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Induction of Labour

Women's Health

Induction of Labour

This leaflet is intended to give you additional information to that received from a healthcare professional.

In most pregnancies, labour starts naturally between 38-42 weeks gestation, leading to the birth of the baby.

WHAT IS INDUCTION OF LABOUR?

Induction of labour is the process used to encourage labour to start artificially. Some of these processes involve administration of drugs; all aim to encourage the cervix to shorten and soften, and ultimately to open (with the help of contractions) to allow the baby to be born.

We do not know exactly what makes women go into labour. Labour cannot be 'switched on' like a light. Induction of labour aims to tip the balance in favour of labour starting, but occasionally this does not work.

WHEN MIGHT I BE OFFERED INDUCTION OF LABOUR?

There are two main reasons why induction of labour is suggested:

- The pregnant woman's or the baby's wellbeing is causing concern and delivering the baby may be beneficial.

Further Information

We endeavour to provide an excellent service at all times, but should you have any concerns please, in the first instance, raise these with the Matron, Senior Nurse or Manager on duty. If they cannot resolve your concern, please contact our Patient Advice and Liaison Service (PALS) on 01932 723553 or email pals@asph.nhs.uk. If you still remain concerned please contact our Complaints Manager on 01932 722612 or email complaints@asph.nhs.uk.

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Gardosi J, Vanner T, et al. (1997). "Gestational age and induction of labour for prolonged pregnancy." *British Journal of Obstetrics & Gynaecology* 104: 792-797

Hannah ME, Huh C, Hewson SA, Hannah WJ. (1996) Post term pregnancy: putting the merits of a policy of induction of labour into perspective. *Birth* ;23:13–19.

NICE (National Institute for Clinical Excellence) 2008 Induction of Labour. Available from <http://www.nice.org.uk/page.aspx?o=20054>

- A healthy pregnancy is approaching the 43rd week of gestation; the risk of stillbirth increases from 3 in 3000 pregnancies at 42 completed weeks of pregnancy to 6 in 3000 pregnancies by 43 completed weeks of pregnancy.

WHEN MIGHT INDUCTION OF LABOUR BE INADVISABLE?

- Some women may develop severe pre-eclampsia which makes them rapidly unwell.
- Placental abruption (the placenta begins to detach itself from the wall of the womb).
- Breech presentation

In these situations, it is not advisable to encourage a labour and a vaginal birth, so induction of labour would not be useful.

WOMEN WHO HAVE HAD AN UNCOMPLICATED HEALTHY PREGNANCY

- Induction of labour is offered to all women between 40 weeks +12 days to 40 weeks +14 days. This follows the guidance from the National Institute for Clinical Excellence (NICE) Induction of Labour. This does not increase the likelihood that you will need a caesarean section in labour.
- 82% of pregnant women will have given birth by 42 weeks: It is extremely likely that you will labour spontaneously before 42 completed weeks (Gardosi et al, 1997) without needing an induction.

- The likelihood of stillbirth or neonatal death remains very low (Hannah et al, 1996).
- Research shows that 500 inductions of labour would be required to prevent 1 baby death (Crowley, 2003).

WHICH METHODS CAN BE USED TO INDUCE LABOUR IN AN UNCOMPLICATED PREGNANCY?

At Ashford and St Peter's, your midwives are responsible for discussing the following options with you;

- Membrane sweep
- Prostaglandin gel
- Artificial rupture of the fetal membranes (breaking the waters)
- Syntocinon augmentation

It is usual to begin with a membrane sweep, and then follow this with one of the other methods. The suitability of each depends on what is happening to the cervix; a vaginal assessment is needed to provide this information. In certain situations, some methods are less suitable and the midwife/obstetrician will inform you of those which are inadvisable in your particular circumstances.

WOMEN WITH AN UNDERLYING CONDITION WHICH MAY IMPACT UPON PREGNANCY AND LABOUR

Your obstetric doctor may advise an induction of labour when getting the baby born is likely to be best for the mother and/or the

A word about castor oil – this encourages strong gripping bowel pains which in turn irritate the pelvic organs including the uterus. This is usually followed by frequent bowel movements. It is not a recommended method to start labour.

FURTHER INFORMATION

Midwifery Digest and Information Resource (MIDIRS)

<http://www.infochoice.org/>

National Institute of Clinical Excellence (NICE)

<http://www.nice.org.uk/page.aspx?o=20054>

References

CEMACH (Confidential Enquiries into Maternal and Child Health) 2006 Available from <http://www.cemach.org.uk/publications.htm>

UKOSS (United Kingdom Obstetric Surveillance System) Annual report 2007

RCOG (Royal College of Obstetricians and Gynaecologists) patient information leaflet 2009

Crowley P. Interventions for preventing or improving the outcome of delivery at or beyond term (Cochrane Review). In: The Cochrane Library, Issue 4, 2003. Chichester, UK: John Wiley & Sons, Ltd.

leave in the body tissues. Very occasionally this leads to too much water staying in the lung tissues.

- When a Syntocinon infusion has been used during labour, the uterus is likely to need further encouragement to expel the placenta and to control bleeding afterwards. It is therefore recommended that you have an actively managed third stage of labour. The midwife will give you an injection of Syntometrine (or Syntocinon if your blood pressure is raised) in your thigh immediately after the birth to encourage the uterus to contract. The midwife or doctor will then deliver the placenta.

ALTERNATIVES TO INDUCTION OF LABOUR

There is limited evidence about the usefulness of complementary therapies, reflexology, and 'old wives tales' to start labour in a healthy pregnancy. If you intend to use complementary therapies to encourage labour to start, it is wise to wait until at least 37 weeks of pregnancy, and hence reduce the risk of a preterm birth.

All treatments have benefits and disadvantages; do not use any treatment that you do not understand fully.

The following are likely to be more beneficial than harmful

- Methods to encourage release of natural prostaglandins; nipple and/or clitoral stimulation, sexual intercourse.
- Stimulation of the muscles of the womb; acupuncture on points which link to the womb, raspberry leaf tea.

baby. This advice is based on an individual assessment of your circumstances.

Common circumstances include:

- The baby is not growing well
- The mother's health is getting worse, for example, pre-eclampsia

Your doctor should perform, or arrange for a midwife to perform, an internal vaginal assessment to make a judgement about how likely it is that induction of labour could be beneficial. At the same time you should be offered a membrane sweep (see next section).

A MEMBRANE SWEEP

This is a vaginal examination which aims to increase the production of the body's own prostaglandins (hormones) which can encourage labour to begin. It also helps the midwife make a judgement on the likelihood of you going into labour spontaneously in the next few days. All women who are being advised to have induction of labour should be offered a membrane sweep as part of that process.

As long as the waters have not broken previously, this procedure does not increase the risk of infection in the mother or the baby.

Benefits

- Can be performed at the community antenatal appointment, in the antenatal clinic or in your own home (depending upon the reasons for suggesting a membrane sweep).
- Does not involve drugs
- Is likely to have the desired effect within 2-5 days (NICE, 2008)
- Can be repeated if you wish
- Reduces the need for other methods of induction of labour (NICE, 2008)

Disadvantages

- The examination does not involve medical instruments of any kind but may be uncomfortable; this discomfort should not persist after the examination.
- Occasionally light 'spotting' of blood occurs.
- Very occasionally, the waters might break during the examination; labour will usually follow naturally in the next 18 hours, but if it does not you may need to decide whether to have contractions artificially stimulated with an intravenous oxytocin hormone drip.

PROSTAGLANDIN GEL

This drug is a gel which contains a synthetic prostaglandin E2. You will need an internal examination to enable the gel to be put high into the vagina behind the cervix. The exact dose of prostaglandin is determined according to how "ready for labour" the cervix feels and the number and timing of doses follow the NICE Induction of Labour guideline.

Disadvantages

- The contractions may be more painful than your own natural ones, so you may find you want an epidural, although you had not necessarily planned this. This may limit your ability to move around and to have an active birth.
- Uncommon side effects include; nausea, vomiting, a skin rash
- Syntocinon is not started until at least 6 hours after vaginal prostaglandin gel.

Risks

- Syntocinon is a powerful drug and its effects must be monitored closely; you will need to have continuous electronic fetal monitoring. Some babies become distressed when contractions are stimulated and this may lead to an emergency caesarean section.
- Women's bodies show different and unpredictable sensitivity to Syntocinon; some women will need large doses to stimulate contractions, others show a dramatic response at low doses. On rare occasions, the uterus and/or placenta may start to tear, endangering the mother and the baby and making emergency caesarean section necessary. There are some women who seem to be insensitive to Syntocinon and do not have any contractions at all.
- Amniotic fluid embolism is also a rare risk associated with Syntocinon use (see section on artificial rupture of membranes).
- Your fluid intake and urinary output will be closely observed, and may be restricted. This is because Syntocinon has a similar chemical structure to the hormone which instructs your kidneys how much water to convert into urine and how much to

SYNTOCINON INTRAVENOUS INFUSION

This is a drip which contains synthetic oxytocin; its action is similar to that of the natural oxytocins which are produced by the human body in order to make the uterus (womb) contract.

The most common reason for needing an oxytocin infusion is because labour has stalled. This is often because the uterus has been contracting well but the cervix does not continue to open or natural contractions have not been able to get the baby to turn its head in the pelvis. Sometimes there is a long period without contractions and continuing with this delay may be inappropriate for you and your baby. This is most common in first time mothers.

Another common reason for needing syntocinon is that the waters around the baby have broken some time ago, but contractions have not started on their own. At the end of pregnancy this happens in 6-19% of pregnancies and most women (86%) will start labour on their own within the next 24 hours (NICE, 2008). The timing of starting the infusion will be discussed with you by the midwife or doctor.

Benefits

- Encourages contractions leading to the cervix opening more, the baby turning its head in the pelvis, the baby being moved down in the pelvis.
- Can help achieve a vaginal birth when labour progress has stalled.

Benefits

- The gel may encourage the cervix to become softer and open; this can allow for your waters to be broken.
- Sometimes the gel works so well that the first dose makes labour start, although this is rare in 1st time mothers.
- The prostaglandin is absorbed into the tissues around the cervix and not into the blood stream. There is no direct effect to the baby.

Disadvantages

- You will need to lie down for one hour to encourage the gel to be absorbed.
- You will need to have the baby's condition monitored closely for the first hour after the gel is given.
- Sometimes more than one dose of the gel is required; the doses must be given at least 6 hours apart, so it may take some time for labour to start.
- You will need to stay in hospital from the time that the first dose of gel is given; at night you will be on the antenatal ward, and your partner will be unable to stay (however we will call your partner as soon as you are in established labour).
- Period type pains are common and can be managed with pain relief tablets and warm baths.
- Some women have strong regular contractions but unfortunately the cervix does not change very much and more doses of gel are needed. This may continue for up to 24 hours and can mean that you feel very tired before labour eventually becomes established; you may need to use pain relief earlier than you had planned.
- Sometimes labour progresses extremely rapidly; you may find this distressing.

- Side effects include nausea, vomiting, diarrhoea, a 'hot flush' or burning sensation in the vagina.

Risks

- On rare occasions the womb contracts so strongly and frequently in response to the gel that the baby becomes distressed, or the womb and / or the placenta may start to separate, and an emergency caesarean section is needed before labour has become established. Amniotic fluid embolus is also a rare reported side effect (see section on artificial rupture of membranes).

ARTIFICIAL RUPTURE OF THE MEMBRANES

This is performed when the cervix has begun to open. When the cervix is open to around 2-3 centimetres, it may be possible to use a plastic hook to tear the amniotic sac. This releases natural prostaglandins and encourages the baby's head to make close contact with the cervix; this further stimulates the release of natural prostaglandins.

Benefits

- The stimulation effects may be enough to encourage contractions to start.
- no drugs are involved

Disadvantages

- The amniotic fluid from around the baby will drain from the vagina, so you will need to wear a sanitary towel.

- It may take 6 hours or more to feel any effect from the procedure; if this does not encourage labour you will be encouraged to have drugs to stimulate contractions (NICE, 2008).
- Once the waters have been broken, there is no going back; you will be encouraged to use one of the other methods to get labour going.

Risks

- There is a small chance that the umbilical cord may slip past the baby's head (a cord prolapse); this is rare but requires immediate caesarean section. The rate of cord prolapses when the waters break, naturally or artificially, is around 1 in 500 labours (RCOG 2008). There were 16 cord prolapses at Ashford and St Peter's in total in the years 2006-2009. The risk of cord prolapse is reduced if the head is engaged in the pelvis prior to performing an artificial rupture of the membranes.
- There is a tiny chance that during, or sometimes immediately following the procedure, a small amount of fluid from around the baby can enter the mother's blood stream; this fluid can move around the mother's body and becomes lodged in the lungs. This amniotic fluid embolus is toxic to the mother's lungs and causes her to have great difficulty in breathing, usually resulting in cardiac arrest. This is an extremely rare event occurring only 19 times from February 2005 – July 2006 in the whole of the UK (UKOSS). Immediate caesarean section is performed as this makes resuscitation of the mother more effective. Unfortunately, women are then extremely sick and need intensive care; many do not recover. In 2003-2005, 17 women died in the UK following amniotic fluid embolism (CEMACH).