

METHODS FOR INDUCTION OF LABOUR

For women with a Bishop Score of ≤ 6 consider a mechanical method of IOL for example a traction catheter or a Cervical Ripening Balloon Catheter. For the following women mechanical methods should be considered as first line management:

- Previous LSCS
- SGA <10th centile
- Baby with abnormal umbilical artery dopplers regardless of EFW
- Woman's choice for mechanical method

Method	Caution (but not contraindicated)	Contraindications	Side Effects	Administration	Post Administration	Removal
Dinoprostone (PROPESS®)	Effect of oxytocin enhanced Grand multiparas History of severe asthma, glaucoma/ raised intra-ocular pressure, hypertension, risk factors for disseminated intravascular coagulation, uterine rupture and uterine scarring	Active cardiac disease Active pulmonary disease Abnormal CTG Fetal malpresentation Placenta praevia or unexplained vaginal bleeding during pregnancy	Uterine tachysystole/ hyperstimulation, nausea, vomiting, diarrhoea	Minimum 30 minutes CTG prior to insertion to confirm fetal wellbeing Inserted into the posterior fornix of the vagina Should be considered for Outpatient IOL -if meets eligibility criteria	Women should be advised to inform the midwife if she has any of the following: • Contractions. • Vaginal bleeding. • Reduced fetal movements. • If it falls out or drops in vagina. • If membranes rupture. • If there are any other concerns. Babies with IUGR, SGA, abnormal doppler or	Remove after 24 hours unless otherwise indicated

					oligohydramnios CTGs should be performed on an individual basis but at least 8 hourly Maternal and fetal wellbeing check should be carried out 4 hourly and documented in the notes. If OP IOL woman to be called twice in the 24 hours they are at home to check wellbeing. Return appointment given for the following day	
Dinoprostone (PROSTIN® 2mg,)	See PROPESS® Not advised for use with VBAC. Max two doses 6 hours apart. Obstetric review required for further prescription	See PROPESS®	See PROPESS®	As above then Inserted into the posterior fornix of the vagina	See PROPESS® Not suitable for OP IOL	The PROSTIN® will dissolve and does not require removal

Angusta® (Misoprostol 25mcg, 50 mcg)	Cardiovascular disease Before 37 weeks Chorioamnionitis Cerebrovascular disease Conditions which predispose to diarrhoea (such as inflammatory bowel disease) Renal failure (eGFR <15)	Any uterine scar including previous caesarean section, myomectomy or other uterine surgery Placenta praevia or unexpected vaginal bleeding from 24 weeks Non cephalic presentation Multiple pregnancy Known fetal compromise requiring urgent delivery Hypersensitive to prostaglandins Suspected obstructed labour Established labour	Chills Diarrhoea Dizziness Fever Flatulence Gastrointestinal upset Nausea Vomiting Headaches Skin reactions	Minimum of 30- minute CTG with confirmation of fetal wellbeing, prior to administration Angusta® low dose oral misoprostol is taken with water. It can be given as 50mcg orally every 4 hours x 4 doses (total 200mcg) Or 25mcg orally every 2 hours x 8 doses (total 200mcg) in women experiencing side effects from 50mcg dose PROM management - if unfavourable cervix and no uterine activity consider 25mcg of Angusta®	The woman should be advised to inform the midwife if she has any of the following: • Contractions. • Vaginal bleeding • Reduced fetal movements. • If membranes rupture • If there are any other concerns Further doses should be withheld if the woman is in established labour, Regular contractions, Tachysystole, Significant vaginal bleeding Abnormal CTG Woman experiences severe nausea and vomiting.	Oral medication does not require removal.
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				followed by another 25mcg 2 hours later orally if no uterine activity. Syntocinon to be commenced 4 hours following if not in established labour. CTG not required prior to every dose unless regular contractions, analgesia requested, or concerns with fetal wellbeing or vaginal bleeding	If hyperstimulation occurs – - Stop miso - left lateral - consider terbutaline - senior obstetric review - continue CTG Consider restarting oral misoprostal if appropriate i.e. if contractions subside and not in established labour. Dose should not exceed 200mcg in 24hrs	
Cervical Ripening Balloon (CRB)		Patient receiving prostaglandins simultaneously Pre-labour Rupture of Membranes (PROM) Pre-term Pre-labour Rupture of Membranes (PPROM) Abnormal CTG	Maternal discomfort during/ post application Device expulsion Spotting caused by cervical irritation	Minimum of 30-minute CTG with confirmation of fetal wellbeing prior to insertion Insert speculum to visualise cervix and clean	The woman should be advised to inform the midwife if she has any of the following: • Contractions. • Vaginal bleeding. • Reduced fetal movements. • If it falls out or drops in vagina.	Recommended for removal at 24 hours, unless earlier indication If the CRB has not self-expelled, deflate balloons through the corresponding vales marked “V” and “U” in 20ml increments

		Fetal malpresentation, Grand multiparas, Placenta praevia or unexplained vaginal bleeding during pregnancy, Previous classical uterine incision or major uterine scar, Active genital herpes, Any contraindications to labour induction, Presenting part above pelvic inlet, Polyhydramnios		DO NOT OVERINFLATE BALLOONS	• If membranes rupture. • If there are any other concerns. Women should have repeat CTG's when clinically indicated or requested by the woman. Maternal observations will vary dependent on reason for admission.	Remove device in case of SROM to facilitate active labour management
Syntocinon Transfusion (OXYTOCIN)	Cannot be commenced within 30 minutes of PROPESS® removal Cannot be commenced	Previous classical uterine incision or major uterine scar Abnormal CTG, suspected chronic hypoxia	Arrhythmias; headaches; nausea; vomiting; uterine hyperstimulation	Intravenous administration via infusion pump **DO NOT COMMENCE SYNTOCINON INFUSION UNTIL	Continuous CTG monitoring Oxytocin has antidiuretic properties, therefore accurate fluid	Discontinue if there are signs of fetal compromise, other clinical indications, or upon maternal request.

	within 6 hours of PROSTIN® administration, Avoid large infusion in women with existing cardiac disease Use cautiously with VBAC or history of uterine surgery Suspected chorioamnionitis (consultant decision) Meconium (consultant decision)	Severe cardiac disease Severe PET		4 HOURS AFTER LAST DOSE OF ORAL MISOPOSTOL** See Appendix 1 of IOL policy for Oxytocin infusion regime	balance monitoring is essential Women should be made aware that oxytocin may increase pain and should be aware of analgesic options available	If adequate contractions have not been achieved at 60 mls/hr discuss with Senior Obstetrician. Syntocinon should not be titrated above 20mls/hr without senior obstetric review and plan.
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