St Helens and Knowsley Teaching Hospitals NHS Trust

Induction of Labour

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Introduction

This leaflet is designed to give you information on what induction of labour (IOL) is, how and why it is performed, what some of the benefits and disadvantages are, and to answer some of your questions.

Induction of labour (IOL)

IOL is a process of artificially starting a labour.

Reasons why labour is induced

The length of a pregnancy is usually **40 weeks**. Some women will go into labour naturally at **38 weeks**, whilst others will not labour until **42 weeks**. Research has shown that the placenta (the food store for the baby also known as the 'afterbirth') will become less efficient in a number of pregnancies after the **41st week.**

If labour has not started naturally, a date for IOL will be offered to you. Your expected date of delivery is calculated from your scan. If IOL is offered, the midwife or doctor will explain the reasons why this is advisable for you. They will make sure that you understand the risks and benefits and will answer any questions you may have.

IOL may also be offered when:

- You have a medical condition such as pregnancy induced hypertension (high blood pressure) or diabetes.
- There is concern over the wellbeing of your baby.
- There are concerns that the placenta is not working well, for example, if there is slowing of the baby's growth.
- The membranes (water around your baby) have broken; labour will often start when this happens, but in some cases it does not. Your midwife will advise you in this situation.
- If you have been booked under midwifery care, your care will be transferred to a consultant if you need IOL – but a midwife will still care for you in labour.

What are the Risks?

Like any drug or medical procedure, induction carries risks, which must be balanced against the potential benefits.

Some women may experience an unusual reaction to the medication and experience strong contractions without a break in between. This is called ‘hyperstimulation’ and can lead to disturbance in the baby’s heartbeat. If this happens, a midwife and a doctor will come and explain what is happening. Sometimes medication is needed to reduce the contractions and this can return the baby’s heart beat to normal. In some cases an urgent delivery by caesarean section is needed.

Induction of labour can be associated with an increase in intervention in deliveries, such as requiring an instrumental delivery (e.g. forceps) or a caesarean section. Occasionally, despite trying all the induction methods, labour may not begin. If this happens to you, a doctor will come and discuss the next steps with you. The options might include a caesarean section for the delivery or resting for a few days and starting the process again.

Your midwife or doctor will be happy to answer any questions or discuss any worries you have throughout the induction process.

What happens if I need to be induced?

If you have not given birth by your due date, you will have an appointment to see your community midwife or a hospital appointment to see a midwife. At this appointment the midwife or doctor will assess your general wellbeing and that of your baby. She or he will feel your abdomen to see how your baby is lying and will listen to your baby’s heartbeat. Following this, they may suggest you have an internal examination to assess the cervix (neck of the womb) and offer you a `membrane sweep.’

What is a membrane sweep?

The cervix is the opening of the womb. A membrane sweep is a process whereby the midwife or doctor places a finger just inside the cervix (neck of the womb) and makes a circular movement. This is to separate the membranes from the cervix. By performing a membrane sweep, the chances of labour starting naturally within the following **48 hours** is increased. Membrane sweep should be the first method used if IOL is advisable and can be performed from full-term onwards.

A membrane sweep may be uncomfortable, and you may have a `show' later in the day. The `show' is a plug of mucus (sometimes brown or spotted with blood) which is released as the cervix begins to open. It can be done in the community or in hospital. The midwife will make an appointment for you to attend the Feto-Maternal Assessment Unit (FMAU) when you are **10 days** over your due date in case you do not go into labour naturally before then.

The midwife in the FMAU will perform a monitoring of your baby's heart rate and arrange for induction of labour when you are **12 days** overdue, or before if it is indicated. They may also offer you another membrane sweep.

How is labour induced?

The following methods can be used to induce your labour:

Prostaglandin

Prostaglandin is a hormone given by a syringe-like device containing the gel which is inserted into the vagina by your midwife or doctor. It induces the labour by encouraging the cervix to soften and shorten (known as ripening).

The use of Prostaglandin will cause the womb to contract, and you may experience some period type pains initially. These may then slow down and disappear but usually build up to become more painful contractions. Your baby's heart beat is monitored before the Prostaglandin is used, then again for about **30 minutes** after the Prostaglandin is given, using an electronic monitor known as a `CTG'. After that you can walk around and eat and drink as usual. You are not likely to need another internal examination for about **six hours**, unless you go into labour.

Sometimes Prostaglandin is enough to start labour, but if labour has not started and the waters cannot be broken you will either be given another Prostaglandin on the same day, or you may be able to get some sleep on the ward overnight. **It is important to note that the induction procedure can sometimes take a number of days.** The following morning your cervix will be assessed again. Sometimes there is little change in the cervix, and if you have not already had a second Prostaglandin, another may be required.

For some women the cervix has become quite thin and short and is beginning to open. In this case, the next stage of IOL is possible. In some cases, even after **2 or 3 doses** of Prostaglandin, it may not be possible to break the waters and the midwife and doctor will discuss the options with you. In some cases **4 doses** of Prostaglandin are given.

If it is still not possible to break the waters the doctor will discuss the options with you and one of the options is likely to be Caesarean Section.

Sometimes Prostaglandin is not necessary because the cervix is already thin enough and beginning to open.

Prostaglandin can increase vaginal sensitivity and cause discomfort during subsequent vaginal examinations.

Artificial Rupture of the Membranes (ARM)

This is also known as `breaking the waters,' and can be done if the cervix has started to ripen and dilate either by itself or by using Prostaglandin gel. A small hole is made in the membranes using a slim plastic instrument during an internal examination performed by the midwife. Having the membranes broken should encourage more effective contractions.

Oxytocin (Syntocinon)

Sometimes Prostaglandin and/or breaking the waters are sufficient to start labour, but some women require a hormone called Syntocinon. This drug is given using a drip into a vein in the arm. It causes the womb to contract and is usually used after the membranes have broken either naturally or artificially. The dose can be adjusted according to how your labour is progressing.

The aim is for the womb to contract regularly until you give birth. When using this method of induction, it is advisable to have your baby's heart rate monitored continuously using a CTG. The contractions can feel quite strong with this type of induction, but the midwife will be able to discuss with you how you are coping and give you information about different methods of pain management.

Can I choose not to be induced?

If you do not wish to be induced at this time, you should tell your midwife or doctor. However, it will be recommended to you that you attend the hospital for the midwives to check how you are and how your baby is. This may be done using the CTG, and may involve you having a scan to check the water around your baby. How often you come to the hospital depends on your situation, and the midwife and the doctor will discuss this with you.

Is it painful?

Labour pains usually start slowly and build up to become closer together and more painful towards birth. Women describe labour pain in different ways. The pain you experience with Prostaglandin is likely to be similar to the pain in early labour. As your labour establishes, the pain will become stronger.

If you need to have a Syntocinon drip the midwife will make sure it is increased in a way that your labour pains would increase naturally, so they will become much stronger as you get closer to the birth of your baby – the same as a natural labour. You will always be cared for by a midwife, and she will support you in your choice of coping skills and pain management.

Why might my induction be postponed?

Midwives and doctors understand that when your IOL is postponed it can make you feel quite upset. However, they will give you reassurance and arrange for your induction not to be too delayed, depending on your circumstances and those of the Delivery Suite.

Your IOL may be postponed if:

- The workload on the Delivery Suite means that there is no midwife available to care for you at that time.

- The midwives and doctors have to prioritise mothers and babies for IOL, and another mother may have a greater need at that time.

Can I be induced and still have a home birth?

Unfortunately not, because IOL usually means you need to have drugs (Prostaglandin and Syntocinon). It is important that your baby is continuously monitored during the induction and your labour.

Contact Numbers:

Delivery Suite……0151 430 1502

Maternity Triage…….....0151 430 4489

Ward 2E Antenatal / Postnatal Ward….0151 430 1666

Antenatal Clinic……..….0151 430 1493

Feto-Maternal Assessment Unit…….0151 430 1939

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