



Understanding the facts about Induction of labour

NICE GUIDELINES 2021 – Induction of labour in uncomplicated pregnancies will now be recommended from 41 weeks. *EEEEKKKK! Please print & read ' the myth of the due date before reading on.*

Induction of labour describes a process of bringing on uterine contractions to start the process of labour/giving birth sooner.

Lets look at the evidence behind these recommendations.

If you go over 41 weeks you may be told your chances of a stillbirth increase by 50%. What you are not being told correctly is that its going up from **0.04% to 0.06%** How your options are presented to you can make a difference to your decision.

See Dct Sarah Wickham book – In your own time page : 98 for statistics.

In some hospitals 75% of inductions end in a caesarean birth.

Sarah Buckleys extensive research noted that some women can experience less efficient contractions when induced, although they may feel very painful and strong. Having less efficient contractions can mean that efforts to induce labour don't work, which can lead to more interventions and more bleeding.

Hannah Dahlen et al 2021 conducted a research study of over 47000 births to see the effects of induction of labour.

- Higher rates of instrumental births & caesareans, episiotomies, tears and postpartum haemorrhage.
- Higher rates of admission to NICU for babies, asphyxia, birth trauma resuscitation and respiratory disorders.
- Higher rates of hospital admissions for ear, nose and throat infections in older children.

"From our study we found if you have an induction with no medical reason as a first time mother, you're more likely to have a baby that's distressed and your chance of having a caesarean is more than double and birth by vacuum is increased". Hannah Dahlen 2021.

NICE guidelines and World Health Organisation guidelines both state that induction of labour should not be carried out simply because a baby is suspected of being big – In the absence of any other complexities such as diabetes or raised BMI we shouldn't be inducing on estimated size alone. When comparing induction of labour with spontaneous labour there is no significant difference in instrumental or caesarean birth rates. Induction did reduce the chances of shoulder dystocia from 6.8% to 4.1%. Although the risk of this happening is small between 4-7%. Induction also increased the chances of severe tears 07% to 2.6%. Growth scans can be up to 25% off as an estimation of birth weight too.

RCOG research shows that 0.58% to 0.7% of babies with shoulder dystosia. This is 99.3% will not experience it. The risk factors are greater when inducing labour for big babies. For example – lying on your back, restricting room for baby to move down into the birth canal. Drugs given (fentanyl) cause the pelvic floor will be floppy and cannot easily guide the baby out. Space is compromised and less ease to mobilise into physiological positions.

While 52% of babies get 'stuck' on way out due to being 'big babies' (according to RCOG report) 48% of babies aren't getting stuck!

Big babies are normal in well resourced countries. Over 10% of babies born in the UK and Australia weigh 4kg (8lb 13oz) or more. Healthy well nourished women grow healthy well nourished babies. Genetic factors also influence the size of babies (big babies run in families); and each baby a woman has usually weighs more than the last. Babies also continue to grow at the end of pregnancy (because placentas continue to nourish them rather than switch off) – so a baby will be bigger at 42 weeks than they were at 40 weeks.

However, abnormal blood glucose levels (BGLs) – with uncontrolled gestational diabetes (GD) – can also cause a baby to grow big. Babies who are big because of high BGLs are a different shape to 'normally' large babies. In particular, their shoulders and chest are larger and fatter, and they are more likely to encounter complications at birth. Unfortunately, research into big babies usually combines the outcomes for GD babies with non-GD babies.

Clinical assessment ie. palpating and measuring pregnant bumps is incorrect more than 50% of the time (Chauhan et al. 2005).

Even the best available method – measuring the baby's abdomen with an ultrasound – only predicts the weight of the baby within 15% of their actual weight (Rossi et al. 2013).

Therefore, lots of women are being incorrectly told that their baby is 'big'. A US study found that one out of three women were told their baby was 'too big' based on ultrasound (Cheng et al. 2015). In this study the average birth weight of the group of babies suspected of being big was 7lb 13oz – ie. not big at all.

Giving birth to a big baby is associated with an increased chance of particular outcomes. The main complication associated with big babies is shoulder dystocia. The incidence of shoulder dystocia increases with the size of the baby. For example, it occurs with around 1% of babies weighing less than 3.9kg (8lbs 8oz), compared to 5–9% of babies weighing between 3.9kg and 4.5kg (9lb 9oz) (Politi et al. 2010).

Other less likely complications associated with big babies are severe perineal tearing (0.6%) and postpartum haemorrhage (1.7%) (Weismann-Brenner et al. 2012).

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If you feel uncomfortable, be careful not to have your decision manufactured for you. Ask for printed evidence of the risks you are being asked to consider and ask for time to read and think it through. This is informed consent.

Refer to : <https://midwifethinking.com/2015/03/18/induction-a-step-by-step-guide/>

There are 3 steps to the induction process. Please note, the new guidance 2021 has been updated to suggest you can stop an induction if you are unhappy.

"recognise that women can decide to proceed with, delay, decline or stop an induction. Respect the woman's decision, even if healthcare professionals disagree with it, and do not allow personal views to influence the care they are given. Record the woman's decision in her notes. [2008, amended 2021]"

- 1) Preparing the cervix
- 2) Breaking the waters
- 3) Making contractions

1) Preparing the cervix a) Sweep

NICE GUIDELINES 2021 – recommend sweeps for all women from 39 weeks is based on no evidence. Routinely offered so please know the facts.

Stretch & sweep or sweeping the membranes. They are seen as a routine procedure to get things moving as you approach or go past your EDD. But are they really necessary and risk free?

Its important to note that there is nothing wrong with consenting to a sweep. As with every procedure in birth, its about understanding your options so you make informed choices.

A sweep involves a midwife inserting a finger into the vagina and past the cervix (the opening of the uterus) and using a sweeping motion to separate the membrane that surrounds baby from the lower part of your uterus. This procedure can only be done if you are already 1cm dilated.

Syntocinon drip

Most inductions eventually require a syntocinon drip to aid labour along. This is more often in first time pregnancy. An IV will be sited and you will be attached to a bag for the hormone drip and a machine that monitors your baby's heart rate. The hormone drip will take you to the contraction strength of active labour, even if your body hasn't dilated to this stage, this strength can happen quickly and feel intense; you need to feel ready for this.

Oxytocin is the natural love hormone our bodies produce when in labour, while breastfeeding, when we feel safe and when we are intimate with our loved partner. It is responsible for causing uterine contractions in labour and primes us for bonding with our baby.

Syntocinon or Pitocin in the US is a synthetic version of this hormone, used to induce or speed up labour. It is also used to prevent/stop excessive bleeding after birth. Synthetic oxytocin is unable to cross the blood brain barrier therefore only works on the uterus to regulate contractions. As it does not transfer to your brain it can interfere with your own natural hormonal process of oxytocin flow.

Dr Kristina Deligiannidis (Feinstein Institute New York) originally thought that Pitocin might be linked to lower rates of postnatal mood disorders as oxytocin is a feel good hormone, however her research team found the exact opposite, compared to women who didn't receive any.

There was a 32% increased risk of postnatal depression/anxiety in those who had syntocinon to induce/speed up labour or delivery of the placenta – Kroll-Desrosiers et al 2017

"Synthetic oxytocin has been classified as a potentially harmful medication and is included in the list of high-alert medications by the Institute for Safe Medication Practices in the USA. Despite this fact, the rate of oxytocin administration in western countries has been reported to be between 44% and 75% over the last decade" (*Reference: The Labor Progression Study: The use of oxytocin augmentation during labor following Zhang's guideline and the WHO partograph in a cluster randomized trial - Dalbye - 2019*)

Disadvantages

- Increased risk of PPH
- Affects bonding and breastfeeding
- May increase chance of Pelvic Floor Muscle injury.
- May have epigenetic repercussions

Observational studies report an association with an increased risk of instrumental vaginal delivery, episiotomy, emergency cesarean section, sphincter ruptures, a low Apgar score, a low cord pH in neonates, and newborn transfer to the neonatal intensive care unit. (*cited in Dalbye et al. 2014*)

Advantage

- Oxytocin seemed to shorten labour by nearly two hours on average.

Research is mixed as to whether a sweep actually works. Evidence suggests if done at 41 weeks it may reduce your chances of going over 42 weeks. Evidence also suggests it may shorten your pregnancy by an average of 4 days. As your cervix already needs to be favourable (1cm) and dilated, there's no way of knowing if you'd naturally go into labour on your own without the sweep and when. If it does trigger labour, it can help to avoid further forms of induction.

Sweeps are not risk free. They can cause infection and may cause bleeding. Some people find it painful, uncomfortable and triggering. There is a 1 in 10 chance that your membranes can be accidentally ruptured and if labour doesn't start this can lead to further induction procedures.

b) Prostaglandin gel or pessary

If your cervix is still firm and closed, attempts will be made to change it so that step 2 (breaking of waters) can be offered. This is usually done by putting artificial prostaglandins (prostin E2 or cervidil) on the cervix in the form of a gel, pessary or sticky tape. Artificial prostaglandins can cause hyperstimulation of the uterus resulting in fetal distress, therefore your baby's heart rate will be monitored by a CTG after the prostaglandin is administered. You may also experience 'prostin pains' which are sharp strong pains sometimes accompanied by contractions. If there are concerns about giving you prostaglandin (eg. previous c-section) your obstetrician may suggest ways of trying to get your own cervix to release natural prostaglandin by 'irritating it' (this is the theory behind membrane sweeps). This is done by inserting a balloon catheter into the cervix and filling it with water ie. you basically have a water balloon sitting in your cervix.

Successfully completing step 1 may take a few attempts with re-insertion of prostaglandins. This can take hours or days because you must wait hours before re-assessment and re-insertion. You may respond to the prostaglandin by going into labour therefore skipping the following steps. However, you are still having an induced labour and will usually be treated as 'high risk'

2) Breaking the waters

Once your cervix has softened and is open enough to get an amnihook in, you will be offered to have your waters broken. This allows induced contractions to be more effective; the baby's head to press harder on the cervix; and may trigger contractions avoiding step 3. There are risks associated with artificially breaking the waters. Once your waters have been broken you can wait a few hours to see if labour starts, or go straight to step 3.

3) Making contractions

You now have a cervix ready to respond to contractions and no amniotic water in the way - next you need contractions. In a natural physiological labour oxytocin is released from the brain and enters the blood stream - it has two main functions:

1. It works on the uterus to regulate contractions
2. It works in the brain to contribute to the altered state of consciousness associated with labour and promotes bonding feelings and behaviour

Informed Consent

"The decision whether to undergo this treatment is one that can reasonably be left to women to decide in the context of a reduction in the length of labour." Bugg et al.

References :

<https://www.nice.org.uk/guidance/ng207>

<https://midwifethinking.com/2016/04/13/the-human-microbiome-considerations-for-pregnancy-birth-and-early-mothering/>

<https://midwifethinking.com/2015/03/18/induction-a-step-by-step-guide/>

<https://www.sarawickham.com/iol/>

VERY IMPORTANT READ - <https://www.sarawickham.com/articles-2/ten-things-i-wish-every-woman-knew-about-induction-of-labour-the-article/>

<https://www.optimalbirth.co.uk/Courses/AdvBiomechLive/AdvBiomechLive.html>

<https://www.aims.org.uk/journal/item/induction-birth-information>

<https://www.aims.org.uk/journal/item/induction-nice-21>

GREAT PODCAST - VICTORIA HIGHLY RECOMMENDS LISTENING TO THIS.

h1. Induction of Labour with Dr Sara Wickham

The birth-ed podcast

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