WHO recommendation on the use of amniotomy alone for treatment of confirmed delay in labour

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Recommendation

The use of amniotomy alone for treatment of delay in labour is not recommended.

(Weak 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 lack of sufficient evidence to conclude on the benefits or harms of amniotomy alone for the treatment of delay in labour in spite of its common use in clinical practice.

- While acknowledging the lack of evidence regarding the benefits of amniotomy as a treatment intervention for confirmed delay in labour progress, the GDG noted that the decision to rupture the membranes could be made on the basis of other considerations, such as the need for fetal monitoring.

- This recommendation may be stronger for HIV-positive women and those with unknown HIV status in HIV prevalent settings, where delayed rupture of membranes is beneficial in terms of reducing the risk of perinatal HIV transmission.

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 was conducted, on use of the partograph as a monitoring tool to identify when intervention becomes indicated during labour.(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 the use of amniotomy alone for treatment of confirmed delay in labour (I), compared to no intervention (C), improve maternal and perinatal outcomes (O)?

Evidence Summary

Evidence related to the use of amniotomy alone to treat delay in the first stage of spontaneous labour was drawn from one Cochrane systematic review that included one trial (40 women) conducted in the United Kingdom comparing amniotomy versus intention to preserve amniotic membranes.(8)
Women were recruited when labour was diagnosed not to be progressing satisfactorily using a partogram.

Most of the critical and important outcomes were not reported.

*Routine amniotomy versus intention to preserve amniotic membranes (no routine amniotomy): maternal outcomes*

- There were no maternal deaths in either group.
- No indicators of serious maternal morbidity were reported.
- There were no observed differences in the rates of caesarean section for any indication (RR 0.95, 95% CI 0.15 to 6.08), caesarean section for fetal distress (RR 2.86, 95% CI 0.12 to 66.11) or caesarean section for prolonged labour (RR 0.47, 95% CI 0.05 to 4.82).

*Routine amniotomy versus intention to preserve amniotic membranes (no routine amniotomy): infant outcomes*

- Reported neonatal outcomes were limited to Apgar score < 7 at five minutes and admission to NICU. Both outcomes were similar between the comparison groups.

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

- What are the comparative effects of oxytocin alone, amniotomy alone and concurrent oxytocin and amniotomy in women with confirmed delay in the first stage of labour?
  - How does the sequence of oxytocin and amniotomy as concurrent interventions affect outcomes when used for labour augmentation?
Related Links

WHO recommendations for augmentation of labour (2014) –full document and evidence tables

Supporting systematic review:


References


Citation


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