Worcestershire Acute Hospitals NHS Trust

Induction of Labour - Previous Caesarean VBAC with Foley Catheter

This guidance does not override the individual responsibility of health professionals to make appropriate decision according to the circumstances of the individual patient in consultation with the patient and /or carer. Health care professionals must be prepared to justify any deviation from this guidance.

Introduction

To provide clinical guidance for women undergoing induction of labour who have previously had a caesarean section.

This guideline is for use by the following staff groups :

Medical and midwifery staff

Lead Clinician(s)

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Approved by Maternity Governance on:	20th September 2019

Key amendments to this guideline

Date	Amendment	Approved by:
20th Sept 19	New document approved	Maternity Governance

Introduction

It is recognised that women who have had a previous Caesarean section are at increased risk of uterine rupture – approximately 1/200. This increases when prostaglandins are used. Mechanical methods such as amniotomy or if this is inappropriate; use of a Foley catheter are safe alternatives in this situation and may reduce the risk of hyperstimulation..

Prostaglandin use is associated with 8.7/1000 risk of rupture.
Cervical ripening with Foleys is associated with a 2.9/1000 risk of rupture

Equipment Required

Instruments required:
• Tray with sterile pack and Sims speculum and aqueous gel.
• Foleys catheter (>12 Fr in size- this can hold 30 mls of saline) -pack contains 10ml saline syringe
• Bowl with 30 mls of saline.
• 50 mls syringe.
• Mepore or other similar tape.

Preparation:

• The woman will be admitted as usual to Delivery Suite on a pre-planned day into a side room initially before transfer to the main ward.

• After assessment by the midwife and the obstetrician- verbal informed consent is obtained for the procedure.

• CTG for 30 mins.

• The woman will be placed in a lithotomy position - consider use of entonox for anxious women.

• A senior registrar/consultant can perform this procedure. (For junior medical staff who are not familiar or not confident the consultant will use the opportunity to teach them).

• Sterile Cusco's speculum is used to visualise the cervix and the Foleys catheter is held with a sponge holding forceps and inserted into the cervix. The distance of insertion should not more than 3 cms so that the balloon part of the catheter is in the cervical canal.(Avoid holding the sponge holder over the balloon end of the catheter-hold at the tip of the catheter).

• Inflate with 30mls of normal saline.

• Tape the Foleys to mother's thigh.

• There is no indication for a CTG after the procedure unless there are clinical reasons such as additional risks like IUGR or the woman is contracting.

Post-insertion of balloon management

• After 4 hours of observation the woman can be moved to the ante/postnatal ward.
• There is no further CTG monitoring required unless labour has commenced and/or rupture of membranes.

• Once spontaneous rupture of membranes has occurred return to delivery suite and treat as usual induction undergoing SROM and assess for oxytocin requirement

• If the balloon is expelled then transfer to delivery suite for ARM.

• All women will return to Delivery Suite after 24 hours for reassessment and for ARM if suitable.

• If cervix is not favourable for an ARM- counsel for a caesarean section as failed induction.

Important Points:

• If the Balloon is expelled it is generally due to the cervix dilated to greater than 3-4 cms and indicates that ARM will be possible. Decision for timing of ARM should be based on clinical safety grounds-maternal/fetal and Delivery Suite status.

• If there is spontaneous rupture of membranes and the balloon is in situ –remove the balloon and reassess the woman to consider oxytocin (there is a risk of infection with SROM and the balloon is in situ).

• If the cervix is uneffaced, a trial of oxytocin can be considered. There is no role for prostaglandins after insertion of a balloon if the cervix is not effaced

The balloon is not associated with uterine hyperstimulation so if it occurs consider possibility of uterine rupture or labour.

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References

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