FOR: Labour Should be Induced at Term

Prof Gordon C.S. Smith.
Department of Obstetrics and Gynaecology, University of Cambridge; NIHR Cambridge Comprehensive Biomedical Research Centre, Box 223 The Rosie Hospital, Cambridge, UK.
Tel: +44 (0)1223 336871, Fax: +44 (0)1223 215327, E-mail: gcss2@cam.ac.uk

Delivery of the fetus is one of the few truly disease modifying therapies available in Obstetrics. Management of multiple conditions involves balancing the risk of delivery versus expectant management. Taking the example of early onset fetal growth restriction, the risk of neonatal death and severe morbidity if the baby is delivered preterm is balanced against the risk of intra-uterine fetal death if the baby is not delivered. The declining risk of neonatal complications with advancing gestational age is the rationale for many guidelines recommending delivery thresholds, e.g. delivery at 37 weeks in the SGA infant with abnormal middle cerebral artery Doppler and delivery at 38 weeks in women with diabetes mellitus.

The same principle should apply when we consider any pregnant women. The factors determining the timing of onset of labour at term are incompletely understood. However, we know that prolonged pregnancy is associated with increased risk of adverse outcomes, both short term and long term. Hence, prolongation of pregnancy beyond the gestational age where outcomes are optimal should be regarded as a complication in the same way that we regard preterm birth as a complication. Moreover, the risk of events such as stillbirth, pre-eclampsia and abruption, are related to the duration of pregnancy. For example, delivery at 39 weeks removes the risk of intra-uterine fetal death at later weeks of gestational age.

Given that outcomes are optimal when the baby is born at 39 to 40 weeks, why do we not already offer induction of labour to all women at this stage of pregnancy? One reason may be a fundamental misconception about the effect of induction of labour. Many believe that increased use of induction of labour would lead to higher rates of intervention, such as caesarean section. However, this is not supported by the current evidence. The most recent systematic review of randomised controlled trials of routine induction of labour at term and post term demonstrated a 12% reduction (95% CI 7% to 17% reduction) in the risk of caesarean section, an effect which was observed irrespective of
parity, indication or risk status. Moreover, the expected benefits on perinatal outcome were also observed, with significant reductions in the risk of stillbirth (50%) and NICU admission (14%).

Clearly, if a woman prefers to avoid intervention, her choice should be respected. However, many women actively request term delivery and are denied the intervention. The balance of risks of continuing pregnancy versus expectant management has certainly been achieved by 40 weeks, and may even be achieved at 39 weeks. Although serious adverse outcomes at or after 40 weeks are rare, it should be for the individual woman to decide: all should be offered the intervention. It might be argued that the costs of this approach would increase the burden on an already over-stretched health service. However, the costs need to be balanced against the clinical gains in terms of perinatal outcome. Moreover, some of the additional demands placed on maternity systems by increased use of induction may be mitigated by reduction in other costs, e.g. reduced costs of antenatal assessment, intrapartum intervention, adverse outcomes and resultant litigation.

Disclosure of interests
(listed for full disclosure only: I do not believe that any of the following materially affect my objectivity in the current publication).
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References
