East Lancashire Hospitals NHS
NHS Trust

Induction of Labour

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Induction of Labour

It is important that you read this information carefully, so that you understand why you are being offered induction of labour, and what will happen to you. Please ask questions if you don't understand either this leaflet, or what is being explained to you.

What is Induction of labour?
In most pregnancies labour starts naturally between 37 and 42 weeks. Induction of labour is a process designed to start labour artificially.

Occasionally, any of the stages of your induction may be delayed until later in the day or until the following day. This may be because Central Birth Suite is very busy. May we apologise in advance if this occurs. We will, of course, give you a full explanation for the delay.

During pregnancy the baby is surrounded by a fluid filled membrane [sac] which offers protection whilst he or she is developing in the uterus [womb]. The fluid inside the membrane is called amniotic fluid. In preparation for labour the cervix [opening of the womb] softens and shortens. This is sometimes referred to as 'ripening of the cervix'.

When is induction of labour recommended?
When it is felt that your, or your baby's, health is likely to benefit, the doctor may offer and recommend induction of labour. On average about one in five labours are induced. There are a number of reasons why induction may be offered and recommended. For example if you have diabetes or pre-eclampsia [high blood pressure].
If you are healthy and have had a trouble free pregnancy, induction of labour may be offered if:

- your pregnancy is between 41 and 42 weeks
- your waters break and labour has not started within 72 hours

When induction of labour is being considered, your doctor or midwife should fully discuss your options with you before any decision is reached. This should include explaining what will happen to you, and what the benefits and risks are to you or your baby.

If you have had a previous caesarean section or have had more than three babies this may affect whether induction is recommended.

What will happen next?

Before arranging your induction your doctor or midwife will examine you internally to enable them to decide which is the most suitable method for you. During this examination the doctor or midwife may suggest, and ask for your consent to perform a membrane sweep.

What is a Membrane Sweep?
Membrane sweeping involves the midwife or doctor placing a finger just inside the cervix and making a circular, sweeping movement to separate the membranes from the cervix. It can be carried out at home, at an antenatal appointment or in hospital. This has been shown to increase the chances of labour starting naturally and can reduce the need for other methods of induction of labour.

If you have agreed to induction of labour, you should be offered a membrane sweep before other methods are used. The procedure may cause some discomfort or slight bleeding, but will not increase the chance of you or your baby getting an infection.
Membrane sweeping is not recommended if your membranes have been ruptured [waters broken].

This procedure may be repeated, and if you don't go into labour, your midwife or doctor may discuss induction of labour with you.

How is labour induced [started]

1. Induction of labour is usually started with a hormone known as Prostaglandin which comes in 2 forms:- Propess pessary or Prostin gel.
   Prostaglandins are used to soften and shorten your cervix in order to allow artificial rupture of membranes (breaking of your waters) to be undertaken (see below). They may also start your labour or you may require further Prostaglandin following the initial pessary or gel.
   Generally most inductions of labour are started with a Propess pessary. This pessary is inserted during a vaginal examination and releases a small amount of Prostaglandin each hour. The pessary can be removed at any time or is left in place for a maximum of 24 hours. Following the 24 hours you will be assessed by a midwife or doctor to ascertain whether further Prostaglandin (in the form of Prostin gel) is required or whether you are suitable for artificial rupture of membranes. If prostin gel is used, sometimes just one dose is required, but many women require two or three doses. These are given no sooner than six hours apart. It is common for women having prostaglandin induction to need artificial rupture of the membranes [breaking your waters] and a syntocinon drip as a second step (see 2 and 3).

2. Artificial rupture of the membranes [Breaking your waters] is performed by the midwife or doctor during an internal examination. This is usually no more uncomfortable than any other internal examination. This procedure needs your cervix to have started to dilate, so is often performed following prostaglandin induction [see 1], this takes place on Central Birth Suite.

3. Syntocinon Drip - if your contractions do not start approximately two hours after artificial rupture of membranes, it may be recommended that you have a drug called syntocinon. It is given through a drip [a needle and small tube in your arm] and enters the blood stream. Syntocinon helps you to have stronger contractions. Once contractions have begun, the rate of the drip can be adjusted to help your contractions become more regular until your baby is born. Whilst you are having the syntocinon drip the midwife will monitor your baby's heartbeat continuously. This type of induction takes place on the Central Birth Suite.

What are the risks of induction of labour?
Induced labour has an impact on the birth experience of women (1). It may be less efficient and is generally more painful than spontaneous labour. It is also more likely to require an epidural and assisted birth [forceps or ventouse] (1). You will have a drip in your arm, which may hinder your mobility.
The drugs used to bring on labour may cause the uterus to contract too much which may affect the pattern of your baby's heartbeat. If this happens you will be asked to lie on your left hand side and the drip will be turned down or off to lessen the contractions.

Sometimes another drug will be given to lessen the contractions, which will be given by injection. The risks are increased in women who have had a previous caesarean section (see VBAC leaflet).

What are the benefits of induction of labour?
The main benefit is avoiding complications from the reason for your induction, e.g. from diabetes, pre-eclampsia or post-maturity (over-due baby). The other benefit is that your labour may to be shorter.

What is the alternative to having labour induced?
Natural methods of induction (such as homeopathy, nipple stimulation, sexual intercourse etc) are not recommended by the National Institute of Clinical Excellence (NICE), as there is no formal evidence to suggest that they work.

What do I need to do?
- A date for induction will be agreed between you and the midwife or obstetrician. You will need to ring the ward before you leave, to check there is a bed.
- The midwife will give you a time to attend the ward.
- The induction process will be discussed with you in detail.
- Your baby's heart rate will need to be monitored before giving the Prostin or Propess.

What if I choose not to be induced?
Please discuss your reasons with your midwife or doctor. From 42 weeks you will be advised to have your baby monitored at least twice a week, at the hospital. The doctor will also arrange to have the volume of your water around your baby (liquor) checked.

What if the induction doesn't work?
If the induction fails to get you into labour, the midwives and doctors will discuss the next steps with you. It will depend on how you and your baby are, and your options will vary from going home (if all is well) to further treatments. You will have the opportunity to ask questions, so that you can make the best decision for you and your baby.

Working with pain
Sometimes, induced labour can be more painful than labour which starts on its own. During induction of labour you will have access to all methods of pain relief and your options will not be restricted because you are undergoing induction. It is important that during the antenatal period you make yourself familiar with the pain relief options available to you and that you discuss your birth plan and how you can work with pain with your midwife. Throughout the induction process you will be supported by midwives to make choices about the most appropriate pain relief for you.

Who do I contact with queries or concerns?
If after reading this information and after speaking to your midwife or doctor you still have any concerns about induction of labour, please contact a Supervisor of midwives who are happy to help and support you.

Please ring:
Supervisors of midwives: 01282 804232

References:

1. NICE Clinical Guideline 70 (2008) Induction of Labour

2. NICE Quality Standard 60 (2014) Induction of Labour

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