Induction of labour in women with gestational diabetes

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Summary

Induction of labour (artificially initiated labour) is becoming more common worldwide. Up to 25% of women in developed countries undergo induction, while in developing countries these rates are generally lower, but increasing. Induction of labour is not risk-free and many women find it to be uncomfortable. These guidelines were developed in order to promote evidence-based practice in inducing labour to improve maternal and newborn outcomes worldwide.

The WHO recommendations for Induction of Labour (2011) contain recommendations on the timing and methods of induction and management of adverse events related to induction of labour.

WHO recommendation

If gestational diabetes is the only abnormality, induction of labour before 41 weeks of gestations is not recommended. (Very-low-quality evidence. Weak recommendation.)

- 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.

- WHO recommendations for induction of labour
- Evidence base and GRADE tables for the WHO recommendations on induction of labour

Evidence for this WHO recommendation was extracted from the Cochrane reviews below:


Abstract

In pregnancies complicated by diabetes the major concerns during the third trimester are fetal distress and the potential for birth trauma associated with fetal macrosomia.

The objective of this review was to assess the effect of a policy of elective delivery, as compared to expectant management, in term diabetic pregnant women, on maternal and perinatal mortality and morbidity.

We searched the Cochrane Pregnancy and Childbirth Group's Trials Register (24 July 2004). We updated
this search on 24 July 2009 and added the results to the awaiting classification section.

All available randomized controlled trials of elective delivery, either by induction of labour or by elective caesarean section, compared to expectant management in diabetic pregnant women at term.

The reports of the only available trial were analysed independently by the three co-reviewers to retrieve data on maternal and perinatal outcomes. Results are expressed as relative risks (RR) and 95% confidence intervals (CI).

The participants in the one trial included in this review were 200 insulin-requiring diabetic women. Most had gestational diabetes, except 13 women with type 2 pre-existing diabetes (class B). The trial compared a policy of active induction of labour at 38 completed weeks of pregnancy, to expectant management until 42 weeks. The risk of caesarean section was not statistically different between groups (relative risk (RR) 0.81, 95% confidence interval (CI) 0.52 - 1.26). The risk of macrosomia was reduced in the active induction group (RR 0.56, 95% CI 0.32 - 0.98) and three cases of mild shoulder dystocia were reported in the expectant management group. No other perinatal morbidity was reported.

The results of the single randomized controlled trial comparing elective delivery with expectant management at term in pregnant women with insulin-requiring diabetes show that induction of labour reduces the risk of macrosomia. The risk of maternal or neonatal morbidity was not different between groups, but, given the rarity of maternal and neonatal morbidity, the number of women included does not permit to draw firm conclusions. Women's views on elective delivery and on prolonged surveillance and treatment with insulin should be assessed in future trials.

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