healthy expectations - **WEEK 35**

Labor Induction

In the United States, approximately one in every five births is induced. You physician may induce labor when labor contractions do not start on their own. While there are many reasons why you physician may feel the need to induce your labor, some of the most common instances include:

- Your water breaks and labor does not begin
- You develop preeclamsia
- You have a previous history of still birth(s) or complications
- Your pregnancy lasts one-two weeks beyond your due date with no signs of labor beginning
- You have too little amniotic fluid or your placenta is not functioning
- You have an illness (chronic or acute) such as high blood pressure or diabetes, that may endanger you or the baby

For labor to begin, or be induced, your cervix has to 'ripen' or thin out and dilate. If your cervix has not 'ripened', your physician can assist in several ways:

Prostaglandins: Once admitted to the hospital, your physician may administer a medication containing prostaglandins into the vagina. This will help to ripen the cervix and may also begin contractions.

Foley Catheter: A catheter with a small balloon on the end is inserted into the cervix, then inflated with water. This method uses pressure on the cervix to release natural prostaglandins and open the cervix.

Stripping the Membranes: Often done in an office exam, your physician may help to separate the amniotic sac from the uterus manually using his/her finger. The patient is then sent home to monitor and await labor over several days. This method may cause some discomfort.

Rupturing the Membranes: Rupturing can be done if your cervix is a minimum of a few centimeters dilated. A small hooked instrument is inserted to break the amniotic sac. This may also cause some discomfort, but may be enough to start contractions.

If contractions do not begin on their own after using any of these procedures, your physician may administer ***Pitocin,*** a synthetic version of the hormone oxytocin, through an IV.

When Should Labor Not Be Induced?

In some instances, when a vaginal birth is dangerous or impossible, labor will not be induced and your physician will order a cesarean (c-section). Some of these cases include:

- You are having 3 or more babies, or when having twins and the first is breech

Risks of Induction

While it is important to talk to your physician and understand the risks involved in labor induction, also keep in mind that your physician will only recommend induction when the risks of not intervening are very high for you and your baby. Placental Abruption or Uterine Rupture is rare but can be caused by the Pitocin of prostaglandins used in labor induction. The risk is significantly higher in women who are attempting a vaginal birth after cesarean (VBAC) and those with a scarred uterus.

To monitor for complications and to check your baby's heat rate and the length and frequency of contractions, you will have continuous electronic fetal monitoring during induction.

Other risks include emotional and psychological stress on you and your partner, as well as the stress of a long induction process. In some cases, a cesarean may still be needed, and the risk of complications increases after a long induction versus a planned cesarean procedure.

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- You have a previous history of uterine sugery, such as a myomectomy or a previous cesarean with a classical vertical incision
- Test results indicate the need for immediate delivery
- You have an active genital herpes infection
- You have a Placenta or Vasa Previa

Fetal Scalp Electrodes

In the case of some high risk pregnancies, your physician may want to increase monitoring of the baby during delivery. This includes monitoring your baby's heartbeat, as well as conditions within the woman and dilation of the cervix. One method that is currently used is called Fetal Scalp Electrodes (FTE). During the procedure, tiny electrodes are actually screwed into the outermost layers of the baby's scalp while still in the womb or birth canal. Wires from the electrodes are then fed to a monitor which displays your baby's heart rate. This method of internal fetal monitoring is usually only used in high risk pregnancies or instances where external monitoring is unsuccessful.

Intrauterine Pressure Catheter

Often used during labor induction and in conjunction with internal fetal monitoring methods, the Intrauterine Pressure Catheter (IUPC) measures the force of contractions during labor. The results can assist your physician in determining the amount of induction medication (pitocin) to use.

Vacuum Delivery

Though every woman hopes to have a smooth delivery, the unexpected can often occur and complications can arise. In some instances, it may be necessary for the physician to aid in speeding up the labor process in order to ensure a safe and healthy delivery for both the baby and the mother. Called an assisted or operative vaginal delivery, in a final effort before turning to Cesarean (C-section), physicians may use the vacuum method to help guide the baby's head safely down the birth canal.

The end of the vacuum device is a soft foam cup, specially designed to comfortably fit the baby's head and minimize discomfort to the mother. When gently placed on the back of the baby's head, the physician can adjust the suction pressure as appropriate and gently pull as the mother pushes. The risk of serious complications from this method are relatively rare, though in some cases, the cup may leave a small mark or some bruising that usually fades within a few days. Prior to your delivery, you should discuss assisted delivery methods with your physician, to understand which methods they are comfortable with and may use, what the risks and benefits are, and any alternatives you may prefer.

Resources

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