Assessment for

Elective Labor Induction

2023 Update

The treatment guideline summarized in this document was created by the Obstetrical Development Team of the Women and Newborns (W&N) Clinical Program at Intermountain Healthcare. The guideline is derived from Intermountain practice outcomes, expert consensus, and recommendations from the American College of Obstetricians\ and Gynecologists (ACOG).

What's New in this Update?

Results of the ARRIVE trial indicate it is reasonable to offer elective induction to low-risk nulliparous women at ≥ 39 weeks gestation

- In the **ARRIVE** trial, 6,106 nulliparous women with low-risk pregnancy were randomly assigned to elective induction at 39 weeks or expectant management as a control group. Almost all participants (>94%) stayed within assigned protocol.
- **RESULTS:**
  - There was no significant difference between treatment and control groups in perinatal mortality or severe perinatal morbidity (primary outcomes).
  - The elective induction cohort showed small but significant decreases in cesarean delivery rate, gestational hypertension, preeclampsia, and need for neonatal respiratory rate within the first 72 hours.
  - There were no differences seen in perinatal mortality or cesarean delivery rates when participants were stratified by race or ethnic group, maternal age, body mass index, or modified Bishop score.

Care Process Model Expert Consultants

Women's Health Clinical Program:

Amy Campbell, MSN, RN
Deborah Chun, MD
Annette Crowley, MSN, RN
Sean Esplin, MD
Tiffany Hanson, MSN, RN
Heidi Thompson, PhD (Medical Writer)

Unless otherwise stipulated, all members are employees of Intermountain Healthcare

This CPM presents a model of best care based on the best available scientific evidence at the time of publication. It is not a prescription for every physician or every patient, nor does it replace clinical judgment. All statements, protocols, and recommendations herein are viewed as transitory and iterative. Although physicians are encouraged to follow the CPM to help focus on and measure quality, deviations are a means for discovering improvements in patient care and expanding the knowledge base. Send feedback to Annette Crowley, Clinical Programs Manager, Intermountain Health, (WomenandNewborns@imail.org).

What's Inside?

Intermountain Measures

To determine if implementation of these evidence-based guidelines improves patient outcomes, Intermountain will assess:

- Incidence of Early Elective Induction (< 39 weeks, non-indicated)

Supporting Evidence

ACOG Practice Bulletin No. 107: Induction of labor. *Obstet Gynecol.* 2009 Aug;114 (2 Pt 1):386-397. (reaffirmed 2019)

Grobman WA, et al. Labor induction versus expectant management in low-risk nulliparous women. Eunice Kennedy Shriver National Institute of Child Health and Human Development Maternal–Fetal Medicine Units Network. *N Engl J Med* 2018;379:513-23

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Elective Labor Induction

NOTE: If re-dating guidelines are needed, follow the ACOG/AIUM/SMFM Committee Opinion Number 700;

Methods for Estimating the Due Date

A. Contraindications

The individual patient and clinical situation should be considered in determining when labor induction is contraindicated. Contraindications include, but are not limited to, the following situations:

- Vasa previa or complete placenta previa
- Persistent malpresentation (transverse or breech)
- Umbilical cord prolapse
- Previous classical C-section
- Active genital herpes infection
- Previous myomectomy entering the endometrial cavity

B. Precautions

Several obstetric situations are not contraindications to labor induction but do necessitate special precautions. These include, but are not limited to, the following:

- One or more previous low-transverse C-sections
- Maternal heart disease
- Multifetal pregnancy
- Polyhydramnios
- Presenting part above the pelvic inlet
- Severe hypertension
- Abnormal fetal heart rate patterns not necessitating emergent delivery

Patient presents with potential for elective labor induction

Establish / Confirm gestational age

ANY ONE of the following can establish gestation ≥39 weeks. This criteria must be met regardless of the results of fetal lung maturity testing.

- Ultrasound measurement at less than 20 weeks of gestation that supports gestational age of ≥ 39 weeks
- Fetal heart tones have been documented as present for 30 weeks by Doppler ultrasonography
- It has been 36 weeks since a positive serum or urine human chorionic gonadotropin pregnancy test result

Is gestational age ≥39 weeks?

no → Elective labor induction **NOT** recommended

yes

Shared decision-making with patient

Discuss the following with the patient regarding induction:

- ☐ Indications and patient preferences/goals
- ☐ Contraindications and precautions (A,B)
- ☐ Agents and methods of labor stimulation
- ☐ Risk for repeat induction or C-section

Decision to induce labor?

no → Manage expectantly

yes

Obtain patient consent

Prepare for labor induction

The following record/personnel should be present and available:

- ☐ Patient's prenatal record attached to patient's chart
- ☐ Personnel familiar with the maternal and fetal effects of uterine-stimulating agents
- ☐ Physician who has privileges to perform C-section

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