WHO recommendation on induction of labour in women with gestational diabetes

15 February 2011

Recommendation

If gestational diabetes is the only abnormality, induction of labour before 41 weeks of gestation is not recommended.

(very low-quality evidence, weak recommendation)

Publication history

First published: February 2011

Updated: No updated planned

Assessed as up-to-date: February 2011

Remarks

Participants in the WHO technical consultation acknowledged that labour induction may be necessary in some women with diabetes – for example, those with placental insufficiency and uncontrolled diabetes.

Background

Induction of labour is defined as the process of artificially stimulating the uterus to start labour.(1) It is usually performed by administering oxytocin or prostaglandins to the pregnant woman or by manually rupturing the amniotic membranes. Over the past several decades, the incidence of labour induction for shortening the duration of pregnancy has continued to rise. In developed countries, the proportion of infants delivered at term following induction of labour can be as high as one in four deliveries. (2–4)

Over the years, various professional societies have recommended the use of induction of labour in circumstances in which the risks of waiting for the onset of spontaneous labour are judged by clinicians to be greater than the risks associated with shortening the duration of pregnancy by induction. These circumstances generally include gestational age of 41 completed weeks or more prelabour rupture of amniotic membranes, hypertensive disorders, maternal medical complications, fetal death, fetal growth restriction, chorioamnionitis, multiple pregnancy, vaginal bleeding and other complications.

Although currently available guidelines do not recommend this, induction of labour is increasingly being used at the request of pregnant women to shorten the duration of pregnancy or to time the birth of the baby.
according to the convenience of the mother and/or health-care workers (5, 6).

Methods

The recommendation was developed using standardized operating procedures in accordance with the process described in the “WHO handbook for guideline development”, guided by the GRADE approach.(7, 8) Outcomes used for this recommendation were aligned with the prioritized outcomes from the WHO recommendations on induction of labour (2011).(9)

A Cochrane systematic review was conducted, on induction of labour in women with gestational diabetes.(10) In the review, randomized controlled trials relevant to the key question were screened by review authors, and data on relevant outcomes and comparisons were extracted. Evidence profiles (in the form of GRADE tables) were prepared for comparisons of interest, including the assessment and judgments for each outcome, and the estimated risks.

WHO convened a Guideline Development Group (GDG) meeting on recommendations induction of labour in April 2010, where this recommendation was developed. The GDG comprised of a group of independent experts, who used the evidence profiles to assess evidence on effects on the pre-specified outcomes. GDG members discussed the balance between desirable and undesirable effects, overall quality of supporting evidence, values and preferences of stakeholders, resource requirements, cost-effectiveness, acceptability, feasibility and equity, to formulate the recommendation. Remarks were added to clarify the recommendation, and aid implementation.

Recommendation question

For this recommendation, we aimed to answer the following question:

- in pregnant women with gestational diabetes (P), does induction of labour (I), compared to no intervention, (C), improve maternal and perinatal outcomes (O)?

Evidence Summary

The evidence related to induction of labour in women with gestational diabetes comes from a systematic review of a single trial.(10) The 200 participants in that trial were women with either gestational diabetes or diabetes type I or type II who were receiving insulin and who had good metabolic control over their condition. There is paucity of data related to the priority comparisons and outcomes. The trial was considered to have a moderate risk of bias and the effect was estimable for only one priority outcome, namely caesarean section. The finding for caesarean section was imprecise and not statistically significant (RR 0.81, 95% CI 0.52–1.26) (EB Table 1.2.1).

Implementation considerations

- The successful introduction of this recommendation into national programmes and health-care services depends on well-planned and participatory consensus-driven processes of adaptation and implementation. The adaptation and implementation processes may include the development or revision of existing national guidelines or protocols based on this recommendation.
- The recommendation should be adapted into a locally appropriate document that can meet the specific
needs of each country and health service. Any changes should be made in an explicit and transparent manner.

- A set of interventions should be established to ensure that an enabling environment is created for the use of the recommendations (including, for example, the availability of induction agents and monitoring capacity), and that the behaviour of the healthcare practitioner changes towards the use of this evidence-based practice.
- In this process, the role of local professional societies is important and an all-inclusive and participatory process should be encouraged.

Research implications

The GDG identified that further research on the following high-priority questions is needed:

- In uncomplicated gestational diabetes, at what gestational age should labour be induced, if at all?

Related Links


Pregnancy, Childbirth, Postpartum and Newborn Care: A guide for essential practice

Managing Complications in Pregnancy and Childbirth: A guide for midwives and doctors (2nd ed)

Supporting systematic review:


References


Citation


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