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Inducing labour

The purpose of this information leaflet is to explain to the patient what induction of labour means, why and how it is performed.

In most pregnancies, labour begins between 37 and 42 weeks of gestation. This type of labour is called spontaneous labour. If medications or medical devices are used to initiate labour before it begins naturally, the term “induced labour” is used. Induced labour is necessary when continuing the pregnancy is no longer safe for maternal or foetal health and it is not possible to wait for spontaneous labour to begin.

The **goal of induction of labour** is to achieve a vaginal delivery by inducing uterine contractions. During induction of labour, the patient must remain in the hospital so that the health and well-being of both the mother and the foetus can be closely monitored.

Methods of labour induction

The choice of induction method is made by the doctor after performing a vaginal examination to assess the maturity of the cervix.

There is no universal definition for describing cervical maturity, but the Bishop scale is often used, which assesses 5 parameters: cervical position, consistency, length, dilation and the position of the anterior part of the foetus in the pelvis.

The patient’s medical history is also important when choosing an induction method; for example, it is important to know whether there have been previous caesarean sections or other uterine surgeries.

The following methods and their combinations are used to induce labour:

- oral misoprostol – a synthetic analogue of the body's own prostaglandin, which acts similarly to prostaglandin and prepares the body for labour. The medication causes the cervix to soften and begin to dilate through uterine contractions.
- balloon catheter – a small soft tube is inserted into the cervix and a balloon at the tip of the tube is filled with fluid to apply mechanical pressure to the cervix. This helps the cervix soften and dilate. The catheter may fall out spontaneously if the cervix is sufficiently dilated; otherwise it is kept in for a certain period of time and then the doctor removes it and opens the amniotic sac.
- amniotomy or artificial rupture of membranes – if the cervix is sufficiently dilated, the amniotic sac can be artificially opened during a vaginal examination. Once the amniotic sac is opened, contractions may begin spontaneously or intravenous medication may be used to stimulate them.
- intravenous synthetic oxytocin – works similarly to the body's own hormone of the same name. The medication is administered as an intravenous infusion and is used to support uterine contractions when the cervix is already dilated. The dose can be increased as needed to achieve regular uterine contractions.

Possible reasons for labour induction

Labour induction is indicated when its benefits outweigh the potential risks.

Induction of labour may be indicated in the following cases:

- the patient has a concomitant disease that complicates pregnancy, such as high blood pressure, diabetes, preeclampsia, intrahepatic cholestasis or another disease;
- twin pregnancy;
- the duration of pregnancy exceeds the normal duration of gestation – the probability of intrauterine foetal death increases after 42 weeks of pregnancy;
- foetal-related problems, such as various foetal growth problems, too little or too much amniotic fluid, changes in the foetal well-being, various diseases that the foetus may have;
- rupture of membranes – if the waters have broken and uterine contractions have not begun within 24 hours, there is an increased risk of infection for both the foetus and the uterus. This indication does not apply to preterm birth, where it is necessary to prepare the foetus’s lungs with a special medication before delivery;
- intrauterine foetal death.

Possible complications of induction of labour

In most cases, serious complications do not occur.

Sometimes, after administering misoprostol, patients may experience fever, chills, vomiting, diarrhoea or overly frequent uterine contractions (tachysystole). If contractions become too frequent, medication is given intravenously to relax the uterus and the induction is stopped until the condition resolves.

Misoprostol is not safe for patients with a previous caesarean section due to the risk of uterine scar rupture. In the case of a scarred uterus, induction can be performed using a balloon catheter and artificial rupture of membranes.

The use of a balloon catheter slightly increases the risk of intrauterine inflammation because it is a foreign body.

When administering oxytocin, in rare cases, the patient may experience a drop in blood pressure, tachycardia or increased heart rate, hyponatraemia or low sodium levels, which can result in headache, loss of appetite, nausea, vomiting, abdominal pain, weakness and drowsiness.

Compared to spontaneous labour, induced labour carries a higher risk of prolonged labour, instrumental vaginal delivery (vacuum or forceps delivery), postpartum haemorrhage, uterine rupture, excessive uterine contractions leading to foetal distress, umbilical cord prolapse and premature placental abruption.

If labour induction is unsuccessful

The duration of induction varies between individuals, but labour typically begins within 24-72 hours. Sometimes it is necessary to use more than one method. Different methods may work at different speeds or have varying effects in different patients.

If the cervix does not dilate, the attending physician will discuss further options. These may include continuing induction later, using another method or delivering the baby by caesarean section.

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