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Elderly nulliparae in midwifery care in Amsterdam

Yvonne Smit, Sicco A. Scherjon and Pieter E. Treffers

Objective: to compare labour complications, after an uncomplicated pregnancy, of first births in women 35 years and older with women 20–30 years old.

Design: an explorative prospective cohort study.

Setting: four independent midwives' practices in Amsterdam.

Participants: a group of 49 elderly nulliparae was compared with a group of 99 younger nulliparae.

Measurements and findings: percentage of referrals and reasons for referral during pregnancy and labour, mode of delivery and obstetric outcome.

Key conclusions: no significant differences in referrals were found between the two compared groups. Obstetric outcome was not different between the groups, except for a lower birthweight in the elderly group. A trend is seen for a raised percentage of referrals during labour in the older group. This is almost completely explained by a failure to progress during first and second stages of labour. Related to this was a trend for an increased incidence of caesarean section in the older group of women.

Implications for practice: after selection, the elderly nullipara, under the care of a midwife, does not have an increased risk of fetal distress or other emergency factors compared to the younger nullipara. However, the referral rates during labour, both of younger and older women, are high.

INTRODUCTION

The 'elderly primigravida or nullipara' was defined in 1958 by the International Federation of Obstetricians and Gynaecologists as aged 35 years or more (Tuck et al 1988). According to the literature elderly nulliparae have a higher risk of pregnancy induced hypertension, gestational diabetes, fetal growth retardation, preterm deliveries, caesarean sections, vaginal operative deliveries, breech presentations and lower Apgar scores (Spiekerman et al 1986, Brasili et al 1987, Tuck et al 1988, Berkowitz et al 1990, Jonas at al 1991, Adashek et al 1993, Vercellini et al 1993, Prysak et al 1995). In most studies perinatal mortality is not increased; this might be explained by better obstetric surveillance, although the studies lack statistical power to support this connection. In developed countries a trend for delayed childbearing raises the question of whether women who are elderly nulliparae by choice, are at a lower risk than the elderly nulliparae during the first half of this century, who were supposed to be at a higher risk than their younger counterparts.

Obstetric care in the Netherlands differs from the care described by most authors: screening by midwives (primary care) takes place during pregnancy, which may result in a referral to secondary care. A list of risk factors devised by the Medical Insurance Board (Ziekenfondsraad) is used as a guideline for referral (van Alten et al 1989, Treffers et al 1990, Treffers 1993). The remaining selected group of healthy women is considered to be at low risk, receiving complete obstetric care by a midwife.

The question remains whether, in this group, the elderly nullipara is still at increased risk of complications during labour, or, in other words, is she (and her infant) safe during labour in primary care, under
the responsibility of the midwife? We have tried to answer this question in a prospective study performed in midwives' practices.

**METHODS**

In the years 1991 and 1992 midwives in four practices in Amsterdam were asked to participate in this study. All nulliparae of 35 years (in the 20th week of gestation) or older, were selected after their first visit to the midwife. They were matched with two younger nulliparae (from 20 up to and including 29 years in the 20th week of gestation) who ‘booked’ in succession to the elderly nullipara, in the same practice and from the same ethnic group. A proforma, completed by the midwife, was stapled to the records and returned after delivery. Anonymity was guaranteed, because the form did not contain the name or birth date of the woman. Only the year, practice and study registration number of all participants (study or matched-control group) was registered. Information on obstetric factors was collected prospectively. After the data were coded they were put in a computer database. No detailed information was available on socio-economic status. To standardise for socio-economic differences the matched younger nulliparae were obtained from the same practice as the elderly nulliparae. Women who were considered to be at high obstetric risk for reasons other than their age and, therefore, had to be referred to secondary care before 20 weeks’ gestation, were excluded.

Data were collected on 51 elderly and 102 younger women. In the beginning of pregnancy two women from the elderly group were excluded; one had a twin pregnancy and the other’s pregnancy was terminated because of trisomy 21. Two other women were referred to secondary care during pregnancy and delivered preterm babies with serious congenital malformations (one with hydrocephalus and the other with transposition of the great vessels). They were not included in the calculation of obstetric outcome variables. In the younger group three women were excluded; one because of a twin pregnancy and two women moved to another country. After exclusion 49 elderly nulliparae and 99 younger nulliparae remained in the study. During prenatal care a further selection took place based on complications and risk factors observed, resulting in a healthy group, with uncomplicated pregnancies, hereafter called ‘the selected low-risk group (74 in the younger group and 36 in the older group). Data on this selection procedure were collected and analysed.

Deliveries of the selected low-risk group took place, under the responsibility of the midwife, in hospital or at home, depending on the preference of the woman, irrespective of age. We studied the referrals during labour, the mode of delivery and the obstetric outcome.

**Analysis**

Group means were compared using the t-test, while differences in outcome between the groups were analysed using $\chi^2$ (Mantel-Haenszel) and Fisher Exact if the cell number was less than five. The level of significance was chosen at 0.05 (two sided).

**FINDINGS**

**Age**

Distribution of the ages of the nulliparae is shown in Figure 1.

**Referral during pregnancy**

During pregnancy 25 women (25%) in the younger group and 13 (26%) in the elderly group were referred to secondary care for the reasons shown in Table 1. There was no difference between the groups in the proportion of women who were referred. The incidence of pre-eclampsia did not differ between the groups.

**Referral during labour**

Of the remaining 74 younger women, 34 (46%) were referred to secondary care during labour. Of the remaining 36 elderly women, 22 (61%) were referred to secondary care during labour (Table 2), but this difference was not significant ($\chi^2=3.37$, df=1, $p=0.14$). The reasons for referral are shown in Table 2.

Seven per cent of the younger women were referred because of signs of fetal distress. None of those in the elderly group were referred for this reason, but the difference was not significant (Table 2).
Table 1: Reasons for referral during pregnancy

<table>
<thead>
<tr>
<th></th>
<th>20-30 years (n=99)</th>
<th>35+ years (n=49)</th>
<th>χ²</th>
<th>df</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>No referral</td>
<td>74</td>
<td>36</td>
<td>0.03</td>
<td>1</td>
<td>0.87</td>
</tr>
<tr>
<td>Post-term pregnancy</td>
<td>8</td>
<td>2</td>
<td>FE</td>
<td>-</td>
<td>0.27</td>
</tr>
<tr>
<td>Pre-eclampsia</td>
<td>6</td>
<td>3</td>
<td>FE</td>
<td>-</td>
<td>0.4</td>
</tr>
<tr>
<td>Pre-term labour</td>
<td>3</td>
<td>3</td>
<td>FE</td>
<td>-</td>
<td>0.4</td>
</tr>
<tr>
<td>Fetal growth retardation (GR)</td>
<td>1</td>
<td>3</td>
<td>FE</td>
<td>-</td>
<td>0.11</td>
</tr>
<tr>
<td>Breech presentation</td>
<td>5</td>
<td>2</td>
<td>FE</td>
<td>-</td>
<td>0.1</td>
</tr>
<tr>
<td>No engagement of fetal head</td>
<td>1</td>
<td>0</td>
<td>FE</td>
<td>-</td>
<td>0.1</td>
</tr>
<tr>
<td>Irregular fetal heartbeat</td>
<td>1</td>
<td>0</td>
<td>FE</td>
<td>-</td>
<td>0.1</td>
</tr>
<tr>
<td>Placenta praevia</td>
<td>0</td>
<td>1</td>
<td>FE</td>
<td>-</td>
<td>0.33</td>
</tr>
</tbody>
</table>

FE = Fisher Exact test

Four women were referred because of complications postpartum. One woman in each group was referred with retained placenta and two women in the younger group were referred because of postpartum haemorrhage. One baby of a younger mother was referred, suspected of having meconium aspiration. After one day of observation in a neonatal intensive care unit the baby was discharged and went home with his mother.

Obstetric outcome

Gestational duration at delivery, the length of the second stage, birthweight and blood loss were examined for differences between the two groups. The only difference was in birthweight where babies born to women in the total elderly group had a lower mean birthweight (3253 gm) when compared with babies born to women in the younger group (3489 gm) (Table 3). The incidence of small for gestational age (SGA) babies (<5th centile, Kloosterman 1970) was four in the elderly group; three of these women had been referred for intra-uterine growth retardation during pregnancy. In the younger group there were two SGA babies; one of these had been detected during pregnancy and referred to secondary care.

Mode of delivery

There was no difference in spontaneous or assisted vaginal delivery between the two groups whether for the whole group or the selected low-risk groups (Table 4). There was no difference in the caesarean section rates between the groups for the total group, but there was a trend for an increased rate in the older group of women in the selected low-risk group (Table 4).

Paediatric outcome

There were no differences in Apgar (Table 5). Four babies born to women in the older group and eight in the younger group had an Apgar score lower than 7 at one minute. Two babies born, by caesarean section, to women in the elderly group still had a low Apgar score at five minutes after delivery.

DISCUSSION

The participating midwives’ practices are situated in different neighbourhoods in Amsterdam, representing high and middle socio-economic levels. Because there are indications that delayed childbirth is influenced by educational level and participation in the labour market (Bonsel & Van der Maas 1994),
Table 3 Obstetric Outcome

<table>
<thead>
<tr>
<th></th>
<th>Total group</th>
<th>20-30 years (n=99)</th>
<th>35+ years (n=47)</th>
<th>t-test</th>
<th>df</th>
<th>p</th>
<th>Selected low-risk group</th>
<th>20-30 years (n=74)</th>
<th>35+ years (n=36)</th>
<th>t-test</th>
<th>df</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gestational age (days)</td>
<td></td>
<td>278</td>
<td>279</td>
<td>0.46</td>
<td>144</td>
<td>&gt;0.6</td>
<td>277</td>
<td>281</td>
<td>1.64</td>
<td>108</td>
<td>&gt;0.05</td>
<td></td>
</tr>
<tr>
<td></td>
<td>SE</td>
<td>22</td>
<td>12</td>
<td></td>
<td></td>
<td></td>
<td>SE</td>
<td>23</td>
<td>8</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Duration of second stage (minutes) (CS excluded)</td>
<td></td>
<td>53</td>
<td>67</td>
<td>2.05</td>
<td>125</td>
<td>&gt;0.05</td>
<td>52</td>
<td>70</td>
<td>1.46</td>
<td>96</td>
<td>&gt;0.3</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(n=10)</td>
<td>(n=9)</td>
<td></td>
<td></td>
<td></td>
<td>(n=5)</td>
<td>(n=7)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Birthweight (gm)</td>
<td></td>
<td>3489</td>
<td>3253</td>
<td>2.38</td>
<td>144</td>
<td>&lt;0.05</td>
<td>3500</td>
<td>3368</td>
<td>0.862</td>
<td>108</td>
<td>&gt;0.3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>SD</td>
<td>542</td>
<td>626</td>
<td></td>
<td></td>
<td></td>
<td>SD</td>
<td>506</td>
<td>520</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood loss (ml)</td>
<td></td>
<td>410</td>
<td>408</td>
<td>0.04</td>
<td>144</td>
<td>&gt;0.9</td>
<td>381</td>
<td>325</td>
<td>0.86</td>
<td>108</td>
<td>&gt;0.5</td>
<td></td>
</tr>
<tr>
<td></td>
<td>SD</td>
<td>324</td>
<td>449</td>
<td></td>
<td></td>
<td></td>
<td>SD</td>
<td>223</td>
<td>220</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Women who underwent caesarean section were excluded from the calculation of duration of second stage. Excluded numbers are given in brackets.

Table 4 Mode of delivery

<table>
<thead>
<tr>
<th></th>
<th>Total group</th>
<th>20-30 years (n=99)</th>
<th>35+ years (n=47)</th>
<th>Selected low-risk group</th>
<th>20-30 years (n=74)</th>
<th>35+ years (n=36)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spontaneous</td>
<td></td>
<td>71</td>
<td>72</td>
<td>28</td>
<td>60</td>
<td>54</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>72</td>
<td>72</td>
<td>28</td>
<td>72</td>
<td>73</td>
</tr>
<tr>
<td>Assisted vaginal delivery</td>
<td></td>
<td>18</td>
<td>18</td>
<td>10</td>
<td>21</td>
<td>15</td>
</tr>
<tr>
<td>Caesarean section</td>
<td></td>
<td>10</td>
<td>10</td>
<td>9</td>
<td>19</td>
<td>5</td>
</tr>
</tbody>
</table>

Differences between abdominal and vaginal deliveries are not significant: $\chi^2 = 2.29$, df = 2, $p=0.13$ in the total group and in the selected low-risk group $p = 0.06$ (Fisher Exact). Differences between spontaneous and assisted deliveries are not significant; $\chi^2 = 2.14$, df = 2, $p=0.14$ in the total group and in the selected low-risk group $\chi^2 = 1.58$, df = 2, $p=0.21$.

Table 5 Apgar scores

<table>
<thead>
<tr>
<th></th>
<th>Total group</th>
<th>20-30 years (n=99)</th>
<th>35+ years (n=47)</th>
<th>t-test</th>
<th>df</th>
<th>p</th>
<th>Selected low-risk group</th>
<th>20-30 years (n=74)</th>
<th>35+ years (n=36)</th>
<th>t-test</th>
<th>df</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apgar score one minute</td>
<td></td>
<td>mean 8.6 median 9</td>
<td>mean 8.5 median 9</td>
<td>0.26</td>
<td>144</td>
<td>&gt;0.7</td>
<td>mean 8.9 median 9</td>
<td>mean 8.2 median 9</td>
<td>1.662</td>
<td>108</td>
<td>&gt;0.1</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Apgar score five minutes</td>
<td></td>
<td>mean 9.7 median 10</td>
<td>mean 9.6 median 10</td>
<td>0.57</td>
<td>144</td>
<td>&gt;0.6</td>
<td>mean 9.9 median 10</td>
<td>mean 9.3 median 10</td>
<td>1.94</td>
<td>108</td>
<td>&gt;0.05</td>
<td></td>
</tr>
</tbody>
</table>

During pregnancy, the group of elderly women receiving prenatal care from the midwife showed no difference in the rate of referrals, nor in reasons for referral when compared with younger women. It is interesting that, in contrast to the literature, the percentage of women with pre-eclampsia was not raised in the group of elderly women. Possibly, this is owing to the fact that in the Netherlands selection at the beginning of pregnancy already excludes women with chronic hypertension from care provision by the midwife.

During labour there was a high rate of referral, both in the elderly and the younger group. This was not a completely unexpected finding: nationwide the percentage of referrals for nulliparae during labour has been reported as 39% (Lems et al 1991) and a similar percentage has been reported in the UK (MacVigar et al 1993). Earlier studies in the Netherlands (Eskes 1989) showed a steady increase of referrals of nulliparous women during labour: 1969–1973 = 12%; 1974–1976 = 13%; 1977–1979 = 18%; and 1980–1983 = 25%. Since then a further
rise in referrals has apparently taken place. This is of
great concern to midwives in the Netherlands, because the high referral rate during labour is a seri-
ous threat to the Dutch system of maternity care. It
may be used as an argument for hospitalisation of all
nulliparce during labour, or even against the inde-
pendent practice of midwives. Our data show that
the majority of referrals were not based on emer-
gency factors, such as fetal distress, but on 'failure
to progress'. Further investigation is necessary to
determine the exact meaning of 'failure'. An expla-
nation could be that, to an increasing extent, both
the woman and the midwife do not accept the duration
of normal labour without interference. As well as the
high rate of referral during labour for all nulliparces,
there was also a trend for an increased referral rate in
the elderly group in labour.

The obstetric outcome in both groups was good;
no differences were found in gestational duration,
Apgar scores and post partum blood loss, however,
weight was significantly lower in the total
group of elderly nulliparce. In the selected low-risk
group this difference was smaller and not signifi-
cant; it did not lead to a higher incidence of fetal dis-
tress during labour. Literature which showed differ-
ences in these outcome variables (Tuck et al 1988,
Vercellini et al 1993, Prysk et al 1995, Fretts et al
1995) did not adjust for the incidence of risk factors,
such as pre-eclampsia, social class or having prena-
tal care. After correction for these factors
(Berkowitz et al 1990) differences in outcome disap-
peared. The length of second stage of labour in the
elderly group was longer, but not significantly, a
finding in agreement with the increased numbers of
referrals during labour in the elderly group.

The caesarean section rate was higher in the
elderly group, though not significantly. If we con-
sider the selected low-risk group, this difference
almost reaches significance (p = 0.06, Fisher Exact).
This finding is in accordance with data from the lit-
erature (Spiekerman et al 1986, Brassil et al 1987,
Tuck et al 1988, Adashek et al 1993, Vercellini et al
1993, Prysk et al 1995) where a trend for a higher
rate of referrals during labour was found as well as a
longer length of the second stage of labour in the
group of the elderly women. This might indicate
that, to a certain extent, mechanical factors hamper
the progress of labour in elderly nulliparces.

In conclusion, the current 'elderly' woman, giv-
ing birth for the first time, is at no higher risk (for
fetal distress or other emergency factors) than her
younger counterpart, if selection at the first visit to
the midwife is made to distinguish the healthy
women from women with medical or obstetric
pathology necessitating secondary care. The find-
ings from this study suggest that the second stage of
labour in elderly nulliparce is more complicated,
posibly owing to mechanical factors. Elderly nulli-
parce need to be informed that they run a consider-
able risk of referral to secondary care during labour.

Apparently, the same holds true for younger nulli-
parce. To further investigate the observed trend a
larger study is necessary, and is currently in progress
in seven independent midwives' practices in and
around Amsterdam.

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