Induction of labour

Information for patients

Telephone Numbers

The Royal Infirmary of Edinburgh

51 Little France Crescent

Edinburgh

EH16 4SA

Obstetric Triage: **0131 242 2657**

Ward 119: **0131 242 1194**

Day Assessment Unit: **0131 242 2656**

St John's Hospital

Howden Road West

Livingston

EH54 6PP

Labour Ward: **01506 524 125**

Ward 11: **01506 524 111**

Daybed: **01506 524 024**

My induction of labour appointment:

Date: _____ Time: _____

Location: _____

Contact: _____

Phone back at this time: _____

My return appointment:

Date: _____ Time: _____

Location: _____

Contact: _____

This leaflet aims to provide you with information on the process of induction of labour and the methods used to allow you to make the best choice for yourself and your baby. If after reading this you have any concerns or questions, please discuss these with your midwife.

What is induction of labour (IOL)?

Induction of labour is a process designed to start labour artificially.

In the UK, around 20% of pregnancies require to have labour induced.

Why is labour induced?

There are a number of reasons why IOL may be recommended for you. You may be offered induction when it is felt IOL may benefit your health or your baby's health.

The risk of stillbirth is very low in pregnancy. At 41-42 weeks gestation the risk is 1 in 1000 births. This increases to 3 in 1000 beyond 42 weeks.

We will discuss induction of labour with you if your labour has not started naturally by your estimated due date.

What happens if I decline IOL?

It is your right to be fully informed and to take an active role in decision making during your pregnancy and labour.

If you choose not to be induced at the time it is recommended, you should inform the midwife or doctor caring for you during your pregnancy. You will be invited to attend a clinic or hospital for monitoring to check how you and your baby are. The midwife or doctor will discuss how often you should attend.

How is labour induced?

The following methods can be used, but which one depends on your individual circumstances (not all methods are suitable for everyone):

1. Membrane sweep
2. Cervical ripening balloon
3. Vaginal prostaglandin
4. Artificial rupture of membranes ("breaking your waters")
5. Intravenous oxytocin.

Membrane sweep

Membrane sweeping involves having a vaginal examination where the midwife or doctor places a finger inside your cervix and makes a circular 'sweeping' movement to separate the membranes from the cervix. This increases the production of hormones called prostaglandins which can encourage labour to start. Some evidence suggests membrane sweeps increase the chances of labour starting naturally within the following 48 hours.

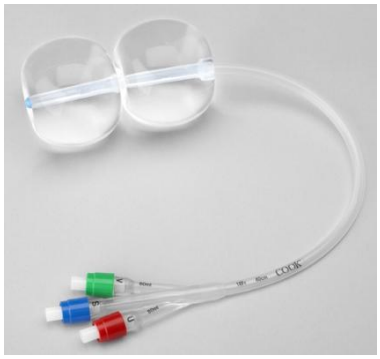
Membrane sweeps can be offered to you by your community midwife from 40 weeks and can be performed in a clinic. Sweeps may also be offered earlier than 40 weeks by your consultant obstetrician if they think that this would benefit you.

The internal examination may be uncomfortable and you may experience some minimal bleeding following this. This is due to the procedure involving stretching your cervix. You may also have a "show" later in the day. A "show" is a plug of mucus, sometimes brown or spotted with blood, which is released as the cervix begins to open. This is normal and will not cause harm to your baby.

It should not cause heavy bleeding and you should seek advice if heavy bleeding occurs.

Cervical ripening balloon (CRB)

What is a CRB?



A cervical ripening balloon is a silicone tube which has two inflatable balloons. The balloons are inflated with sterile water. This is a safe, drug-free, mechanical method of ripening the cervix.

The method

The CRB is inserted either during a vaginal examination or with a speculum (this is a device used by medical professionals to assist a vaginal examination). The top balloon is inflated in your uterus (below baby's head) and the bottom balloon is inflated below your cervix (at the top of your vagina), as pictured below.

The constant gentle pressure applied to both the inside and outside of your cervix increases the natural production of the hormone prostaglandin, similar to a membrane sweep. This allows the cervix to ripen and dilate. After insertion you may experience some mild to moderate period like cramps, usually for 2-3 hours, but these usually wear off.

The CRB stays in place for a minimum of 12 hours and a maximum of 24 hours and is removed by deflating the balloons by taking out the water. It may be removed between 12 and 24 hours if the labour ward can accommodate you. Once removed you will be required to have a vaginal examination to assess if your cervix is dilated enough to have your waters broken. The CRB has been shown to reduce the length of your induction of labour by 12 hours when compared to prostaglandin use.

Outpatient IOL – going home with a CRB

There are a number of medical reasons for IOL where it is safe to go home with a CRB in place. For example:

- Being past your due date
- Gestational Diabetes (GDM)
- Symphysis Pubis Dysfunction (SPD)
- Previous caesarean section.

The benefit of having an outpatient IOL is that being in your own home environment allows you to relax and mobilise better and encourages your body to produce hormones to help dilate your cervix.

If you are suitable to go home, you will be asked to phone the hospital 12 hours after insertion, to allow us to check on how you are and how things are progressing.

The labour ward may phone you between 12 and 24 hours to return to have the balloon removed when they have a room available for you.

You will be given an appointment to return to the antenatal ward at 24 hours if the labour ward has not been able to accommodate you, for assessment and to have the CRB removed.

After returning home with the CRB you must phone the hospital for any of the following:

- Unable to pass urine
- Bleeding
- Your waters break
- You are concerned about your baby's movements
- The balloon falls out
- You feel unwell.

Inpatient IOL – staying in the hospital with a CRB

There are some medical reasons for IOL where it is not suitable to go home with a CRB. In these cases, you would be offered induction as an inpatient and would stay in hospital for the entire induction process.

Vaginal prostaglandin

Vaginal prostaglandin is a synthetic (artificial) hormone used as an alternative method of ripening your cervix when using a CRB is not appropriate.

If during a vaginal examination the midwife or doctor finds that your baby's head is too high up in the pelvis, this means that a CRB should not be used and vaginal prostaglandin will be recommended.

If your waters have broken pre-labour (before contractions start) a CRB would not be recommended due to the small risk of infection. In this case, vaginal prostaglandin will be recommended.

There are two methods used to deliver the artificial hormone:

1. The first method we use is called 'Propess'. This is a pessary within a mesh tape that is placed behind your cervix during a vaginal examination. A small amount of the tape will hang out for easy removal of the pessary. The pessary will stay in for a maximum of 24 hours and once removed you will be required to have a vaginal examination to assess if your cervix is dilated enough to have your waters broken.
2. The second method we use is called Dinoprostone. It comes in tablet form and is similarly placed behind your cervix during a vaginal examination. This method is used when the Propess pessary has not been effective enough in dilating your cervix. The tablet will melt over 6 hours at which point you will be re-examined to check if it has been effective. You may have up to two rounds of the Dinoprostone tablet.

The use of prostaglandin may cause the uterus to contract and you may experience some period like pains. It is normal for contractions to come and go but usually they build up to more painful contractions. Sometimes prostaglandin is sufficient to start your labour and then labour progresses naturally.

Outpatient IOL – going home with Propess

If you have had a low risk pregnancy, with no complications and are between 41 and 42 weeks pregnant, then you may be suitable for an outpatient IOL with Propess.

If you are suitable to go home, you will be asked to phone the hospital 12 hours after the Propess pessary is inserted to allow us to check in on how you are and how things are progressing.

You will be given an appointment to return to the antenatal ward 24 hours after the insertion.

After returning home with the Propess pessary you must phone the hospital for any of the following:

- Propess falls out
- Bleeding
- Your waters break
- You are concerned about your baby's movements
- You feel unwell
- You are having regular/painful contractions.

Inpatient IOL (Propess)– staying in the hospital

If you do not meet the criteria for going home with the Propess pessary, an inpatient IOL would be recommended. This would mean that you would stay in hospital for the duration of the induction of labour process.

You may want to bring in books, magazines, or a portable tablet to watch TV shows/films on. You may also bring a mobile phone with you to keep in touch with family/friends.

Pre-labour rupture of membranes/prolonged rupture of membranes

If your waters have broken pre-labour, or for a prolonged period of time, then you will be offered a Propess pessary to induce labour. This will stay in for a maximum for 12 hours to encourage your body to go into labour and this must be performed as an inpatient (while staying in hospital).

It is important to note that induction of labour can be a slow process and last several days (sometimes up to five) and may not always be successful. A midwife will be there to support you and advocate for you through every step and every decision that needs to be made. If your IOL is unsuccessful, you will have an opportunity to discuss your options with an obstetrician to decide the next step in safely delivering your baby.

Artificial rupture of membranes

This is the process of "breaking your waters" and can be performed if the cervix has started to ripen and is around 2cm dilated. A vaginal examination is performed by the midwife or doctor, who will insert two fingers through your cervix and use a slim, sterile, plastic instrument to make a hole in the membranes that contain the amniotic fluid around your baby. This can only be performed on the labour ward, not on the antenatal ward. For some women this is enough to stimulate labour and contractions naturally.

Intravenous oxytocin

We use a synthetic form of oxytocin to make your contractions stronger. This hormone is delivered to you by a small tube which is infused into a vein in your arm (intravenous). The drip can be adjusted according to how your labour is progressing. The aim is for the uterus to contract regularly until you give birth. Intravenous oxytocin can only be used on those whose membranes have ruptured, either spontaneously or artificially.

If you have not had a baby before, it is recommended you begin the drip immediately after you have an artificial rupture of membranes because it is unlikely your contractions will start spontaneously. If you have had a baby before, we would wait four hours to see if your contractions start by themselves. If there were no contractions within the 4 hours, then intravenous oxytocin would be recommended.

During the time you are on the intravenous oxytocin drip, your baby's heartbeat will need to be continuously monitored using a Cardiotocograph (CTG). Your ability to walk around will be limited by the drip and the CTG, but your midwife will be able to support you into good positions that are comfortable for you whether it is standing or using a birthing ball. It is not advised that you use a bath or pool whilst having intravenous oxytocin due to the electrical equipment used with the drip.

What are the risks?

Occasionally, prostaglandins or oxytocin can cause the uterus to contract too frequently, which may affect the pattern of your baby's heartbeat. If this happens, your midwife will stop or remove the hormones and medical staff will be asked to attend. Sometimes another drug is required to be given to stop the contractions in an attempt to normalise the baby's heartbeat.

Can I use the Lothian Birth Centre?

This is only possible if your pregnancy is considered low risk, outpatient propess is being used and you return to the hospital in established labour with no complications. Most women undergoing the induction of labour process are only suitable for the labour ward.

What pain relief can I use?

Whilst on the antenatal ward oral pain relief such as paracetamol and dihydrocodeine can be administered.

If you are in a single room aromatherapy can be used with caution. Unfortunately oils cannot be used in a four bedded bay as it could cause complications for other people in the bay.

When you have moved to the labour ward you may use any and all forms of pain relief offered:

- Entonox (gas and air)
- Aromatherapy oils
- Morphine injection
- Epidural.

Advantages and disadvantages of induction of labour

Advantages

- IOL may relieve a medical condition which may otherwise worsen with continued pregnancy
- Having an IOL ensures your pregnancy does not go beyond a date where the placenta may not function as well as it did earlier in the pregnancy
- IOL may be beneficial to prevent you or your baby developing an infection if your waters have broken and labour has not started.

Disadvantages

- It can be a lengthy process, taking several days from starting, to the birth of your baby
- You may have several vaginal examinations
- The IOL process may not be successful, in which case an obstetrician will discuss your options with you, one of which is a caesarean section
- Induction hormones (prostaglandin/oxytocin) can cause the uterus to contract too frequently, which may affect the pattern of your baby's heartbeat.

Sometimes if your booked hospital is too busy, you may be asked to attend one of the other hospitals.