PROTOCOL FOR INDUCTION OF LABOUR (IOL)

Contents

General principles

- Offer and perform **membrane sweeping ("stretch and sweep", or artificial separation of membranes)** at the 39–40-week visit in all women for whom a spontaneous vaginal delivery is anticipated, provided there are no contraindications; and repeat this weekly if labour does not start spontaneously.[1]
- **All inductions of labour in viable babies must start with an intra-cervical catheter bulb, irrespective of Bishop score, unless explicitly contraindicated:**[1]
    - Evidence from RCTs and meta-analyses shows mechanical methods have equivalent efficacy to prostaglandins but a better safety profile.
    - Mechanical methods are slower than PGEs in achieving vaginal birth within 24 hours, but outcomes are equivalent at 36 and 48 hours.
    - Safety advantages of mechanical methods include reduced risk of uterine hyperstimulation and fetal compromise.
    - Resource benefits: Mechanical methods reduce need for repeated CTGs and vaginal examinations during cervical ripening.
    - Cost and time savings: Lower monitoring requirements translate into healthcare budget efficiencies.
    - Suitability for outpatient care: Mechanical methods are appropriate for home cervical ripening
- In women newly diagnosed with HIV, or non-compliant on ARVs- start ARVs as soon as possible, and postpone the IOL until viral suppression is achieved (about 4 weeks[2]) if possible
- Complete the **Induction of Labour Safety Checklist** *before* commencing any induction.
- **All elective IOLs must be discussed with a consultant**, who must sign the form or give documented telephonic consent.
- The **indication for IOL must be sufficiently compelling to proceed to caesarean section** should the induction fail.
- **IOL for maternal request or convenience is not appropriate in our resource-constrained setting**
- **Before initiating induction of labour (IOL), review labour ward bed availability and staffing capacity. Discuss and prioritise (triage) cases in consultation with the responsible consultant and the nursing team.**

Contra- indications for labour induction

Any condition precluding safe vaginal delivery, including:

- Malpresentation (e.g. transverse lie, footling breech)
- Cord presentation
- Contracted or abnormal pelvis
- Active genital herpes
- Major placenta praevia

- Suspected large baby (EFW >4.5 kg in women without diabetes, >4.0 kg in women with diabetes; clinical judgement preferred)
- Previous **major uterine surgery** (e.g. classical caesarean section)

Pre-Induction Assessment

- Full maternal assessment
- Abdominal examination (lie, presentation, EFW, engagement)
- Baseline vaginal examination (Bishop score for documentation)
- **10-minute CTG** if fetus viable
- Completion of IOL Safety Checklist including consultant approval

1. Elective (planned, non-urgent) IOL in a Viable Pregnancy Without Previous Uterine Surgery (Singleton or Multiple pregnancy)

1.1 Bishop Score <8, or cervix clinically unfavourable

- Ensure pre-induction CTG is normal
- Obtain informed (verbal) consent and explain the procedure
- Insert one Foley catheter trans-cervically (see detailed technique below)
- Inflate balloon with 30–60 mL sterile fluid
- May be further managed as inpatient or outpatient depending on risk profile
- Further CTG monitoring not required unless contractions develop; or otherwise clinically indicated
- Leave the catheter in situ until it expels, or for up to 24 hours
- Do maternal observations as per ward protocol (if inpatient)

1.2 Once bulb expels, or after 24 hours of a single bulb

- If not in active labour, proceed to three-bulb technique for another 24 hours (see technique below)
- Consider initiating antibiotic prophylaxis.

1.3 If Cervix Clinically Favourable (or Bishop ≥8)

- Proceed directly to three-bulb technique for 24-48 hours (see technique below)
- If not in active labour after 48 hours, perform **AROM**, if not contraindicated

- If contractions inadequate after 1-2 hour of AROM→ commence oxytocin

Detailed technique of single bulb insertion:

Option A: Speculum-guided insertion

- Position the patient in lithotomy.
- Cleanse the vagina thoroughly using antiseptic solution (Chlorhexidine gluconate in water).
- Visualize the cervix using a Sim's speculum.
- If necessary, stabilize the anterior lip of the cervix with a swab-holding forceps.
- Grasp the sterile Foley catheter 4–8 cm from the tip using a swab-holding forceps.
- Gently pass the catheter through the cervical canal into the extra-amniotic space.
- Advance until the balloon is judged to be fully above the internal os.
- Maintain catheter position while an assistant inflates the balloon with sterile fluid (usually 30–60 ml).
- Tape the catheter to the thigh for convenience during patient movement
    - Avoid adding traction (weighted or taped to thigh) to an intracervical Foley catheter during cervical ripening as this does not decrease time to delivery.

Option B: Blind digital insertion

- May be performed without a speculum **by a clinician experienced in bulb placement**.
- Seems to be less painful compared with placement with the use of a speculum
- Evidence suggests non-inferiority in terms of infection risk
- Both placement methods seem to be associated with similar efficacy

Duration and Antibiotic Use

- Maximum duration of catheter placement: up to 48 hours.
- If catheter remains in situ beyond 24 hours, consider initiating antibiotic prophylaxis in high-risk women:
    - Immunocompromised (e.g. women living with HIV with unsuppressed viral load or low CD4)
    - Concurrent infection, e.g. urinary tract infection, STIs (trichomoniasis, chlamydia, gonorrhoea, syphilis), or bacterial vaginosis
    - Foley balloon is safe for cervical ripening in women with GBS colonization, provided routine intrapartum prophylaxis is given[3]

Documentation

- Time of insertion
- Number of catheters placed
- Volume of balloon inflation
- Bishop score

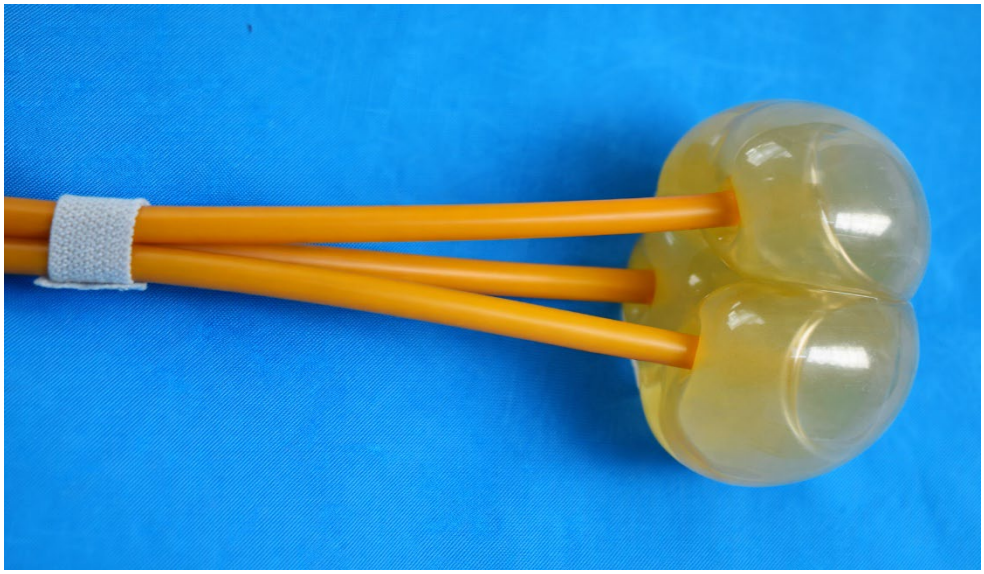
- Method of insertion
- Traction method
- Any complications or re-insertion events

This mechanical induction method is NOT the recommended method for:

- Patient with overt lower genital tract infection
- Patients with ruptured membranes

Three-Balloon Technique[4,5]

- Speculum-guided insertion
- Insert two or three Foley catheters side-by-side through the cervical canal
- This increases effective cervical dilation without displacing the presenting part.
- Balloons positioned in the extra-amniotic space above the internal os
- Inflate each balloon symmetrically (typically 30–60 mL each)
- **Tape catheters together** to maintain alignment and prevent displacement (see picture)
- Then tape the catheters to the inner thigh for convenience



1.4 Artificial rupture of membranes / amniotomy (AROM)

- This should only be done if there are no contra-indications; AND a normal CTG
- This is a clean procedure (clean hands, sterile gloves, clean the perineum with tap water)
- Can be done in Women Living with HIV if compliant on TLD for at least the last 4 weeks and/or with a recent (within the last 4 weeks) lower than detectable viral load
- Rupture of membranes should be followed by a clinical examination 1-2 hours hour later

- If not adequate contractions by then (three contractions of at least 40s per 10 min), prescribe oxytocin
- Do not routinely prescribe oxytocin at the time of AROM, as it may then be administered before a clinical assessment was done

Contra- indications for AROM in these circumstances

- Women Living with HIV (If viral load unknown or any detectable viral load)
- Breech
- IUFD (except if acute abruption suspected)
- Unengaged presenting part (except in controlled AROM with severe polyhydramnios)
- Preterm fetus (Gestational age <35w0d)- discuss with consultant

1.5 Pharmacological / medical methods

When to use:

- If bulb induction is unsuccessful, contra-indicated or difficult to place
- If IOL is urgent (e.g. for eclampsia)- use extra-amniotic Foley catheter (as above) PLUS one of the options below
  - Women induced with misoprostol–cervical Foley combination are nearly twice as likely to deliver earlier than those given misoprostol or Foley alone, with more deliveries achieved by 12 and 24 hours[6]

1.6 Prostaglandins

Prostaglandins E_1 (misoprostol) for IOL is contra-indicated in women with a scarred uterus (previous CS or open myomectomy). See 2.0 for dinoprostone use in carefully selected TOLAC patients.

Dinoprostone (PGE_2) has less uterotonic activity than misoprostol (PGE_1) but is significantly more expensive. Misoprostol (PGE_1) remains the prostaglandin of choice for most medical induction of labour indications.

Dinoprostone (PGE_2) may be considered **preferentially (instead of misoprostol; when PG is considered), in women with**

- Parity 5 or more
- Fetal growth restriction and/or abnormal Doppler studies (if CS not advised by fetal medicine team)
  - In small fetuses (SGA or late fetal growth restriction) , mechanical induction of labour is still associated with fewer composite adverse intrapartum outcomes, including lower rates of operative vaginal delivery, caesarean for non-reassuring fetal status, uterine tachysystole, or non-reassuring CTG patterns; when compared to dinoprostone or misoprostol.[7]

Dinoprostone dose

- Available preparations:
  - Prandin E_2 Gel 1mg/3g
- Assemble the syringe as shown in packaging.
  - Insert 1 mg into the posterior vaginal fornix; speculum not needed.
  - Repeat every 6hrs x2 (not exceeding 3mg in total; or three insertions in total).
    - Patient to remain supine for 30 minutes after insertion.
    - Do a CTG for 60 minutes after each dose

Misoprostol dose

Misoprostol (oral solution of 25µg 2-hourly x 24 hours)

Oral Solution

- Add a single 200 microgram tablet of misoprostol to a bottle of 200 mL tap water
- Shake the bottle well until the tablet has dissolved.
- Label the bottle with the dilution, date and time.
- Ensure a normal CTG before starting.
  - CTG tracing not needed before or after oral doses, except if continuous CTG is indicated for specific obstetric reasons.
- Give 25 mL (equal to 25µg) of the solution orally every two hours, for 24 hours
- As soon as the woman reports painful contractions, do a vaginal examination and do a repeat CTG
  - If she is in established labour, stop the misoprostol.
- If there are no contractions in 24 hours, repeat the Bishop score and act accordingly (bulb, oxytocin or rupture of membranes)
- Do not give oxytocin less than six hours after giving misoprostol.
- Do not repeat the misoprostol course more than twice.
- Discard unused solution after 24 hours.
- If there are no cervical changes after two courses of misoprostol, confirm intra-uterine pregnancy and discuss with consultant.
- Watch out for **uterine hypercontractility** (see below for diagnosis and management)

Oxytocin dose

Oxytocin for IOL- general remarks

- Only administer in labour ward with **continuous CTG** including **tocograph tracing**
- Not to be used within 6 hours of any prostaglandin administration

- Suitable after AROM or expulsion of the cervical balloon catheter
- Suitable in trial of labour after previous CS (TOLAC) (for induction only, not to be used for augmentation; e.g. after 5cm of cervical dilatation)

Preparing the infusion:

- Put 12 Units Oxytocin in 200ml Normal Saline as a side infusion
- Prime the administration set before connecting with IV line
- Write drug content in large black permanent marker (Koki pen)

Use the standard protocol sheet for Oxytocin infusion

- Start at low dose (1-2mU/min) (at 2 dpm if using 60 dropper set or 2ml/h if IVAC)
- Every 30 minutes, assess the CTG, including fetal condition and the contraction pattern on the tocograph. In addition, assess contractions by abdominal palpation for 10 minutes.
- Only increase the dose if the CTG is normal and there are fewer than 3 strong contractions (lasting more than 40 seconds) in 10 minutes on palpation, with no other signs of uterine hypercontractility, such as prolonged contractions lasting more than 60 seconds or more than 5 contractions in 10 minutes.
- Increase with 2ml/h increments at 30 minute intervals until 3 to 4 strong contractions / 10min.
- Up to a maximum of 20ml/h (20mU/min)
- Review oxytocin when not in labour after 6 hours on maximum dose
    - Discuss further management with the consultant on call.

Stop or decrease the infusion when there are any of the following:

- Signs of **uterine hypercontractility** including:
    - 5 or more contractions / 10 minutes (tachysystole)
    - Uterus not relaxing between contractions
    - Contractions lasting > 60–90 seconds
    - < 60 seconds resting tone between contractions
    - Any hyperstimulation with CTG changes
    - If CTG is suspicious or pathological
- Management
    - Stop oxytocin administration
    - Do intra-uterine resuscitation (IUR; turn mother on left side, give a 200 ml IV crystalloid fluid bolus).
    - If ongoing contractions and fetal distress, suppress contractions with Salbutamol 250 µg in 10 ml water, slowly IVI (Provided there are no **contra-indications** to salbutamol)
    - If CTG does not improve, consider immediate delivery.
    - Good documentation of intra-partum resuscitation measures must be made in the notes

- If there is a positive response to IUR, wait 1 hour and start oxytocin again at lower dose (2 steps lower than before).
- If misoprostol was used, consider alternative IOL method (e.g. balloon catheter) or wait at least 6 hours and start misoprostol again

In grand multiparas and TOLAC wean infusion (stepwise) after 2 hours of sustained 3 or 4 strong contractions/10 min:

- If contractions fade away after lowering the dose, increase it again to the previous level

Modified Bishop score

Modified Bishop Score				
Cervical Feature	Score			
	0	1	2	3
Dilatation	< 1cm	1-2cm	3-4cm	>4cm
Length	>4cm	3-4cm	1-2cm	<1cm
Station	-3	-2	-1 / 0	+1 / +2
Consistency	Firm	Medium	Soft	
Position	Posterior	Mid	Anterior	
The following modifiers can be used for the 'Modified Bishop Score'	Add 1 point to score for: ◆ Preeclampsia ◆ Each prior vaginal delivery		Subtract 1 point from score for: ◆ Postdates pregnancy ◆ Nulliparity ◆ Premature/prolonged ROM	

2. IOL in a scarred uterus

In women with a previous uterine scar (e.g. previous caesarean section):

- In-depth counselling about the risks and benefits of IOL versus repeat CS, as well as the risks associated with waiting for spontaneous labour.
- Use mechanical means (single followed by three bulb method) as described earlier
- If medical induction of labour is required, dinoprostone (PGE_2) can be used:
  - This should only occur:
    - After careful counselling regarding risks and benefits
    - With clear documentation of the counselling and decision-making process
    - Note that the use of dinoprostone in this setting is listed as a contra-indication in the package insert and therefore represents off-label use.
- All prostaglandin use in women with a uterine scar should be undertaken with:
  - Close maternal and fetal monitoring
  - Immediate access to operative delivery
  - Consultant consent

3. Failed Induction of Labour (IOL)

- There is no single universal definition of failed induction of labour. A failed IOL is best understood as the inability to achieve established (active) labour despite the use of appropriate induction methods over an adequate period.
- Latent phase duration during induction is highly variable, and premature diagnosis of failed IOL increases unnecessary caesarean birth. Allow sufficient time for cervical ripening and labour progression, provided maternal and fetal conditions remain reassuring.
- When considering a diagnosis of failed IOL, the following must always be considered:
    - Indication for induction and urgency of delivery
    - Maternal condition and comorbidities
    - Fetal condition and monitoring findings
    - Cervical status and response to induction
    - Maternal preferences and informed consent
- All decisions regarding possible failed IOL should involve discussion with a senior clinician/consultant.
- Failed IOL may be considered only if:
    - Adequate cervical ripening methods have been used without achieving sufficient cervical change to:
        - Allow safe artificial rupture of membranes (AROM), or
        - Establish regular contractions with progressive cervical change
    - Multiple ripening cycles may be appropriate if maternal and fetal conditions are stable.
- Always attempt safe AROM before diagnosing failed IOL, if feasible and not contraindicated.
- Oxytocin induction is considered adequate only after:
    - Ruptured membranes (spontaneous or artificial), and
    - Adequate dosing and titration have been achieved
- Oxytocin-based induction should not be labelled as failed unless:
    - At least 12–18 hours of oxytocin administration after membrane rupture without progression to established labour (≥5 cm dilatation)
- Where clinically appropriate and not contraindicated:
    - An alternative induction method (e.g. prostaglandin after oxytocin failure, or vice versa) may be considered
    - This should occur after senior review and counselling
    - If no further induction options are suitable or acceptable, the IOL may then be considered failed.
    - Documentation and counselling. The diagnosis of failed IOL must be clearly documented, including methods used and timeframes
    - Accompanied by documented counselling regarding:

- Risks and benefits of continued induction vs caesarean delivery
- Maternal preferences and informed decision-making

4. FIGO misoprostol regimens for any other indication for IOL

Mifepristone & Misoprostol Dosing Chart

Recommended Regimens 2023

FIGO International Federation of Gynecology and Obstetrics
the Global Voice for Women's Health

≤12 weeks	13-17 weeks	18-24 weeks	25-27 weeks	≥28 weeks	Postpartum Use
Induced Abortion Mifepristone 200mg PO Wait 1-2 days then, Misoprostol 800µg BU/SL/PV x1 ≥10 weeks give misoprostol BU/SL/PV every 3 hours until expulsion[1]	**Induced Abortion** Mifepristone 200mg PO Wait 1-2days then, Misoprostol 400 every 3 hours BU/SL/PV until expulsion[5]	**Induced Abortion** Mifepristone 200mg PO Wait 1-2 days then, Misoprostol 400 every 3 hours BU/SL/PV until expulsion[5]	**Induced Abortion** Mifepristone 200mg PO Wait 1-2 days then, Misoprostol 200 every 4 hours until expulsion BU/SL/PV[5,9]	**Induced Abortion** Mifepristone 200mg PO Wait 1-2 days then, Misoprostol 50-100µg every 4 hours PV OR Misoprostol 50-100 µg every 2 hours PO[6,9]	**Prophylaxis of Postpartum heamorrhage (PPH)** Misoprostol 600µg SL x 1
Missed Abortion/ Anembryonic Pregnancy Mifepristone 200mg PO Wait 1-2 days then, Misoprostol 800µg BU/SL/PV x1 ≥10 weeks give misoprostol BU/SL/PV every 3 hours until expulsion [1]	**Missed Abortion** Mifepristone 200mg PO Wait 1-2 days then, Misoprostol 400 every 3 hours BU/SL/PV until expulsion[5]	**Fetal Demise** Mifepristone 200mg PO Wait 1-2 days then, Misoprostol 400 every 3 hours BU/SL/PV until expulsion	**Fetal Demise** Mifepristone 200mg PO Wait 1-2 days then, Misoprostol 200 every 4 hours BU/SL/PV until expulsion[5]	**Fetal Demise** Mifepristone 200mg PO Wait 1-2 days then, Misoprostol 25-50µg every 4 hours PV OR Misoprostol 50-100 µg every 2 hours PO[6]	**Treatment of Postpartum heamorrhage (PPH)** Misoprostol 800µg SL x 1
Incomplete Abortion 400µg misoprostol SLx1 600µg misoprostol PO x1 800µg misoprostol BU x 1 dose[4]	**Incomplete Abortion** Misoprostol 400 every 3 hours BU/SL until expulsion	**Incomplete Abortion** Misoprostol 400 every 3 hours BU/SL until expulsion	**Induction of Labour** Misoprostol 25-50µg every 4 hours PV[7,8] OR Misoprostol 50-100µg every 2 hours PO[6,7,8]	**Induction of Labour** Misoprostol 25-50µg every 4 hours PV[7] OR Misoprostol 50-100µg every 2 hours PO[6,7]	
Cervical Preparation Before Aspiration Not required [2]	**Cervical Preparation Before Aspiration** Misoprostol 400µg 1-3hrs BU/SL/PV before the procedure[3]	**Cervical Preparation Before D&E (*Use of multiple modalities is recommended)*** Mifepristone 200µg PO & Osmotic Dilators 1-2 days before. [4]	**LEGEND:** Buccal(BU) Sublingual (SL) Per Vagina (PV) Per Oral (PO)		

1. <12 weeks induced & missed abortion can be self-managed at home.
2. Consider using 400µg misoprostol 1-2 hours before procedure in patients ≤ 17 years of age.
3. Consider using Osmotic Dilators in patients ≤17 years old or in patients with a stenotic cervix.
4. Can use Misoprostol 400µg 1-2 hours before D&E if mifepristone is not available.
5. Dosing based on Society of Family Planning Guidelines (20111, 20133) A comprehensive systematic review and Meta -Analysis published 2020
6. Dosing based on Cochrane Database Syst Rev. (CD014484) published 2021
7. Buccal and Sublingual Misoprostol is not recommended for induction of labour with viable pregnancies, it is associated with more tachysystole and fetal distress.
8. There is a lack of strong evidence for misoprostol dosing for this indication at this gestational age.
9. Induced fetal cardioplegia should be considered for induced abortion after fetal viability

NOTES:
- SL/PO route is associated with more side effects.
- Avoid vaginal route if there is vaginal bleeding.
- Misoprostol is SAFE below 28 weeks EVEN with history of Cesarean Delivery.
- Misoprostol is not recommended in women ≥28 weeks gestational age with a prior Cesarean Delivery.
- There is NO Maximum dose of misoprostol. If an abortion is not complete after 5 doses, you may continue additional doses or rest for 12 hours and start again
- Misoprostol is not contraindicated in grand multipara.
- Routine aspiration after medication abortion is not required or recommended

See FIGO website for latest versions[8]

5. Indications for IOL- Tygerberg modified criteria 24 March 2026

In response to extreme bed occupancy pressures across the clinical platform, the Department has, as an interim measure, implemented a more conservative policy regarding the timing and indications for induction of labour, necessitated by the system's current inability to accommodate prevailing volumes in the labour and antenatal ward. The following modifications have been made to the timing of IOL (the associated full protocols will be updated as soon as possible)

1. Uncomplicated DC/DA twins with leading baby cephalic: deliver by 38 weeks and 6days
2. Diabetes in pregnancy:
    a. Gestational diabetes (well controlled on diet; or low dose metformin (500mg twice a day), no maternal or fetal complications)- deliver by 40 weeks plus 6 days.
    b. Type 2 diabetes (well controlled, with no hypertension): deliver by 38 weeks plus 6 days, unless otherwise indicated by the special care team.
3. PPROM
    a. If completely stable at 34 weeks, consider transferring to a district hospital for further expectant management and IOL (not later than 36 weeks and 6 days)[9]

The following can undergo MISOPROSTOL induction in the antenatal ward (F2 or J4) **If stable maternal condition with no organ dysfunction; and normal fetal assessment**
Chronic hypertension
Gestational hypertension
Diabetes Mellitus
Previous abruptio placentae
Prelabour Rupture of membranes (at ≥ 34w0d)
Previous Intra-uterine death (not due to abruptio placentae)
Post-term pregnancy
Previous IUFD ≥24 weeks gestation, of unknown/unexplored cause in uncomplicated pregnancy

The following can undergo CATHETER BULB CERVICAL RIPENING in the antenatal ward (F2 or J4) **if Outpatient management is not feasible**
Chronic hypertension
Gestational hypertension
Pre-eclampsia without any severe features
Diabetes Mellitus
Grand Multiparas (parity 5 or more)
Previous IUFD ≥24 weeks gestation, of unknown/unexplored cause in uncomplicated pregnancy
Previous uterine scar
Previous Intra-uterine death (not due to abruptio placentae)
Previous abruptio placentae
Post-term pregnancy

Abbreviations

EDV	Absent end diastolic flow	AROM	Artificial rupture of membranes
ASHT	Acute Severe Hypertension	IPR	Intra-partum resuscitation
BMI	Body mass index	CS	Caesarean Section
CPR	Cerebroplacental ratio	CTG	Cardio-tocograph
EASI	Extra-amniotic saline infusion	EFW	Estimated fetal weight
IUFD	Intra-uterine fetal death	IUGR	Intra-uterine growth restriction
IOL	Induction of labour	PGWC	Provincial Government Western Cape
PG	Prostaglandin	PO	Orally
TOLAC	Trial of labour after Caesarean Section	UAD	Umbilical artery Doppler

This IOL protocol replaces all previous versions

AUTHORISED BY	GS Gebhardt
COMMITTEE RESPONSIBLE	GS Gebhardt, S Budhram, D Mason, L de Waard, E Langenegger
DATE REVISED	24 March 2026
DATE EFFECTIVE	1 April 2026
REVIEW DATE	1 April 2029, or if evidence changes before then

These protocols have been developed using the best available evidence tailored to a local setting. They are intended as general guidance to support clinical decision-making for clinicians working at Tygerberg Hospital only. Obstyger accepts no responsibility for changes in circumstances or new information arising after publication, and acknowledges that local resource constraints may influence certain recommendations. Protocols must not be relied upon in isolation or used as a substitute for assessing the individual needs of each patient. The online version (available at www.obstyger.co.za) is always the latest version.

Further Reading

1. Gupta J, Baev O, Gomez JD, Garabedian C, Hellmeyer L, Mahony R, et al. Mechanical methods for induction of labor. Eur J Obstet Gynecol Reprod Biol. 2022 Feb 1;269:138–42. doi:10.1016/j.ejogrb.2021.10.023 PubMed PMID: 34740471.

2. Waitt C, Orrell C, Walimbwa S, Singh Y, Kintu K, Simmons B, et al. Safety and pharmacokinetics of dolutegravir in pregnant mothers with HIV infection and their neonates: A randomised trial (DolPHIN-1 study). PLOS Med. 2019 Sep 20;16(9):e1002895. doi:10.1371/journal.pmed.1002895

3. Bromwich KA, McCoy JA, Cahill AG, Sciscione AC, Levine LD. Association between intracervical Foley balloon and clinical chorioamnionitis among patients with group B streptococcus colonization undergoing induction with standardized labor management. Am J Obstet Gynecol MFM. 2023 Nov 1;5(11). doi:10.1016/j.ajogmf.2023.101167 PubMed PMID: 37741625.

4. Matshitsa L, Mercy-Nkuba N, Hofmeyr GJ. Extended balloon labour induction: A single arm proof of concept trial. Eur J Obstet Gynecol Reprod Biol X. 2023 Sep;19:100226. doi:10.1016/j.eurox.2023.100226 PubMed PMID: 37649714; PubMed Central PMCID: PMC10462842.

5. Hofmeyr GJ, Dalmacio R. Novel side by side Foley catheter balloons for 'extended labour induction': Concept, simulation study and clinical application. Eur J Obstet Gynecol Reprod Biol. 2021 Nov 1;266:133–7. doi:10.1016/j.ejogrb.2021.09.032

6. Levine LD, Downes KL, Elovitz MA, Parry S, Sammel MD, Srinivas SK. Mechanical and Pharmacologic Methods of Labor Induction: A Randomized Controlled Trial. Obstet Gynecol. 2016 Dec;128(6):1357–64. doi:10.1097/AOG.0000000000001778 PubMed PMID: 27824758; PubMed Central PMCID: PMC5127406.

7. Familiari A, Khalil A, Rizzo G, Odibo A, Vergani P, Buca D, et al. Adverse intrapartum outcome in pregnancies complicated by small for gestational age and late fetal growth restriction undergoing induction of labor with Dinoprostone, Misoprostol or mechanical methods: A systematic review and meta-analysis. Eur J Obstet Gynecol Reprod Biol. 2020 Sep 1;252:455–67. doi:10.1016/j.ejogrb.2020.07.020

8. FIGO Mifepristone & Misoprostol and Misoprostol Only Dosing Charts 2023 | Figo [Internet]. [cited 2026 Mar 29]. Available from: https://www.figo.org/figo-mifepristone-misoprostol-and-misoprostol-only-dosing-charts-2023

9. Dayal S, Jenkins SM, Hong PL. Preterm and Term Prelabor Rupture of Membranes (PPROM and PROM). In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2026 [cited 2026 Mar 29]. Available from: http://www.ncbi.nlm.nih.gov/books/NBK532888/ PubMed PMID: 30422483.