Term pregnancy has traditionally been defined as one in which 260–294 days have elapsed since the first day of the last menstrual period. Neonates born before this interval (less than 37 completed weeks of pregnancy) are classified as preterm, whereas those delivered beyond this interval (42 weeks and beyond) are designated postterm.\textsuperscript{1,2} Although the potential hazards of both preterm birth and postterm pregnancy have been long recognized, little attention has been given to the differential morbidity experienced by neonates born within the broad category of term gestation. Term birth has previously been considered a homogeneous group to which risks associated with preterm and postterm births are compared, but there is a growing body of data that suggests that significant differences exist in the outcomes of infants delivered within this 5-week interval. Because the designation term carries with it significant clinical implications with respect to the management of pregnancy complications as well as the timing of both elective and indicated delivery, a reevaluation of the concept of term pregnancy in light of current data is in order. We propose new definitions as described in Table 1.

\section*{HISTORICAL PERSPECTIVES}

Over 100 years ago, J. Whitworth Williams wrote in the first edition of what was to become the classic text, \textit{Williams Obstetrics}, “We possess no reliable means of estimating the exact date (of confinement) but are obliged to content ourselves with the method proposed by Naegele, which is based upon the belief that labor occurs two hundred eighty days from the beginning of the last menstrual period.”\textsuperscript{3} It was not until 50 years later, in 1948, that the World Health Assembly proposed an international definition of a premature infant as one with a birth weight of less than 2,500 g, a gestational age of less than 38 completed weeks, or both.\textsuperscript{4} One year later, in 1949, the Standard Certificate of Live Birth developed by the U.S. National Center for Health Statistics of the Centers for Disease Control and Prevention was revised to include reporting of the length of pregnancy in weeks and was revised in 1956 to specify the reporting of “completed weeks” of gestation.\textsuperscript{5} A 1961 report by the
Table 1. Definition and Description of Gestational Age

<table>
<thead>
<tr>
<th>Description</th>
<th>Gestational Age (wk)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preterm</td>
<td>Less than 37</td>
</tr>
<tr>
<td>Late preterm</td>
<td>34 0/7 to 36 6/7</td>
</tr>
<tr>
<td>Term</td>
<td>37 0/7 to 41 6/7</td>
</tr>
<tr>
<td>Early term</td>
<td>37 0/7 to 38 6/7</td>
</tr>
<tr>
<td>Full term</td>
<td>39 0/7 to 41 6/7</td>
</tr>
<tr>
<td>Postterm</td>
<td>42 or greater</td>
</tr>
</tbody>
</table>

Expert Committee on Maternal and Child Health of the World Health Organization recognized a distinction between premature and low birth weight infants. Nine years later, in 1970, a group of obstetricians and pediatricians at the Second European Congress of Perinatal Medicine outlined a classification that placed the boundary between preterm and term at 37 weeks of gestation. This appears to be the basis for the current definition of prematurity that is widely accepted by professional organizations. The precise origins of the 42-week definition of postterm pregnancy are somewhat more obscure but appear to be related to a report from Sweden in 1956 of a dramatic increase in perinatal mortality seen beyond this time during the years 1943–1952.

TERM GESTATION

Thus, it appears that the definition of term gestation was determined somewhat arbitrarily with reference primarily to differentiating this period from the complications associated with earlier and later gestational periods. However, gestational age is a biologic continuum and new data reveal important insights into the outcomes of babies born during this 5-week period called term. New epidemiologic studies reveal that the most common length of gestation in spontaneous singleton live births has changed significantly in the decade before 2002. During this period, the most common length of gestation decreased from 40 weeks to 39 weeks with deliveries at 40 weeks or more decreasing significantly, whereas those at 34–39 weeks increased. In addition, there are increasing data to support that “early term” births, neonates born between 37 0/7 and 38 6/7 weeks of gestation, have increased mortality and neonatal morbidity as compared with neonates born later at term. An analysis of U.S. singleton live births at term between 1995 and 2001 found that the mortality rate decreased with increasing gestational age from 0.66 per 1,000 live births at 37 weeks to 0.33 per 1,000 live births at 39 weeks and remained stable from 39 to 40 weeks. Despite a low absolute risk of infant death at term, the risks were more than 50% higher at 37 weeks than at 40 weeks, and although the main analysis was restricted to non-Hispanic whites, there were similar patterns among non-Hispanic African Americans. An abstract analyzing the 2001 National Center for Health Statistics birth cohort of singleton gestations also found increased neonatal and infant mortality rates for early term births at 37 and 38 weeks compared with 39 weeks of gestation. The rates for neonatal infection and later sudden infant death syndrome also decrease with increasing gestational age.

Previous studies as early as the mid-1990s have shown that neonatal respiratory morbidity was associated with term elective cesarean delivery (cesarean delivery before labor) before 39 weeks of gestation with one large study showing decreasing risk with increasing gestational age. There is more current evidence that elective early term births are associated with increased short-term respiratory morbidities and newborn intensive care admissions as compared with full-term neonates. Two recent studies, one examining elective repeat cesarean deliveries at 37 and 38 weeks and the other reporting on elective cesarean delivery at term before 39 weeks, were associated with a higher risk of neonatal complications, including respiratory distress requiring mechanical ventilation and admission to a neonatal intensive care unit compared with deliveries at 39 weeks. Another study found that elective delivery before 39 weeks of gestation (including elective inductions, elective repeat cesarean deliveries, and elective primary cesarean deliveries) is associated with significant neonatal morbidity with 17.8% of neonates delivered electively at 37 to 38 weeks and 8% of those delivered electively at 38 to 39 weeks requiring admission to a newborn special care unit for an average of 4.5 days compared with 4.6% of neonates delivered at 39 weeks or beyond. Neonatal morbidities experienced by these early-term neonates lead to increased admission to newborn intensive care units, which results in increased medical costs. These cost implications need to be further documented and considered, especially in light of preventable early term births resulting from elective delivery. In summary, there appears to be a continuous relationship between gestational age and neonatal morbidities with a nadir at 39 weeks of gestation. Rather than reaching a critical threshold, the rate of neonatal morbidity decreases gradually as gestational age increases from 34 weeks and plateaus at 39–40 weeks.

The American College of Obstetricians and Gynecologists recommends that no elective induction or cesarean delivery be performed before 39 weeks.
without clinical indication or evidence of fetal lung maturity\textsuperscript{20,21} and points out that even “a mature fetal lung test result before 39 weeks of gestation, in the absence of appropriate clinical circumstances, is not an indication for delivery.”\textsuperscript{22} In addition, the National Quality Forum and the Joint Commission recently endorsed as one of their standardized perinatal care measurements reporting of all singletons delivered at 37 or more completed weeks of gestation that are electively delivered before 39 completed weeks of gestation.\textsuperscript{22,23} Although there are clearly instances when delivery before 39 weeks of gestation is medically indicated, our concern is for nonmedical factors leading to elective delivery before 39 weeks such as maternal request, physician schedules, or a combination of social factors related to convenience. Moreover, early induction has a greater chance of resulting in a cesarean delivery, particularly with an unfavorable cervix.\textsuperscript{24} A survey of women who recently gave birth found that over half believed that full term was reached at 37–38 weeks of gestation and that most believed it is safe to deliver before 39 weeks of gestation when there are no other medical complications requiring early delivery.\textsuperscript{25} Thus, in addition to quality improvement programs and physician education to address this issue from the perspective of the provider, it is also important to communicate to pregnant women and their families the possible negative consequences of early elective delivery.

**RETHINKING THE DEFINITION OF “TERM PREGNANCY”**

In recent years, there has been general agreement about the use of a new expression, “late preterm,” to define neonates born between 34 0/7 and 36 6/7 weeks of gestation.\textsuperscript{26,27} This subcategory of preterm births was instituted based on new epidemiologic and outcome data and has been useful in highlighting a subgroup of preterm births that contributes significantly to the growing rate of prematurity in the United States and has been shown to have a higher risk of neonatal complications than previously appreciated. We believe it makes similar sense to create a new subcategory of term births called early term, from 37 0/7 to 38 6/7 weeks, to focus on an important period in gestation that also has been shown to have a higher risk of neonatal complications and would benefit from more careful assessment and concern.

**CONCLUSIONS**

Term birth has previously been considered a homogeneous group to which risks associated with preterm and postterm births are compared. However, the data suggest that neonates born at term form a heterogeneous group and that those born earlier in the term period and those born later need to be considered as separate subgroups. Additional research is needed to elucidate associated long-term adverse outcomes for those babies born early term between 37 0/7 and 38 6/7 weeks as compared with babies born later at 39–41 weeks or “full term.” There is also a need to elucidate the cost implications of the elective delivery of these early term neonates. Moreover, clearer terminology separating early term from full-term births would be useful to educate women when discussing implications of the best timing for delivery. We suggest the universal adoption of the use of early term to describe the subcategory of term births born between 37 0/7 and 38 6/7 weeks of gestation. Management of pregnancies in each of these categories should clearly be guided by data derived from gestational-age specific studies. We call on epidemiologists, clinicians, and researchers to collect data distinguishing early term births and their outcomes from babies born later at full term to provide new insights and strategies for improving birth outcomes.

**REFERENCES**


