SYNTOCINON INDUCTION OR AUGMENTATION OF LABOUR GUIDELINE

1. OPTIMAL OUTCOMES
   - Successful induction of labour using a syntocinon regime
   - Successful augmentation of labour using a syntocinon regime

2. PATIENT
   - Women requiring induction or augmentation of labour with syntocinon

3. STAFF
   - Registered midwives
   - Student midwives
   - Medical officers

4. EQUIPMENT
   - Normal saline
   - Syntocinon 10 unit ampoule
   - Giving set for infusion pump
   - Infusion pump
   - Cardiotocograph monitor (CTG)

5. CLINICAL PRACTICE
   - Induction of labour
     - Induction with Syntocinon should not be started until 6 hours following administration of vaginal prostaglandins
     - Admit to Delivery Suite
     - Perform midwifery admission for labour
     - Notify appropriate medical staff of admission
     - Perform medical admission and prescribe syntocinon regime
     - Insert 16 gauge intravenous cannula
     - Collect and send appropriate blood
     - Perform vaginal examination and artificial rupture of membranes where appropriate
   - Augmentation of labour
     - Consult and refer to appropriate medical staff for medical admission
     - Discuss with senior medical officer augmentation with Syntocinon for:
       - Women 7cm dilated or greater
       - Multiparous patients
       - Previous uterine surgery
       - Breech
       - Multiple pregnancy
     - Perform medical admission and prescribe syntocinon regime
     - Insert 16 gauge intravenous cannula
     - Collect and send appropriate blood
     - Perform vaginal examination and artificial rupture of membranes where appropriate

cont'd ..../2
• Commence the recommended regimen as per table
• Increase the rate at intervals of 30 minutes
• Titrate the increase against uterine contractions aiming for a maximum of 3-4 contractions every 10 minutes
• Do not exceed 32 milliunits per minute
• Recommend continuous electronic fetal monitoring during labour

Standard dilution as follows:

<table>
<thead>
<tr>
<th>Time after starting infusion in minutes</th>
<th>Oxytocin Dose (mU/min)</th>
<th>Volume infused (mls/hr)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>30</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>60</td>
<td>4</td>
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<td>8</td>
<td>24</td>
</tr>
<tr>
<td>120</td>
<td>12</td>
<td>36</td>
</tr>
<tr>
<td>150</td>
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<td>84</td>
</tr>
<tr>
<td>270</td>
<td>32</td>
<td>96</td>
</tr>
</tbody>
</table>

• Decrease or discontinue syntocinon in cases of uterine hypercontractility
• Consider administration of 100 – 250 micrograms of salbutamol in cases of uterine hypercontractility associated with fetal heart rate abnormality

6. HAZARDS/SUB-OPTIMAL OUTCOMES
• Uterine hypercontractility
• Unsuccessful induction of labour
• Hyponatremia
• Uterine rupture
• Inadvertent administration of bolus syntocinon

7. DOCUMENTATION
• Partogram
• Integrated notes
• Fluid balance chart
8. EDUCATIONAL NOTES

- In women with intact membranes amniotomy should be performed where feasible prior to commencement of an infusion of oxytocin; an exception to this may be in the case of fetal death in utero
- To reduce error a standard dilution of Syntocinon should be used
- Adequate contractions are most likely to be established at 8-12 milliunits per minute
- In cases of suspected uterine hypercontractility with a suspicious or pathological FHR pattern secondary to oxytocin infusion, decrease or discontinue infusion
- Syntocinon should be stored in the fridge

9. RELATED POLICIES/ PROCEDURES

- First stage labour care
- Second stage labour care
- Artificial rupture of membranes
- Fetal heart rate monitoring – antenatal
- Fetal heart rate monitoring – intrapartum

10. REFERENCES

- National Institute for Clinical Excellence (2001) *Induction of labour clinical guideline* available online @ www.nice.org.uk
- Royal College of Obstetricians and Gynaecologists (2001) *Induction of labour national evidence based guideline* available online @ www.rcog.org.uk