Induction of Labour and Management of Term Pre-Labour Rupture of Membranes guideline (GL861)

Approval

<table>
<thead>
<tr>
<th>Approval Group</th>
<th>Job Title, Chair of Committee</th>
<th>Date</th>
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<tbody>
<tr>
<td>Maternity &amp; Children’s Services Clinical Governance Committee</td>
<td>Chair, Maternity Clinical Governance Committee</td>
<td>6th December 2019</td>
</tr>
</tbody>
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Change History

<table>
<thead>
<tr>
<th>Version</th>
<th>Date</th>
<th>Author, job title</th>
<th>Reason</th>
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<tbody>
<tr>
<td>4.3</td>
<td>Aug 2019</td>
<td>C Harding (Consultant MW)</td>
<td>CTG criteria expanded to state 1 hourly maternal / FH obs if CTG Normal</td>
</tr>
<tr>
<td>5.0</td>
<td>Nov 2019</td>
<td>Dr Alex Novak, ST3 O&amp;G C Harding (Consultant MW)</td>
<td>Overhaul of guidelines to include new procedure for cervical ripening balloon to be used</td>
</tr>
</tbody>
</table>

To be read in conjunction with:

- Diabetes in pregnancy GL983
- Hypertension in pregnancy GL952
- Planning place of birth GL887

Author: A Novak, C Harding, Date: December 2019
Job Title: ST3 O&G, Consultant Midwife, Review Date: December 2021
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1. INDUCTION OF LABOUR GUIDELINE

1.1 Introduction
Induction of labour is indicated for either pregnancy complications or prolonged pregnancy. See NICE guidance CG190/CG70 for further information.

1.2 Indications:
See Appendix 3 for RBFT IOL indications and priority.

- Post-maturity (40+12)
- Maternal age >=40 at conception (T) (C)
- Diabetes (see Diabetes in pregnancy GL983)
- Hypertension/Pre-eclampsia (see Hypertension in pregnancy GL952)
- Fetal growth restriction (with consultant agreement only)
- Intrauterine fetal death (see Intrauterine death GL862)

1.3 Contra-indications:
- Breech presentation
- Severe fetal growth restriction with confirmed fetal compromise

1.4 Process of Induction of Labour – see IOL pathway flowchart (Appendix 1)

- Inductions of labour will be booked by community midwives or in ANC.
- Induction of labour will be commenced on the IOL suite, level 4.
- The IOL midwife will co-ordinate the workload on the IOL suite, inviting women into hospital when a bed is available, 24 hours a day. She will instigate communication with women waiting at home by telephone, keeping them up to date with the situation on the IOL suite and Delivery Suite/Birth Centre.
- On arrival women will be assessed by the IOL midwife, to include:
  - Discussion about process, what to expect and obtain consent
  - Confirmation of dates and indication for IOL
  - Abdominal palpation and ultrasound scan to confirm cephalic presentation
  - 20 minute CTG
  - Baseline observations (HR, RR, BP, temperature, urinalysis) and MOWS score
  - VE to assess the cervix and calculate the Bishop score and determine method of IOL
1.5 Methods of Induction of Labour

1.5.1 Cervical ripening balloon

- Induction of labour using a cervical ripening balloon is undertaken on the IOL suite. It is a silicone double balloon catheter. The maximum balloon inflation is 80ml/balloon which should be filled with saline.
- The CRB is designed to gradually dilate the cervix and facilitate induction of labour by providing gentle and constant pressure at the level of the cervix at both the external and internal os.
- Exclusions:
  - Any contraindication to vaginal birth (placenta previa, vasa previa, Breech etc),
  - Ruptured membranes
  - Unstable presenting part which is not in the pelvis
- The balloon should be inserted by relevant trained staff on the IOL suite or delivery suite.
- Encourage women to pass urine prior to insertion.
- Once inserted monitor bladder function. If unable to pass urine every 3-4 hours remove 10-20ml from the vaginal balloon.
♦ Undertake maternal observations and CTG twice daily, more frequently if necessary depending on reason for induction of labour
♦ Inform women that they may feel some abdominal discomfort 2-3 hours following insertion of the CRB and offer simple analgesia
♦ CRB should remain in for 12 hours before removal and assessment for ARM + oxytocin. If labour ward is busy it may remain in situ for a maximum of 24 hours.
♦ There must be good communication between the induction midwife and delivery suite coordinator to ensure patient flow through the service is optimised
♦ ARM may be carried out on the IOL suite prior to transfer to delivery suite provided a midwife is available for labour care
♦ Oxytocin should be commenced ideally within 2 hours of ARM. However this should be discussed with and agreed by the woman.
♦ If contractions start within the first two hours following ARM assess suitability for care on the midwife led unit
♦ If the presenting part is high after balloon removed encourage to walk around for 60 minutes before ARM. If the presenting part remains unstable refer to a senior obstetrician for advice before undertaking ARM
♦ CRB should not be used in conjunction with prostaglandins.
♦ If SROM occurs the balloon should be removed
♦ If the balloon falls out reassure the woman that this means it has been effective and arrange ARM and transfer
♦ All women to have inpatient IOL with cooks balloon during introductory period.
♦ Please see Appendix 4 for insertion guide

1.5.2 PROPESS
♦ Should be second line option for induction of labour only where induction with CRB is contraindicated, or staff have been unable to insert balloon.
♦ Controlled release form of Dinoprostone (10mg), with an attached tape, given as a single dose lasting 24 hours
♦ May be given to patients with a uterine scar, provided the head is engaged in the pelvis. (A management plan should be written in the notes)
♦ Should not be given where contractions are already present or in the presence of an abnormal CTG.
♦ Is inserted into the posterior fornix and rotated into a transverse position. The fingers should be removed carefully so that the tape unravels towards
the vulva. Most of the tape should be placed in the lower part of the vagina, to prevent the woman accidentally pulling the propess out.

- The woman should remain lying down for at least 30 minutes following insertion.
- Observations while propess is in situ: 4 hourly HR, BP, temp, RR and auscultation of fetal heart
- Further vaginal assessment is necessary only if the woman is contracting 3-4:10 or the membranes rupture
- Once contractions begin, a CTG should be performed for fetal wellbeing and 1 Hourly maternal observations / FH if initial CTG Normal.
- If pain is experienced and opioid analgesia is requested this should prompt the midwife to commence a CTG
- Remove propess if there are regular contractions and the cervix if >3cm dilated
- If SROM is confirmed, the propess may remain in-situ unless in established labour or 24 hours has lapsed
- If not removed before, the propess should be removed after 24 hours.

- Hyperstimulation
  - >5 uterine contractions in 10 minutes accompanied by FHR abnormalities
  - If the hyperstimulation does not settle despite removing the propess, refer to duty obstetrician for administration of Terbutaline 0.25mg subcutaneously.

- Tachysystole
  - >5 uterine contractions in 10 minutes with no FHR abnormalities
  - Pessary should not be removed. CTG should be observed and continued

- If the pessary falls out
  - If it is in the bed or the woman’s pants, reinsert the same pessary as soon as possible
  - If the pessary falls down the toilet/floor, insert a new pessary as soon as possible
  - The 24 hours is still calculated from the time the first propess is inserted

- 2nd propess
  - If unsuitable for ARM on removal of the 1st propess, a second propess may be inserted after discussion with medical staff
  - Patients with a uterine scar are not suitable for a second propess
• **Propess Induction as an outpatient**
  - Women who meet the following criteria should be encouraged to have outpatient IOL:
    - 37 completed weeks of pregnancy
    - Low risk
    - Singleton pregnancy
    - No SROM
    - Cephalic presentation and non-ballotable head
    - Unscarred uterus
    - The women must understand the information leaflet and be able to follow the instructions/advice (‘Information for women who are given Propess for Induction of Labour’)
    - The woman must have a responsible adult who can stay at home with her
    - The woman must be happy to go home and have transport to return
  - Reasons to return prior to the arranged date and time:
    - Starts contracting
    - SROM
    - Liquor changes colour (meconium/bleeding)
    - Decreased fetal movements
    - Feels unwell
    - Raised temperature/flu-like symptoms
    - Worried for any reason
    - Propess falls out

1.5.3 **PROSTIN**
  - Dinoprostone 1mg
  - May be used where there has been failure to induce a woman after 1 or 2 propess has been given.
  - May be used by the midwife (reference Prostin PGD100) to induce labour at 18-24hrs following PROM
  - The patient must be discussed with a consultant before administration (exception: term PROM low risk)
  - The applicator is inserted into the posterior fornix and the gel released, taking care not to insert any gel into the cervical canal
Monitor the fetus with a CTG continuously for 1 hour following insertion or longer if necessary.
Repeat CTG when contractions begin

1.5.4 AMNIOTOMY

- To be performed where Bishop score >6 at the beginning of the induction or in situations in which it is deemed possible to undertake ARM
- To be performed after removal of CRB or propess
- May be performed on the IOL suite, after discussion with the DS co-ordinator
- The patient will need to be moved to Delivery Suite in a timely manner in order that oxytocin is commenced within 2 hours if not in established labour.

Women who go into labour after CRB, 1 Propess and/or Amniotomy may labour on Rushey MLU if they otherwise remain low risk. A CTG must be undertaken as part of a full assessment prior to transferring to the MLU for labour care.

Women with GBS should be prescribed IV antibiotics at the start of their induction and these should be administered when ARM (SROM) occurs.

1.6 Patients declining IOL at 42 weeks (or 40 weeks for women > 40 years at conception)

- Counsel the women about the risks and benefits of declining IOL, so she is able to make an informed decision
- Ensure that there:
  - Is no medical or obstetric reason for delivery
  - Are adequate fetal movements
  - Is no IUGR and normal liquor volume (USS for growth and LV)
  - Is a reassuring CTG
- If the above are normal, arrange for the woman to have:
  - Twice weekly liquor volume
  - Alternate day CTG’s
  - Weekly ANC appointments
- Delivery should be strongly advised if there are any non-reassuring changes in fetal movements, CTG traces or a reduction in liquor volume
2. PRE-LABOUR RUPTURE OF MEMBRANES: AUGMENTATION OF LABOUR

2.1 Introduction

In patients with confirmed term (>=37 weeks) pre-labour rupture of membranes, labour is induced with the aim of minimising fetal and maternal infection, while maximising the normal delivery rates.

2.2 Process

- Women with suspected SROM should be seen in the unit and the following assessment carried out:
  - Maternal observations (BP, RR, HR, temp) and MOWS score
  - Abdominal palpation for presentation and determining how many fifths of the presenting part are palpable
  - Auscultation of fetal heart rate in low risk mothers
  - 20 minute CTG for consultant care patients or any patient where there is concern for fetal or maternal wellbeing
  - If obvious PROM (i.e. liquor is seen), offer VE to assess the cervix using the modified Bishop’s score and exclude cord/limb presentation
  - If no liquor seen, perform a sterile speculum examination to confirm SROM and exclude cord or limb prolapse
  - If no liquor seen on speculum, perform an AmniSure test to confirm SROM
  - Follow up with a sterile vaginal examination to assess the cervix if PROM diagnosed

- Women should be given the leaflet ‘Pre-labour Rupture of Membranes’

- The aim is for the baby to be born within 48 hours following SROM (at term)

- Women should be offered expectant management for 18-24 hours following SROM or the choice of proceeding with the induction ASAP.

- Women undergoing expectant management may wait at home. They should be advised to return if:
  - Liquor becomes meconium stained
  - Contractions become regular and painful
  - Maternal pyrexia (37.2)
  - Change in fetal movements

- Discuss with doctor (ST3 or above) and aim to augment the labour ASAP in women with:
• Meconium
• Known GBS carriers
• Pyrexia

Start antibiotics in patients with pyrexia/ >48 hours post-ROM:

• Oral (not in labour)
  ▪ Amoxicillin 1g 8 hourly for 7 days or until in established labour.
  ▪ Azithromycin 500mg 24 hourly for 7 days or until in established labour for women with penicillin allergy

• Intravenous (in labour)
  ▪ Benzylpenicillin 3g stat dose followed by 1.5g 4 hourly until delivered

• IV teicoplanin 10mg/kg STAT dose and then 10mg/kg every 12hours until delivered if penicillin allergy. If GBS positive commence IV antibiotics when SROM diagnosed and advise immediate augmentation.

• If the cervix is unfavourable (suggested BS ≤ 6), consider administration of Propess or Prostin gel following discussion with an obstetrician. Arrange this via the IOL suite or DAU.

• If Propess has been inserted, commence Oxytocin 24 hours later

• If Prostin has been inserted, commence Oxytocin 6-8 hours later

• When SROM is confirmed, the woman’s details (including phone number) must be recorded on the appropriate board on delivery suite and the DS coordinator made aware.

• She should be encouraged to phone delivery suite to arrange a suitable time to be admitted this will usually be between 18 and 24 hours after SROM.

3. References

3.1 NICE guidance CG70 https://www.nice.org.uk/guidance/cg70, July 2008

3.2 NICE guidance CG190 https://www.nice.org.uk/guidance/cg190, Dec 2014 updated Feb 2017
Appendix 1: Flowchart

**INDUCTION OF LABOUR PATHWAY: Nov 2019**

- Planned/Community ANC
- Induction Booking
  - Comm to women re admission
  - Admit to IDL Suite
    - Clinical assessment – IDL, MW decide 1st Intervention: ARM or CRB
    - Unsuitable for CRB
      - Proceed as outpatient or inpatient as appropriate
      - Return to IDL suite in labour/Rehabe triage
    - CRB
      - Remain on IDL Suite
        - 12-24 hours following CRB insertion: Remove balloon, ARM, and transfer to DS
        - Clinical assessment by IDL, MW – if suitable for ARM, transfer to DS, if further proceed to arrange for obstetric review
        - Contraction start within 2 hours of ARM
          - Labour onset
          - Delivery Suite
        - If not able to transfer to DS by 24 hours, remove balloon and transfer as soon as possible
        - If not able to ARM, raise with obstetrician for plan
    - MW inserts CRB
      - Paracetamol and codeine prescribed: Routine care
- Unplanned/emergency/PROM
  - Patient info re: Induction
  - Diary booking: Access from ANC/Comm/IDL/MW
    - Criteria for admission: vacant bed on IDL suite Priority: PROM/medical indicators – 1:1 care required – admit to DS
    - MW POD – patients/Patientata for low risk women (push dates, PROM, CRB) – IDL booked by obstetrician
      - All other women – decision for IDL to be made by obstetrician and then refer to POD
    - Partner to be able to stay birthing aid comfort wife for women
  - PROM – Assess for PEB 18-24 hr – if at first assessment Bishop score < 6 (6-8hrs transfer to DS for oxytocin)
Appendix 2: PGD Inclusion and Exclusion Criteria for Midwifery prescribing of Prostin and Propess

Pregnancy equal to or greater than 38 weeks gestation

Indications for IOL where a midwife can administer Propess include:

- Post-dates pregnancies**
- Immediate induction for term pre-labour rupture of membranes**
- Reduced fetal movements
- Gestational diabetes/diabetes
- Pregnancy Induced Hypertension and/or PET
- Reduced liquor volume

Obstetric Cholestasis *In the presence of the following clinical findings:*

- Normal maternal observations
- Engaged, Cephalic presentation.
- Normal CTG prior to administration.
- Unfavourable cervix with a Bishop’s score <8 and intact membranes (except PROM indication).
- Not in labour.
- Absence of uterine scar

**Decision for induction for these indications can be made by a midwife. Decision for IOL for all other indications has to be made by an Obstetrician.

IOL for any other indication not listed above, Propess has to be prescribed by an Obstetrician

The following situations must be discussed with an obstetrician before propess is prescribed and administered

- Previous Caesarean Section
- Regular contractions
- Preterm pregnancy
- Unengaged cephalic presentation
### Appendix 3 RBFT Tool to inform induction of labour decision

<table>
<thead>
<tr>
<th>CLINICAL CONDITION</th>
<th>RECOMMENDED GESTATION OF IOL (WEEKS)</th>
<th>PRIORITY LEVEL</th>
</tr>
</thead>
<tbody>
<tr>
<td>POST DATES</td>
<td>40+12</td>
<td>1</td>
</tr>
<tr>
<td>PRE-EXISTING DIABETES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Type 1 or 2</td>
<td>37+0 to 38+6</td>
<td>1</td>
</tr>
<tr>
<td>GDM LOW RISK</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diet/Metformin/Insulin</td>
<td>40+3 - 40 + 6</td>
<td>2</td>
</tr>
<tr>
<td>• Stable blood glucose (most readings in target)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Normal amniotic fluid volume and normal growth</td>
<td></td>
<td></td>
</tr>
<tr>
<td>GDM POSSIBLE COMPLICATIONS</td>
<td></td>
<td></td>
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<tr>
<td>• Macrosomia (AC &gt;95&lt;sup&gt;th&lt;/sup&gt; centile and/or EFW &gt;95&lt;sup&gt;th&lt;/sup&gt; centile at 36 weeks accelerated growth from previous scans) (also consider CS)</td>
<td>37-40</td>
<td>2</td>
</tr>
<tr>
<td>• Increased risk shoulder dystocia (previous shoulder dystocia or short maternal stature) (also consider CS)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Fetal Growth Restriction - arrange through SGA clinic</td>
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<tr>
<td>MATERNAL AGE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 40 years old or more at booking</td>
<td>40</td>
<td>2</td>
</tr>
<tr>
<td>IUGR/SGA</td>
<td>Individual at request of consultant obstetrician</td>
<td>1</td>
</tr>
<tr>
<td>Including low CPR/Raised Dopplers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual recommendation for IOL on delivery suite should be made by fetal medicine consultant / associate specialist only</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PET (ONLY IF INPATIENT)</td>
<td>Consultant decision</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Diagnosed at &lt;37+0 weeks - induce as soon possible after diagnosis (usually within 48 hours)</td>
<td>1</td>
</tr>
<tr>
<td>Indication</td>
<td>Timing</td>
<td>ICU Needs</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>--------------</td>
<td>-----------</td>
</tr>
<tr>
<td><strong>HYPERTENSION</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(non-proteinuric and normal bloods)</td>
<td>40 – 40+6</td>
<td>2</td>
</tr>
<tr>
<td>Not requiring admission</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>RAISED PCR (≥ 30)</strong></td>
<td>40 – 40+6</td>
<td>2</td>
</tr>
<tr>
<td><strong>RAISED PCR (≥ 30) with hypertension/PET symptoms</strong></td>
<td>39-40+6</td>
<td>2</td>
</tr>
<tr>
<td><strong>OBSTETRIC CHOLESTASIS</strong></td>
<td></td>
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<tr>
<td>(irrelevant of treatment):</td>
<td>37+0 – 39+6</td>
<td>2</td>
</tr>
<tr>
<td>Bile acids &gt; 100 (AT ANY STAGE)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>PATIENTS ON FULL THERAPEUTIC ANTICOAGULATION IF MDT RECOMMENDS NOT SPONT LABOUR</strong></td>
<td>39</td>
<td>1</td>
</tr>
<tr>
<td>After discontinuing LMWH for 24 hours – to avoid repeated episodes of missing anticoagulation</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>APH (ONLY IF INPATIENT)</strong></td>
<td>Individualise</td>
<td>1</td>
</tr>
<tr>
<td><strong>↓PAPP-A / ↑AFP WITH ASSOCIATED SGA/IUGR</strong></td>
<td>39 – 39+6</td>
<td>2</td>
</tr>
<tr>
<td><strong>PREVIOUS TRAUMATIC BIRTH</strong></td>
<td>≥38+3 weeks</td>
<td></td>
</tr>
<tr>
<td><strong>SEVERE ANXIETY</strong></td>
<td>Booked through consultant midwife clinic / ANC following discussion with consultant obstetrician</td>
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<tr>
<td><strong>MENTAL HEALTH</strong></td>
<td>≥38+3 weeks</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Booked ONLY through joint perinatal mental health clinic, or consultant mw clinic after discussion with PMH practitioner and consultant obstetrician</td>
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</table>

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**Date:** December 2019  
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**Review Date:** December 2021  
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*This document is valid only on date last printed*
Appendix 4: Cook ® balloon insertion

- Induction of labour first line will be using a cervical ripening balloon catheter (CRB) undertaken at RBFT using a Cook ® balloon.

- It is a silicone double balloon catheter with maximum inflation of 80ml per balloon.

- Advantages of balloon is that it safely ripens and dilates the cervix without any pharmaceutical involvement (prostaglandins). This should mean that there is a reduction in hyperstimulation and safe to use in IUGR/SGA babies.

- Steps of insertion:
  
  o Perform a VE. Insert 2 fingers into the vagina. Using the other hand advance the catheter through the cervix such that both balloons pass through the cervical canal.

  o Inflating the first balloon into the catheter valve U (uterus) with 40mls of sterile saline. Once inflated pull the device back until the inflated balloon reaches the internal os.
<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>o Once the other balloon is outside the external os</td>
<td>inflate</td>
</tr>
<tr>
<td></td>
<td>the vaginal</td>
</tr>
<tr>
<td></td>
<td>balloon</td>
</tr>
<tr>
<td></td>
<td>catheter</td>
</tr>
<tr>
<td></td>
<td>(marked V)</td>
</tr>
<tr>
<td></td>
<td>with a further</td>
</tr>
<tr>
<td></td>
<td>of saline</td>
</tr>
<tr>
<td>o Once happy that the balloons are sited on either side of the</td>
<td>fill with</td>
</tr>
<tr>
<td>cervix slowly fill with saline in 20ml increments to a maximum of</td>
<td>saline</td>
</tr>
<tr>
<td>80ml per balloon.</td>
<td></td>
</tr>
<tr>
<td>o The catheter can hang loosely.</td>
<td></td>
</tr>
</tbody>
</table>

♦ As an alternative the procedure can be done with speculum by placing the lady in the correct position or lithotomy, inserting the speculum to visualise the cervix. Passing the cervical ripening balloon through the cervix with sponge forceps (or using the stylet) and follow the above steps.

♦ If using the stylet then ensure the distal tip of the stylet is in line with the distal tip of the balloon catheter. Then tighten it so the wire cannot move and place the light blue handle into the blue port labelled S. Once you have transversed the internal os remove the stylet before advancing the catheter any further.

♦ Once both balloons have been inflated with the first amount (40mls of saline in the uterine balloon and 20mls in the vaginal balloon) remove the speculum.

♦ Explain to the woman that she may experience some abdominal discomfort approximately 2-3 hours after insertion and offer codeine and paracetamol.

♦ If more severe discomfort is experienced remove up to 20mls of saline from the balloons. If this does not relieve the discomfort discuss whether the woman would prefer the balloon to be removed.

♦ If unable to pass urine remove up to 20mls of saline from the uterine balloon and ensure bladder function resumes.