OUTCOMES OF LABOUR INDUCTION FOR WOMEN WITH GESTATIONAL HYPERTENSION

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Introduction.

Approximately 10% to 15% of all pregnancies are complicated by hypertensive disorders. The vast majority of these cases occur after 32 weeks. The only causal treatment of the disease is delivery. Labour induction is an important option for the termination of pregnancy, when the progression of pregnancy increases the risks on the maternal health as well as on growing fetus. Labour induction with unfavorable cervix is done with prostaglandins, then followed by amniotomy and augmentation with oxytocin, when cervix is favorable then induction with amniotomy and augmentation with oxytocin is carried out.

Women with gestational hypertension or with mild pre-eclampsia at term, induction of labour is less costly than expected, but before taking the decision for labour induction women should be thoroughly evaluated regarding subsequent harmful effects of induction. Surprisingly the effectiveness for the induction of labour is not proven, so decision for induction of labour must be individualized. The safety and effectiveness of labour induction depends on the health of the woman and her baby, previous obstetrical history, appropriate time and method of induction and the availability of the birth capacity.

Labour induction in women with gestational hypertension who had completed 38 weeks pregnancy duration results in better outcome in comparison with those women in whom induction of labour is carried out at earlier gestation period. In these women there are increased risks for the babies like breathing problems, infections as well as neonatal intensive care unit admission. Despite a clinical benefit of induction of labour, long-term health-related quality of life is equal after the induction of labour and expectant management in women with gestational hypertension or pre-eclampsia beyond 36 weeks of gestation

Methods:

The informations of research were collected from 46 pregnant women with gestational hypertension. These pregnant women were between 34-40 weeks of gestational period in whom labour was induced. In those women, other reasons and conditions for labour induction were excluded, which means hypertension disorders were only instruction for induction. These women were registered on the predesigned proforma.

These women were managed with the departmental management protocol for pregnancy-induced hypertension, pre-eclampsia, and eclampsia, when their condition was established; labour induction was decided with pelvic assessment, cervical condition, for fetal assessment cardiotocographic examination was carried. Appropriate mode for labour induction was decided after Bishop scoring and following the result of cervix estimation by Bishop scoring one of the induction methos was choosen. Patients general condition, fetal condition and labour progress was vigilantly monitored with partographic record and fetal condition was monitored with cardiotocography. Immediate intervention steps were taken with any maternal or fetal problem according to the available institutional facilities along with multidisciplinary approach

Results:

Out of total 46 women included in the study 18% women were 21-26 years of age, 24% women were 27-34years, while 58% women were between 34-42 years of age. The mean age with standard deviation was 28.93±5.037. The primigravid women with gestational hypertension with labour induction were more frequent -56.5% in comparison with multiparous - 43.5%. Moreover, majority of these women 61.8% were having gestational period between 35-38 weeks, whereas women with pregnancy duration between 30-34 weeks were 38.2%.

Common presenting symptoms, which complicated pregnant women, were oedema 86.23%, headache 65.21%, and pain in epigastrium 26.52%, blurring of vision 17.1%. Cervical condition was favorable in 55.8% women, and unfavorable in 44.2% women. Labour induction was done with prostaglandin in 58.7% women, while other methods of induction of labour used in 44.2% women.

Labour induction outcome resulted in normal vaginal delivery in 71.69 % women, while Caesarean section was performed totally in 28.3% women, out of these, failed induction comprises 30.76 women and 69.23% women had in emergency Caesarean section for maternal or fetal reasons. Maternal complications observed were uncontrolled hypertension in 16.7% cases, intensive care unit admission in 15.2% cases, emergency anaesthesia complications in 12.3% cases, postpartum haemorrhage in 6.52% cases, perineal tear in 30.3% cases and shoulder dystocia was seen in 9.09% cases. Fetal birth with good Apgar score was seen in 63% cases, while fetal complications observed were birth asphyxia in 21.7% cases, intensive care neonatal unit admission in 10.9% cases, and early neonatal death was seen in 2.1%cases

Conclusion:

Caesarean section rate was high due to failed induction and fetomaternal reasons in emergency. Maternal morbidity as well as fetal morbidity and mortality rate was high. Appropriate decision prior to induction of labour considering the condition of mother and fetus is very important. Vigilant labour monitoring, timely decision for intervention, and proper newborn care will help in decreasing morbidity and mortality

References:

1. Rudra P, Basak S, Patil D, Latoo MY. Recent Advances in the management of pre-eclampsia. *BJMP*. 2011;4(3):14–22. [Google Scholar]
2. Langenveld J, Broekhuijsen K, van Baaren GJ, van Pampus MG, van Kaam AH, Groen H. Induction of labour versus expectant monitoring for gestational hypertension or mild pre-eclampsia between 34 and 37 weeks, gestation (HYPITAT-II): a multicentre, open-label randomized controlled trial. *BMC Pregnancy Child Birth*. 2011;11:50–59. doi:10.1186/1471-2393-11-50. [PMC free article] [PubMed] [Google Scholar]
3. Vijgen SM, Koopmans CM, Opmeer BC, Groen H, Bijlenga D, Aarnoudse JG, et al. An economic analyses of induction of labour and expectant monitoring in women with gestational hypertension or pre-eclampsia at term (HYPITAT trial) *BJOG*. 2010;117(13):1577–1585. doi:10.1111/j.1471-0528.2010.02710.x. [PubMed] [Google Scholar]
4. Mozurkewich E, Chilimigras J, Koepke E, Keeton K, King VJ. Indications for induction of labour: A best-evidence review. *BJOG*. 2009;116(5):626–636. doi:10.1111/j.1471-0528.2008.02065.x. [PubMed] [Google Scholar]
5. Koopmans CM, Bijlenga D, Groen H. Induction of labour versus expectant monitoring for gestational hypertension or mild pre-eclampsia after 36 weeks, gestation(HYPITAT): A multicentre, open-label randomized controlled trial. *Lancet*. 2009;374:979–988. [PubMed] [Google Scholar]

6. Barton JR, Barton LA, Istwan NB. Elective delivery at 34(0/7) to 36 (6/7) weeks, gestation and its impact on neonatal outcomes in women with stable mild gestational hypertension. *Am J Obstet Gynecol*. 2011;204(1):441–445. doi:10.1016/j.ajog.2010.08.030. [PubMed] [Google Scholar]
7. Bijlenga D, Koopmans CM, Birnie E, Van der Post JA, Bllomenkamp Health- related quality of life after induction of labour versus expectant monitoring in gestational hypertension or preeclampsia at term. *Hpertens Pregnancy*. 2011;30(3):260–274. doi:10.3109/10641955.2010.486458. [PubMed] [Google Scholar]