WHO recommendation on administration of enema for reducing the use of labour augmentation

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Recommendation

Administration of enema for reducing the use of labour augmentation is not recommended.

(Strong recommendation, very low-quality evidence)

Publication history

First published: May 2014

Updated: prioritized for updating in 2018

Assessed as up-to-date: May 2014

Remarks

- The GDG noted that the routine use of enema has neither been shown to reduce the duration of labour nor confer any other clinical benefits. It is considered invasive and associated with discomfort for women.

- The GDG put its emphasis on the feasibility of implementing this recommendation, the reduction in health resource use and acceptability by caregivers and women and therefore made a strong recommendation against this intervention.

Background

Difficult labour (or dystocia) is characterized by abnormally slow labour progress arising from inefficient uterine contractions, abnormal fetal presentation or position, inadequate bony pelvis or abnormalities of the pelvic soft tissues of the mother. (1, 2) Evidence suggests that up to one third of first-time mothers experience delay in the first stage of labour. (3)

Augmentation of labour is the process of stimulating the uterus to increase the frequency, duration and intensity of contractions after the onset of spontaneous labour. It has commonly been used to treat delayed
labour when uterine contractions are assessed to be insufficiently strong or inappropriately coordinated to dilate the cervix. Labour augmentation has traditionally been performed with the use of intravenous oxytocin infusion and/or artificial rupture of amniotic membranes (amniotomy). The procedure aims to shorten labour in order to prevent complications relating to undue prolongation, and to avert caesarean section. There is evidence that a significant proportion of women with uncomplicated pregnancies are subjected to routine augmentation of labour with oxytocin. (4)

While augmentation of labour may be beneficial in preventing prolonged labour, its inappropriate use may cause harm. Augmentation with synthetic oxytocin may result in uterine hyperstimulation, with adverse effects such as fetal asphyxia and uterine rupture, and thus increase the risk of a cascade of interventions during labour and delivery. (5)

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. (6) Outcomes used for this recommendation were aligned with the prioritized outcomes from the WHO recommendations on augmentation of labour (2014). (7)

A Cochrane systematic review relating to administration of enemas in labour was conducted. (8) 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 on augmentation of labour in September 2013, 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 in labour (P), does routine administration of enema (I), compared to no intervention, (C) improve maternal and perinatal outcomes (O)?

Evidence Summary

Evidence was drawn from a Cochrane systematic review of four trials (almost 2000 women) (8), although for most of the outcomes reported, data were available from only one or two trials. The trials were conducted in the USA, Thailand, Colombia and the United Kingdom.

Few critical and important maternal and infant outcomes were reported and overall, there were no significant differences between groups.
Enema versus no enema: maternal outcomes

- Two trials (1179 women) reported on the total duration of labour; no statistically significant difference was observed in the duration of labour (MD 28.04 min, 95% CI –131.01 to 187.10) but there was a high level of heterogeneity between the findings of the two trials.

- There was also no observed difference between groups regarding the duration of the second stage of labour (MD 5.2 min, 95% CI –2.56 to 12.96).

- No significant differences were observed in the rates of second or third degree perineal trauma (RR 0.68, 95% CI 0.39 to 1.21). Intrapartum infection was marginally increased among women who received routine enema (RR 4.62, 95% CI 1.03 to 20.68) but women requiring systemic antibiotics following the birth were similar between the two comparison groups (RR 1.16, 95% CI 0.73 to 1.84; one trial, 428 women).

- One trial (1027 women) reported women’s level of satisfaction with childbirth (measured on a Likert scale but reported as a continuous outcome): the mean scores were identical in the two groups (MD 0.00, 95% CI –0.10 to 0.10).

Enema versus no enema: infant outcomes

- The review reported very little information on infant outcomes. There was no significant difference in the rate of infants with low Apgar scores at five minutes (RR 1.31, 95% CI 0.57 to 3.06). Rates of neonatal infection (variously defined) were similar between the groups (RR 0.61, 95% CI 0.24 to 1.52).

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 augmentation 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 did not identify further research priorities on this topic.

Related Links

WHO recommendations for augmentation of labour (2014) –full document and evidence tables
Supporting systematic review:


References


Citation


Published on RHL (https://extranet.who.int/rhl)

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