HOW WILL LABOR BE DIFFERENT IF I CHOOSE LABOR INDUCTION AT 39 WEEKS?

Recently, the American College of Obstetricians and Gynecologists stated that it is reasonable to offer induction at 39 weeks to women with low-risk pregnancies who are sure of their due dates.[1] Induction at 39 weeks does not result in better outcomes for the baby, but it may slightly reduce the risk for cesarean surgery (although some health care providers disagree with this). If you choose induction at 39 weeks, your experience of labor and birth will be different than if you let labor begin on its own. This chart explains the differences. It is based on the most common labor induction method of using IV synthetic oxytocin (known as Pitocin in the U.S. and in Canada) to induce labor and assumes that your pregnancy is considered low-risk.

INDUCED LABOR AT 39 WEEKS	LABOR BEGINS ON ITS OWN
CERVICAL RIPENING	
Usually some time during the 38th week of pregnancy, your health care provider should do a vaginal exam and evaluate the readiness of your cervix for birth using the "Bishop Score." If your modified Bishop Score is less than 5, indicating that your cervix is not ready for labor, you will undergo "cervical ripening" in conjunction with or followed by IV administration of synthetic oxytocin.[1,2] Cervical ripening will be one of the first procedures done after you have been admitted to the hospital for induction or sometimes it is done the day or evening before your scheduled induction. Medications or devices may be used to "ripen" your cervix so that it will stretch (dilate) for labor.	In the weeks and days before labor starts on its own, your cervix will gradually soften, thin, and may begin to open (dilate). In addition to cervical ripening, hormones (catecholamines) are released in the weeks or days before labor begins to prepare the fetal lungs for air breathing.[3,4]
IV FLUIDS	
Yes. You will have IV fluids, including IV synthetic oxytocin (Pitocin).	No. You will be encouraged to drink fluids to meet hydration and caloric needs.[5]
FETAL MONITORING	
You will have continuous electronic fetal monitoring.[6] The monitors can be external (2 belts) or internal.	The baby's heart beat can be monitored intermittently with a hand-held device[5] – usually every 15 to 30 minutes during active labor and every 15 minutes in 2nd stage before pushing and every 5 minutes during pushing.[7]
MOBILITY/AMBULATION DURING LABOR	
Most laboring women who are induced with IV synthetic oxytocin stay in bed or stand or sit right next to the bed. A few women walk with portable monitoring devices called telemetry.	You are free to move around, choosing the positions most comfortable for you, and walking if you wish.[5]
LABOR CONTRACTION PAIN/PAIN MANAGEMENT	
Your contractions may peak sooner and feel more intense than spontaneous labor contractions. You are more likely to ask for epidural analgesia.[8]	You can try nonpharmacologic comfort measures such as a warm bath or shower.[5] (Note: Epidural analgesia requires IV fluids and continuous fetal monitoring.)
NEED FOR URINARY CATHETER	
If you have epidural analgesia, you may have problems urinating.[9] You may need to be catheterized to empty your bladder.	Problems with urinating are associated with epidural analgesia.
LENGTH OF LABOR	
Your labor may be longer than if labor had begun on its own. Health care providers are encouraged to allow up to 24 hours or more for the latent phase of labor and to administer Pitocin for at least 12-18 hours after membrane rupture before calling the induction a failure (and recommending cesarean surgery).[10]	The latent phase of labor can be prolonged (> than 20 hours in first-time mothers). However, you are encouraged to stay at home for most of this time, only going to the hospital when labor becomes "active" at about 6 cm.[5,10]

References and information on sharing this handout on back.

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