Induction of Labour is changing from 23rd July

Propess pessaries

Or

Cook's Balloon catheters

(Prostin for pre labour SROM)

Information for all staff caring for women undergoing induction of labour

New guideline available on ICID

IOL using Propess

- Propess is a 10 mg Pessary (Vaginal pessary containing 10 mgs Dinoprostone – prostaglandin E20)
- One pessary last 24 hours
- Delivers 0.3mg per hour dinoprostone
- A thin, flat, rectangular, polymetric pessary contained in a knitted polyester retrieval system
- It can easily be removed in the event of hyperstimulation.
- Increased maternal satisfaction with less vaginal examinations throughout the induction process.

In an unfavourable cervix Propess will cause cervical ripening, but this process may take 18 hours or even longer.

In a favourable cervix they may not only ripen the cervix, but may induce labour directly.

PROPESS IS NOT SUITABLE FOR WOMEN WHO HAVE HAD PREVIOUS CAESAREAN SECTION

MOMA JULY 2018

Propess Insertion

- Routine observations, risk assessment and 30 minute pre Propess CTG
- If normal CTG continue, if abnormal refer appropriately
- VE, if bishops score less than 7 Propess inserted into posterior fornix
- CTG for 30 minutes post Propess insertion
- CTG 6 hourly or earlier if
    - Contractions commence
    - Vaginal bleeding
    - Rupture of membranes
    - Clinically indicated or care plan as specified by Obstetric team

When to remove Propess

- When labour is established
- Vaginal Bleeding
- Uterine hyperstimulation or hypertonic uterine contractions
- Evidence of fetal compromise
- Evidence of maternal adverse dinoprostone effects (nausea, vomiting and diarrhoea)
- At least **30 minutes** prior to starting an intravenous infusion of oxytocin
- Following 24 hours, even if labour is not established

To remove Propess, apply gentle traction on the retrieval tape (the insert will have swollen to 2-3 times its original size and be pliable).

SROM with Propess in situ

- CTG for 30 minutes.
- If normal continue IOL.
- If no uterine activity leave Propess in situ.
- If there is regular uterine activity (contracting 3-4:10 over at least one hour), remove Propess following discussion with midwife in charge or registrar/Consultant.
- A cervical assessment is only indicated if established labour is suspected.

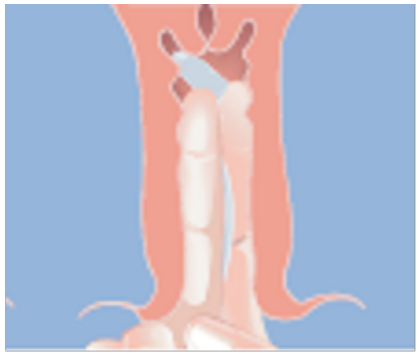
After 24 hours

- Propess should be removed (but can be left in situ for up to 30 hours).
- Syntocinon can be commenced 30 minutes after removal of Propess.

Propess Insertion and Removal

1. Insertion

Holding the Propess® insert between the index and middle fingers of the examining hand, insert it high into the vagina towards the posterior vaginal fornix using only small amounts of water soluble lubricants.



2. Positioning

The index and middle fingers should now be twisted a quarter turn clockwise, pushing the Propess insert higher up, behind the posterior fornix and turning it through 90º so that it lies transversely in the posterior fornix.

3. After positioning

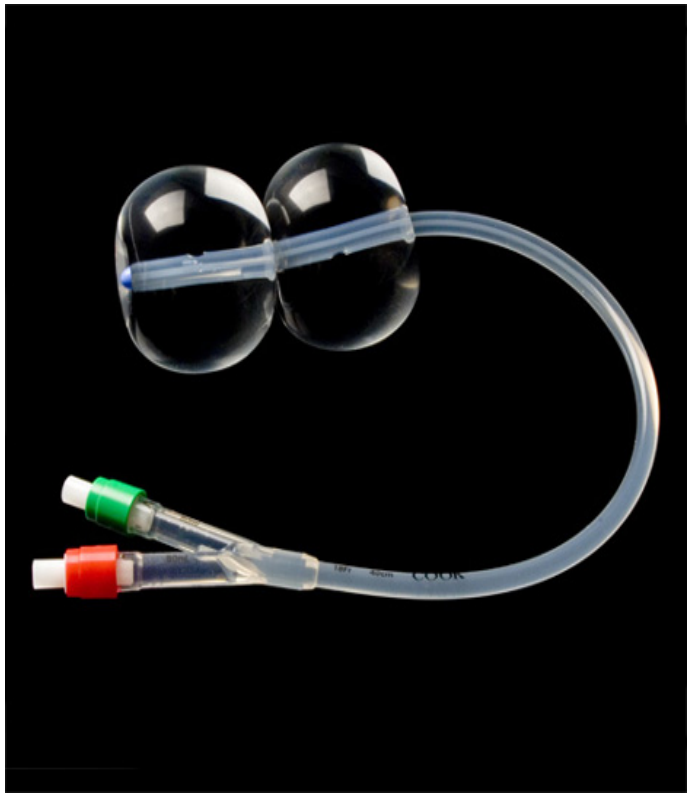
Carefully withdraw the fingers leaving the Propess® insert in the position shown in this diagram where it should remain *in situ*. After insertion ensure that the patient remains recumbent for 20-30 minutes to allow time for the Propess® insert to swell. Again, this will help it to remain in place for the duration of the treatment. Allow sufficient tape to remain outside the vagina to permit easy retrieval.

4. Removal

To stop prostaglandin E2 release, gently pull the retrieval tape and remove the Propess insert.

IOL using Cook's Catheter

Cook's Catheter is a silicone double-balloon catheter with an adjustable-length malleable stylet. It is intended for mechanical dilation of the cervical canal prior to labour induction at term when the cervix is unfavourable for induction.



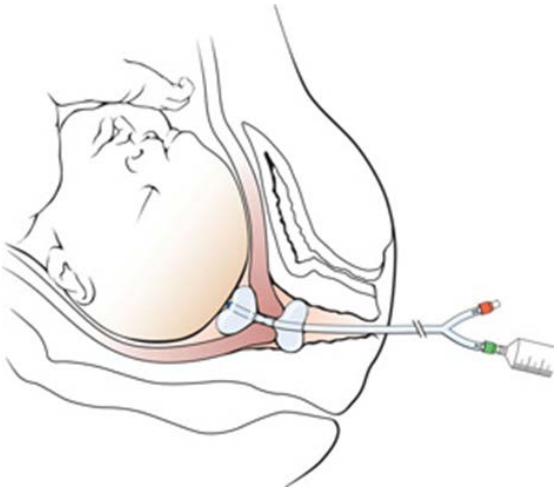
Used for outpatient Induction of labour for low risk women from term +11, or as an inpatient induction for women who have had previous caesarean section or are high risk.

Any contraindication to induction of labour using Cook's Catheter

- Low lying placenta.
- Planned elective caesarean.
- Maternal refusal.
- Placenta praevia.
- HIV infection.
- Active herpes lesions.
- Vasa praevia.
- Malpresentation.
- Ruptured membranes.
- Abnormal fetal heart rate patterns.
- Invasive cervical cancer.
- Simultaneous use of pharmacological cervical priming

Instructions.

Women should be admitted in the evening for catheter insertion eg term +11 for low risk induction, in anticipation of having an ARM in the morning



- Perform abdominal palpation.
- CTG for at least 20 minutes.
- Explain procedure and gain consent.
- Insert speculum to visualise the cervix and clean the cervix.
- Insert the catheter until both balloons are in the cervical canal and inflate the uterine balloon to 40 ml. Once the uterine balloon is inflated pull back until it is resting against the internal os.
- Inflate the vaginal balloon with 20ml N/Saline.
- Once the speculum is removed inflate the balloons up to 80 ml each (in increments of 20 ml).

Some discomfort may occur once the balloon has been inserted.

The balloon stays in situ for approximately 12 hours. **Women with low risk pregnancies may go home overnight**.

A CTG is performed every 6 hours for high risk women or as soon as regular contractions are felt.

It should be removed after approximately 12 hours, or if SROM for active management of induction.

Artificial rupture of membranes should be performed as soon as possible once the balloon has been removed.

If unable to perform ARM discuss with obstetrician for further plan of care. (E.g. may progress to Prostin insertion).