Induction of Labor FAQ

This FAQ covers common questions about OBI's new induction of labor (IOL) initiative. For other topics or site-specific concerns, contact the OBI Coordinating Center.

Balloons

Which brands/sizes of Foley or other balloon catheters do you recommend for cervical ripening, especially those with larger volumes (e.g., 60ml)?
Foley balloons are less expensive and have more supporting data. However, Foley and Cook balloons are equally effective for induction.

Is it appropriate or recommended to use a Foley balloon in patients with ruptured membranes?
Use of a Foley balloon for cervical ripening in the setting of ruptured membranes does not increase the chance of vaginal birth, but does increase the risk of chorioamnionitis. Use is not recommended.

Does the method of balloon placement (traction, tug and tape, or indwelling) affect efficacy or safety?
Adding traction to an intracervical Foley catheter during cervical ripening does not decrease time to delivery, but does decrease time to balloon expulsion. Therefore, some variation in the placement method is reasonable based on site resources and patient desires. (Schoen et al., 2022)

Medications & Ripening Agents

What are the pros and cons of misoprostol (oral, buccal, vaginal) versus Cervidil for induction?
There is data that cervidil (i.e., dinoprostone) does not work as well as misoprostol. Dinoprostone is significantly more expensive, and data indicate that it is strongly associated with inductions lasting more than 36 hours. If multiple prostaglandins are available on the unit, the recommendation is to use misoprostol.

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Is misoprostol or a Foley balloon contraindicated in fetal growth restriction or other fetal concerns?
These are not contraindications; however, misoprostol may be avoided based on clinical judgement (e.g., decelerations, abnormal Dopplers). Oxytocin can be used for dual agent ripening if the half-life of the pharmacologic method is important in the context of considerations around fetal well-being or reduced placental/fetal reserve.

Should oxytocin be titrated or held constant when combined with balloon?
Pitocin should be titrated, as per usual unit policy, when used with a balloon catheter. A cervical balloon alone is not an indication to hold the oxytocin rate constant.

What does the evidence say about balloon plus misoprostol vs. balloon plus pitocin?
Misoprostol should be used until there are more than 3 painful contractions in 10 minutes, at which point Pitocin should be used instead of misoprostol. Misoprostol plus balloon appears to be the optimal combination based on network meta-analysis.

What does the evidence say about Foley balloon use in patients with GBS?
In a secondary analysis of a large randomized trial using a standardized labor protocol (Bromwich et al., 2023), there was no increased risk of infection with Foley balloon use in patients with group B streptococcus. This study suggests that a Foley balloon can be safely used for cervical ripening in patients with group B streptococcus colonization.

Assessment & Monitoring

How important are Bishop scores when assessing progress and deciding next steps in management during induced labor?
Bishop scores do not need to be recalculated during an induction. Management based on cervical dilation and contraction frequency (e.g., algorithmic decision points) is reasonable.

Can we take breaks during an induction?
An induction is a medical procedure; once an induction is initiated, there should be very few periods of inaction. Long breaks lengthen overall induction duration, which is associated with complications and harm (e.g., infection, hemorrhage) and can hamper a patient's birth experience.

Is frequent vaginal examination necessary, or does it increase infection risk?
Frequent exams have some benefits in observational studies, because they allow for timely management decisions — for example, determining when an amniotomy should be performed. When inductions are actively managed, a patient may receive more frequent examinations but fewer total examinations due to a shorter overall time in labor. The length of the induction (e.g., 12 hours vs. 48 hours) is more likely to be the driver for infection, rather than the frequency of exams.

Who should perform the membrane sweep and when—before admission or after induction starts?
Membrane sweep can be performed, with patient consent, by a trained clinician conducting a vaginal exam. Ideally, a membrane sweep should be performed before admission (e.g., during a prenatal visit), but it can also be done upon admission if it has not yet been done and is clinically appropriate and feasible. In a meta-analysis, membrane sweep added to formal induction significantly increased vaginal delivery rates, especially in nulliparas, compared with formal induction alone (Liu et al., 2018).

Amniotomy & Fetal Position

When and how should amniotomy (AROM) be performed with asynclitic, high, or malpositioned heads or polyhydramnios?
Amniotomy should be performed if deemed safe by the provider. It is feasible in the majority of birthing people by 4 cm or soon after balloon ripening. Providers may consider using a fetal scalp electrode (FSE) wire or performing amniotomy in an operating room in the setting of significant polyhydramnios, though experience and resources at a site may guide these practices. If there is an initial assessment that the presenting part is not in a position deemed safe for amniotomy by the provider, this assessment should be repeated in 1-2 hours to not lose the benefit of early amniotomy when it is feasible and safe.

Is there a risk of infection with early amniotomy, especially in GBS-positive patients?
Early amniotomy does not increase the risk of chorioamnionitis or NICU admission (De Vivo et al., 2019).
Appropriate antibiotics should be given in the setting of Group B Strep (GBS).

Patient Experience & Communication

How can clinicians balance evidence-based protocols with patient preferences for minimal intervention?
Counseling, ideally prenatally, in the office, where patients have time to learn about what an induction entails, is recommended—especially if they are considering an elective induction. A shared decision-making process that elicits an individual patient's preferences, values, and goals, and offers adequate, accurate, and understandable information about the induction process supports individualized decision-making. This approach helps patients understand what evidence-based induction procedures involve and, in the case of elective induction, whether this procedure aligns with their goals for the experience of their labor and birth outcome.

Is there patient education or written material for induction protocols and expected interventions?
Yes! OBI has created a handout for patients that explains what induction of labor is, the potential benefits and risks, what to expect during the induction process, and how to prepare.

Find this tool and explore the entire Induction of Labor (IOL) toolkit on OBI's website.

Has patient satisfaction, mental health, or pain experience during labor induction been studied?
These are understudied areas of induction of labor. However, studies show that both pain control and "quick" inductions seem important for patient satisfaction. Proactive communication and shared decision-making during induction are likely to improve patient satisfaction. To further characterize the patient experience of induction, OBI has included specific questions about induction in our Patient Voices survey.

How much should we fill the Foley balloon?
Some studies suggest the benefit of filling the balloon with up to 60cc of liquid. However, even 30cc appears to be beneficial, and clinicians can follow their institutional policies.

What is the protocol for prolonged induction (e.g., >3 days) and the criteria for moving to cesarean?
Inductions lasting >48 hours should be very rare when evidence-based practices are used. There is no protocol in this setting; shared decision-making on risks of ongoing oxytocin versus cesarean should be discussed with the patient after attempts at cervical ripening and rupture of membranes have been attempted.

Literature, Data, and Practice Variation

Where can clinicians find supporting literature and evidence for recommended protocols?
Supporting literature and evidence for recommended protocols can be found in OBI's Evidence-Based Induction of Labor Clinical Practice Guide. This practical resource helps clinicians implement evidence-based techniques proven to shorten induction time and improve clinical outcomes for mothers and infants.

Find this tool and explore the entire Induction of Labor (IOL) toolkit on OBI's website.

Will OBI provide EHR templates for induction of labor?

OBI has created Induction of Labor EHR templates, including SmartPhrase and order set examples, to support standardized documentation of induction of labor in the electronic health record (EHR).

You can find this tool and explore the entire Induction of Labor (IOL) toolkit on OBI's website.