



Induction of Labour

In most pregnancies, labour starts naturally between 37 and 42 weeks. When labour starts, a number of changes occur in your body:

- your cervix (opening of your uterus / womb) will 'ripen' and become soft and open
- you will experience strong, regular contractions that dilate (open) your cervix leading to the birth of your baby
- the bag of membranes ('waters') around your baby may break

When labour starts on its own, it is called spontaneous labour.

A labour that is started with medical treatment is called 'induced' labour.

An induction of labour may be recommended when you or your baby will benefit from birth being brought on sooner rather than waiting for labour to start naturally.

The most common reasons for induction are:

- you have a specific health concern, such as high blood pressure
- your baby is overdue
- there are concerns with your baby (less movements, low fluid, not growing well)
- your waters have already broken but your contractions have not started naturally

What type of induction am I likely to have?

There are different ways to induce labour. To determine the best method of induction for you, your doctor or midwife will do a vaginal examination to check how ready your cervix is.

Based on this examination, they will recommend one of the following methods of induction:

- a hormone called prostaglandin
- balloon catheter
- artificial rupture of membranes (ARM)
- a hormone called syntocinon

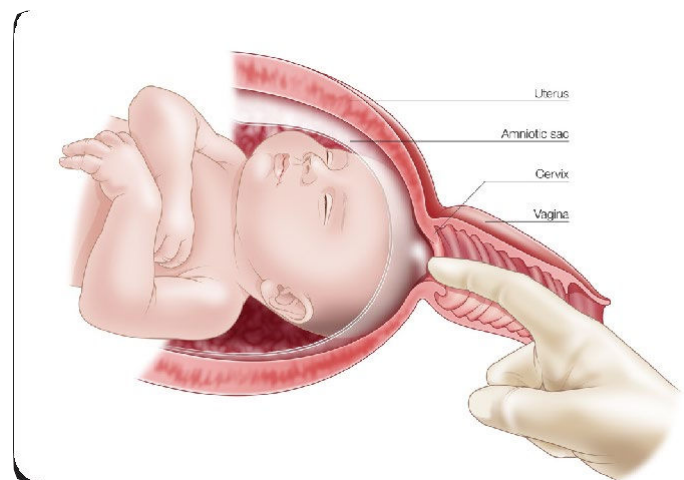
The process of induction will vary for everyone. It may require one or a combination of these methods.

Methods of induction

Prostaglandins

Prostaglandin is a naturally occurring hormone that prepares your body for labour. A synthetic version has been developed to mimic your body's natural hormone. This hormone is placed in your vagina either as a gel or pessary (like a tampon) that works to ripen your cervix. Once the prostaglandin has been inserted, your baby will be monitored and you will need to stay in hospital.

Occasionally you may need more than one dose of prostaglandin. When the prostaglandin takes effect, your cervix will be soft and open and the next steps of your induction can start.



Some women may have their membranes ruptured ('waters broken') but this may happen naturally. Some women may require syntocinon to stimulate contractions.

Balloon catheter

Prostaglandins are not suitable for all women, for example, if you have had a previous caesarean section or a reaction to prostaglandins in the past. Your doctor may therefore recommend a balloon catheter to ripen your cervix.

This catheter is a thin tube which is placed inside your cervix and a small balloon inflated to place pressure on your cervix. This pressure should soften and open your cervix. This catheter will stay in place for several hours until either it falls out (indicating your cervix has opened) or until you are re-examined.



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Artificial rupture of membranes ('breaking your waters')

If your waters have not broken, artificial rupture of membranes may be recommended. This is when your doctor or midwife puts a small hole in the bag of membranes or waters around your baby. This is done with a small instrument during a vaginal examination and can only occur once your cervix is open. Once your membranes have ruptured, contractions may start naturally, if not, a syntocinon infusion will be started.

Syntocinon

Syntocinon is a synthetic hormone that mimics your body's natural hormone called Oxytocin. It is given through an intravenous infusion (drip) in your arm and stimulates contractions of the uterus. The infusion is slowly increased until you are having strong regular contractions. The infusion will continue until after your baby is born.

Once syntocinon has started, your baby's heart rate will be monitored throughout labour using a CTG machine. More information about monitoring your baby's heart rate in labour can be found on the RANZCOG website under Patient Information.



Increased intervention

According to contemporary studies, induction of labour when performed appropriately does not increase the chances of obstetric interventions. However, it is always important to balance the risks and benefits of induction of labour carefully and discuss with your doctor or midwife.

Making your choice

When considering induction of labour, some women will choose a 'wait and see' approach to whether labour will start naturally. Others will choose induction.

Ask your doctor:

- Why has an induction been recommended?
- What are the potential risks with continuing your pregnancy until labour starts naturally?
- What are the potential risks with having an induction of labour?
- What are the procedures and care that are involved with an induction?

It is important that you are aware of the benefits and risks of both options so you can decide what is best for you and your baby.

What risks are involved with an induction of labour?

The induction may not work.

Occasionally, the process to ripen the cervix does not work, which means your cervix has not opened enough for the membranes to be ruptured. If this happens, your doctor will talk to you about your options. These may include, returning home until a later date, using a different method of induction, or you may require a caesarean section. Sometimes, after your membranes have ruptured, contractions may not start and labour does not become established. In this situation, your doctor will recommend a caesarean section.

Over-stimulation of the uterus.

One of the side effects of the synthetic hormones is they may cause the uterus to contract too much. This can sometimes cause stress to you and your baby. If this occurs, you may be given medicine to relax the uterus. If you have a hormone pessary, it will be removed.

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