

Retrospective analysis of use of vaginal Misoprostol for Induction of Labour in a tertiary care institute in India.

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INTRODUCTION

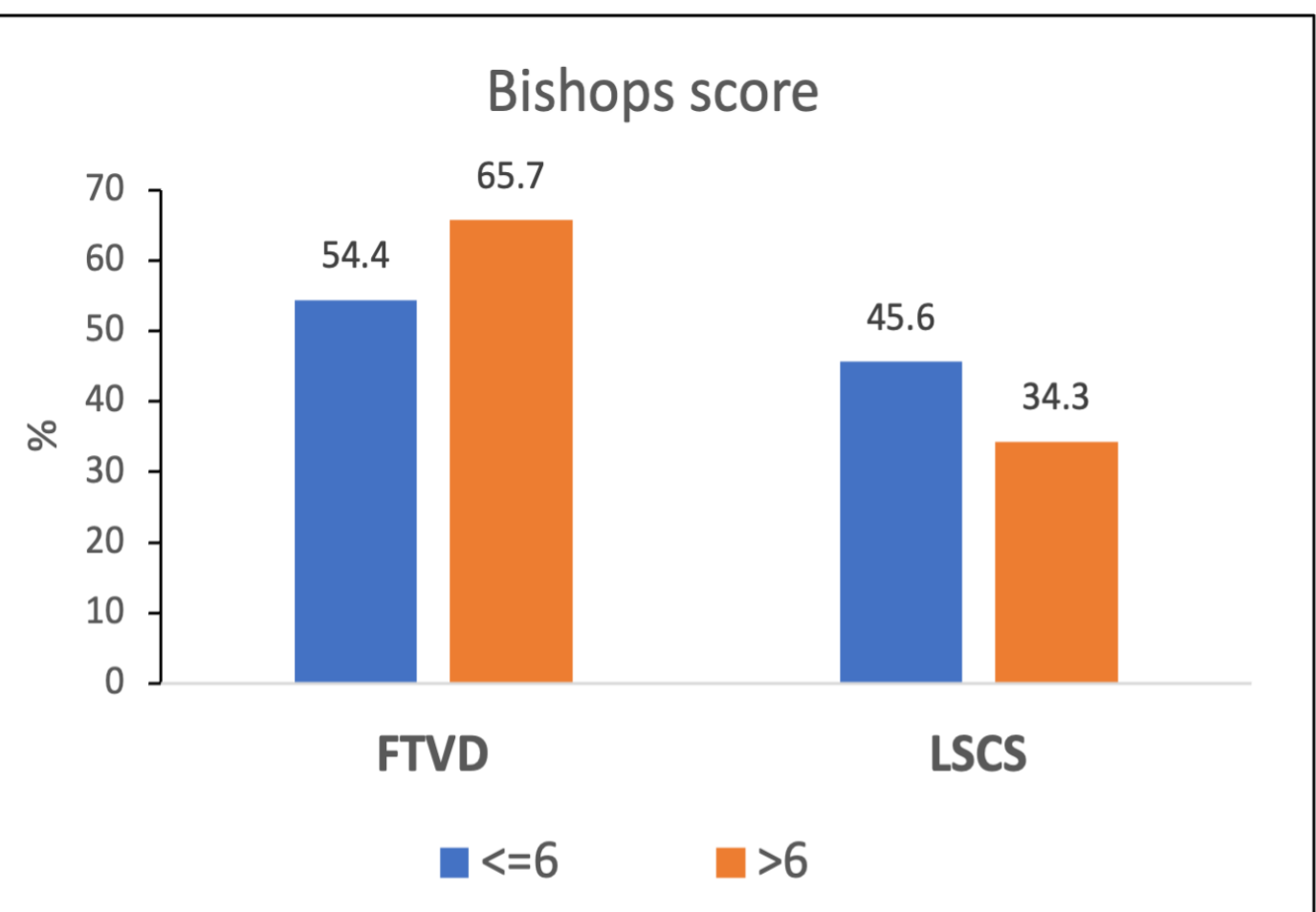
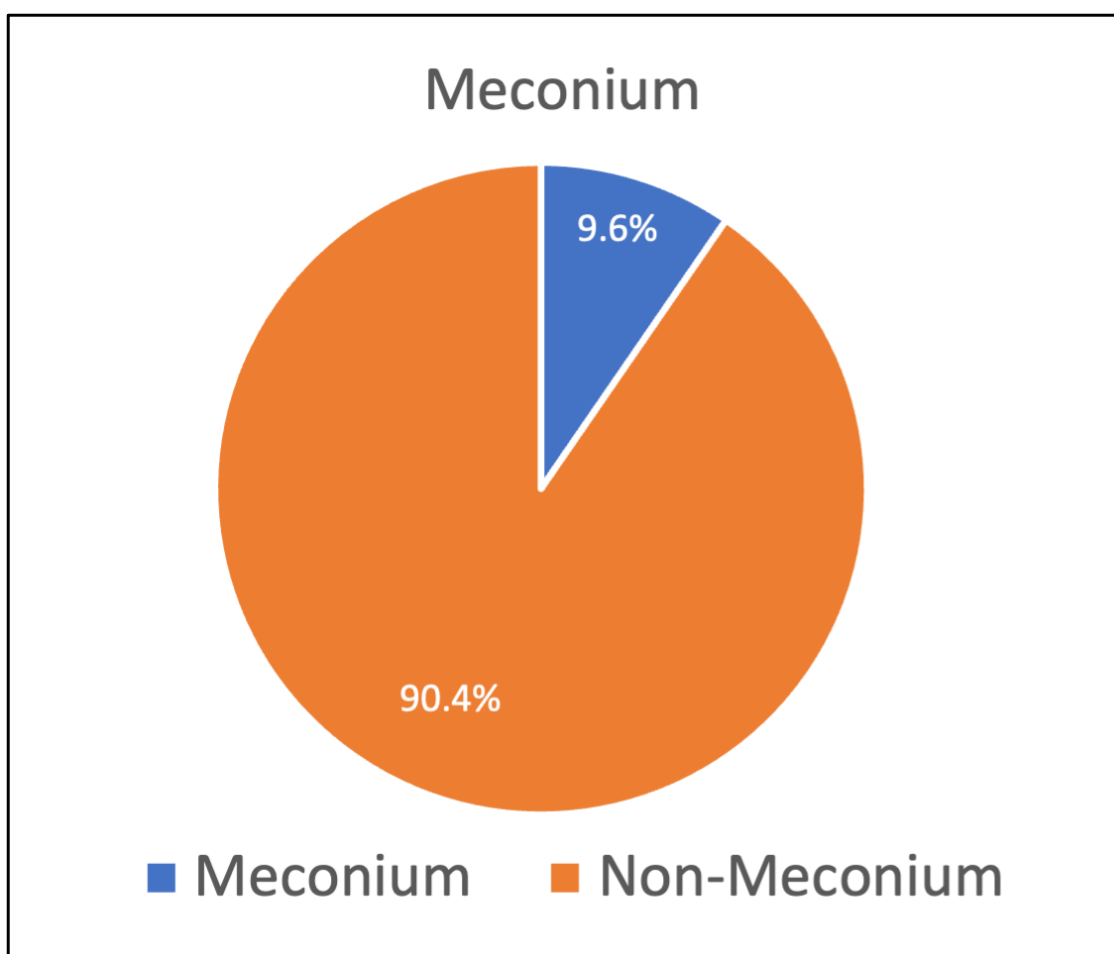
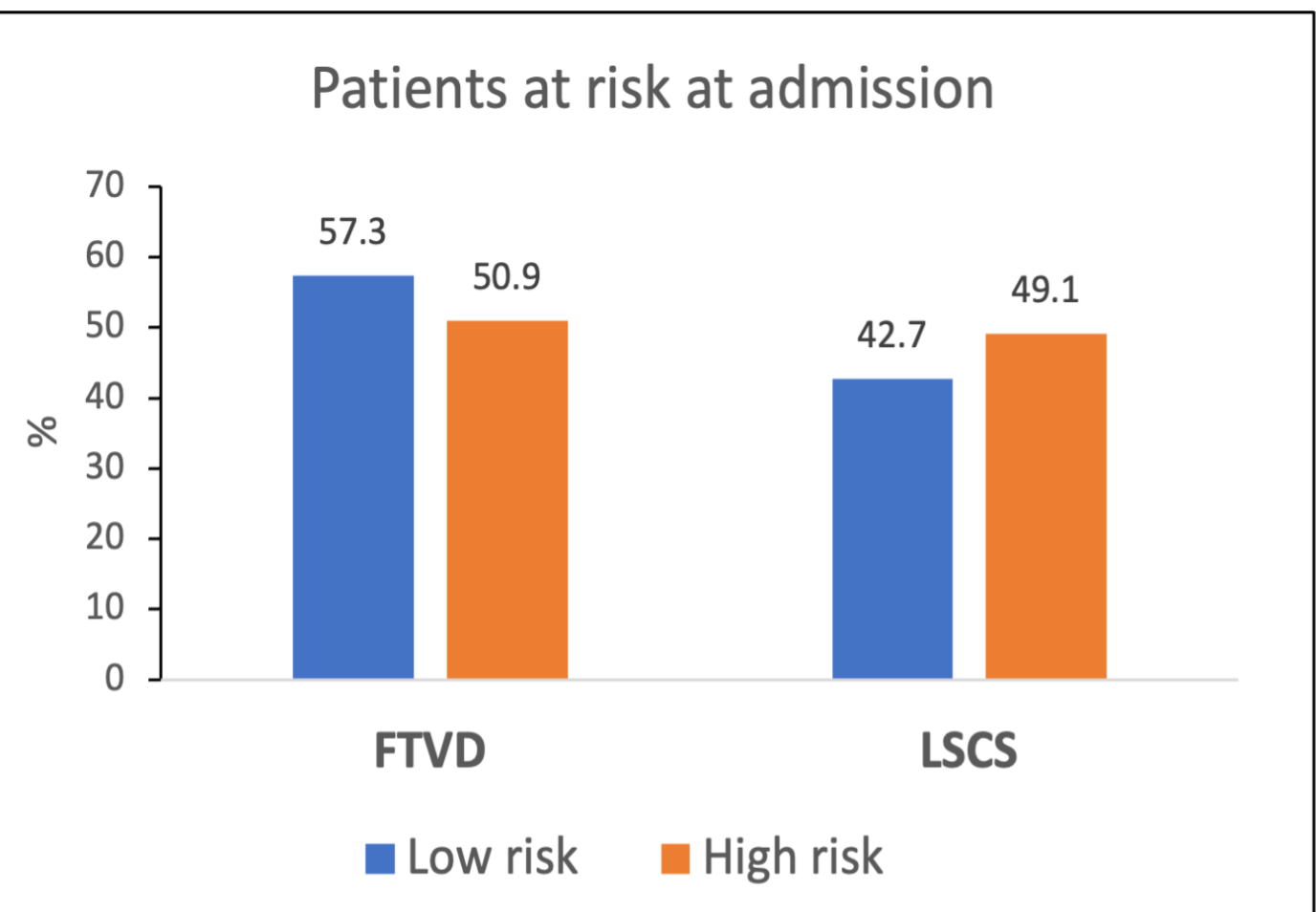
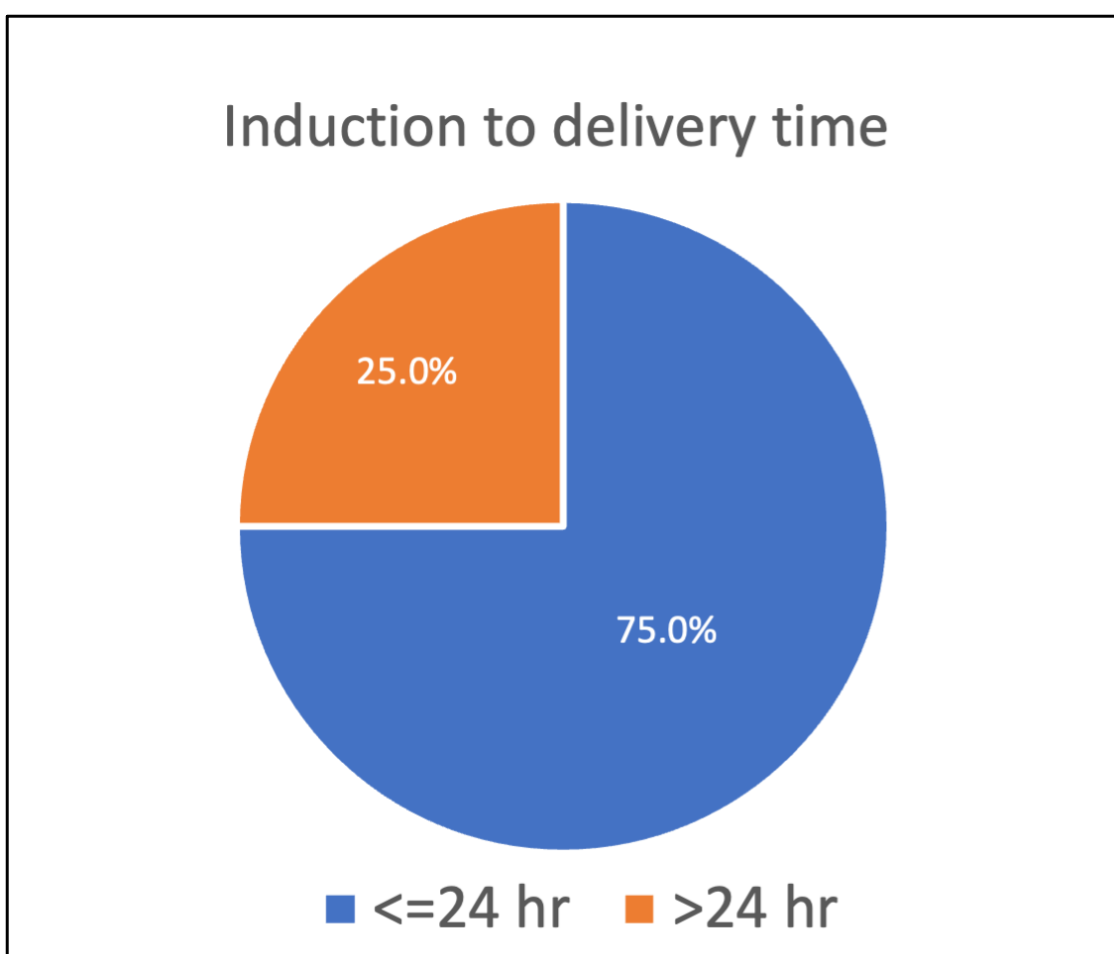
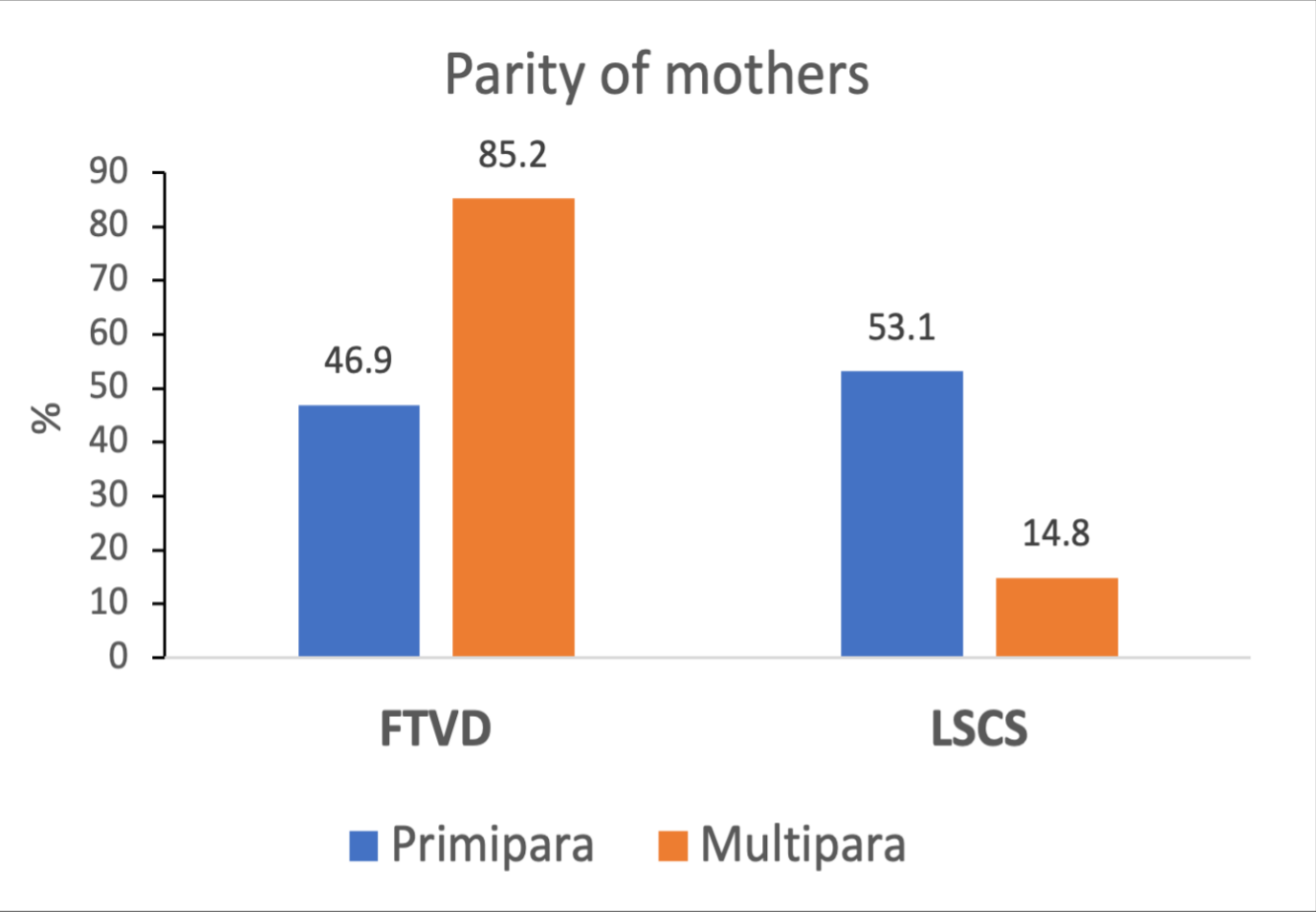
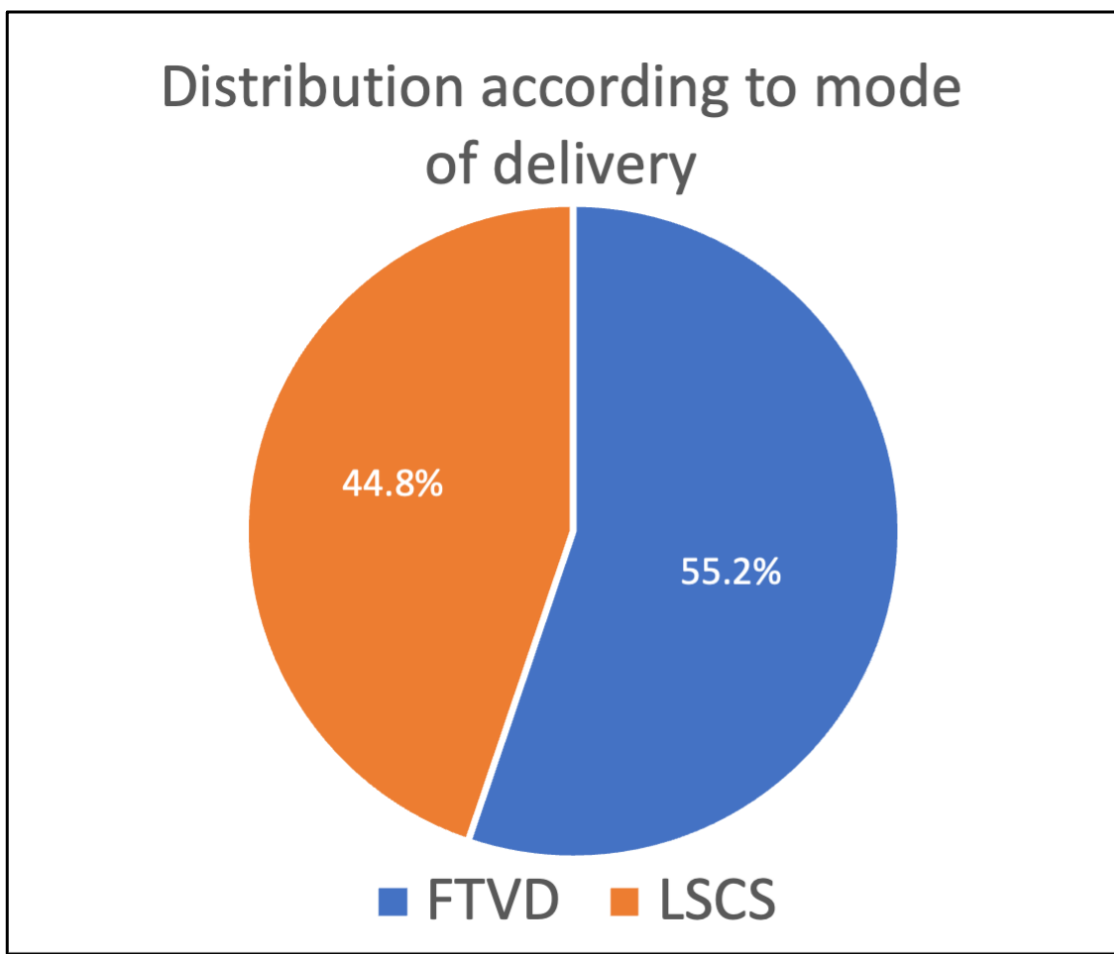
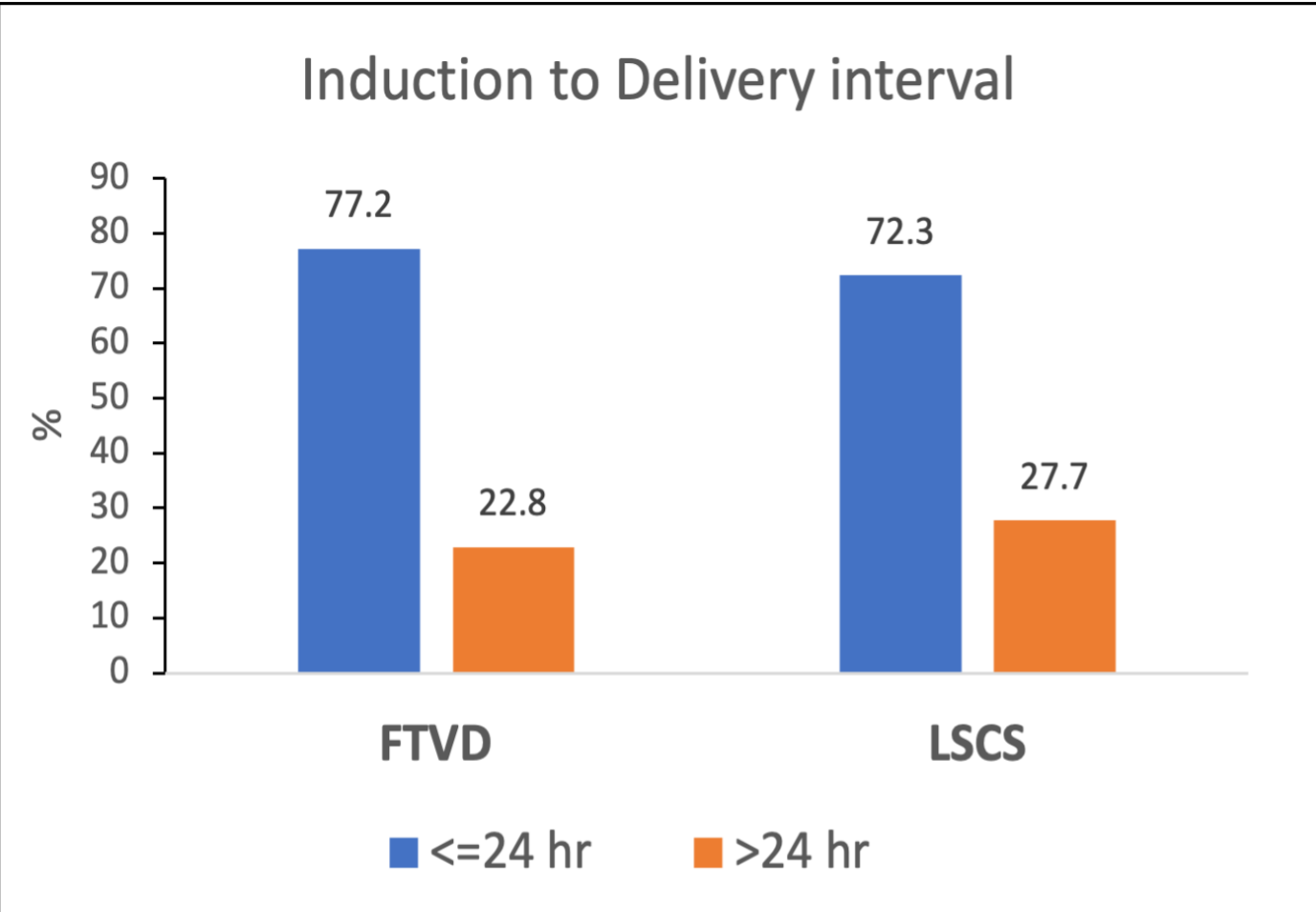
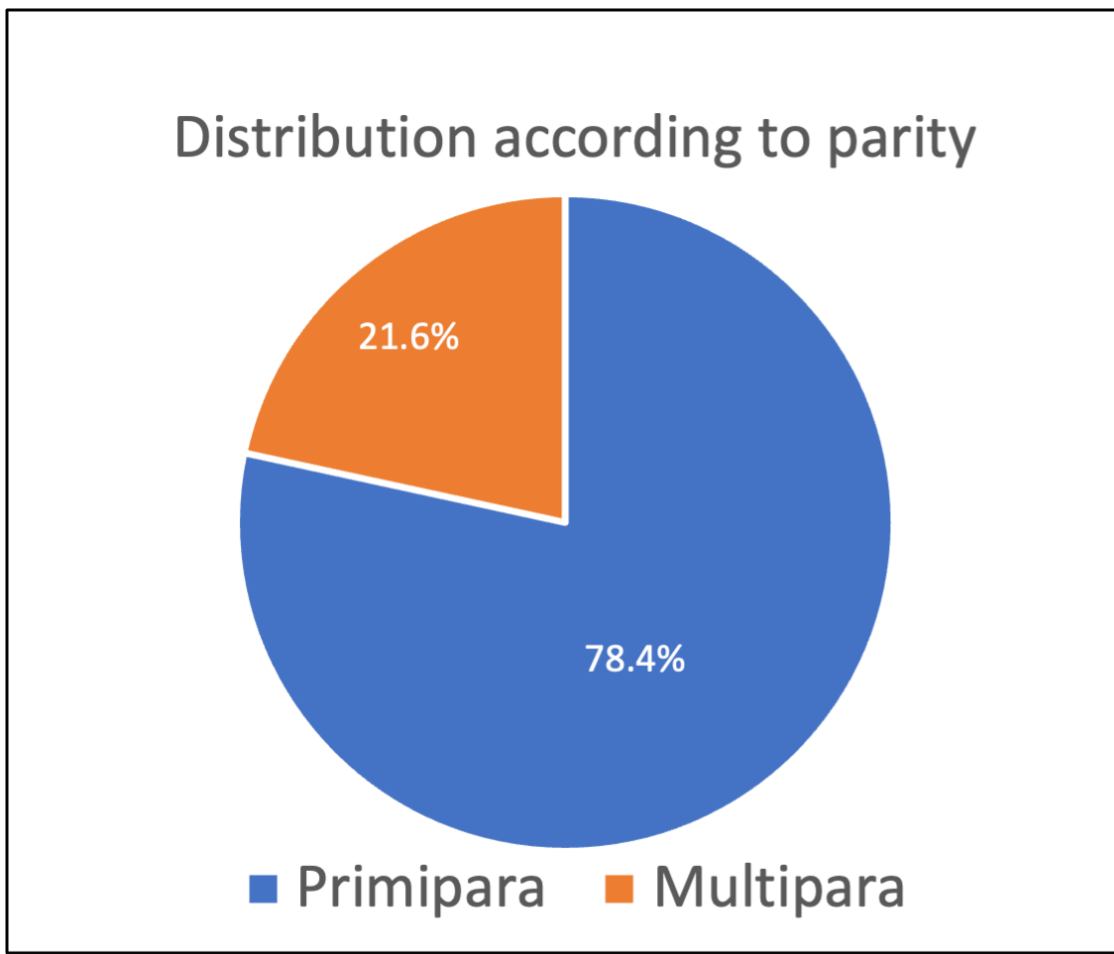
Induction of labour is the most commonly performed obstetric intervention. Prevalence of induction of labour is reported from 10 to 25%. It is increasing in recent times due to various factors including lifestyle. Various methods for induction of labour are described in literature and practiced widely across the world including PGE2 gel, and oral or vaginal Misoprostol (PGE1), mechanical methods and membrane sweeping. Misoprostol is a safe, effective, cheap induction agent which is stable at room temperature and therefore important in day-to-day obstetric practice. We hereby present a retrospective study of 500 cases of induction of labour using low-dose vaginal Misoprostol 25 mcg 4 hourly in a tertiary healthcare institute in India in urban population.

AIMS AND OBJECTIVES

To determine the safety and efficacy of use of low dose vaginal Misoprostol 25 mcg for induction of labour.

MATERIALS AND METHODS

A retrospective analysis of 500 cases of Induction of labour with vaginal Misoprostol 25 mcg 4 hourly administered, upto maximum 6 doses. All women who required induction of labour were studied including those with high risk factors like GDM, PIH, FGR. The induction to delivery interval, percentage of women requiring caesarean section, incidence of fetal distress, meconium staining and failure of induction was studied.



DISCUSSION

The overall incidence of vaginal delivery in women who underwent induction of labour was 55.2%. In low-risk patients, the incidence was 57.3% and in high-risk patients, it was 50.9%. Among primiparas (392), rate of vaginal delivery was 46.9% (184) whereas among the multipara (108), it was 85.2% (92). Rate of vaginal delivery was 54.4% (253) even in women with Bishop score</=6. Thus, use of vaginal Misoprostol for induction of labour is suitable even in cases with unfavourable Bishop score. Induction to delivery interval was </=24 hours in 75% cases. Incidence of Meconium staining of amniotic fluid was seen in 9.6% cases (48). Of all the cesarean sections, LSCS for suspected fetal compromise was performed in 54.9% (123) cases. The use of vaginal Misoprostol resulted in fewer cases of failed inductions of 2% (10). Thus, vaginal Misoprostol for induction of labour is effective in achieving vaginal births, reducing the induction to delivery time with very few cases of failed inductions. It is cheap, easy to administer, stable at room temperature, so no need for freezing. Vaginal Misoprostol has an additional advantage that it can be removed in case there is hyperstimulation after administration.

CONCLUSION

Low dose vaginal Misoprostol 25 mcg 4 hourly can be considered as a good option for induction of labour in low resource countries considering low costs and ease of administration, promising success rate and very few cases of failure of induction. Induction to delivery interval of less than 24 hours was observed in 75% cases thus reducing the costs and burden on resources. A larger multi-centre study may be needed to confirm the results.

REFERENCES

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