Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Induction of Labour

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Induction of Labour

Patient Information

Obstetrics & Gynaecology Service

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What is Induction of labour?

Induction of labour (IOL) is a process which aims to artificially start your labour. It is a common procedure occurring in around one third of pregnancies. You may be offered or recommended IOL for a variety of reasons, for example, if there are concerns about the wellbeing of yourself or your baby, or if your waters break before labour starts. Each woman's situation varies; the aim is to ensure that the safest gestational window to deliver your baby is tailored to each individual circumstance. One of the most common reasons for IOL in a low-risk pregnancy with no complications is because your pregnancy is overdue. In line with national guidance (National Institute for Health and Care Excellence (NICE 2021)), we offer IOL from 41 weeks gestation if you have not spontaneously (naturally) gone into labour. Your obstetrician or midwife will guide you on the risks versus benefits of IOL for you and your baby.

We want this leaflet to help women who may have their labour induced, and help their babies, partners and families, by making sure that:

- better information and support are given in pregnancy to help women understand their birth options, and when induction of labour might be offered
- the benefits and risks of inducing labour are explained clearly, including how it might affect the woman's personal choices about giving birth
- women know they can choose not to have their labour induced, and what this means for their care.

Why you may be induced

The most common reasons for having an induction are:

Prolonged pregnancy – 41 weeks +

Available evidence tells us that after 41 completed weeks of pregnancy, the risk of a baby developing health problems increases slightly, because the efficiency of the placenta starts to decrease.

Induction is a very common and safe procedure. Deciding whether to be induced at 41 weeks or wait till 42 weeks is a personal choice. Research shows that the risk of stillbirth is very low but does rise gradually the longer the pregnancy continues after 40 weeks.

At 40 weeks, about **1-2 babies in every 1,000** pregnancies may be stillborn; at 42 weeks, about **2-3 babies in every 1,000** pregnancies may be stillborn. The risk is roughly twice as high as 40 weeks, but overall, still low.

Perinatal death (baby's death before, during or shortly after birth): the risk is very small at both 41 and 42 weeks. At 41 weeks, about **4 babies in every 10,000** may die around the time of birth; at 42 weeks, about **7 babies in every 10,000** may die around the time of birth. **Induction at 41 weeks slightly reduces this risk compared to waiting till 42weeks.**

Admission to NNU (Neonatal Unit) after birth. Some babies need extra care after birth. At 41 weeks, about **31 babies in every 1,000** may need admission to the NNU for enhanced care; at 42 weeks, about **36 babies in every 1,000** may need admission to the Neonatal Unit for enhanced care.

Caesarean birth is sometimes needed if labour does not progress, or if there are concerns about you or your baby. The chance of needing a caesarean section following IOL is about the same whether you are induced at 41 or 42 weeks (171 vs 174 in every 1,000 women).

If a pregnancy continues beyond 42 weeks, the risks for both you and baby are higher:

- Increased risk of stillbirth and perinatal death.
- Baby more likely to need NNU care
- Slightly higher chance of needing assisted birth (forceps) or caesarean section

At Wrightington, Wigan and Leigh NHS Foundation Trust, we offer induction from 41 weeks (NICE 2021), unless there are medical reasons to induce labour earlier.

There are some outcomes where risks remain the same whether you accept the offer of induction of labour, await spontaneous labour or choose a caesarean birth. These include:

- If your baby passes meconium during labour and breathes in the particles this is known as - Meconium aspiration syndrome. Meconium is your baby's first bowel movement. It is a thick, sticky substance that is usually dark green or black in colour.
- Hypoxic Ischemic Encephalopathy (HIE) - a type of brain injury when baby doesn't get enough oxygen or blood flow for a period of time during birth.
- Instrumental birth
- Maternal Death

Your midwife or doctor will discuss the options available to you. You will have the opportunity to discuss:

- the option of membrane sweep
- advantages and disadvantages of induction
- options available if you do not want induction
- methods of induction available
- what happens if induction is unsuccessful.

It is not possible to predict which babies will be affected. This is why induction is recommended after 41 weeks; we understand this may affect your birth experience and encourage you to discuss your preferences with your midwife or a doctor.

Pre-labour rupture of membranes at term (waters breaking before labour establishes at or after 37 weeks)

During pregnancy, your baby is in a bag of waters known as amniotic fluid. Sometimes, the membrane around these waters breaks before labour starts. This happens in 1 in 20 pregnancies and is called Pre-Labour Rupture of Membranes. If you think your waters may have broken, wear a maternity sanitary towel (not a tampon) and make a note of the colour and amount of fluid leaking from your vagina. Please phone maternity triage immediately to get advice from our team of midwives (open 24 hours a day, 7 days a week).

Most women go into labour soon after their waters break:

- 60% of women go into labour naturally within 24 hours

- 91% of women go into labour naturally within 48 hours

Benefits and risks of these options will be discussed with you, considering your individual circumstances and preferences. Therefore, you will be given the choice of waiting for up to 24 hours for labour to start naturally or opt for induction of labour as soon as possible. A discussion for immediate induction of labour will take place for women who have known Group B Streptococcus.

Preterm prelabour rupture of membranes

If your waters break before 37 weeks, we usually recommend close monitoring until 37 weeks (unless there are signs of infection, or your baby is in difficulty). **A few factors need to be considered** when deciding to induce labour at less than 37 weeks. These include certain risks to you, such as infection/ sepsis, and the possible need for a caesarean birth if induction fails. The risks to the baby include general risks connected with being premature, and infection/sepsis and admission to a Neonatal Unit (thus the need to check the local availability of Neonatal intensive care facilities). Your individual circumstances and preferences will be considered when making a shared plan of care.

If your waters break after 34 weeks, and you are known to have a positive group B streptococcus test result (GBS) at any time in this current pregnancy, you will be offered immediate induction of labour or caesarean section.

Medical reasons

There are several medical reasons why induction of labour may be considered. These include diabetes, high blood pressure, persistent bleeding during pregnancy, and your baby being smaller than we would expect for the stage of pregnancy.

If it is of benefit to you and/or your baby to give birth earlier than expected for a medical reason, then the risks and benefits will be explained to you.

You will then be able to make an informed decision regarding having an Induction of Labour, and an individualised plan of care will be made.

Previous caesarean section

If you have had a previous caesarean birth, we recommend a mechanical method of induction of labour. Currently in our Unit we use Dilapan-S (see below 'How is labour induced' (4) Dilapan-S mechanical method). Induction of labour is associated with the increased risk of emergency caesarean birth and could lead to an increased risk of uterine rupture (tear of the womb). You would be 3 times more at risk of this if traditional drugs (like Prostin) are used. Use of mechanical methods such as Dilapan-S does not increase the risk significantly. If labour needs to be induced, a choice of induction of labour, **or** a planned caesarean birth will be discussed with you, and an individualised plan of care made.

Maternal request

We do consider your requests for induction of labour even if there is no medical problem. In this case, we will discuss the benefits and risks of induction and consider your circumstances and preferences before making an individualised plan of care. However, IOL or CS prior to 39 weeks is not recommended if there are no clinical indications. Baby is more likely to experience respiratory problems due to the immaturity of the lungs, particularly when the IOL has not been effective and a caesarean section has been undertaken. This is because the fluid has not been expelled from the baby's lungs by contractions and birthing vaginally. IOL less than 39 weeks, where the body is not ready for labour, can take longer and in certain cases the cervix does not dilate, so there is a benefit of waiting till after 39 weeks if the baby is not at any risk.

What are the risks of induction?

- Labour can take longer to start, sometimes taking up to 48 hours or more.

- There is a small risk that your baby will not tolerate the induction process or labour. (This is more common with premature or growth restricted babies).

- Induced labours can be more painful. Women who undergo induction are more likely to request medical pain relief during labour.

- You are more likely to need an assisted delivery (ventouse-suction cup method or forceps-curved metal instruments that look like large spoons) -1 in 10 women.

- Slight increase in the risk of having a blood loss greater than 500mls (10/100 induced vs 8/100 not induced)

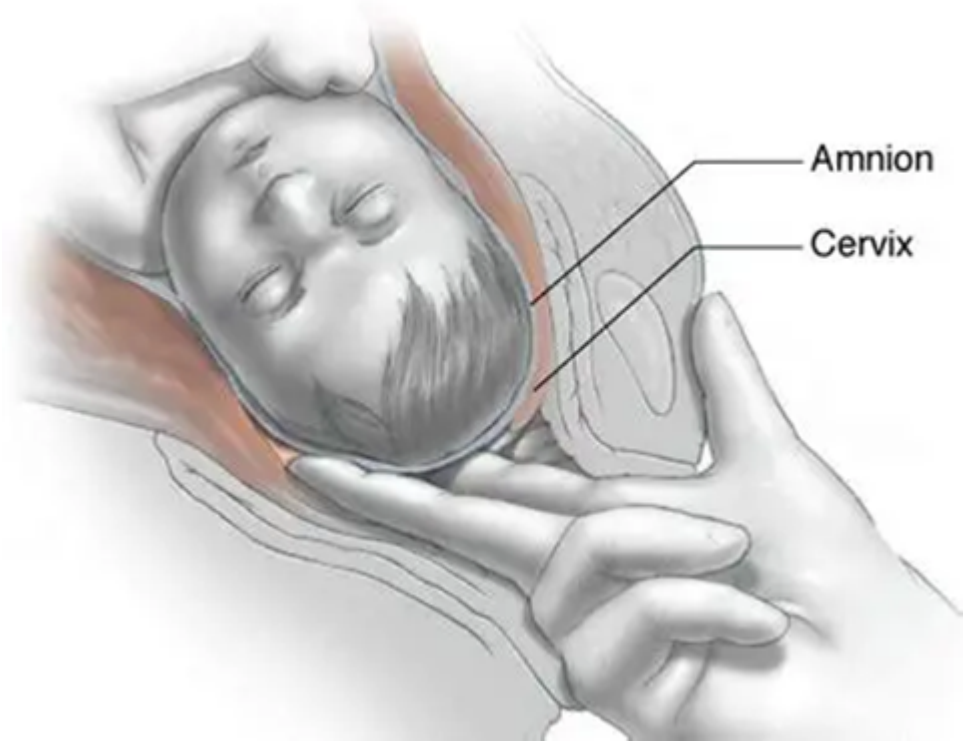
- Hyperstimulation - this can occur during induction or during labour when hormone methods are used (prostaglandins or Syntocinon). It causes the uterus to over contract more frequently and can sometimes lead to changes in the baby's heart rate, causing distress. Treatment is either of the following: the Syntocinon infusion is slowed down/stopped, or an injection is given to help relax the womb muscles (Terbutaline).

How is labour induced?

Depending on your individual circumstances, there are several ways your labour may be induced. You may need only one, or possibly all of them:

Membrane sweeping

Membrane sweeping (or a 'cervical sweep') is when the midwife or doctor places a finger just inside your cervix and makes a circular, sweeping movement to separate the membranes from the cervix. It can be carried out from 37 completed weeks by a doctor, or 39 completed weeks by a midwife. The benefit of a Membrane Sweep is that it is a drug free method that could initiate labour within 48 hours; however, it has a low success rate. You may be offered this before any other method of Induction of Labour.



Membrane sweeping can be carried out at home, in the antenatal clinic or in hospital; it may cause you some discomfort. Afterwards, it is not uncommon for you to have a blood-stained loss from your vagina, or a mucous show. This will not cause any harm to your baby, and it does not increase the risk of infection to you or your baby.

If your waters have broken, membrane sweeping is not recommended because of the risk of infection.

Prostin gel Induction

Prostin E2 Vaginal Gel contains a hormone (prostaglandin) that is used to “induce” labour. This means that the gel will encourage the cervix to soften and shorten (known as ripening), and it will encourage your uterus (womb) to start contracting. When this happens, your cervix will begin to open. The Prostin in the gel is similar to the natural prostaglandins which are made in your body when labour starts naturally.

Before you are given this gel, you will be examined by your doctor or midwife. They need to know the position of your baby's head and how dilated (open) your cervix (neck of the womb) is. You will be given a numbered score after you have been examined. This is known as the "Bishop score". The lower your Bishop score, the less ready you are to go into labour on your own.

Prostin E2 Vaginal Gel will be inserted high up in your vagina while you are lying down. You will then be asked to lie on your side for at least 30 minutes. The insertion of the gel can be repeated up to a maximum of 3 doses at 6 hourly intervals if needed, until your cervix is dilated enough to break your waters.

If the maternity unit is busy, it may not be safe to start your induction of labour.

Any delays will be fully explained to you on the day, and we always encourage you to ask any questions about the care and management of your labour and delivery.

Your birth partner may stay with you in the Induction of Labour Bay (located in delivery suite) during the partners' visiting periods.

There are currently no facilities for birth partners to stay on the maternity ward overnight while induction of labour is being performed.

Prostin Tablets (3MG dinoprostone E2)

Sometimes, if your waters have ruptured and your cervix on vaginal assessment is still unfavourable, you may benefit from having a prostin tablet inserted close to your cervix. The hormones in the tablet will dissolve and cause the uterus (your womb) to contract. You may notice a creamy discharge afterwards, which is normal.

Propess pessary Prostaglandin

The pessary is a small, tampon-like device that is inserted into the vagina. The Propess pessary contains dinoprostone, a naturally occurring hormone in women, also known as prostaglandin. After insertion, it remains in place for up to 24 hours, slowly releasing the medication to help soften and prepare (ripen) the cervix. A string is attached to the pessary so it can be easily removed when needed; this string is positioned inside the vagina.



Before you're given the pessary, the midwife will:

- Feel your tummy to check the baby's position.
- Do a vaginal examination to see if you need prostaglandin.
- Monitor your baby's heartbeat using a CTG machine.

After the prostaglandin is inserted:

- You’ll lie on the bed for about 30 minutes while the CTG checks your baby again.
- If everything looks good, the monitor will be removed and you can get up and move around.

What you might feel:

- It’s normal to have short, frequent tightening’s or mild contractions at first.
- These are caused by the prostaglandin and **are not true labour**.
- How uncomfortable this feels varies from person to person.
- Pain relief is available if you want it.

Other things to know:

- There’s no evidence that labour started with prostaglandins is more painful than natural labour.
- If you are still not having strong, regular contractions after 24 hours, the midwife will examine you internally to check your cervix.
- **If your cervix is soft and starting to open**, you’ll be advised to have your waters broken and start an intravenous drip to help bring on stronger contractions.

- **If your cervix is not yet ready**, the midwife will talk with you about the next steps, which may include having a second Propess pessary.

A small number of women are very sensitive to prostaglandins. In rare cases, this can make the uterus contract too often, which may affect your baby's heart rate pattern. If this happens, it is usually managed by changing your position and giving medication to help relax the uterus.

Dilapan- S (Mechanical method)

This is a mechanical cervical dilator used to dilate and soften the cervix. It is a synthetic rod made of hydrogel (a gel in which the liquid component is water). It does not contain any chemicals or hormones. It is recommended for women with one previous caesarean section who opt for induction of labour, or for women who prefer this method of induction. A midwife or doctor will use a speculum to see the cervix (neck of womb) and then insert 3-5 silicone rods into the cervix; they are left for 12 hrs.

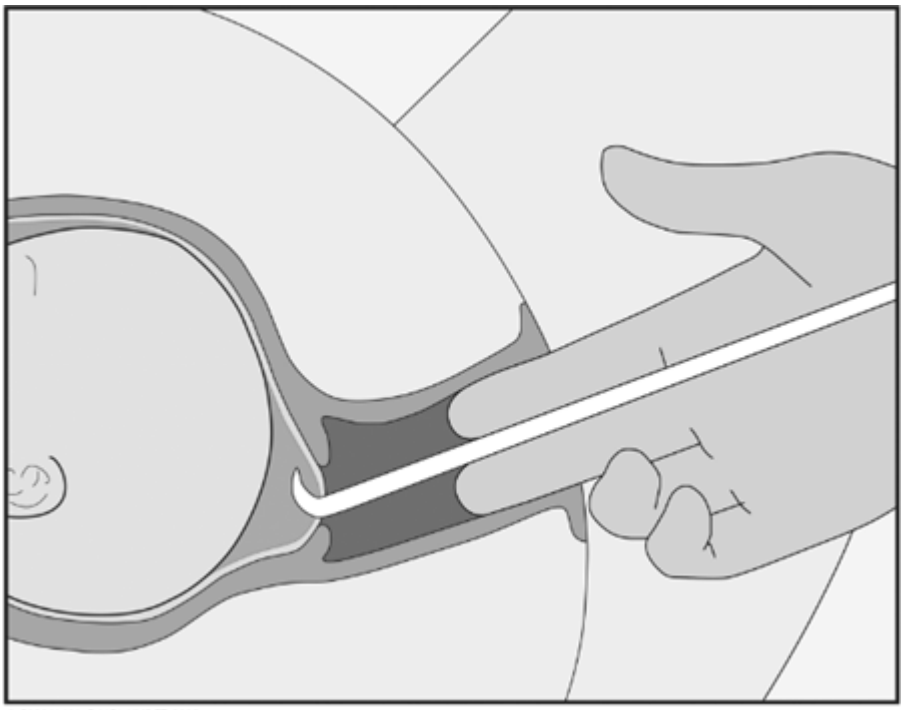


The rods work by absorbing fluid from the cervix and so dilating it to help break your waters. It is safe and effective and does not increase the risk of a tear of the womb. Inserted Dilapan-S does not limit your regular activities; you can go to the bathroom, shower

normally and perform as per normal. The Dilapan-S rods should be removed 12-15 hours of insertion. The midwife or doctor will perform a vaginal examination and remove the rods and then determine if your cervix has sufficiently dilated to break your waters.

Breaking the waters – Artificial Rupture of the Membranes (ARM)

Once your cervix is beginning to open, if your waters have not broken, you will be offered a procedure called Artificial Rupture of the Membranes (ARM), which is performed in the Delivery Suite (labour ward).


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This is when the midwife or doctor breaks your waters using a slim plastic instrument called an Amnihook. The procedure involves an internal examination, during which the Amnihook is passed through the vagina and cervix, and a small hole is made in the membranes surrounding the baby. This allows the fluid surrounding the baby to drain away. This procedure, although it may be slightly uncomfortable, will not harm you or your baby, and it stimulates contractions to start or become more effective.

Oxytocin (Syntocinon)

If your contractions do not start despite any of the above methods, a drip containing

Syntocinon can be used. Syntocinon is an artificial version of the hormone Oxytocin that your body naturally produces during labour, and which makes your uterus contract. You and your baby will be closely monitored whilst receiving Syntocinon. The drip is adjusted throughout labour, so that your contractions are strong enough to help your labour progress. This can only be given once your waters have broken.

Pain Relief during Induction of Labour

It is normal to experience some pain as part of the induction process. This is because induced labours involve medication and usually take place in an environment that is not as comfortable as your own home; therefore, the pain can sometimes be more difficult to cope with than natural labour.

After the Prostin gel/tablets have been inserted, you may feel abdominal tightening and pains in your back. These may develop into contractions, or they may simply be pains that are preparing the cervix for labour.

The early labour pain you may have after the use of Prostin gel can last for a long time, but there are several options for pain relief during the early stages of an induction. These can differ from the pain relief options you will be offered when you are in full labour. You can ask for painkillers (such as paracetamol and dihydrocodeine); a warm bath may help, as can moving around; or you can bring in a TENS machine for your induction. A TENS machine is a small, battery-operated device that can help manage pain. You should be offered emotional support and whatever pain relief is appropriate to you – in the same way as if labour had not been induced.

Occasionally, full labour can happen very quickly once the induction procedure has begun. If you are experiencing intense pain that you feel unable to cope with, please inform your midwife, who will assess you further

What if labour hasn’t started?

Induction of labour is not always successful for approximately 1 in 100 women (1%). If this happens, your doctor and midwife will discuss your options. These include having a rest day, a further dose of Prostin, use of mechanical method or having a caesarean section.

What to bring with you into hospital

The induction bay is located on level 3 adjacent to the delivery suite at Royal Albert Edward Infirmary. Please bring your hospital bag with you when you come and bring all your hospital notes. As induction can be a long process, please do make sure you bring plenty of things to keep you comfortable and occupied such as comfortable clothes, nightwear, slippers, cushion, books, magazines, tablet, headphones

Alternative options

If you choose not to have your labour induced, an individual plan of care will be made by the clinical team. This may include additional monitoring while you await the start of natural labour or having a caesarean section. This will be decided on an individual basis, considering your current and previous pregnancy and any complications.

You can contact your midwife or maternity unit if you have concerns about your baby (for example, if the baby's movements are not as frequent, or if they are different).

Further information

If you require any further information, please discuss this with your midwife or doctor.

References

NICE Inducing Labour NG 207 published 4th November 2021.

Contact Numbers

Delivery Suite 01942 778505

Maternity Ward 01942 778506

Antenatal Clinic 01942 774700 (Thomas Linacre Centre)

Antenatal Clinic 01942 264242 (Leigh Infirmary)

Community Midwifery Office 01942 778630

Maternity triage 01942 778628 *option 1* (all calls are now recorded).



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