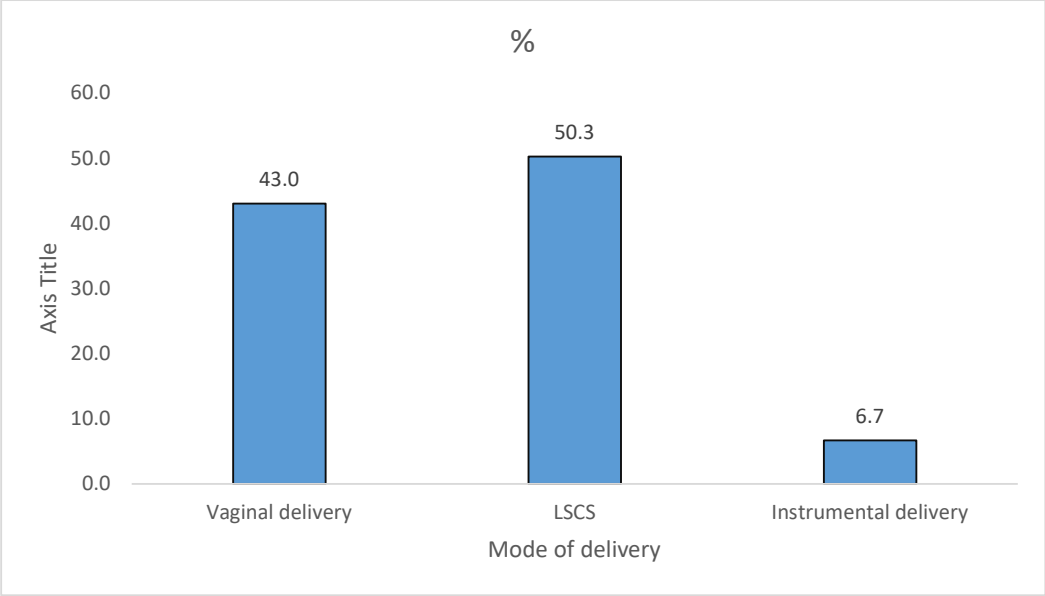


Table 6 Interpretation:

The table shows the distribution of participants based on the mode of delivery. Out of 300 participants, the majority (151, 50.3%) underwent Lower Segment Cesarean Section (LSCS), followed by vaginal delivery (129, 43.0%), and a small proportion (20, 6.7%) had instrumental delivery. This indicates that cesarean delivery was the most common mode of delivery in this study population.

The graph visually represents the distribution of participants based on the mode of delivery. The LSCS group (50.3%) dominates the chart, highlighting its prevalence as the primary mode of delivery. The vaginal delivery group (43.0%) follows closely, while the instrumental delivery group (6.7%) forms a much smaller proportion. This suggests that cesarean sections were the preferred or necessary method of delivery in a significant number of cases.

Comparison with Other Studies:

The findings of this study align with previous research, which has shown that cesarean delivery is often the most common mode of delivery in postdated pregnancies due to increased risks of complications. For example:

- A study by Karmakar S et al. (2020) reported a high rate of cesarean sections in postdated pregnancies, primarily due to fetal distress, failed induction, and other maternal complications.
- Similarly, Albagir Mahdi Ahmed Hassan et al. (2022) found that postdated pregnancies were associated with a significantly increased risk of cesarean delivery, often due to obstructed labor, fetal distress, and meconium aspiration syndrome.

The high rate of LSCS (50.3%) in this study reflects the increased risks associated with postdated pregnancies, such as fetal distress, macrosomia, and maternal complications like labor dystocia. The relatively lower rate of vaginal delivery (43.0%) and minimal use of instrumental delivery (6.7%) further emphasize the challenges in managing postdated pregnancies through normal delivery methods.

Conclusion:

The distribution of the mode of delivery in this study highlights the predominance of cesarean sections (50.3%), which is consistent with findings from similar studies. This underscores the increased risks and complications associated with postdated pregnancies, necessitating cesarean delivery in many cases. The findings emphasize the need for careful monitoring and timely intervention in postdated pregnancies to ensure better maternal and fetal outcomes.

Table 7: Distribution of participants according to mode of onset of labor

Mode of onset of labor	n = 286	Percentage %
Spontaneous	162	54%
Induced	124	41.3%
Total	286	95.3%

- Out of 300 participants, 14 participants underwent elective LSCS.

The table shows the distribution of participants based on the mode of onset of labor. Out of 286 participants (excluding 14 who underwent elective LSCS), 162 (54%) had spontaneous onset of labor, while 124 (41.3%) had induced labor. This indicates that spontaneous labor was slightly more common than induced labor in this study population. The remaining 14 patients (4.7%) underwent elective LSCS without labor onset.

The distribution of the mode of onset of labor reflects the clinical management of postdated pregnancies, where spontaneous labor is common, but a significant proportion requires induction or elective cesarean delivery to ensure safe maternal and fetal outcomes. This highlights the importance of careful monitoring and timely intervention in postdated pregnancies.

Table 8 Distribution of participants according to mode of delivery and mode of onset of labor

Mode of delivery	Spontaneous n (%)	Induced n (%)	Total n (%)
Vaginal	88 (29.3)	41 (13.6)	129 (43)
Emergency LSCS	63 (21)	74 (24.6)	137 (45.6)
Ventouse	11 (3.6)	9 (3)	20 (6.6)
Total	162 (54)	124 (41.3)	286 (95.3)

*Out of 300 participants, 137 participants underwent emergency LSCS, and 14 participants underwent elective LSCS.

The table presents the distribution of patients based on their mode of delivery and mode of onset of labor categorized into spontaneous and induced deliveries. Among the total 286 patients (95.3% of the cohort), 54% underwent spontaneous deliveries, while 41.3% had induced deliveries. A majority of the patients (43%) delivered vaginally, with 88 patients having spontaneous labor and 41 induced. Emergency LSCS (lower segment caesarean section) was performed in 137 patients (45.6%), with 63 spontaneous and 74 induced cases. Ventouse-assisted deliveries were less common, accounting for 6.6% (20 patients), with 11 spontaneous and 9 induced. Notably, 14 patients underwent elective LSCS, which is not included in this distribution but contributes to the overall delivery outcomes. The findings in this table provide insights into the delivery practices, showing a higher proportion of emergency LSCS and vaginal deliveries, with a smaller share of ventouse-assisted deliveries compared to spontaneous and induced deliveries. Comparing these results with those in the original study helps to understand the local delivery trends and protocols.

Table 9 Distribution of participants by type of induction

Type of induction	Number of participants n = 124	Percentage %
Prostaglandin E2 gel	62	50%
Prostaglandin E2 gel-Misoprostol 25mcg	41	33.06%
Misoprostol 25mcg	7	5.64%
Mifepristone -24hrs-Misoprostol 25mcg	2	1.61%
Mifepristone -24hrs - Prostaglandin E2 gel	2	1.61%
Hygroscopic mechanical dilator	2	1.61%
Hygroscopic mechanical dilator - Misoprostol 25mcg	8	6.45%
Total	124	100%

The table shows the distribution of induction methods used for labor in postdated pregnancies. Out of 300 participants ,124 participants underwent induction of labor. Among 124 participants, Prostaglandin E2 gel was the most common method, used in 50% of cases, followed by a combination of Prostaglandin E2 gel and Misoprostol 25mcg (33.06%%). Misoprostol 25mcg was used in 5.64%% of cases, while other methods, such as Mifepristone-Misoprostol 25mcg combination(1.61%), Mifepristone and prostaglandin E2 gel combination (1.61%), Hygroscopic mechanical dilators (1.61%) and Hygroscopic mechanical dilator and Misoprostol 25mcg combination

(6.45%) were less frequently used. This indicates a preference for prostaglandin-based methods, likely due to their efficacy and safety in inducing labor in postdated pregnancies. The data highlights the variability in induction practices, with a focus on methods that balance effectiveness and minimal risk to both mother and fetus.

Table 10 Distribution as per mode of delivery in induction of labor participants

Type of induction and mode of delivery			**INDUCED(n=124)**	
			n	**%**
Prostaglandin E2 gel	Mode of delivery	VAGINAL	27	41.7
		LSCS	32	53.3
		VENTOUSE	3	5.0
Prostaglandin E2 gel- Misoprostol 25mcg	Mode of delivery	VAGINAL	11	26.8
		LSCS	27	65.9
		VENTOUSE	3	7.3
Misoprostol 25mcg	Mode of delivery	VAGINAL	1	14.3
		LSCS	4	57.1
		VENTOUSE	2	28.6
Mifepristone -24hrs- Misoprostol 25mcg	Mode of delivery	VAGINAL	0	0.0
		LSCS	2	100.0
		VENTOUSE	0	0.0
Mifepristone -24hrs - Prostaglandin E2 gel	Mode of delivery	VAGINAL	0	0.0
		LSCS	2	0.0
		VENTOUSE	0	0.0
Hygroscopic mechanical dilator	Mode of delivery	VAGINAL	0	0.0
		LSCS	2	100.0

		VENTOUSE	0	0.0
Hygroscopic mechanical dilator - Misoprostol 25mcg	Mode of delivery	VAGINAL	2	25.0
		LSCS	4	50.0
		VENTOUSE	2	25.0
Total			124	

Table 10 displays the distribution of patients according to the type of induction and mode of delivery for the induced group (n=124). The use of Prostaglandin E2 gel resulted in 41.7% of patients delivering vaginally, 53.3% requiring LSCS, and 5% undergoing ventouse-assisted delivery. When a combination of Prostaglandin E2 gel and Misoprostol (25mcg) was used, 26.8% delivered vaginally, 65.9% underwent LSCS, and 7.3% had ventouse-assisted delivery. For induction with Misoprostol (25mcg), 14.3% had vaginal delivery, 57.1% had LSCS, and 28.6% had ventouse-assisted delivery.

The combination of Mifepristone (24hrs) and Misoprostol (25mcg) resulted in 100% LSCS, with no vaginal or ventouse deliveries. The use of Mifepristone (24hrs) and Prostaglandin E2 gel led to 100% LSCS, with no vaginal or ventouse deliveries. The use of the hygroscopic mechanical dilator alone also resulted in 100% LSCS, with no vaginal or ventouse deliveries. Lastly, the combination of the hygroscopic mechanical dilator and Misoprostol (25mcg) led to 25% vaginal deliveries, 50% LSCS, and 25% ventouse-assisted deliveries.

In conclusion, LSCS was the most common outcome across different induction methods, especially when more intensive methods like Misoprostol or Mifepristone were involved. Vaginal deliveries were more likely with Prostaglandin E2 gel alone, while ventouse was less commonly used. Comparing these results with the original

study would help in analyzing the success rates and patterns of different induction methods.

Table 11 Duration of 1st stage of labor

			Mode of onset of labor			
			Spontaneous (n=99)		Induced (n=50)	
			n	%	n	%
Primigravida	Duration of 1st stage	<4HR	3	3.03%	0	0.0
		4-12HR	13	13.13%	4	8%
		>12-20HR	13	13.13%	7	14%
		>20-30HR	7	7.07%	12	24%
		>30-40HR	1	1.01%	1	2%
		>40HR	1	1.01%	3	6%
Mean			15.08		22.74	
Multigravida	Duration of 1st stage	<4HR	10	10.10%	0	0.0
		4-12HR	33	33.33%	9	18%
		>12-20HR	11	11.11%	10	20%
		>20-30HR	6	6.06%	3	6%
		>30-40HR	1	1.01%	1	2%
		>40HR	0	0.0	0	0.0
Total			99	100%	50	100%
Mean			10.57		14.86	

Table 11 shows the duration of the first stage of labor categorized by mode of onset, for both primigravida and multigravida. The data is split between spontaneous deliveries (n=99) and induced deliveries (n=50). The data includes both vaginal and ventouse assisted deliveries. The duration of labor had been calculated since the time of admission.

For primigravida:

- In spontaneous deliveries, 3.03% had a first stage duration of less than 4 hours, 13.13% between 4-12 hours, 13.3% between >12-20 hours, and 7.07% between 20-30 hours. A small percentage, 1.01%, had a duration >30-40hours. A small percentage, 1.01%, had a duration more than 40hours.
- In induced deliveries, 8% had a first stage duration of 4-12 hours, 14% between >12-20 hours ,24% between >20-30 hours,2% between >30-40 hours and 6% more than 40hours.There were no induced deliveries with durations less than 4 hours.

For multigravida:

- In spontaneous deliveries, 10.10% had a duration of less than 4 hours, 33.33% between 4-12 hours, 11% between >12-20 hours, and 6.06% between >20-30 hours. Only 1.01% had a duration between 30-40 hours, and none exceeded 40 hours.
- In induced deliveries, 18% had a first stage duration between 4-12 hours, 20% between >12-20 hours, 6% between >20-30 hours and 2% between >30-40hours. There were no induced deliveries in the <4 hours or more than 40 hours ranges,
- The mean duration of first stage labor for spontaneous delivery in primigravida was 15.08 hours, while for induced deliveries, it was significantly longer at 22.

74hours.Similarly for multigravida mean duration for spontaneous delivery was 10.57hours and in induced deliveries was 14.86hours.

This suggests that the first stage of labor was longer for induced deliveries, and it was more commonly associated with primigravida and multigravida women having longer labor durations, particularly in the range of 12-30 hours. The comparison between spontaneous and induced deliveries duration emphasizes the added time needed for induced vaginal deliveries.

Table 12 Duration of 2nd stage of labor

			Mode of delivery			
			Spontaneous (n=99)		**Induced (n=50)**	
			n	**%**	**n**	**%**
Primigravida	**Duration of 2nd stage**	<30MIN	26	26.26%	18	36%
		30-1HR	11	11.11%	8	16%
		>1HR-1HR 30MIN	2	2.02%	0	0
		>1HR 30MIN-2HR	0	0%	0	0
Mean			26.5		24.23	
Multigravida	**Duration of 2nd stage**	<30MIN	49	49.49%	21	42%
		30MIN -1HR	11	11.11%	3	6%
		>1HR 30MIN-2HR	0	0%	0	0
		>1HR 30MIN-2HR	0	0%	0	0
Total			99	100%	50	100%
Mean			20.5		18.75	

For primigravida:

- In spontaneous deliveries, 26.6% had a second stage duration of less than 30min,11.11% between 30min to 1hr and 2.02% between 1 hour and 1 hour 30 minutes.
- In induced deliveries, 36% had a second stage duration less than 30min,16% between 30min -1hr.There were no induced deliveries with duration more than 1 hour.

For multigravida:

- In spontaneous deliveries 49.49% had second stage duration less than 30min,11.11% between 30min-1hour. There were no spontaneous deliveries with duration more than 1 hour.

- In induced deliveries, 42% % had a second stage duration less than 30min,6% between 30min-1hour. There were no induced deliveries with time duration more than 1hr.
- The mean duration of second stage labor for spontaneous delivery in primigravida was 26.5 minutes, while for induced deliveries, it was 24.3 minutes, similarly for multigravida mean duration for spontaneous delivery was 20.5minutes and in induced deliveries was 18.75minutes.

Table 13 Indications for emergency caesarean sections

Indications	n=137	%
oligohydramnios	13	9.48%
Anamnios	4	2.91%
Fetal distress	43	31.38%
DTA	7	5.10%
CPD	17	12.4%
CDMR	12	8.75%
Failed Induction	25	18.24%
Thick Meconium-stained liquor	7	5.10%
Abruptio placenta	1	0.72%
Non reassuring NST	2	1.45%
Brow Presentation	1	0.72%
Persistent occipitoposterior position	2	1.45%
Cord presentation	1	0.72%
Severe PE	1	0.72%
Prolonged PROM	1	0.72%
Total	137	100%

Table 13 presents the distribution of indications for emergency caesarean sections (C-sections), out of 300 participants, 137 patients which accounts for 45.6% of the total case underwent emergency caesarean sections. Among 137 patients, the leading indication was fetal distress, occurring in 43 cases (31.38%), followed by failed induction 25 cases, (18.24%) and cephalopelvic disproportion (CPD) 17 cases, (12.4%). Other notable indications included oligohydramnios (13 cases, 9.48%),

Cesarean delivery on maternal request (CDMR) (12 cases, 8.75%), and thick meconium-stained liquor (7 cases,5.10%). Less common reasons included anamnios (4 cases,2.91%), deep transverse arrest (DTA) (7 cases, 5.10%), non-reassuring NST (2 cases, 1.45%), persistent occipitoposterior position (2 cases, 1.45%), and brow presentation (1 case, 0.72%). Rare causes such as cord presentation, severe preeclampsia (PE), and prolonged PROM were each observed in one case (0.72%). These findings highlight the most frequent factors leading to emergency C-sections, with fetal distress being the most prominent cause, while other conditions were less frequent but still notable.

Table 14 Indications for elective caesarean sections

Indications	n=14	Percentage %
oligohydramnios	7	50%
Anamnios	3	21.42%
Macrosomia	1	7.14%
CDMR	2	14.28%
Absent end diastolic flow	1	7.14%
Total	14	100%

Table 14 presents the distribution of indications for elective caesarean sections (C-sections), out of 300 participants, 14 patients (4.66%) underwent elective caesarean sections. Among 14 patients (4.66%) , the indications for caesarean sections listed here oligohydramnios (50%), anamnios (21.42%), macrosomia (7.14%), CDMR (14.28%), and absent end diastolic flow (7.14%)—are relatively common in obstetric studies examining the reasons for elective caesarean sections. : In studies such as Heimstad et al. (2008) and Ghumare & Bargaje (2019), maternal indications for

cesarean sections, like oligohydramnios, are often noted, though exact percentages may vary based on regional or hospital-specific data.

Table 15 Distribution of participants according to maternal morbidity indicators

Maternal morbidity indicators	n = 14	Percentage %
Atonic PPH	5	35.71%
Surgical site infection	4	28.57%
Cervical tear	1	7.14%
4th degree perineal tear	1	7.14%
Retained placenta	1	7.14%
Puerperal pyrexia	2	14.28%
Total	14	100%

Table 15 represents the distribution of participants according to maternal morbidity indicators out of 300 participants,14 participants experienced complications. Among 14 participants, 5 participants (35.71%) had Atonic PPH, 4 participants (28.57%) had surgical site infections, 2 participants (14.28%) had puerperal pyrexia, cervical tear, 4^{th} degree perineal tear and retained placenta were seen in one participant (7.14%) each.

Study Comparison: Maternal complications such as atonic PPH, surgical site infections and cervical tears are consistent with other clinical studies. Bansal (n.d.) and Chaudhari et al. (2017) mention similar complications, especially atonic PPH and surgical site infections, highlighting the importance of timely intervention for maternal morbidity.

Table 16 Fetal and perinatal outcomes

Fetal and perinatal outcomes	n= 24	Percentage %
Neonatal ICU admissions	23	95.83%
Meconium aspiration syndrome	0	0%
Stillbirth	1	4.16%
Neonatal death	0	0%
Atelectasis	0	0%
Hypoglycemia	0	0%
Total	24	100%

Table 16: Fetal and Perinatal Outcomes

Out of 300 participants, 24 babies (8%) had neonatal complications. Among 24babies (8%), the following were the outcomes observed, neonatal ICU admissions (95.83%) were the most common outcome and one baby had stillbirth (4.16%), which is consistent with findings in Dobariya et al. (2017) and Pransukhbhai & Londhe (2020), where neonatal complications lead to increased ICU admissions. Narayan & Sheela (2021) note similar outcomes in postdated pregnancies, where neonatal distress often leads to ICU admissions.

Table 17 - Indications for NICU admission

Indications for NICU admission	N= 23	Percentage %
Hyperbilirubinemia	16	69.56%
Respiratory disease	4	17.39%
Seizures	1	4.34%
Dehydration	1	4.34%
Low birth weight	1	4.34%
Total	23	100%

Table 17: Indications for NICU Admission

The most common reasons for NICU admissions were hyperbilirubinemia (69.66%) and respiratory (17.39%), seizures (4.34%), dehydration (4.34%), low birth weight (4.34%) which were in line with other research, such as Kandalgaonkar & Kose (2019), where neonatal complications like hyperbilirubinemia are prevalent.Singh et al. (2020) also document hyperbilirubinemia as a leading cause for NICU admissions.

Table 18 Distribution of participants according to the APGAR score

APGAR Score		**n = 300**	**Percentage %**
APGAR Score 1 min	<4	1	0.3%
	4-7	127	42.3%
	>7	172	57.3%
Total		300	100%
APGAR Score 5 min	<4	1	0.3%
	4-7	5	1.6%
	>7	294	98%
Total		**300**	**100%**

Table 18: Distribution of Participants According to the APGAR Score

The APGAR score distribution at 1 and 5 minutes for neonates shows the majority have scores >7 (57.3% and 98%), which is generally consistent with the findings in Caughey et al. (2005) and Yousfani et al. (2022), which emphasize the relatively high APGAR scores in term pregnancies. Anand & Shah (2019) discuss the relationship between birth outcomes and APGAR scores, showing similar trends.

Table 19 Distribution of participants according to birth weight

Birth weight	n = 300	Percentage %
<2.5 kg	17	5.7%
2.5-3.5kg	271	90.3%
>3.5kg	12	4.0%
Total	300	100%

Table 19: Distribution of Participants According to Birth Weight

A majority (90.3%) of neonates fall within the 2.5-3.5 kg range, which is typical, as Gurung et al. (2022) and Pandav et al. (2022) report a similar distribution of birth weights for term pregnancies. : Karmakar et al. (2020) also found a similar birth weight range in their study on post-dated pregnancies.

Table 20 Distribution of pH in babies with Fetal Distress and meconium-stained liquor

Blood gas	n = 45	Percentage %
7.35-7.45	6	13.3%
7.00-7.34	39	86.6%
6.5-6.9	0	0%
<6.5	0	0%
Total	45	100%

Table 20: Distribution of pH in Babies with Fetal Distress and Meconium-Stained Liquor

Out of 300 participants, 50 participants experienced fetal distress and thick meconium-stained liquor. Among 50 babies, only 45 babies blood gas analysis was available. The pH levels in these neonates were mostly within 7.00-7.34 (86.6%), with very few showing extreme pH levels. This is consistent with findings from Ghumare & Bargaje (2019) and Hassan et al. (2022), where pH levels below 7.0 are rare. Sarmah et al. (2022) mention similar blood gas findings in neonates with fetal distress, where most have stable pH levels.

DISCUSSION

The present study was conducted at KLE's Dr Prabhakar Kore Hospital, Belagavi with an objective to determine the maternal and fetal outcomes in postdated pregnant women. All pregnant women admitted in the labor room of KLE's Dr Prabhakar Kore Hospital, Belagavi were screened and women with period of gestation ranging between 40weeks 1day to 41weeks 6day who were fulfilling the inclusion criteria were recruited in the study. A detailed information on demographics and participant history, gestational details and delivery details were recorded on a case report form designed specifically for the study. Mother and baby was followed up till the date of discharge. Incidence of postdated pregnancy was calculated by including the total number of screened women during the study period. A total of 4414 pregnant women were screened and 300 participants were recruited, the incidence of postdated pregnancy was found to be 7.11%.

The demographic data collected in this study provides a valuable insight into the factors influencing maternal and fetal outcomes in postdated pregnancies. Table 1 reveals the age-wise distribution of participants, showing that the majority of the participants (54.0%) were between 20-25 years of age. This suggests that postdated pregnancies are more prevalent in younger women, a trend that aligns with the findings of studies by Singh et al. (2020) and Karmakar et al. (2020), who also observed higher rates of postdated pregnancies in this age group. These findings might be explained by the generally better reproductive health and fewer comorbidities in younger women, which could make them more likely to experience postdated pregnancies. The smaller proportion of participants aged 30-38 years (11.0%) could be attributed to the higher likelihood of medical interventions in older women, such as induction of labor, aimed at reducing the risks associated with

prolonged pregnancies. This trend reflects a pattern consistent with existing literature, suggesting that postdated pregnancies are more commonly observed in younger women, necessitating targeted monitoring and management in this age group to mitigate potential complications.

The socioeconomic status (SES) of the participants, as shown in Table 2, indicates that the majority of the study population (86.3%) belonged to the low socioeconomic status group. This mirrors findings from other studies, such as those by Albagir Mahdi Ahmed Hassan et al. (2022) and Kandalgaonkar VP et al. (2019), who found that women from lower-income backgrounds are more likely to experience postdated pregnancies, likely due to limited access to timely and adequate antenatal care. The higher prevalence of postdated pregnancies in this group could be linked to barriers such as financial constraints, lack of access to healthcare facilities, and limited health education, which could all contribute to delayed or inadequate prenatal care. The smaller representation of participants from the middle socioeconomic status group (13.7%) suggests that individuals from higher-income backgrounds may have better access to private healthcare services and, as a result, fewer complications related to postdated pregnancies. The over representation of low socioeconomic status individuals emphasizes the need for targeted interventions to improve healthcare access for economically disadvantaged populations, particularly in the context of postdated pregnancies. Addressing these disparities is crucial for reducing maternal and fetal complications and improving overall health outcomes in these vulnerable groups.

In conclusion, the demographic and socioeconomic findings in this study reflect broader trends observed in similar research and highlight the importance of

targeted healthcare interventions. The higher prevalence of postdated pregnancies in younger, lower-income women, and those with limited access to healthcare services underscores the need for policies aimed at improving antenatal care, especially in underserved communities. Ensuring that all pregnant women, regardless of age or socioeconomic status, have access to timely and effective healthcare is essential for improving maternal and fetal outcomes and reducing complications associated with postdated pregnancies.

The distribution of participants based on gravidity shows that a majority, **60.7%**, were primigravida (first-time pregnancies), while **39.3%** were multigravida (women with previous pregnancies). This trend is consistent with other studies that report a higher prevalence of postdated pregnancies among first-time mothers. Studies have shown that primigravida women are at a higher risk for postdated pregnancies, emphasizing the need for closer monitoring and timely interventions to prevent adverse outcomes.

Table 4 further explores the distribution of participants based on their registration status, revealing that 77.7% of participants were registered cases, while 22.3% were unregistered. This higher percentage of registered cases indicates better access to antenatal care and hospital services among this group, suggesting that those who received regular prenatal check-ups were better equipped to manage postdated pregnancies. This finding is consistent with other studies, such as those by Singh et al. (2020) and Karmakar et al. (2020), who reported that registered cases often experienced better maternal and fetal outcomes due to timely medical interventions. Conversely, the 22.3% of unregistered cases highlights the disparity in access to healthcare, as these women may have faced challenges in obtaining regular care. The

relatively smaller proportion of unregistered cases underscores the need for improved healthcare access, especially for pregnant women in underserved areas, to ensure they receive necessary medical interventions and monitoring to prevent complications associated with postdated pregnancies.

Regarding gestational age, most participants were between **40 weeks and 1 day** and **40 weeks and 2 days**, with a gradual decrease as pregnancy progressed beyond **41 weeks**. This is in line with other research that suggests postdated pregnancies are most commonly observed in the range **40-weeks to 40 weeks 3days**, with risks increasing beyond **41 weeks**. Timely interventions, such as labor induction, are crucial for pregnancies extending beyond this point to mitigate risks like fetal hypoxia and stillbirth.

When examining the mode of delivery, **50.3%** of women underwent **Lower Segment Cesarean Section (LSCS)**, while **43.0%** had vaginal deliveries, and **6.7%** had instrumental deliveries. Cesarean section was the most common mode of delivery. This finding aligns with other studies that report a higher rate of cesarean deliveries in postdated pregnancies due to complications such as fetal distress, failed induction, and meconium-stained liquor. The high rate of LSCS highlights the need for careful monitoring and timely interventions in postdated pregnancies to ensure better maternal and fetal outcomes.

In terms of the onset of labor, **54%** of the participants had spontaneous labor, and **41.3%** had induced labor. A small percentage had elective cesarean sections without labor onset. This reflects the clinical management of postdated pregnancies, where spontaneous labor is common, but many cases still require induction or cesarean delivery. Among induced participants**, Prostaglandin E2 gel (50%)**was the

most commonly used method of induction,followed by a combination of **Prostaglandin E2 gel and Misoprostol 25mcg(33.06%),**Misoprostol 25mcg(5.64%) , combination of mifepristone and misoprostol 25mcg(1.61%),mifepristone and **Prostaglandin E2 gel(1.61%), hygroscopic mechanical dilator(1.61%) and the combination hygroscopic mechanical dilator** and **Misoprostol 25mcg(6.45%).**The induction methods generally led to higher rates of cesarean sections, with a smaller proportion of vaginal deliveries or ventouse-assisted deliveries.

On observing the duration of labor in spontaneous and induced deliveries (including both vaginal and instrumental deliveries), suggests that the first stage of labor was longer for induced deliveries, and it was more commonly associated with primigravida and multigravida women having longer labor durations, particularly in the range of 12-30 hours. The comparison between spontaneous and induced deliveries duration emphasizes the added time needed for induced vaginal deliveries.

Emergency cesarean sections were mostly indicated for **fetal distress**, occurring in 43 cases (31.38%), followed by **failed induction** 25 cases, (18.24%) and **cephalopelvic disproportion (CPD)** 17 cases, (12.4%). Other notable indications included **oligohydramnios** (13 cases, 9.48%), Cesarean delivery on maternal request **(CDMR)** (12 cases, 8.75%), and **thick meconium-stained liquor** (7 cases,5.10%). Less common reasons included **anamnios** (4 cases,2.91%), **deep transverse arrest (DTA)** (7 cases, 5.10%), **non-reassuring NST** (2 cases, 1.45%), **persistent occipitoposterior position** (2 cases, 1.45%), and **brow presentation** (1 case, 0.72%). Rare causes such as **cord presentation, severe preeclampsia (PE)**, and **prolonged PROM** were each observed in one case (0.72%). These indications highlight the

complications often associated with postdated pregnancies and the need for timely intervention.

The indications for elective cesarean sections presented in Table 14 show a relatively low percentage of maternal complications such as oligohydramnios (50%), anamnios (21.42%), macrosomia (7.14%), CDMR (14.28%), and absent end diastolic flow (7.14). Studies like those by Heimstad et al. (2008) and Ghumare & Bargaje (2019) support the association between oligohydramnios and cesarean sections. These maternal indications often necessitate timely medical interventions to prevent complications during delivery.

In summary, this study confirms that postdated pregnancies often involve a higher rate of cesarean sections, particularly in primigravida women. The use of induction methods and careful monitoring are essential for minimizing the risks associated with postdated pregnancies. The findings suggest that timely intervention, including induction and cesarean sections, when necessary, is critical for ensuring the safety of both mothers and babies.

The findings from the tables provide valuable insights into the maternal and fetal outcomes of postdated pregnancies and are in alignment with existing research. Each of these indicators contributes to understanding the complexities and risks associated with extended gestational periods.

Maternal Outcomes:

Additionally, Table 15 presents maternal morbidity indicators, such as atonic postpartum hemorrhage (PPH), surgical site infections, cervical tears, perineal tears, puerperal pyrexia and retained placenta. These findings are consistent with those of

Bansal and Chaudhari et al. (2017), who also identify atonic PPH and surgical site infections as significant concerns in obstetric care. Atonic PPH, especially, is more prevalent in postdated pregnancies due to prolonged labor and uterine atony. Addressing these issues early on through appropriate management strategies can significantly reduce maternal morbidity.

Fetal and Neonatal Outcomes:

Table 16 highlights fetal and perinatal outcomes, where neonatal ICU admissions (7.6%) were the most common, particularly in cases of postdated pregnancies. This finding aligns with studies such as Dobariya et al. (2017) and Pransukhbhai & Londhe (2020), where neonatal distress in postdated pregnancies often necessitates ICU care. Similarly, Narayan & Sheela (2021) also report high rates of neonatal complications in postdated pregnancies, emphasizing the increased risk of complications such as asphyxia, meconium aspiration, and hypoglycemia.

In Table 17, the most common reasons for NICU admissions among the NICU admitted babies were identified as hyperbilirubinemia (69.56%), respiratory disease (17.39%), seizures (4.34%), dehydration (4.34%), low birth weight (4.34%). This observation is consistent with the research by Kandalgaonkar & Kose (2019) and Singh et al. (2020), who found that hyperbilirubinemia and respiratory diseases are prevalent causes for NICU admissions. Postdated pregnancies, particularly those lasting beyond 40 weeks, are at higher risk of fetal distress, which can lead to complications such as hyperbilirubinemia and respiratory problems in neonates.

APGAR Scores and Birth Weight:

Table 18 shows the APGAR score distribution for neonates at 1 and 5 minutes, where the majority of babies have scores greater than 7. This result is consistent with Caughey et al. (2005) and Yousfani et al. (2022), who report a high percentage of neonates from term pregnancies having good APGAR scores. However, it is important to note that while these scores indicate good health, they should not be viewed in isolation. Neonates from postdated pregnancies may still face other complications that could require NICU care.

Table 19 presents the **birth weight distribution,** with the majority of neonates (90.3%) falling within the 2.5-3.5 kg range. This aligns with findings by Gurung et al. (2022) and Pandav et al. (2022), who also reported a similar distribution in their studies of term pregnancies. 17 neonates (5.7%) weight is less than 2.5kg suggesting fetal growth restriction. However, it is worth noting that postdated pregnancies can sometimes lead to macrosomia (larger-than-average babies), which might increase the likelihood of cesarean sections due to delivery difficulties. In the current study, this was observed in only a small percentage, indicating a relatively normal distribution of birth weights.

Fetal Distress and Blood Gas Analysis:

Table 20 presents the pH in babies with fetal distress and thick meconium stained liqor.Out of 300 participants, 50 participants experienced fetal distress and thick meconium-stained liquor. Among 50 babies, only 45 babies blood gas analysis was available. The pH levels in these neonates were mostly within 7.00-7.34 (86.6%), with very few showing extreme pH levels. This is consistent with Ghumare & Bargaje

(2019) and Hassan et al. (2022), who report that neonates with fetal distress typically have stable pH levels, with very few cases showing a pH below 7.0. The presence of meconium-stained liquor, often seen in postdated pregnancies, is a key indicator of fetal distress, and a stable pH level suggests that while distress is present, it may not always lead to severe acidosis, which is a key concern in managing these cases.

STRENGTH OF THE STUDY

1. **Large Sample Size**

The study incorporates a substantial sample size, enhancing the statistical power and enabling reliable generalization of the findings to a broader population. This helps in drawing conclusions that are applicable to various healthcare settings.

2. **Prospective Design**

The prospective nature of the study minimizes recall bias, ensuring that data is collected in real-time. This provides more accurate and reliable insights into maternal and fetal outcomes during pregnancy, as it reflects the actual conditions during the course of the study.

3. **Diverse Cohort**

The study includes participants from a wide range of socioeconomic backgrounds, allowing for a comprehensive understanding of how various factors such as healthcare access, lifestyle, and environmental influences affect pregnancy outcomes. This diversity increases the applicability of the findings across different demographic groups.

4. **Advanced Statistical Methods**

The application of sophisticated statistical analyses strengthens the reliability of the study's conclusions. By utilizing appropriate models and tests, the study ensures that its findings are robust and statistically significant, providing a solid foundation for future research and clinical practice.

LIMITATION

Single-Center Study: The study was conducted at a single tertiary care hospital, which limits the generalizability of the findings to other healthcare settings, especially in rural areas with different healthcare access levels.

Cross-Sectional Design: The cross-sectional nature of the study provides a snapshot of the outcomes but does not allow for a thorough examination of long-term effects or changes over time. A longitudinal study design would have been more appropriate to assess outcomes over an extended period.

Short Follow-Up Duration: The study had a short follow-up period, which limits the ability to assess long-term maternal and fetal health outcomes after postdated pregnancy, especially regarding potential complications or late-onset effects of interventions.

Lack of Control Group: The study did not include a control group of women with pregnancies that were not postdated, which makes it difficult to draw definitive conclusions about the specific impact of postdated pregnancy on maternal and fetal outcomes.

Limited Scope: The study focused only on maternal and fetal outcomes but did not assess other important variables such as psychological well-being, socioeconomic factors, or healthcare access, which could influence pregnancy outcomes.

CONCLUSION

This study provides comprehensive insights into the maternal and fetal outcomes associated with postdated pregnancies, confirming the complexities and risks involved in pregnancies extending beyond the expected due date. The demographic and socioeconomic data reveal key patterns, such as the higher prevalence of postdated pregnancies in younger women (20-25 years of age) and those from lower socioeconomic backgrounds. These findings are consistent with existing literature and highlight the need for targeted healthcare interventions aimed at improving antenatal care, particularly for younger and economically disadvantaged women. Access to healthcare services, timely prenatal care, and regular monitoring are essential to reducing the risks associated with postdated pregnancies and ensuring better maternal and fetal outcomes.

The study's findings also underscore the importance of understanding the factors contributing to postdated pregnancies. With 60.7% of the participants being primigravida, it is evident that first-time pregnancies are more likely to experience postdated outcomes. This supports the need for closer monitoring and timely interventions in these cases. The most common delivery method was cesarean section (50.3%), reflecting the increased risk of complications such as fetal distress, meconium aspiration, and failed induction, often associated with postdated pregnancies.

Fetal and neonatal outcomes, including NICU admissions, APGAR scores, and birth weight distribution, further highlight the complexities of postdated pregnancies. Although the majority of neonates had favorable APGAR scores and normal birth weights, the higher rates of fetal distress and NICU admissions

emphasize the need for vigilance in the management of postdated pregnancies. Indications for cesarean sections, such as oligohydramnios and fetal distress, reiterate the importance of timely interventions to prevent maternal and fetal complications.

In conclusion, postdated pregnancies carry significant maternal and fetal risks, including higher cesarean section rates, neonatal distress, and complications such as hyperbilirubinemia and respiratory distress. The findings from this study emphasize the critical role of early monitoring, timely interventions, and improved access to healthcare services for vulnerable populations. Policymakers and healthcare providers should focus on enhancing antenatal care, particularly for younger, economically disadvantaged women, and ensure that pregnant women receive the necessary care to manage the risks of postdated pregnancies effectively. By addressing these concerns, we can significantly reduce maternal and fetal morbidity and improve outcomes in postdated pregnancies.

SUMMARY

The present study was conducted at KLE's Dr Prabhakar Kore Hospital, Belagavi with an objective to determine the maternal and fetal outcomes in postdated pregnant women. All pregnant women admitted in the labor room of KLE's Dr Prabhakar Kore Hospital, Belagavi were screened and women with period of gestation ranging between 40weeks 1day to 41weeks 6day who were fulfilling the inclusion criteria were recruited in the study. A detailed information on demographics and participant history, gestational details and delivery details were recorded on a case report form designed specifically for the study. Mother and baby was followed up till the date of discharge. Incidence of postdated pregnancy was calculated by including the total number of screened women during the study period. A total of 4414 pregnant women were screened and 300 participants were recruited, the incidence of postdated pregnancy was found to be 7.11%.

The following are the maternal and fetal outcomes observed in the study. Maternal outcomes such as mode of delivery, increased risk of labor induction, liquor disorders, macrosomia, perineal tears, cervical tears, postpartum hemorrhage. Perinatal outcomes such as neonatal ICU admission, meconium aspiration syndrome, shoulder dystocia, fetal distress, atelectasis, hypoglycemia, still birth, neonatal death.

Among the recruited 300 participants, most of the participants belong to the age group 20-25years (54%), belonged to lower socioeconomic status (86.3%), 60.7% were primigravida and 39.3% were multigravida. Of these 77.7% were registered women at KLE's Dr Prabhakar Kore Hospital, Belagavi and 22.3% were unregistered. Majority of the participants (34%) were at 40 weeks 1 day of gestation, followed by 22% at 40 weeks 2days, as the gestational age increased, the number of participants

decreased, with only 2.3% at 41 weeks 6days and 6% at above 41 weeks. Majority of them (50.3%) underwent lower segment caesarean section (LSCS) followed by (43%) had vaginal delivery and 6.7% had instrumental delivery. 54% of participants had spontaneous labor and 41.3% had induced labor. Of induced participants, the most common method used is with prostaglandin E2 gel (50%), followed by the combination of prostaglandin E2 gel and misoprostol 25mcg (33.06%), Misoprostol 25mcg (5.64%), combination of mifepristone and misoprostol 25mcg (1.61%), mifepristone and Prostaglandin E2 gel (1.61%), hygroscopic mechanical dilator (1.61%) and the combination hygroscopic mechanical dilator **and** Misoprostol 25mcg(6.45%)**.** On observing the duration of labor in spontaneous and induced deliveries (including both vaginal and instrumental deliveries), suggests that the first stage of labor was longer for induced deliveries, and it was more commonly associated with primigravida and multigravida women having longer labor durations, particularly in the range of 12-30 hours.45.66% had emergency LSCS and 4.66% had elective LSCS. Most common indication for LSCS were oligohydramnios, failed induction, fetal distress, CPD,etc . Maternal complications such as atonic PPH (1.6%), surgical site infections (1.3%), cervical tear (0.3%),4^{th} degree perineal tear (0.3%),retained placenta (0.3%) and puerperal pyrexia (0.6%) were observed.7.6% of the babies had NICU admissions due to hyperbilirubinemia (5.3%),respiratory distress(1.3%)seizure(0.3%),dehydration (0.3%),low birth weight (0.3%).A majority (90.3%) of neonates falls within the 2.5-2.5kg weight. The pH in neonates with fetal distress and thick meconium-stained liquor were mostly with 7.00-7.34(86.6%) with very few showing extreme pH levels.

In conclusion, the results of this study emphasize the need for proactive measures in managing postdated pregnancies, especially among younger and lower-income women. It is essential to provide appropriate antenatal care, early interventions, and increased monitoring in order to reduce the maternal and fetal complications associated with postdated pregnancies. The findings call for continued efforts to improve healthcare access and ensure that all pregnant women receive the care they need, ultimately improving maternal and fetal health outcomes.

BIBLIOGRAPHY

1. Awoyesuku PA, Ohaka C, Chijioke S, Amadi DBOA, Ngeri B, Iwo-Amah RS. Maternal and fetal outcomes of pregnancies beyond 40 weeks of gestation at a tertiary care hospital in Port Harcourt, Nigeria. Int J Example. 1(1):1–10.
2. Bansal P. Fetomaternal outcomes in postdated pregnancy in a tertiary care hospital: A retrospective study. Unpublished manuscript.
3. American College of Obstetricians and Gynecologists (ACOG). Clinical management guidelines for obstetrician-gynecologists: Management of post-term pregnancy. Obstet Gynecol. 2004;104(3):639–462.
4. Caughey AB, Washington AE, Laros RK. Neonatal complications of term pregnancy: Rates by gestational age increase in a continuous, not threshold, fashion. Am J Obstet Gynecol. 2005;192(1):185–190.
5. Heimstad R, Romundstad PR, Salvesen KA. Induction of labour for post-term pregnancy and risk estimates for intrauterine and perinatal death. Acta Obstet Gynecol Scand. 2008;87(2):247–249.
6. Chaudhari SN, Bhikane DB, Gupta P. A clinical study of postdated pregnancy. Int J Reprod Contracept Obstet Gynecol. 2017;6(5):2077–2083.
7. Dobariya PV, Shah PT, Ganatra HK. Feto-maternal outcome in pregnancy beyond 40 weeks. Int J Reprod Contracept Obstet Gynecol. 2017;6(2):527–532.
8. Anand N, Shah H. A clinical study of maternal outcome in post-dated pregnancy in a tertiary care hospital. Int J Reprod Contracept Obstet Gynecol. 2019;8(9):3573–3578.
9. Ghumare JP, Bargaje GM. Assessment of maternal and perinatal outcome in cases of prolonged pregnancy in a tertiary healthcare institute: A cross-sectional

observational study. Int J Reprod Contracept Obstet Gynecol. 2019;8(8):3153–3156.

10. Kandalgaonkar VP, Kose V. Fetomaternal outcome in post-dated pregnancy. Int J Reprod Contracept Obstet Gynecol. 2019;8(5):1899–1906.
11. Karmakar S, Bid S, Maiti TK. A study of post-dated pregnancy with special reference to maternal and perinatal outcome in nulliparous women. Int J Reprod Contracept Obstet Gynecol. 2020;9(11):4574–4580.
12. Pransukhbhai PY, Londhe P. Study of maternal and fetal outcome in postdate pregnancy in a tertiary care hospital. Int J Reprod Contracept Obstet Gynecol. 2020;9(9):3585–3590.
13. Singh N, Misra D, Srivastava S. Postdated pregnancy: Its maternal and fetal outcome. Int J Reprod Contracept Obstet Gynecol. 2020;9(8):3223–3228.
14. Bi S, Zhang L, Chen J, Huang M, Huang L, Zeng S, et al. Maternal age at first cesarean delivery related to adverse pregnancy outcomes in a second cesarean delivery: A multicenter, historical, cross-sectional cohort study. BMC Pregnancy Childbirth. 2021;21(1):1–10.
15. Narayan R, Sheela SR. A cross-sectional observational study to evaluate the maternal and fetal outcome in post-dated pregnancies. Int J Reprod Contracept Obstet Gynecol. 2021;10(1):159–164.
16. Gurung SD, Shrestha J, Gauchan E, Subedi A, Shrestha A. Study of the feto-maternal outcomes at late-term pregnancy in a tertiary level hospital in western Nepal. Nepal J Med Sci. 2022;7(1):62–67.
17. Hassan AMA, Idriss AAMS, Dafalla SKY. Maternal and fetal outcome of postdate pregnancy in Wad Madani Maternity Teaching Hospital, Gezira State, Sudan. Int J Adv Res. 2022;10(8):1040–1049.

18. Pandav CR, Deshmukh VL, Gadappa S, Kandalkar P. Clinical study of fetomaternal outcome of post-dated pregnancy in a tertiary care center. Eur J Mol Clin Med. 2022;9(3):1741–1749.
19. Sarmah H, Borah BK, Roy DK, Ghosh T. Assessment of maternal and perinatal outcome in post-dated pregnancies in a tertiary care center. New Indian J OBGYN. 2022;9(1):99–105.
20. Yousfani NA, Zafar M, Irshad F, Soomro RA, Ahmed A, Wagan F. A cross-sectional comparative study to observe the obstetric complication associated with extreme (<18–>35) maternal age. J Pharm Res Int. 2022;34(39B):1–10.
21. Auma JH. Comparison of pregnancy outcomes between early/full term and late/post-term gestations at Kenyatta National Hospital between 2017 and 2019: A comparative cross-sectional study. Doctoral dissertation, University of Nairobi; 2023.
22. Emannuel G, Martin O, Peter OS, Obeagu EI, Daniel K. Factors influencing early neonatal adverse outcomes among women with HIV with post-dated pregnancies delivering at Kampala International University Teaching Hospital, Uganda. Asian J Pregnancy Childbirth. 2023;6(1):203–211.
23. Sadaf R, Shamsher S, Tabassum S, Kishwar N, Rauf B, Parveen Z. Study of postdatism with respect to fetomaternal outcome at a tertiary care hospital. J Gandhara Med Dent Sci. 2023;10(2):17–20.
24. Saurabh S. A study to assess the maternal and perinatal outcome of post-dated pregnancy at a tertiary care institution of Eastern India. Int J Reprod Contracept Obstet Gynecol. 2023;12(12):3469–3474.

25. Gaikwad V, Bhadoriya A, Gaikwad S. A comparative study of fetal and maternal outcomes in registered and unregistered antenatal cases in a tertiary care center. Cureus. 2024;16(8):e66066.
26. Jahan E, Alam R, Ara A, Rahman N. Cesarean section in post-dated pregnancies: Evidence from a hospital-based cross-sectional study in Bangladesh. Int J Sci Res Arch. 2024;11(2):1675–1682.
27. Mane SM, Aghav PA, Karad SD, Kharde AL. Maternal and fetal outcome of post-dated pregnancy: A cross-sectional study. Int J Sci Res Arch. 2024;13(1):227–233.
28. Masembe S, Migisha R, Turyasingura G, Aheisibwe H, Nzabandora E, Lule JC. Adverse maternal outcomes and associated factors among mothers of advanced age delivering at a tertiary hospital, southwestern Uganda: A cross-sectional study. BMC Pregnancy Childbirth. 2024;24(1):348.
29. American College of Obstetricians and Gynecologists. Practice Bulletin No. 146: Management of Late-Term and Post-term Pregnancies. Obstet Gynecol. 2019;134(3):e122–e136.
30. American College of Obstetricians and Gynecologists. ACOG Committee Opinion No. 818: Delayed Umbilical Cord Clamping After Birth. Obstet Gynecol. 2020;136(6):e100–e106.
31. Crowley P. Intervention for post-term pregnancy (Review). Cochrane Database Syst Rev. 2000;(2):CD000170.
32. Laughon SK, Zhang J, Grewal J, Sundaram R, Beaver J, Reddy UM. Induction of labor in a contemporary obstetric cohort. Am J Obstet Gynecol. 2012;206(6):486.e1–486.e9.

33. Klein L, Sciscione A, Colmorgen G. Prognosis of late-term pregnancies complicated by abnormal antenatal testing. J Matern Fetal Neonatal Med. 2011;24(7):926–930.
34. Salomon LJ, Alfirevic Z, Da Silva Costa F, Deter RL, Figueras F, Ghi T. ISUOG Practice Guidelines: Ultrasound assessment of fetal biometry and growth. Ultrasound Obstet Gynecol. 2019;53(6):715–723.
35. Arrowsmith S, Wray S, Quenby S. Maternal obesity and labour complications following induction of labour in prolonged pregnancy. BJOG. 2011;118(5):578–588.
36. Divon MY, Ferber A, Nisell H, Westgren M, Hanhisen M. Male gender predisposes to prolongation of pregnancy. Am J Obstet Gynecol. 2008;198(2):163.e1–163.e5.
37. Caughey AB, Sundaram V, Kaimal AJ, Gienger A, Cheng YW, McDonald KM. Systematic review: Elective induction of labor versus expectant management of pregnancy. Ann Intern Med. 2009;151(4):252–263.
38. Henriksen T. The macrosomic fetus: A challenge in current obstetrics. Acta Obstet Gynecol Scand. 2008;87(2):134–145.
39. Delaney M, Roggensack A, Leduc D, Ballermann C, Biringer A, Cooper S. Guidelines for the management of pregnancy at 41+0 to 42+0 weeks. J Obstet Gynaecol Can. 2008;30(9):800–810.
40. Anderson GM, Lomas J, Enkin MW. Mode of delivery and pregnancy outcomes in post-term gestation: Induction or expectant management? Obstet Gynecol. 1994;83(2):211–216.

41. Neal JL, Lowe NK. Physiologic partograph to improve birth safety and outcomes among low-risk, nulliparous women with spontaneous labor onset. Med Hypotheses. 2012;78(3):319–326.
42. Mounsey A, Wilcox L. Management of post-term pregnancy. Am Fam Physician. 2014;90(1):34–40.
43. Kingdom JC, Kaufmann P. Oxygen and placental vascular development. Adv Exp Med Biol. 1997;430:259–274.
44. Caughey AB, Bishop JT, Matera DL, Harris HW. Neonatal outcomes in term, post-term, and late-term pregnancies. Clin Obstet Gynecol. 2016;59(1):151–162.
45. Miller CM, McPherson JA. Anxiety in late-term pregnancy: A prospective cohort study. BMC Pregnancy Childbirth. 2019;19(1):35.
46. Vayssiere C, Haumonte JB, Chantry A, Coatleven F, Debord MP, Gomez C. Prolonged and post-term pregnancies: Guidelines for clinical practice from the French College of Gynaecologists and Obstetricians. Eur J Obstet Gynecol Reprod Biol. 2013;169(1):10–16.
47. Thornton JG, Hornbuckle J. Fetal scalp blood sampling for fetal well-being assessment in labour. Cochrane Database Syst Rev. 2003;(3):CD000127.
48. Phelan JP, Smith CV, Broussard P, Small M. Amniotic fluid volume assessment with the four-quadrant technique at 36-42 weeks' gestation. J Reprod Med. 1987;32(7):540–542.
49. Wuntakal R, Hollingworth T. Maternal obesity: A challenge for our future. J Obstet Gynaecol. 2009;29(7):541–543.
50. Kalish RB, Thaler HT, Chasen ST, Gupta M, Berman SJ, Rosenwaks Z. First- and second-trimester ultrasound assessment of gestational age. Am J Obstet Gynecol. 2004;191(3):975–978.

51. Miller DA, Rabello YA. Nonstress testing, contraction stress testing, and biophysical profiling. Obstet Gynecol Clin North Am. 2019;46(2):295–304.
52. Neal JL, Lamp JM, Lowe NK, Gillespie SL, Ryan SL. Outcomes of nulliparous women with spontaneous labor onset admitted to hospital in early versus active labor. J Midwifery Womens Health. 2014;59(1):28–34.
53. Freeman RK, Garite TJ, Nageotte MP. Fetal heart rate monitoring. Lippincott Williams & Wilkins; 2003.

KAHERs JNMC
BELAGAVI

From,

REG. NO. BJ0122011

POSTGRADUATE,
DEPARTMENT OF OBSTETRICS AND GYNAECOLOGY
J. N. MEDICAL COLLEGE, BELAGAVI.

TO,

THE CHAIRMAN,
INSTITUTIONAL ETHICAL COMMITTEE
FOR HUMAN SUBJECT RESEARCH,
J.N. MEDICAL COLLEGE, BELAGAVI.

(Through proper channel)

Sub: Request for waiver of informed consent for my dissertation

Respected sir.

I, **REG. NO. BJ0122011** ,Post graduate in the department of obstetrics and gynaecology , hereby inform you that the subject chosen for my dissertation is :**Maternal and fetal outcome in postdated pregnancy in a teritary care hospital - cross sectional observational study.**

:, department of obstetrics and gynaecology, J.N. Medical college. BELAGAVI. The data required for the study will be collected from the medical records of the cases according to inclusion and exclusion criteria. The study does not involve any interaction with the cases and no identifiable information will be collected. Patient's name and identity will not be revealed. The waiver of consent will not adversely affect the rights and welfare of the subjects. Hence we request you to consider this for waiver of consent.

Thanking you,

Yours faithfully,

REG. NO. BJ0122011

Department of obstetrics and gynaecology,
J.N. MEDICAL COLLEGE, BELAGAVI.

ANNEXURE I:

SCREENING FORM

TITLE- MATERNAL AND FETAL OUTCOMES IN POSTDATED PREGNANCY IN A TERTIARY. CARE HOSPITAL-A ONE YEAR CROSS SECTIONAL STUDY.

Screening form no:

Date of Screening:

Name:

Age:

IP no:

Address:

Phone Number:

Obstetric score:

LMP –

EDD by LMP -

Dating scan (reliable scan with CRL)– yes/no CEDD-yes/no

If yes EDD-

Period of gestation(weeks+days):

Previous Normal delivery / LSCS Patient enrolled – yes / no

If yes enrolment number -

PROFORMA

TITLE- MATERNAL AND FETAL OUTCOMES IN POSTDATED PREGNANCY IN A TERTIARY. CARE HOSPITAL-A ONE YEAR CROSS SECTIONAL STUDY.

ENROLLMENT NO-

AGE: **IP NO:**

DOA: **DOD:**

OCCUPATION:

ADDRESS:

REGISTERED CASE / UNREGISTERED CASE

PHONE NUMBER:

SOCIO-ECONOMICS : Low / Middle / High

PRESENTING COMPLAINTS AT THE TIME OF ADMISSION:

OBSTETRIC SCORE:

G **P** **L** **A**

LMP (DD/MM/YY):

EDD(DD/MM/YY):

Period of Gestation(weeks+days):

EDD As per Dating scan:

MENSTRUAL HISTORY :

Cycles – Regular/Irregular

Flow – Moderate/Excessive

LOW RISK /HIGH RISK (if high risk factor identified)

Hypertension yes/no

Pre-eclampsia yes /no

If yes mild / severe

Eclampsia yes/no

Antepartum Haemorrhage yes/no

If yes Placenta praevia/ Abruptio placenta

Jaundice in pregnancy yes/no

Rh Negative pregnancy yes/no

GDM yes/no

Macrosomia yes/no

PROM yes/no

Thyroid abnormality yes/no

FGR yes/no

Heart disease yes/no

Anaemia yes/no

HIV Reactive / Non-Reactive

HbsAg Reactive / Non-Reactive

VDRL Reactive / Non-Reactive

Others:

GENERAL PHYSICAL EXAMINATION:

Built:

General Condition:

Height: **Weight:**

BMI:

Pulse: **Blood pressure:**

Temperature:

Pallor :

Icterus :

Edema:

Breast :

Thyroid :

Spine :

SYSTEMIC EXAMINATION:

Respiratory system:

Cardiovascular examination:

Per abdomen examination:

Per Speculum/Per Vaginal examination:

INTRAPARTUM HISTORY:

Induced Labor/Spontaneous labor

If induction – Type of induction –

Augmentation of labour- Yes/No

Intrapartum status- Uncomplicated / Complicated

If Complicated – Complication noted:

Abruptio Placenta yes/no

Scar Dehiscence/Uterine Rupture yes/no

Cord Prolapse yes/no

Meconium-Stained Liquor yes/no

CPD yes/no

DTA yes/no

Maternal Hypotension yes/no

Maternal Hypertension yes/no

Others:

1st stage of labour duration:

2nd stage of labour duration:

Fetal distress Detected in :

Latent phase of Labour / Active phase of Labour

1st stage of Labour / 2nd stage of labour

Type of delivery:

Full Term Normal Delivery / Full Term Ventose Delivery / Full Term Forceps Delivery / Full Term Emergency LSCS

If Emergency LSCS:

Indication for LSCS –

DETAILS OF DELIVERY:

Maternal complications if any :

Live birth: yes/no

Cried at birth: yes/no

Resuscitation measures taken for baby yes/no

If yes

Bag & mask ventilation yes/no

O2 inhalation yes/no

PPV yes/no

Intubation yes/no

Inotropes yes/no

Others:

APGAR score:

1'

5'

Baby gender: Male / Female

Baby weight at birth:

NICU ADMISSION YES/NO

If Yes Reason:

Duration of NICU admission:

Duration of Hospital stay for baby:

Condition of baby at discharge: Healthy / AMA / Expired

Morbidity Noted:

UMBILICAL ARTERY CORD BLOOD GAS ANALYSIS:

pH:

pCO2:

pO2:

HCO3:

SIGNATURE AND NAME OF INVESTIGATOR

S.NO	ENROLMENT NUMBER	AGE	R/UR CASE	SOCIO ECONOMIC STATUS	OBSTETRIC SCORE	POG	LOW/HIGH RISK	HEIGHT	WEIGHT	BMI	SPONTANEOUS/INDUCED LABOUR	TYPE OF INDUCTION	INTRAPARTUM COMPLICATIONS	DURATION OF 1ST STAGE	DURATION OF 2ND STAGE	FETAL DISTRESS AT WHAT STAGE	MODE OF DELIVERY	INDICATION FOR LSCS	APGAR 1'MIN	APGAR 5'MIN	RESUSCITATION MEASURES	BABY WEIGHT	NICU ADMISSION	DURATION OF HOSPITAL STAY	CONDITION OF BABY AT DISCHARGE	MATERNAL COMPLICATIONS	RISK FACTORS	BLOOD GAS ANALYSIS - BABY
1	ER001	34Y	R	LOW	PRIMIGRAVIDA	40WEEKS 2DAYS	LOW RISK	160CM	79KG	30.85	INDUCED	1 CP	NO	16HRS	22MIN	NO	VAGINAL	NA	7	9	NO	2.8KG	NO	5DAYS	HEALTHY	ATONIC PPH {600ML}	NO	ABG - NOT SENT
2	ER002	27Y	R	LOW	PRIMIGRAVIDA		HIGH RISK	146CM	59KG	27.6	AUGMENTED	6CT'S	THICK MSL	19HRS	NA	NO	LSCS	THICK MSL(4CM)	7	8	NO	3.1KG	NO	7DAYS	HEALTHY	NO	RHD	PH-7.32
3	ER003	20Y	R	LOW	PRIMIGRAVIDA	40WEEKS 1DAY	LOW RISK	150CM	58KG	25.7	SPONTANEOUS	NA	CPD	UNKNOWN	UNKNOWN	NO	LSCS	2ND STAGE ARREST	7	8	NO	2.8KG	NO	5DAYS	HEALTHY	NO	NO	ABG - NOT SENT
4	ER004	24Y	R	LOW	PRIMIGRAVIDA	40WEEKS 1DAY	LOW RISK	146CM	72KG	33.7	AUGMENTED	5CT'S	THICK MSL	21HRS 15MIN	NA	NO	LSCS	THICK MSL	7	9	NO	3.7KG	NO	6DAYS	HEALTHY	NO	NO	PH-7.32
5	ER005	22Y	R	LOW	PRIMIGRAVIDA	40WEEKS 6DAYS	LOW RISK	150CM	40KG	17.7	INDUCED	4CT'S	NO	NA	NA	NO	LSCS	CDMR[INTA OP MSL]	9	10	NO	2.33KG	NO	5DAYS	HEALTHY	NO	NO	ABG - NOT SENT
6	ER006	23Y	R	LOW	MULTIGRAVIDA	40WEEKS 1DAY	LOW RISK	150CM	60KG	26.6	SPONTANEOUS	NO	THICK MSL	NA	NA	YES	LSCS	FETAL DISTRESS	6	7	YES	1.8KG	YES[RESPIRATORY DISTRESS	30DAYS	HEALTHY	SSI F/B SECONDARY SUTURING	NO	PH-7.25
7	ER007	23Y	R	MIDDLE	MULTIGRAVIDA	40WEEKS 1DAY	LOW RISK	153CM	52.6KG	22.4	SPONTANEOUS	NA	NO	14HRS 15MIN	18MIN	NO	VAGINAL	NA	7	9	NO	2.9KG	NO	5DAYS	HEALTHY	NO	NO	ABG - NOT SENT
8	ER008	28Y	R	MIDDLE	MULTIGRAVIDA	40WEEKS 1DAY	LOW RISK	152CM	55KG	23.8	SPONTANEOUS	NA	THICK MSL	10HRS	NA	NO	LSCS	THICK MSL	8	9	NO	2.52KG	NO	4DAYS	HEALTHY	NO	NO	ABG - NOT SENT
9	ER009	25Y	R	LOW	MULTIGRAVIDA	40WEEKS 1DAY	HIGH RISK	156CM	55KG	22.6	INDUCED	2CP'S	NO	26HRS	10MIN	NO	VAGINAL	NA	9	10	NO	3.45KG	NO	5DAYS	HEALTHY	NO	ANEMIA	ABG - NOT SENT
10	ER010	33Y	UR	LOW	MULTIGRAVIDA	40WEEKS 1DAY	LOW RISK	150CM	58KG	25.7	INDUCED	1CT	NO	16HRS	32MIN	NO	VENTOUSE	NA	7	9	NO	3.2KG	YES(HYPERBILIRUBINEMIA)	6DAYS	HEALTHY	NO	NO	ABG - NOT SENT
11	ER011	30Y	UR	LOW	MULTIGRAVIDA	40WEEKS 2DAYS	LOW RISK	160CM	66KG	25.7	SPONTANEOUS	NA	NO	12HRS 20MI	10MIN	NO	VAGINAL	NA	8	9	NO	3.3KG	NO	4DAYS	HEALTHY	NO	NO	ABG - NOT SENT
12	ER012	23Y	UR	LOW	PRIMIGRAVIDA	40WEEKS 4DAYS	LOW RISK	156CM	57KG	23.4	SPONTANEOUS	NA	CPD	9HRS 25MIN	NA	NO	LSCS	CPD	8	9	NO	3.5KG	NO	7DAYS	HEALTHY	NO	NO	ABG - NOT SENT
13	ER013	29Y	R	LOW	MULTIGRAVIDA	41WEEKS 1DAY	LOW RISK	156CM	55KG	22.6	SPONTANEOUS	NA	NO	9HRS	19MIN	NO	VAGINAL	NA	8	9	NO	3KG	YES(HYPERBILIRUBINEMIA)	4DAYS	HEALTHY	NO	NO	ABG - NOT SENT
14	ER014	27Y	R	LOW	MULTIGRAVIDA	40WEEKS 1DAY	LOW RISK	152CM	56KG	24.2	SPONTANEOUS	NA	NO	6HRS 30MIN	14MIN	NO	VAGINAL	NA	8	10	NO	2.6KG	NO	3DAYS	HEALTHY	NO	NO	ABG - NOT SENT
15	ER015	28Y	R	LOW	PRIMIGRAVIDA	40WEEKS 2DAYS	LOW RISK	152CM	60KG	25.9	INDUCED	1 CP	THICK MSL	11HRS 15MIN	NA	NO	LSCS	THICK MSL	8	9	NO	2.7KG	NO	7DAYS	HEALTHY	NO	NO	PH-7.26
16	ER016	23Y	R	LOW	PRIMIGRAVIDA	40WEEKS 1DAY	LOW RISK	150CM	57KG	25.3	SPONTANEOUS	NA	THIN MSL	7HRS 30MIN	4MIN	NO	VENTOUSE	NA	8	9	NO	2.7KG	YES(HYPERBILIRUBINEMIA)	6DAYS	HEALTHY	NO	NO	ABG - NOT SENT
17	ER017	23Y	R	LOW	MULTIGRAVIDA	40WEEKS 2DAYS	LOW RISK	152CM	60KG	25.9	INDUCED	1CP	NO	8HRS 30MIN	9MIN	NO	VAGINAL	NA	7	9	NO	2.8KG	NO	9DAYS	HEALTHY	4TH DEGREE PERINEAL TEAR - REPAIRED	NO	ABG - NOT SENT
18	ER018	30Y	UR	LOW	PRIMIGRAVIDA	40WEEKS 1DAY	LOW RISK	157CM	68KG	27.5	INDUCED	5CT'S	OLIGOHYDRAMNIOS	30HRS	NA	NO	LSCS	OLIGOHYDRAMNIOS	8	9	NO	2.4KG	NO	5DAYS	HEALTHY	NO	NO	ABG - NOT SENT
19	ER019	20Y	UR	LOW	PRIMIGRAVIDA	41WEEKS	HIGH RISK	140CM	44KG	22.4	NA	NA	NO	NA	NA	NO	LSCS	OLIGOHYDRAMNIOS	7	9	NO	2.6KG	NO	4DAYS	HEALTHY	NO	HYPOTHYROIDISM	ABG - NOT SENT
20	ER020	21Y	R	LOW	PRIMIGRAVIDA	40WEEKS 4DAYS	LOW RISK	148CM	51KG	23.2	INDUCED	2CP'S	NO	18HRS	NA	YES	LSCS	FETAL DISTRESS	7	8	NO	3.1KG	NO	6DAYS	HEALTHY	NO	NO	PH-7.30
21	ER021	31Y	R	LOW	MULTIGRAVIDA	40WEEKS 1DAY	LOW RISK	150CM	57KG	25.3	INDUCED	2CP'S	NO	12HRS 30MIN	11MIN	NO	VAGINAL	NA	8	9	NO	3.5KG	NO	4DAYS	HEALTHY	NO	NO	ABG - NOT SENT
22	ER022	24Y	R	LOW	PRIMIGRAVIDA	40WEEKS 1DAY	HIGH RISK	152CM	54KG	23.3	INDUCED	2CP'S	NO	13HRS	NA	NO	LSCS	OLIGOHYDRAMNIOS	7	9	NO	3.2KG	NO	5DAYS	HEALTHY	NO	RH NEGATIVE	ABG - NOT SENT
23	ER023	26Y	R	LOW	PRIMIGRAVIDA	40WEEKS 2DAYS	LOW RISK	150CM	58KG	25.7	SPONTANEOUS	NA	NO	1HR 25MIN	16MIN	NO	VAGINAL	NA	8	9	NO	2.9KG	NO	3DAYS	HEALTHY	NO	NO	ABG - NOT SENT
24	ER024	20Y	R	LOW	PRIMIGRAVIDA	40WEEKS 2DAYS	LOW RISK	160CM	66KG	25.7	INDUCED	3CP'S-6CT'S	NO	62HRS	NA	NO	LSCS	FAILED INDUCTION	7	9	NO	2.9KG	NO	10DAYS	HEALTHY	YES-POST OP FEVER	NO	ABG - NOT SENT
25	ER025	22Y	UR	LOW	MULTIGRAVIDA	41WEEKS 4DAYS	LOW RISK	152CM	46KG	19.9	INDUCED	2CP'S	NO	14HRS	17MIN	NO	VAGINAL	NA	8	9	NO	2.9KG	NO	6DAYS	HEALTHY	NO	NO	ABG - NOT SENT
26	ER026	31Y	R	MIDDLE	PRIMIGRAVIDA	40WEEKS 4DAYS	HIGH RISK	166CM	106KG	38.4	AUGMENTED	1CP	CPD	12HRS	NA	NO	LSCS	CPD	8	9	NO	3.4KG	NO	5DAYS	HEALTHY	NO	OBESITY	ABG - NOT SENT
27	ER027	23Y	R	LOW	PRIMIGRAVIDA	40WEEKS 2DAYS	LOW RISK	150CM	49.4KG	21.9	INDUCED	2CP'S	NO	27HRS	59MIN	NO	VENTOUSE	NA	7	9	NO	2.9KG	NO	4DAYS	HEALTHY	NO	NO	ABG - NOT SENT
28	ER028	24Y	R	LOW	PRIMIGRAVIDA	40WEEKS 1DAY	LOW RISK	151CM	57.8KG	25.3	INDUCED	2CP'S	THIN MSL	23HRS 15MIN	23MIN	NO	VAGINAL	NA	8	9	NO	2.8KG	NO	4DAYS	HEALTHY	NO	NO	ABG - NOT SENT
29	ER029	23Y	UR	LOW	MULTIGRAVIDA	40WEEKS 5DAYS	LOW RISK	156CM	62KG	25.4	SPONTANEOUS	NA	NO	NA	2MIN	NO	VAGINAL	NA	7	9	NO	3.1KG	NO	3DAYS	HEALTHY	NO	NO	ABG - NOT SENT
30	ER030	32Y	UR	MIDDLE	MULTIGRAVIDA	40WEEKS 4DAYS	LOW RISK	142CM	40KG	19.8	INDUCED	2CP'S	NO	16HRS	42MIN	NO	VENTOUSE	NA	7	9	YES	2.6KG	YES[RESPIRATORY DISTRESS	5DAYS	HEALTHY	NO	NO	ABG - NOT SENT
31	ER031	38Y	R	LOW	MULTIGRAVIDA	40WEEKS 4DAYS	LOW RISK	155CM	47.3KG	19.6	INDUCED	2CP'S	NO	15HRS 45MIN	16MIN	NO	VAGINAL	NA	7	9	NO	2.6KG	NO	5DAYS	HEALTHY	NO	NO	ABG - NOT SENT
32	ER032	32Y	R	LOW	PRIMIGRAVIDA	40WEEKS 1DAY	HIGH RISK	148CM	54KG	24.6	INDUCED	MIFEGEST - 1CP	DTA	16HRS	1HR	NO	LSCS	DTA	7	9	NO	2.9KG	YES(HYPERBILIRUBINEMIA)	6DAYS	HEALTHY	NO	GHTN	ABG - NOT SENT
33	ER033	32Y	UR	LOW	MULTIGRAVIDA	40WEEKS 3DAYS	LOW RISK	150CM	58KG	25.7	AUGMENTED	2CP'S	NO	23HRS	29MIN	NO	VAGINAL	NA	7	9	NO	2.8KG	NO	4DAYS	HEALTHY	NO	NO	ABG - NOT SENT
34	ER034	23Y	R	LOW	PRIMIGRAVIDA	40WEEKS 2DAYS	HIGH RISK	150CM	60KG	26.6	AUGMENTED	2CT'S	CPD	21HRS 30MIN	NA	NO	LSCS	CPD	8	9	NO	2.7KG	NO	6DAYS	HEALTHY	NO	FGR	ABG - NOT SENT
35	ER035	21Y	R	LOW	MULTIGRAVIDA	41WEEKS 2DAYS	LOW RISK	161CM	76KG	29.3	AUGMENTED	3CP'S	CPD	23HRS 11MIN	NA	NO	LSCS	CPD	7	9	NO	3.7KG	NO	5DAYS	HEALTHY	NO	NO	ABG - NOT SENT
36	ER036	27Y	R	LOW	MULTIGRAVIDA	40WEEKS 1DAY	LOW RISK	150CM	60KG	26.6	AUGMENTED	1CP	NO	4HRS 45MIN	30MIN	NO	VAGINAL	NA	9	10	NO	2.7KG	NO	3DAYS	HEALTHY	NO	NO	ABG - NOT SENT
37	ER037	30Y	R	LOW	MULTIGRAVIDA	40WEEKS 2DAYS	HIGH RISK	150CM	60KG	26.6	INDUCED	3CP'S-3CT'S	NO	37HRS 30-MIN	NA	YES	LSCS	FETAL DISTRESS	7	8	NO	2.9KG	NO	6DAYS	HEALTHY	NO	HYPOTHYROIDISM	PH-7.33
38	ER038	25Y	R	LOW	MULTIGRAVIDA	40WEEKS 3DAYS	LOW RISK	150CM	64KG	28.4	AUGMENTED	1CP	THIN MSL	6HRS 30MIN	NA	YES	LSCS	FETAL DISTRESS	7	9	NO	3.2KG	NO	5DAYS	HEALTHY	NO	NO	PH-7.37
39	ER039	30Y	R	LOW	PRIMIGRAVIDA	40WEEKS 1DAY	LOW RISK	160CM	70KG	27.3	INDUCED	3CP'S	NO	12HRS	NA	NO	LSCS	NON PROGRES OF LABOUR	9	10	NO	4KG	NO	5DAYS	HEALTHY	NO	NO	ABG - NOT SENT
40	ER040	28Y	R	LOW	PRIMIGRAVIDA	41WEEKS 3DAYS	LOW RISK	153CM	50KG	21.3	INDUCED	2CP'S	NO	10HRS	30MIN	NO	VAGINAL	NA	7	9	NO	2.6KG	NO	3DAYS	HEALTHY	NO	NO	ABG - NOT SENT
41	ER041	25Y	R	LOW	PRIMIGRAVIDA	40WEEKS 5DAYS	HIGH RISK	151CM	62.3KG	27.3	AUGMENTED	1CP	NO	26HRS	NA	NO	LSCS	NON PROGRES OF LABOUR	8	9	NO	2.8KG	NO	6DAYS	HEALTHY	NO	GHTN	ABG - NOT SENT
42	ER042	28Y	R	LOW	PRIMIGRAVIDA	40WEEKS 1DAY	HIGH RISK	158CM	55KG	22	AUGMENTED	3CP'S	NO	18HRS 15MIN	NA	NO	LSCS	OLIGOHYDRAMNIOS	8	9	NO	3.56KG	NO	7DAYS	HEALTHY	NO	RH NEGATIVE	ABG - NOT SENT
43	ER043	24Y	R	LOW	PRIMIGRAVIDA	40WEEKS 1DAY	HIGH RISK	151CM	75KG	32.8	AUGMENTED	1CP	NO	15HRS	1HR 16MIN	NO	VENTOUSE	NA	6	9	YES	2.7KG	YES(HYPERBILIRUBINEMIA)	6DAYS	HEALTHY	NO	HYPOTHYROIDISM	ABG - NOT SENT
44	ER044	25Y	R	LOW	PRIMIGRAVIDA	40WEEKS 1DAY	HIGH RISK	150CM	61.3	27.2	INDUCED	MIFEGEST-3CP'S	NO	36HRS	NA	NO	LSCS	NON PROGRES OF LABOUR	8	9	NO	3.7KG	NO	6DAYS	HEALTHY	NO	RH NEGATIVE	ABG - NOT SENT
45	ER045	19Y	UR	LOW	PRIMIGRAVIDA	40WEEKS 4DAYS	LOW RISK	152CM	52KG	22.5	SPONTANEOUS	NA	NO	12HRS	17MIN	NO	VAGINAL	NA	8	9	NO	3KG	NO	5DAYS	HEALTHY	ATONIC PPH	NO	ABG - NOT SENT
46	ER046	25Y	R	LOW	PRIMIGRAVIDA	40WEEKS 4DAYS	HIGH RISK	152CM	64KG	27.9	INDUCED	2CT'S	NO	12HRS	NA	NO	LSCS	OLIGOHYDRAMNIOS	8	9	NO	2.6KG	NO	5DAYS	HEALTHY	NO	RH NEGATIVE	ABG - NOT SENT
47	ER047	23Y	R	LOW	PRIMIGRAVIDA	40WEEKS 4DAYS	LOW RISK	152CM	48.7KG	21	AUGMENTED	2CP'S	NO	13HRS	1HR 3MIN	YES	VENTOUSE	NA	7	9	NO	2.7KG	YES(HYPERBILIRUBINEMIA)	3DAYS	HEALTHY	NO	NO	ABG - NOT SENT
48	ER048	25Y	R	LOW	MULTIGRAVIDA	40WEEKS 2DAYS	LOW RISK	152CM	49KG	21	SPONTANEOUS	NA	NO	30MIN	NA	YES	LSCS	FETAL DISTRESS	8	9	NO	2.7KG	NO	5DAYS	HEALTHY	NO	NO	ABG - NOT SENT
49	ER049	26Y	R	LOW	MULTIGRAVIDA	40WEEKS 1DAY	LOW RISK	155CM	75KG	31.2	INDUCED	2CP'S	NO	9HRS 20MIN	10MIN	NO	VAGINAL	NA	8	9	NO	2.7KG	NO	4DAYS	HEALTHY	NO	NO	ABG - NOT SENT
50	ER050	26Y	UR	LOW	MULTIGRAVIDA	40WEEKS 4DAYS	HIGH RISK	150CM	64KG	28.4	SPONTANEOUS	NA	THIN MSL	2HRS	22MIN	NO	VAGINAL	NA	7	8	NO	1.9KG	YES(LBW)	6DAYS	HEALTHY	NO	GHTN	ABG - NOT SENT
51	ER051	31Y	UR	LOW	PRIMIGRAVIDA	40WEEKS 5DAYS	LOW RISK	151CM	57.8KG	25.3	SPONTANEOUS	NA	THIN MSL	16HRS 45MIn	18MIN	NO	VENTOUSE	NA	5	8	YES	2.9KG	NO	5DAYS	HEALTHY	NO	NO	ABG - NOT SENT
52	ER052	27Y	R	LOW	MULTIGRAVIDA	40WEEKS 4DAYS	LOW RISK	150CM	63KG	28	SPONTANEOUS	NA	NO	1HR 30MIN	2MIN	NO	VAGINAL	NA	6	8	NO	3.1KG	YES(HYPERBILIRUBINEMIA)	4DAYS	HEALTHY	NO	NO	ABG - NOT SENT
53	ER053	23Y	R	LOW	PRIMIGRAVIDA	40WEEKS 2DAYS	LOW RISK	158CM	59KG	23.6	INDUCED	3CP'S-1CT	CPD	12HRS 30MIN	NA	NO	LSCS	CPD	8	9	NO	3.2KG	NO	8DAYS	HEALTHY	NO	NO	ABG - NOT SENT
54	ER054	32Y	UR	LOW	MULTIGRAVIDA	40WEEKS 3DAYS	LOW RISK	150CM	58KG	25.7	NA	NA	NA	NA	NA	NO	LSCS	CORD PRESENTATION	8	9	NO	3KG	NO	6DAYS	HEALTHY	NO	NO	ABG - NOT SENT
55	ER055	28Y	R	LOW	PRIMIGRAVIDA	40WEEKS 2DAYS	LOW RISK	158CM	58KG	23.2	NA	NA	NA	NA	NA	NO	LSCS	ANAMNIOS	8	9	NO	2.3KG	NO	5DAYS	HEALTHY	NO	NO	ABG - NOT SENT
56	ER056	22Y	UR	LOW	PRIMIGRAVIDA	40WEEKS 3DAYS	LOW RISK	150CM	71KG	30.7	INDUCED	3CP'S-1CT	NO	21HRS 30MIN	27MIN	NO	VAGINAL	NA	7	9	NO	2.9KG	NO	3DAYS	HEALTHY	NO	NO	ABG - NOT SENT
57	ER057	21Y	R	LOW	PRIMIGRAVIDA	40WEEKS 1DAY	LOW RISK	166CM	55KG	19.9	AUGMENTED	3CP'S	NO	32HRS 30MIN	24MIN	NO	VAGINAL	NA	7	9	NO	2.3KG	NO	4DAYS	HEALTHY	NO	NO	ABG - NOT SENT

S.NO	ENROLMENT NUMBER	AGE	R/UR CASE	SOCIO ECONOMIC STATUS	OBSTETRIC SCORE	POG	LOW/HIGH RISK	HEIGHT	WEIGHT	BMI	SPONTANEOUS/INDUCED LABOUR	TYPE OF INDUCTION	INTRAPARTUM COMPLICATIONS	DURATION OF 1ST STAGE	DURATION OF 2ND STAGE	FETAL DISTRESS AT WHAT STAGE	MODE OF DELIVERY	INDICATION FOR LSCS	APGAR 1'MIN	APGAR 5'MIN	RESUSCITATION MEASURES	BABY WEIGHT	NICU ADMISSION	DURATION OF HOSPITAL STAY	CONDITION OF BABY AT DISCHARGE	MATERNAL COMPLICATIONS	RISK FACTORS	BLOOD GAS ANALYSIS - BABY
58	ER058	19Y	UR	LOW	PRIMIGRAVIDA	40WEEKS 5DAYS	LOW RISK	150CM	54KG	24	SPONTANEOUS	NA	NO	NA	NA	NO	LSCS	PROM	9	10	NO	2.4KG	NO	4DAYS	HEALTHY	NO	NO	ABG - NOT SENT
59	ER059	22Y	R	LOW	MULTIGRAVIDA	40WEEKS 1DAY	LOW RISK	152CM	52KG	22.5	AUGMENTED	2CP'S	NO	23HRS	7MIN	NO	VENTOUSE	NA	7	8	NO	2.7KG	NO	4DAYS	HEALTHY	NO	NO	ABG - NOT SENT
60	ER060	29Y	UR	MIDDLE	PRIMIGRAVIDA	40WEEKS 2DAYS	HIGH RISK	150CM	75KG	33.3	INDUCED	3CP'S	NO	18HRS	NA	NO	LSCS	CDMR	8	9	NO	2.5KG	NO	7DAYS	HEALTHY	NO	HYPOTHYROIDISM	ABG - NOT SENT
61	ER061	21Y	R	LOW	PRIMIGRAVIDA	40WEEKS 3DAYS	LOW RISK	150CM	47KG	20.8	SPONTANEOUS	NA	NO	1HR	30MIN	NO	VAGINAL	NA	8	9	NO	2.2KG	YES(HYPERBILIRUBINEMIA)	4DAYS	HEALTHY	NO	NO	ABG - NOT SENT
62	ER062	21Y	R	LOW	PRIMIGRAVIDA	40WEEKS 3DAYS	LOW RISK	156CM	58KG	23.8	NA	NO	NO	NA	NA	NO	LSCS	ANAMNIOS	8	9	NO	3,2KG	NO	5DAYS	HEALTHY	NO	NO	ABG - NOT SENT
63	ER063	25Y	R	LOW	MULTIGRAVIDA	40WEEKS 2DAYS	LOW RISK	152CM	65KG	28.1	SPONTANEOUS	NA	NO	NA	10MIN	NO	VAGINAL	NA	8	9	NO	2.3KG	NO	3DAYS	HEALTHY	NO	NO	ABG - NOT SENT
64	ER064	20Y	R	LOW	PRIMIGRAVIDA	40WEEKS 3DAYS	LOW RISK	145CM	55KG	26.1	INDUCED	3CP'S-3CT'S	NO	30HRS	NA	NO	LSCS	FAILED INDUCTION	9	10	NO	2.8KG	NO	5DAYS	HEALTHY	NO	NO	ABG - NOT SENT
65	ER065	29Y	R	LOW	MULTIGRAVIDA	40WEEKS 3DAYS	LOW RISK	150CM	55KG	24.4	AUGMENTED	2CP,S-3CT'S	DTA	38HRS 30MIN	1HR 10MIN	NO	LSCS	DTA	7	9	NO	2.9KG	NO	7DAYS	HEALTHY	NO	NO	ABG - NOT SENT
66	ER066	22Y	R	LOW	MULTIGRAVIDA	40WEEKS 1DAY	LOW RISK	156CM	57KG	23.4	SPONTANEOUS	NA	NO	2HRS 30MIN	12MIN	NO	VAGINAL	NA	6	7	YES	3.3KG	YES(HYPERBILIRUBINEMIA)	10DAYS	HEALTHY	AXILLARY LUMP -ADV FOR FNAC	NO	ABG - NOT SENT
67	ER067	26Y	UR	LOW	MULTIGRAVIDA	40WEEKS 1DAY	HIGH RISK	152CM	53KG	22.9	INDUCED	1CP-5CT'S	NO	26HRS	10MIN	NO	VENTOUSE	NA	8	9	NO	2.9KG	NO	6DAYS	HEALTHY	NO	CHD-OPERATED	ABG - NOT SENT
68	ER068	21Y	R	LOW	MULTIGRAVIDA	40WEEKS 1DAY	LOW RISK	150CM	62KG	27.5	AUGMENTED	3CP'S	NO	18HRS	23MIN	NO	VAGINAL	NA	8	10	NO	3.4KG	NO	6DAYS	HEALTHY	NO	NO	ABG - NOT SENT
69	ER069	22Y	UR	LOW	PRIMIGRAVIDA	40WEEKS 2DAYS	LOW RISK	146CM	64KG	30	INDUCED	2CP'S-2CT'S	NO	27HRS 15MIN	14MIN	NO	VAGINAL	NA	8	9	NO	3.25KG	NO	4DAYS	HEALTHY	NO	NO	ABG - NOT SENT
70	ER070	28Y	R	LOW	PRIMIGRAVIDA	40WEEKS 4DAYS	LOW RISK	150CM	66KG	29.3	SPONTANEOUS	NA	NO	29HRS	17MIN	NO	VAGINAL	NA	8	9	NO	2.4KG	NO	4DAYS	HEALTHY	NO	NO	ABG - NOT SENT
71	ER071	25Y	UR	LOW	PRIMIGRAVIDA	40WEEKS 2DAYS	LOW RISK	168CM	76KG	26.9	AUGMENTED	1CT	NO	5HRS 15MIN	NA	NO	LSCS	CDMR	8	9	NO	3.6KG	NO	4DAYS	HEALTHY	NO	NO	ABG - NOT SENT
73	ER072	27Y	R	LOW	MULTIGRAVIDA	40WEEKS 2DAYS	LOW RISK	160CM	64KG	25	AUGMENTED	OXYTOCIN	NO	20HRS 30MIN	35MIN	NO	VAGINAL	NA	8	9	NO	3.2KG	NO	6DAYS	HEALTHY	NO	NO	ABG - NOT SENT
74	ER073	21Y	R	LOW	PRIMIGRAVIDA	40WEEKS 4DAYS	LOW RISK	150CM	54KG	24	AUGMENTED	2CP'S	NO	29HRS	36MIN	NO	VENTOUSE	NA	6	7	YES	2.8KG	YES[RESPIRATORY DISTRESS	5DAYS	HEALTHY	NO	NO	ABG - NOT SENT
75	ER074	27Y	R	LOW	PRIMIGRAVIDA	40WEEKS 3DAYS	LOW RISK	150CM	47KG	20.8	SPONTANEOUS	NO	CPD	22HRS	NA	NO	LSCS	CPD	8	9	NO	2.9KG	NO	11DAYS	HEALTHY	SSI-MEDICAL MANAGEMENT	NO	ABG - NOT SENT
76	ER075	29Y	UR	MIDDLE	PRIMIGRAVIDA	40WEEKS 3DAYS	LOW RISK	150CM	74KG	32.8	INDUCED	2CP'S	NO	8HRS 30MIN	NA	NO	LSCS	CDMR	9	10	NO	3.34KG	YES[AMBIGUOUS GENETALIA]	5DAYS	HEALTHY	NO	NO	ABG - NOT SENT
77	ER076	22Y	R	MIDDLE	MULTIGRAVIDA	40WEEKS 4DAYS	LOW RISK	155CM	60KG	24.9	AUGMENTED	2CP'S	NO	15hrs 30min	28min	NO	VAGINAL	NA	7	9	NO	3.67KG	NO	3DAYS	HEALTHY	NO	NO	ABG - NOT SENT
78	ER077	24Y	R	LOW	PRIMIGRAVIDA	40WEEKS 1DAY	LOW RISK	167CM	74KG	26.5	INDUCED	3CP'S-6CT'S	NO	34HRS	NA	NO	LSCS	FAILED INDUCTION	8	9	NO	2.8KG	NO	8DAYS	HEALTHY	NO	NO	ABG - NOT SENT
79	ER078	21Y	R	LOW	MULTIGRAVIDA	40WEEKS 5DAYS	LOW RISK	150CM	52KG	23.1	SPONTANEOUS	NA	THIN MSL	4HRS 30MIN	19MIN	NO	VAGINAL	NA	9	10	NO	2.8KG	NO	4DAYS	HEALTHY	NO	NO	ABG - NOT SENT
80	ER079	20Y	R	LOW	PRIMIGRAVIDA	40WEEKS 2DAYS	LOW RISK	146CM	51KG	23.9	SPONTANEOUS	NA	CPD	23HRS	NA	NO	LSCS	CPD	8	9	NO	2.7KG	NO	7DAYS	HEALTHY	NO	NO	ABG - NOT SENT
81	ER080	24Y	R	MIDDLE	PRIMIGRAVIDA	40WEEKS 6DAYS	LOW RISK	157CM	68KG	27.5	SPONTANEOUS	NA	NO	NA	NA	NO	LSCS	CDMR	9	10	NO	2.9KG	NO	4DAYS	HEALTHY	NO	NO	ABG - NOT SENT
82	ER081	22Y	R	LOW	PRIMIGRAVIDA	40WEEKS 2DAYS	LOW RISK	148CM	55KG	25.4	SPONTANEOUS	NA	NO	5HRS 30MIN	30MIN	NO	VAGINAL	NA	8	9	NO	2.9KG	NO	5DAYS	HEALTHY	NO	NO	ABG - NOT SENT
83	ER082	24Y	R	LOW	PRIMIGRAVIDA	40WEEKS 1DAY	LOW RISK	158CM	68KG	27.2	INDUCED	3CP'S	THICK MSL	24HRS 30MIN	NA	YES	LSCS	FETAL DISTRESS	7	9	NO	3KG	NO	8DAYS	HEALTHY	NO	NO	ABG - NOT SENT
84	ER083	22Y	R	LOW	PRIMIGRAVIDA	40WEEKS 1DAY	LOW RISK	159CM	69KG	27.2	SPONTANEOUS	NA	NO	21HRS 30MIN	36MIN	NO	VAGINAL	NA	9	10	NO	2.4KG	YES(HYPERBILIRUBINEMIA)	6DAYS	HEALTHY	POST OP ANAEMIA	NO	ABG - NOT SENT
85	ER084	26Y	R	LOW	PRIMIGRAVIDA	40WEEKS 1DAY	LOW RISK	152CM	71KG	30.7	INDUCED	DILAPIN-3CT'S	ABRUPTIO PLACENTA	26HRS	NA	NO	LSCS	ABRUPTIO PLACENTA	9	10	NO	3.3KG	NO	7DAYS	HEALTHY	NO	NO	ABG - NOT SENT
86	ER085	27Y	R	LOW	PRIMIGRAVIDA	40WEEKS 1DAY	LOW RISK	161CM	76KG	29.3	AUGMENTED	2CP'S	NO	13HRS	41MIN	NO	VAGINAL	NA	9	10	NO	2.9KG	NO	5DAYS	HEALTHY	NO	NO	ABG - NOT SENT
87	ER086	29Y	R	LOW	MULTIGRAVIDA	41WEEKS	LOW RISK	160CM	78KG	30.4	SPONTANEOUS	NA	NO	4HRS	45MIN	NO	VAGINAL	NA	8	9	NO	2.9KG	NO	3DAYS	HEALTHY	NO	NO	ABG - NOT SENT
88	ER087	32Y	R	LOW	PRIMIGRAVIDA	40WEEKS 2DAYS	HIGH RISK	157CM	76KG	30.8	NA	NA	NO	NA	NA	NO	LSCS	OLIGOHYDRAMNIOS	8	9	NO	2.2KG	YES(DEHYDRATION)	7DAYS	HEALTHY	NO	HYPOTHYROIDISM	ABG - NOT SENT
89	ER088	24Y	R	LOW	PRIMIGRAVIDA	40WEEKS 1DAY	LOW RISK	150CM	54KG	24	INDUCED	1CP	NO	8HRS	NA	YES	LSCS	FETAL DISTRESS	8	9	NO	2.3KG	NO	6DAYS	HEALTHY	NO	NO	PH-7.3O
90	ER089	24Y	R	LOW	PRIMIGRAVIDA	41WEEKS 1 DAY	HIGH RISK	160CM	70KG	27.3	SPONTANEOUS	NA	NO	NA	NA	NO	LSCS	SEVERE PE	8	9	NO	3.3KG	NO	9DAYS	HEALTHY	UNCONTROLLED BP	PREECLAMPSIA	ABG - NOT SENT
91	ER090	21Y	R	LOW	PRIMIGRAVIDA	40WEEKS 1DAY	LOW RISK	150CM	76KG	33.7	SPONTANEOUS	NA	NO	NA	NA	NO	LSCS	OLIGOHYDRAMNIOS	8	9	NO	3.5KG	YES(HYPERBILIRUBINEMIA)	6DAYS	HEALTHY	NO	NO	ABG - NOT SENT
92	ER091	22Y	UR	LOW	PRIMIGRAVIDA	40WEEKS 6DAYS	LOW RISK	154CM	80KG	33.7	INDUCED	3CP'S-1CT	DTA	32HRS 30MIN	2HRS	NO	LSCS	DTA	8	9	NO	3.1KG	YES(HYPERBILIRUBINEMIA)	8DAYS	HEALTHY	NO	NO	ABG - NOT SENT
93	ER092	19Y	UR	LOW	PRIMIGRAVIDA	40WEEKS 2DAYS	HIGH RISK	150CM	60KG	26.6	SPONTANEOUS	NA	NO	4HRS 25MIN	22MIN	NO	VENTOUSE	NA	8	9	NO	3.5KG	YES(SEIZURES)	6DAYS	HEALTHY	ATONIC PPH	PREECLAMPSIA	ABG - NOT SENT
94	ER093	23Y	R	LOW	PRIMIGRAVIDA	40WEEKS 1DAY	LOW RISK	150CM	60KG	26.6	INDUCED	6CT'S	NO	32HRS 15MIN	32MIN	NO	VAGINAL	NA	8	9	NO	2.9KG	NO	5DAYS	HEALTHY	NO	NO	ABG - NOT SENT
95	ER094	27Y	UR	MIDDLE	PRIMIGRAVIDA	40WEEKS 1DAY	LOW RISK	160CM	74KG	28.9	INDUCED	2CP'S	THICK MSL	24HRS 30MIN	NA	NO	LSCS	THICK MSL	7	8	YES	3.5KG	NO	4DAYS	HEALTHY	NO	NO	ABG - NOT SENT
96	ER095	24Y	R	LOW	PRIMIGRAVIDA	40WEEKS 1DAY	LOW RISK	154CM	68KG	28.6	INDUCED	3CP'S	MSL	23HRS 30MIN	NA	YES	LSCS	FETAL DISTRESS	8	9	NO	3.5KG	NO	6DAYS	HEALTHY	NO	NO	PH-7.33
97	ER096	24Y	UR	LOW	MULTIGRAVIDA	40WEEKS 6DAYS	LOW RISK	148CM	56KG	25.5	AUGMENTED	2CP'S	NO	22HRS	19MIN	NO	VAGINAL	NA	9	10	NO	2.46KG	NO	5DAYS	HEALTHY	NO	NO	ABG - NOT SENT
98	ER097	21Y	R	MIDDLE	PRIMIGRAVIDA	40WEEKS 2DAYS	LOW RISK	152CM	70KG	30.2	AUGMENTED	2CP'S	NO	26HRS	15MIN	NO	VAGINAL	NA	7	9	NO	2.7KG	YES(HYPERBILIRUBINEMIA)	5DAYS	HEALTHY	NO	NO	ABG - NOT SENT
99	ER098	19Y	R	LOW	PRIMIGRAVIDA	40WEEKS 1DAY	LOW RISK	149CM	71KG	31.9	AUGMENTED	4CT'S	CPD	14HRS	NA	NO	LSCS	CPD	8	9	NO	3.2KG	YES(HYPERBILIRUBINEMIA)	4DAYS	HEALTHY	NO	NO	ABG - NOT SENT
100	ER099	28Y	R	LOW	MULTIGRAVIDA	40WEEKS 1DAY	LOW RISK	150CM	55KG	24.4	INDUCED	2CP'S	NO	10HRS	18MIN	NO	VAGINAL	NA	7	8	NO	2.5KG	NO	3DAYS	HEALTHY	NO	NO	ABG - NOT SENT
101	ER100	23Y	UR	LOW	PRIMIGRAVIDA	40WEEKS 5DAYS	LOW RISK	152CM	60KG	25.9	INDUCED	MIFEGEST-6CTS	NO	24HRS	NA	NO	LSCS	FAILED INDUCTION	7	8	NO	3.2KG	NO	9DAYS	HEALTHY	NO	NO	ABG - NOT SENT
102	ER101	23Y	R	MIDDLE	MULTIGRAVIDA	40WEEKS 2DAYS	LOW RISK	156CM	56KG	23	SPONTANEOUS	NA	NO	8HRS	20MIN	NO	VAGINAL	NA	8	9	NO	3.7KG	NO	7DAYS	HEALTHY	NO	NO	ABG - NOT SENT
103	ER102	21Y	UR	LOW	PRIMIGRAVIDA	40WEEKS 3DAYS	HIGH RISK	157CM	50KG	20.2	SPONTANEOUS	NA	NO	NA	NA	NO	LSCS	OLIGOHYDRAMNIOS	7	8	NO	3.2KG	NO	6DAYS	HEALTHY	NO	HYPOTHYROIDISM	ABG - NOT SENT
104	ER103	23Y	UR	MIDDLE	PRIMIGRAVIDA	40WEEKS 5DAYS	LOW RISK	155CM	51KG	21.2	NA	NA	NO	NA	NA	NO	LSCS	OLIGOHYDRAMNIOS	9	10	NO	3.1KG	NO	4DAYS	HEALTHY	NO	NO	ABG - NOT SENT
105	ER104	25Y	R	LOW	MULTIGRAVIDA	40WEEKS 3DAYS	LOW RISK	160CM	56KG	21.8	INDUCED	1CP	NO	6HRS	11MIN	NO	VAGINAL	NA	8	9	NO	3.1KG	NO	4DAYS	HEALTHY	NO	NO	ABG - NOT SENT
106	ER105	27Y	R	MIDDLE	PRIMIGRAVIDA	40WEEKS 2DAYS	LOW RISK	150CM	58KG	25.7	INDUCED	2CP'S	NO	8HRS 45MIN	12MIN	NO	VAGINAL	NA	7	8	NO	3.3KG	NO	4DAYS	HEALTHY	NO	NO	ABG - NOT SENT
107	ER106	23Y	UR	LOW	PRIMIGRAVIDA	40WEEKS 1DAY	LOW RISK	176CM	80KG	25.8	SPONTANEOUS	NO	NO	NA	NA	NO	LSCS	OLIGOHYDRAMNIOS	7	8	NO	3KG	NO	10DAYS	HEALTHY	SSI-MEDICAL MANAGEMENT	NO	ABG - NOT SENT
108	ER107	24Y	UR	LOW	MULTIGRAVIDA	41WEEKS 4DAYS	LOW RISK	157CM	50KG	20.2	SPONTANEOUS	NA	NO	9HRS 20MIN	25MIN	NO	VAGINAL	NA	8	9	NO	3.3KG	NO	4DAYS	HEALTHY	NO	NO	ABG - NOT SENT
109	ER108	25Y	R	MIDDLE	MULTIGRAVIDA	40WEEKS 5DAYS	LOW RISK	160CM	71KG	27.7	INDUCED	2CP'S	NO	8HRS 13MIN	13MIN	NO	VAGINAL	NA	7	9	NO	2.9KG	NO	3DAYS	HEALTHY	NO	NO	ABG - NOT SENT
110	ER109	21Y	R	MIDDLE	PRIMIGRAVIDA	40WEEKS 2DAYS	LOW RISK	158CM	81KG	32.4	INDUCED	2CP'S	NO	8HRS	NA	YES	LSCS	FETAL DISTRESS	7	9	NO	3.8KG	NO	7DAYS	HEALTHY	NO	NO	PH-7.18
111	ER110	26Y	UR	LOW	MULTIGRAVIDA	40WEEKS 1DAY	LOW RISK	156CM	52KG	21.3	SPONTANEOUS	NA	NO	11HRS 15MIN	12MIN	NO	VAGINAL	NA	7	9	NO	3.5KG	NO	3DAYS	HEALTHY	NO	NO	ABG - NOT SENT
112	ER111	24Y	UR	MIDDLE	PRIMIGRAVIDA	40WEEKS 3DAYS	LOW RISK	152CM	52KG	22.5	SPONTANEOUS	NA	NA	NA	NA	NO	LSCS	CDMR	8	9	NO	2.7KG	NO	4DAYS	HEALTHY	NO	NO	ABG - NOT SENT
113	ER112	21Y	R	LOW	PRIMIGRAVIDA	40WEEKS 1 DAY	LOW RISK	157CM	69KG	27.9	AUGMENTED	3CTS	NO	10HRS 45MIN	8MIN	NO	VAGINAL	NA	9	10	NO	3.1KG	NO	4DAYS	HEALTHY	NO	NO	ABG - NOT SENT
114	ER113	20Y	UR	MIDDLE	PRIMIGRAVIDA	40 WEEKS 2DAYS	LOW RISK	156CM	70KG	28.7	AUGMENTED	2CT	NO	7HRS 30MIN	NA	NO	LSCS	OLIGOHYDRAMNIOS	8	9	NO	2.9KG	NO	5DAYS	HEALTHY	NO	NO	ABG - NOT SENT
115	ER114	31Y	R	LOW	PRIMIGRAVIDA	40WEEKS 1 DAY	HIGH RISK	164CM	66KG	24.5	INDUCED	MIFEGEST-CT	MSL	24HRS	NA	YES	LSCS	FETAL DISTRESS	8	9	NO	2.5KG	NO	6DAYS	HEALTHY	NO	FGR	PH-7.24

S.NO	ENROLMENT NUMBER	AGE	R/UR CASE	SOCIO ECONOMIC STATUS	OBSTETRIC SCORE	POG	LOW/HIGH RISK	HEIGHT	WEIGHT	BMI	SPONTANEOUS/INDUCED LABOUR	TYPE OF INDUCTION	INTRAPARTUM COMPLICATIONS	DURATION OF 1ST STAGE	DURATION OF 2ND STAGE	FETAL DISTRESS AT WHAT STAGE	MODE OF DELIVERY	INDICATION FOR LSCS	APGAR 1'MIN	APGAR 5'MIN	RESUSCITATION MEASURES	BABY WEIGHT	NICU ADMISSION	DURATION OF HOSPITAL STAY	CONDITION OF BABY AT DISCHARGE	MATERNAL COMPLICATIONS	RISK FACTORS	BLOOD GAS ANALYSIS - BABY
116	ER115	26Y	R	LOW	MULTIGRAVIDA	40WEEKS 5 DAYS	LOW RISK	152CM	59KG	25.5	SPONTANEOUS	NA	NO	30MIN	30MIN	NO	VAGINAL	NA	8	9	NO	3KG	NO	4DAYS	HEALTHY	NO	NO	ABG - NOT SENT
117	ER116	20Y	R	LOW	PRIMIGRAVIDA	41WEEKS	LOW RISK	150CM	51KG	22.6	AUGMENTED	2CP'S	MSL	16HRS	24MIN	NO	VAGINAL	NA	7	9	NO	2.7KG	NO	5DAYS	HEALTHY	NO	NO	ABG - NOT SENT
118	ER117	26Y	R	LOW	MULTIGRAVIDA	40 WEEKS 2DAYS	LOW RISK	150CM	60KG	26.6	AUGMENTED	2CP'S	NO	16HRS 20MIN	4MIN	NO	VAGINAL	NA	8	9	NO	2.8KG	NO	5DAYS	HEALTHY	NO	NO	ABG - NOT SENT
119	ER118	21Y	UR	LOW	PRIMIGRAVIDA	40WEEKS 3DAYS	LOW RISK	152CM	62KG	26.8	INDUCED	DILAPIN	FETAL DISTRESS	16HRS	NA	YES	LSCS	FETAL DISTRESS	7	8	NO	3.2KG	NO	12DAYS	HEALTHY	SSI-MEDICAL MANAGEMENT	NO	PH-7.27
120	ER119	35Y	R	LOW	MULTIGRAVIDA	40WEEKS 3DAYS	LOW RISK	149CM	53KG	23.8	SPONTANEOUS	NA	NO	NA	NA	NO	LSCS	BROW PRESENTATION	6	8	NO	3.3KG	NO	5DAYS	HEALTHY	NO	NO	ABG - NOT SENT
121	ER120	22Y	R	LOW	PRIMIGRAVIDA	40WEEKS 1 DAY	HIGH RISK	147CM	51KG	23.6	INDUCED	2CP'S	NO	21HRS 30MIN	4MIN	NO	VENTOUSE	NA	7	8	NO	2.9KG	NO	5DAYS	HEALTHY	NO	GHTN	ABG - NOT SENT
122	ER121	26Y	R	LOW	PRIMIGRAVIDA	40WEEKS 1 DAY	LOW RISK	156CM	52KG	21.3	INDUCED	3CP'S	NO	12HRS	NA	NO	LSCS	FAILED INDUCTION	8	9	NO	2.7KG	NO	7DAYS	HEALTHY	NO	NO	ABG - NOT SENT
123	ER122	21Y	UR	LOW	PRIMIGRAVIDA	40WEEKS 4DAYS	LOW RISK	153CM	69KG	29.4	INDUCED	3CP'S	NO	12HRS	NA	NO	LSCS	FAILED INDUCTION	8	10	NO	3.15KG	NO	6DAYS	HEALTHY	NO	NO	ABG - NOT SENT
124	ER123	27Y	R	LOW	MULTIGRAVIDA	40WEEKS 1 DAY	LOW RISK	152CM	45KG	19.4	SPONTANEOUS	NA	NO	NA	NA	NO	LSCS	CDMR	8	9	NO	3.2KG	NO	7DAYS	HEALTHY	NO	NO	ABG - NOT SENT
125	ER124	23Y	R	LOW	MULTIGRAVIDA	40 WEEKS 2DAYS	LOW RISK	150CM	55KG	24.4	SPONTANEOUS	NA	NO	11HRS 15MIN	25MIN	NO	VAGINAL	NA	7	9	NO	3.2KG	NO	4DAYS	HEALTHY	NO	NO	ABG - NOT SENT
126	ER125	30Y	R	LOW	MULTIGRAVIDA	41WEEKS 1DAY	LOW RISK	167CM	82KG	29.4	INDUCED	2CT,S	THIN MSL	11HRS 40MIN	7MIN	NO	VENTOUSE	NA	8	9	NO	3.3KG	NO	4DAYS	HEALTHY	NO	NO	ABG - NOT SENT
127	ER126	28Y	UR	MIDDLE	PRIMIGRAVIDA	40WEEKS 1 DAY	LOW RISK	150CM	78KG	34.6	AUGMENTED	CP-OXYTOCIN	NO	11HRS	NA	YES	LSCS	FETAL DISTRESS	8	9	NO	3.4KG	NO	5DAYS	HEALTHY	NO	NO	PH-7.32
128	ER127	23Y	R	MIDDLE	MULTIGRAVIDA	40WEEKS 2DAYS	LOW RISK	154CM	66.4KG	27.9	SPONTANEOUS	NA	NO	17HRS 5MI N	35MIN	NO	VAGINAL	NA	8	9	NO	3.4KG	NO	3DAYS	HEALTHY	NO	NO	ABG - NOT SENT
129	ER128	33Y	R	LOW	PRIMIGRAVIDA	40WEEKS 1 DAY	LOW RISK	146CM	49KG	22.9	INDUCED	3CP'S-6CT'S	NO	33HRS	NA	NO	LSCS	FAILED INDUCTION	9	10	NO	2.9KG	NO	8DAYS	HEALTHY	NO	NO	ABG - NOT SENT
130	ER129	25Y	R	LOW	PRIMIGRAVIDA	41WEEKS 1DAY	HIGH RISK	145CM	76KG	35.6	SPONTANEOUS	NA	NO	11HRS 30MIN	35MIN	NO	VENTOUSE	NA	8	9	NO	3KG	NO	8DAYS	HEALTHY	NO	GHTN	ABG - NOT SENT
131	ER130	23Y	R	LOW	MULTIGRAVIDA	40WEEKS 5 DAYS	LOW RISK	144CM	48KG	23.1	INDUCED	3CPS	NO	18HRS	20MIN	NO	VAGINAL	NA	9	10	NO	2.2KG	NO	4DAYS	HEALTHY	NO	NO	ABG - NOT SENT
132	ER131	27Y	R	MIDDLE	MULTIGRAVIDA	41WEEKS	LOW RISK	150CM	56KG	24.8	AUGMENTED	CP	MSL	13HRS 30MIN	NA	YES	LSCS	FETAL DISTRESS	8	9	NO	2.7KG	NO	7DAYS	HEALTHY	NO	NO	PH-7.33
133	ER132	30Y	R	LOW	MULTIGRAVIDA	40WEEKS 1 DAY	LOW RISK	147CM	62KG	28.6	INDUCED	3CP'S-6CT	NO	44HRS	NA	NO	LSCS	FAILED INDUCTION	8	9	NO	3.3KG	NO	9DAYS	HEALTHY	NO	NO	ABG - NOT SENT
134	ER133	23Y	R	LOW	PRIMIGRAVIDA	40WEEKS 1 DAY	LOW RISK	151CM	64KG	28	AUGMENTED	2CP'S	NO	17HRS 15MIN	18MIN	NO	VAGINAL	NA	8	9	NO	2.8KG	NO	5DAYS	HEALTHY	NO	NO	ABG - NOT SENT
135	ER134	28Y	R	LOW	PRIMIGRAVIDA	4OWEEKS 3DAYS	LOW RISK	150CM	53KG	23.5	INDUCED	3CP'S-1CT	THICK MSL	28HRS 30 MIN	NA	NO	LSCS	THICK MSL	8	9	NO	2.5KG	NO	8DAYS	HEALTHY	NO	NO	PH-7.36
136	ER135	27Y	R	LOW	MULTIGRAVIDA	40WEEKS 1 DAY	LOW RISK	152CM	62KG	26.8	INDUCED	CP	NA	NA	NA	NO	LSCS	CDMR	8	9	NO	4KG	NO	5DAYS	HEALTHY	NO	NO	ABG - NOT SENT
137	ER136	23Y	R	LOW	MULTIGRAVIDA	4OWEEKS 3DAYS	LOW RISK	143CM	54KG	23	NA	NA	ANAMNIOS	NA	NA	NO	LSCS	ANAMNIOS	8	9	NO	3.3KG	NO	5DAYS	HEALTHY	NO	NO	ABG - NOT SENT
138	ER137	25Y	R	LOW	MULTIGRAVIDA	4O WEEKS 2 DAYS	LOW RISK	161CM	72KG	27.7	INDUCED	2CP'S	NON REASSURING NST	26HRS	NA	NO	LSCS	NON REASSURING NST	7	9	NO	3.25KG	NO	5DAYS	HEALTHY	NO	LOW RISK	ABG - NOT SENT
139	ER138	26Y	R	LOW	MULTIGRAVIDA	40WEEKS 5DAYS	HIGH RISK	144CM	48KG	23.1	INDUCED	CP	NO	4HRS 30MIN	11MIN	NO	VAGINAL	NA	7	9	NO	2.5KG	NO	5DAYS	HEALTHY	NO	LATE ONEST FGR	ABG - NOT SENT
140	ER139	26Y	UR	MIDDLE	PRIMIGRAVIDA	4O WEEKS 2 DAYS	HIGH RISK	142CM	50KG	24.7	NA	NA	CPD WITH THICK MSL	NA	NA	NO	LSCS	CPD	8	9	NO	3.2KG	NO	6DAYS	HEALTHY	FEVER ON POD 2	IMPAIRED GLUCOSE TOLERANCE	ABG - NOT SENT
141	ER140	24Y	R	LOW	PRIMIGRAVIDA	40WEEKS 1 DAY	LOW RISK	144CM	52KG	25	INDUCED	3CP'S-6CT	NO	36HRS	NA	NO	LSCS	FAILED INDUCTION	7	9	NO	2.9KG	NO	8DAYS	HEALTHY	NO	NO	ABG - NOT SENT
142	ER141	22Y	R	LOW	MULTIGRAVIDA	4OWEEKS 3DAYS	HIGH RISK	150CM	68KG	30.2	SPONTANEOUS	NA	NO	6HRS 15MIN	14MIN	NO	VAGINAL	NA	7	9	NO	2.9KG	NO	4DAYS	HEALTHY	NO	LATE ONEST FGR	ABG - NOT SENT
143	ER142	22Y	UR	LOW	PRIMIGRAVIDA	4OWEEKS 3DAYS	LOW RISK	163CM	98KG	36.8	INDUCED	1CP	FETAL DISTRESS	7HRS	NA	YES	LSCS	FETAL DISTRESS	8	9	NO	3.47KG	NO	7DAYS	HEALTHY	NO	NO	PH-7.31
144	ER143	19Y	R	LOW	PRIMIGRAVIDA	40WEEKS 4DAYS	LOW RISK	152CM	62KG	26.8	INDUCED	3CP'S-6CT	NO	40HRS	NA	NO	LSCS	FAILED INDUCTION	8	9	NO	3KG	NO	6DAYS	HEALTHY	NO	NO	ABG - NOT SENT
145	ER144	25Y	R	LOW	PRIMIGRAVIDA	4OWEEKS 3DAYS	LOW RISK	148CM	56KG	25.5	AUGMENTED	1CP	NO	6HRS 30MIN	17MIN	NO	VAGINAL	NA	8	9	NO	2.7KG	NO	5DAYS	HEALTHY	NO	NO	ABG - NOT SENT
146	ER145	25Y	R	LOW	MULTIGRAVIDA	40WEEKS 5 DAYS	LOW RISK	153CM	44KG	18.7	INDUCED	2CP'S	FETAL DISTRESS	6HRS 30MIN	NA	YES	LSCS	FETAL DISTRESS	7	9	NO	2.7KG	NO	6DAYS	HEALTHY	NO	NO	PH-7.33
147	ER146	25Y	R	LOW	MULTIGRAVIDA	4O WEEKS 2 DAYS	LOW RISK	153CM	75KG	32	AUGMENTED	DILAPIN - SRM	NO	26HRS 15MIN	6MIN	NO	VAGINAL	NA	8	9	NO	3.1KG	NO	5DAYS	HEALTHY	NO	NO	ABG - NOT SENT
148	ER147	21Y	R	LOW	MULTIGRAVIDA	40WEEKS 5 DAYS	LOW RISK	146CM	60KG	28.14	AUGMENTED	DILAPIN - SRM	NO	36HRS	23MIN	NO	VAGINAL	NA	6	7	YES	3.18KG	YES(RESPIRATORY DISTRESS)	6DAYS	HEALTHY	NO	NO	ABG - NOT SENT
149	ER148	24Y	UR	MIDDLE	PRIMIGRAVIDA	4O WEEKS 2 DAYS	LOW RISK	156CM	58KG	23.8	SPONTANEOUS	NA	NO	24HRS 45MIN	23MIN	NO	VAGINAL	NA	6	9	YES	2.8KG	NO	5DAYS	HEALTHY	NO	NO	ABG - NOT SENT
150	ER149	31Y	R	LOW	MULTIGRAVIDA	40 WEEKS 2DAYS	LOW RISK	163CM	65KG	24.4	SPONTANEOUS	NA	NO	7HRS	20MIN	NO	VAGINAL	NA	8	9	NO	3.6KG	NO	3DAYS	HEALTHY	NO	NO	ABG - NOT SENT
151	ER150	23Y	R	LOW	MULTIGRAVIDA	4OWEEKS 3DAYS	HIGH RISK	156CM	53KG	21.7	SPONTANEOUS	NA	NO	10HRS	19MIN	NO	VAGINAL	NA	7	9	NO	3.2KG	NO	4DAYS	HEALTHY	NO	LATE ONEST FGR	ABG - NOT SENT
152	ER151	26Y	R	LOW	PRIMIGRAVIDA	40WEEKS 1 DAY	LOW RISK	158CM	58KG	23.2	NA	NA	NA	NA	NA	NO	LSCS	ABNORMAL FETAL DOPPLER	8	9	NO	2.8KG	NO	8DAYS	HEALTHY	NO	NO	PH-7.32
153	ER152	23Y	R	MIDDLE	PRIMIGRAVIDA	40 WEEKS 2DAYS	LOW RISK	158CM	61KG	24.4	AUGMENTED	1CP	NO	23HRS 20MIN	20MIN	NO	VAGINAL	NA	8	9	NO	2.4KG	NO	4DAYS	HEALTHY	NO	NO	ABG - NOT SENT
154	ER153	26Y	R	LOW	MULTIGRAVIDA	40WEEKS 4DAYS	LOW RISK	152CM	64KG	27.7	INDUCED	3CP-1CT	NO	24HRS	22MIN	NO	VAGINAL	NA	7	9	NO	2.9KG	NO	4DAYS	HEALTHY	NO	NO	ABG - NOT SENT
155	ER154	21Y	R	LOW	PRIMIGRAVIDA	40WEEKS 3DAYS	LOW RISK	144CM	60KG	28.9	INDUCED	DILAPIN-CT	NO	24HRS	NA	NO	LSCS	FAILED INDUCTION	7	9	NO	3.2KG	NO	5DAYS	HEALTHY	NO	NO	ABG - NOT SENT
156	ER155	28Y	UR	LOW	PRIMIGRAVIDA	40WEEKS 2DAYS	HIGH RISK	157CM	63KG	25.5	NA	NA	NA	NA	NA	NO	LSCS	MACROSOMIA	7	8	NO	3.45KG	NO	5DAYS	HEALTHY	NO	IGT WITH MACROSOMIA	ABG - NOT SENT
157	ER156	26Y	R	LOW	MULTIGRAVIDA	40WEEKS 4DAYS	LOW RISK	158CM	60KG	24	SPONTANEOUS	NA	NO	5HRS	9MIN	NO	VENTOUSE	NA	8	9	NO	3.1KG	NO	7DAYS	HEALTHY	NO	NO	ABG - NOT SENT
158	ER157	30Y	R	MIDDLE	MULTIGRAVIDA	40WEEKS 1DAY	LOW RISK	162CM	62KG	23.6	SPONTANEOUS	NA	NO	5HRS	37MIN	NO	VAGINAL	NA	7	9	NO	3.2KG	NO	4DAYS	HEALTHY	NO	NO	ABG - NOT SENT
159	ER158	26Y	R	LOW	PRIMIGRAVIDA	40WEEKS 1 DAY	HIGH RISK	157CM	75KG	30.4	SPONTANEOUS	NA	NO	7HRS	NA	NO	LSCS	CPD	8	9	NO	3.4KG	NO	8DAYS	HEALTHY	NO	NO	ABG - NOT SENT
160	ER159	27Y	R	LOW	PRIMIGRAVIDA	40WEEKS 1 DAY	LOW RISK	163CM	70KG	26.3	SPONTANEOUS	NA	NO	NA	NA	NO	LSCS	ANAMNIOS	7	9	NO	3.3KG	NO	5DAYS	HEALTHY	NO	NO	ABG - NOT SENT
161	ER160	25Y	R	LOW	PRIMIGRAVIDA	40WEEKS 1 DAY	LOW RISK	154CM	63KG	26.5	AUGMENTED	DILAPIN-CT	NO	41HRS	33MIN	NO	VAGINAL	NA	8	9	NO	3.1KG	NO	5DAYS	HEALTHY	NO	NO	ABG - NOT SENT
162	ER161	20Y	R	LOW	PRIMIGRAVIDA	40WEEKS 6DAYS	LOW RISK	155CM	65KG	27	INDUCED	2CP'S	NO	14HRS	23MIN	NO	VAGINAL	NA	8	9	NO	2.8KG	NO	5DAYS	HEALTHY	NO	NO	ABG - NOT SENT
163	ER162	25Y	R	MIDDLE	PRIMIGRAVIDA	40WEEKS 1 DAY	LOW RISK	156CM	55KG	22.6	INDUCED	DILAPIN - SRM	YES(THICK MSL)	30HRS	NA	YES	LSCS	FETAL DISTRESS	7	9	NO	2.8KG	NO	6DAYS	HEALTHY	NO	NO	PH-7.38
164	ER163	33Y	UR	MIDDLE	PRIMIGRAVIDA	40 WEEKS 2DAYS	HIGH RISK	150CM	64KG	28.4	INDUCED	2CP'S	NO	15HRS	NA	NO	LSCS	FAILED INDUCTION	7	9	NO	2.5KG	NO	6DAYS	HEALTHY	NO	HYPOTHYROIDISM	ABG - NOT SENT
165	ER164	20Y	R	LOW	PRIMIGRAVIDA	40WEEKS 4DAYS	LOW RISK	150CM	53KG	23.5	INDUCED	3CPS	YES(FETAL DISTRESS	29HRS	23MIN	YES	LSCS	FETAL DISTRESS	7	9	NO	2.8KG	NO	5DAYS	HEALTHY	NO	NO	PH-7.33
166	ER165	28Y	R	LOW	PRIMIGRAVIDA	40WEEKS 1 DAY	LOW RISK	148CM	59KG	26.9	NA	NA	NA	NA	NA	NO	LSCS	CDMR	8	9	NO	3.2KG	NO	5DAYS	HEALTHY	NO	NO	ABG - NOT SENT
167	ER166	34Y	UR	MIDDLE	MULTIGRAVIDA	40WEEKS 1 DAY	HIGH RISK	156CM	55KG	22.6	AUGMENTED	2CT,S	NO	8HRS 30MIN	16MIN	NO	VAGINAL	NA	8	9	NO	3KG	NO	4DAYS	HEALTHY	NO	IMPAIRED GLUCOSE TOLERANCE	ABG - NOT SENT
168	ER167	27Y	R	LOW	PRIMIGRAVIDA	40WEEKS 2DAYS	LOW RISK	144CM	60KG	28.9	SPONTANEOUS	NA	NO	NA	NA	NO	LSCS	CPD	9	10	NO	3.5KG	NO	5DAYS	HEALTHY	NO	NO	ABG - NOT SENT
169	ER168	24Y	R	LOW	PRIMIGRAVIDA	40WEEKS 1 DAY	LOW RISK	152CM	61KG	26.4	INDUCED	3CP-3CT	NO	26HRS	NA	NO	LSCS	FAILED INDUCTION	9	10	NO	3.2KG	NO	5DAYS	HEALTHY	NO	NO	ABG - NOT SENT
170	ER169	20Y	R	LOW	PRIMIGRAVIDA	40WEEKS 1DAY	LOW RISK	150CM	45KG	20	INDUCED	3CP'S	NO	44HRS 15MIN	27MIN	NO	VAGINAL	NA	7	8	NO	3.2KG	NO	4DAYS	HEALTHY	NO	NO	ABG - NOT SENT
171	ER170	25Y	R	LOW	MULTIGRAVIDA	40WEEKS 1 DAY	LOW RISK	146CM	68KG	31.9	SPONTANEOUS	NA	CPD	NA	NA	NO	LSCS	CPD	8	9	NO	3.3KG	NO	6DAYS	HEALTHY	NO	NO	ABG - NOT SENT

S.NO	ENROLMENT NUMBER	AGE	R/UR CASE	SOCIO ECONOMIC STATUS	OBSTETRIC SCORE	POG	LOW/HIGH RISK	HEIGHT	WEIGHT	BMI	SPONTANEOUS/INDUCED LABOUR	TYPE OF INDUCTION	INTRAPARTUM COMPLICATIONS	DURATION OF 1ST STAGE	DURATION OF 2ND STAGE	FETAL DISTRESS AT WHAT STAGE	MODE OF DELIVERY	INDICATION FOR LSCS	APGAR 1'MIN	APGAR 5'MIN	RESUSCITATION MEASURES	BABY WEIGHT	NICU ADMISSION	DURATION OF HOSPITAL STAY	CONDITION OF BABY AT DISCHARGE	MATERNAL COMPLICATIONS	RISK FACTORS	BLOOD GAS ANALYSIS - BABY
172	ER171	31Y	R	MIDDLE	MULTIGRAVIDA	40WEEKS 4DAYS	LOW RISK	150CM	61KG	27.1	SPONTANEOUS	NA	NO	2HRS 15MIN	14MIN	NO	VAGINAL	NA	7	8	NO	3.5KG	NO	5DAYS	HEALTHY	RETAINED PLACENTA - MANUAL REMOVAL	NO	ABG - NOT SENT
173	ER172	21Y	R	MIDDLE	MULTIGRAVIDA	40WEEKS 3DAYS	LOW RISK	152CM	52KG	22.5	SPONTANEOUS	NA	NO	1HR 15MIN	27MIN	N O	VAGINAL	NA	7	8	NO	3.3KG	NO	3DAYS	HEALTHY	NO	NO	ABG - NOT SENT
174	ER173	19Y	R	LOW	PRIMIGRAVIDA	40WEEKS 1 DAY	LOW RISK	156CM	58KG	23.8	INDUCED	3CP-3CT	NO	28HRS	5MIN	NO	VAGINAL	NA	8	9	NO	2.5KG	NO	5DAYS	HEALTHY	NO	NO	ABG - NOT SENT
175	ER174	28Y	UR	LOW	MULTIGRAVIDA	40 WEEKS 2DAYS	LOW RISK	153CM	65KG	27.7	AUGMENTED	1CP-SRM	NO	12HRS 30MIN	19MIN	NO	VAGINAL	NA	7	9	NO	3.2KG	NO	4DAYS	HEALTHY	NO	NO	ABG - NOT SENT
176	ER175	23Y	R	LOW	PRIMIGRAVIDA	40WEEKS 1 DAY	HIGH RISK	146CM	74KG	34.71	INDUCED	2CP'S	CPD	20HRS	NA	NO	LSCS	CPD	7	9	NO	3.3KG	NO	5DAYS	HEALTHY	NO	HYPOTHYROIDISM	ABG - NOT SENT
177	ER176	25Y	R	LOW	MULTIGRAVIDA	40WEEKS 1 DAY	HIGH RISK	150CM	58KG	25.9	SPONTANEOUS	NA	NO	5HRS	13MIN	NO	VAGINAL	NA	8	9	NO	3.3KG	NO	4DAYS	HEALTHY	NO	HYPOTHYROIDISM	ABG - NOT SENT
178	ER177	28Y	R	LOW	PRIMIGRAVIDA	40WEEKS 2DAYS	LOW RISK	155CM	52KG	21.6	INDUCED	2CP,S-SRM-4CT,S	THICK MSL	34HRS	NA	NO	LSCS	NON PROGRES OF LABOUR	8	9	NO	3.1KG	NO	7DAYS	HEALTHY	NO	NO	ABG-NOT SENT
179	ER178	27Y	UR	LOW	MULTIGRAVIDA	40WEEKS 4DAYS	HIGH RISK	150CM	64KG	28.4	SPONTANEOUS	NA	NO	4HRS	2MIN	NO	VAGINAL	NA	8	9	NO	3.1KG	NO	4DAYS	HEALTHY	NO	IMPAIRED GLUCOSE TOLERANCE	ABG- NOT SENT
180	ER179	24Y	R	LOW	MULTIGRAVIDA	40WEEKS 5 DAYS	HIGH RISK	156CM	68KG	27.9	INDUCED	1CP-SRM	NO	15HRS	35MIN	NO	VAGINAL	NA	8	9	NO	2.3KG	NO	5DAYS	HEALTHY	NO	LATE ONSET FGR	ABG- NOT SENT
181	ER180	24Y	R	LOW	PRIMIGRAVIDA	41WEEKS 3DAYS	LOW RISK	152CM	67KG	28.9	INDUCED	CP-SRM-CT	OLIGOHYDRAMNIOS	13HRS	NA	NO	LSCS	OLIGOHYDRAMNIOS	8	10	NO	3.1KG	NO	8DAYS	HEALTHY	NO	NO	ABG- NOT SENT
182	ER181	28Y	R	LOW	PRIMIGRAVIDA	40WEEKS 1 DAY	LOW RISK	150CM	61KG	27.1	INDUCED	2CP'S	NO	NA	NA	NO	LSCS	CDMR	7	8	NO	2.9KG	NO	5DAYS	HEALTHY	NO	NO	ABG- NOT SENT
183	ER182	26Y	R	LOW	PRIMIGRAVIDA	40WEEKS 3DAYS	LOW RISK	154CM	61KG	25.7	INDUCED	3CP'S-6CT	NO	45HRS	NA	NO	LSCS	FAILED INDUCTION	8	9	NO	3.2KG	NO	6DAYS	HEALTHY	NO	NO	ABG- NOT SENT
184	ER183	26Y	R	MIDDLE	PRIMIGRAVIDA	40WEEKS 1 DAY	HIGH RISK	156CM	64KG	26.2	SPONTANEOUS	NA	NO	NA	NA	NO	LSCS	CPD	7	9	NO	3.5KG	NO	4DAYS	HEALTHY	NO	GRAVES DISEASE	ABG- NOT SENT
185	ER184	33Y	UR	MIDDLE	PRIMIGRAVIDA	40WEEKS 2DAYS	HIGH RISK	155CM	64KG	26.6	INDUCED	3CP-2CT	NO	35HRS	NA	NO	LSCS	CDMR	8	9	NO	2.7KG	NO	7DAYS	HEALTHY	NO	HYPOTHYROIDISM	ABG- NOT SENT
186	ER185	29Y	R	LOW	MULTIGRAVIDA	40WEEKS 3DAYS	HIGH RISK	148CM	56KG	25.5	INDUCED	CT	FETAL DISTRESS	1HR	NA	YES	LSCS	FETAL DISTRESS	8	9	NO	3KG	NO	4DAYS	HEALTHY	NO	PROM	PH-7.31
187	ER186	27Y	R	LOW	PRIMIGRAVIDA	40WEEKS 1 DAY	HIGH RISK	152CM	50KG	21.6	SPONTANEOUS	NA	NO	3HRS	23MIN	NO	VAGINAL	NA	7	8	NO	2.8KG	NO	6DAYS	HEALTHY	NO	HYPOTHYROIDISM	ABG- NOT SENT
188	ER187	24Y	R	LOW	MULTIGRAVIDA	40WEEKS 1 DAY	HIGH HISK	150CM	60KG	26.6	SPONTANEOUS	NA	NO	2HRS	23MIN	NO	VAGINAL	NA	8	9	NO	3.1KG	NO	4DAYS	HEALTHY	NO	HBSAG+	ABG- NOT SENT
189	ER188	23Y	UR	LOW	PRIMIGRAVIDA	40WEEKS 4DAYS	HIGH RISK	158CM	64KG	25.6	AUGMENTED	2CP,S	NO	17HRS 15MIN	16MIN	NO	VAGINAL	NA	8	9	NO	2.56KG	NO	5DAYS	HEALTHY	NO	PROM	ABG- NOT SENT
190	ER189	26Y	R	MIDDLE	PRIMIGRAVIDA	40WEEKS 4DAYS	LOW RISK	165CM	60KG	22.03	INDUCED	3CP'S-SRM-4CT	NO	42HRS 30MIN	NA	NO	LSCS	FAILED INDUCTION	7	8	NO	3.3KG	NO	5DAYS	HEALTHY	NO	NO	ABG- NOT SENT
191	ER190	29Y	R	MIDDLE	PRIMIGRAVIDA	40 WEEKS 2DAYS	HIGH RISK	155CM	81KG	33.7	INDUCED	3CP'S	NO	21HRS 30MIN	NA	NO	LSCS	FAILED INDUCTION	8	9	NO	3.4KG	YES(HYPERBILIRUBINEMIA)	8DAYS	HEALTHY	NO	HYPOTHYROIDISM	ABG- NOT SENT
192	ER191	27Y	R	LOW	PRIMIGRAVIDA	40WEEKS 1 DAY	HIGH RISK	153CM	54KG	23.06	INDUCED	DILAPIN-CT	NO	25HRS	9MIN	NO	VENTOUSE	NA	8	9	NO	3KG	NO	7DAYS	HEALTHY	NO	GDM	ABG- NOT SENT
193	ER192	26Y	R	LOW	PRIMIGRAVIDA	40WEEKS 1 DAY	LOW RISK	158CM	65KG	26.03	INDUCED	DILAPIN-CT	NO	44HRS	25MIN	NO	VENTOUSE	NA	7	9	NO	3.3KG	NO	8DAYS	HEALTHY	YES(ATONIC PPH)	NO	ABG- NOT SENT
194	ER193	27Y	R	LOW	PRIMIGRAVIDA	40WEEKS 1 DAY	LOW RISK	161CM	63KG	24.3	AUGMENTED	CT	FETAL DISTRESS	41HRS	52MIN	YES	LSCS	FETAL DISTRESS	7	8	NO	3.7KG	NO	5DAYS	HEALTHY	NO	NO	PH-7.27
195	ER194	20Y	R	LOW	PRIMIGRAVIDA	40WEEKS 2DAYS	LOW RISK	155CM	60KG	24.9	INDUCED	3CP-1CT	NO	18HRS 20MIN	22MIN	NO	VENTOUSE	NA	8	9	NO	3.13KG	NO	5DAYS	HEALTHY	NO	NO	ABG- NOT SENT
196	ER195	31Y	R	LOW	MULTIGRAVIDA	40WEEKS 3DAYS	LOW RISK	167CM	74KG	26.5	AUGMENTED	2CP,S	THICK MSL	7HRS 30MIN	NA	NO	LSCS	THICK MSL	8	9	NO	3.3KG	NO	6DAYS	HEALTHY	NO	NO	PH-7.26
197	ER196	23Y	R	LOW	PRIMIGRAVIDA	40WEEKS 3DAYS	HIGH RISK	150CM	52KG	23.1	AUGMENTED	2CP'S	NO	8HRS 30MIN	40MIN	NO	VAGINAL	NA	8	9	NO	2.8KG	NO	4DAYS	HEALTHY	NO	HYPOTHYROIDISM	ABG- NOT SENT
198	ER197	26Y	R	LOW	PRIMIGRAVIDA	40WEEKS 6DAYS	HIGH RISK	146CM	51KG	23.9	NA	NA	ANAMNIOS	NA	NA	NO	LSCS	ANAMNIOS	9	10	NO	2.7KG	NO	7DAYS	HEALTHY	NO	HIGH RISK (THROMBOCYTOPENIA)	ABG- NOT SENT
199	ER198	27Y	R	LOW	MULTIGRAVIDA	40WEEKS 2DAYS	HIGH RISK	157CM	68KG	27.5	SPONTANEOUS	NA	NO	6HRS 20MIN	10MIN	NO	VAGINAL	NA	8	10	NO	2.9KG	NO	5DAYS	HEALTHY	NO	PROM	ABG- NOT SENT
200	ER199	26Y	R	LOW	PRIMIGRAVIDA	40WEEKS 3DAYS	HIGH RISK	148CM	55KG	25.4	AUGMENTED	3CP'S-4CT'S	DTA	28HRS 15MIN	1HR	NO	LSCS	DTA	8	9	NO	3.2KG	NO	7DAYS	HEALTHY	NO	OVULATION INDUCTION	ABG- NOT SENT
201	ER200	25Y	R	LOW	PRIMIGRAVIDA	40WEEKS 1 DAY	HIGH RISK	158CM	68KG	27.2	INDUCED	DILAPIN-CT	NO	28HRS	46MIN	NO	VAGINAL	NA	8	9	NO	2.8KG	NO	5DAYS	HEALTHY	NO	HYPOTHYROIDISM	ABG- NOT SENT
202	ER201	39Y	UR	LOW	MULTIGRAVIDA	40WEEKS 1 DAY	HIGH RISK	159CM	69KG	27.2	AUGMENTED	2CP,S	NO	8HRS 30MIN	10MIN	NO	VAGINAL	NA	9	10	NO	3.7KG	NO	5DAYS	HEALTHY	NO	GHTN WITH GDM	ABG- NOT SENT
203	ER202	25Y	R	LOW	MULTIGRAVIDA	40WEEKS 4DAYS	HIGH RISK	152CM	71KG	30.7	INDUCED	3CP'S	NO	13HRS 15MIN	15MIN	NO	VAGINAL	NA	8	9	N0	3KG	NO	6DAYS	HEALTHY	YES(ATONIC PPH)	OVERT DIABETES MELLITUS	ABG- NOT SENT
204	ER203	23Y	R	LOW	PRIMIGRAVIDA	41WEEKS	HIGH RISK	161CM	76KG	29.3	SPONTANEOUS	NA	THICK MSL	NA	NA	YES	LSCS	FETAL DISTRESS	7	9	NO	3KG	NO	7DAYS	HEALTHY	NO	MODERATE ANEMIA	PH-7.34
205	ER204	27Y	UR	LOW	MULTIGRAVIDA	41WEEKS	HIGH RISK	160CM	78KG	30.4	INDUCED	CP-CT	ANAMNIOS	NA	NA	YES	LSCS	ANAMNIOS	7	9	NO	2.7KG	NO	6DAYS	HEALTHY	NO	RVD +	ABG- NOT SENT
206	ER205	27Y	R	MIDDLE	MULTIGRAVIDA	40WEEKS 3DAYS	LOW RISK	157CM	76KG	30.8	AUGMENTED	1CP	NO	9HRS 20MIN	12MIN	NO	VAGINAL	NA	7	8	NO	3.3KG	NO	6DAYS	HEALTHY	NO	NO	ABG- NOT SENT
207	ER206	24Y	R	LOW	MULTIGRAVIDA	40WEEKS 1 DAY	LOW RISK	150CM	54KG	24	SPONTANEOUS	NA	NA	12HRS 30MIN	12MIN	NO	VAGINAL	NA	7	9	NO	3.2KG	NO	4DAYS	HEALTHY	NO	NO	ABG- NOT SENT
208	ER207	23Y	R	LOW	PRIMIGRAVIDA	40WEEKS 1 DAY	HIGH RISK	160CM	70KG	27.3	NA	NA	NA	NA	NA	NO	LSCS	OLIGOHYDRAMNIOS	7	9	NO	3.3KG	NO	5DAYS	HEALTHY	NO	OLIGOHYDRAMNIOS	ABG- NOT SENT
209	ER208	31Y	R	LOW	MULTIGRAVIDA	40WEEKS 4DAYS	LOW RISK	150CM	76KG	33.7	INDUCED	2CP'S	NA	8HRS 15MIN	12MIN	NO	VAGINAL	NA	7	9	NO	3.2KG	NO	6DAYS	HEALTHY	NO	NO	ABG- NOT SENT
210	ER209	31Y	R	LOW	MULTIGRAVIDA	40 WEEKS 2DAYS	LOW RISK	154CM	80KG	33.7	INDUCED	2CP'S	FETAL DISTRESS	9HRS 25MIN	NA	YES	LSCS	FETAL DISTRESS	7	9	NO	2.8KG	NO	6DAYS	HEALTHY	NO	NO	PH-7.35
211	ER210	23Y	R	MIDDLE	PRIMIGRAVIDA	40 WEEKS 2DAYS	LOW RISK	150CM	60KG	26.6	SPONTANEOUS	NA	NO	13HRS 15MIN	NA	NO	LSCS	FETAL DISTRESS	7	8	NO	3.35KG	NO	7DAYS	HEALTHY	NO	NO	PH-7.34
212	ER211	26Y	R	LOW	PRIMIGRAVIDA	40WEEKS 1 DAY	LOW RISK	150CM	60KG	26.6	INDUCED	DILAPIN-CT	NO	26HRS 30MIN	42MIN	NO	VAGINAL	NA	7	9	NO	3KG	NO	5DAYS	HEALTHY	NO	NO	ABG- NOT SENT
213	ER212	21Y	UR	LOW	MULTIGRAVIDA	40WEEKS 4DAYS	HIGH RISK	160CM	74KG	28.9	SPONTANEOUS	NA	NO	6HRS 40MIN	38MIN	NO	VAGINAL	NA	7	9	NO	2.4KG	NO	5DAYS	HEALTHY	NO	OLIGOHYDRAMNIOS	ABG- NOT SENT
214	ER213	26Y	R	LOW	MULTIGRAVIDA	40WEEKS 1 DAY	HIGH RISK	154CM	68KG	28.6	NA	NA	NA	NA	NA	NO	LSCS	OLIGOHYDRAMNIOS	6	8	YES	2.44KG	YES[RESPIRATORY DISTRESS	7DAYS	HEALTHY	NO	OLIGOHYDRAMNIOS	ABG- NOT SENT
215	ER214	23Y	R	LOW	MULTIGRAVIDA	40WEEKS 3DAYS	LOW RISK	148CM	56KG	25.5	INDUCED	3CP'S-4CT'S	NO	34HRS 12MIN	NA	NO	LSCS	NON PROGRES OF LABOUR	7	8	NO	2.6KG	NO	7DAYS	HEALTHY	NO	NO	ABG- NOT SENT
216	ER215	25Y	UR	LOW	PRIMIGRAVIDA	40WEEKS 3DAYS	HIGH HISK	152CM	70KG	30.2	NA	NA	NA	NA	NA	NO	LSCS	OLIGOHYDRAMNIOS	7	9	NO	2.7KG	NO	6DAYS	HEALTHY	NO	OLIGOHYDRAMNIOS	ABG- NOT SENT
217	ER216	23Y	UR	LOW	PRIMIGRAVIDA	40WEEKS 4DAYS	LOW RISK	149CM	71KG	31.9	INDUCED	3CP'S-6CT	NO	38HRS15MIN	NA	NO	LSCS	NON PROGRES OF LABOUR	7	9	NO	3.2KG	NO	7DAYS	HEALTHY	NO	NO	ABG- NOT SENT
218	ER217	26Y	R	LOW	PRIMIGRAVIDA	40WEEKS 1 DAY	LOW RISK	150CM	52KG	23.1	AUGMENTED	2CT'S	FETAL DISTRESS	10HRS 30MIN	NA	YES	LSCS	FETAL DISTRESS	7	9	NO	2.9KG	NO	6DAYS	HEALTHY	NO	NO	PH-7.30
219	ER218	24Y	R	LOW	PRIMIGRAVIDA	40WEEKS 1 DAY	LOW RISK	146CM	51KG	23.9	INDUCED	DILAPIN-CT	FETAL DISTRESS	22HRS	NA	YES	LSCS	FETAL DISTRESS	7	9	NO	3.3KG	NO	7DAYS	HEALTHY	NO	NO	PH-7.32
220	ER220	23Y	R	LOW	MULTIGRAVIDA	40WEEKS 1 DAY	HIGH HISK	157CM	68KG	27.5	SPONTANEOUS	NA	NO	3HRS 20MIN	10MIN	NO	VAGINAL	NA	7	8	NO	2.8KG	NO	5DAYS	HEALTHY	NO	HYPOTHYROIDISM	ABG- NOT SENT
221	ER221	26Y	R	LOW	PRIMIGRAVIDA	40 WEEKS 2DAYS	HIGH RISK	156CM	58KG	23.8	INDUCED	3CP,S-2CT'S	NO	18HRS 15MIN	28MIN	NO	VAGINAL	NA	8	9	NO	2.8KG	NO	5DAYS	HEALTHY	NO	RH NEGATIVE	ABG- NOT SENT
222	ER222	25Y	R	LOW	PRIMIGRAVIDA	40WEEKS 4DAYS	HIGH RISK	152CM	65KG	28.1	INDUCED	CP	FETAL DISTRESS	5HRS	NA	YES	LSCS	FETAL DISTRESS	8	9	NO	2.5KG	NO	6DAYS	HEALTHY	NO	HYPOTHYROIDISM	PH-7.30
223	ER223	27Y	R	LOW	MULTIGRAVIDA	40WEEKS 1 DAY	HIGH RISK	145CM	55KG	26.1	SPONTANEOUS	NA	NO	5 HRS 10MIN	10MIN	NO	VAGINAL	NO	7	8	NO	3.4KG	NO	5DAYS	HEALTHY	NO	NO	ABG- NOT SENT
224	ER224	24Y	R	LOW	PRIMIGRAVIDA	40WEEKS 3DAYS	HIGH RISK	150CM	55KG	24.4	AUGMENTED	3CP'S	NO	17HRS 10MIN	38MIN	NO	VENTOUSE	NA	8	9	NO	3.1KG	NO	5DAYS	HEALTHY	NO	GDM	ABG- NOT SENT
225	ER225	24Y	R	MIDDLE	MULTIGRAVIDA	40WEEKS 2DAYS	LOW RISK	156CM	57KG	23.4	SPONTANEOUS	NA	NO	3HRS 10MIN	5MIN	NO	VAGINAL	NA	8	9	NO	3.1KG	NO	4DAYS	HEALTHY	NO	NO	ABG- NOT SENT
226	ER226	19Y	UR	LOW	MULTIGRAVIDA	40 WEEKS 2DAYS	LOW RISK	152CM	53KG	22.9	SPONTANEOUS	NA	CPD	NA	NA	NO	LSCS	CPD	8	9	NO	3.2KG	NO	6DAYS	HEALTHY	NO	NO	ABG- NOT SENT
227	ER227	23Y	R	LOW	PRIMIGRAVIDA	40WEEKS 1 DAY	LOW RISK	150CM	62KG	27.5	AUGMENTED	CP	NO	7HRS 22MIN	32MIN	NO	VAGINAL	NA	8	9	NO	3.3KG	NO	4DAYS	HEALTHY	NO	NO	ABG- NOT SENT

S.NO	ENROLMENT NUMBER	AGE	R/UR CASE	SOCIO ECONOMIC STATUS	OBSTETRIC SCORE	POG	LOW/HIGH RISK	HEIGHT	WEIGHT	BMI	SPONTANEOUS/INDUCED LABOUR	TYPE OF INDUCTION	INTRAPARTUM COMPLICATIONS	DURATION OF 1ST STAGE	DURATION OF 2ND STAGE	FETAL DISTRESS AT WHAT STAGE	MODE OF DELIVERY	INDICATION FOR LSCS	APGAR 1'MIN	APGAR 5'MIN	RESUSCITATION MEASURES	BABY WEIGHT	NICU ADMISSION	DURATION OF HOSPITAL STAY	CONDITION OF BABY AT DISCHARGE	MATERNAL COMPLICATIONS	RISK FACTORS	BLOOD GAS ANALYSIS - BABY
228	ER228	25Y	UR	LOW	MULTIGRAVIDA	40WEEKS 2DAYS	HIGH RISK	146CM	64KG	30	SPONTANEOUS	NA	DTA	8HRS 10MIN	1HR 30MIN	NO	LSCS	DTA	7	9	NO	2.2KG	YES(LBW)	6DAYS	HEALTHY	NO	HYPOTHYROIDISM	ABG- NOT SENT
229	ER229	22Y	R	LOW	PRIMIGRAVIDA	40WEEKS 3DAYS	HIGH HISK	150CM	66KG	29.3	SPONTANEOUS	NA	THICK MSL	NA	NA	NO	LSCS	OLIGOHYDRAMNIOS	7	9	NO	3.75KG	NO	6DAYS	HEALTHY	NO	OLIGOHYDRAMNIOS	ABG- NOT SENT
230	ER230	24Y	R	LOW	MULTIGRAVIDA	40WEEKS 3DAYS	LOW RISK	168CM	76KG	26.9	SPONTANEOUS	NA	NO	1HR	15MIN	NO	VAGINAL	NA	7	9	NO	3.5KG	NO	5DAYS	HEALTHY	NO	NO	ABG- NOT SENT
231	ER231	23Y	R	LOW	MULTIGRAVIDA	40WEEKS 1 DAY	LOW RISK	160CM	64KG	25	INDUCED	3CP'S-2CT'S	NO	20 HRS 26MIN	NA	NO	LSCS	CDMR	8	9	NO	3.2KG	NO	7DAYS	HEALTHY	NO	NO	ABG- NOT SENT
232	ER232	26Y	R	LOW	MULTIGRAVIDA	40WEEKS 1 DAY	LOW RISK	150CM	54KG	24	SPONTANEOUS	NA	NO	6 HRS 15MIN	12MIN	NO	VAGINAL	NA	7	9	NO	2.6KG	NO	5DAYS	HEALTHY	NO	NO	ABG- NOT SENT
233	ER233	21Y	R	LOW	PRIMIGRAVIDA	40WEEKS 4DAYS	LOW RISK	150CM	47KG	20.8	AUGMENTED	3CP'S-1CT	NO	28HRS 30 MIN	32MIN	NO	VAGINAL	NA	7	8	NO	3.4KG	NO	5DAYS	HEALTHY	NO	NO	ABG- NOT SENT
234	ER234	27Y	R	LOW	MULTIGRAVIDA	40WEEKS 3DAYS	HIGH RISK	150CM	74KG	32.8	INDUCED	3CP,S-4CT'S	DTA	30HRS	1HR 20MIN	NO	LSCS	DTA	7	8	NO	2.8KG	NO	6DAYS	HEALTHY	NO	BRONCHIAL ASTHMA	
235	ER235	26Y	R	LOW	MULTIGRAVIDA	40WEEKS 3DAYS	LOW RISK	151CM	64KG	28	SPONTANEOUS	NA	NO	12HRS 30MIN	46MIN	NO	VAGINAL	NA	7	8	NO	3KG	NO	5DAYS	HEALTHY	NO	NO	ABG- NOT SENT
236	ER236	29Y	R	LOW	MULTIGRAVIDA	40WEEKS 3DAYS	LOW RISK	150CM	53KG	23.5	AUGMENTED	3CP,S-2CT'S	NO	29HRS	36MIN	NO	VAGINAL	NA	7	9	NO	3KG	NO	5DAYS	HEALTHY	NO	NO	ABG- NOT SENT
237	ER237	26Y	R	LOW	PRIMIGRAVIDA	40WEEKS 5 DAYS	LOW RISK	152CM	62KG	26.8	NA	NA	NO	NA	NA	NO	LSCS	OLIGOHYDRAMNIOS	8	9	NO	3KG	NO	6DAYS	HEALTHY	NO	NO	ABG- NOT SENT
238	ER238	31Y	R	LOW	MULTIGRAVIDA	40WEEKS 1 DAY	HIGH RISK	143CM	54KG	23	SPONTANEOUS	NA	NO	10HRS 20MIN	34MIN	NO	VAGINAL	NA	8	9	NO	3.1KG	NO	5DAYS	HEALTHY	NO	GHTN	ABG- NOT SENT
239	ER239	24Y	R	LOW	MULTIGRAVIDA	40WEEKS 1 DAY	HIGH RISK	161CM	72KG	27.7	INDUCED	3CP'S-4CT'S	NO	36HRS 30MIN	22MIN	NO	VAGINAL	NA	8	9	NO	3.1KG	NO	4DAYS	HEALTHY	NO	INCREASED RESISTANCE ON DOPPLER	ABG- NOT SENT
240	ER240	26Y	R	LOW	PRIMIGRAVIDA	40 WEEKS 2DAYS	LOW RISK	144CM	48KG	23.1	SPONTANEOUS	NA	NO	6HRS 20MIN	20MIN	NO	VAGINAL	NA	8	9	NO	2.7KG	NO	5DAYS	HEALTHY	NO	NO	ABG- NOT SENT
241	ER241	24Y	UR	LOW	PRIMIGRAVIDA	40WEEKS 1 DAY	HIGH RISK	142CM	50KG	24.7	SPONTANEOUS	NA	THIN MSL	12HRS 30MIN	NA	YES	LSCS	FAILED INDUCTION	7	8	NO	2.5KG	NO	6DAYS	HEALTHY	NO	GHTN	ABG- NOT SENT
242	ER242	23Y	R	LOW	MULTIGRAVIDA	40WEEKS 4DAYS	LOW RISK	144CM	52KG	25	NA	NA	NO	NA	NA	NO	LSCS	CDMR	8	9	NO	3.1KG	NO	7DAYS	HEALTHY	NO	NO	ABG- NOT SENT
243	ER243	30Y	R	LOW	MULTIGRAVIDA	40WEEKS 3DAYS	LOW RISK	150CM	68KG	30.2	AUGMENTED	3CT'S	NO	17HRS 20MIN	32MIN	NO	VAGINAL	NA	8	9	NO	3.1KG	NO	6DAYS	HEALTHY	NO	NO	ABG- NOT SENT
244	ER244	24Y	R	LOW	MULTIGRAVIDA	40WEEKS 4DAYS	LOW RISK	163CM	98KG	36.8	AUGMENTED	3CP,S	NO	19HRS 50MI	35MIN	NO	VAGINAL	NA	8	9	NO	3.2KG	NO	5DAYS	HEALTHY	NO	NO	ABG- NOT SENT
245	ER245	26Y	R	LOW	PRIMIGRAVIDA	40WEEKS 1 DAY	LOW RISK	152CM	62KG	26.8	AUGMENTED	2CP'S	NO	11HRS 20MIN	24MIN	NO	VAGINAL	NA	7	8	NO	2.7KG	NO	5DAYS	HEALTHY	NO	NO	ABG- NOT SENT
246	ER246	29Y	R	MIDDLE	MULTIGRAVIDA	40 WEEKS 2DAYS	LOW RISK	148CM	56KG	25.5	AUGMENTED	4CT'S	CPD	18HRS	NA	NO	LSCS	CPD	8	9	NO	3.6KG	NO	7DAYS	HEALTHY	NO	NO	ABG- NOT SENT
247	ER247	32Y	UR	LOW	MULTIGRAVIDA	40WEEKS 5 DAYS	HIGH RISK	153CM	44KG	18.7	INDUCED	3CP'S-3CT'S	NO	30HRS	NA	NO	LSCS	NON PROGRES OF LABOUR	8	9	NO	3KG	NO	6DAYS	HEALTHY	NO	HYPOTHYROIDISM	ABG- NOT SENT
248	ER248	31Y	UR	MIDDLE	PRIMIGRAVIDA	40WEEKS 2DAYS	LOW RISK	153CM	75KG	32	INDUCED	3CP'S-2CT'S	NO	29HRS	15MIN	NO	VAGINAL	NA	8	9	NO	3KG	NO	5DAYS	HEALTHY	NO	NO	ABG- NOT SENT
249	ER249	27Y	R	LOW	MULTIGRAVIDA	41WEEKS	LOW RISK	146CM	60KG	28.14	SPONTANEOUS	NA	NO	11HRS 15MIN	40MIN	NO	VAGINAL	NA	6	8	YES	2.5KG	NO	5DAYS	HEALTHY	NO	NO	ABG- NOT SENT
250	ER250	38Y	R	LOW	MULTIGRAVIDA	40 WEEKS 2DAYS	LOW RISK	156CM	58KG	23.8	SPONTANEOUS	NA	NO	6HRS 15MIN	10MIN	NO	VAGINAL	NA	8	9	NO	3.2KG	NO	6DAYS	HEALTHY	NO	NO	ABG- NOT SENT
251	ER251	22Y	R	LOW	PRIMIGRAVIDA	40WEEKS 1 DAY	LOW RISK	163CM	65KG	24.4	INDUCED	3CP'S-6CT	NO	42HRS 30MIN	36MIN	NO	VAGINAL	NA	8	9	NO	2.9KG	NO	4DAYS	HEALTHY	NO	NO	ABG- NOT SENT
252	ER252	24Y	UR	LOW	PRIMIGRAVIDA	40WEEKS 1 DAY	LOW RISK	156CM	53KG	21.7	SPONTANEOUS	NA	NO	18HRS 15MIN	24MIN	NO	VAGINAL	NA	8	9	NO	2.7KG	NO	5DAYS	HEALTHY	NO	NO	ABG- NOT SENT
253	ER253	23Y	R	LOW	PRIMIGRAVIDA	40WEEKS 1 DAY	LOW RISK	158CM	58KG	23.2	SPONTANEOUS	NA	NO	12HRS 3OMIN	34MIN	NO	VAGINAL	NA	8	9	NO	2.9KG	NO	5DAYS	HEALTHY	NO	NO	ABG- NOT SENT
254	ER254	24Y	R	LOW	MULTIGRAVIDA	40WEEKS 4DAYS	LOW RISK	158CM	61KG	24.4	SPONTANEOUS	NA	NO	5HRS 30MIN	5MIN	NO	VAGINAL	NA	8	9	NO	2.7KG	NO	5DAYS	HEALTHY	NO	NO	ABG- NOT SENT
255	ER255	20Y	R	LOW	PRIMIGRAVIDA	40 WEEKS 2DAYS	LOW RISK	152CM	64KG	27.7	AUGMENTED	2CT'S	FETAL DISTRESS	10HRS 10MIN	NA	YES	LSCS	FETAL DISTRESS	7	9	NO	2.8KG	NO	7DAYS	HEALTHY	NO	NO	PH-7.29
256	ER256	32Y	R	LOW	MULTIGRAVIDA	40WEEKS 4DAYS	HIGH RISK	144CM	60KG	28.9	INDUCED	2CP'S	NO	16HRS	12MIN	NO	VAGINAL	NA	6	7	YES	2.7KG	NO	5DAYS	HEALTHY	NO	MODERATE ANEMIA	ABG- NOT SENT
257	ER257	24Y	R	LOW	PRIMIGRAVIDA	40WEEKS 3DAYS	LOW RISK	157CM	63KG	25.5	INDUCED	3CP'S-6CT'S	NO	46HRS 10MIN	NA	NO	LSCS	FAILED INDUCTION	8	9	NO	3KG	NO	6DAYS	HEALTHY	NO	NO	ABG- NOT SENT
258	ER258	28Y	R	LOW	MULTIGRAVIDA	40WEEKS 3DAYS	HIGH RISK	158CM	60KG	24	AUGMENTED	1CP	NO	7HRS 10MIN	5MIN	NO	VAGINAL	NA	7	9	NO	2.7KG	NO	5DAYS	HEALTHY	NO	LATE ONSET FGR	ABG- NOT SENT
259	ER259	23Y	R	LOW	PRIMIGRAVIDA	40WEEKS 3DAYS	LOW RISK	162CM	62KG	23.6	INDUCED	2CP,S	NO	12HRS	22MIN	NO	VAGINAL;	NA	6	9	YES	2.4KG	NO	4DAYS	HEALTHY	NO	NO	ABG- NOT SENT
260	ER260	24Y	UR	LOW	PRIMIGRAVIDA	40WEEKS 1 DAY	LOW RISK	157CM	75KG	30.4	SPONTANEOUS	NA	YES	NA	NA	YES	LSCS	FETAL DISTRESS	8	9	NO	3.2KG	NO	7DAYS	HEALTHY	NO	NO	PH-7.30
261	ER261	22Y	R	LOW	PRIMIGRAVIDA	40WEEKS 3DAYS	LOW RISK	163CM	70KG	26.3	INDUCED	3CP,S 3CT'S	NO	27HRS 10MIN	26MIN	NO	VAGINAL	NO	8	9	NO	2.9KG	NO	5DAYS	HEALTHY	NO	NO	ABG- NOT SENT
262	ER262	33Y	UR	MIDDLE	MULTIGRAVIDA	40WEEKS 5 DAYS	LOW RISK	150CM	68KG	30.2	SPONTANEOUS	NA	FETAL DISTRESS	NA	NA	YES	LSCS	FETAL DISTRESS	8	10	NO	2.8KG	NO	6DAYS	HEALTHY	NO	NO	PH-7.31
263	ER263	31Y	R	LOW	PRIMIGRAVIDA	40WEEKS 1 DAY	HIGH RISK	163CM	98KG	36.8	INDUCED	CP-CT	FETAL DISTRESS	14HRS	NA	YES	LSCS	FETAL DISTRESS	7	8	NO	3.1KG	NO	7DAYS	HEALTHY	NO	HYPOTHYROIDISM	PH-7.36
264	ER264	25Y	R	LOW	PRIMIGRAVIDA	40WEEKS 3DAYS	HIGH RISK	167CM	74KG	26.5	INDUCED	3CP'S-3CT'S	FETAL DISTRESS	30HRS	34MIN	YES	VENTOUSE	NA	8	9	NO	2.5KG	NO	5DAYS	HEALTHY	NO	GHTN	PH-7.18
265	ER265	22Y	UR	LOW	PRIMIGRAVIDA	40WEEKS 1 DAY	HIGH RISK	150CM	52KG	23.1	AUGMENTED	2CT,S	THICK MSL	NA	NA	YES	LSCS	FETAL DISTRESS	8	9	NO	2.8KG	NO	7DAYS	HEALTHY	NO	PROM	PH-7.34
266	ER266	24Y	R	LOW	PRIMIGRAVIDA	40WEEKS 5 DAYS	HIGH RISK	146CM	51KG	23.9	INDUCED	3CP'S	NO	13HRS 15MIN	28MIN	NO	VAGINAL	NA	8	9	NO	2.7KG	NO	4DAYS	HEALTHY	NO	LATE ONSET FGR	ABG- NOT SENT
267	ER267	26Y	UR	LOW	PRIMIGRAVIDA	40WEEKS 2DAYS	LOW RISK	157CM	68KG	27.5	SPONTANEOUS	NA	NO	NA	NA	NO	LSCS	CDMR	8	9	NO	3KG	NO	6DAYS	HEALTHY	NO	NO	ABG- NOT SENT
268	ER268	23Y	R	LOW	PRIMIGRAVIDA	40WEEKS 1 DAY	LOW RISK	148CM	55KG	25.4	SPONTANEOUS	NA	NO	12HRS 3OMIN	26MIN	NO	VAGINAL	NA	8	9	NO	2.9KG	NO	5DAYS	HEALTHY	NO	NO	ABG- NOT SENT
269	ER269	20Y	R	LOW	PRIMIGRAVIDA	40 WEEKS 2DAYS	LOW RISK	158CM	68KG	27.2	INDUCED	2CP'S	FETAL DISTRESS	10HRS	NA	YES	LSCS	FETAL DISTRESS	8	9	NO	3.1KG	NO	7DAYS	HEALTHY	NO	NO	PH-7.26
270	ER270	22Y	R	LOW	PRIMIGRAVIDA	40WEEKS 1 DAY	HIGH RISK	159CM	69KG	27.2	SPONTANEOUS	NA	THICK MSL	NA	NA	YES	LSCS	FETAL DISTRESS	8	9	NO	2.5KG	NO	6DAYS	HEALTHY	NO	GDM	PH-7.35
271	ER271	24Y	R	LOW	PRIMIGRAVIDA	40WEEKS 4DAYS	HIGH RISK	152CM	71KG	30.7	INDUCED	3CP'S-1CT	NA	26HRS 30 MIN	34MIN	NO	VAGINAL	NO	8	9	NO	3KG	NO	5DAYS	HEALTHY	NO	BETA THALASSEMIA	ABG- NOT SENT
272	ER272	25Y	R	MIDDLE	PRIMIGRAVIDA	40WEEKS 3DAYS	LOW RISK	161CM	76KG	29.3	INDUCED	CP	FETAL DISTRESS	5HRS 15MIN	NA	YES	LSCS	FETAL DISTRESS	8	9	NO	2.5KG	NO	6DAYS	HEALTHY	NO	NO	PH-7.23
273	ER273	24Y	R	LOW	MULTIGRAVIDA	40WEEKS 6DAYS	HIGH RISK	160CM	78KG	30.4	INDUCED	2CP,S	FETAL DISTRESS	9HRS 2OMIN	NA	YES	LSCS	FETAL DISTRESS	7	9	NO	2.6KG	NO	7DAYS	HEALTHY	NO	LATE ONSET FGR	PH-7.31
274	ER274	23Y	R	LOW	PRIMIGRAVIDA	40WEEKS 4DAYS	LOW RISK	157CM	76KG	30.8	INDUCED	3CP'S	NO	15HRS	32MIN	NO	VAGINAL	NA	7	9	NO	2.9KG	YES(HYPERBILIRUBINEMIA)	5DAYS	HEALTHY	NO	NO	ABG- NOT SENT
275	ER275	24Y	UR	LOW	PRIMIGRAVIDA	41WEEKS 1 DAY	HIGH RISK	150CM	54KG	24	SPONTANEOUS	NA	ANAMNIOS	NA	NA	NO	LSCS	ANAMNIOS	8	9	N0	3KG	NO	4DAYS	HEALTHY	NO	SEVERE PREECLAMPSIA	ABG- NOT SENT
276	ER276	20Y	R	LOW	PRIMIGRAVIDA	40 WEEKS 2DAYS	LOW RISK	160CM	70KG	27.3	SPONTANEOUS	3CPS	NO	13HRS 30MIN	NA	NO	LSCS	CPD	8	9	NO	2.9KG	NO	7DAYS	HEALTHY	NO	NO	ABG- NOT SENT
277	ER277	23Y	R	LOW	PRIMIGRAVIDA	40 WEEKS 2DAYS	LOW RISK	150CM	76KG	33.7	SPONTANEOUS	NA	NO	16HRS	32MIN	NO	VAGINAL	NA	7	8	NO	2.8KG	NO	5DAYS	HEALTHY	CERIVICAL TEAR	NO	ABG- NOT SENT
278	ER278	30Y	R	LOW	PRIMIGRAVIDA	40 WEEKS 2DAYS	LOW RISK	154CM	80KG	33.7	INDUCED	2CPS	THICK MSL	9HRS 2OMIN	NA	YES	LSCS	FETAL DISTRESS	8	9	NO	3.1KG	NO	6DAYS	HEALTHY	NO	NO	PH-7.30
279	ER279	26Y	R	LOW	PRIMIGRAVIDA	40 WEEKS 2DAYS	LOW RISK	150CM	60KG	26.6	INDUCED	CP	NO	7HRS 30MIN	20MIN	NO	VAGINAL	NA	8	9	NO	2.8KG	NO	4DAYS	HEALTHY	NO	NO	ABG- NOT SENT
280	ER280	24Y	UR	LOW	PRIMIGRAVIDA	40WEEKS 4DAYS	HIGH RISK	150CM	60KG	26.6	AUGMENTED	OXYTOCIN	THICK MSL	5HRS	26MIN	NO	VAGINAL	NA	0	0	NA	3.3KG	NO	5DAYS	HEALTHY	NO	IUD	ABG- NOT SENT
281	ER281	26Y	R	LOW	PRIMIGRAVIDA	40 WEEKS 2DAYS	LOW RISK	160CM	74KG	28.9	INDUCED	2CP'S	FETAL DISTRESS	8HRS 15MIN	NA	YES	LSCS	FETAL DISTRESS	8	9	NO	3.2KG	NO	6DAYS	HEALTHY	NO	NO	PH-7.25
282	ER282	27Y	R	LOW	PRIMIGRAVIDA	40WEEKS 3DAYS	LOW RISK	154CM	68KG	28.6	INDUCED	3CP-2CT	NO	22HRS 3OMIN	NA	NO	LSCS	PERSISTENT OCCIPO POSTERIOR	8	9	NO	3.3KG	NO	6DAYS	HEALTHY	NO	NO	ABG- NOT SENT
283	ER283	24Y	UR	MIDDLE	PRIMIGRAVIDA	40WEEKS 3DAYS	HIGH RISK	148CM	56KG	25.5	INDUCED	DILAPIN-CT	MSL	20HRS	NA	YES	LSCS	FETAL DISTRESS	7	9	NO	3.3KG	NO	6DAYS	HEALTHY	NO	HYPOTHYROIDISM	PH-7.23

S.NO	ENROLMENT NUMBER	AGE	R/UR CASE	SOCIO ECONOMIC STATUS	OBSTETRIC SCORE	POG	LOW/HIGH RISK	HEIGHT	WEIGHT	BMI	SPONTANEOUS/INDUCED LABOUR	TYPE OF INDUCTION	INTRAPARTUM COMPLICATIONS	DURATION OF 1ST STAGE	DURATION OF 2ND STAGE	FETAL DISTRESS AT WHAT STAGE	MODE OF DELIVERY	INDICATION FOR LSCS	APGAR 1'MIN	APGAR 5'MIN	RESUSCITATION MEASURES	BABY WEIGHT	NICU ADMISSION	DURATION OF HOSPITAL STAY	CONDITION OF BABY AT DISCHARGE	MATERNAL COMPLICATIONS	RISK FACTORS	BLOOD GAS ANALYSIS - BABY
284	ER284	24Y	R	MIDDLE	MULTIGRAVIDA	40WEEKS 1 DAY	HIGH RISK	152CM	70KG	30.2	AUGMENTED	1CP	NO	5HRS 10MIN	30MIN	NO	VAGINAL	NO	7	8	NO	2.7KG	NO	5DAYS	HEALTHY	NO	FGR WITH BRAIN SPARING EFFECT	ABG- NOT SENT
285	ER285	21Y	R	LOW	MULTIGRAVIDA	40WEEKS 3DAYS	LOW RISK	149CM	71KG	31.9	SPONTANEOUS	NA	NO	6HRS 30NIN	6MIN	NO	VAGINAL	NO	8	9	NO	3.3KG	NO	4DAYS	HEALTHY	NO	NO	ABG- NOT SENT
286	ER286	20Y	R	LOW	MULTIGRAVIDA	40 WEEKS 2DAYS	LOW RISK	151CM	64KG	28	SPONTANEOUS	NA	NO	8HRS 15MIN	3MIN	NO	VAGINAL	NO	7	8	NO	2.9KG	YES(HYPERBILIRUBINEMIA)	3DAYS	HEALTHY	NO	NO	ABG- NOT SENT
287	ER287	22Y	R	LOW	PRIMIGRAVIDA	40WEEKS 5 DAYS	LOW RISK	150CM	53KG	23.5	AUGMENTED	2CP'S	FETAL DISTRESS	7HRS 30MIN	NA	YES	LSCS	FETAL DISTRESS	8	9	NO	3.2KG	NO	6DAYS	HEALTHY	NO	NO	PH-7.32
288	ER288	23Y	R	LOW	PRIMIGRAVIDA	40WEEKS 5 DAYS	LOW RISK	152CM	62KG	26.8	INDUCED	3CPS-1CT	FETAL DISTRESS	18HRS 22MIN	NA	YES	LSCS	FETAL DISTRESS	7	8	NO	2.9KG	NO	7DAYS	HEALTHY	NO	NO	PH-7.26
289	ER289	21Y	UR	LOW	PRIMIGRAVIDA	41WEEKS	HIGH RISK	143CM	54KG	23	INDUCED	CP	THICK MSL	7HRS	NA	YES	LSCS	FETAL DISTRESS	7	8	NO	2.8KG	NO	6DAYS	HEALTHY	NO	LATE ONSET FGR	ABG- NOT SENT
290	ER290	28Y	UR	LOW	MULTIGRAVIDA	40 WEEKS 2DAYS	LOW RISK	161CM	72KG	27.7	INDUCED	CP	THICK MSL	8HRS 30MIN	NA	YES	LSCS	FETAL DISTRESS	7	9	NO	3.5KG	NO	6DAYS	HEALTHY	NO	NO	PH-7.30
291	ER291	31Y	R	LOW	PRIMIGRAVIDA	40 WEEKS 2DAYS	LOW RISK	144CM	48KG	23.1	SPONTANEOUS	NA	NO	NA	NA	NO	LSCS	OLIGOHYDRAMNIOS	7	9	NO	2.9KG	NO	6DAYS	HEALTHY	NO	NO	ABG- NOT SENT
292	ER292	28Y	R	LOW	PRIMIGRAVIDA	40WEEKS 1 DAY	LOW RISK	142CM	50KG	24.7	INDUCED	2CP-CT	NO	14HRS 15MIN	24MIN	NO	VAGINAL	NA	8	9	NO	3KG	NO	4DAYS	HEALTHY	NO	NO	ABG- NOT SENT
293	ER293	27Y	R	LOW	PRIMIGRAVIDA	40WEEKS 1 DAY	LOW RISK	144CM	52KG	25	SPONTANEOUS	NA	NO	NA	NA	NO	LSCS	FETAL DISTRESS	8	9	NO	3KG	NO	7DAYS	HEALTHY	NO	NO	ABG- NOT SENT
294	ER294	24Y	R	LOW	PRIMIGRAVIDA	40WEEKS 4DAYS	LOW RISK	150CM	68KG	30.2	SPONTANEOUS	3CP'S-6CT	NO	38HRS 30MIN	NA	NO	LSCS	FAILED INDUCTION	7	8	NO	3.2KG	YES(HYPERBILIRUBINEMIA)	8DAYS	HEALTHY	NO	NO	ABG- NOT SENT
295	ER295	26Y	R	LOW	PRIMIGRAVIDA	40 WEEKS 2DAYS	HIGH RISK	163CM	98KG	36.8	SPONTANEOUS	NA	NO	NA	NA	NO	LSCS	ANAMNIOS	7	8	NO	2.4KG	NO	6DAYS	HEALTHY	NO	ANAMNIOS	ABG- NOT SENT
296	ER296	26Y	R	LOW	PRIMIGRAVIDA	40WEEKS 3DAYS	HIGH RISK	160CM	74KG	28.9	INDUCED	3CP'S-5CT	NO	42HRS	NA	NO	LSCS	NON REASSURING NST	8	9	NO	2.7KG	NO	7DAYS	HEALTHY	NO	LATE ONSET FGR	ABG- NOT SENT
297	ER297	37Y	R	LOW	MULTIGRAVIDA	40WEEKS 1 DAY	HIGH RISK	154CM	68KG	28.6	INDUCED	2CP'S	NO	13HRS	10MIN	NO	VAGINAL	NA	7	9	NO	2.4KG	NO	5DAYS	HEALTHY	NO	GHTN	ABG- NOT SENT
298	ER298	33Y	UR	LOW	MULTIGRAVIDA	40WEEKS 4DAYS	HIGH RISK	154CM	80KG	33.7	SPONTANEOUS	NA	THICK MSL	NA	NA	NO	LSCS	FETAL DISTRESS	7	9	NO	2.8KG	NO	6DAYS	HEALTHY	NO	GHTN WITH PROM	ABG- NOT SENT
299	ER299	28Y	UR	LOW	MULTIGRAVIDA	40 WEEKS 2DAYS	LOW RISK	157CM	76KG	30.8	INDUCED	2CP'S	NO	12HRS	10MIN	NO	VAGINAL	NA	7	8	NO	3.1KG	NO	5DAYS	HEALTHY	NO	NO	ABG- NOT SENT
300	ER300	26Y	R	LOW	PRIMIGRAVIDA	40WEEKS 1 DAY	HIGH RISK	150CM	54KG	24	NA	NA	NA	NA	NA	NO	LSCS	ANAMNIOS	7	9	NO	2.5KG	YES(HYPERBILIRUBINEMIA)	6DAYS	HEALTHY	NO	OLIGOHYDRAMNIOS	ABG- NOT SENT