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Compilation

« Déclenchement de l'accouchement »

Base de données de l'AFAR
http://afar.info

Etude réalisée le 27 juillet 2004

Compilation
« Déclenchement de l'accouchement »

Méthode de travail : Nous avons sélectionné 51 fiches parmi les 75 contenant le mot-clé « Déclenchement » dans la base de données de l'AFAR, fin juillet 2004.

Convention : Le numéro entre [crochets] est celui de la fiche dans la base de données.

Les services qui font autour de 20 % de déclenchements ont environ 2 % de césariennes. Par contre, les services qui font autour de 50 % ont 6 % de césariennes. Il semble donc qu'il faille garder une certaine mesure. N'en faisons-nous pas trop ?	[877] Si l'on admet les avantages : - Amélioration de la sécurité des naissances, - Accessibilité à la péridurale, - Organisation individuelle et collective de l'obstétrique moderne. Il faut néanmoins pratiquer une analyse autocritique. Trois problèmes se posent : Le premier danger est celui de la prématurité induite, il faut savoir attendre quelques jours même quand le col est très favorable plutôt que de déclencher trop près des 38 semaines. Le deuxième danger est une réflexion d'obstétricien qui dit : la décision de déclencher le travail est une décision responsable, il ne faut pas que cela devienne une responsabilité transformée en culpabilité, c'est à dire que nous avons tous mal vécu le fait qu'un déclenchement ne se passe pas comme il avait été prévu; Par rapport à l'accouchement spontané où l'obstétricien est considéré comme le sauveur et par rapport au déclenchement médical où la femme est prévenue des risques de pathologie et du risque de césarienne, dans le déclenchement de principe, on se sent responsable d'où des déviations dans la décision obstétricale difficile à prendre dans ces cas. Comme disait MALINAS, dans le déclenchement, l'objectivité et la sérénité doivent être mises à l'honneur. On pratique parfois les césariennes trop tôt par manque de patience mais parfois aussi trop tard, ce qui expliquerait le taux de morbidité un peu élevé. Troisième danger : Développement de politiques obstétricales " actives " Il n'y a sans doute pas de taux idéal de déclenchement mais incontestablement entre 10 % de déclenchements et 50 %, les cas ne sont pas les mêmes. Le problème est de savoir si en augmentant de façon importante le taux de

	déclenchement, on ne devient pas nocif en déclenchant dans des conditions médiocres. Plus il y a de déclenchements et plus il y a de déclenchements difficiles; il se peut qu'au delà de 30 ou 35 %, on rentre dans une certaine pathologie Les services qui font autour de 20 % de déclenchements ont environ 2 % de césariennes. Par contre, les services qui font autour de 50 % ont 6 % de césariennes. Il semble donc qu'il faille garder une certaine mesure. N'en faisons-nous pas trop ? J'étais prêt il y a quelques mois à augmenter mon taux de déclenchements mais je pense maintenant revenir un peu en arrière, un taux de déclenchement de 30 à 40% me semblant idéal **Guerre, Philippe. L'induction artificielle du travail est-elle susceptible d'entraîner un risque foetal ? Congrès « La programmation systématique de l'accouchement », 19 novembre 1994, Bordeaux, Collège de Gynécologie de Bordeaux.** http://www.gyneweb.fr/Sources/obstetrique/bx/94/souffoe.html
Le déclenchement de l'accouchement est paradoxal: il fonctionne au mieux quand on en a le moins besoin, et il échoue souvent quand on en a le plus besoin.	[22] "Déclenchement du travail: c'est la Nature qui sait le mieux que faire." -- Le déclenchement de l'accouchement est paradoxal: il fonctionne au mieux quand on en a le moins besoin, et il échoue souvent quand on en a le plus besoin. De plus, il est souvent à la source même des problèmes qu'il est supposé prévenir. **Goer, Henci. Induction of Labor: Mother Nature Knows Best. In "The Thinking Woman's Guide to a Better Birth. Practical Information for a Safe, Satisfying Childbirth." New York: Berkley, p.49-74** http://www.hencigoer.com/betterbirth/ Remarques : Pour commander l'ouvrage: http://www.amazon.fr/exec/obidos/ASIN/0399525173/
Aucune donnée ni aucun indice ne prouve que le déclenchement systématique à n'importe quel âge gestationnel n'améliore les résultats périnataux.	[36] "Dépassement de terme: déclenchement, ou surveiller et attendre?" Mythe: Pour éviter tout problème, le travail devrait être déclenché en cas de dépassement du terme de deux (ou même une) semaines. Réalité: Il apparaît dans toute la littérature scientifique qu'aucune donnée ni aucun indice ne prouve que le déclenchement systématique à n'importe quel âge gestationnel n'améliore les résultats périnataux. **Goer, Henci. Postdates Pregnancy: Induction Versus Watching and Waiting. In "Obstetric Myths Versus Research Realities: A Guide to the Medical Literature." Westport: Bergin & Garvey, p.180-202**

	http://www.hencigoer.com/obmyth/epis.html Remarques : Pour commander l'ouvrage: http://www.amazon.com/exec/obidos/tg/detail/-/0897894278/
L'accompagnement global réduit le nombre des interventions.	[718] OBJECTIVE: To review randomised controlled trials of alternative maternity services characterised by continuity of midwifery care. METHODS: A systematic review of randomised controlled trials, analysed on an intention to treat basis, in which the study intervention was characterised by a midwife or small group of midwives providing care from early pregnancy to the postnatal period (defined as that provided on the postnatal ward); and the controls by standard maternity care as practised in the place where the trial was conducted. The seven trials identified included 9148 women. Main outcome measures were interventions during labour, maternal outcomes and infant outcomes. RESULTS: The alternative models with continuity of midwifery care were associated with less use of obstetric interventions during labour (eg, induction, augmentation of labour, electronic fetal monitoring, obstetric analgesia, instrumental vaginal delivery and episiotomy). However, the caesarean section rate did not differ statistically between the trial groups (OR 0.91; 95% CI 0.78 to 1.05). The lower episiotomy rate in the alternative models of care (OR 0.69; 95% CI 0.61 to 0.77) was associated with a significantly higher rate of perineal tears in the pooled alternative groups (OR 1.15; 95% CI 1.05 to 1.26). The percentage of intact perineums was very similar for the two groups (OR 1.11; 95% CI 1.00 to 1.24). There was no maternal death, and rates of maternal complications based on unpooled estimates did not show any statistically significant differences. The proportion of babies with an Apgar score < 7 at five minutes after the birth was approximately the same in the pooled alternative groups as in the control groups (OR 1.13 95% CI 0.69 to 1.84). Admission to intensive care or special care baby unit was similar (OR 0.86; 95% CI 0.71 to 1.04). The difference in perinatal deaths was bordering on statistical significance (OR 1.60; 95% CI 0.99 to 2.59). CONCLUSION: Continuity of midwifery care is associated with lower intervention rates than standard maternity care. No statistically significant differences were observed in maternal and infant outcomes. However, more research is necessary to make definite conclusions about safety, for the infant as well as for the mother. This review illustrates the variation in the different models of alternative and standard maternity care, and thus the problems associated with pooling data from different trials.

	Waldenstrom U, Turnbull D. A systematic review comparing continuity of midwifery care with standard maternity services. **Br J Obstet Gynaecol. 1998 Nov;105(11):1160-70.** http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=9853764
Les taux de ruptures utérines dans des tentatives d'accouchement vaginal après une ou deux césariennes sont de 0.8 et 3.7% respectivement. (Période d'observation: 1984-1996)	[330] OBJECTIVE: We sought to determine whether there is a difference in the rate of symptomatic uterine rupture after a trial of labor in women who have had 1 versus 2 prior cesarean deliveries. STUDY DESIGN: The medical records of all women with a history of either 1 or 2 prior cesarean deliveries who elected to undergo a trial of labor during a 12-year period (July 1984-June 1996) at the Brigham and Women's Hospital were reviewed. Rates of uterine rupture were compared for these 2 groups. Potential confounding variables were controlled by using logistic regression analyses. RESULTS: Women with 1 prior cesarean delivery (n = 3757) had a rate of uterine rupture of 0.8%, whereas women with 2 prior cesarean deliveries (n = 134) had a rate of uterine rupture of 3.7% (P =.001). In a logistic regression analysis that was controlled for maternal age, use of epidural analgesia, oxytocin induction, oxytocin augmentation, the use of prostaglandin E(2) gel, birth weight, gestational age, type of prior hysterotomy, year of trial of labor, and prior vaginal delivery, the odds ratio for uterine rupture in those patients with 2 prior cesarean deliveries was 4.8 (95% confidence interval, 1.8-13. 2) CONCLUSIONS: Women with a history of 2 prior cesarean deliveries have an almost 5-fold greater risk of uterine rupture than those with only 1 prior cesarean delivery. **Caughey AB, Shipp TD, Repke JT, Zelop CM, Cohen A, Lieberman E. Rate of uterine rupture during a trial of labor in women with one or two prior cesarean deliveries.** **Am J Obstet Gynecol. 1999 Oct;181(4):872-6.** http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&list_uids=10521745&dopt=Abstract
Le taux de ruptures utérines est multiplié par 4 à 6 en cas de déclenchement avec accélération du travail, dans une tentative d'accouchement	[331] OBJECTIVE: Our purpose was to examine the risk of uterine rupture during induction or augmentation of labor in gravid women with 1 prior cesarean delivery. STUDY DESIGN: The medical records of all gravid women with history of cesarean delivery who attempted a trial of labor during a 12-year period at a single center were reviewed. The current analysis was limited to women at term with 1 prior cesarean delivery and no other deliveries. The rate of uterine rupture in gravid women within that group undergoing induction was compared with

vaginal après une césarienne.	that in spontaneously laboring women. The association of oxytocin induction, oxytocin augmentation, and use of prostaglandin E(2) gel with uterine rupture was determined. Logistic regression analysis was used to examine these associations, with control for confounding factors. RESULTS: Of 2774 women in the analysis, 2214 had spontaneous onset of labor and 560 women had labor induced with oxytocin or prostaglandin E(2) gel. The overall rate of rupture among all patients with induction of labor was 2.3%, in comparison with 0.7% among women with spontaneous labor (P =.001). Among 1072 patients receiving oxytocin augmentation, the rate of uterine rupture was 1.0%, in comparison with 0.4% in nonaugmented, spontaneously laboring patients (P =.1). In a logistic regression model with control for birth weight, use of epidural, duration of labor, maternal age, year of delivery, and years since last birth, induction with oxytocin was associated with a 4.6-fold increased risk of uterine rupture compared with no oxytocin use (95% confidence interval, 1.5-14.1). In that model, augmentation with oxytocin was associated with an odds ratio of 2.3 (95% confidence interval, 0.8-7.0), and use of prostaglandin E(2) gel was associated with an odds ratio of 3.2 (95% confidence interval, 0.9-10.9). These differences were not statistically significant. CONCLUSION: Induction of labor with oxytocin is associated with an increased rate of uterine rupture in gravid women with 1 prior uterine scar in comparison with the rate in spontaneously laboring women. Although the rate of uterine rupture was not statistically increased during oxytocin augmentation, use of oxytocin in such cases should proceed with caution. **Zelop CM, Shipp TD, Repke JT, Cohen A, Caughey AB, Lieberman E. Uterine rupture during induced or augmented labor in gravid women with one prior cesarean delivery.** **Am J Obstet Gynecol. 1999 Oct;181(4):882-6.** http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&list_uids=10521747&dopt=Abstract
Facteurs de risque de rupture utérine pendant un essai d'accouchement vaginal: notamment le déclenchement, avec ou sans amniotomie, et la maturation artificielle du col.	[299] The purpose of this study is to identify pregnancy and labor factors that place women at increased risk for symptomatic uterine rupture during trial of labor following cesarean section. The study population consisted of 16 women with uterine rupture after a trial of labor who were compared with 32 women without uterine rupture after a trial of labor. Using a case-control study design with a 1:2 match, we examined risk factors that might be associated with an increased risk of uterine rupture. Cases were more likely to have an induction of labor with the use of oxytocin and/or amniotomy (56 vs. 34%) and more likely

	to undergo augmentation with oxytocin (25 vs. 19%) in comparison with controls. In addition, cases were more likely to be given oxytocin (for either induction or augmentation) (75 vs. 50%) and cervical ripening agents (31 vs. 9%) versus controls. Neonates born after uterine rupture had a higher rate of significant acidosis (pH < 7.0, 57 vs. 0%, p = 0.0002) and lower Apgar scores. There was a significantly higher risk of maternal infection (36 vs. 3%, p = 0.003), transfusion (13 vs. 0%, p = 0.03), and longer length of stay in patients with uterine rupture. There is a trend for increased use of augmentation and induction agents to be associated with uterine rupture. Serious maternal and fetal morbidities are increased following uterine rupture. **Miles AL, Monga M, Waller DK, Dande D, Pschirrer ER. Risk factors for symptomatic uterine rupture during a trial of labor: the 1990s. Am J Perinatol. 2000;17(7):385-9.** http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&list_uids=12141526&dopt=Abstract
Etude des effets de l'implémentation d'un protocole pour le déclenchement de l'accouchement	[314] BACKGROUND: To examine the effect of implementation of guidelines for induction of labor on the process of care and outcome measures. METHOD: Guidelines for induction of labor were implemented in January 1996 following an audit report identifying inconsistency in clinical practice. A prospective audit was carried out following the implementation of a new strategy directed towards pre-induction cervical ripening in nulliparae with unfavorable cervices and the use of low dosages of vaginal prostaglandin E2 for induction of labor. Level of compliance and outcome measures were compared before and after implementation of guidelines. RESULTS: In the period of January 1995 to November 1997, 1,230 women were induced with a singleton viable pregnancy in a cephalic presentation with a gestational age > or = 37 weeks with no history of rupture of membranes or cesarean section. Completed forms were available for 1,147 women (370, 421 and 356 in 1995, 1996 and 1997, respectively). Among nulliparous women, there was a reduction in the number of women who were admitted with cervical score of < or = 4 (24%, 40%, and 54% in 1997, 1996, and 1995, respectively; p=0.0001), an increase in the number of women who had amniotomy on admission (32%, 25% and 12% in 1997, 1996, and 1995, respectively; p=0.0001) and a shorter induction-delivery interval. No change in outcome measures was noted among multiparous women despite reduced dose of prostaglandin E2 used for induction of labor. A marginal reduction of both Cesarean section and failed induction rates were

	noted in both nulliparae and multiparae. Level of compliance improved with successive rounds of audit. CONCLUSION: Explicit guidelines do improve clinical practice, when introduced and monitored in the context of rigorous evaluations. However, the size of improvement could vary. **Mousa HA, Mahmood TA. Do practice guidelines guide practice? A prospective audit of induction of labor three years experience.** **Acta Obstet Gynecol Scand. 2000 Dec;79(12):1086-92.** http://www.blackwell-synergy.com/openurl?genre=article&sid=nlm:pubmed&issn=0001-6349&date=2000&volume=79&issue=12&spage=1086
Le déclenchement de l'accouchement par amniotomie précoce augmente les taux de césariennes.	[403] OBJECTIVE: To evaluate the effect of early amniotomy in term gestation on the mode of delivery and pregnancy outcome in comparison with premature rupture of membranes (PROM) and oxytocin induction. STUDY DESIGN: The study population consisted of 60 consecutive parturients induced by early amniotomy. The two comparison groups were 147 women admitted with term PROM and 65 patients induced by oxytocin. All study participants were evaluated prospectively and had unfavorable cervical scores. RESULTS: The duration of the first stage of labor was significantly longer in the PROM group (987.8 +/- 572.3 min) as compared with the early amniotomy group (615.0 +/- 389.6 min) and the oxytocin induction group (650.9 +/- 349.5 min, P<0.001). Higher rates of CS were found in the study group (26.7%) as compared to the controls (11.6% in the PROM and 16.9% in the oxytocin groups, p=0.012). Neonatal outcome was similar in all groups. A stratified analysis comparing the risk of CS while controlling for a previous one did not show a significant difference between the early amniotomy and the oxytocin administration groups. CONCLUSIONS: Early amniotomy is associated with a higher rate of CS. While controlling for a previous CS, both ways of induction were comparable. In order to decrease the CS rates, induction should probably start with cervical ripening techniques in order to improve the Bishop scores. **Sheiner E, Segal D, Shoham-Vardi I, Ben-Tov J, Katz M, Mazor M. The impact of early amniotomy on mode of delivery and pregnancy outcome.** **Arch Gynecol Obstet. 2000 Sep; 264(2): 63-7.** http://www.springerlink.com/app/home/contribution.asp?wasp=99a0hcrxtp4kqmm3ng86&referrer=parent&backto=issue,2,15;journal,22,50;linkingpublicationresults,id:100399,1
Etude de la	[404] BACKGROUND: Amniotomy (deliberate rupture of the

pratique de l'amniotomie seule pour le déclenchement: pas de conclusion précise.	membranes) is a simple procedure which can be used alone for induction of labour if the membranes are accessible, thus avoiding the need for pharmacological intervention. However, the time interval from amniotomy to established labour may not be acceptable to clinicians and women, and in a number of cases labour may not ensue. This is one of a series of reviews of methods of cervical ripening and labour induction using standardised methodology. OBJECTIVES: To determine the effects of amniotomy alone for third trimester labour induction in women with a live fetus. SEARCH STRATEGY: The Cochrane Pregnancy and Childbirth Group trials register, the Cochrane Controlled trials register and bibliographies of relevant papers. SELECTION CRITERIA: The criteria for inclusion included the following: (1) clinical trials comparing amniotomy alone for third trimester cervical ripening or labour induction with placebo/no treatment or other methods listed above it on a predefined list of labour induction methods; (2) random or pseudo-random allocation to the treatment or control group; (3) ideally adequate allocation concealment (4) violations of allocated management not sufficient to materially affect conclusions; (5) clinically meaningful outcome measures reported; (6) data available for analysis according to the random allocation; (7) missing data insufficient to materially affect the conclusions. DATA COLLECTION AND ANALYSIS: This is one of a series of reviews of methods of cervical ripening and labour induction using standardised methodology. A strategy was developed to deal with the large volume and complexity of trial data relating to labour induction. This involved a two-stage method of data extraction. The initial data extraction was done centrally, and incorporated into the series of primary reviews arranged by methods of induction of labour. The data from the primary reviews will be incorporated into a series of secondary reviews, arranged by category of woman to reflect clinical scenarios. To avoid duplication of data in the primary reviews, the labour induction methods have been listed in a specific order, from one to 25. Each primary review includes comparisons between one of the methods (from two to 25) with only those methods above it on the list. This review includes comparisons between amniotomy alone (number 5 on the list) with only those methods above it on the list (no treatment / placebo; intravaginal prostaglandins; intracervical prostaglandins; and oxytocin alone). MAIN RESULTS: Two trials comprising 50 and 260 women respectively were eligible for inclusion in this review. No conclusions could be drawn from comparisons of amniotomy alone versus no intervention, and amniotomy

	alone versus oxytocin alone (small trial, only one pre-specified outcome reported). No trials compared amniotomy alone with intracervical prostaglandins. One trial compared amniotomy alone with a single dose of vaginal prostaglandins for women with a favourable cervix, and found a significant increase in the need for oxytocin augmentation in the amniotomy alone group (44% versus 15%; RR 2.85, 95% CI 1.82-4.46). This should be viewed with caution as this was the result of a single centre trial. Furthermore, secondary intervention occurred 4 hours after amniotomy, and this time interval may not have been appropriate. REVIEWER'S CONCLUSIONS: Data is lacking about the value of amniotomy alone for induction of labour. While there are now other modern methods available for induction of labour (pharmacological agents), there remain clinical scenarios where amniotomy alone may be desirable and appropriate, and this method is worthy of further research. This research should include evaluation of the appropriate time interval from amniotomy to secondary intervention, women and caregivers' satisfaction and economic analysis. **Bricker L, Luckas M. Amniotomy alone for induction of labour.** **Cochrane Database Syst Rev. 2000; (4): CD002862.** http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&list_uids=11034776&dopt=Abstract
Comparaison du trinitrate de glycérine et de la prostaglandine E2 pour la maturation du col à terme.	[405] OBJECTIVE: To estimate the adverse effects of glyceryl trinitrate compared with prostaglandin (PG) E2 vaginal tablet for cervical ripening in term pregnancy. METHODS: One hundred ten women with term pregnancies referred for induction of labor with Bishop scores of 6 or less were randomly assigned to receive a 500-microg glyceryl trinitrate tablet vaginally (n = 54) or a 3-mg PGE2 tablet vaginally (n = 56), every 6 hours for maximum of two doses. Subjects were sent to the labor ward for amniotomy or oxytocin if their Bishop scores were more than 6 or their cervices were not ripe 24 hours after treatment. Adverse effects, changes in the Bishop scores, progress, and outcomes of labor were assessed. RESULTS: Glyceryl trinitrate was associated with fewer episodes of uterine tachysystole (0% versus 9%; P =.02). The median Bishop score after 12 hours was lower in women given glyceryl trinitrate compared with those given PGE2. Adverse effects, including headache and palpitations, were more frequent with glyceryl trinitrate than with PGE2. The cesarean rate was not significantly different between groups. CONCLUSION: Cervical ripening with glyceryl trinitrate resulted in fewer episodes of tachysystole, but there were significantly more minor side effects. It can be

	used for cervical ripening at term, but it was not as effective as PGE2. **Chanrachakul B, Herabutya Y, Punyavachira P. Randomized comparison of glyceryl trinitrate and prostaglandin E2 for cervical ripening at term.** **Obstet Gynecol. 2000 Oct; 96(4): 549-53.** http://www.sciencedirect.com/science?_ob=ArticleURL&_udi=B6TB2-417N83M-F&_coverDate=10%2F31%2F2000&_alid=141982247&_rdoc=1&_fmt=&_orig=search&_qd=1&_cdi=5130&_sort=d&view=c&_acct=C000050221&_version=1&_urlVersion=0&_userid=10&md5=b5243821aa66f3e73b98b1384fc745ae
Essai randomisé d'administration de gel de prostaglandine E2 pour le déclenchement du travail, le matin ou le soir.	[411] OBJECTIVE: To compare the outcome of induction of labor and patient's preferences using a protocol with the first dose of prostaglandin E2 endocervical gel in the evening versus a protocol with the first dose in the morning. DESIGN: We performed a randomized trial comparing administration of prostaglandin E2 endocervical gel in the morning with administration of prostaglandin E2 gel in the evening, followed if necessary by a second dose being given after six hours if labor had not started or the cervix was still unripe. Formal induction of labor by amniotomy and oxytocin infusion was performed the morning after the initial prostaglandin E2 dose. Patients' preferences were assessed using a questionnaire that was completed after delivery. SETTING: Tertiary care hospital in the Netherlands with 1,600 deliveries per year. PARTICIPANTS: One-hundred and twenty-six women with viable singleton pregnancies at term who had induction of labor with prostaglandins. MAIN OUTCOME MEASURES: Time of delivery (daytime, evening or night) and patient's satisfaction. RESULTS: Fifty-eight women were allocated for administration of gel in the morning, whereas 68 had their gel in the evening. Administration of gel in the evening did not significantly reduce delivery between 23.00 hours and 08.00 hours, although there was a reduction in delivery between 23.00 hours and 08.00 hours in nulliparae. None of the multiparous women delivered between 18.00 hours and 23.00 hours after induction of labor in the evening. The relative risk for delivery by vacuum or forceps was increased after allocation of gel in the evening (4.2; 95% confidence limits 1.4 to 13). Patients' preferences favored administration of gel in the morning. CONCLUSIONS: There was no benefit in starting induction of labor with prostaglandin E2 in the evening, compared with starting in the morning.

	Oei SG, Jongmans L, Mol BW. Randomized trial of administration of prostaglandin E2 gel for induction of labor in the morning or the evening. **J Perinat Med. 2000; 28(1): 20-5.** http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&list_uids=10765510&dopt=Abstract
Une politique de déclenchement systématique des grossesses à 41 - 42 semaines n'a pas d'influence sur le risque d'accouchement par césarienne par rapport à une attitude expectative. L'induction du travail à 41 semaines ou plus permet une réduction de la mortalité fœtale ou néonatale.	[878] Il y a dix-neuf études randomisées ou quasiment randomisées qui ont comparé une politique de déclenchement de l'accouchement avec une attitude expectative sous surveillance fœtale serrée (17). Dans le groupe des patientes suivies de manière expectative, 20 à 36 % des femmes ont eu une induction de l'accouchement ou une césarienne avant le début du travail (31). Cela implique qu'une attitude expectative ne signifie pas forcément que le travail pourra commencer spontanément. Il n'y a aucune évidence qu'une politique de déclenchement systématique augmente la probabilité d'accouchement par césarienne (17). Dans certaines études (26), les patientes subissant un déclenchement artificiel du travail à 41 semaines ou plus, avaient un taux significativement plus bas de césarienne par rapport aux patientes avec prise en charge expectative (26, 32). Cette réduction du taux de césarienne a été observée aussi bien pour les nullipares que les multipares (26). Le fait d'induire le travail à 41 semaines ou plus permet d'obtenir une réduction du nombre de CTG suspects selon plusieurs auteurs. On note également un plus faible taux de liquide amniotique méconial et de macrosomie (17). L'induction du travail à 41 semaines ou plus permet une réduction de la mortalité fœtale ou néonatale (à l'exclusion des malformations congénitales létales ou majeures) (17), par rapport à l'attitude expectative (risque relatif 0.23; intervalle de confiance à 95%: 0.06 à 0.90). Cette réduction est en grande partie due à une diminution du risque de mort in utero et la plupart des décès observés dans ces études sont associés à des asphyxies ou à des aspirations méconiales. Enfin, l'adoption d'une politique de déclenchement à 41 semaines ou plus permet une diminution du coût des soins par rapport à une attitude expectative (33). En résumé, le dépassement de terme entraîne un risque plus élevé de complications maternelles fœtales et néonatales que les grossesses se terminant spontanément à terme. Lorsque des morts périnatales surviennent, elles sont fréquemment associées à des phénomènes d'asphyxie ou à des aspirations de liquide amniotique méconial. Il y a de nombreuses méthodes disponibles pour effectuer une surveillance fœtale dans les grossesses à terme, mais leur efficacité est encore incertaine. Les

	études randomisées comparant l'induction systématique du travail à 41 semaines de gestation avec une attitude expectative associée à une surveillance fœtale montrent que l'induction à 41 semaines diminue les anomalies du CTG, les liquides amniotiques méconiaux, les macrosomies fœtales et le risque de décès durant la période périnatale. L'évidence à disposition suggère qu'une politique de déclenchement systématique des grossesses à 41 - 42 semaines n'a pas d'influence sur le risque d'accouchement par césarienne par rapport à une attitude expectative. Les patientes atteignant 41 semaines de gestation devraient être orientées de manière adéquate. Elles devraient être informées des risques et des bénéfices des différentes attitudes. Les résultats de la littérature suggèrent qu'un déclenchement devrait être discuté avec la patiente. On peut estimer que 500 déclenchements artificiels sont nécessaires pour éviter une mort périnatale (17). Commission Qualité de la Société Suisse de Gynécologie et Obstétrique. Recommandations pour la pratique clinique : Surveillance et prise en charge en cas de dépassement de terme. http://www.sggg.ch/F/guidelines/pdf/ueberwachung_f.pdf
Le misoprostol est contre-indiqué chez les femmes avec césarienne antérieure, étant donné le risque de rupture utérine.	[885] De nombreux auteurs ont évalué le misoprostol comme moyen de déclenchement du travail. Ce produit semble avoir une efficacité au moins équivalente aux PGE2 ou à l'ocytocine. Le risque d'effets secondaires (hypercinésie, contracture utérine, hyperstimulation accompagnée d'anomalies du tracé foetal, liquide amniotique méconial) semble plus important, surtout lorsque des doses élevées sont utilisées. À faible dose, les effets secondaires maternels et néo-nataux semblent comparables à ceux des PGE2 ou de l'ocytocine. La voie et la dose optimale restent à déterminer. Les comprimés de misoprostol coûtent moins cher que les prostaglandines E2. Toutefois, l'analyse du rapport coût/efficacité n'a pas été réalisée. Ce produit est stable à la température ambiante, ce qui facilite le stockage. Le misoprostol est contre-indiqué chez les femmes avec césarienne antérieure, étant donné le risque de rupture utérine. **M. Boulvain, C.-M. Stan. Misoprostol pour le déclenchement du travail. Mises à jour en gynécologie obstétrique, tome XXIV, volume Gynécologie obstétrique, p. 47. CNGOF** http://www.cngof.asso.fr/D_PAGES/PUMA_2000.HTM#47
Faut-il utiliser les oestrogènes seuls, ou en association avec l'amniotomie, pour la	[303] BACKGROUND: Studies in sheep showed that there is a pre-labour rise in oestrogen and a decrease in progesterone, both of these changes stimulate prostaglandin production and may help initiate labour. Though oestrogen has been suggested as an effective cervical ripening or induction agent, research in humans

maturation du col ou le déclenchement?	have failed to demonstrate a similar physiological mechanism. The use of oestrogen as an induction agent is not currently common practice, as such this systematic review should be regarded as an historical review. This is one of a series of reviews of methods of cervical ripening and labour induction using a standardised methodology. OBJECTIVES: To determine, from the best available evidence, the effectiveness and safety of oestrogens alone or with amniotomy for third trimester cervical ripening and induction of labour in comparison with other methods of induction of labour. SEARCH STRATEGY: The Cochrane Pregnancy and Childbirth Group trials register, the Cochrane Controlled Trials Register and bibliographies of relevant papers. Last searched: April 2001. SELECTION CRITERIA: (1) randomised controlled trials comparing oestrogens alone used for third trimester cervical ripening or labour induction with placebo/no treatment or other methods listed above it on a predefined list of labour induction methods; (2) random allocation to the treatment or control group; (3) adequate allocation concealment; (4) violations of allocated management not sufficient to materially affect conclusions; (5) clinically meaningful outcome measures reported; (6) data available for analysis according to the random allocation; (7) missing data insufficient to materially affect the conclusions. DATA COLLECTION AND ANALYSIS: A generic strategy has been developed to deal with the large volume and complexity of trial data relating to labour induction. This involved a two-stage method of data extraction. The initial data extraction was done centrally. MAIN RESULTS: When comparing oestrogen with placebo there was no difference between the rate of caesarean section (7.1% versus 10.3%, relative risk (RR) 0.70, 95% confidence interval (CI) 0.30,1.62). There were no differences between rates of uterine hyperstimulation with or without fetal heart rate changes or instrumental vaginal delivery. None of the studies reported the rates of either vaginal delivery not achieved in 24 hours, or cervix unfavourable/unchanged after 12-24 hours. There were insufficient data to make any meaningful conclusions when comparing oestrogen with vaginal PGE2, intracervical PGE2, oxytocin alone or extra amniotic PGF2a, as to whether oestrogen is effective in inducing labour. REVIEWER'S CONCLUSIONS: There were insufficient data to draw any conclusions regarding the efficacy of oestrogen as an induction agent. **Thomas J, Kelly AJ, Kavanagh J. Oestrogens alone or**

	with amniotomy for cervical ripening or induction of labour. **Cochrane Database Syst Rev. 2001;(4):CD003393.** http://www.cochrane.org/cochrane/revabstr/AB003393.htm
L'amniotomie associée aux ocytocines en intraveineuse pour le déclenchement	[304] BACKGROUND: Induction of labour is a common obstetric intervention. Amniotomy alone for induction of labour is reviewed separately and oxytocin alone for induction of labour is being prepared for inclusion in The Cochrane Library. This review will address the use of the combination of these two methods for induction of labour in the third trimester. This is one of a series of reviews of methods of cervical ripening and labour induction using standardised methodology. OBJECTIVES: To determine, from the best available evidence, the efficacy and safety of amniotomy and intravenous oxytocin for third trimester induction of labour. SEARCH STRATEGY: The Cochrane Pregnancy and Childbirth Group Trials Register, the Cochrane Controlled Trials Register and reference lists of articles were searched. Date of last search: May 2001. SELECTION CRITERIA: The criteria for inclusion included the following: (1) clinical trials comparing amniotomy plus intravenous oxytocin used for third trimester cervical ripening or labour induction with placebo/no treatment or other methods listed above it on a predefined list of labour induction methods; (2) random allocation to the treatment or control group; (3) adequate allocation concealment; (4) violations of allocated management not sufficient to materially affect conclusions; (5) clinically meaningful outcome measures reported; (6) data available for analysis according to the random allocation; (7) missing data insufficient to materially affect the conclusions. DATA COLLECTION AND ANALYSIS: Trial quality assessment and data extraction were done by both reviewers. A strategy was developed to deal with the large volume and complexity of trial data relating to labour induction. This involved a two-stage method of data extraction. The initial data extraction was done centrally, and incorporated into a series of primary reviews arranged by methods of induction of labour, following a standardised methodology. The data is to be extracted from the primary reviews into a series of secondary reviews, arranged by category of woman. MAIN RESULTS: Seventeen trials involving 2566 women were included. Amniotomy and intravenous oxytocin were found to result in fewer women being undelivered vaginally at 24 hours than amniotomy alone (relative risk (RR) 0.03, 95% confidence intervals (CI) 0.001-0.49). This finding was based on the results of a single study of 100 women. As regards secondary results amniotomy and intravenous

	oxytocin resulted in significantly fewer instrumental vaginal deliveries than placebo (RR 0.18, CI 0.05-0.58). Amniotomy and intravenous oxytocin resulted in more postpartum haemorrhage than vaginal prostaglandins (RR 5.5, CI 1.26-24.07). Significantly more women were also dissatisfied with amniotomy and intravenous oxytocin when compared with vaginal prostaglandins, RR 53, CI 3.32-846.51. REVIEWER'S CONCLUSIONS: Data on the effectiveness and safety of amniotomy and intravenous oxytocin are lacking. No recommendations for clinical practice can be made on the basis of this review. Amniotomy and intravenous oxytocin is a combination of two methods of induction of labour and both methods are utilised in clinical practice. If their use is to be continued it is important to compare the effectiveness and safety of these methods, and to define under which clinical circumstances one may be preferable to another. **Howarth GR, Botha DJ. Amniotomy plus intravenous oxytocin for induction of labour. Cochrane Database Syst Rev. 2001;(3):CD003250.** http://www.cochrane.org/cochrane/revabstr/AB003250.htm Remarques : Je suis pas sure que c'est tout public, mais je mets systematiquement les Cochrane Review en Tout public .
Injection intraveineuse d'ocytocines (sans amniotomie) pour la maturation du col ou le déclenchement	[305] BACKGROUND: Oxytocin is the commonest induction agent used worldwide. It has been used alone, in combination with amniotomy or following cervical ripening with other pharmacological or non-pharmacological methods. Prior to the introduction of prostaglandin agents oxytocin was used as a cervical ripening agent as well. In developed countries oxytocin alone is more commonly used in the presence of ruptured membranes whether spontaneous or artificial. In developing countries where the incidence of HIV is high, delaying amniotomy in labour reduces vertical transmission rates and hence the use of oxytocin with intact membranes warrants further investigation. This review will address the use of oxytocin alone for induction of labour. Amniotomy alone or oxytocin with amniotomy for induction of labour has been reviewed elsewhere in the Cochrane Library. Trials which consider concomitant administration of oxytocin and amniotomy will not be considered. This is one of a series of reviews of methods of cervical ripening and labour induction using a standardised methodology. OBJECTIVES: To determine the effects of oxytocin alone for third trimester cervical ripening or induction of labour in comparison with other methods of induction of labour or placebo/no treatment. SEARCH STRATEGY: The Cochrane Pregnancy and Childbirth

	Group Trials Register, the Cochrane Controlled Trials Register and bibliographies of relevant papers. Last searched: May 2001. SELECTION CRITERIA: The criteria for inclusion included the following: (1) clinical trials comparing vaginal prostaglandins used for third trimester cervical ripening or labour induction with placebo/no treatment or other methods listed above it on a predefined list of labour induction methods; (2) random allocation to the treatment or control group; (3) adequate allocation concealment; (4) violations of allocated management not sufficient to materially affect conclusions; (5) clinically meaningful outcome measures reported; (6) data available for analysis according to the random allocation; (7) missing data insufficient to materially affect the conclusions. DATA COLLECTION AND ANALYSIS: A strategy was developed to deal with the large volume and complexity of trial data relating to labour induction. This involved a two-stage method of data extraction. The initial data extraction was done centrally, and incorporated into a series of primary reviews arranged by methods of induction of labour, following a standardised methodology. The data is to be extracted from the primary reviews into a series of secondary reviews, arranged by category of woman. MAIN RESULTS: In total, 110 trials were considered; 52 have been excluded and 58 included examining a total of 11,129 women. Comparing oxytocin alone with expectant management: Oxytocin alone reduced the rate of unsuccessful vaginal delivery within 24 hours when compared with expectant management (8.3% versus 54%, relative risk (RR) 0.16, 95% confidence interval (CI) 0.10,0.25) but the caesarean section rate was increased (10.4% versus 8.9%, RR 1.17, 95% CI 1.01,1.36). This increase in caesarean section rate was not apparent in the subgroup analyses. Women were less likely to be unsatisfied with induction rather than expectant management, in the one trial reporting this outcome (5.5% versus 13.7%, RR 0.43, 95% CI 0.33, 0.56). Comparing oxytocin alone with vaginal prostaglandins: Oxytocin alone was associated with an increase in unsuccessful vaginal delivery within 24 hours (52% versus 28%, RR 1.85, 95% CI 1.41, 2.43), irrespective of membrane status, but there was no difference in caesarean section rates (11.4% versus 10%, RR 1.12, 95% CI 0.95, 1.33). Comparing oxytocin alone with intracervical prostaglandins: Oxytocin alone was associated with an increase in unsuccessful vaginal delivery within 24 hours when compared with intracervical PGE2 (51% versus 35%, RR 1.49, 95% CI 1.12,1.99). For all women with an unfavourable cervix regardless of membrane status, the caesarean section rates were increased (19.0% versus 13.1%, RR 1.42, 95% CI 1.11, 1.82).

	REVIEWER'S CONCLUSIONS: Overall, comparison of oxytocin alone with either intravaginal or intracervical PGE2 reveals that the prostaglandin agents probably overall have more benefits than oxytocin alone. The amount of information relating to specific clinical subgroups is limited, especially with respect to women with intact membranes. Comparison of oxytocin alone to vaginal PGE2 in women with ruptured membranes reveals that both interventions are probably equally efficacious with each having some advantages and disadvantages over the others. With respect to current practice in women with ruptured membranes induction can be recommended by either method and in women with intact membranes there is insufficient information to make firm recommendations. **Kelly AJ, Tan B. Intravenous oxytocin alone for cervical ripening and induction of labour. Cochrane Database Syst Rev. 2001;(3):CD003246.** http://www.cochrane.org/cochrane/revabstr/AB003246.htm
Comparaison de l'efficacité du misoprostol et de la prostaglandine E(2) pour le déclenchement	[306] BACKGROUND: Amniotomy and oxytocin infusion are the routine methods most frequently applied to induce labor. These methods are not effective when the cervix is unripe. Prostaglandins may accelerate the process of cervical ripening independently of the stimulation of uterine contractions, since they induce the formation of a gap junction (spread of excitation) and release uterine contractions. The purpose of this study is a comparative analysis of the effectiveness and safety of misoprostol and PGE2 in the process of cervical ripening and inducing labor in patients at full term delivery with a live fetus and indications for inducing labor due to an unripe uterine cervix. MATERIAL AND METHODS: The experimental group consisted of 30 patients at 38-41 weeks of gestation who received misoprostol administered into the posterior vaginal fornix (group M). The control group included 26 patients at 39-42 weeks of gestation in whom labor was induced using natural prostaglandin E(2) (group P). RESULTS: There were no statistically significant differences in maternal age, body weight and height, or uterine cervical ripening between the two groups of patients. The average time of gestation was 0.92 weeks shorter in group M. The time from administration of the drug to the onset of regular contraction activity of the uterus and delivery of an infant was shorter in the group of patients receiving misoprostol intravaginally. CONCLUSIONS: Our results would seem to indicate that misoprostol is an effective drug that can be used for elective preinduction and induction of labor. However, the application of this drug to induce labor with a live fetus requires special caution and care, as well as continuous cardiotocographic monitoring to assure the

	safety of both the mother and the infant. **Leszczynska-Gorzelak B, Laskowska M, Oleszczuk J. Comparative analysis of the effectiveness of misoprostol and prostaglandin E(2) in the preinduction and induction of labor.** **Medical Science Monitor. 2001 Sep-Oct;7(5):1023-8.** http://www.medscimonit.com/medscimonit/modules.php?name=GetPDF&pg=2&idm=1731
Effets de la prostaglandine E2 par voie orale pour le déclenchement	[308] BACKGROUND: This is one of a series of reviews of methods of cervical ripening and labour induction using standardised methodology. OBJECTIVES: To determine the effects of oral prostaglandin E2 for third trimester induction of labour. SEARCH STRATEGY: The Cochrane Pregnancy and Childbirth Group trials register, the Cochrane Controlled Trials Register and bibliographies of relevant papers. Date of last search: December 2000. SELECTION CRITERIA: The criteria for inclusion included the following: (1) clinical trials comparing oral prostaglandin E2 used for third trimester cervical ripening or labour induction with placebo/no treatment or other methods listed above it on a predefined list of labour induction methods; (2) random allocation to the treatment or control group; (3) adequate allocation concealment; (4) violations of allocated management not sufficient to materially affect conclusions; (5) clinically meaningful outcome measures reported; (6) data available for analysis according to the random allocation; (7) missing data insufficient to materially affect the conclusions. DATA COLLECTION AND ANALYSIS: A strategy has been developed to deal with the large volume and complexity of trial data relating to labour induction. This involves a two-stage method of data extraction. The initial data extraction is done centrally, and incorporated into a series of primary reviews arranged by methods of induction of labour, following a standardised methodology. The data will then be extracted from the primary reviews into a series of secondary reviews, arranged by category of woman. To avoid duplication of data in the primary reviews, the labour induction methods have been listed in a specific order, from one to 25. Each primary review includes comparisons between one of the methods (from two to 25) with only those methods above it on the list. MAIN RESULTS: There were 19 studies included in the review. Of these 15 included a comparison using either oral or intravenous oxytocin with or without amniotomy. The quality of studies reviewed was not high. Only seven

	studies had clearly described allocation concealment. Only two studies stated that providers and/or participants were blinded to treatment group. For the outcome of vaginal delivery not achieved within 24 hours, in the composite comparison of oral PGE2 versus all oxytocin treatments (oral and intravenous, with and without amniotomy), there was a trend favoring oxytocin treatments (relative risk (RR) 1.97, 95% confidence interval (CI) 0.86 to 4.48). For the outcome of cesarean section, in the comparison of PGE2 versus no treatment or placebo, PGE2 was favored (relative risk (RR) 0.54, 95% confidence interval (CI) 0.29,0.98). Otherwise, there were no significant differences between groups for this outcome. Oral prostaglandin was associated with vomiting across all comparison groups. REVIEWER'S CONCLUSIONS: Oral prostaglandin consistently resulted in more frequent gastrointestinal side effects, in particular vomiting, compared with the other treatments included in this review. There were no clear advantages to oral prostaglandin over other methods of induction of labour. **French L. Oral prostaglandin E2 for induction of labour.** **Cochrane Database Syst Rev. 2001;(2):CD003098.** http://www.cochrane.org/cochrane/revabstr/AB003098.htm
L'utilisation du misoprostol par voie orale pour le déclenchement	[309] BACKGROUND: Prostaglandins are hormones naturally present in the uterus that cause contractions during labour. A synthetic prostaglandin analogue misoprostol is produced in tablets that can be given orally or vaginally, but it is not yet licensed for use in pregnancy. Unlicensed use of misoprostol in pregnancy is increasingly common, because misoprostol is cheap, stable at room temperature and effective in causing uterine contractions. Oral use of the drug misoprostol may be convenient, but high doses could cause uterine hyperstimulation and uterine rupture which may be life-threatening for both mother and fetus. OBJECTIVES: The objective of this review was to assess the effects of oral misoprostol used for labour induction in women with a viable fetus in the third trimester of pregnancy. SEARCH STRATEGY: The Cochrane Pregnancy and Childbirth Group trials register and the Cochrane Controlled Trials Register were searched in December 2000. SELECTION CRITERIA: Randomised trials of oral misoprostol versus other methods, placebo or no treatment, given to women with a viable fetus for labour induction. DATA COLLECTION AND ANALYSIS: This is one of a series of the Cochrane reviews of methods of cervical ripening and labour induction using standardised methodology. This

	review includes comparisons between oral misoprostol with placebo, vaginal prostaglandins, intracervical prostaglandins, oxytocin, amniotomy, oxytocin and amniotomy or vaginal misoprostol. Data from all relevant trials are extracted by the reviewer using centrally designed data sheets. MAIN RESULTS: One trial with 80 randomised women with prelabour rupture of membranes at term showed that, compared with placebo, oral misoprostol reduces the need for oxytocin infusion from 51 percent to 13 percent (relative risk 0.25, 95% confidence interval (CI) 0.1 to 0.6) and shortens delivery time by 8.7 hours (95% CI 6.0 to 11.3). Compared with vaginal or intracervical prostaglandins, oral misoprostol showed no beneficial or harmful effects. However, only two trials with 962 randomised women in total compared oral misoprostol with vaginal dinoprostone and one trial with 200 women compared oral misoprostol with intracervical dinoprostone. Two small trials with 188 women in total compared oral misoprostol and oxytocin in women with term ruptured membranes and found no significant differences in prespecified outcomes. In seven trials with 1278 randomised women that compared oral with vaginal misoprostol, oral misoprostol appeared to be less effective. More women in the oral misoprostol group did not achieve vaginal delivery within 24 hours of randomisation (50%) compared with 39.7% in the vaginal misoprostol group (relative risk 1.27, 95% confidence intervals 1.09 to 1.47). The caesarean section rate was lower in the oral misoprostol group (16.7%) compared with 21.7% in the vaginal misoprostol group (relative risk 0.77, 95% confidence intervals 0.61 to 0.97). There was no difference in uterine hyperstimulation with fetal heart rate changes (8.5% versus 7.4%; relative risk 1.11, 95% confidence intervals 0.78 to 1.59). There were no reported cases of severe neonatal and maternal morbidity. REVIEWER'S CONCLUSIONS: Oral misoprostol is an effective method for labour induction in the third trimester. However, the data on optimal regimens and safety are lacking. It is possible that effective oral regimens may have an unacceptably high incidence of complications such as uterine hyperstimulation and possibly uterine rupture. **Alfirevic Z. Oral misoprostol for induction of labour. Cochrane Database Syst Rev. 2001;(2):CD001338.** http://www.cochrane.org/cochrane/revabstr/AB001338.htm
Le déchirement des membranes lors d'un examen vaginal favorise le déclenchement de l'accouchement	[310] BACKGROUND: This is one of a series of reviews of methods of cervical ripening and labour induction using standardised methodology. Sweeping of the membranes, also commonly named stripping of the membranes, is a relatively simple technique usually performed without admission to hospital. During vaginal examination, the clinician's finger is introduced into the cervical os.

mais ne produit pas de résultat clinique intéressant.	Then, the inferior pole of the membranes is detached from the lower uterine segment by a circular movement of the examining finger. This intervention has the potential to initiate labour by increasing local production of prostaglandins and, thus, reduce pregnancy duration or pre-empt formal induction of labour with either oxytocin, prostaglandins or amniotomy. OBJECTIVES: To determine the effects of membrane sweeping for third trimester induction of labour. SEARCH STRATEGY: The Cochrane Pregnancy and Childbirth Group trials register, the Cochrane Controlled Trials Register and bibliographies of relevant papers (last searched November 2000). SELECTION CRITERIA: The criteria for inclusion included the following: (1) clinical trials comparing membrane sweeping used for third trimester labour induction with no vaginal examination or vaginal examination for cervical assessment only or with other methods listed above it on a predefined list of labour induction methods (i.e. administration of prostaglandins and oxytocin); (2) random allocation to the treatment or control group; (3) adequate or unclear allocation concealment; (4) violations of allocated management not sufficient to materially affect conclusions; (5) clinically meaningful outcome measures reported; (6) data available for analysis according to the random allocation; (7) missing data insufficient to materially affect the conclusions. DATA COLLECTION AND ANALYSIS: The data extraction was done centrally and incorporated into a series of reviews arranged by methods of induction of labour, following a standardised methodology. Two of the reviewers also assessed trial quality and extracted data. To avoid duplication of data in the reviews, the labour induction methods have been listed in a specific order, from one to 25. Each review includes comparisons between one of the methods with only those methods above it on the list. Therefore, sweeping of membranes was compared to no treatment, intravaginal prostaglandins and oxytocin. Results are reported as relative risk (RR) and their 95% confidence interval (CI) and number-needed-to-treat (NNT). MAIN RESULTS: Nineteen trials were included, 17 comparing sweeping of membranes with no treatment, three comparing sweeping with prostaglandins and one comparing sweeping with oxytocin (two studies reported more than one comparison). Risk of caesarean section was similar between groups (RR 0.97, 95% CI 0.73 to 1.28). Sweeping of the membranes, performed as a general policy in women at term, was associated with reduced duration of pregnancy and reduced frequency of pregnancy continuing beyond 41 weeks (RR 0.62, 95% CI 0.49 to 0.79) and 42 weeks (RR 0.28, 95% CI 0.15 to 0.50). To avoid one

	formal induction of labour, sweeping of membranes must be performed in seven women (NNT = 7). There was no evidence of a difference in the risk of maternal or neonatal infection. Discomfort during vaginal examination and other adverse effects (bleeding, irregular contractions) were more frequently reported by women allocated to sweeping. Studies comparing sweeping with prostaglandin administration are of limited sample size and do not provide evidence of benefit. REVIEWER'S CONCLUSIONS: Routine use of sweeping of membranes from 38 weeks of pregnancy onwards does not seem to produce clinically important benefits. When used as a means for induction of labour, the reduction in the use of more formal methods of induction needs to be balanced against women's discomfort and other adverse effects. **Boulvain M, Stan C, Irion O. Membrane sweeping for induction of labour.** **Cochrane Database Syst Rev. 2001;(2):CD000451.** http://www.cochrane.org/cochrane/revabstr/AB000451.htm
Comparaison de l'utilisation du misoprostol par voie orale et vaginale pour le déclenchement à terme	[313] OBJECTIVE: To compare the efficacy of oral with vaginal misoprostol for induction of labour at term. DESIGN: Randomised trial. SETTING: Tertiary Care hospital. PARTICIPANTS: One hundred and sixty-seven women requiring induction of labour. METHODS: The women were randomised to receive 50 microg of misoprostol orally or vaginally every 6 h until the cervix was favourable for amniotomy, spontaneous rupture of membranes, or active labour occurred. Sample size was calculated with a two-tailed alpha of 0.05 and a power of 95% to detect a 5 h difference in induction-to-delivery time. Student's t test was used for comparison of normally distributed continuous variables and the Mann-Whitney U test was used for non-Gaussian distributed continuous variables. Fisher' s exact and chi2 tests were used for comparison of categorical variables. The main outcome measure was induction to delivery time. RESULTS: The median induction to delivery time was significantly shorter with vaginal misoprostol (15.7 h range 4.3-55.7), compared with oral misoprostol (23.0 h range 3.2-141.7, P = 0.0013). The median number of doses was also significantly less in the vaginal misoprostol group, 1 (range 1-3), compared with the oral group, 2 (range 1-8), (P < 0.0001). The significant differences in outcome held true when nulliparous and multiparous women were analysed separately. There were no differences between the two routes of administration with respect to rates of hyperstimulation or neonatal

	asphyxia. There were more caesarean sections in the vaginal misoprostol group, but the difference was not statistically significant. CONCLUSIONS: Compared with oral misoprostol, vaginal misoprostol for induction of labour at term results in a shorter induction-to-delivery time, with fewer doses required per patient. Vaginal misoprostol may be associated with higher rates of caesarean section than oral misoprostol. **Kwon JS, Davies GA, Mackenzie VP. A comparison of oral and vaginal misoprostol for induction of labour at term: a randomised trial.** **BJOG, International Journal of Obstetrics and Gynaecology. 2001 Jan;108(1):23-6.**
Les résultats de cette étude (7430 cas) suggèrent que le déclenchement du travail est associé à un risque accru de césariennes (2.4 fois plus) et de certaines complications périnatales: soins intensifs, réanimation etc.	[872] Nous avions pour objectif d'évaluer les risques de morbidité maternelle et périnatale associés au déclenchement du travail pour des grossesses à terme sans complications. Nous avons mené une étude rétrospective concernant 7430 femmes qui n'avaient pas été transférées d'une autre institution, et qui attendaient un bébé en position de vertex après 38 à 40 semaines de gestation. Parmi ces femmes, 3546 ont été exclues de l'étude car elles avaient eu des complications de grossesse avant le début du travail. Nous avons calculé les risques relatifs (RR), ajustés selon la parité, comparant 3353 femmes dont le travail avait débuté spontanément, avec 531 dont le travail avait été déclenché. Nous avons trouvé que le déclenchement du travail était associé à un risque accru de césarienne [RR = 2.4, 95% CI 1.8, 3.4]. L'utilisation d'analgésie autre que la péridurale [RR = 1.5, 95% CI 1.2, 1.8] et de la péridurale [RR = 1.4, 95% CI 1.1, 1.7] ont été plus fréquentes après un déclenchement. La réanimation du nouveau-né [RR = 1.2, 95% CI 1.0, 1.5] et son admission en soins intensifs [RR = 1.6, 95% CI 1.0, 2.4] ou en photothérapie [RR = 1.3, 95% CI 1.0, 1.6] ont été plus fréquentes après un déclenchement. Les résultats étaient semblables lorsqu'on contrôlait simultanément la parité, l'âge maternel, l'âge gestationnel, l'année de l'accouchement, le poids à la naissance et le médecin chargé de la surveillance, dans une analyse de régression logistique. Les résultats de cette étude suggèrent que le déclenchement du travail est associé à un risque accru de césariennes et de certaines complications périnatales. Il devrait être réservé aux cas pour lesquels les bénéfices maternels et périnataux dépassent ces risques de complications. **Boulvain, Marcoux, Bureau, Fortier and Fraser. Risks of induction of labour in uncomplicated term pregnancies. Paediatric**

	& Perinatal Epidemiology 15 (2), 131-138. http://www.blackwell-synergy.com/Journals/content/abstracts/ppe/2001/15/2/abstract_ppe337.asp?journal=ppe&issueid=6360&artid=119523&cid=ppe.2001.2&ftype=abstracts
	[294] Induction of labor is one of the most important means for therapeutic intervention in modern obstetrics. The aim of labor induction is to achieve a better perinatal result for mother and baby as compared to expectative management. Different methods for induction include administration of oxytocin or prostaglandins, amniotomy, and mechanical means of cervical dilatation. The success of the labor induction depends primarily on the readiness of the uterus to go into labor, and the method used for induction. If the cervical ripeness is very advanced, induction with amniotomy and oxytocin seems beneficial. However if the cervix is not yet ready, intravaginal or intracervical prostaglandins are more promising. Until recently, prostaglandins E2 are used in the first line. Now, the prostaglandin E1-analogon misoprostol is also increasingly used. As a rule, induction of labor should be performed as an inpatient procedure in order to be able to provide the surveillance for maternal and fetal safety. **Surbek DV, Hosli I, Holzgreve W. [Current aspects of labor induction] [Article in German]** **Ther Umsch. 2002 Dec;59(12):650-9.** http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&list_uids=12584952&dopt=Abstract
Le choix d'une prostaglandine pour le déclenchement	[295] Slow release prostaglandin pessary (propess) is compared with instant release prostaglandin gel (prostin) for the induction of labour in nulliparous women with a modified Bishop's score of less than 6. In this randomised study 50 women received prostin gel and 45 received propess. More than one dose of prostaglandin was required to achieve amniotomy more often in the propess group (53%) compared with the prostin group (34%) (P=0.03). Propess was unable to demonstrate any advantage over Prostin gel group. Propess was not cost-effective in this study. **Mukhopadhyay M, Lim KJ, Fairlie FM. Is propess a better method of induction of labour in nulliparous women?** **J Obstet Gynaecol. 2002 May;22(3):294-5.** http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&list_uids=12521503&dopt=Abstract
Le dosage optimal du misoprostol pour un déclenchement	[296] OBJECTIVE: To compare the efficacy and safety of 100 microg oral misoprostol for induction of labor between the regimen of 3 hour and 6 hour interval administration. METHODS: Singleton pregnancies indicated for induction of labor between 34 and 42 weeks of gestation in the condition of unfavorable cervix (Bishop score < or = 4)

	and no contraindication for prostaglandins therapy were recruited into the study. All pregnant women were randomly assigned to receive 100 microg oral misoprostol every 3 hours or 6 hours until the cervix was favorable for amniotomy, spontaneous rupture of membranes or active labor occurred. RESULTS: The mean time interval from induction to vaginal delivery was significantly shorter in the 3 hour interval group, compared with the 6 hour interval group (13.82 +/- 6.98h and 17.66 +/- 7.48h, P = 0.0019). There was no significant difference between the groups with regard to mode of delivery, analgesic requirement, maternal complication and neonatal outcome. CONCLUSIONS: 100 microg oral misoprostol every 3 hours is more effective for labor induction than every 6 hours but there was no difference in mode of delivery, analgesic requirement, maternal complications and neonatal outcome. A dose of 100 microg misoprostol orally every 3 hours seems to be the optimum regimen and the new option for labor induction. However, further study should be performed. **Pongsatha S, Sirisukkasem S, Tongsong T. A comparison of 100 microg oral misoprostol every 3 hours and 6 hours for labor induction: a randomized controlled trial. J Obstet Gynaecol Res. 2002 Dec;28(6):308-12.** http://www.blackwell-synergy.com/openurl?genre=article&sid=nlm:pubmed&issn=1341-8076&date=2002&volume=28&issue=6&spage=308
Comparaison de l'efficacité et des effets secondaires du mononitrate isosorbide et du misoprostol pour la maturation du col	[298] OBJECTIVES: To assess the adverse effects of isosorbide mononitrate (IMN) compared with misoprostol for cervical ripening at term. METHODS: One hundred and seven women with term pregnancies referred for induction of labor with Bishop scores of 6 or less were randomly allocated to receive either a 40-mg IMN tablet vaginally (n = 55) or 50 microg misoprostol vaginally (n = 52) every 6 h for a maximum of three doses. They were sent to the labor ward for amniotomy or oxytocin if either their Bishop scores were more than 6 or their cervices were not ripe 24 h after the treatment. Adverse effects, progress, and outcomes of labor were assessed. RESULTS: Isosorbide mononitrate was associated with fewer adverse effects especially uterine tachysystole (0 vs. 19.2%, P < 0.01) and hyperstimulation (0 vs. 15.4%, P < 0.01). The time from start of medication to vaginal delivery in IMN group was significantly longer (25.6 +/- 6.1 vs. 14 +/- 6.9 h, P < 0.01). Oxytocin was needed in 51 women (92%) of the isosorbide mononitrate group and six women (11%) of the misoprostol group (P < 0.001). The cesarean rate was not significantly different between the groups, but the major indications were different: dystocia (45%) in the IMN group vs.

	persistent non-reassuring fetal heart rate pattern (56%) in the misoprostol group. CONCLUSIONS: Cervical ripening with IMN resulted in fewer adverse effects, but was less effective than misoprostol. **Chanrachakul B, Herabutya Y, Punyavachira P. Randomized trial of isosorbide mononitrate versus misoprostol for cervical ripening at term.** **Int J Gynaecol Obstet. 2002 Aug;78(2):139-45.** http://www.sciencedirect.com/science?_ob=ArticleURL&_udi=B6T7M-462BNYK-2&_coverDate=08%2F31%2F2002&_alid=136283461&_rdoc=1&_fmt=&_orig=search&_qd=1&_cdi=5062&_sort=d&view=c&_acct=C000050221&_version=1&_urlVersion=0&_userid=10&md5=b10287aefa7b791c9f9ff1bad802eba5
Comparaison de l'amniotomie pratiquée immédiatement, ou après administration d'ocytocine, suite à la maturation du col avec un catheter de Foley	[301] OBJECTIVES: Ripening of the cervix with a Foley catheter commonly results in cervical dilatation without contractions. We examined the outcome of labour in women who underwent induction of labour using a Foley catheter, followed by either 1. early amniotomy, or 2. augmentation of labour by oxytocin and late amniotomy. DESIGN: Prospective randomised clinical trial. SETTING: Labour and delivery ward of a university teaching hospital. PARTICIPANTS: Pregnant women > or =38 weeks of a singleton gestation, who had had no prior caesarean section. METHODS: All women underwent cervical ripening using a Foley catheter. Following removal of the catheter, women were randomly assigned to either early (n = 80) or late amniotomy (n = 88). MAIN OUTCOME MEASURES: Comparison of mode of delivery and duration of labour between the two groups. RESULTS: The rate of caesarean section was significantly higher in the early amniotomy group compared with the late amniotomy group (25% vs 7.9%; relative risk 1.74; 95% CI 1.3 - 2.34). The increase in caesarean section rate was due primarily to dystocia (15% vs 3.3%; relative risk 1.8; 95% CI 1.32 - 2.45). When excluding caesarean deliveries, no significant difference was found in duration of labour between the groups (8.3 hours (3.8) vs 7.7 hours (2.9)). CONCLUSIONS: In women who undergo cervical ripening with a Foley catheter, augmentation of labour by oxytocin followed by amniotomy during active labour results in a lower rate of caesarean delivery for dystocia. **Levy R, Ferber A, Ben-Arie A, Paz B, Hazan Y, Blickstein I, Hagay ZJ. A randomised comparison of early versus late amniotomy following cervical ripening with a Foley**

	catheter. **BJOG. 2002 Feb;109(2):168-72.** http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&list_uids=11888099&dopt=Abstract
Le déclenchement de convenance entraîne un taux significativement plus important de césariennes, et légèrement plus élevé d'extractions instrumentales.	[881] Introduction: Labor induction is considered elective when it is undertaken for the purpose of convenience and in the absence of any maternal or fetal condition that justifies delivery. The elective labor induction is commonly practiced in Flanders (North Belgium). From 1996 to 1997, 30% of all deliveries were induced, of which 71% were elective. Therefore, 1 in 5 pregnant woman in Flanders had a labor induction for convenience. The outcome of elective induction compared with labor of spontaneous onset has not been extensively studied. Aims: The study was designed to determine whether the current practice of elective labor induction in Flanders was associated with differences in mode of delivery, demand for pain relief, and need for neonatal care when compared with labor of spontaneous onset. Methods: During the study, from January 1, 1996, through December 31, 1997, 124,680 deliveries took place in Flanders. Labor was induced in 30% of the deliveries, and elective labor induction took place in 21% of the deliveries. Of the deliveries, 46% were nulliparous; 14.3%were cesarean deliveries; 13.2% were instrumental deliveries; 53% required epidural analgesia; 16.8% were transferred to the neonatal ward; and 1.7% of infants had congenital malformations. The perinatal mortality rate was 0.7%. The inclusion criteria for the woman with electively induced labor and those with a labor of spontaneous onset were as follows: nulliparous woman with a low-risk, singleton pregnancy in cephalic presentation, and delivery of a liveborn infant. Both study groups were matched for maternal age, gestational age (between 266 and 287 dy), birth weight (between 3000 and 4000 g), and gender of the infant. There were 7683 cases of electively induced labor and 7683 cases of spontaneous labor selected as controls. The variables studied included: incidence of cesarean delivery, instrumental delivery, epidural analgesia, transfer to the neonatal ward, congenital malformations, and neonatal death. The nonparametric Mann-Whitney U test was used for comparing the induction rates in the hospitals with a different level of specialization. Chi-square tests were used to evaluate the association between discrete variables. The relative risks were given together with their 95% confidence intervals to measure the strength of these associations. Results: Elective labor induction was most frequently performed in the four university hospitals (mean, 25%) followed by the teaching hospitals (mean, 23%). The induction ratio in the peripheral hospitals amounted to 20% (P < 0.001 Mann-Whitney U test). Induced labor was

	associated with significantly more cesarean deliveries (9.9% versus 6.5%) and slightly, but significantly, more instrumental deliveries. The increased frequency of cesarean delivery in induced labor was predominantly the result of higher incidence of first-stage dystocia (5.9% versus 3.3%). Fetal distress as a reason for cesarean delivery was more frequently encountered when labor had been electively induced (2.6% versus 1.8%). Babies who were born after induced labor were transferred more often to the neonatal ward (10.7% versus 9.4%). The epidural analgesia was utilized more often in the elective induction group (79.8% versus 57.6%). **Cammu H, Martens G, Ruyssinck G, Amy J. Outcome after elective labor induction in nulliparous women: a matched cohort study. Am J Obstet Gynecol 2002, 186:240–244.** http://www.biomedcentral.com/content/pdf/cr-wr312ct.pdf
Etant donnée la popularité croissante des déclenchements d'accouchements, même un faible risque de césarienne pour les nullipares peut se traduire à l'échelle du pays par une augmentation importante du nombre d'accouchements en césarienne.	[882] Methods: This study was based on the data from the National Center for Health Statistics during the years 1989 to 1999. The study analyzed several variables in nulliparous and multiparous patients. Results: Between 1990 and 1998, the rate of labor induction increased from 9.5% to 19.4% of all births nationwide. White woman were more likely to have induced labor in comparison with those of other races (20.6% versus 14%). Maternal age had little impact, except in the very young age group, in whom induction of labor was less common. Nulliparas had a higher rate than multiparas. The rate of labor induction for complicated pregnancies increased substantially, especially for those with renal diseases during pregnancy and those who had previously given birth to an infant who weighed less than 4000 g. The induction rate for pregnancies with an abruptio placentae, breech presentation, and multi-fetal pregnancy remained low during the study period; however, the rate increased significantly. The induction rate increased with education and earlier initiation of prenatal care. Based on these findings, the authors conclude that given the increasing popularity of elective induction of labor, even a small risk of cesarean delivery in nullipara may translate into a large number of cesarean deliveries in excess nationwide. Considering the direct financial costs, potential increase in maternal morbidity, and likelihood of repeat cesarean delivery in subsequent pregnancies, the convenience of elective induction of labor bears a stiff price. Editor's comments Based on this study, there is no question that elective induction of labor is becoming much more common. The rate of elective induction of labor has doubled in the past 10 years and is expected to reach 30% by the year 2007. The cause for an increased rate of elective

	induction of labor is most likely due to increased fetal surveillance, improvements in neonatal care, improvements in cervical ripening agents, and increased number of patients with medical risks (due to older maternal age, reproductive technologies). However, the article states that the increase in indicated induction was significantly smaller than the overall increase (70% versus 100% increase), which suggests that the rate of elective induction has risen much more rapidly. The use of pre-induction diagnoses such as impending macrosomatia and impending pregnancyinduced hypertension, and induction for patient or physician convenience have impacted this rate of growth. We should begin to study and review our methods of practice regarding elective inductions because long-term ramifications of cesarean sections and more complicated pregnancy outcomes might result, specifically for the nulliparous patient. Experienced obstetricians know from years of practice that an elective induction of labor in a multiparous patient with a ripe cervix is completely different from induction in a nulliparous patient with an unripe cervix. Most likely, the answer for the future is to become more stringent with guidelines in the primiparous patient and less concerned with the multiparous patient with a ripe cervix. **Zhang J, Yancy MK, Henderson C. U.S. National Trends in Labor Induction, 1989–1999. J Reprod Med 2002, 47:120–124.** http://www.biomedcentral.com/content/pdf/cr-wr312ct.pdf
L'administration massive d'ocytocines -- combinée ou non avec des procédures de maturation du col -- ne permet pas en général d'initier le travail progressif, à moins qu'il ne soit sur le point de se déclencher lui-même.	[883] Les complications des déclenchements ont deux origines: la physiologie du début du travail et les effets secondaires des procédures et des médicaments. Pour commencer, contrairement à ce qu'on croit communément, les obstétriciens ne peuvent pas démarrer un accouchement en pressant un bouton… Pour démarrer le travail et lui donner de l'intensité, il faut mettre en place une cascade de mécanismes en boucle rétroactive qui se renforcent et se limitent mutuellement. Il s'agit d'une danse élégante et subtile d'hormones et autres substances échangées entre le bébé, qui initie et contrôle le processus, et sa mère. L'administration massive d'ocytocines -- combinée ou non avec des procédures de maturation du col -- ne permet pas en général d'initier le travail progressif, à moins qu'il ne soit sur le point de se déclencher lui-même. C'est la raison principale pour laquelle les études montrent de manière cohérente que le déclenchement de l'accouchement, quelle qu'en soit la raison, augmente considérablement la probabilité d'une césarienne pour les femmes qui accouchent de leur premier enfant. (Quelques études sont arrivées à la conclusion inverse. Les raisons en sont intéressantes à connaître, et nous les abordons dans la 2e partie.)

	Goer, Henci. Elective Induction of Labor. Revised and reprinted from Childbirth Instructor Magazine. http://www.hencigoer.com/articles/elective_induction/
Nous ne devrions pas procéder à des déclenchements dans une population de femmes et de bébés qui vont bien, à moins qu'ils soient vraiment dans une situation propice à l'accouchement.	[17] En avoir assez d'être enceinte, ou vouloir faire coincider l'accouchement avec les dates du vol de la belle mère font partie des raisons les moins convaincantes de déclencher un accouchement. "On me demande tout le temps des déclenchements" remarque Natale, qui ajoute que beaucoup de praticiens ne considèrent pas le côté pratique comme une raison suffisante pour déclencher le travail. Pourquoi pas ? Comme tout autre médicament ou procédure médicale, les déclenchements comportent un risque qui doit être pesé par rapport au bénéfice potentiel. Certaines femmes peuvent avoir une réaction inhabituelle au médicament, et avoir des contractions intenses, sans interruption qui n'ouvrent pas toujours le cervix, et qui peuvent causer une détresse foétale. Particulièrement si le cervix n'a pas commencé à se ramollir, un travail déclenché peut durer plus longtemps qu'un travail qui a commencé spontanément, augmentant ainsi la probabilité qu'une femme optera pour la péridurale. Quelques études ont montré une relation entre ce genre d'anti-douleur et des accouchements plus longs, ce qui peut alors augmenter les chances d'interventions supplémentaires, telles que l'épisiotomie et même les césariennes. « Si vous comparez les femmes pour lesquelles le travail commence spontanément avec celles, sans aucun risque identifiable, dont le travail est déclenché, le second groupe pourrait en fait avoir un taux de césarienne plus élevé » explique Natale. Difficile de dire de combien celui-ci est plus élevé. Les recherches sont en désaccord : selon certaines études, le déclenchement plus que double les chances de césarienne ; cependant, une revue de la littérature scientifique a conclu que le déclenchement n'a aucun effet sur le taux d'accouchement chirurgical, du moins dans le cas de grossesses dont le terme est dépassé. Alors qu'une étude publiée en 2001 dans « obstetrics and gynecology » a montré un lien entre le déclenchement et la césarienne, les auteurs affirment que c'est le taux de péridurale plus élevé parmi les femmes dont le travail a été déclenché et les facteurs de risque tels que : premier accouchement, et un cervix non dilaté avant le déclenchement qui sont à blâmer et non la procédure elle-même. Il est également important de remarquer que beaucoup de femmes dont le travail est déclenché pour soit disant dépassement de terme ne remplissent pas vraiment les critères, ce qui pourrait aussi augmenter la probabilité de la césarienne. Un audit d'un gros hôpital a montré

	qu'avant qu'un protocole ferme concernant le déclenchement soit mis en place, 1/3 des patientes qui étaient déclenchées pour dépassement du terme n'avaient en fait pas encore atteint la limite des 41 semaines et 6 jours. Quand le travail est déclenché trop tôt, les médicaments sont moins susceptibles de déclencher un véritable travail, ce qui peut déclencher une réaction en chaîne d'interventions finissant en césarienne. "Dans le cas de déclenchements, la cause de césarienne la plus commune est probablement un déclenchement raté" dit Mc Donald. C'est parce qu'un déclenchement c'est un peu comme prendre un tapis roulant ; il est parfois difficile d'appuyer sur le bouton stop une fois que vous êtes en route. Par exemple, si les prostaglandines ou les ocytocines ne marchent pas, il peut être difficile de vous convaincre ou de convaincre le personnel hospitalier de laisser les choses évoluer pendant quelques jours, même si vous et votre bébé êtes en bonne santé. Egalement, si votre poche des eaux a été rompue pour installer le moniteur interne ou pour essayer de faire avancer le travail vous pouvez être forcée d'accoucher dans une période donnée, et si vous ne le faîtes pas, vous pouvez vous retrouver en chemin pour la salle d'opération. Et, bien sûr, un accouchement chirurgical a ses propres risques, depuis les sérieuses complications telles que l'infection, jusqu'à l'inconfort suivant la naissance qui rend les soins du bébé plus difficiles. « Nous ne devrions pas procéder à des déclenchements dans une population de femmes et de bébés qui vont bien, à moins qu'ils soient vraiment dans une situation qui soit favorable à l'accouchement » souligne Natale. **Haaf, Wendy. Induction of Labour. The Cons of Induction** http://www.todaysparent.com/pregnancybirth/labour/article.jsp?content=20030523_131728_1388
Le choix d'une méthode pour le déclenchement	[288] Induction of labour is a common obstetric instrument to employ when the potential risk to continue a pregnancy is higher than to terminate it. The methods of induction can be pharmacological or mechanical; the choice of the method mainly depends by the cervical ripening, as it is significantly able to influence, according to the type of induction, its final issue. The mechanical methods are: stripping and sweeping of the membranes, hand dilatation of cervix, intrauterine pressure catheters, Laminaria Japonicum, transcervical Foley catheter and amniotomy. To pharmacological methods include some agents such as the prostaglandins (PG), the most common approach to induce a labour, and used above all by vaginal way in patients with unripe cervix. They simulate the natural PG effects at the beginning of delivery and show a great efficiency. There are a lot of PG on the market, but except some of them, as

	Dinoprostone for PGE(2) and Misoprostol for PGE(1), no one of them shows the same safety in management of labour. Oxitocin, another inductive method, administered by diluted intravenous infusion, is utilized alone or mainly with other methods when the labour is started or with rupture of the membranes, because it begins or maintains the myometrial contraction. **Tinelli A, Tinelli R, Tinelli FG. [Induction of labour: which method to use?] [Article in italian] Minerva Ginecol. 2003 Dec;55(6):463-82.** http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&list_uids=14676736&dopt=Abstract
Combien de temps attendre avant de déclencher après une rupture spontanée des membranes, sur un col favorable?	[289] Premature rupture of membranes (PROM) occurs in 8% of term deliveries. In this situation labour induction with prostaglandins, compared with expectant management, results in a reduced risk of chorioamnionitis, neonatal antibiotic therapy, neonatal intensive care (NICU) admission, and increased maternal satisfaction. The use of prostaglandin is associated with an increased rate of diarrhoea and use of analgesia/anaesthesia. Compared with oxytocin, prostaglandin induction results in a lower rate of epidural use and internal fetal heart rate monitoring but a greater risk of chorioamnionitis, nausea, vomiting, more vaginal examinations, neonatal antibiotic therapy, NICU admission and neonatal infection. Women should be informed of the risks and benefits of each method of induction.Misoprostol is gaining increasing interest as an alternative induction agent. It appears to be an effective method of labour induction with term PROM. Further research is needed to identify the preferred dosage, route and interval of administration, and to assess uncommon maternal and neonatal outcomes.There has been limited research on the use of prostaglandins, including misoprostol, for induction of labour with a favourable cervix and intact membranes. Compared with intravenous oxytocin (with and without amniotomy), labour induction using vaginal prostaglandins in women with a favourable cervix (with and without PROM) results in a higher rate of vaginal delivery within 24 hours and increased maternal satisfaction. In women with a favourable cervix, artificial rupture of membranes followed by oral misoprostol has similar time to vaginal delivery compared with artificial rupture of membranes followed by oxytocin. Further research with prostaglandins, including misoprostol, is needed to evaluate other maternal and neonatal outcomes in women being induced with a favourable cervix.No form of prostaglandin induction in women with PROM or favourable cervix has proven clearly superior to oxytocin infusion. **Crane JM, Young DC. Induction of labour with a favourable cervix and/or pre-labour rupture of membranes.** **Best Pract Res Clin Obstet Gynaecol. 2003 Oct;17(5):795-**

	809. http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&list_uids=12972015&dopt=Abstract
Comment déclencher après une rupture spontanée des membranes, sur un col défavorable?	[290] Labour induction is undertaken when the advantages for the mother and/or the baby are considered to outweigh the disadvantages. When the uterine cervix is unfavourable, oxytocin, with or without amniotomy, is frequently ineffective. Vaginal prostaglandin E(2) is most commonly used if it is affordable. Evidence regarding many alternative methods is discussed in this chapter. Of particular interest are misoprostol and extra-amniotic saline infusion.Misoprostol, an orally active prostaglandin E(1) analogue, has been used widely by the vaginal and oral routes for labour induction at or near term. Several recent trials have confirmed that it is highly effective. Overall Caesarean section rates appear to be reduced, despite a relative increase in Caesarean sections for fetal heart rate abnormalities. Concern remains regarding increased rates of uterine hyperstimulation and meconium-stained amniotic fluid, although data on perinatal outcome have been reassuring. Postpartum haemorrhage may be increased following labour induction with misoprostol, and isolated reports of uterine rupture, with or without previous Caesarean section, have appeared. Using small dosages appears to reduce adverse outcomes. Very large trials are needed to evaluate rare adverse outcomes.Extra-amniotic saline infusion is an effective method which appears to reduce the risk of uterine hyperstimulation that occurs with the use of exogenous uterotonics. **Justus Hofmeyr G. Induction of labour with an unfavourable cervix.** **Best Pract Res Clin Obstet Gynaecol. 2003 Oct;17(5):777-94.** http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&list_uids=12972014&dopt=Abstract
Etude randomisée de l'administration vaginale de mononitrate isosorbide pour la maturation du col.	[366] OBJECTIVE : Our aim was to examine the effect of the nitric oxide donor isosorbide mononitrate on the uterine cervix at term and to evaluate possible adverse effects of this treatment. STUDY DESIGN : Term pregnant women were randomly selected to receive either 40 mg vaginally administered isosorbide mononitrate or placebo 4 hours before elective cesarean section. Cervical status, maternal blood pressure, maternal pulse rate, fetal heart rate, umbilical arterial Doppler indices, and various side effects were examined. RESULTS : Isosorbide mononitrate induced a significant increase in cervical distensibility. It also caused a significant change in maternal blood pressure and maternal pulse rate. In addition, the frequency of maternal headache and palpitations was significantly higher in the isosorbide mononitrate group versus the

	placebo group. However, the intensity of these symptoms was moderate. CONCLUSION : Vaginal administration of 40 mg of isosorbide mononitrate induces cervical ripening at term. Although the majority of women experienced side effects, no serious clinical maternal or fetal adverse effects, resulting in specific medication or emergency cesarean section, were diagnosed. **Ekerhovd E, Bullarbo M, Andersch B, Norström A. Vaginal administration of the nitric oxide donor isosorbide mononitrate for cervical ripening at term: a randomized controlled study.** **American Journal of Obstetrics and Gynecology 2003;189(6):1692-1697.**
	[393] **Pitkin RM. Commentary on pelvic scoring for elective induction. : Bishop EH. Pelvic scoring for elective induction. Obstet Gynecol 1964;24:266-8, Page 846. Obstetrics & Gynecology 2003;101(5):846. Editorial.** http://www.sciencedirect.com/science?_ob=ArticleURL&_udi=B6TB2-4BGH1GH-M2&_user=10&_handle=W-WA-A-A-VD-MsSAYWA-UUA-AUDVYDUYDD-AEEYWCAEB-VD-U&_fmt=summary&_coverDate=05%2F31%2F2003&_rdoc=4&_orig=browse&_srch=%23toc%235130%232003%23998989994.7998%23476526!&_cdi=5130&view=c&_acct=C000050221&_version=1&_urlVersion=0&_userid=10&md5=8a8de94b7b60dc4a9b69ddb26cecfeab
Plus de déchirures sévères lorsque l'accouchement est en dépassement de terme, déclenché avec macrosomie foetale, utilisation de la péridurale, extraction instrumentale (notamment forceps), ou simplement conduit par un obstétricien.	[795] BACKGROUND: The incidence of anal sphincter tears is highest among nulliparous women. The aim of this study was to ascertain if there were other factors that increased their risk. METHODS: This was a retrospective study of all primigravid vaginal deliveries that had sustained an anal sphincter tear (n = 122), compared with deliveries that did not have this complication (n = 16,050). The study sample was drawn from a computerized maternity information database, comprising 52 916 deliveries in the South Glamorgan region during 1990-99. SPSS version 10 was used for statistical analysis. RESULTS: The incidence of anal sphincter tears in this study population was 0.8% (122/16172). Postdates (OR = 1.8, 95% CI = 1.3-2.6) and fetal macrosomia (OR = 3.8, 2.4-6) together with induction of labor (OR = 1.5, 1.01-2.2), use of spinal analgesia at delivery (OR = 3.1, 1.1-8.4), assisted vaginal delivery (OR = 1.9, 1.3-2.7; especially the use of forceps, OR = 2.2, 1.3-3.9) and doctor-conducted deliveries (OR = 2.2, 1.6-3.2) were found to be associated with a significantly higher incidence of anal sphincter tears. Logistic regression revealed fetal macrosomia and doctor-conducted deliveries to be independent risk factors that, when occurring together, were associated with a fourfold increase in the risk of occurrence of anal sphincter

	tears. CONCLUSIONS: This study suggests that careful assessment and counseling of women, particularly > 40 weeks gestation or those potentially having macrosomic fetuses, especially if forceps are to be used for prolonged second stage in primigravid women, may help to identify those at significant risk of anal sphincter tears. **Gupta N, Kiran TU, Mulik V, Bethel J, Bhal K. The incidence, risk factors and obstetric outcome in primigravid women sustaining anal sphincter tears. Acta Obstet Gynecol Scand. 2003 Aug;82(8):736-43.** http://www.blackwell-synergy.com/openurl?genre=article&sid=nlm:pubmed&issn=0001-6349&date=2003&volume=82&issue=8&spage=736
N'y aurait-il pas risque, aussi bien pour le soignant que les parents mais aussi l'enfant, à ainsi perturber un phénomène qui ne donnait aucun signe de problème ? Cette étude approfondie a été publiée par les Dossiers de l'Obstétrique.	[876] La maîtrise d'une technique médicale – dans le cas présent, le déclenchement de l'accouchement – implique-t-elle la nécessité d'étendre l'utilisation de cette technique au plus grand nombre de parturientes possible ? N'y aurait-il pas comme une perversion du rôle du médecin, rôle qui consiste à soigner et soulager, à défaut de toujours guérir, à inférer ainsi dans un processus – l'accouchement – qui ne requiert médicalement son intervention que dans dix à quinze pour cent des cas au plus ? N'y aurait-il pas risques, aussi bien pour le soignant que les parents mais aussi l'enfant, à ainsi perturber un phénomène qui ne donnait aucun signe de problème ? Et L'ENFANT ? C'est SA NAISSANCE, et il ne naîtra qu'une fois… Cette naissance que de nombreux chercheurs d'obédiences diverses appellent "moment fondateur", cette naissance qui semble s'imprimer, pour le meilleur ou pour le pire. au fer rouge, au plus profond de l'individu… Le premier respect de l'enfant à naître ne serait-il pas – quand tout se déroule bien – de le laisser venir en SON temps et en SON heure ? Nous ne savons pas à moyen et long termes les répercussions réelles du déclenchement de convenance sur l'individu, sur sa vie et sa santé à venir ni sur sa façon de gérer ses relations et ses problèmes… Pourtant, un certain nombre d'études sur les retentissements de la naissance sur l'individu devrait, pour le moins, inciter à la plus grande des prudences… L'interventionnisme médical INUTILE autour de l'accouchement semble laisser des séquelles durables dans un nombre de cas non négligeable. **Poitel, Blandine. Programmation de l'accouchement : les sirènes de la toute puissance. Les Dossiers de**

	l'Obstétrique No 316, mai 2003, p.10-15; No 317, juin 2003, p.16-21; No 318, juillet 2003, p.30-33. http://users.swing.be/carrefour.naissance/Articles/sc/ProgramAcc.htm Remarques : Pour commander un tiré à part de cet article, il suffit d'envoyer vos nom prénom et adresse, ainsi que votre règlement (10 euros, comprenant les frais de port) à Blandine POITEL, 1 Rue du Docteur Calmette, logement 38, 17000 LA ROCHELLE.
Les médecins ont de la difficulté à reconnaître leurs erreurs. Or celle-ci est de taille: le déclenchement des accouchements vaginaux après césariennes à l'aide du Cytotec (misoprostol), recommandé par l'American College of Obstetricians and Gynecologists, qui persiste depuis des années…	[880] Doctors find it difficult to admit mistakes. Here we have a big mistake—Cytotec induction with VBAC—that went on for years. Yet, there is no discussion of the error or what to do so it won't happen again. Those doctors and midwives using Cytotec for induction of labor off-label need to understand that they are taking very big chances with the safety of the women and babies they serve. Just about everyone in the world, after taking a careful look at the scientific evidence, has concluded we don't yet know enough about the risks to be willing to use it. This is illustrated in the following list of organizations that do and do not recommend Cytotec (misoprostol) for labor induction: Recommends 1. American College of Obstetricians and Gynecologists (ACOG) Does not recommend 1. U.S. Food and Drug Administration 2. Best scientific opinion—Cochrane Database 3. Searle (manufacturer of Cytotec) 4. Society of Obstetricians and Gynaecologists of Canada 5. British Royal College of Obstetricians and Gynecologists 6. All obstetric organizations in Scandinavia 7. FIGO (International Federation of Gynecology and Obstetrics) 8. World Health Organization 9. Obstetric organizations and drug regulatory agencies in many other countries How can ACOG possibly be willing to stand alone in opposition to the best scientific opinion in the world? Because so many of ACOG's members already use Cytotec induction off-label for its incredible convenience, the organization needs to support its members by recommending this practice. This means ACOG must find a paper published in a prominent U.S. journal supporting Cytotec induction. In ACOG's recommendation on Cytotec induction, the organization leans heavily on a paper by A.B. Goldberg and other authors published in the New

	England Journal of Medicine (2). Let's take a careful look at the contents of this paper, as it is a superb example of torturing the data until it confesses to what the authors want it to say… **Wagner, Marsden. Cytotec Induction and Off-Label Use. Midwifery Today, 67, Fall 2003.** http://www.midwiferytoday.com/articles/cytotec.asp
En matière de déclenchement, tout est loin d'être réglé. Ce qui compte par-dessus tout, c'est l'indication du déclenchement. Il faut en peser les avantages et les inconvénients, pour la mère et son enfant, après une lecture critique des données épidémiologiques.	[884] Le déclenchement de l'accouchement est une pratique devenue fréquente (22 % des accouchements en France sont déclenchés). Ce n'est pourtant pas un exercice toujours facile notamment lorsque les conditions locales sont défavorables. À terme, toutes indications et parités confondues, les déclenchements sur conditions locales défavorables sont grevés d'un taux de césariennes supérieur à 20 %. Les indications doivent donc être posées avec rigueur. Hors indication médicale, plusieurs enquêtes de pratique montrent un excès de césariennes en cas de déclenchement, résultats contraires à ceux des travaux randomisés ; probablement les strictes conditions d'inclusion de ces derniers ont-elles été oubliées au quotidien de l'exercice obstétrical. En cas d'indication médicale, il ne semble pas en première analyse que les déclenchements soient délétères ; attention cependant de ne pas dépasser dans la pratique les conclusions des meilleurs travaux. Personne n'a jamais démontré qu'il fallait déclencher à 41 semaines plutôt qu'à 41 semaines + 6 jours ; personne n'a jamais montré une supériorité quelconque du déclenchement avant terme dans les ruptures prématurées des membranes par rapport à une surveillance bien conduite. Les espoirs venus des techniques de maturation sont un peu déçus quel que soit le procédé utilisé ; certes les scores de Bishop s'améliorent, certes les naissances sont plus rapides après maturation, mais les taux de césariennes restent sensiblement les mêmes. Il apparaît donc qu'en matière de déclenchement tout est loin d'être réglé. Ce qui compte par-dessus tout, c'est l'indication du déclenchement. Il faut en peser les avantages et les inconvénients, pour la mère et son enfant, après une lecture critique des données épidémiologiques. **Marpeau, L. Maturation du col utérin. Déclenchement du travail. Apport des systèmes intravaginaux de PGE2. Mises à jour en gynécologie obstétrique, tome XXVII, volume Gynécologie obstétrique, p. 125. CNGOF** http://www.cngof.asso.fr/D_PAGES/PUMAGO_2003.HTM#125
Etude de la fiabilité du	[423] OBJECTIVE: To evaluate the agreement within three pairs of observers regarding the Bishop score and an

score de Bishop avant le déclenchement à terme	informal global evaluation of the cervix (favourable/unfavourable). STUDY DESIGN: We conducted a reliability study of the Bishop score. Three pairs of examiners (A?B, A?C and D?E) performed independently a cervical examination in 156 term pregnant women admitted for labour induction. We calculated the proportion of agreement and the Kappa coefficient. RESULTS: Perfect agreement between two observers for the Bishop score was found in 44 women (28%). Accepting a difference of one point between the observers, agreement increased to 66%. Weighted Kappa coefficients for the Bishop score were 69, 54 and 35% for each pair of observers. Kappa coefficients for the informal evaluation of the cervix were 64, 45 and 46, respectively. CONCLUSION: Agreement between two observers evaluating the cervix is fair to substantial. An informal evaluation of the cervix is as reliable as the Bishop score. **Faltin-Traub EF, Boulvain M, Faltin DL, Extermann P, Irion O. Reliability of the Bishop score before labour induction at term.** **European Journal of Obstetrics & Gynecology and Reproductive Biology 2004;112(2):178-181.** http://www.sciencedirect.com/science?_ob=ArticleURL&_udi=B6T69-4B7HM19-2&_user=10&_handle=W-WA-A-A-BU-MsSAYZW-UUW-AUDCZAAEAD-WADAYBWCZ-BU-U&_fmt=summary&_coverDate=02%2F10%2F2004&_rdoc=11&_orig=browse&_srch=%23toc%235025%232004%23998879997%23476654!&_cdi=5025&view=c&_acct=C000050221&_version=1&_urlVersion=0&_userid=10&md5=abec8194f001fab82343455f178693a4
Essai comparatif randomisé de deux protocoles de gestion active du travail en présence d'un col défavorable	[457] OBJECTIVE : The purpose of this study was to compare the efficacy of two protocols for active management of labor at term in the presence of an unfavorable cervix. STUDY DESIGN : Pregnancies that underwent labor induction at 37 weeks of gestation with an unfavorable cervix (Bishop score, 6) were randomly assigned to receive vaginally either a single dose of sustained-release dinoprostone (Cervidil) with concurrent low-dose oxytocin or multidosing of misoprostol (25 g every 4 hours) followed by high-dose oxytocin. The primary outcome was the time interval from induction to vaginal delivery. Other parameters included excess uterine activity and cesarean delivery rates. RESULTS : A total of 151 patients (dinoprostone, 74 patients; misoprostol, 77 patients) were enrolled. The mean time from the initiation of induction to vaginal delivery was the same in the dinoprostone and misoprostol groups (15.7 hours; 95% CI, 13.7-17.7 hours

	vs 16.0 hours; 95% CI, 14.1-17.8 hours; P = .34), regardless of parity. The dinoprostone and misoprostol groups did not differ statistically in the percent of patients who were delivered vaginally by 12 hours (36.2% vs 29.7%), 18 hours (63.8% vs 56.3%), and 24 hours (81.0% vs 81.3%). Excess uterine activity was not more common in either group, and hyperstimulation syndrome was absent in all cases. Primary cesarean delivery rates were similar (dinoprostone, 21.6%; misoprostol, 16.9%; relative risk, 1.3; 95% CI, 0.7-2.5), with a failed induction that occurred in one case in each group. CONCLUSION : Sustained-release dinoprostone with concurrent low-dose oxytocin and intermittent misoprostol with delayed high-dose oxytocin are effective alternatives for active management of labor with an unfavorable cervix. **Bolnick JM, Velazquez MD, Gonzalez JL, Rappaport VJ, McIlwain-Dunivan G, Rayburn WF. Randomized trial between two active labor management protocols in the presence of an unfavorable cervix.** **American Journal of Obstetrics and Gynecology 2004;190(1):124-28.** http://www.sciencedirect.com/science?_ob=ArticleURL&_udi=B6W9P-4BHSWFC-X&_user=10&_handle=W-WA-A-A-CY-MsSAYZA-UUA-AUDZCZWVUB-WBZVAAEUU-CY-U&_fmt=full&_coverDate=01%2F31%2F2004&_rdoc=22&_orig=browse&_srch=%23toc%236688%232004%23998099998%23476806!&_cdi=6688&_artOutline=Y&view=c&_acct=C000050221&_version=1&_urlVersion=0&_userid=10&md5=f93789c57eb432ad0078d018ec783bbf#toc5
Le risque de césarienne est multiplié par 12.4 pour une nullipare ayant dépassé 41 semaines d'âge gestationnel avec un bébé en vertex, s'il n'est pas encore engagé.	[458] OBJECTIVE : The purpose of this study was to determine whether an unengaged vertex significantly increased the risk of cesarean delivery in nulliparous patients at 41 weeks or greater. STUDY DESIGN : The medical records from all nulliparous patients greater than 41 weeks' gestation delivered at a single institution were reviewed. Patients undergoing both spontaneous and induced labor were included. Multivariate analyses were used to compare the influence of admission fetal station versus induction of labor on the risk of cesarean delivery. RESULTS : Four hundred forty-eight nulliparous women at greater than 41 weeks' gestation were delivered at our institution during the study period. Sixty-two percent of these patients underwent induction of labor. There was a statistically significant increase in cesarean delivery rate compared with station (6% of patients at -1 station, 20% at -2 station, 43% at -3 station, and 77% at -4 station; P = .001). Compared with patients with an engaged vertex, patients with an unengaged vertex had 12.4 times the risk of cesarean delivery. Most of the cesarean deliveries were performed for failure to progress. On the basis of multivariate analysis, the

	odds of cesarean delivery were better predicted by fetal station than induction of labor. CONCLUSION : Nulliparous patients at 41 weeks or greater with an unengaged vertex are 12.4 times more likely to be delivered by cesarean section than a patient with an engaged vertex. **Shin KS, Brubaker KL, Ackerson LM. Risk of cesarean delivery in nulliparous women at greater than 41 weeks' gestational age with an unengaged vertex. American Journal of Obstetrics and Gynecology 2004;190(1):129-34.** http://www.sciencedirect.com/science?_ob=ArticleURL&_udi=B6W9P-4BHSWFC-Y&_user=10&_handle=W-WA-A-A-CY-MsSAYZA-UUA-AUDZCZWVUB-WBZVAAEUU-CY-U&_fmt=summary&_coverDate=01%2F31%2F2004&_rdoc=23&_orig=browse&_srch=%23toc%236688%232004%23998099998%23476806!&_cdi=6688&view=c&_acct=C000050221&_version=1&_urlVersion=0&_userid=10&md5=2b83b7225434c6c34f859a17f20717d5
La pratique d'une échographie au premier trimestre permet de réduire les taux de déclenchement pour dépassement de terme. (Essai randomisé)	[743] Objective This study was designed to test the null hypothesis that first trimester ultrasound crown-rump length measurement for gestational age determination will result in no difference in the rate of induction of labor for postterm pregnancy, compared with second trimester biometry alone. Study design Two hundred eighteen women were randomly assigned to receive either first trimester ultrasound screening or second trimester ultrasound screening to establish the expected date of confinement. Sample size was calculated by using a 2-tailed = .05 and power (1-) = 80%. Data were analyzed with 2 and Fisher exact tests. Results Of 104 women randomly assigned to the first trimester screening group, 41.3% had their gestational age adjusted on the basis of the crown-rump length measurement. Of 92 women randomly assigned to the second trimester screening group, 10.9% were corrected as a result of biometry (P < .001, relative risk = 0.26, 95% CI = 0.15-0.46). Five women in the first trimester screening group and 12 women in the second trimester screening group had labor induced for postterm pregnancy (P = 0.04, relative risk = 0.37, 95% CI = 0.14-0.96). Conclusion The application of a program of first trimester ultrasound screening to a low-risk obstetric population results in a significant reduction in the rate of labor induction for postterm pregnancy.

	Bennett KA, Crane JMG, O'Shea P, Lacelle J, Hutchens D, Copel JA. First trimester ultrasound screening is effective in reducing postterm labor induction rates: A randomized controlled trial. **American Journal of Obstetrics and Gynecology 2004;190(4):1077-1081.** http://www.sciencedirect.com/science/article/B6W9P-4C7D32V-1P/1/d9bc1c466c103af200260c4a069d29c7
Grande disparité des taux de péridurale, déclenchement, épisiotomie, déchirures, forceps, entre deux maternités françaises.	[791] BUT: Comparer les pratiques obstétricales entre une maternité de type 1 et une de type 3 chez les nullipares à bas risque. MATERIEL ET METHODES: Étude rétrospective en 2000 et 2001 regroupant 1 532 nullipares à bas risque dans 2 maternités d'Île-de-France. Le critère de jugement principal était le taux de césariennes pendant travail. Les autres critères recherchés ont été le taux de déclenchement et d'extraction instrumentale, le type d'analgésie, les conséquences périnéales et néonatales. RESULTATS: Le taux de césariennes pendant travail n'était pas siginificativement différent entre les deux maternités (11,5 % dans le type 3 versus 10,2 % dans le type 1). Le taux de déclenchement était significativement plus élevé dans la maternité de type 1 (14,2 % versus 8,7 %, p < 0,01). Le taux de péridurales est plus élevé dans la maternité de type 3 (95,1 % versus 75,5 %, p < 0,01) avec deux fois moins d'anesthésie générale (0,6 % versus 1,2 %, p < 0,01). Les taux de forceps (27,5 % versus 17,4 %, p < 0,01) et d'épisiotomie (72,7 % versus 39,3 %) étaient significativement plus élevés dans la maternité de type 3 mais avec plus de déchirures périnéales dans la maternité de type 1 (29,8 % versus 17,4 %, p < 0,01). Les transferts en médecine néonatale étaient plus fréquents dans le type 3. CONCLUSION: Dans cette étude, certaines attitudes obstétricales, mais pas toutes, semblent moins « interventionnistes » parmi les médecins et les sages-femmes qui prennent en charge essentiellement des grossesses à bas risque que parmi ceux qui prennent en charge quotidiennement des grossesses pathologiques mais sans différence sur le taux de césariennes. Les différences principales concernent les taux de péridurales, de forceps, et d'épisiotomie alors que les taux de déclenchement et de déchirures périnéales sont plus élevés dans la maternité de type 1. Les raisons ne sont pas forcément liées au type de structure, et ne peuvent donc pas être généralisées à l'ensemble des maternités de type 1 et 3, mais peuvent être liées à des politiques obstétricales différentes au sein des deux équipes. **Le Ray C, Gaudu S, Teboul M, Cabrol D, Goffinet F. Prise en charge du travail et de l'accouchement chez la nullipare à bas risque : comparaison d'une maternité de**

	type 1 et d'une maternité de type 3 **J Gynecol Obstet Biol Reprod 2004 Feb;33:30-6.** http://www.e2med.com/index.cfm?fuseaction=viewArtDossier&DartIdx=171071&DIssIdx=9532&DChapIdx=71852
En cas de rupture spontanée des membranes à terme, la meilleure approche consiste à déclencher si le travail n'a pas débuté spontanément après 24 heures.	[823] OBJECTIVES: To determine the significant predictors of clinical chorioamionitis and neonatal infection in patients with prelabor rupture of the membranes at term, and to apply this information to determination of optimal timing of labor induction. STUDY DESIGN: A retrospective case control series of women at 37 weeks' with prelabor rupture of the membranes. The study group consisted of women with evidence of maternal or neonatal infection. Controls had no evidence of infection. Three types of management were compared. (1) Immediate induction of labor, (2) expectant management up to 24 h followed by induction of labor if still necessary, or (3) expectant management for over 24 h. Univariate and multivariate analyses were performed by stepwise logistic regression (SPSS software package). The size of the study and the control groups was calculated for a 90% power with two sided P value of 0.05 in order to demonstrate an odds ratio of 2 for expectant management (two groups: early and late) versus immediate induction of labor (132 and 279 women in the study and the control groups, respectively). RESULTS: The rate of expectant management for over 24 h versus expectant management until 24 h followed by induction of labor when still necessary, was higher among cases than among controls (OR=1.84; P<0.017; 95% CI, 1.127–3.003). Conversely, the rate of immediate induction of labor versus expectant management until 24 h followed by induction of labor when still necessary, was also higher among cases (OR=2.66; P<0.001; 95% CI, 0.222–0.644). CONCLUSION: In women with prelabor rupture of the membranes at term, the best approach is to induce labor if spontaneous labor has not begun after 24 h. **Ezra Y, Michaelson-Cohen R, Abramov Y, Rojansky N. Prelabor rupture of the membranes at term: when to induce labor?** **European Journal of Obstetrics & Gynecology and Reproductive Biology 2004;115(1):23-27.** http://www.sciencedirect.com/science/article/B6T69-4CGNT17-4/1/2b63503ab51d04e690131492aea8c275
Il existe une distinction fondamentale entre accouchement vaginal (c'est-à-dire naissance par les voies	[834] Le débat actuel entourant la possibilité pour les femmes d'obtenir de leur obstétricien une césarienne sur demande a fait l'objet d'un article paru dans votre journal en mars 2004. Dans cet article, Hannah nous informe du fait que seule une nouvelle étude randomisée contrôlée pourrait permettre d'évaluer les risques et les avantages d'une césarienne programmée par opposition à un accouchement vaginal planifié. Afin d'illustrer

naturelles) et accouchement physiologique (expression d'un processus physiologique normal non perturbé).	certains avantages de la césarienne élective, Hannah introduit plusieurs résultats statistiques reliés en particulier aux taux d'incontinence urinaire. Or, dans cet article, le terme d'accouchement vaginal spontané mériterait d'être mieux défini. Quand Hannah fait référence au taux d'incontinence urinaire suivant un accouchement vaginal spontané, on est en droit de se demander, par exemple, si dans l'étude citée les femmes mettant au monde leur bébé ont fait l'expérience d'une poussée physiologique involontaire, non dirigée, faisant intervenir le réflexe de poussée. Ou plutôt, s'il s'est agit d'un accouchement vaginal spontané, sous péridurale par exemple, durant lequel à dilatation complète la femme s'est vu encouragée à inspirer, bloquer, pousser. Les résultats et les conséquences sur le périnée féminin sont-ils les mêmes d'une manière ou de l'autre? Ceci nous amène à questionner l'autorité que l'on doit accorder à Hannah dès lors qu'elle fait référence à la notion d'accouchement vaginal spontané. Lorsqu'on parle de spontané cela veut dire que l'accouchement s'est déroulé spontanément, c'est-à-dire physiologiquement. Si c'est le cas, l'induction, la stimulation, le monitoring, la restriction des positions pour la poussée, la péridurale, le «coaching» de la poussée, l'épisiotomie, les ventouses, les pressions abdominales, les forceps, seraient tous des éléments qui excluraient ces accouchements de la catégorie accouchement vaginal spontané. Il est évident pour ceux qui en ont été témoins qu'il existe une distinction fondamentale entre accouchement vaginal (c'est-à-dire naissance par les voies naturelles) et accouchement physiologique (expression d'un processus physiologique normal non perturbé). Le milieu hospitalier est reconnu comme un milieu où les comportements sont fortement codifiés et structurés. Une femme qui y accouche aujourd'hui ne devrait trop espérer y être soutenue dans sa «spontanéité». L'accouchement vaginal spontané observé en milieu hospitalier comporte un biais énorme, celui-là même d'avoir lieu dans un espace, l'hôpital, où le processus physiologique normal de la mise au monde d'un bébé est quasiment toujours perturbé. L'hôpital est un biais systématique important introduit dans toutes les études sur l'accouchement, sans jamais être mentionné comme une des limites des études. L'accouchement vaginal spontané devrait être clairement défini dans les futures études scientifiques, incluant celles dirigées par Hannah. Si l'on souhaite vraiment comparer les césariennes sur demande avec l'accouchement vaginal spontané, on devrait le faire en se concentrant sur l'espace le plus propice à un accouchement spontané et physiologique, c'est-à-dire l'accouchement à la maison.

	Gerbelli C. Elective cesarean section. Letters. Canadian Medical Association Journal 2004;171(1):15. http://www.cmaj.ca/cgi/content/full/171/1/15?etoc http://www.cmaj.ca/cgi/reprint/171/1/15-a.pdf
Les obstétriciens devraient être intransigeants envers les patients comme envers eux-mêmes quand ils envisagent un déclenchement de travail sans indication particulière, afin d'éviter de prendre des risques d'échec de déclenchement, ou de césarienne causée par une progression inadéquate du travail.	[873] Le déclenchement du travail est une intervention controversée, et les obstétriciens, assez souvent, sont confrontés aux demandes des patientes, soit de reporter le déclenchement alors qu'il est justifié par une indication médicale, soit encore de demander un déclenchement sans indication particulière. La seule indication, pour nous, d'un déclenchement "de routine", est le dépassement de terme au delà de 42 semaines de gestation. La décision de déclencher le travail dépend des risques de continuer la grossesse en comparaison avec ceux de l'interrompre. Il existe des complications obstétricales dont on sait bien qu'elles induisent des risques caractérisés pour le foetus et la mère, notamment la pré-éclampsie modérée ou sévère, le diabète, la maladie de rhésus et une forte insuffisance placentaire. Les autres indications sont moins fortes, et les obstétriciens devraient être intransigeants envers les patients comme envers eux-mêmes quand ils envisagent un déclenchement de travail pour de telles indications, afin d'éviter de prendre des risques d'échec de déclenchement ou de césarienne causée par un travail dysfonctionnel. **Danny Tucker. Induction of labour - A guide for SHO's. Jessop Hospital for Women, Sheffield (UK).** http://www.womens-health.co.uk/iol.htm
Ressources bibliographiques sur le déclenchement	[874] MAJOR RECOMMENDATIONS Each recommendation is rated based on the level of the evidence and the grades of recommendation. Definitions of the grades of the recommendations (A, B, C, Good Practice Points) and level of the evidence (Level I-Level IV) are presented at the end of the Major Recommendations field. C - Induction of labour is indicated when the benefits of delivery to the mother or foetus outweigh those of continuing with the pregnancy. The risks of induction should be weighed against the benefits of continuing with the pregnancy. (Grade C, Level IV) C - The decision to perform a social induction of labour should be taken on a case-by-case basis, after fully discussing the potential risks and disadvantages with the patient (Royal College of Obstetricians & Gynaecologists [RCOG], 1998). (Grade C, Level IV) C - Induction of labour should be performed in an environment where trained personnel and facilities are

	available to deal immediately with any complication of induction of labour. (Grade C, Level IV) C - Continuous electronic foetal heart rate monitoring in active labour is recommended (RCOG, 1998; American College of Obstetricians & Gynaecologists, 1995; Spencer & Ward, 1993). (Grade C, Level IV) A - The favourability of the cervix, or otherwise, should be assessed prior to induction. If the cervix is unfavourable and the induction necessary, ripening of the cervix is useful. (Grade A, Level Ia) C - Prostaglandins should be administered at a facility where continuous uterine activity and foetal heart rate monitoring can be performed. (Grade C, Level IV) A - The oxytocin levels required to produce effective contractions vary widely among individuals (Amico, Seitchik, & Robinson, 1984; Arulkumaran et al, 1985) and thus the oxytocin titrated must be individualised. (Grade A, Level Ib) C - Continuous electronic foetal monitoring is recommended whenever an oxytocin infusion is used. (Grade C, Level IV) B - Induction of labour is not contraindicated in women with one previous low segment transverse caesarean section as long as the labour is monitored closely. (Grade B, Level III) Grades of Recommendation Grade A (evidence levels Ia, Ib): Requires at least one randomized controlled trial as part of the body of literature of overall good quality and consistency addressing the specific recommendation. Grade B (evidence levels IIa, IIb, III): Requires availability of well conducted clinical studies but no randomised clinical trials on the topic of recommendation. Grade C (evidence level IV): Requires evidence obtained from expert committee reports or opinions and/or clinical experiences of respected authorities. Indicates absence of directly applicable clinical studies of good quality. Good Practice Points: Recommended best practice based on the clinical experience of the guideline development group. Levels of Evidence Level Ia: Evidence obtained from meta-analysis of randomised controlled trials.

	Level Ib: Evidence obtained from at least one randomised controlled trial. Level IIa: Evidence obtained from at least one well-designed controlled study without randomisation. Level IIb: Evidence obtained from at least one other type of well-designed quasi-experimental study. Level III: Evidence obtained from well-designed non-experimental descriptive studies, such as comparative studies, correlation studies and case studies. Level IV:Evidence obtained from expert committee reports or opinions and/or clinical experiences of respected authorities. **Ministry of Health, Singapore. Induction of labour. Bibliographic sources. Singapore Ministry of Health. Induction of labour. Singapore: Singapore Ministry of Health; 2000 Aug. 22 p. [28 references]** http://www.guideline.gov/summary/summary.aspx?doc_id=2839&nbr=2065
Le déclenchement peut s'avérer une procédure utile lorsqu'il est urgent de faire naître le bébé, mais il présente des inconvénients.	[875] Le déclenchement peut s'avérer une procédure utile lorsqu'il est urgent de faire naître le bébé, mais il présente des inconvénients: * On pensait autrefois que le déclenchement augmentait le risque que le travail se finisse par une césarienne. Les travaux de recherche ont montré que ce n'est pas le cas lorsque la seule raison du déclenchement est le dépassement de terme. * Il peut y avoir un risque accru de césarienne si la cause du déclenchement est la pré-éclampsie ou toute autre raison signifiant que le bébé ne se porte pas bien. Toutefois, dans ces cas, il existe un risque que le bébé naisse par césarienne, de toute manière, et il est difficile de prouver que ce risque serait accru par le déclenchement. * Les accouchements déclenchés peuvent être rapides et violents. Certains femmes se réjouissent que tout se soit passé rapidement, tandis que d'autres auraient préféré une transition plus graduelle vers la maternité ! Si votre accouchement doit être déclenché, il faut vous préparer à des contractions soudaines et fortes, et discuter avec votre partenaire de naissance vos choix de traitement de la douleur. **Babyworld site (UK). Risks of induction** http://www.babyworld.co.uk/information/birth/induction/risks_induction.asp Remarques :

	Cette page parle de résultats des recherches mais ne cite aucune référence à l'appui de ses affirmations. Elle n'aborde pas le sujet des déclenchements pour convenance, voir par exemple la fiche 872 de cette base: Risks of induction of labour in uncomplicated term pregnancies. Paediatric & Perinatal Epidemiology 15 (2), 131-138.