National Institute for Health and Care Excellence

Final

Inducing labour

Summary of deleted and amended recommendations

NICE guideline NG207

Supplement 6

November 2021

Final

These supplementary materials were developed by the National Guideline Alliance which is a part of the Royal College of Obstetricians and Gynaecologists

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ISBN: 978-1-4731-4327-2

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Summary of deleted and updated recommendations

Table 1: Recommendations that have been deleted

Recommendation in 2008 guideline	Comment
1.2.1.2 Women with uncomplicated pregnancies should usually be offered induction of labour between 41+0 and 42+0 weeks to avoid the risks of prolonged pregnancy. The exact timing should take into account the woman's preferences and local circumstances.	This recommendation has been replaced by new recommendations as a new evidence review was carried out: 1.2.3 Using the information in Appendix A explain to women that the risks associated with a pregnancy continuing beyond 41+0 weeks may increase over time, and these include: • increased likelihood of caesarean birth • increased likelihood of admission of the baby to a neonatal intensive care unit • increased likelihood of stillbirth and neonatal death [2021] 1.2.4 Discuss with women that induction of labour from 41+0 weeks may reduce these risks, but that they will also need to consider the impact of induction on their birth experience (see recommendation 1.1.3) when making their decision. **[2021]**
1.2.9.5 For women who have intrauterine fetal death and who have had a previous caesarean section, the risk of uterine rupture is increased. The dose of vaginal Prostaglandin[3] should be reduced accordingly, particularly in the third trimester.	This recommendation has been replaced by new recommendations as a new evidence review was carried out: 1.2.30 If a woman with an intrauterine fetal death chooses an induced labour, follow the recommendations on monitoring of uterine contractions (preferably using manual assessment) and provide one-to-one midwifery care of the woman during labour and birth. [2021] 1.2.32 Advise women who have intrauterine fetal death, and who have had a previous lower segment caesarean birth, that : • induction of labour could lead to an increased risk of uterine rupture • the methods used for induction of labour will be guided by the need to reduce these risks (for example, by using mechanical methods). See the

	recommendations on Methods for inducing labour. [2021]
1.2.10.1 In the absence of any other indications, induction of labour should not be carried out simply because a healthcare professional suspects a baby is large for gestational age (macrosomic).	This recommendation has been replaced by a new recommendation as a new evidence review was carried out: 1.2.24 Discuss with women without diabetes and with suspected fetal macrosomia that: • the options for birth are expectant management, induction of labour or caesarean birth (see the NICE guideline on caesarean birth) • there is uncertainty about the benefits and risks of induction of labour, but: o with induction of labour the risk of shoulder dystocia is 4,100 cases in every 100,000 births, compared with expectant management where it is 6,800 cases in every 100,000 births o with induction of labour the risk of third- or fourth-degree perineal tears is 2,600 cases in every 100,000 births, compared with expectant management where it is 690 cases in every 100,000 births • there is evidence that the risk of perinatal death, brachial plexus injuries in the baby, or the need for emergency caesarean birth is the same between the 2 options • they will also need to consider the impact of induction on their birth experience and on their baby (see recommendation 1.1.3). Discuss the options for birth with the woman, taking into account her individual circumstances and her preferences, and respect her decision. Support recruitment into clinical trials, if available. [2021] 1.2.25 For guidance on suspected fetal macrosomia in women with pre-existing or gestational diabetes see the NICE guideline on diabetes in pregnancy. [2021]
1.3.1.4 When a vaginal examination is carried out to assess the cervix, the	This recommendation has been deleted as the committee agreed that offering

opportunity should be taken to offer the woman a membrane sweep.	membrane sweeps at antenatal appointments or before formal induction of labour covered all likely timings already, and this recommendation was a duplication.
1.3.2.1 Vaginal PGE2 is the preferred method of induction of labour, unless there are specific clinical reasons for not using it (in particular the risk of uterine hyperstimulation). It should be administered as a gel, tablet or controlled-release pessary. Costs may vary over time, and trusts/units should take this into consideration when prescribing PGE2. For doses, refer to the SPCs. The recommended regimens are: • one cycle of vaginal PGE2 tablets or gel: one dose, followed by a second dose after 6 hours if labour is not established (up to a maximum of two doses) • one cycle of vaginal PGE2 controlled-release pessary: one dose over 24 hours.	This recommendation has been replaced by a new recommendation as a new evidence review was carried out: 1.3.4 Explain to women that a vaginal examination to assess the readiness of the cervix (recorded as the Bishop score), will help to decide which method of induction will be offered first, and obtain consent ot carry this out. [2021] 1.3.6 For women with a Bishop score of 6 or less, offer induction of labour with dinoprostone as vaginal tablet, vaginal gel or controlled-release vaginal delivery system or with low dose (25 microgram) oral misoprostol tablets. [2021]
1.3.2.2 When offering PGE2 for induction of labour, healthcare professionals should inform women about the associated risks of uterine hyperstimulation.	This recommendation has been replaced by a new recommendation as a new evidence review was carried out: 1.3.5 Discuss with women the risks and benefits of different methods to induce labour. Include that: • uterine activity and fetal condition must be monitored regularly with pharmacological methods • both dinoprostone and misoprostol can cause hyperstimulation (see information on hyperstimulation rates in appendix B) • if hyperstimulation does occur, the induction treatment will be stopped by giving no further medication, or by removal of vaginally administered products when possible • there are differences in the ease with which different vaginal products can be removed (for example, dinoprostone controlled-release vaginal delivery systems can be more easily removed than gel or vaginal tablets) • hyperstimulation can be treated with tocolysis, but hyperstimulation caused by misoprostol may be more difficult to reverse

	• mechanical methods are less likely to cause hyperstimulation than pharmacological methods. [2021] Follow the manufacturers' guidance on the use of dinoprostone and misoprostol preparations for the induction of labour, including when to remove dinoprostone controlled-release vaginal delivery systems. [2021]
1.3.2.3 Misoprostol should only be offered as a method of induction of labour to women who have intrauterine fetal death (see section 1.2.9) or in the context of a clinical trial.	This recommendation has been replaced by a new recommendation as a new evidence review was carried out: 1.3.6 For women with a Bishop score of 6 or less, offer induction of labour with dinoprostone as vaginal tablet, vaginal gel or controlled-release vaginal delivery system or with low dose (25 microgram) oral misoprostol tablets. [2021]
1.3.2.4 Mifepristone should only be offered as a method of induction of labour to women who have intrauterine fetal death (see section 1.2.9).	This recommendation has been deleted because it has already been stated in the section on intrauterine death, and therefore does not require repetition under the section entitled 'Other methods for inducing labour'.
1.4.3.1 Amniotomy, alone or with oxytocin, should not be used as a primary method of induction of labour unless there are specific clinical reasons for not using vaginal PGE2, in particular the risk of uterine hyperstimulation.	This recommendation has been replaced by a new recommendation as a new evidence review was carried out: 1.3.12 For women with a Bishop score of more than 6, offer induction of labour with amniotomy and an intravenous oxytocin infusion. [2021]
1.4.4.1 Mechanical procedures (balloon catheters and laminaria tents) should not be used routinely for induction of labour.	This recommendation has been replaced by a new recommendation as a new evidence review was carried out: 1.3.7 For women with a Bishop score of 6 or less, consider a mechanical method to induce labour (for example, a balloon catheter or osmotic cervical dilator) if: • pharmacological methods are not suitable (for example, in women with a higher risk of hyperstimulation or those who have had a previous caesarean birth) **or** • the woman chooses to use a mechanical method. [2021]
1.5 Setting and timing	This heading was replaced with '1.6 Outpatient induction' as all the recommendations relating to timing of induction were deleted (see below) and all the recommendations relating to outpatient care were grouped together.

1.5.1.2 The practice of induction of labour in an outpatient setting should be audited continuously.	This recommendation has been deleted because the committee agreed that outpatient induction was carried out routinely in many units and it was not therefore necessary to audit this continuously.
1.5.1.3 In the inpatient setting, induction of labour using vaginal PGE2 should be carried out in the morning because of higher maternal satisfaction.	This recommendation has been deleted because the committee agreed that it was no longer standard practice to carry out induction in the morning, and timing would be discussed with the woman.
1.6.2.5 The opportunity to labour in water is recommended for pain relief.	This recommendation has been deleted because the use of labouring in water for pain relief has been added to the recommendation on choice of analgesia (1.5.8).

Table 2: Amended recommendation wording (change to intent) without an evidence review

Recommendation in 2008 guideline	Recommendation in current guideline	Reason for change
1.1.1.1 Women should be informed that most women will go into labour spontaneously by 42 weeks. At the 38-week antenatal visit, all women should be offered information about the risks associated with pregnancies that last longer than 42 weeks, and their options. The information should cover: • membrane sweeping • that membrane sweeping makes spontaneous labour more likely, and so reduces the need for formal induction of labour to prevent prolonged pregnancy • what a membrane sweep is • that discomfort and vaginal bleeding are	1.2.1 Explain to women that labour usually starts naturally by 42+0 weeks, based on the gestational age estimated by their dating scan (see Table 1) [2008, amended 2021] 1.1.2 Confirm a woman's preferences for birth at antenatal visits towards the end of pregnancy as these may have changed since earlier discussions. 1.3.1 Explain to women: • what a membrane sweep is • that membrane sweeping might make it more likely that labour will start naturally without the need for additional pharmacological or mechanical methods of induction • that pain, discomfort and vaginal bleeding are possible from the procedure. [2008, amended 2021]	The language relating to onset of labour has been updated from 'spontaneously' to 'naturally', the gestational age has been clarified as that based on the dating scan, and a cross-reference to a table of spontaneous labour by gestational age has been included. The information about birth options has been moved to the start of the guideline and the mention of specific gestational weeks has been removed as these discussions can be ongoing. The bullets on membrane sweeping have been moved to a separate recommendation at

possible from the procedure • induction of labour between 41+0 and 42+0 weeks • expectant management.		the beginning of the section of methods of induction of labour so that all the recommendations on membrane sweeping are together in one place, and the wording has been amended.
1.1.1.2 Healthcare professionals should explain the following points to women being offered induction of labour: • the reasons for induction being offered • when, where and how induction could be carried out • the arrangements for support and pain relief (recognising that women are likely to find • induced labour more painful than spontaneous labour) (see also 1.6.2.1 and 1.6.2.2) • the alternative options if the woman chooses not to have induction of labour • the risks and benefits of induction of labour in specific circumstances and the proposed • induction methods • that induction may not be successful and what the woman's options would be.	1.1.4 Discuss with women being offered induction of labour: • the reasons for induction being offered • when, where and how induction could be carried out • the arrangements for support and pain relief (see also recommendations 1.5.7 and 1.5.8) • the alternative options if the woman chooses not to have induction of labour, or decides at a later stage that she no longer wishes to proceed with the induction process • the risks and benefits of induction of labour in specific circumstances, and the proposed induction methods • that induction may not be successful, and how this would affect what the woman's options (see the recommendations on unsuccessful induction). [2008, amended 2021]	The recommendation has been amended to clarify that women can change their mind about induction, to improve the readability of the unsuccessful induction bullet, and to remove the bullet about increased pain, as this is now in the previous recommendation.
1.1.1.3 Healthcare professionals offering induction of labour should: • allow the woman time to discuss the information	1.1.5 When offering induction of labour: • give women time to discuss this information with others (for example, thier partners, birthing companion or family) if	The wording of the recommendation has been amended from ‘allow’ to ‘give’, and the family or birthing companion have been included as well as the partner. This information has

with her partner before coming to a decision • encourage the woman to look at a variety of sources of information • invite the woman to ask questions, and encourage her to think about her options • support the woman in whatever decision she makes.	they wish to do so before making a decision • encourage women to look at other information about induction (for example, by providing written information leaflets or encouraging them to look at information on the NHS website) • ensure women have the opportunity to ask questions, and time to think about her options • 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**]	been used to clarify that this is the information discussed in the recommendations above. The 'variety of sources' has been changed to 'information about induction' to clarify this, and exmaples of leaflets or the NICE website have been included. The third bullet has been amended to make it less paternalistic and to recognise that induction is a choice
1.2.1.3 If a woman chooses not to have induction of labour, her decision should be respected. Healthcare professionals should discuss the woman's care with her from then on.	1.2.6 If a woman chooses not to have induction of labour, discuss the woman's care options from this point on with her (for example, expectant management or caesarean birth) and record the woman's decision in her notes. [2008, amended 2021]	The wording has been amended to make it less paternalistic, to include the other birth options available and to ensure this is recorded so woman do not have to justify this decision on repeated occasions.
1.2.1.4 From 42 weeks, women who decline induction of labour should be offered increased antenatal monitoring consisting of at least twice-weekly cardiotocography and ultrasound estimation of maximum amniotic pool depth.	1.2.7 Discuss with women who choose not to have their labour induced if they wish to have additional fetal monitoring from 42 weeks Advise women that: • monitoring only gives a snapshot of the current situation, and cannot predict reliably any deterioration after monitoring ends, but provides information on how	Antenatal has been changed to fetal, as the committee advise that it is monitoring the baby that is important. An additional sentence has been added, based on the expertise of the committee, to advise women that even

	their baby is at the moment and so may help them make a decision on options for birth • adverse effects on the baby (including stillbirth) and when these events might happen, cannot be predicted reliably or prevented even with monitoring • fetal monitoring might consist of twice-weekly cardiotocography and ultrasound estimation of maximum amniotic pool depth. [**2008, amended 2021**] 1.2.8 Offer choose to await the spontaneous onset of labour the opportunity to discuss their decision again at all subsequent reviews, if they wish to do so . [2021] 1.2.9Advise women to contact their maternity unit if they change their mind before their next appointment, or as soon as possible have concerns about their baby, for example reduced or altered fetal movements.	with this extra monitoring, a prolonged pregnancy may lead to adverse consequences, and that extra monitoring can prevent adverse events. The recommendation about what the monitoring should include has been softened as there is no evidence for any specific monitoring regimen. Two new additional recommendations have been added to ensure that women who decline induction are reviewed regularly and advised when to escalate their care.
1.2.2.1If a woman has preterm prelabour rupture of membranes, induction of labour should not be carried out before 34 weeks unless there are additional obstetric indications (for example, infection or fetal compromise).	1.2.10 If a woman has preterm prelabour rupture of membranes, do not carry out induction of labour before 34+0 weeks unless there are additional obstetric indications (for example, infection or fetal compromise). Offer expectant management until 37+0 weeks. [2008, updated 2021]	The recommendation to offer expectant management to 37 weeks has been added, as the recommendation told users what not to do, but there was no advice on what they should do instead.
1.2.2.2 If a woman has preterm prelabour rupture of membranes after 34 weeks, the maternity team should discuss the following factors with her before a decision is made about whether to induce labour using vaginal PGE2:	1.2.11 If a woman has preterm prelabour rupture of membranes after 34+0 weeks (but before 37+0 weeks), discuss the options of expectant management until 37+0 weeks or induction of labour with her. When making a shared decision,	The text has been amended to make it clear this is a shared decision. The exact gestational period this applies to has been clarified. Expectant management to

• risks to the woman (for example, sepsis, possible need for caesarean birth) • risks to the baby (for example, sepsis, problems relating to preterm birth) • local availability of neonatal intensive care facilities.	take into consideration the following factors: • risks to the woman (for example, sepsis, possible need for caesarean birth) • risks to the baby (for example, sepsis, problems relating to preterm birth) • local availability of neonatal intensive care facilities • the woman's individual circumstances and her preferences. [**2008, amended 2021**]	37+0 weeks has been added in as an option. Details of methods for induction of labour have been removed, as these are covered separately in the guideline.
1.2.3.1 Women with prelabour rupture of membranes at term (at or over 37 weeks) should be offered a choice of induction of labour with vaginal PGE2, or expectant management.	1.2.13 Offer women with prelabour rupture of membranes at term (at or after 37+0 weeks) a choice of: • expectant management for up to 24 hours. • induction of labour as soon as possible Discuss the benefits and risks and benefits of these options with the woman, and take into account her individual circumstances and preferences. [**2008, amended 2021**]	Then wording has been clarified to state that induction can be offered immediately or women can choose to wait for 24 hours. Details of methods for induction of labour have been removed, as these are covered separately in the guideline. The recommendation to discuss the risks and benefits has been added.
1.2.3.2 Induction of labour is appropriate approximately 24 hours after prelabour rupture of the membranes at term.	1.2.14 For women who choose expectant management after prelabour rupture of the membranes at term (at or over 37+0 weeks) offer induction of labour if labour has not started naturally after approximately 24 hours. See the NICE guideline on intrapartum care. [**2008, amended 2021**] 1.2.15 Respect the woman's decision if she chooses to wait for the spontaneous onset of labour for over 24 hours after prelabour rupture of membranes at term. Discuss the woman's options	Clarification has been added that induction of labour is indicated if labour has not started after 24 hours, and an additional recommendation has been added to clarify what to do if women decline induction after 24 hours.

	for birth from this point onwards with her. [2021]	
1.2.4.1 If delivery is indicated, women who have had a previous caesarean section may be offered induction of labour with vaginal PGE2, caesarean section or expectant management on an individual basis, taking into account the woman's circumstances and wishes. Women should be informed of the following risks with induction of labour: • increased risk of need for emergency caesarean section during induced labour • increased risk of uterine rupture.	1.2.17 Advise women who had a previous caesarean birth that: • induction of labour could lead to an increased risk of need for emergency caesarean birth • induction labour could lead to an increased risk of uterine rupture • the methods used for induction of labour will be guided by the need to reduce these risks (for example by using mechanical methods). See the recommendations on Methods for inducing labour. • some methods used for induction of labour may not be suitable (for example, both dinoprostone and misoprostol are contraindicated in women with a uterine scar), [2008, amended 2021] 1.2.18 If birth needs to be expedited, offer women who have had a previous caesarean birth a choice of: • induction of labour **or** • planned caesarean birth Take into account the woman's circumstances and preferences and record the discussions and plans in the woman's notes. 1.2.19. Advise women that they can choose not to have induction of labour or caesarean birth, even when it may benefit their or their baby's health. [2008, amended 2021]	The recommendation has been split into two recommendations to make it easier to read. The method of induction of labour has been removed as that is covered later in the guideline. However, additional bullet points have been added to highlight that methods of induction will need to take into account the fact that woman has had a previous caesarean section, that some methods are not suitable as they are contraindicated. The need to record these discussions in the woman's notes has been added to avoid the woman having to repeat these discussions.

1.2.5.1 Induction of labour should not routinely be offered on maternal request alone. However, under exceptional circumstances (for example, if the woman's partner is soon to be posted abroad with the armed forces), induction may be considered at or after 40 weeks.	1.2.20 Consider requests for induction of labour only after discussing the benefits and risks with the woman, taking into account the woman's circumstances and wishes. [2008, amended 2021]	The recommendation has been updated and the specific example removed, as the committee agreed that the decision should be made based on risks, benefits, and individual circumstances.
1.2.6.1 Induction of labour is not generally recommended if a woman's baby is in the breech presentation. If external cephalic version is unsuccessful, declined or contraindicated, and the woman chooses not to have an elective caesarean section, induction of labour should be offered, if delivery is indicated, after discussing the associated risks with the woman.	1.2.21 Induction of labour is not generally recommended if a woman's baby is in the breech position. [2008, amended 2021] 1.2.22 Consider induction of labour for babies in the breech position if: • birth needs to be expedited **and** • external cephalic version is unsuccessful, declined or contraindicated **and** • the woman chooses not to have a planned caesarean birth. Discuss the possible benefits and risks associated with induction of labour with the woman. [2008, amended 2021]	The wording of the recommendation has not changed but it has been split into 2 recommendations to make it easier to read, and the second part has been changed to a bulleted list to improve readability. Presentation has been changed to position as this is a more easily understood term.
1.2.7.1 If there is severe fetal growth restriction with confirmed fetal compromise, induction of labour is not recommended.	1.2.23 Do not induce labour if there is fetal growth restriction with confirmed fetal compromise. Offer caesarean birth instead. [2008, amended 2021]	The recommendation has been changed from 'not recommended' to 'do not' as the committee advised this was what was meant. The recommendation to offer caesarean birth was also added to make it clear that in this situation expectant management is not an appropriate option. The word 'severe' was removed as any

		growth restriction with fetal compromise would mean labour should not be induced.
1.2.9.2 In the event of an intrauterine fetal death, if the woman appears to be physically well, her membranes are intact and there is no evidence of infection or bleeding, she should be offered a choice of immediate induction of labour or expectant management.	1.2.28 In the event of an intrauterine fetal death, if the woman appears to be physically well, her membranes are intact and there is no evidence of infection or bleeding, discuss the options for birth (expectant management, induction of labour or caesarean birth) and respect the woman's decision. [2008, amended 2021]	The option of caesarean birth has been added to the recommendation, and it has been clarified that this should be discussed with women.
1.2.9.3 In the event of an intrauterine fetal death, if there is evidence of rupture membranes, infection or bleeding, immediate induction of labour is the preferred management option.	1.2.29 In the event of an intrauterine fetal death, if there is evidence of ruptured membranes, infection or bleeding, offer immediate induction of labour or caesarean birth. [2008, amended 2021]	The wording has been changed from 'the preferred management option' to 'offer' as the committee advised this was what was meant. Immediate induction of labour has been changed to immediate birth (by induction of labour or caesarean birth) as these are the 2 options available to women in this situation.
-	Women with a non-scarred uterus Women who have had a previous caesarean birth	New sub-headings have been added to emphasise that the methods for induction of labour after intrauterine fetal death differ in these 2 groups of women.
1.2.9.4 If a woman who has had an intrauterine fetal death chooses to proceed with induction of labour, oral mifepristone, followed by vaginal PGE2 or vaginal misoprostol[5], should be offered. The choice and dose of vaginal prostaglandin should take into account the	1.2.31 If a woman with an intrauterine fetal death chooses an induced labour, offer oral: • mifepristone 200 mg followed by vaginal dinoprostone or oral or vaginal misoprostol, Base the choice and dose of drug used on clinical	The dose of mifepristone has been included. Mechanical methods have been included as an option. The wording has been amended from 'vaginal prostaglandin' to

clinical circumstances, availability of preparations and local protocol.	circumstances and national protocols, or • a mechanical method of induction .. [2008, amended 2021] 1.2.30 If a woman with an intrauterine fetal death chooses an induced labour, follow the recommendations on monitoring of uterine contractions (preferably using manual assessment) and provide one-to-one midwifery care of the woman. during labour and birth. [2021]	'drug' as several drugs are named in the sentence above. Local protocols has been changed to national protocols as FIGO guidance is available, and RCOG guidance is anticipated. The advice to care for the woman on a 1:1 basis and monitor uterine contractions has been added in a separate new recommendation (this applies to women with intact and scarred uterus so has placed in the guideline to make this clear).
1.3.1.2 At the 40- and 41-week antenatal visits, nulliparous women should be offered a vaginal examination for membrane sweeping.	1.3.4 At antenatal visits after 39+0 weeks, discuss with women if they would like a vaginal examination for membrane sweeping, and if so obtain verbal consent from them before carrying out the membrane sweep. [2008, amended 2021]	These 2 recommendations have been combined as the committee agreed it was not necessary to differentiate based on parity, and that membrane sweeping could be offered after 39 weeks in all women.
1.3.1.3 At the 41-week antenatal visit, parous women should be offered a vaginal examination for membrane sweeping.	See above	See above
1.3.1.5 Additional membrane sweeping may be offered if labour does not start spontaneously.	1.3.5 Discuss with women whether they would like to have additional membrane sweeping if labour does not start spontaneously following the first sweep. [2008, amended 2021]	'May be offered' has been clarified as 'discuss with women, as this is their choice.
1.4.1.1 Do not use the following for induction of labour:	1.4.1 Be aware that the available evidence does not support the use of the following methods for induction of labour: • oral dinoprostone	The committee did not think there was enough evidence of harm from these interventions to make a 'do not'

• oral PGE2 • intravenous PGE2 • extra-amniotic PGE2 • intracervical PGE2 • intravenous oxytocin alone • hyaluronidase • corticosteroids • oestrogen • vaginal nitric oxide donors.	• intravenous dinoprostone • extra-amniotic dinoprostone or PGF2 • intracervical dinoprostone • vaginal PGF2 • intravenous oxytocin alone • hyaluronidase • corticosteroids • oestrogen • relaxin • mifepristone (except in combination for intrauterine fetal death, see recommendation 1.2.27 and 1.2.29) • vaginal nitric oxide donors. [2008, amended 2021]	recommendation so they amended the wording to just raise awareness. The list of pharmacological methods that are not recommended for the induction of labour was modified to include new interventions which had been included in the evidence review, but which the committee did not agree to recommend.
1.5.1.1 In the outpatient setting, induction of labour should only be carried out if safety and support procedures are in place.	1.6.1 Consider outpatient induction of labour with vaginal dinoprostone preparations or mechanical methods in women who wish to return home and who have no without co-existing medical conditions or obstetric complications. Discuss the benefits and risks of returning home with the woman and respect her decision. [2008,amended 2021] 1.6.2 Carry out a full clinical assessment of the woman and fetus (see recommendation 1.5.1 and 1.5.2) and ensure safety and support procedures are in place. [2008, amended 2021]	The committee advised that outpatient induction of labour is carried out routinely by many units and so amended the recommendation to make it more permissive but to clarify that this should only be carried out in low risk women. They also clarified which methods were suitable for use in the outpatient setting and added that a full clinical assessment of the woman and fetus was required before outpatient induction
1.6.1.1 Wherever induction of labour is carried out, facilities should be available for continuous electronic fetal heart rate and uterine contraction monitoring.	1.5.2 Ensure facilities are available for cardiotocography wherever induction of labour is started. [2008, amended 2021]	'Electronic fetal monitoring and uterine contraction monitoring' has been changed to 'cardiotocography' as this is the preferred term in line with

		other NICE guidelines. 'Carried out' has been amended to 'started' as the committee advised this monitoring would only be necessary at the beginning of induction and not necessarily throughout.
1.6.1.2 Before induction of labour is carried out, Bishop score should be assessed and recorded, and a normal fetal heart rate pattern should be confirmed using electronic fetal monitoring.	1.5.1 Ensure the position of the baby and the woman's condition are suitable for induction by: • abdominally assessing the level and stability of the fetal head in the lower part of the uterus at or near the pelvic brim • carrying out an ultrasound scan if there are any concerns about the position of the baby (for example, if it might be in the breech position) • assessing and recording the Bishop score • confirming a normal fetal heart rate pattern using antenatal cardiotocography interpretation. • confirming the absence of significant uterine contractions (not Braxton-Hicks) using cardiotocography. [2008, amended 2021]	The committee agreed that it was important to confirm the baby's position and uterine activity before starting induction and so they added this. 'Electronic fetal monitoring' has been changed to 'cardiotocography' as this is the preferred term in line with other NICE guidelines, and it has been clarified that this is antenatal interpretation.
1.6.1.3 After administration of vaginal PGE2, when contractions begin, fetal wellbeing should be assessed with continuous electronic fetal monitoring. Once the cardiotocogram is confirmed as normal, intermittent auscultation should be used unless there are clear indications for continuous electronic fetal monitoring as described in	1.5.3 When uterine contractions begin after administering dinoprostone or misoprostol, assess fetal wellbeing and uterine contractions with intrapartum cardiotocography interpretation and: • if the cardiotocogram is confirmed as normal, review the individual circumstances and if	These 2 recommendation have been combined into 1 recommendation with bullet points to make it easier to read. 'Electronic fetal monitoring' has been changed to 'cardiotocography' as this is the preferred

'Intrapartum care' (NICE clinical guideline 55). 1.6.1.4 If the fetal heart rate is abnormal after administration of vaginal PGE2, recommendations on the management of fetal compromise in 'Intrapartum care' (NICE clinical guideline 55) should be followed.	considered low risk, use intermittent auscultation unless there are clear indications for cardiotocography • if the fetal heart rate is abnormal or there are excessive uterine contractions: ○ continue or restart cardiotocography ○ do not administer any more doses and, ○ remove any vaginal pessaries or delivery systems if possible. Follow the advice on monitoring during labour in the NICE guideline on intrapartum care. [2008, amended 2021]	term in line with other NICE guidelines. It has been clarified that this is now intrapartum interpretation. Monitoring of uterine contractions has been added, as this is important to assess if there is hyperstimulation. Further guidance has been given that after assessment, in low-risk situations, intermittent auscultation can be used Misoprostol has been added into this recommendation as it is now a treatment option, and the same monitoring requirements would apply. Advice to restart cardiotocography, not to give more doses and remove any vaginal pessaries or delivery systems if the fetal heartrate is abnormal has also been added to the recommendation on the advice of the committee.
1.6.1.5 Bishop score should be reassessed 6 hours after vaginal PGE2 tablet or gel insertion, or 24 hour after vaginal PGE2 controlled-release pessary insertion, to monitor progress.	1.5.4 Offer to reassess the wellbeing of the woman and baby and the Bishop score at appropriate intervals to monitor progress, depending on the method of induction being used, and the clinical condition of the woman. [2008, amended 2021]	As a wider range of methods are now recommended for induction of labour (dinoprostone, misoprostol or mechanical methods) the recommendation has been updated to state that monitoring intervals will depend

		on the preparation used and the clinical condition, and to clarify that wellbeing as well as Bishop score should be checked..
1.6.1.6 If a woman returns home after insertion of vaginal PGE2 or tablet or gel, she should be asked to contact her obstetrician/midwife: • when contractions begin, or • if she has had no contractions after 6 hours.	1.6.3 For induction being undertaken on an outpatient basis, agree a review plan with the woman before she returns home. [2008, amended 2021] 1.6.3 Ask women to contact their midwife, maternity unit or obstetrician: • when contractions begin **or** • if there are no contractions (in an agreed timeframe, depending on the method used) **or** • if her membranes rupture **or** • if she develops bleeding **or** • if she has any other concerns, such as reduced or altered fetal movements, excessive pain or uterine contractions, side-effects or loss of the pessary. [2008, amended 2021]	This recommendation has been split into 2 recommendations to make it easier to read. The recommendation has been amended on the advice of the committee to 'agree a review plan' as this may differ for different women and circumstances. The committee also agreed that there would be other circumstances where it was necessary for a woman to contact her obstetrician or midwife, and therefore added these to the list. The specific mention of PGE2 has been removed from the recommendation, as the requirement to agree a plan applies to all methods.
1.6.2.3 During induction of labour, healthcare professionals should provide women with the pain relief appropriate for them and their pain (as described in 'Intrapartum care' [NICE clinical guideline 55]). This can range from simple analgesics to epidural analgesia. 1.6.2.4 Birth attendants (carers and healthcare professionals) should offer women support and	1.5.8 During induction of labour, provide women with the pain relief appropriate for them and their pain as described in the NICE guideline on intrapartum care. This can include simple analgesia, labour in water and epidural analgesia. [2008, amended 2021]	The recommendation was amended as the committee advised that it sounded like birth attendants could give pain relief, and that advising women to use their own coping strategies was too paternalistic. The recommendation to labour in water was combined with

analgesia as required, and should encourage women to use their own coping strategies for pain relief. 1.6.2.5 The opportunity to labour in water is recommended for pain relief.		other options for pain relief
1.7.1.1 Tocolysis should be considered if uterine hyperstimulation occurs during induction of labour.	1.7.1 If uterine hyperstimulation occurs during induction of labour: • carry out a fetal assessment • do not administer any more doses and remove any vaginal pessaries or delivery systems if possible • consider tocolysis. [2008, amended 2021]	The recommendation to carry out a fetal assessment, stop doses and remove vaginal treatments has been added as this would be the first-line action.
1.7.2 Failed induction	Unsuccessful induction	This heading has been changed to avoid the use of the negative term 'failed'.
1.7.2.1 If induction fails, healthcare professionals should discuss this with the woman and provide support. The woman's condition and the pregnancy in general should be fully reassessed, and fetal wellbeing should be assessed using electronic fetal monitoring.	1.7.2 If induction is unsuccessful, discuss this with the woman and provide support. Fully reassess the woman's condition and the pregnancy in general, and assess fetal wellbeing using antenatal cardiotocography interpretation. [2008, amended 2021]	'Electronic fetal monitoring' has been changed to 'cardiotocography' as this is the preferred term in line with other NICE guidelines, and it has been clarified that this is using antenatal interpretation.
1.7.2.2. If induction fails, decisions about further management should be made in accordance with the woman's wishes, and should take into account the clinical circumstances.	1.7.3 If induction is unsuccessful, discuss and agree a plan for further management with the woman, including whether she would like further attempts at induction, taking into account the clinical circumstances and her preferences. [2008, amended 2021]	The recommendation has been amended to make it more consultative.
1.7.2.3 If induction fails, the subsequent management options include: • a further attempt to induce labour (the timing should depend on the	1.7.4 If induction is unsuccessful, the subsequent management options include: • offering a rest period if clinically appropriate and	The option of offering a rest period has been added, based on the committee's clinical experience. Expectant

clinical situation and the woman's wishes) • caesarean section (refer to 'Caesarean section' [NICE clinical guideline 13]).	then re-assessing the woman • expectant management • further attemptsto induce labour caesarean birth. See the NICE guideline on caesarean section. [2008, amended 2021]	management has been added as some women may choose this option.
1.7.3.1 To reduce the likelihood of cord prolapse, which may occur at the time of amniotomy, the following precautions should be taken: • before induction, engagement of the presenting part should be assessed • obstetricians and midwives should palpate for umbilical cord presentation during the preliminary vaginal examination and avoid dislodging the baby's head • amniotomy should be avoided if the baby's head is high.	1.7.5 Take the following precautions to avoid the adverse effects of cord prolapse, which may occur if labour is induced: • before induction, abdominally assess the level and stability of the fetal head in the lower part of the uterus at or near the pelvic brim (see the recommendations on assessment before induction) • during the preliminary vaginal examination, obstetricians and midwives should palpate for umbilical cord presentation and avoid dislodging the baby's head • carry out continuous cardiotocography during induction after the membranes have ruptured if the presenting part is not stable and not well-applied to the cervix. In this situation, discuss the. risks and benefits of induction of labour with the woman, and if necessary consider caesarean birth. If the presenting part stabilises and the cardiotocogram is normal, use intermittent auscultation unless there are clear indications for further tocography. [2008, amended 2021]	The stem has been changed as these actions may reduce the risk of cord prolapse and any adverse effects resulting from it. The committee advised that the terminology in this recommendation should be updated and ‘the level and stability of the fetal head’ was more useful to assess than ‘engagement of the presenting part’. The 3rd bullet ‘if the baby’s head is high’ should be replaced by ‘if the presenting part is not stable and well-applied to the cervix’, and that in this situation, continuous cardiotocography would be needed to ensure that cord prolapse didn’t occur and go unnoticed, and the risks should be discussed with the woman. The committee agreed that these precautions would apply to all methods of induction not just amniotomy and so made this clear in the stem of the recommendation.

	Placenta praevia, low-lying placenta or a previous history of antepartum haemorrhage.	A new sub-heading has been added as the recommendation about low-lying placenta was mixed in with the recommendations about cord prolapse.
1.7.3.2 Healthcare professionals should always check that there are no signs of a low lying placental site before membrane sweeping and before induction of labour.	1.7.6 Check there is no evidence of a low-lying placenta on previous scans before membrane-sweeping and induction of labour. [2008, amended 2021]	It has been clarified that the signs of a low-lying placenta would be seen on scans
1.7.4.1 If uterine rupture is suspected during induced labour, the baby should be delivered by emergency caesarean section (refer to 'Caesarean section' [NICE clinical guideline 13]).	1.7.7 If uterine rupture is suspected during induced labour, carry out an immediate category 1 caesarean birth. See the NICE guideline on caesarean section. [2008, amended 2021]	The terminology for the category of caesarean has been updated in accordance with NICE guidelines on caesarean section.