INDUCTION OF LABOR FAQ

These days physicians aim to carry all pregnancies to term, or at least until 39 weeks — which means labor should not be induced electively (without a medical reason) before then. The following is some of the things you might expect along the way.

What does it mean to induce labor?

Induction of labor is the process of helping your body to be ready for delivery of your baby when it has not yet started to soften and dilate the cervix or to have uterine contractions. The very definition of labor is: uterine contractions that cause the cervix to change. Sometimes you may require extra medication to get the cervix to dilate or the uterus to contract. The goal in the end is to cause those contractions that will change the cervix and lead to a vaginal delivery.

There are many reasons for induction. Some of them are medical reasons that include being past your due date, gestational diabetes, high blood pressure, fetal indications and early rupture of membranes. Sometimes it is a personal choice by you the patient or an elective induction. There are timing requirements for each of these types of inductions and they will be discussed with you by your physician.

How does labor induction work?

If you do end up being induced, the process involves a number of steps, though you usually won't go through all of them:

- **Cervical ripening**. Usually your cervix will open up naturally on its own once you're ready to go into labor. However if your cervix shows no signs of dilating and effacing (softening, opening, thinning) to allow your baby to leave the uterus and enter the birth canal, your physician will need to get the ripening rolling. Usually they do this by administering a form of the hormone prostaglandin (oral pill or a vaginal suppository) to your cervix. Your cervix will be checked after a few hours; often, this will be enough to get labor and contractions started. However if the prostaglandin is doing its work ripening the cervix but contractions haven't started, the process continues on to the following steps. (Note that sometimes if you've had a C-section or other previous uterine surgery, you won't be given prostaglandin due to increased risk of uterine rupture. And in some cases, your physician may use a mechanical agent to ripen the cervix, such as a catheter with an inflatable balloon instead.)
- **Membrane sweeping**. If your bag of waters (amniotic sac) is still intact, your physician may get labor started by swiping their finger across the fine membranes that connect the amniotic sac. This causes the uterus to release prostaglandin, just as it would if labor began naturally, which should in turn cause the cervix to soften and contractions to start. This process isn't always pain-free, and while it isn't meant to break your water it sometimes does.
- **Rupturing the membrane.** If your cervix has already begun to dilate and efface on its own but your water hasn't broken, your physician might jump-start your contractions by artificially rupturing the membranes. In other words, they will break the bag of waters that surrounds your baby manually using an instrument that looks like a long crochet hook with a sharp tip. It might feel uncomfortable, but it shouldn't be painful.
- **Pitocin**. If neither the prostaglandin nor the stripping or rupturing of the membranes has brought on regular contractions within a couple of hours, your physician will slowly give you the medication Pitocin (a synthetic form of the naturally-occurring hormone oxytocin) via an IV to

induce or augment contractions. When Pitocin is used, contractions — which usually start about 30 minutes later — are usually more regular and more frequent than those where labor has begun naturally (though if this is your first baby, you won't have anything to compare it with). Typically it does take a few hours to really start feeling pain with contractions. During this time you are free to move about with wireless fetal monitoring and can even use the whirlpool tub to help with pain control.

When a C-section might be recommended instead

There are some circumstances where labor shouldn't be induced and a C-section is preferable, including:

- The need (because of fetal distress, for instance) for immediate delivery
- If the placenta is near or covering your cervix (placenta previa)
- If there's a prolapsed cord (the cord has slipped down into the vagina before the baby's head)
- If you're experiencing a genital herpes outbreak
- If your baby is breech

Recent Research

A lot of research has been done to look at how the cesarean section rate has increased so dramatically over the past 20 years. Previous studies found a correlation between induction of labor and an increased rate of cesarean section (9.3%) when compared with spontaneous labor (8.4%). That risk is barely increased compared to the induction group which should help put you at ease. You might still feel a little uneasy about an induction, but there is newer more applicable data available. In 2016 and 2018 two different studies were performed that looked at induction of labor vs waiting to induce until there was a medical reason (expectant management). Each of these studies found very similar information. In pregnancies that were induced between 39 wks 0 days and 39 wks 4 days showed a lower perinatal morbidity (newborn disease or health problems related to delivery) and a lower risk of cesarean section (18.6% vs 22.2%) compared to expectant management. An increased risk of high blood pressure, more severe perineal lacerations and larger infants at time of delivery were seen in the expectant management group. Additionally, labor pain scores and length of stay were also higher in the expectant management group.

What does this mean for you?

Your physician wants you to deliver vaginally. It has less inherent risk for you and your unborn child. It also confers less risk to future pregnancies compared to a cesarean delivery. There are a lot of factors that go into making the decision of induction of labor when it is considered elective. Following current guidelines help to ensure that this happens in the safest and most effect means possible.

In the end, it is your decision to proceed with an induction or not and your doctor wants to support you in that choice.