Induction of Labour (with Propess)

What is Induction of Labour?

Induction of labour or 'being induced' is a process that starts your labour artificially. In most pregnancies labour starts naturally between 37 and 42 weeks, leading to the birth of the baby.

When is induction of labour recommended?

When it is felt that your health - or your baby's health - is likely to benefit, the midwife or doctor may offer and recommend induction of labour. On average one in five women may have their labour induced.

When induction is being considered, your midwife or doctor will fully discuss your options with you before any decision is reached. They will explain all the procedures and care involved and whether there are any risks to you and your baby.

There are a number of medical reasons why induction may be offered and recommended e.g. if you have diabetes or pre-eclampsia (high blood pressure) or a small baby. If you are healthy and have had a trouble free pregnancy, induction of labour is offered when:

- Your pregnancy is more than 41+5 weeks
- If your waters break before labour starts

If your pregnancy is more than 41 weeks

Even if you have had a healthy trouble free pregnancy, you will be offered induction of labour after 41+5 weeks because from this stage the risk of your baby developing health problems increases. This is in line with national ('NICE') guidelines.

If you choose not to be induced at this stage then from 42 weeks it is recommended you should have:

- Twice weekly checks of your baby's heart beat using an electronic fetal heart monitor called a CTG
- An ultrasound scan to check the depth of amniotic fluid (the water) surrounding the baby.

However, even if these tests are normal, the baby is still at increased risk of problems after 42 weeks usually because the placenta may become less efficient. You will be offered a consultant appointment to discuss the relative pros and cons of your decision.

How is Labour Induced?

There are a variety of methods that are used to induce labour. You may need one or all of the methods described depending on your individual circumstances.

Membrane sweep

Membrane sweeping involves your midwife or doctor performing a vaginal examination and placing a finger just inside your cervix (neck of the womb) and making a circular sweeping movement to separate the membranes from the cervix, stimulating natural hormones to be released. This has been shown to increase the chances of your labour starting naturally within the next 48hrs and can reduce the need for other methods of induction of labour.

This procedure is usually offered to you as the first method to try and start your labour. You do not need to come to hospital for a sweep; it is often performed by your community midwife at a routine antenatal check, either at home or in the clinic.

If it is your first baby you will be offered a membrane sweep at 40 weeks

If it is not your first baby you will be offered a membrane sweep at 41 weeks.

The procedure may cause some discomfort and mild bleeding. This will not cause any harm to your baby and will not increase the chance of you or your baby acquiring an infection.

Sweeping the membranes will not be offered if your waters have broken.

Using Propess pessary prostaglandin

Prostaglandins are drugs that encourage the cervix to soften and shorten (ripen). This process allows the cervix to open and contractions to start.

The prostaglandin is given in the form of a Propess pessary. The pessary looks like a very small tampon which is inserted into the vagina. The Propess pessary contains the active ingredient dinoprostone, which is a naturally occurring female hormone also known as prostaglandin. Once inserted into the vagina the pessary will stay there for 24hours slowing releasing the dinoprostone to ripen your cervix. There is a string attached to the pessary to allow us to remove it easily. The string will be placed inside the vagina.

Before giving the pessary your midwife will palpate your abdomen to determine the position and presentation of the baby and perform vaginal examination to determine if you need the prostaglandin. Your baby's heartbeat will be monitored using a ‘CTG’ (electronic fetal heart rate monitor). After being given prostaglandin you will need to lie on the bed for at least 30 minutes so the baby's heart beat can be monitored using a CTG. Once everything is satisfactory the monitor will be discontinued and you will be able to move around.

During this time it is quite common to experience frequent brief tightenings/contractions of the uterus. This is the initial effect of the prostaglandins and is not true labour. The level of discomfort experienced is very variable, and pain relief is available if you need it. There is no evidence to suggest that labour induced with prostaglandins is more painful than labour that has started naturally, although prostaglandins may sometimes cause vaginal soreness.

If you are not contracting strongly and frequently after 24 hours the doctor will ask to examine you internally to feel your cervix. If your cervix is ripe and starting to open you will be advised to have your waters broken and start an intravenous drip to make your contractions come. If your cervix is not ripe the doctor will discuss further treatment with you at this time and the possible need for a second propess pessary.

Some women are sensitive to prostaglandins and on rare occasions this can cause the uterus to contract too frequently and this may affect the pattern of your baby's heart beat. If this happens the situation is resolved by changing your position, giving medication that helps the uterus to relax.

Prostaglandins are generally not used if you have had a caesarean section in the past because they may increase the risk of uterine rupture. This means the scar on the womb from the

previous caesarean thins out and may open up. However, you may be offered one of two other procedures which are described below.

Artificial rupture of membranes (ARM)

If your waters have not broken, a procedure called an aminotomy (Artificial rupture of membranes) may be performed to encourage labour to continue or establish. A hole is made in the membranes to release (break) the amniotic fluid (waters). This procedure is done through the vagina and cervix using a small instrument called an amnihook. This will not cause any harm to the baby, but the vaginal examination needed to perform this procedure may cause mild discomfort.

Using Oxytocin

This drug encourages contractions. It is often commenced following prostaglandin and artificial rupture of membranes. It is given through a drip and enters the blood stream through a small plastic tube into a vein in your arm. Once contractions have started, the rate that oxytocin is administered is adjusted so that the contractions occur regularly until your baby is born.

Whilst being given oxytocin you baby's heart beat should be monitored continuously, to ensure the baby is coping with the contractions.

The drip and CTG monitor limit movement, although the midwives will encourage you to be as active as possible and this helps to relieve pain.

Cooks Balloon Induction

This is a consultant authorised method of induction where a small balloon in inserted into the cervix – for more information on this please go to:
https://www.nice.org.uk/guidance/ipg528/resources/insertion-of-a-double-balloon-catheter-for-induction-of-labour-in-pregnant-women-without-previous-caesarean-section-477214132165

'Failed' Induction of Labour

Women respond differently to the drugs and procedures that are used in the process of induction: some women do not go into labour. This is more likely to happen if the pregnancy has not reached full term.

What happens after a failed induction depends on the health of the mother and baby and will be discussed with the Consultant Obstetrician.

Your birth partner

Your birth partner may stay with you at all times. We do have ‘open visiting’ for your birthing partner only. Please ask a member of staff for information on ‘open visiting’.

Summary

Benefits

- For some women, improved health benefits than if the pregnancy were to continue.
- For some babies, improved health benefits than if the pregnancy were to continue.

Risks

- Uterus contracting too frequently.
- Changes in fetal heart rate pattern.

- May increase the use of epidural analgesia (and the need for an assisted delivery - ventouse/forceps.
- 'Failed' induction increasing risk of caesarean section.

Date and time for planning IOL

The date and time for your induction of labour has been provisionally arranged for:

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Please arrive on Murray Ward at 07.30am.

Sources of information

NICE - National Institute for Clinical Excellence. Website: www.nice.org.uk

Important information

This patient information is for guidance purposes only and is not provided to replace professional clinical advice from a qualified practitioner.

Your comments

We are always interested to hear your views about patient information. If you have any comments please contact our Patient Advice and Liaison Service (PALS) – details below.

Hand hygiene

The trust is committed to maintaining a clean, safe environment. Hand hygiene is very important in controlling infection. Alcohol gel is widely available at the patient bedside for staff use and at the entrance of each clinical area for visitors to clean their hands before and after entering.

Other formats

This information is available in alternative formats such as large print or electronically on request. Interpreters can also be booked. Please contact the Patient Advice and Liaison Service (PALS) offices, found in the main reception areas:

Conquest Hospital

Email: **palsh@esht.nhs.uk** - Telephone: **01424 758090**

Eastbourne District General Hospital

Email: **palse@esht.nhs.uk** - Telephone: **01323 435886**

After reading this information are there any questions you would like to ask? Please list below and ask your nurse or doctor.

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Reference

Written by: Cathy O'Callaghan Service Manager and Supervisor of Midwives

The following clinicians have been consulted and agreed this patient information:
Gayle Clarke Practice Development Specialist Midwife, Dexter Pascall Consultant obstetrician and Gynaecologist

The directorate group that have agreed this patient information leaflet:
Women and Children's Clinical Unit

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