Postmaturity syndrome pdf

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The normal length of pregnancy is 37 to 41 weeks. Early term is from 37 weeks to 38 weeks and 6 days. Full term is 39 weeks to 40 weeks and 6 days. Late term is 41 weeks to 41 weeks and 6 days. Postmaturity (dysmaturity) is a word used to describe babies born after 42 weeks. Very few babies are born at 42 weeks or later. Other terms often used to describe these late births include post-term, postmaturity, prolonged pregnancy, and post-dates pregnancy. What causes postmaturity in the newborn? Researchers don't know why some pregnancies last longer than others. Sometimes a mother's pregnancy due date is off because she is not sure of her last menstrual period. Getting the date wrong may mean the baby is born earlier or later than expected. Getting an ultrasound in the first trimester (the first 12 weeks) is the most accurate way to tell the date of pregnancy, unless the date of conception is specifically known, such as with in vitro fertilization. Who is at risk for postmaturity in the newborn? Postmaturity is more likely to happen when a mother has had a post-term pregnancy before. After one post-term pregnancy, the risk of a second post-term birth increases by 2 to 3 times. Other, minor risk factors include: First pregnancy Male baby Older mother Obese mother Mother or father with personal history of postmaturity White mother What are the symptoms of postmaturity in the newborn? Each baby may show different symptoms of postmaturity. Some of those symptoms are: Dry, loose, peeling skin Overgrown nails Large amount of hair on the head Visible creases on palms and soles of feet Small amount of fat on the body Green, brown, or yellow coloring of skin from baby passing stool in the womb More alert and "wide-eyed" Symptoms of postmaturity sometimes look like other health conditions. Make sure your child sees his or her healthcare provider for a diagnosis. How is postmaturity in the newborn diagnosed? Your baby's healthcare provider will check: Your baby's physical appearance The length of your pregnancy How old your baby appears to be How is postmaturity in the newborn treated? Your healthcare provider will check your unborn baby's health and look for any problems. Tests may need to be done such as: Ultrasound Nonstress testing. This looks at how the fetal heart rate responds to fetal movement. Checking the amount of amniotic fluid Your healthcare provider may decide to start your labor early, depending on several things. During labor, your baby's heart rate may be watched with an electronic monitor. This will help spot changes in the heart rate caused by low oxygen levels. Changes in your baby's condition may require a cesarean delivery. Special care of the post-term baby may include: Checking for breathing problems caused by baby's breathing in fluid containing the first stools (meconium) Blood tests for low blood sugar What are the possible complications of postmaturity in the newborn? Post-term babies are born after the normal length of pregnancy. Because of this they may grow larger than full-term babies. This may be a problem during labor and delivery. Also, because the placenta ages toward the end of pregnancy, it may not work as well as before. Concerns from placental aging include: Less amniotic fluid. This may stop the baby from gaining weight or may even cause weight loss. Poor oxygen supply. Babies who don't get enough oxygen may have problems during labor and delivery. Meconium aspiration. Babies who stay in the womb longer are more likely to breathe in fluid containing meconium. Hypoglycemia or low blood sugar. This happens when the baby has already used up his or her stores of glucose. Can postmaturity in the newborn be prevented? Knowing your due date is the best way to know if your baby may be post-term. Keep track of the first day of your menstrual period. This can help estimate a baby's due date. An ultrasound test early in pregnancy can also help your healthcare provider figure out your baby's age by checking the baby's size. Ultrasound is also a good way to check the placenta for signs of aging. Key points about postmaturity in the newborn Postmaturity is a word used to describe babies born after 42 weeks. Researchers don't know why some pregnancies last longer than others. Postmaturity is more likely to happen when a mother has had a post-term pregnancy before. Your healthcare provider may decide to start your labor early. An ultrasound test early in pregnancy can help your healthcare provider figure out your baby's age by checking the baby's size. Next steps Tips to help you get the most from a visit to your child's healthcare provider: Know the reason for the visit and what you want to happen. Before your visit, write down questions you want answered. At the visit, write down the name of a new diagnosis, and any new medicines, treatments, or tests. Also write down any new instructions your provider gives you for your child. Know why a new medicine or treatment is prescribed and how it will help your child. Also know what the side effects are. Ask if your child's condition can be treated in other ways. Know why a test or procedure is recommended and what the results could mean. Know what to expect if your child does not take the medicine or have the test or procedure. If your child has a follow-up appointment, write down the date, time, and purpose for that visit. Know how you can contact your child's provider after office hours. This is important if your child becomes ill and you have questions or need advice. The obstetric problem of going past the date of expected confinement has no medical significance, provided the fetus in its demands does not outgrow placental capability. The problem of relative placental insufficiency, however, is a serious one with a total fetal wastage in the neighborhood of 15 per cent.Antepartum indications of such placental insufficiency have not yet been well documented. However, a decrease in the fundal measurements and particularly where associated with an otherwise unexplained loss of maternal weight has proved an ominous sign.In a study of application of reported criteria for determining when a patient is "at term" by vaginal cytologic methods, the results were approximately 75 per cent accurate. Cytologic studies when coupled with other physical findings may be of assistance in determining in which cases labor should be induced and in which the fetuses should be accorded the special attention that is demanded by the chronic state of low grade anoxia.Full text is available as a scanned copy of the original print version. Get a printable copy (PDF file) of the complete article (679K), or click on a page image below to browse page by page. Down syndrome, or trisomy 21, is a genetic disorder and chromosomal condition characterized by a third copy of chromosome 21. Normally, people are born with 46 chromosomes, but in a person with Down syndrome, 47 chromosomes are present. The cause of Down syndrome is unknown, but risk factors for having a baby with Down syndrome include: being pregnant over the age of 35, having a sibling with Down syndrome, having a child with Down syndrome. People with Down syndrome have distinctive features including a flat face, slanted eyes, and small ears and mouths. They also have shorter necks, arms, and legs than the norm. In almost all cases, those with Down syndrome will have physical and mental disabilities. Adults with Down syndrome function intellectually at an 8- or 9-year-old level. They also have an increased risk for other health problems. People with Down syndrome begin cognitive decline at an earlier age than those without. Typically, at around the age of 50, they will start to experience gradual loss of memory, judgement, and their ability to function. Approximately 50% of people with Down syndrome will develop Alzheimer's disease. When I began my Pediatrics residency in 1971, "Clifford's syndrome" was a common diagnosis in the neonatal intensive care unit. Clifford described the unique features of this disorder in his now classic article in The Journal of Pediatrics in 1954—post-term delivery; scrawniness; loss of vernix; dry, peeling, green to yellow discolored skin; frequent asphyxia; pathology of the lungs (meconium and amniotic fluid aspiration) and the central nervous system (hypertonicity, seizures, and intracranial hemorrhage); and a high mortality rate. Clifford attributed this disorder to placental dysfunction, which he defined as increasing failure to transfer nutrients to the fetus as the placenta aged past normal term (300 days since conception according to Clifford's definition). Clifford noted that the post-term condition occurred more commonly in the older (late 20s!) primagravida, most of whom did not get pregnant again (the reasons why are still ambiguous), and accounted for a major fraction of perinatal deaths, more prenatally than postnatally. We don't see "Clifford's Syndrome" as often any more. Improved fetal surveillance identifies placental and fetal growth restriction and decreased placental blood flow more commonly and earlier in pregnancy, leading to pre-emptive delivery, often before term. We also know that placental insufficiency is not due simply to aging of the placenta, but to placental and fetal pathology, although mechanisms responsible for decreased placental growth and nutrient transfer remain poorly understood. We also understand that the apparent reduction of fetal growth towards term is the result of including growth restricted with normally grown infants in cross sectional neonatal estimates of fetal growth. However, direct observation by ultrasound shows linear fetal growth curves to the end of gestation. Animal and human studies show an increase in placental nutrient transfer capacity with gestational age, even when placental growth naturally slows or stops. Prolonged gestation, however, is still a highly morbid and often mortal condition, prompting elective delivery before 42 weeks in most cases. Even today for those infants with clinical features described by Clifford 50 years ago, long-term complications of poor neurodevelopment are common. Fetal pathology (such as abnormal neurodevelopment, fetal infection, thrombophilia with fetal stroke, etc) from other than (or including) placental growth and nutrient transfer failure is responsible for the failed development of the normal fetal signals that activate or contribute to the onset of labor and normal term delivery.Clifford SH. J Pediatr 1953;44:1-13DOI: � 2004 Elsevier Inc. Published by Elsevier Inc. All rights reserved.Access this article on ScienceDirect

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