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Pregnancy at Advanced Maternal Age: Maternal and Fetal Implications—A Narrative Review

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Abstract

Background: Having a pregnancy at an advanced maternal age (AMA), which is usually set at 35 years or older when delivery is expected, is becoming more common. While this age threshold is helpful for the purpose of surveillance and for giving advice, the risks associated with age increase continuously and become more clinically significant after the age of 40. The decision to have children later in life is linked to decreased fertility, a higher reliance on assisted reproductive technologies, the build-up of chronic diseases, the effects of vascular and metabolic aging, and placental dysfunction.

The aim is to draw together current evidence regarding the effects of AMA on mothers, the fetus, newborns, and the obstetric situation, and to establish a method of care that is based on assessing the level of risk at preconception, antenatal, during labour, and in the postpartum period.

Methods: We carried out a narrative review of the major professional guidelines and peer-reviewed observational studies, systematic reviews, and meta-analyses. In our review we focused on the evidence relating to age-specific gradients, as well as on clinically important maternal and perinatal outcomes and on interventions which can modify risk.

Findings show that, when compared to younger adults, pregnant women who are of advanced age have higher rates of infertility, early pregnancy loss, fetal aneuploidy, hypertensive disorders, gestational diabetes, placenta previa, placental abruption, cesarean birth, postpartum hemorrhage, preterm birth, fetal growth abnormalities, stillbirth, and admission of the newborn to neonatal intensive care. Although the absolute risk for most of these outcomes is only modest in women aged 35 to 39 years who are otherwise healthy, it increases considerably at 40 years of age and again at 45 years or above. The effect of chronological age operates via a number of mechanisms and is often intensified by nulliparity, obesity, assisted conception, multifetal pregnancy, and the presence of pre-existing cardiovascular or metabolic disease. Advanced age on its own is not a reason to have a cesarean delivery. For women who plan to deliver at 40 years of age or older, the current consensus guidelines recommend assessing fetal growth in the third trimester, carrying out antenatal fetal surveillance, and delivering at 39 weeks when the gestational age can be accurately determined.

We should regard AMA as a measure of varying risk rather than as a simple diagnostic category; the best outcomes can be achieved by carrying out a personal preconception assessment, providing early genetic counseling, preventing preeclampsia specifically, keeping a close watch on metabolic and blood pressure factors, carrying out detailed imaging of the fetus, properly assessing both fetal growth and its well-being, and making joint decisions regarding when and how the baby should be born.

Keywords: Advanced Maternal Age; Pregnancy; Aneuploidy; Preeclampsia; Gestational Diabetes; Stillbirth; Fetal Growth; Cesarean Delivery; Perinatal Outcome.

Introduction

In many areas the age at which a person has their first child and at subsequent births has increased due to longer periods of education and employment and economic factors, people choosing to enter into partnerships later, the effective use of contraception, changes in reproductive preferences, and better access to assisted reproductive technology (ART). Consequently, clinicians are now more often dealing with pregnant individuals in their late thirties and forties. AMA is generally taken to mean that the mother's age at delivery is expected to be 35 years or more. This definition originated historically from the balance between the age-related risk of fetal aneuploidy and the risk of loss associated with invasive prenatal diagnosis; it must not be seen as indicating a biological threshold at the age of thirty-five [1,2].

The current evidence shows that risk follows a continuous pattern. In the case of most outcomes, the rise in risk between 35 and 39 years is less than the increase seen after 40 years, and the highest rates are found in people who are 45 years of age or older [1,3]. Yet the majority of healthy pregnant women aged 35 years or above will go on to have a live birth without experiencing severe complications. Counselling in this situation therefore needs to prevent both giving false reassurance and using deterministic language. The question that is really important from a clinical point of view is not whether age involves a risk, but rather how age interacts with baseline health, reproductive history, method of conception, placental function, and the quality of maternity care.

The review looks at the biological basis and clinical implications of AMA, summarizes the risks to both mother and fetus, and suggests a practical approach to risk-stratified management. The term "maternal" is still used since it is the standard in the literature, but in order to provide respectful and inclusive care, each patient's preferred terminology should be used.

Methods

The narrative review has drawn on guidelines issued by the American College of Obstetricians and Gynecologists (ACOG), the Society for Maternal-Fetal Medicine (SMFM), and the American Society for Reproductive Medicine (ASRM), as well as on cohort studies and systematic reviews and meta-analyses that were found in PubMed. The search terms used were "advanced maternal age", "very advanced maternal age", "pregnancy outcome", "aneuploidy", "miscarriage", "preeclampsia", "gestational diabetes", "placenta", "preterm birth", "stillbirth", and "induction of labor". Preference was given to evidence in English that had direct clinical relevance. Since this was a narrative not a systematic review, neither a pooled reanalysis nor a formal risk-of-bias assessment was carried out.

Defining and Classifying the Risks

While using a single age threshold of 35 years simplifies clinical pathways it masks significant heterogeneity. The ACOG and SMFM suggest that age should be recognised in five-year groups—35 to 39, 40 to 44, 45 to 49, and 50 years and over—when data are available [1]. Risk is likewise affected by parity, whether conception is spontaneous or achieved by assisted methods, whether the pregnancy is a singleton or multifetal one, the interval between pregnancies, body mass index, smoking, socioeconomic conditions, and access to high-quality antenatal care; nulliparity and the use of ART, both of which are more common in older age groups, independently increase a number of obstetric risks.

Age at anticipated delivery	Interpretation	Clinical emphasis
35–39 years	Modest increase in several outcomes; absolute risk often remains low in healthy singleton pregnancies.	Offer all genetic screening and diagnostic options; detailed anatomy scan; manage additional risk factors. Routine surveillance based on age alone is not clearly supported.
40–44 years	More consistent rise in hypertensive, metabolic, placental, operative-delivery, growth, and stillbirth risk.	Consider low-dose aspirin when criteria are met; third-trimester growth assessment; offer antenatal surveillance; plan delivery at 39+0 to 39+6 weeks if well dated and uncomplicated.
≥45 years	Very advanced maternal age with substantial maternal and obstetric risk; ART and donor oocytes are common.	Multidisciplinary preconception and antenatal care; careful cardiac/metabolic assessment; individualized surveillance and delivery planning.

The biological basis of the risks associated with age

1. The ageing of the ovaries, subfertility, and loss of pregnancy

The amount of ovarian reserve and the quality of the egg decrease as a result of the gradual exhaustion of the follicular pool and an increasing frequency of meiotic errors. Due to age-related problems with chromosomal cohesion, spindle dysfunction, impairment of the mitochondria, and a change in DNA-repair ability, the number of aneuploid oocytes and embryos rises. It therefore follows that natural fertility drops, the time taken to become pregnant increases, and the chance of both infertility and miscarriage goes up. The American Society for Reproductive Medicine suggests that infertility testing should be started after six months of failing to conceive in women who are 35 years of age or older and that this should be done more quickly in those over 40 or in cases where there is a known fertility-affecting condition [4,5].

In older patients, early pregnancy loss is mainly due to chromosomal abnormalities in the embryo, even though uterine disorders, endocrine diseases, and factors on the father's side may also play a role. While ART can deal with certain obstacles to fertilization, it does not counteract the ageing of the oocyte when one's own oocytes are used. Although using donor oocytes reduces the problem of embryonic aneuploidy linked to the recipient's age, the older recipient's cardiovascular and obstetric risks still persist; furthermore, donor-oocyte pregnancies may also have a higher, independent risk of developing hypertensive disease.

2. Maternal vascular and metabolic aging

As people get older their arteries become stiffer, their endothelium functions abnormally, their cardiovascular reserve decreases, they develop insulin resistance, they gain in adiposity, and they have a greater total exposure to hypertension, diabetes, renal disease, and other chronic illnesses. Pregnancy places a large demand on the body's hemodynamics and metabolism. In a patient who has only a limited reserve it will be more difficult for them to cope with the increase in plasma volume, cardiac output, and insulin demand, thus raising their risk of developing hypertensive disorders, gestational diabetes, cardiac complications, and severe maternal morbidity.

3. Placental mechanisms

The link between advanced maternal age and conditions such as preeclampsia, fetal growth restriction, placental abruption, and stillbirth can be explained by impaired trophoblast invasion, altered uteroplacental perfusion, oxidative stress, inflammation, and accelerated placental senescence. However, while some studies do not show an independent effect of age when comorbidities are taken into account, this still indicates that placental dysfunction is the result of both biological aging and the buildup of other concurrent risk factors. Nevertheless, population data always reveal an age gradient for complications that are mediated by the placenta [2,6].

Maternal Implications

1. Hypertensive problems during pregnancy

As people get older, chronic hypertension becomes more common and so do the risks of gestational hypertension and preeclampsia. The reasons for this are endothelial dysfunction, vascular stiffness, metabolic disease, and abnormal placentation. The link becomes more pronounced after the age of 40 and is worsened by nulliparity, obesity, diabetes, renal disease, multifetal gestation, ART, and a previous history of preeclampsia. Older age is considered a moderate risk factor for preeclampsia; in such cases, low-dose aspirin is usually advised if there is one or more moderate-risk factors or if there is a high-risk factor, as long as there is no contraindication [1]. It is particularly important to optimize blood pressure before conception and to carry out a baseline assessment of renal function and proteinuria early in pregnancy among women who have chronic hypertension.

2. Gestational diabetes and metabolic illness

There is an independent association between maternal age and gestational diabetes mellitus (GDM). A meta-analysis found that the risk of GDM increases progressively from one age group to the next, which is in keeping with a decreasing pancreatic β -cell reserve and a growing degree of insulin resistance [7]. Factors which modify the absolute risk include obesity, ethnicity, family history, polycystic ovary syndrome, and a previous case of GDM. If other risk factors are present, early testing for obvious diabetes or for early dysglycemia should be carried out, and then routine gestational screening should be done if the early tests are normal. Managing blood glucose levels effectively reduces the morbidity associated with macrosomia and may also reduce complications related to hypertension and the neonate.

3. Disorders of the placenta and bleeding in obstetrics

Placenta previa, placental abruption, and postpartum hemorrhage are more common in later pregnancies, even though previous cesarean delivery, being a multiparous woman, uterine procedures, the use of ART, and the presence of comorbid conditions account for some of this association. If placenta previa occurs in a woman who has had a previous cesarean section then the chance of placenta accreta spectrum increases. If the position of the placenta and the risk of invasion are identified during antenatal care, the delivery can take place at a hospital that has the appropriate facilities.

In cases where several risk factors are present, the risk of hemorrhage should be assessed, antenatal anemia should be corrected, active management of the third stage should be carried out, and immediate access to uterotonics and blood products should be ensured.

4. Cesarean section and interventions during labour

As a woman gets older, the number of caesarean sections tends to increase. Possible reasons for this include higher incidences of placenta previa, hypertensive disease, diabetes, malpresentation, induction, a previous operation on the uterus, and fetal distress, but even after making adjustments for these factors an independent link usually remains. Contributions to this association may be made by decreased efficiency of the uterine muscle, slower progress of labour, lower thresholds for opting for an operation, and patient or doctor preference. For women aged 45 years or more, a 2023 meta-analysis found an odds ratio of 2.87 for caesarean delivery when compared to younger controls, although there was a great deal of variation between the studies [3]. Advanced age by itself should not be considered a reason for having a caesarean birth. If there is no other indication, a planned vaginal birth is safe and suitable [1].

5. The case of serious maternal morbidity and mortality

Population studies show higher rates of intensive care admission, transfusion, thromboembolism, stroke, acute kidney injury, cardiac events, and maternal death at older ages, particularly at 45 years or older [8,9]. Absolute event rates remain low, but the consequences justify systematic preconception and antenatal review of cardiovascular symptoms and risk factors. Individuals with established cardiac, renal, or metabolic disease benefit from multidisciplinary assessment. Pregnancy should not be framed as contraindicated on 5.6 Considerations of a psychological and social nature if Parents who are older might begin a pregnancy following a struggle with infertility, the burden of treatment, or earlier losses and may therefore feel greater anxiety regarding the possibility of miscarriage, the baby having a disorder, and complications during birth. On the other hand, a higher level of emotional readiness, greater education, financial stability, and having a pregnancy that is properly planned could act as a safeguard. When giving advice, counselors should take a non-directive approach and should avoid using stigmatizing terms such as "elderly gravida", and carrying out screening for anxiety and depression, ensuring continuity of care, and providing a clear explanation of the absolute—not just the relative—risks can help improve the quality of the decisions made and the overall pregnancy experience. lanation of absolute—not only relative—risk can improve decision quality and the pregnancy experience.

Effects on the Fetus and Newborn

1. Aneuploidy and birth defects

The likelihood of fetal aneuploidy increases as the oocyte gets older, particularly in the case of trisomies 21, 18 and 13 as well as sex-chromosome aneuploidies. Every pregnant person, no matter their age, should be given the choice between prenatal genetic screening and diagnostic testing. The screening methods available are cell-free DNA testing and those based on serum and ultrasound; diagnostic tests include chorionic villus sampling and amniocentesis. Although cell-free DNA is the most sensitive of the screening tests for the common trisomies it is not diagnostic and does not detect all genetic or structural disorders. Before making irreversible decisions about the pregnancy a positive screen must be confirmed by diagnostic testing; a negative result lowers but does not remove the risk [1].

Since the risk of aneuploidy and perhaps the risk of non-chromosomal anomalies is higher, a detailed fetal anatomic ultrasonogram is recommended in cases where delivery is expected at 35 years of age or above [1]. Fetal echocardiography should be carried out according to standard indications such as a suspected cardiac abnormality, a specific maternal disease, a family history, or certain circumstances associated with assisted reproductive technology rather than on the basis of age only.

2. Miscarriage and fetal loss

Miscarriage means the loss of a pregnancy before 20 weeks. Most miscarriages happen in the first trimester. Common causes include genetic problems in the fetus, problems with the uterus or cervix, infections, and certain health conditions in the mother like diabetes or thyroid disease. Symptoms often include vaginal bleeding, cramping, and pain in the lower abdomen. Some women may not notice symptoms until a routine ultrasound shows no heartbeat.

Fetal loss after 20 weeks is called stillbirth. Causes can include problems with the placenta, infections, birth defects, or chronic health problems in the mother. Symptoms of stillbirth can be a sudden stop in fetal movement or other signs that the pregnancy is not progressing.

Both miscarriage and stillbirth can have a strong emotional impact. Support and counseling can help families cope with the loss.

The risk of spontaneous abortion rises considerably as a woman gets older, mainly due to embryonic aneuploidy. For this reason, the denominator when calculating live births is selective in that only those pregnancies which have gone beyond the first trimester have survived the phase of greatest age-related loss. When appropriate, clinicians should carry out an early viability assessment and then give sensitive, evidence-based advice following a loss. In cases of recurrent miscarriage, evaluation should be carried out in accordance with the established criteria rather than simply attributing it to advanced age without first conducting an assessment.

3. Fetal growth abnormalities

Small-for-gestational-age (SGA) and large-for-gestational-age (LGA) babies are both more frequently reported in cases of advanced maternal age. Placental insufficiency and hypertensive disease are factors that lead to SGA and restricted fetal growth, while diabetes and maternal adiposity are associated with LGA. For pregnancies expected to reach 40 years of age or older, ACOG/SMFM recommend that an ultrasound should be carried out to assess fetal growth in the third trimester [1]. However, there is not enough evidence to establish a single recommended number or time for such scans; management should take into account fundal growth, any comorbidities, the woman's previous obstetric history, and local guidelines. If abnormal growth is found, then surveillance should be carried out and delivery planning should be done in accordance with the particular diagnosis.

4. Preterm birth and complications in newborns

AMA is linked with preterm birth, low birth weight, the need for admission to neonatal intensive care, and, in certain datasets, with lower Apgar scores or respiratory morbidity [2,6,10]. A significant portion of preterm births are medically indicated due to preeclampsia, growth restriction, placenta previa, or maternal disease rather than being the result of spontaneous preterm labour. This point is important since reducing iatrogenic prematurity requires that the underlying maternal and placental disorder be either prevented or detected, while at the same time avoiding unnecessary early delivery.

5. The case of stillbirth and perinatal death

The risk of stillbirth goes up as a woman's age increases and as the length of the pregnancy progresses; this rise is most significant for women who are 40 years of age or older and after 39 weeks [1,11]. Possible explanations involve placental ageing, disorders of fetal growth, chronic diseases, and a decreased physiological reserve, although in some cases the cause of the loss is not known. A systematic review showed that the risks of stillbirth and maternal mortality increase in the older age groups [11]. These findings form the basis for the advice to provide close monitoring in pregnancies where the mother is expecting to deliver at 40 years of age or over and to refrain from routinely continuing the pregnancy beyond the 39th week when the due date can be accurately determined and there are no earlier signs indicating the need to do so.

The clinical management throughout the reproductive continuum

1. Preconception care

The best chance to alter risk is available through preconception consultation. The assessment must include an examination of the individual's reproductive aims, previous pregnancies, menstrual and fertility history, medications, vaccinations, genetic and family history, body mass index, blood pressure, and any symptoms or diagnoses that point to cardiovascular, renal, endocrine, or thrombotic disease. It is important to optimise diabetes and hypertension, to change teratogenic drugs where possible, to prescribe folic acid, to deal with smoking and alcohol use, and to promote healthy nutrition and physical activity. When giving fertility advice, it should be recognised that fecundity declines over time; evaluation should be carried out after six months of infertility in women who are 35 years of age or older and without delay if a woman is over 40 or if there is a known risk factor [4,5].

2. First trimester

Early care should verify the gestational age and viability, detect the presence of a multifetal pregnancy, record the patient's baseline blood pressure and any comorbid conditions, and address the issues of genetic screening and diagnostic testing. The counseling provided must be tailored to the individual patient since, although the AMA raises the prior probability of aneuploidy, it does not require any testing to be carried out. When the criteria for preventing preeclampsia are fulfilled, low-dose aspirin should be started between 12 and 28 weeks of pregnancy, preferably before 16 weeks, in accordance with the relevant guidelines. Baseline creatinine levels, liver function tests, urine protein assessment, glycated hemoglobin levels, or early glucose testing should all be individualized.

3. Second trimester

It is advisable to carry out a thorough structural survey, typically between 18 and 22 weeks; attention should be paid to the position of the placenta, especially in cases where a previous cesarean section has been performed or assisted reproductive technology has been used. Standard screening for gestational diabetes mellitus is carried out between 24 and 28 weeks unless the patient has already been diagnosed. At each appropriate visit, blood pressure, the presence of symptoms of preeclampsia, gestational weight gain, and the fetal growth pattern should be evaluated.

4. Third trimester and fetal surveillance

For patients aged 40 years or older at anticipated delivery, a third-trimester growth ultrasound is suggested, and antenatal fetal surveillance should be offered because of increased stillbirth risk [1]. ACOG/SMFM note that evidence does not establish a single best starting week or frequency; beginning surveillance between 32 and 36 weeks is reasonable, tailored to age and comorbidity. For age 35–39 years alone, evidence is insufficient to recommend routine surveillance without another indication. Use non-stress testing, biophysical profile, amniotic-fluid assessment, and Doppler studies according to the clinical scenario. 7.5 Timing and way of delivery rituals [1,12].

5. Timing and mode of delivery

In the case of a pregnancy that is well-dated and otherwise uncomplicated with an expected delivery date of 40 weeks or later, delivery should be carried out between 39 weeks and 6 days and 39 weeks and 6 days because stillbirth and neonatal morbidity rise after that time [1]. For women aged between 35 and 39 years, routine delivery can be timed according to standard obstetric guidelines since there is not enough evidence to support early delivery based on age. Induction at term does not seem to increase the chances of a caesarean section, the need for assisted vaginal birth, or postpartum haemorrhage when compared with expectant management in the AMA population [13]. The method of delivery should be decided upon the basis of obstetric indications and the woman's informed preference, with vaginal delivery being suitable whenever there are no contraindications.

6. Postpartum care

During the period after childbirth, one should remain alert to the possibility of hypertension, hemorrhage, venous thromboembolism, cardiac symptoms, and glucose intolerance. Women who have had gestational diabetes must have their diabetes checked after giving birth and should then have ongoing metabolic monitoring. Since hypertensive disorders indicate an increased future risk of cardiovascular disease, they should lead to a transition to primary care. Before leaving the hospital and also at any subsequent visits, contraception, the length of time between pregnancies, support for breastfeeding, mental health, and future fertility plans should all be discussed.

Phase	Core assessment	Risk-reduction actions
Preconception	Fertility history; BP/BMI; diabetes; cardiovascular, renal, and medication review; genetics.	Optimize chronic disease; folate and vaccination; lifestyle support; timely fertility referral.
First trimester	Dating/viability; aneuploidy counseling; baseline labs guided by risk; preeclampsia risk.	Offer screening and diagnostic options; start aspirin when indicated; establish multidisciplinary care if needed.
Second trimester	Detailed anatomy; placental location; BP and metabolic surveillance.	Routine/early GDM testing as appropriate; investigate abnormal placentation or fetal anatomy.
Third trimester	Growth assessment and surveillance according to age and comorbidity; delivery planning.	At ≥ 40 years, offer growth scan and fetal surveillance; plan delivery during week 39 if uncomplicated and well dated.
Postpartum	Hemorrhage, hypertension, thrombosis, glucose, cardiac and mental health review.	Ensure postpartum testing, contraception, risk-factor modification, and transition to primary care.

The interpretation of the evidence and the areas in which there is uncertainty

A large portion of the literature is based on observation and is susceptible to residual confounding. There is a great deal of variation among the comparator groups, the age cutoffs, the parity, the exposure to ART, the number of babies, and the adjustment methods used. Moreover, clinical intervention might also affect the outcomes that are observed since a higher rate of induction or cesarean section could indicate an appropriate reaction to the disease, to the perception of risk, or to both. Although the relative risks may seem high the actual risks will still be low, especially among women aged 35 to 39 years. On the other hand, if all individuals aged 35 years and over are combined together, the higher risk observed after 40 or 45 years can be diluted.

Future studies ought to report age in more specific age groups, differentiate between spontaneous and medically indicated preterm birth, separate cases of autologous conception from those involving donor oocytes, and look into whether surveillance methods reduce stillbirth without leading to unnecessary interventions. The studies should also take into account patient-reported outcomes, mental health, health inequalities, and the impact of having multiple chronic conditions. Prediction tools that combine age with blood pressure, metabolic health, obstetric history, placental biomarkers, and fetal growth may be more useful than relying solely on age thresholds.

Discussion

AMA can best be seen as an indicator of the interaction between reproductive, vascular, metabolic, and placental processes. The reason for the close association with infertility, miscarriage, and aneuploidy is oocyte aging, while maternal comorbidities and placental dysfunction are responsible for complications that occur in later pregnancy. The evidence consistently shows higher risks of hypertensive disorders, GDM, placental abnormalities, cesarean delivery, preterm birth, growth problems, and stillbirth, with the most marked increase occurring at age 40 or older and in particular after 45 years [1–3,6,8,11].

The clinical approach should be appropriate. It would be unnecessary and could cause anxiety to apply all high-risk interventions to a healthy 35-year-old, while treating a 43-year-old with chronic hypertension who is having a baby through ART as if the only factor were age would underestimate the level of risk. A step-by-step approach is better: the age band should serve as the starting point, and the care pathway should then be adjusted according to parity, number of pregnancies, method of conception, obstetric history, cardiovascular and metabolic health, placental findings, and fetal growth.

It is important to have a shared decision-making process. Counseling must outline the direction and give an estimate of the level of risk, clarify the difference between screening and diagnosis, and explain the boundaries of surveillance. Patients need to be made aware that testing will not prevent every stillbirth and that the fact that cesarean sections become more common with age does not mean that a cesarean delivery is required. Delivering on time at 39 weeks for women who are 40 years of age or older is one of the only age-specific interventions that is directly supported by the current consensus, whereas other decisions should be based on the full clinical picture.

Conclusion

Having a pregnancy at an advanced maternal age has important implications for both the mother and the fetus, but age should be seen as a continuous range rather than as a diagnosis. For many healthy people between 35 and 39 years of age the risks increase only slightly and become more significant after 40, the risks being greatest at very advanced ages. Proper care should start before conception and include fertility advice, the optimization of any chronic conditions, making informed choices regarding genetic testing, the prevention and early identification of complications such as hypertension and metabolic disorders, a thorough evaluation of the fetus, close monitoring of its growth and well-being, and the development of a personal delivery plan. By adopting a risk-based and non-stigmatizing approach it is possible to reduce preventable illness while at the same time respecting autonomy and avoiding any interventions solely on the grounds of age.

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