

# Induction of labour versus expectant management for women over 35 years

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<b>Registration date</b> 23/08/2012	<b>Overall study status</b> Completed	<input type="checkbox"/> Statistical analysis plan <input checked="" type="checkbox"/> Results
<b>Last Edited</b> 11/03/2016	<b>Condition category</b> Pregnancy and Childbirth	<input type="checkbox"/> Individual participant data

## Plain English summary of protocol

### Background and study aims

British women are increasingly delaying childbirth, and if they wait till over the age of 35 they are at higher risk of many pregnancy complications. One concern is the increased risk of stillbirth (baby dying before birth) or the death of a baby within its first 28 days of life. These so called 'perinatal deaths' affect 1% of all pregnancies to women over the age of 35 years. Many doctors offer labour induction to women in this age group in the hope of forestalling the risk of the baby dying. This is popular with some parents, but many others are fearful that it will increase the need for caesarean delivery. However, recent research in other high-risk pregnancies (if the pregnancy has gone overdue, if baby is abnormally small or abnormally big, or if the mother has high blood pressure) has not shown any increase in the need for caesarean. Indeed, the effect has been rather the reverse. If induction for women over 35 did not increase caesareans, or even reduced them, it would probably save many babies lives and be very popular. We therefore plan to perform a study to test the effect of such an induction policy on caesarean section rates.

### Who can participate?

Women who are pregnant with their first baby and who will be 35 years of age by the time of their expected date of delivery can take part. They must be having a single baby and the baby must be head down (cephalic presentation), which means the babys head has entered their pelvis.

### What does the study involve?

We are comparing two ways of managing the pregnancies of women over 35 years of age, induction of labour at 39 weeks or no intervention. Participating women will be randomly allocated to one of these two groups. Women in the induction of labour group will have their labour induced or started artificially at 39 weeks. They will be allocated a date for induction and will come to the delivery suite that day. When they arrive the midwife will check the babys heartbeat and examine the womans cervix or neck of the womb by performing an internal examination. Depending on whether the cervix is already opening up they will start labour either with a drug called prostaglandin administered through the vagina, or by breaking the waters and giving a drug called oxytocin by intravenous infusion (a drip). Prostaglandins are inserted into the vagina in the form of a tablet, gel or a pessary by the midwife. If one dose doesnt get a woman into labour then they may need repeating. Alternatively a slow release pessary may be

used for 24 hours. Amniotomy is where the midwife artificially breaks the waters during an internal examination. This may be done right at the outset of the induction, or after the prostaglandins have had a chance to soften and open the neck of the womb. Labour induction may involve the use of a hormone called syntocinon, which causes the womb to contract; this is given through a drip or a small tube which sits in a vein that is inserted using a needle. The process of induction of labour will be exactly the same as that used in the hospital for all other women having their labour induced. Women in the no intervention group will await spontaneous labour unless a situation develops where their labour needs to be induced or they need a Caesarean section.

What are the possible benefits and risks of participating?

We believe that induction of labour at 39 weeks for women over the age of 35 is safer for babies. Complications of pregnancy and labour are more common in women over 35 years of age. Older mothers have a higher risk of stillbirth throughout pregnancy and the peak risk period is 37-41 weeks. Although women over 35 are known to be a high-risk group they are currently managed the same as younger women by the majority of obstetricians. We cannot promise this study will help you but the information we get from this study will provide evidence how best to manage pregnancies in women over 35 and we hope will improve outcomes for mothers and their babies. Induction of labour is a common procedure: about 20% of pregnant women will have their labour induced for a variety of reasons. Induction of labour is not always successful and you may require a caesarean section if we fail to get you into labour. By giving drugs to stimulate the womb to contract, occasionally the womb can become over stimulated; this can result in abnormalities in the baby's heart rate trace that may require action. A complication of breaking your waters artificially is that the baby's umbilical cord can fall out with the first rush of amniotic fluid and this necessitates urgent delivery of your baby.

Where is the study run from?

Nottingham City Hospital (UK)

When is the study starting and how long is it expected to run for?

June 2012 to July 2014

Who is funding the study?

NIHR Research for Patient Benefit Programme (UK)

Who is the main contact?

Dr Kate Walker

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## Contact information

### Type(s)

Scientific

### Contact name

Dr Kate Walker

### Contact details

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## **Additional identifiers**

**Protocol serial number**  
11891

## **Study information**

### **Scientific Title**

Induction of labour versus expectant management for nulliparous women over 35 years of age

### **Acronym**

35/39 Trial

### **Study objectives**

The primary aim of this randomised controlled trial is to test the null hypothesis that a policy of induction of labour at 39 weeks gestation for women over the age of 35 years reduces caesarean section rates. It will also enable us to collect data to test the feasibility of a larger study to test the effect of the policy of induction on perinatal death and serious neonatal morbidity. There is already evidence, albeit from non randomised studies, that such a policy would reduce adverse perinatal outcomes, in particular late stillbirth. The policy is not currently widely implemented because of fears that it would increase caesarean section rates. If induction of labour reduces the risk of intra-partum caesarean section then it would be adopted widely. This would almost certainly result in reduced late stillbirths at no maternal cost. We will also measure participants views about the two study arms to ensure that both are acceptable to women. This project provides an important opportunity to not only influence clinical practice in this important area, but to add to the increasing body of unbiased knowledge about the effects of policies of labour induction for various indications near term.

### **Ethics approval required**

Old ethics approval format

### **Ethics approval(s)**

Derby 1 REC, 12/01/2012, ref: 12/EM/0003

### **Study design**

Multi-centre randomised controlled trial

### **Primary study design**

Interventional

### **Study type(s)**

Prevention

### **Health condition(s) or problem(s) studied**

## **Interventions**

Treatment group: Women over the age of 35 years with a singleton live fetus in a cephalic presentation will be assigned to induction of labour between 39 + 0/7 and 39 + 6/7 weeks.

Control group: Women over the age of 35 years with a singleton live fetus in a cephalic presentation will be assigned to expectant management i.e. awaiting spontaneous onset of labour. Those without any medical indication for induction will be offered induction of labour anywhere between T+7 and T+14, the exact time to be determined by consultants usual practice.

## **Intervention Type**

Other

## **Phase**

Not Applicable

## **Primary outcome(s)**

Caesarean section

## **Key secondary outcome(s))**

Maternal outcomes

1. Mode of delivery
  - 1.1 Vaginal delivery
  - 1.2 Assisted vaginal delivery (forceps or ventouse)
  - 1.3 Caesarean section
2. Onset of labour
  - 2.1 Spontaneous
  - 2.2 Induction
  - 2.3 Planned caesarean section
3. Indication for induction of labour
  - 3.1 Randomised to treatment
  - 3.2 Gestational age > 41 weeks
  - 3.3 Preterm (< 37 weeks) prelabour rupture of membranes
  - 3.4 Term (> 37 weeks) prelabour rupture of membranes > 24 hours
  - 3.5 Fetal growth restriction
  - 3.6 Reduced fetal movements
  - 3.7 Intrauterine fetal death
  - 3.8 Pregnancy induced hypertension
  - 3.9 Pre-eclampsia
  - 3.10 Eclampsia
  - 3.11 Obstetric cholestasis
  - 3.12 Gestational diabetes
  - 3.13 Suspected fetal distress
  - 3.14 Maternal request
  - 3.15 Other
4. Method of induction of labour (as many as apply)
  - 4.1 Prostaglandin tablet regime
  - 4.2 Prostaglandin gel regime
  - 4.3 Prostaglandin slow-release pessary
  - 4.4 Artificial rupture of amniotic membranes

#### 4.5 Oxytocin

#### 5. Indication for Caesarean section

##### 5.1 Arrest of first stage of labour

##### 5.2 Arrest of second stage of labour

##### 5.3 Failed instrumental delivery

##### 5.4 Fetal distress

##### 5.5 Failure to progress and fetal distress

##### 5.6 Maternal complication

##### 5.7 Elective

##### 5.9 Other

#### 6. Intrapartum complications

##### 6.1 Placental abruption

##### 6.2 Cord prolapse

##### 6.3 Postpartum haemorrhage

##### 6.4 Shoulder dystocia

#### 7. Postpartum morbidity

##### 7.1 Requiring blood transfusion

##### 7.2 Systemic infection temp > 38C

#### Neonatal outcomes

##### 1. Live birth

##### 2. Stillbirth (a baby delivered with no signs of life after 24 completed weeks of pregnancy)

##### 3. Birth weight

##### 4. Sex

##### 5. Death before discharge from hospital

##### 6. Apgar at 1 min

##### 7. Apgar at 5 min

##### 8. Apgar at 10 minutes allow missing data

##### 9. Cord blood artery pH and BD allow missing data

##### 10. Cord blood vein pH and BD allow missing data

##### 11. NICU admission duration (days)

##### 12. If no cord blood and NICU admission required first fetal pH obtained

##### 13. Birth trauma

##### 13.1 Subdural haematoma

##### 13.2 Intracerebral or intraventricular haemorrhage

##### 13.3 Spinal-cord injury

##### 13.4 Basal skull fracture

##### 13.5 Peripheral-nerve injury present at discharge from hospital

##### 13.6 Long bone fracture

##### 13.7 Seizures (occurring at less than 24 hr of age or requiring two or more drugs to control them)

##### 13.8 Hypotonia (for at least 2 hrs)

##### 13.9 Abnormal level of consciousness (hyperalert, drowsy or lethargic; stupor/decreased response to pain; coma)

##### 13.10 Tube feeding for > 4 days

##### 13.11 Intubation and ventilation for > 24 hrs

##### 13.12 Cooling required

##### 13.13 Oxygen required

##### 13.14 CPAP required

#### Outcomes for pilot study

##### 1. The recruitment rate per hospital.

##### 2. The age distribution of participating women.

3. Compliance with the treatment arms of the trial.
4. The overall gestational age distribution of the two groups.
5. Completeness of outcome data

Maternal delivery expectation/experience measured by the Childbirth Experience Questionnaire (Dencker et al, BMC Pregnancy and Childbirth 2010). We will invite a sample of participants to join focus groups to explore in-depth their views.

**Completion date**

02/07/2014

## Eligibility

**Key inclusion criteria**

Nulliparous women who will be over 35 years at the expected date of delivery, with:

1. A singleton live fetus
2. A cephalic presentation
3. Gestational age between 36 weeks + 0 days and 39 weeks + 6 days
4. No medical contra-indication to induction of labour
5. No medical contra-indication to pregnancy being allowed to proceed to term plus 10 days
6. Willingness to participate in the trial
7. Written informed consent
8. Female participants

**Participant type(s)**

Patient

**Healthy volunteers allowed**

No

**Age group**

Adult

**Sex**

Female

**Key exclusion criteria**

1. Women with a known lethal fetal congenital abnormality.
2. Women with a contra-indication to labour or vaginal delivery (e.g. evidence of fetal compromise such that labour would be contra-indicated; fetal congenital anomaly or condition that might cause a mechanical problem at delivery such as hydrocephalus or cystic hygroma; placenta praevia)
3. Women with a contra-indication to expectant management (e.g. gestational diabetes, proteinuric hypertension (>250mg/l or BP > 140/90 on more than two occasions, two hrs apart)
4. Women with a previous myomectomy.
5. Women who book late for antenatal care and have no dating scan performed between before 22 weeks to provide an accurate EDD.
6. Women who have undergone IVF using donor eggs in the current pregnancy

**Date of first enrolment**

11/06/2012

**Date of final enrolment**

02/07/2014

## **Locations**

**Countries of recruitment**

United Kingdom

England

**Study participating centre**

**Nottingham City Hospital**

Nottingham

United Kingdom

NG5 1PB

## **Sponsor information**

**Organisation**

Nottingham University Hospitals NHS Trust (UK)

**ROR**

<https://ror.org/05y3qh794>

## **Funder(s)**

**Funder type**

Government

**Funder Name**

NIHR Research for Patient Benefit Programme (UK)

## **Results and Publications**

Individual participant data (IPD) sharing plan

IPD sharing plan summary

Not provided at time of registration

## Study outputs

Output type	Details	Date created	Date added	Peer reviewed?	Patient-facing?
<a href="#">Results article</a>	results	03/03/2016		Yes	No
<a href="#">Protocol article</a>	protocol	11/12/2012		Yes	No
<a href="#">Participant information sheet</a>	Participant information sheet	11/11/2025	11/11/2025	No	Yes
<a href="#">Study website</a>	Study website	11/11/2025	11/11/2025	No	Yes