



Date of induction meaning in hindi. Post dates induction of labour. Dates for induction of labour. Date of induction meaning. Induction of labour in post dated pregnancy. Date of induction programme. Date of induction military.

Hello, everyone. on today's podcast, we'll talk about the evidence on the induction of work to exceed the expiry date. Welcome to birth based on evidence. Join me every week while working together to get evidence-based information in the hands of families and professionals around the world. As a reminder, this information is not a medical advice. see ebbirth.com/disclaimer for more details. Hello, everyone. on today's podcast, we will talk about the evidence on education against waiting for work when you go beyond the expiry date. I will be reached by anna berton, mph, our research editor at birth based on evidence to talk about this topic. Before we start, I have a quick announcement, and this is the next week that we are hosting free webinars for the public all over the birth class of evidence. Monday, March 2, we host a special webinars for the public all over the birth class of evidence. based on birth birth. then on Tuesday, March 3, we would have a special webinar only for birth professionals to give you a class tour based on the birth of evidence so that you can decide whether it is something you like to recommend your customers or not. you can register for these free webinars on testbasedbirth.com/childbirthclasswebinar. this is all a word / childbirthclasswebinar. All right, now go back to the topic at your fingertips, inducing the job to get over your due dates. Now before you start, I want to give a short trigger warning. in our discussion on research tests on this subject, we will talk about death and newborn. so there has been a lot of new research on induction tests against waiting for work when you go beyond the expiry date. we decided to separate our signature articles. so we still have the original article, the evidence on the dates due, which you can find on ebbirth.com/Dedates. and although we updated that article a little, it remained very similar to the previous additions. speaks of the length of a normal pregnancy, factors that can make you more or less likely to have a long pregnancy, et cetera. but then we separated the induction research into a new article that you can find on ebbirth.com/inducingDedates. this is a peer-reviewed article that covers all induction research compared to something called "excessive" management" to exceed the expiry date. and in today's podcast, we will update the latest information we found for that article. Just a stubborn, we won't cover the research evidence on education39 weeks. We have already covered the arrival study, a randomized process that examined the induction against the pending management for 39 weeks of pregnancy in Episode 10 of theBirth podcast. And only a suggestion, if you have difficulty finding one of our previous episodes of this podcast, iTunes stopped to show the first podcast, but they are still outside and you can find on Spotify and any other podcast. won't talk about induction to 39 weeks. Instead, we are focusing on induction tests against work awaiting work once you reach 41 weeks. And to do so, we'll talk to our search editor, Anna. So, Welcome, Anna, to the balancing podcasts based on trials. Anna Bertone: Thank you! I'm happy to be back on the podcast. So I want to start explaining to our audience a bit of a background of why this topic is important. In the last 30 years there are increasing inductions for non-medical reasons in the United States and all over the advantages and risks of elective induction to pass over the expected date. And we will talk even if your goals and preferences for your birth matter, which naturally do, but this kind of plays a role as well. How often are people induced for having passed their appointment? Well, we don't know for sure because this has not been measured recently. But according to 2013 listening to the survey of mothers III, which was published about seven years ago, more than 4 mothers out of 10 in the United States said their care provider tried to induce work. Induce work to go beyond the due date was one of the most common reasons for induction. From all those who have had an induction in this study, 44% said they were induced because their child was at full time and was close to due date. Another 18% said they were induced because the health care provider was worried that the mother was late. Disease Control Centers in the United States also reported in 2018 that about 27% of people had their job induced, but we think the number is probably low and that the percentage of people who have led the job is Under-reported in the Vital Statistics Program in the United States. So Anna, you can talk a little about why there is so many controversy on this concept of elected work inductions by definition are construction inductions that do not have a clear medical reason to take place. They occur for social reasons, such as the supplier who wants the mother to start before the supplier bends from the city or other non-medical reasons such as pregnancy uncomfortable and for the convenience of the mother. But there is also an area on what constitutes an elective induction. Many suppliers consider only an induction be "elective" when the mother is healthy, pregnant with only one child and pregnancy goes beyond 41 weeks, some suppliers believe it is medically indicated induction rather than elective induction. But in general, inductions are considered clinically indicated when there are accepted medical problems or complications with pregnancy. For many years, and I remember when I joined the birthplace in 2012, a lot of people talked about the fact that if you have an induction doubles the likelihood of cesareus And then suddenly there were people saying that it was not true. So, can you talk to us about this controversy? Anna Bertone: For many years it has been believed that elective induction doubled the rate of cesarean, especially in neo-madri. But researchers nowadays consider those previous studies as defective. In previous studies, what they would have done is to compare people assigned to elective induction with people entering spontaneous labor. Today, these two groups are no longer confronted. They compare people assigned to elective induction with people assigned to what is called waiting management, or in other words waiting for work. And in that group, the person may go into spontaneous labor or may require induction for medical reasons (so it would be clinically indicated induction), or may choose elective induction later in pregnancy. So this is a subtle difference, but important, because in previous studies they compared the elective induction to spontaneous work. But today you don't have the choice to go into spontaneous labor. Your choice must be induced today or wait for the labor to begin. And sometimes during this waiting period you can develop complications that require induction, or you can develop complications that require induction, or you can develop complications that require induction and decide to have an elective induction. assigned to the elective induction with a group assigned to the pending management. An example of this was the ARRIVE process. The ARRIVE study was a study that compared the elective induction to 39 weeks with the management of expectation. We will not enter into the details of that process because we have already treated it in detail in Episode 10 of the podcasts Evidence Based Birth. But they found a lower risk of cesareus in the elective induction group. Researchers think it had to deal with the fact that people in the waiting management group, more than they developed problems with blood pressure that required medical inductions and increased risk for complications. So once again, this shows that it makes a difference when comparing induction with the management of expectations. Although, one thing you have to keep in mind with the ARRIVAL the Management of expectations. 22% in the waiting management group. So these research results probably cannot be generalized to environments with extremely high caesarean rates or high caesarean rates or high caesarean rates or high caesarean rates or high caesarean rates with induction. We have some, for example, some professional members of the Evidence Battered Birth that they told us about where they are practicing and how high the caesarean rates with the elective induction. So I think you should be careful about how to generalize or apply the study data arrives, and we will talk about it more in episode 10 of the podcast. Which leads me to another point, and that is some warnings on the tests. When I say generalize, I intend to take research from a research study, and see if you can apply to where people are giving birth to in your community. So it is important to understand that there are big disadvantages in some of the research we will talk about. Many of the studies are conducted in an environment in which culturally there are low caesarean rates, this may not apply to a hospital with high caesarean rates. If the hospital has high rates of â â â â induction failed "and rigorous time limits regarding the duration of labor, the evidence of these studies may not be applicable to you because induction could be more risky in the TM Community Hospital. Furthermore, another disclaimer on trials, in these studies, people are randomly assigned to the management of induction or expectation. And it is important to remember that the persons assigned to the management do not always work spontaneously. There is a mixture of people in that group. Some of them have a spontaneous labor. Others have an elective induction later, and others have a medical induction for complications. Also, you have to look at what they are doing for fetal tests in studies. In some studies in which they have not performed any standard fetal monitoring during the expected management. So those results may not be valid for your community if your community makes fetal monitoring, and the study does not have fetal monitoring. Finally, another disclaimer about the evidence of research is that the induction protocols vary from Studio to Studio, and also within the studies themselves. So to know what the protocol for induction in that study can be very useful to decide if this will apply to your particular situation in your local community or not. Therefore, with all these exclusions of There have been many new research in the last year on 41 week induction. So, Anna, can you talk to me about one of the most recent studies? Let's talk about the Index Index studio Netherlands. There were two studies published in 2019, two large randomized control studies. LetâINDEX first. Anna Bertone: Of course. So the INDEX is synonymous with induction at 41 weeks, management waiting up to 42 weeks. This was a large multi-centre studio. It has been conducted in 123 obstetric clinics and 45 hospitals. Most of these pregnancies were managed by midwives. So this was the model of assistance guided by midwives. So this was the model of assistance guided by midwives. So this was the model of assistance guided by midwives. before 42 weeks with an uncomplicated pregnancy. A"While in the United States it is rare to see someone going to 42 weeks, in the Netherlands they usually do not induce except for medical reasons. up to 42 weeks, in the Netherlands they usually do not induce except for medical reasons. with single babies and upside down. Gestational age was evaluated with ultrasound before 16 weeks of pregnancy. People with a previous Caesarean section, with hypertension disorders, with expected problems in the child's growth, abnormal foetal heart rate, or known foetal malformations (congenital abnormalities) were excluded. In both groups, the methods of cervical maturation and induction. It was based on local protocol. It's like the one Rebecca was talking about before. In this study, there was no standard protocol for both groups for cervical maturation and induction. It was based on local protocol. And that's a major weakness of the study, because vendors may have handled labor induction differently depending on whether someone was induced electively or assigned to the waiting management group. It also limits the general population, as providers do not have an induction protocol that they can replicate. So we can learn from what has happened in this study, but for us it is difficult to apply it at all levels, because there is no specific induction protocol that can be followed. Al Anna Bertone: Yes. What happened was in the elective induction group, 29% of the participants went into labor before their induction and 71% were induced. Then, in the waiting management group, 74% of the had spontaneous labour before scheduled induction and 26% induced it. "And before I talk about the length of pregnancies, I think it's important people to understand that when you have a randomized controlled process like this, researchers do something called intent to deal with the analysis. So no matter what kind of birth they had, whether it was spontaneous labor or medical induction, the data were analyzed according to the group they were originally assigned to. So if you've been assigned to an elective induction, but you happen to quickly go to work on your own before the induction, but you happen to quickly go to work on your own before the induction. important distinction for people to understand. â Anna Bertone: Yes. What happened with these results is that the median pregnancy was only two days shorter in the elective induction group than in the waiting management group. This is interesting because they still found a difference between these two groups, but- ... And that's important because a lot of people ask us how, "Well, I just want to wait another day, or two more days, or three or four more days, rates. This was taking place in a country with low Caesarean rates. This was a model of obstetric care and the rates were very low in both groups (11%). They also had a result called a composite result, which is a combined result for mothers, and there was no difference to that extent. They were looking for things like excessive bleeding after birth, manual removal of the placenta, severe tears, intensive care admission, and maternal deaths in either group. As for poor outcomes for mothers, there were about 11% to 14% in both groups, but not different And then for the children? â Anna Bertone: And then for the children in the elective induction group had a lower composite outcome rate. And in this composite result, what they were looking at was perinatal death, Apgar score less than seven to five minutes, low pH, meconium aspiration syndrome, nerve injury, brain bleeding, or admission to a NICU. And here they found a low composite negative outcome rate with children in the elective induction group? Anna Bertone: They think it was mainly due to the lower rate of Apgar scores less than seven to five minutes, and that probably contributed the most to having a lower negative outcome rate children in the elective induction group. The author's note that there was no difference in the rates of Apgar score less than four to five minutes and fetal malformations excluded. So, basically, children in the elective induction group had better Apgar scores overall. What about the dead? Because it is like the main reason why these types of elective induction are doing, it is to reduce the risk of rebirth. a revival that occurred in the elective induction group. It was 40 weeks and six days before the mother was induced. Then, there were two still lifes that occurred in the management group waiting for work. Anna Bertone: I've been looking for more details about those properties because I was interested in this. Of the two still deaths that occurred in the waiting management group, one was a small for the child gestational age to 41 weeks and four days. The placenta of the mother showed signs of infection (infection of the membranes). Then, what happened in the elective induction group at 41 weeks was to an experienced mother (some who had already born before), and who was at 40 weeks and six days, and there was no explanation for that. But with two against one, they did not find significant differences of still life between those groups. And what was the protocol for fetal monitoring in this study? Anna Bertone: There was no protocol for fetal monitoring. It depended on the local guidelines, just like the protocol of induction and cervical maturation. But study on the INDEX? Anna Bertone: They found that elective induction at 41 weeks led to similar rates and less overall negative results for children than waiting for work up to 42 weeks. However, they say that the absolute risk of a bad outcome was low in both groups. It was 1.7% in the elective induction group against 3.1% in the waiting management group (the group that waited up to 42 weeks). All right. Well, the next study we wanted to talk about was the SWEPIS process from Sweden, also published in 2019, even outside Europe. It is S-W-E-P-I-S, and is for the Swedish post-term induction study, or SWEPIS. He has a lot of media attention with titles like... There was one who said: "Research on short-term pregnancy canceled after six dead children." And it is true that this study was finished early after death in the studio. Researchers haveenroll 10,000 mothers from multiple centers across Sweden, but ended up stopping the study with about 1,380 people in each group after their data security and and the council found a significant difference in perinatal death among groups. Data security and monitoring boards are basically a tab that tracks what is happening in the studies. This is a standard part of a lot of randomized controlled trials is to have one of these security cards. Similarly to the INDEX process in the Netherlands, Sweden, work is not induced before 42 weeks if you have a simple pregnancy. Similar to the Netherlands, in Sweden, ostetrics manage most pregnancy and birth. It is an obstetric guide model. The purpose of the SWEPIS study was to compare elective induction to 41 weeks and zero to two days against management and induction waiting to 42 weeks and zero to one day if the mother had not entered work within that point. The study was carried out in the years 2015-2018. The researchers have enrolled healthy mothers with single children in the first position. They had accurate gestational ages. They excluded people with cesarean, diabetes and other complications such as hypertension, small for gestational age, or known fetal malformations. There is a rather low growth rate in Sweden, so they thought they would need about 10,000 people to see a difference between groups, but they and the great set and t strengths of the SWEPIS process is that in contrast to the INDEX process, in the SWEPIS process they defined an induction protocol and used the same protocol with all in the elective induction group and all in the expected management group that had an induction. The protocol was basically if the cervix of the mother was already mature, simply broke the water and gave her oxytocin according to the needs of the IV. If the cervix of the mother was not mature or the head of the child was not engaged, they used mechanical methods or Misoprostol, or prostaglandine, or oxytocin, but they did cervical maturation before. In the elective induction group, most people were induced. 86% led their work. 14% entered work spontaneously before induction. In the waiting management group, 67% of them went into work spontaneously and 33% ended with an induction. Similarly to the INDEX process, there was a small difference in the length of pregnancy among groups. Pregnancy in the elective induction group was generally only three shorter days of pregnancy in the waiting management group, but nevertheless they continued to find significant differences. What the SWEPIS process found is that for children - that's why this study was interrupted- there were five deaths for a death rate of 4.4 deaths for 1,000 women. In the elective induction group, zero was killed on 1,381 participants. 5 properties in the waiting management group happened in 41 weeks, six days. Three of the buildings had no explanation. One was for a child who was small for the gestational age. The other was with a child who had a heart defect. There was a newborn death that occurred four days after birth due to a failure of multiple organs in a child that was great for the gestational age. Authors said that when complications are present at the end of pregnancy, such as placenta problems, or umbilical cord, or fetal growth, these problems can become more and more important as every day of pregnancy progresses, which they believe is why they found a higher death rate with pending management over 41 weeks. Another key point in the study was that all these deaths occurred to first-time mothers, which suggests that induction of 41 weeks can be particularly useful for first-time mothers children. They discovered that it took only 230 inductions to 41 weeks to prevent a death for a child, and this was a very lower number than previously thought. If you remember, however, as Anna said, the INDEX process did not find a significant difference in death between the induction group and the waiting management group. We think that the reason why SWEPIS study found a difference was because it was a wider study, it was better able to detect differences in rare results such as death. In addition, with the SWEPIS study, there may not have been a good fetal monitoring. So it is possible that the best fetal monitoring of participants between 41 weeks and 42 weeks in the INDEX process could have been protective, leading to less perinatal deaths. We cannot be sure, however, because there have been no fetal monitoring protocols in both processes. Another thing to note is that participants in the management group waiting for INDEX. This could help explain the highest perinatal mortality rate in the pending management group in SWEPIS. They found no difference in what they call the composite negative perinatal result, which included death, low Apgar scores, low pH, cerebral hemorrhage, brain injury, seizures, and several other major complications, but there was that significant difference in perinatal death (both having a birth or a newly born death). In addition, elective induction children were less likely to have an admission to intensive care, 4% versus 2,3%, and less of them were large children, 4,9% versus 8,3%. For mothers, the results were pretty good. There were noIn Caesarean rates similar to the other process. The caesarean rate in this study in both groups was about 10% to 11%. Other mothers of the elective induction group had an inflammation of the internal coating of the uterus called endometritis, 1.3% against 0.4%. And on the other hand, more mothers in the expected management developed high blood pressure, 3% vs. 1.4%. They also interviewed the women in both groups and found that the mothers in the waiting to go into labor. So, Anna, can you talk a little bit about foetal monitoring in this study and how it might differ from the other study? Anna Bertone: Of course. Fetal monitoring in this study was done according to local guidelines. So there was no study protocol for foetal monitoring during the 41st week of pregnancy. However, mothers recruited from a region of Sweden called the Stockholm Region, which accounted for about half of the people in the study, had ecological measurements of their amniotic fluid volume and abdominal diameter at 41 weeks, while people from other parts of Sweden in the study occurred in the study of their amniotic fluid volume and abdominal diameter at 41 weeks, while people from other parts of Sweden in the study of the six deaths in this study of the six deaths in this study occurred in the study of the six deaths in this study of the six deaths in the study did not received the six deaths in the study of the six deaths in the six deaths in the study of the six deaths in the six deaths how important this foetal monitoring is. Could it have made the difference between participants from the Stockholm regions did? Anna Bertone: So that's just one important thing to keep in mind with this study is that fetal monitoring may have made the difference in perinatal outcomes. It also means that the results of the SWEPIS study may not apply equally to mothers, which tells us that the results may not apply as much to mothers who had a later child, none of them experienced this birth death or birth death, right? Anna Bertone: Exactly. Yeah. Okay. So all the perinatal deaths occurred in the first-time mothers. Anna Bertone: And the first mothers, by the way, only made up about half of the participants in the championship, so it was about 50/50 split. Thus all foetal and neonatal deaths in this study came from first-time mothers living in areas of Sweden who did not do any prescribed foetal monitoring during that 41st week of pregnancy. Anna Bertone: That's my understanding. That's right Okay. So these are the two large randomized trials that came out in 2019. Before they were published, there was a Cochrane meta-analysis. 2018. Anna, I was wondering if you could talk about it in our article. So you can explain to our listeners some of this Cochrane Cochrane Anna Bertone: Of course. There was a review of Cochrane 2018 and Middleton's meta-analysis. Unlike these randomized control trials that we were talking about, they didn't focus specifically on the 41st week of pregnancy versus the 42nd week of pregnancy. It was much wider than that. What they did was they looked at people who were electively induced at some point, and compared them to people who waited for work to start on their own up to some point. So there was a much wider range of gestational age there. But they included 30 randomized control trials with over 12,000 mothers, and compared a policy of induction at or beyond term against waiting management. All tests took place in Norway, China, Thailand, the United States, Austria, Turkey, Canada, the United States, Austria, Turkey, about 75% of the data, and that was Hannah's post-term process that I think Rebecca is going to talk about soon. Because this process dominated so much this meta-analysis, most of the data was in labor at 41 weeks or later. And they didn't include the ARRIVE, INDEX or SWEPIS. So, in its next update, it will be updated with those three randomized control tests. But they included 30 more randomized control tests. But they included 30 more randomized control tests. 16 deaths in the people assigned to the planned management. Anna Bertone: Hannah's post-term trial ruled out deaths due to fetal malformations, but some of the smaller tests that were included in the induction group and 14 in the waiting management group. Thus it does not change the results too general to rule out fetal malformations. Overall, they found that the number needed to treat was 426 people with induction in the long term or beyond. That was a different number needed to treat compared to the SWEPIS process, which found it took only 230 induction at 41 weeks to prevent perinatal death. Anna Bertone: Yes. I think part of the reason why the SWEPIS process was so innovative and got so much media attention is because it found a lower number needed to deal with that had been Previously. Thus the absolute risk of perinatal death was 3.2 per 1,000 births with the management policy envisaged against 0.4 deaths per 1,000 births with induction policy at or beyond term. They found out that a political policywas related to a little less Caesarean section than fixed management, 16.3% against 18.4%. Anna Bertone: Less children assigned to induction had an Apgar score of less than seven to five minutes compared to those assigned to waiting management. They did not find any differences between the groups with the rate of pliers or vacuum care at birth, perinatal trauma, excessive bleeding after birth, total length of hospital stay for the mother, neonatal intensive care admissions or neonatal trauma. Authors concluded that one-to-one counselling could help pregnant people to choose between elective induction or beyond the term or to keep waiting for work. They stress that providers should honor the values and preferences of mothers. We need more research to know who would or would not benefit from elective induction or beyond the term or to keep waiting for work. induction. And the optimal timing for induction is still not clear from research, which is what they said in 2018. I think Rebecca will be talking about Hannah's famous post-term study, which accounted for 75% of the data in that meta-analysis of 2018 where they said the optimal time for induction is unclear, but they stated that before the two new randomized study ever done on this topic, largest also of index or Swepis. And check out most of the results in that meta-analysis of Cochrane that Anna just described. So look at what happened in this study because it plays so much of a role in meta-analysis. It was carried out between 1985 and 1990, when a group of researchers enrolled 3,407 low-risk pregnant people from six different hospitals in Canada in the study. Women could be included if they were pregnant with a single live fetus, and were excluded if they were already dilating, if they had a previous caesarean rupture membrane, pre-labour, or a medical reason for induction. This study had a very different waiting management protocol than the index or the Swepis because unlike those studies where the longest would have been 42 weeks and zero to one or two days, in Hannah's post-term study, the management of waiting people was monitored until 44 weeks of pregnancy before they were induced, so up to one month beyond the expiration date, which is almost unheard today. At about 41 weeks, people who agreed to be in the study were randomly assigned to have labour induction or foetal monitoring with a Waiting. In the induction group, work was immature and the fetal heart rate was normal, they received a prostaglandin E2 gel to mature the They used up to three doses of gel every six hours. If this did not induce labor or if they did not need the gel, people received oxytocin until 12 hours after the last dose of prostaglandin. One of the strengths of this study is that it had a defined induction protocol that vendors could replicate. But the big weakness of this study is that the waiting management group did not have the same induction protocol. In the monitored or planned management group, people were instructed to do daily kick count and were subjected to non-stress tests three times a week. They also had their amniotic fluid levels checked with ultrasound two or three times a week. And labor was induced if the non-stress test results were relevant, or if the amniotic fluid was low, or if the amniotic fluid was low, or if the mother developed complications, or if the mother developed complications and the baby should be born. receive any cervical maturation. Instead, they either ruptured their water and/or intravenous oxytocin, or they went straight to a C-section without labor. So, Anna, do you want to talk a little bit about what the researchers found in the study? Anna Bertone: What the researchers found in the study? people were induced and 34% started labor on their own before induction. And in the waiting group and zero in the induction group. This difference was not considered statistically significant, which means we don't know if it happened by chance or if it was a real difference between groups. The most interesting result to observe with Hannah's post-term study are the results of the two original groups, which were people randomly assigned to induction and then those assigned to waiting management, or you can look at the breakdown of what really happened to people in the two original started spontaneous labor. o. Anna Bertone: So what happened in the groups originally assigned at random? Considering the two original groups, the overall Caesarean section rate was lower in the induction group. It was 21.2% against 24.5%. This is even after taking into account factors such as the time of entry into the study. Or you could look at what happened to the people who have actually been induced or that they are actually entered into travers. And if you look at this, you see two very interesting things. See that the people who went spontaneous work, regardless of the group to which they were assigned, had a cesarean rate of only 25.7%. But if people in the control group had an induction, their cesarean rate was much higher than all other groups. It was 42%. The same was true for the neo-madri and mothers who had previously born. Anna Bertone: What do you mean? It means that only people who have been handled in a predictable way and then entered into labor spontaneously did not have a higher cesarean rate. One possible reason for this, for the highest rate of cesarean observed in people of this group could have been at greater risk from the beginning, since a medical complication could lead to their induction. People assigned to the management of pregnancy and who have never developed complications that require induction, were those at a lower risk, which means they were less likely to give birth with cesarean. Anna Bertone: Another important factor I know Rebecca discussed earlier is that doctors could have been faster in requiring a cesarean when they assisted people with medical induction if their pregnancy lasted over 42 weeks. Maybe they were less patients waiting for labor. "Or more easily concerned. So, basically, it seems that from Hannah's post-term experimentation, one of the advantages of considering the management of expectation is that if you have a spontaneous labor, your chances of having a cesarean are quite low. But the risk is to develop medical complications and require induction, in which case a 42-week induction will be more risky than a 41-week induction. So, what do you think? We have all these researches from around the world, from Hannah's post-term trial to 2018 meta-analysis, to two trials in 2019. Do you still think that routine induction at 41 weeks is still controversial, and I think everyone is still controversial, and I think everyone is still controversial or not? Wennerholm, who conducted the SWEPIS study in Sweden, and she said she was working on a secondary data analysis. They speak of the economic implications of the results obtained in Sweden and what it means for Swedish national policy. So I think it's still controversial. People are still discussing what to do with these discoveries. Anna Bertone: There was another systematic review of 2019 by This is out too early to include Swepis and Index tests, but it's still interested in Induction during the 41st week of pregnancy compared to the 42nd week of pregnancy. So, in their analysis, they have limited studies only to people who have a routine induction at 41 weeks and zero at six days against routine induction at 42 weeks and zero at six days. If you remember, Cochrane review was much broader than that. They have also watched studies published only in the last 20 years. They examined only his studies with low-risk participants, and ended up with three observational studies, two randomized controlled tests, and two studies who called $\hat{a} \in ceWhat$ experimental studies $\hat{a} \in ceWhat$ experimental studies who called $\hat{a} \in ceWhat$ experimental studies who called $\hat{a} \in ceWhat$ experimental studies who called $\hat{a} \in ceWhat$ experimental studies \hat{c} , who grouped with randomized trials controlled tests, and two studies who called $\hat{a} \in ceWhat$ experimental studies \hat{c} , who grouped with randomized trials controlled tests and six dead in the induction group of 42 weeks. It was a rate of 0.4 against 2.4 per 1,000. This observation was not statistically significant. In other words, we have no strong evidence that this could not happen by chance. These same studies, these two randomized controlled studies and the two almost experimental studies have no strong evidence in caesarean rates between groups. But the authors reported that an observational study has found an increase in the caesarean rate with the 41 week induction test during the 41st week compared to the 42th week, then there may not be a significant difference in the death rate. But that study Riedel from 2019 is already overcome because this was before the two great randomized studies emerged. Anna Bertone: Yes. We need to see a systematic review and a meta-analysis that includes those two randomized controlled tests and see if this changes. increasing with 41 week induction because it is the SWEPIS process and the index process took place in countries with very low Caesarean rates if they had taken place in countries with higher rates of cesarean, such as the United States Anna Bertone: I think it's still controversial. There are also countries that are changing their policies on induction and go back and look if that policy change has led to any difference in results. A country of this kind is Denmark. They have just published a study in which they compared the results of the birth since 2000 to 2010 compared to 2012 to 2016. And at that time there was a change in politics to recommend induction to 42 weeks and zero days at 41 weeks And three to five days. They included over 150,000 births in the dataset. And when they compared the period first compared to the change of politics. The perinatal mortality rate was already in decline decline The change in politics in 2011 and continued to descend without any additional impact by the 2011 policy to pass from 42 weeks to 41 weeks. Anna Bertone: A ¢ â, ¬ "It is just an example of how it is still controversial. The countries implement new policies and Sweden and the Netherlands can implement new policies based on the Index and SWEPIS studies. Then they probably lead a study In the same way as Denmark has had to see whether this change in policies based on the Index and SWEPIS studies. Denmark, passed from 42 weeks and from zero days to 41 weeks and from three to five days, and this may not have been soon enough to have been soon of a couple of days that made the difference between the low highest rate of the mortifice. Anna Bertone: Å, Å ¢ lett. Exactly. Pen I know that future researchers should not drive 41 week and the next part of the 41st week because, as you said, SWEPIS and L ' Index found that waiting only two or three days do a difference in the results during to wait for work since everything is that we have most of the tests. I would say that research shows that the Pros to induce work at 41 weeks include a lower risk of mortitbirth, especially among those with risk factors for Christmas natures as being pregnancies at 40 weeks, 7 out of 10,000 pregnancies at 40 weeks, 17 out of 10,000 pregnancies at 41 weeks and 32 Christmas Christmas Christmas ities out of 10,000 pregnancies at 42 weeks. The research also shows a lower risk of the child with jaundice, the lowest risk of the child is great for gestational age and risk more Low to need a caesarean, even if that discovery can depend on your practice setting. There is a lower risk of the mother who develops a high blood pressure disorder. At the end of pregnancy. And for some people, they can find an elected induction of a convenient 41 weeks and could help you finish an uncomfortable pregnancy. Moreover, in our article, we do to a study that found some cognitive benefits for children. It suggests that the cognitive benefits for the baby of the mother remaining pregnant appear to increase up to about 40-41 weeks after which there are no cognitive benefits to the baby's brain development to continue Get pregnant. So Anna, can you share the elective induction cones at 41 weeks? Anna Bertone: Yes. One of the cones to be induced to 41 weeks instead of continuous fetal monitoring to wait and see if you go to work is the potential for medicalization, while you may not get continuous fetal monitoring if you go into work alone spontaneously during that 41st week. Anna Bertone: Another conductor would be a failed induction potential leading to a cesarean. This also depends on your practical setting. Another with is the potential increase in the risk of uterine breaking with medical induction. This is especially important among people with a previous cesarean who have a VBAC. Anna Bertone: Another with increased the risk of mother getting inflammation of the uterus, endometritis. A study found that as a possible risk of induction 41 weeks. Then, medically induced contractions could increase pain and make epidural use more likely. We also have a section in the article where we talk about whether there are advantages to go beyond the due date, one of the main benefits of waiting for spontaneous work are the hormonal benefits, which Anna briefly mentioned. In our article, we connect to the book Hormonal Physiology of the Child that Dr. Sarah Buckley, who speaks of physiological knowledge and physiological knowledge and physiology of the Child that Dr. Sarah Buckley, who speaks of physiological knowledge and physiology of the Child that Dr. Sarah Buckley, who speaks of physiological knowledge and physiology of the Child that Dr. Sarah Buckley, who speaks of physiological knowledge and physiology of the Child that Dr. Sarah Buckley, who speaks of physiological knowledge and physiological knowledge and physiology of the Child that Dr. Sarah Buckley, who speaks of physiological knowledge and physiological know reason why some people prefer to wait for spontaneous work. So Anna, if someone wants to wait for the job to start alone and are talking to their service provider about the pending management, what is kind of bottom line of this? Anna Bertone: I think the bottom line of this? date due, they may talk to their service provider about the benefits and risks of elective induction against continuing to wait for work and how such benefits and risks for both options, values, goals and preferences of the pregnant person should participate in decision-making. Anna Bertone: It is important for families waiting to be aware of the increasing evidenceresearch showing that there might be worse health outcomes for those with Risk factors for dead borns. But in the end, after receiving accurate information based on trials and have conversed with their assistance suppliers, pregnant women have the right to decide if they prefer to induce labor or waiting for spontaneous labor with adequate fetal monitoring. I also want to make people know a couple of multiple resources that are in this article on evidenceebasedbirth.com/inducingduedates. We have a section on how people and their healthcare professionals can use when they talk about the risks of death births. We also link to different organizations about 41 weeks induction. Then we also have our section called The bottom line. So, Anna, what are some of the elected induction conclusions at 41 weeks and from zero to two days could help reduce dead born and bad health results of newborns without increasing damage, such as the risk of Cesarean for mothers . We are getting them from those two great randomized controlled studies published in 2019 that both have found less perinatal death with 41 weeks of induction and the other has found fewer poor health results for children as hospitalization in intensive care unit and low Apgar scores with 41 Weeks of induction. None of these studies has detected an increase in the risk of caesarean birth with 41 induction. None of these studies has detected an increase in the risk of caesarean birth with 41 weeks. took place in countries that follow the obstetric assistance model and the total cesarean rates have been very low. So I think that it remains to be seen how this will translate into countries like the United States that have higher Cesarean rates. management. Make sure you check the blog article that goes with this podcast episode for all resources, links, search references. We also have a free brochure of a page that can be downloaded that summarizes the results of this search. Just go to evidencebasedbirth.com/inducingduedates to download the new article. Thank you very much, Anna, to be united to us to help our listeners understand the tests. Anna Bertone: happy to do it, Rebecca. Thanks. Today's podcast has been brought from the PDF library to the extension of the Evidence Based Birth Professional Membership. 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