Induction of Labour

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Induction of Labour

- SOGC Clinical Practice Guideline
  - No. 296, September 2013
  - 25 recommendations
- Induction rates are increasing
  - 1991/92 – 12.9%
  - 1999/00 – 19.7%

Induction of Labour

- #1- The indication for induction must be documented, and discussion should include reason for induction, method of induction, and risks, including failure to achieve labour and possible increased risk of Caesarean section.

Induction of Labour

- Indicated when the risk of continuing the pregnancy exceeds the risk associated with induction.

- High priority:
  - Preeclampsia >37 weeks
  - Significant maternal disease
  - Stable antepartum hemorrhage
  - Chorioamnionitis
  - Suspected fetal compromise
  - Term PROM with +GBS

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- Other indications:
  - Postdates > 41+0 or post term >42+0 weeks
  - Uncomplicated twins >38 weeks
  - Diabetes
  - IUGR
  - Oligohydramnios
  - Gestational hypertension >38 weeks
  - IUFD or previous IUFD
  - PROM at or near term –GBS
  - Logistical concerns (distance to hospital)

Induction of Labour

- Unacceptable Indications
  - Convenience for patient or care provider
  - Suspected fetal macrosomia (EFW > 4000gm) in a non diabetic.

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- Risks of Induction
  - Failure to achieve labour
  - Caesarean section
  - Operative vaginal delivery
  - Tachsystole
  - Chorioamnionitis
  - Cord prolapse
  - Iatrogenic prematurity
  - Uterine rupture

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- #5- Health care providers should assess the cervix to determine the likelihood of success and to select the appropriate method of induction. (II-2A)

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- Modified Bishop Score

Factor	0	1	2
Dilatation	0	1-2	3-4
Effacement %	0-30	40-50	60-70
Length	>3	1-3	<1
Consistency	Firm	Medium	Soft
Position	Posterior	Mid	Anterior
Station	Sp-3	Sp-2	Sp-1 or 0

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- Options for Cervical Ripening for Unfavourable Cervix
- #12-Intracervical Foley catheters are acceptable agents (II2B) that are safe both in the setting of a vaginal birth after Caesarean section (IB) and in the outpatient setting(II2B)
- Summary Statements
  - Prostaglandins E2 (cervical and vaginal) are effective agents of cervical ripening and induction of labour for an unfavourable cervix
  - Intravaginal prostaglandins E2 are preferred to intracervical prostaglandins E2 because they result in more timely vaginal deliveries.

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- #16-Misoprostol can be considered a safe and effective agent for labour induction with intact membranes and on an inpatient basis (IA)
- Most studies use 25-50 mcg orally or vaginally.

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- Induction with a Favourable Cervix:
- #19-Amniotomy should be reserved for women with a favourable cervix. Particular care should be given in the case of unengaged presentation because there is a risk of cord prolapse. (IIIB)
- #20-After amniotomy, oxytocin should be commenced early in order to establish labour. (IIIB)

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- #21-In the setting of ruptured membranes at term, oxytocin should be considered before expectant management (1A)
- #22-Women positive for GBS should be started on oxytocin as early as possible after ruptured membranes in order to establish labour within 24 hours (IIIB)

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- #23-Both high and low dose oxytocin may be considered within a hospital protocol (IIB).
- #24-Because of the various concentrations, oxytocin infusion rates should always be recorded in mU/min rather than ml/hr (IIIL).
- #25-Oxytocin induction maybe considered in the hospital setting of vaginal birth after Caesarean section(II-3B).

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- Prevention of Induction:
- #8-Every woman should ideally have an ultrasound, preferably in the first trimester, to confirm gestational age (IA).

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- #10-Women should be offered induction of labour between 41+0 and 42+0 weeks as this intervention may reduce perinatal mortality and meconium aspiration syndrome without increasing the Caesarean section rate (IA).
- #11-Women who chose to delay induction >41+0 weeks should undergo twice weekly assessment for fetal well being (IA).

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- CMAJ
  - June 10, 2014
  - Use of labour induction and risk of cesarean delivery: a systematic review and meta-analysis.
  - Meta-analysis
    - 157 Randomized control trials
  - Risk of cesarean delivery was 12% lower among women whose labour was induced than among those managed expectantly in term and post term gestations.

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