5 INTRAPARTUM CARE

5.1 INDUCTION OF LABOUR

Date Issued: July 2008
Date Revised: February 2010
Review Date: February 2013
Authorised by: OGCCU
Review Team: OGCCU

5.1.4 TRANSCERVICAL FOLEY CATHETER

This guideline should be used in conjunction with Clinical Guideline Section B 5.1 Induction of Labour

AIM

To provide a non pharmacological method of induction of labour in situations where birth is indicated but not urgent, and the Bishop's score is less than 7 with an unfavourable cervix.

BACKGROUND INFORMATION

The use of the transcervical Foley's catheter for cervical ripening has been shown to be an efficient, safe, cost effective, reversible method to induce labour, and is associated with a low incidence of uterine contractile abnormalities.[1] An additional benefit is that it provides an option for cervical ripening when there are contraindications to pharmacological agents.[2] Balloon catheter use has been shown to improve Bishop's scores and decrease the interval until birth.[3]

The lower risk for hypertonus when compared to prostaglandins may result in lower risk for uterine rupture in women who have had a previous caesarean section. Therefore, the use of the Foley catheter may provide a safer option for women requiring cervical ripening for vaginal birth after caesarean birth (VBAC).[1]

A recent randomised trial found that ripening an unfavourable cervix in primiparous women with a Foley's catheter with the balloon inflated with 80mL rather than 30 mL, provided a more effective dilatation, faster labour, and a decreased need for oxytocin. This did not apply to the multiparous women and using the larger inflated balloon may increase the risk for cord prolapse in this group.[4]

PRIOR TO INSERTION OF THE TRANSCERVICAL FOLEY CATHETER

1. See Clinical Guideline Section B 5.1 Induction of labour for preparation prior to commencing all types of IOL.
2. Encourage the woman to empty her bladder.
3. Perform an abdominal palpation to confirm presentation.
4. Perform a 20 minute cardiotocograph (CTG) to assess fetal well-being.
5. Place the woman in the lithotomy position for the procedure.

EQUIPMENT

- Bi-valve Cuscoe speculum
- 16 gauge Foley catheter (30mL sized balloon) and spigot
- Sponge forceps
- Sterile water
- Syringe – 10ml or 20 ml
- Lubricating gel
- Tape

INSERTING THE TRANSCERVICAL FOLEY CATHETER

1. Cleanse the vulvo-vaginal area.
2. Insert the speculum. Visualise the cervix.
3. Pass the Foley catheter through the internal os of the cervix using the sponge forceps to assist.[1]
4. Inflate the balloon with 50 mL sterile water.
5. Spigot the catheter.
6. Gently withdraw the catheter until it rests at the level of the internal os.[1]
7. Tape the catheter to the inner aspect of the woman's thigh.[1]
8. Assess fetal heart rate after the procedure. Monitor the woman as required. See Clinical Guidelines Section B 5.6 Intrapartum Fetal Heart Rate Monitoring

INDICATIONS FOR REMOVAL OF THE FOLEY'S CATHETER

1. Uterine hyperstimulation or hypertonic uterine contractions
2. Fetal distress
3. Maternal request

MANAGEMENT AFTER INSERTION

1. Women with an **uncomplicated** pregnancy will be considered suitable for transfer to an obstetric ward if, after 1 hour post-insertion of the Foley catheter, both the maternal and fetal observations are normal. The midwifery staff can make this decision.
2. Midwifery staff shall perform a vaginal examination 12 hours post insertion, and again at 18 hours, to ensure the catheter balloon is not sitting in the vagina. The catheter may remain in situ for 18-24 hours before medical review for removal, ARM or prostaglandins.
3. The woman shall be transferred back to the Labour and Birth Suite in the event that they require prostaglandins.
4. If at any time the woman has spontaneous rupture of membranes or is experiencing contractions, she must be transferred to Labour and Birth Suite.
5. If the catheter falls out prior to 12 hours post insertion, perform a vaginal examination. If the cervix is favourable, the woman will be transferred to the Labour and Birth Suite at 12 hours. If the cervix is still unfavourable, discuss the situation with the medical staff with a view to transferring her to Labour and Birth Suite for prostaglandins.
6. The woman may remain on the obstetric ward until medical review.

OBSERVATIONS

Fetal Observations

- 4 hourly fetal heart rate (FHR) and movements, including overnight (only when awake)
- Notify the Medical Officer of any fetal heart rate abnormalities. A CTG should be commenced if any abnormality is identified on intermittent auscultation.

Maternal Observations

- 4 hourly uterine activity, vaginal loss, pulse and blood pressure, including overnight (Only when awake)
- Assess and record any maternal systemic effects e.g. nausea and vomiting.

REFERENCES

1. Gelber S, Sciscione A. Mechanical Methods of Cervical Ripening and Labor Induction. **Clinical Obstetrics and Gynecology**. 2006;49(3):642-57.
2. Idrisa A, Kyari O, Kawuwa MB, et al. Preparation for induction of labour with an unfavourable cervix using a Foley's catheter. **Journal of Obstetrics and Gynecology**. 2007;27(2):157-8.
3. Sanchez-Ramos L. Induction of labor. **Obstetric and Gynecological Clinics of North America**. 2005;32(2):181-200.
4. Levy R, Kanengiser B, Furman B, et al. A randomized trial comparing a 30-mL and an 80-mL Foley catheter balloon for preinduction cervical ripening. **American Journal of Obstetrics and Gynecology**. 2004;191:1632-6.