Ziekenhuis Amstelland
aangenaam dichtbij

Patient information

Induced labour

Introduction
During induction, labour is artificially initiated. This occurs with medications which stimulate contractions. Induction always occurs in the hospital under the care of a gynaecologist. More information is contained in this leaflet.

Why is labour induced?
The gynaecologist usually recommends induction if he or she anticipates that the situation for the child outside the uterus will be more favourable than inside the uterus. Labour is stimulated at a time that the condition of the child is (still) good and it is expected that the baby can withstand a normal birth. Serious complaints from you can also be a reason to induce labour. Some common reasons for induction are:

- being postterm;
- water broke more than 24 hours ago;
- slowed growth of the child;
- decreasing placental function.

Being postterm
If you are two weeks past your expected due date and have not given birth, it is called being 'postterm'. You are then 42 weeks pregnant. The medical term for this is serotinity. The gynaecologist usually assesses the quantity of amniotic fluid by means of ultrasound examination. A CTG (cardiotocograph) will also be made, which is a registration of the cardiac sounds of the baby, combined with the firmness of the mother's belly. If all these examinations lead to the conclusion that the child's condition is deteriorating, the gynaecologist will advise that labour should be induced. More information can be found in the 'Serotinity' leaflet.

Water broke more than 24 hours ago
The breaking of water can be the first sign of the onset of labour. If the water broke more than 24 hours ago, labour can still begin on its own. If the water has been broken for more than three days during a full term pregnancy, there is little chance that contractions will begin on their own. The gynaecologist usually recommends induction between 24 hours and three days after the water broke. If the water breaks before 37 weeks, induction is often postponed as long as there are no signs of infection.

Slowed growth of the baby
If the obstetrician or gynaecologist finds that your baby is too small, an ultrasound examination will be performed to see if that is correct. Little amniotic fluid can also indicate that a child is small or too small.

Regular ultrasounds can provide information about the further growth of the child. If necessary, the condition of the child will be monitored with a CTG. In the case of insufficient growth or imminent deterioration of the condition of your child, your gynaecologist can recommend induction.

Deterioration of placental function
The baby receives nutrients and oxygen via the placenta. In the event of high blood pressure or diabetes during the pregnancy, for example, the placenta

cannot function as well. If it seems better for the child to be born, the gynaecologist will discuss induction.

Other reasons
There are many other reasons for induced labour to be recommended. This may have to do with the progress of the previous pregnancy or with other accompanying problems during the current pregnancy.

Preparation
To determine whether it is possible to begin labour, the gynaecologist will perform an internal examination. This is performed at the outpatient clinic.

When is induction possible?
Induction is only possible if the cervix is "ripe". An unripe cervix is still long and feels firm. Usually there is no dilation. A ripe cervix is generally shorter. It feels softer and there is often already some dilation.

If the cervix is unripe
When the cervix is unripe and there is an urgent reason to induce labour, the gynaecologist can recommend 'ripening' the cervix. In medical terms, this is called 'priming'.

The most common method is inserting a balloon catheter into the cervix. This is done when the cervix still feels fairly firm. The catheter is inserted inside the cervix. Another method is the use of prostaglandins in gel form. Prostaglandins are hormones which contribute to the ripeness of the cervix. They are inserted by means of:

- Vaginal internal examination (with two fingers). A vaginal internal examination is usually not painful, although it can be unpleasant.
- A speculum. The insertion of a speculum can sometimes create an unpleasant sensation.

The gynaecologist will discuss with you which method is most practical.

Induced labour
During induction contractions are initiated and the condition of the child is monitored.

The stimulation of contractions
Contractions are often stimulated by means of an IV drip. A needle is inserted in a blood vessel in the hand or the lower arm and connected to a thin tube. Afterwards, the membranes are ruptured. It is possible that you will feel the running of warm amniotic fluid. A pump will administer medication (oxytocin) to initiate the contractions. This dosage will be increased in stages. The contractions will gradually begin.

Monitoring of the child and contractions
The condition of your child is monitored with a CTG. This occurs externally (via the abdomen). Sometimes an electrode will be placed on the head of the baby to record the heart sounds. The electrode will be inserted via the vagina and secured to the head of the baby. To measure the strength of the contractions, the contractions are recorded with a band on the abdomen.

How does the birth continue?
After starting the induction the course is, in principle, the same as a 'normal' birth. The contractions slowly become more intense and more painful. In general, you have the freedom to deal with the contractions in your own way: sitting on a chair, standing next to the bed, or lying/sitting on the bed.

The pushing (the expulsion) and the birth of the child and the placenta are no different than during a 'normal' pregnancy. The riper the cervix is, the faster dilation occurs. The birth of a second or third child usually goes more quickly than the birth of the first child.

Should the contractions become too painful, you can request painkillers. There is more information in the leaflet 'Pain management during birth'.

After the birth
After the birth, the physician or obstetrician will examine your child. If there is a reason for it, the paediatrician will do this. After you have showered, the nurse will remove the IV drip. You can then go home, unless there is a medical need for you or your child to remain at the hospital.

Risks and complications
Most inductions progress without complications and the risks of induced labour are usually not greater than those of a normal birth. It is, however, important that induction occurs under close monitoring and proper guidance. An opinion frequently heard is that induced labour would be more painful than a normal birth. This is difficult to prove because no two births are the same.

Alternative
An option for initiating labour without induction is 'stripping'. Here the midwife or the gynaecologist detaches the cervix from the membranes with the fingers during a vaginal internal examination. This can only be done if the cervix is ripe. If you would like to know more about this, discuss it with your gynaecologist.

Notes on this leaflet
If any information in this leaflet is unclear or incomplete, please notify us. You can share your remarks with us via voorlichting@zha.nl.