PIPADOR REVISION

MRCOG Part 1 Revision Notes

Induction

CLINICAL MANAGEMENT • LECTURE 476

VISUAL EXAMINATION REVISION NOTES

2026 Edition

476

MRCOG PART 1 REVISION NOTES | CLINICAL MANAGEMENT

Induction

Definitions, indications, methods, monitoring and special situations in induction of labour (NICE NG207)

≈ 1 in 3	Bishop > 6	41+0	Tachysystole
UK births induced	Favourable cervix	Offer IOL for prolonged pregnancy	> 5 in 10 min

■ KEY FACTS: Learning objectives

- Define induction of labour, cervical ripening, Bishop score, failed induction and uterine tachysystole.
- Describe the indications, contraindications and methods of induction (NICE NG207).
- Describe monitoring, complications and induction in special situations (previous CS, PROM, outpatient IOL).

476.1 Key definitions

Term	Definition
Induction of labour (IOL)	Artificially starting labour before it begins spontaneously
Cervical ripening	Softening, thinning and opening of the cervix before labour (pharmacological or mechanical)
Bishop score	Score (0–13) of cervical dilatation, length, station, consistency and position — ≤ 6 unfavourable, > 6 favourable
Amniotomy (ARM)	Artificial rupture of the membranes
Failed induction	Labour does not start after one complete cycle of treatment (NICE NG207)
Uterine tachysystole	• More than 5 contractions in 10 minutes (averaged over 30 min) • Hyperstimulation if with FHR changes
Outpatient induction	Cervical ripening at home after initial assessment (selected low-risk women)

■ IN PLAIN ENGLISH: Induction

Induction is a **medical intervention** offered when the benefits of birth now outweigh waiting for labour. It needs informed decision-making, the right method for the cervix and the woman's history, and careful monitoring.

476.2 Indications and contraindications

Common indications	Notes
Prolonged pregnancy	Offer from 41+0 weeks (birth by 42+0) — NICE NG207
Prelabour rupture of membranes at term	• Offer choice: IOL as soon as possible or expectant management up to 24 h

Common indications	Notes
	• Immediate IOL if GBS positive (with IAP), or meconium/infection concerns
Hypertension/pre-eclampsia	Pre-eclampsia ≥ 37+0 weeks (NICE NG133)
Diabetes	• GDM: birth by 40+6 weeks • Pre-existing diabetes: 37+0–38+6 weeks (NICE NG3)
FGR/SGA, reduced fetal movements	Per FGR pathway (Lecture 470)
Obstetric cholestasis	According to bile acid level (RCOG GTG 43)
Maternal request, age ≥ 40, high BMI, previous stillbirth	Individualised discussion (NICE NG207 suggests considering earlier IOL for some groups)
Intrauterine fetal death	Mifepristone + misoprostol (RCOG GTG 55)

- **Contraindications**: placenta praevia/vasa praevia, transverse lie, cord presentation
  - Active genital herpes (primary 3rd trimester)
  - Previous classical CS or uterine rupture
  - Situations where vaginal birth is contraindicated.

476.3 Methods

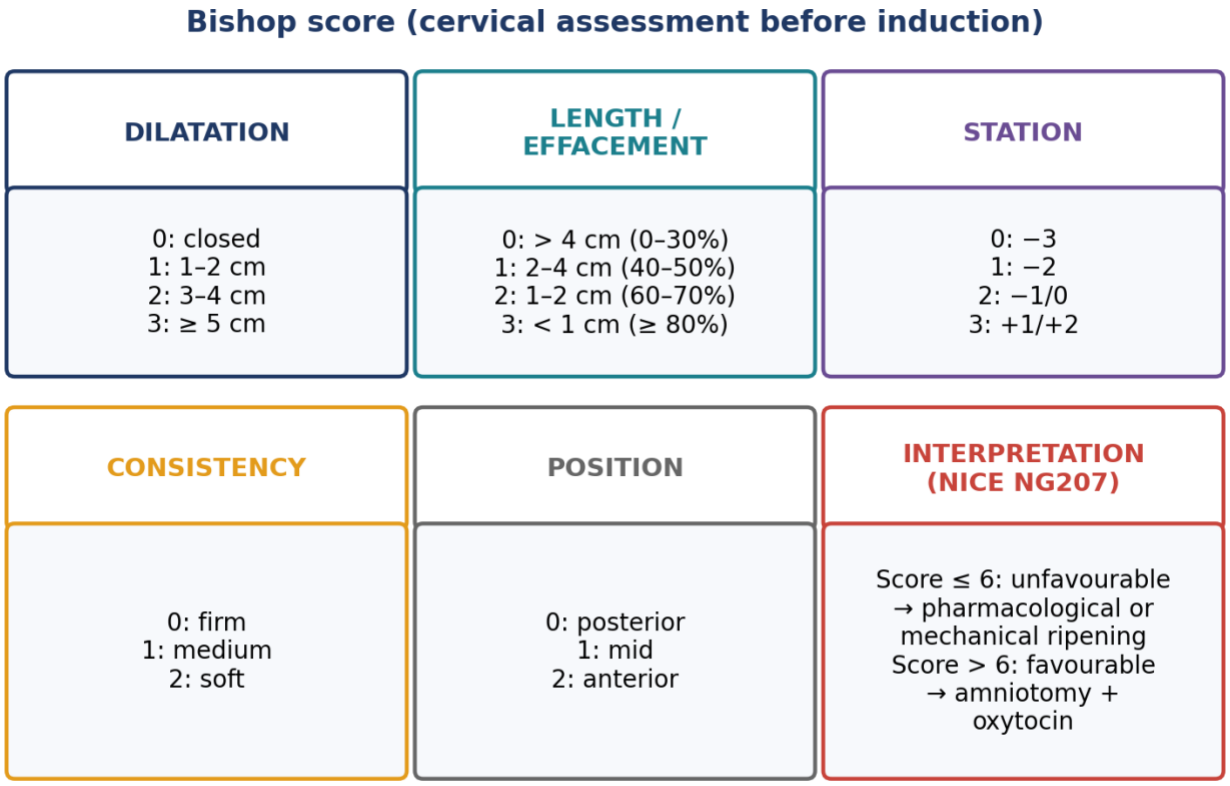


Figure 476.1 — Bishop score

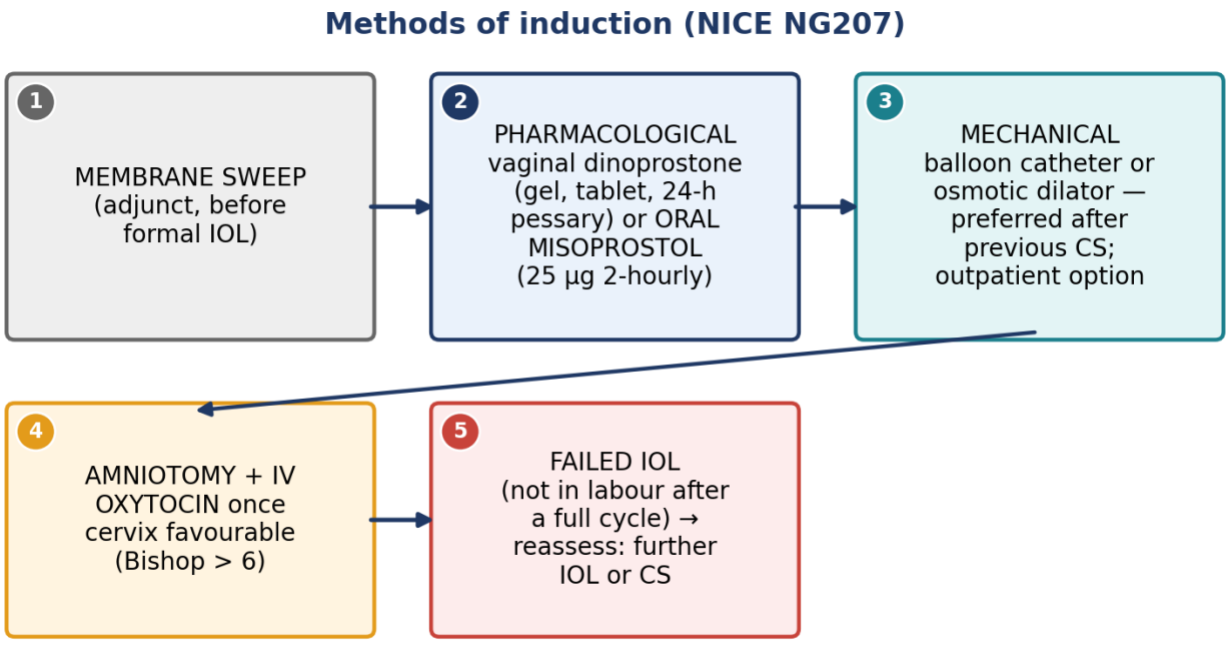


Figure 476.2 — Methods of induction

Method	Key points (NICE NG207)
Membrane sweep	• Offer at term antenatal visits as an adjunct • Reduces need for formal IOL
Vaginal dinoprostone (PGE_2)	• Gel, tablet or 24-hour controlled-release pessary • Monitor CTG • Risk of tachysystole (remove pessary)
Oral misoprostol (PGE_1)	Low dose (25 µg every 2 h, or as per protocol) — not after previous CS
Mechanical (balloon catheter, osmotic dilator)	• Lower tachysystole risk • Preferred after previous CS • Suitable for outpatient IOL
Amniotomy + oxytocin	• When Bishop > 6 • Oxytocin started after ARM (allow time for labour to start or start immediately — discuss)

476.4 Monitoring and complications

- CTG before IOL and after prostaglandin administration; continuous CTG once oxytocin started.
- **Tachysystole/hyperstimulation**: remove pessary/stop oxytocin, left lateral, IV fluids, **tocolysis** (terbutaline 250 µg SC) if CTG abnormal.
- Other risks: failed induction
  - ↑ intervention (instrumental/CS — though IOL at term does not increase CS overall)
  - Uterine rupture (previous CS)
  - Cord prolapse at ARM (high head), infection, PPH, longer labour
  - Less satisfying experience.
- **Failed IOL**: reassess — further cycle of IOL, ARM if possible, or CS depending on clinical circumstances and woman's wishes.

476.5 Special situations

Situation	Approach
Previous caesarean section	• Discuss risks: uterine rupture ↑ (≈ 2–3× with IOL) • Mechanical methods preferred • Avoid misoprostol • Careful oxytocin use • Continuous CTG
Outpatient IOL	Low-risk women with balloon or dinoprostone pessary — clear instructions to return
Grand multiparity	Caution with prostaglandins/oxytocin (rupture)
Breech at term	Planned vaginal breech IOL possible after counselling (RCOG GTG 20b)

■ **COMMON PITFALLS**

Starting IOL without documenting the indication and the woman's informed decision.

Using misoprostol in women with a previous CS.

ARM with an unengaged head (cord prolapse).

476.6 Must-know summary

■ **EXAM TIP**

- IOL = artificially starting labour; offer from 41+0 for prolonged pregnancy; PROM at term → IOL or wait ≤ 24 h.
- Bishop ≤ 6 → dinoprostone, oral misoprostol or mechanical; > 6 → ARM + oxytocin.
- Tachysystole > 5/10 min → stop/remove, tocolysis if CTG abnormal.
- Previous CS: mechanical preferred, avoid misoprostol, rupture risk ↑; failed IOL = not in labour after one cycle.

■ **MNEMONIC / MEMORY AID**

Bishop score — 'Dilatation, Length, Station, Consistency, Position' ('Don't Let Silly Cervix Prevail').