

The Work Group systematically reviewed evidence related to this recommendation. ([86](#), [90](#), [92-96](#)) Therefore, it is categorized as *Reviewed, New-added*. The Work Group's confidence in the quality of the evidence was very low. The body of evidence had some limitations, including challenges with blinding active interventions, short-term follow-up periods, diversity of intervention methodologies, and variability in the outcome measurement tools used. The benefits of supervised pelvic muscle training by a rehabilitation provider improved rates of urinary incontinence and QoL measure scores that outweighed the potential harms (no reported significant adverse outcomes) or burdens (increased health care use rates). Patient values and preferences varied somewhat because some patients might not want to or are unable to participate in rehabilitation care because of increased life responsibilities as a new parent. Thus, the Work Group made the following recommendation: We suggest referral to pelvic health rehabilitation for patients with reported urinary incontinence in the postpartum period.

d. Selected Conditions

Recommendation

7. We recommend offering scheduled delivery to patients who reach 41 weeks and 0/7 days undelivered. Antepartum fetal testing should begin at 41 weeks and 0/7 days if not delivered.

(Strong for | Not reviewed, Amended)

Discussion

Perinatal and maternal complications increase as a pregnancy extends beyond term. Multiple studies demonstrated that perinatal mortality steadily increased with gestational age past 41 weeks. ([98](#), [99](#)) Previously reviewed evidence suggested that induction of labor at 41 weeks was associated with a decrease in perinatal mortality without negatively impacting other neonatal and maternal outcomes. ([100](#), [101](#)) A national cohort study showed a significant reduction in perinatal mortality from 1.3–0.8% ($p=0.033$) following the implementation of an induction or fetal surveillance policy starting at 41 weeks. ([100](#)) An SR also showed that induction of labor at 41 weeks was associated with a significant reduction in cesarean delivery rates and a trend toward lower perinatal mortality rates. ([101](#)) Although not part of the previous systematic evidence review from the 2018 VA/DoD Pregnancy CPG, subsequent studies continued to support the findings that induction of labor at 41 weeks is associated with a reduction in perinatal mortality and a reduction in rates of cesarean section. ([102](#), [103](#)) Additionally, a recent RCT published in 2018 evaluating the outcomes of elective induction starting at 39 weeks showed no increased risk of maternal or perinatal adverse outcomes while demonstrating a reduction in cesarean deliveries. Although there was also no demonstration of improved maternal or perinatal outcomes by offering induction at this time, this finding would suggest that providers could consider offering elective delivery starting at 39 weeks without increasing the risk of cesarean delivery. Based on the moderate quality of evidence from the 2018 systematic evidence review, the Work Group makes a strong recommendation for offering patients a scheduled