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The timing and indications of labor induction in term pregnancy

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The timing of delivery is crucial for pregnancy outcomes, which must balance both the maternal and newborn risks and benefits of continuation or termination of pregnancy. It is generally suggested to avoid non-medically indicated delivery before 39 weeks. If there is a medical or obstetrical indication, such as hypertension, deferring delivery to the 39th week is not recommended. Induction of labor is certainly one of the most frequently performed obstetric procedures in the world. Common indications for labor induction include premature rupture of membranes, hypertensive disorders (ex. preeclampsia), uncontrolled gestational diabetes, oligohydramnios, and fetal growth restriction. Induction should be taken into consideration when the vaginal route is thought to be the most appropriate for delivery, a concept that is broader than the simple absence of contraindications to vaginal birth. A general concern is that induction might increase the rate of cesarean delivery and have an impact on the experience of birth, as in women undergoing induction it is generally less favorable, even though it is not always easy to separate the effect of the procedure per se from that of the perception of the obstetric risk that makes induction necessary or from its outcome. Therefore, shared decision making with informed consent is suggested after thorough explanation and discussion with the patient.

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The methods and complications of labor induction in term pregnancy

Labor induction is the process or treatment that stimulates childbirth and delivery. Inducing labor can be accomplished with pharmaceutical or non-pharmaceutical methods. In Western countries, it is estimated that one-quarter of pregnant women have their labor medically induced with drug treatment. Inductions are most often performed either with prostaglandin drug treatment alone, or with a combination of prostaglandin and intravenous oxytocin treatment. There are several methods using clinically for labor induction including intravaginal / oral administration of prostaglandin (PGE1 or PGE2), intravenous injection of oxytocin, mechanical device for cervical ripening, artificial rupture of the membrane etc. However, some severe complications happened during the period of labor in the past years. We have to learn and try our best to avoid the obstetrical complications if following the standard protocol. In this talk, we will show the methods and all complications regarding the labor induction.

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Uterine rupture in non-scar uterus during pregnancy

Rupture of the pregnant uterus can be life-threatening for the mother and fetus. Most ruptures occur in women who have had a previous transmyometrial surgical incision. Rupture of the unscarred uterus is rare, but is associated with higher major maternal and neonatal morbidity than cases of rupture of the scarred uterus. Uterine rupture can lead to multiple adverse and interrelated maternal outcomes, including sequelae of severe hemorrhage, bladder laceration, hysterectomy, and death. Perinatal complications include death or serious morbidity from prolonged intrauterine hypoxia.

Rupture of an unscarred uterus may be caused by trauma or congenital or acquired weakness of the myometrium. Risk factors for rupture of the unscarred uterus include exposure to uterotonic drugs, high parity, uterine anomalies, dystocia, macrosomia, and multiple gestation. The clinical presentation of rupture can vary depending on the uterine site and the type of analgesia, so a high index of suspicion is needed. Uterine ruptures in unscarred uteri could happen antepartum, intrapartum or postpartum, but most cases were detected during intrapartum. Common clinical presentations are fetal heart rate changes, loss of station, vaginal bleeding, abdominal pain, cessation of contractions and hemodynamic changes. Once uterine rupture is diagnosed, prompt delivery is mandatory. To repair or remove the ruptured uterus is decided according to clinical conditions. In this talk, I will be discussing about the clinical manifestations, diagnosis and management of uterine rupture in non-scar uterus in pregnancy.

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Uterine rupture in uterus with previous laparoscopic myomectomy during pregnancy

Background

The incidence of uterine rupture through a previous cesarean scar (CS) is declining as a result of a lower parity and fewer options for vaginal birth after cesarean. However, uterine ruptures attributable to other causes that traumatize the myometrium are on the rise.

Material s& methods

To determine whether changes in the causes of uterine rupture had occurred in recent years, we retrospective retrieved the clinical records of all singletons with uterine rupture observed in the delivery room of a Taiwanese tertiary obstetric center over a 15-year period.

Results

The overall uterine rupture rate was 3.8 per 10,000 deliveries. A total of 22 cases in 20 women (with two of them experiencing two episodes). Seven uterine ruptures occurred through a previous cesarean scar (CS ruptures, 32%), 13 through a non-cesarean scar (non-CS ruptures, 59%), whereas the remaining two (9%) were in women who did not previously undergo any surgery. All of the 13 non-CS ruptures were identified in women with a history of laparoscopic procedures to the uterus. Specifically, 10 (76%) occurred after a previous laparoscopic myomectomy, one (8%) following a hysteroscopic myomectomy, and two (16%) after a laparoscopic wedge resection of cornual ectopic pregnancy. Severe bleeding (blood loss >1500 mL) requiring transfusions was more frequent in women who experienced non-CS compared with CS ruptures (10 versus 1 case, respectively, $P = 0.024$).

Conclusion

Patients with a history of endoscopic uterine surgery should be aware of uterine rupture during pregnancy.

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Diagnosis and management of uterine rupture during pregnancy

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Rupture of the gravid uterus, defined as complete disruption of all uterine layers during pregnancy, is a rare incidence but can lead to catastrophic maternal and fetal consequences. The incidence was previously reported at around 0.8 to 5.3 per 10,000 births in literature. However, the incidence gradually increased over the recent decades, which may be associated with the increased trend of advanced maternal age, increasing numbers of transmyometrial surgeries prior to conception as well as a higher rate of induction or augmentation with prostaglandin or oxytocin. The complications could be severe, including maternal hemorrhage, blood transfusion, hysterectomy, bladder injury, and maternal death, as well as the fetal prematurity, lower Apgar scores, and deaths. The poorer outcomes could result from the delayed identification and management because of the unexpectedness and rareness.

The risk factors of uterine ruptures included advanced maternal age, overdue pregnancy, macrosomia, shorter interval of deliveries, single-layer uterine closure, repeated cesarean section, and trial of labor after cesarean section, as well as laparoscopic or abdominal myomectomy or adenomyomectomy. However, there were reports of rupture in unscarred gravid uteri. The risk factors may be associated with the weakness of the myometrium due to trauma, congenital anomaly, or multiple gestation and the use of uterotonic agents. Nevertheless, none of these risk factors of scarred or unscarred uterine rupture was clinically reliable to predict individual risk of antepartum or intrapartum uterine rupture. Although, there was no clinical reliable prediction or prevention of uterine rupture, doctors' awareness and timely management could decrease maternal and neonatal morbidity.