

# Evolution des pratiques de déclenchement: impact sur l'organisation des soins

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LES **53<sup>ÈMES</sup>** JOURNÉES NATIONALES

DE LA **SOCIÉTÉ FRANÇAISE** DE  
**MÉDECINE PÉRINATALE**

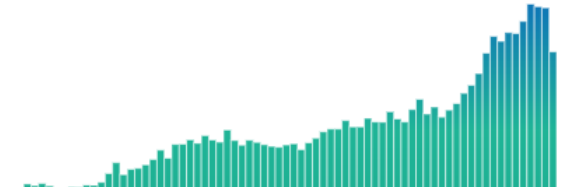
**16 • 18 OCTOBRE 2024 | NANCY**



# Problématique

RESULTS BY YEAR

20,744 results

Page  of 2,075 **Induction of labor** on request in a **resource-poor** setting.

4 Chigbu CO, Ezeome IV, Okezie AO, Oyefara B.

Cite Int J Gynaecol Obstet. 2007 Sep;98(3):208-11. doi: 10.1016/j.ijgo.2007.03.022. Epub 2007 Apr 19.

PMID: 17445817

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OBJECTIVE: To determine the prevalence of and reasons for **induction of labor** on maternal request in a setting where aversion to **induction of labor** is the norm. ...RESULTS: The prevalence of **induction of labor** on maternal request was 7.4%. ...

 **Probiotic treatment for women with gestational diabetes to improve maternal and infant health and well-being.**

5 Okesene-Gafa KA, Moore AE, Jordan V, McCowan L, Crowther CA.

Cite Cochrane Database Syst Rev. 2020 Jun 24;6(6):CD012970. doi: 10.1002/14651858.CD012970.pub2.

PMID: 32575163 [Free PMC article.](#)

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Probiotics are naturally occurring micro-organisms, which when ingested in adequate amounts, may confer **health** benefits. Evidence of the role of probiotics as treatment for GDM is limited. ...SELECTION CRITERIA: Randomised controlled trials (RCTs) comparing the use of prob ...

labor induction an

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133 results



Pourtant problème quotidien

Problématique soulevée dès la publication d'ARRIVE

## SMFM Statement on Elective Induction of Labor in Low-Risk Nulliparous Women at Term: the ARRIVE Trial

Other questions remain, including how generalizable these findings will be to settings outside of a clinical trial or to institutions with cesarean delivery rates that are lower or higher than those of the participating centers. In addition, there is concern from centers about how to accommodate women who desire elective IOL when all induction slots are taken by women who have medical or obstetric indications for delivery. Finally, the cost implications of elective IOL are not yet known but will become available with planned secondary analyses. Offering elective IOL will depend not only on patient preferences but also on the capacity of the facility and available staff, including nurses and anesthesiologists. More data about the impact of implementation on resource use in different clinical settings and practices across the United States are needed.



**FRENCH-ARRIVE**

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Labor Induction versus Expectant Management in Low-Risk  
Nulliparous Women

William A. Grobman, M.D., Madeline M. Rice, Ph.D., Uma M. Reddy, M.D., M.P.H., Alan T.N. Tita, M.D., Ph.D.,  
Richard E. Nelson, PhD, Gretio Sandoval, MA, M. Sean Esplin, MD



**Health resource utilization of labor induction versus  
expectant management**

William A. Grobman, MD, MBA; Grecio Sandoval, MA; Uma M. Reddy, MD, MPH; Alan T. N. Tita,

**Cost of Elective Labor Induction Compared  
With Expectant Management in  
Nulliparous Women**

*Brett D. Einerson, MD, MPH, Richard E. Nelson, PhD, Grecio Sandoval, MA, M. Sean Esplin, MD,*

APRIL 2020 **American Journal of Obstetrics & Gynecology**

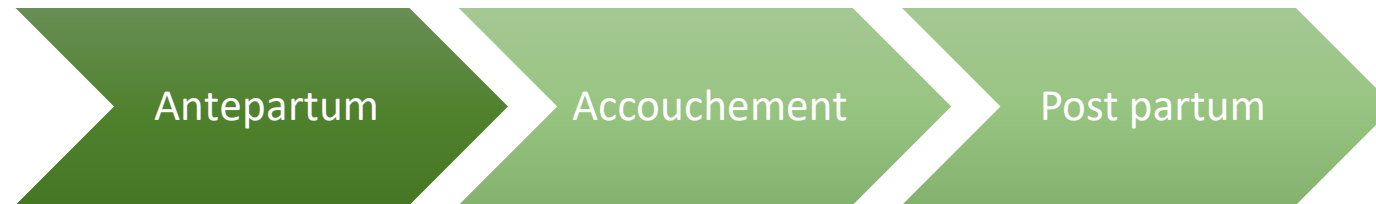
*(Obstet Gynecol 2020;136:19–25)*

# Health resource utilization of labor induction versus expectant management

APRIL 2020 American Journal of Obstetrics & Gynecology

William A. Grobman, MD, MBA; Grecio Sandoval, MA; Uma M. Reddy, MD, MPH; Alan T. N. Tita,

- Analyse secondaire prévue de l'essai ARRIVE
- Analyse en intention de traiter. Pas d'imputation des données manquantes
- 3 périodes définies:
  - Antepartum depuis la randomisation
  - Accouchement (déclenchement, post partum immédiat)
  - Post partum jusqu'à 8 semaines



Antepartum

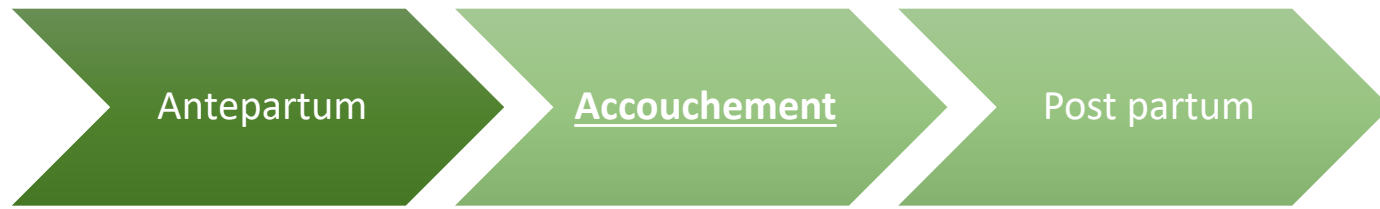
Accouchement

Post partum

**TABLE 2**

**Proportion (percentage) of women with at least 1 antepartum encounter with the health care system, stratified by randomized group assignment**

Variables	Induction of labor (n = 3059)	Expectant management (n = 3037)	Pvalue	RR (95% CI)
<b>Ambulatory</b>				
Office visit, routine prenatal care	32.4	68.4	< .001	0.47 (0.45–0.50)
Office visit, unanticipated	0.5	2.6	< .001	0.20 (0.12–0.34)
Urgent care/emergency department/obstetric triage visit	16.2	44.3	< .001	0.37 (0.33–0.40)
<b>Inpatient</b>				
Hospital admission	0.8	2.2	< .001	0.39 (0.25–0.61)



	Induction of labor (n = 3059)	Expectant management (n = 3037)	p	RR (95%CI)
Cervical ripening	62.8	28.7	< .001	2.19 (2.06-2.33)
Oxytocin infusion	84.5	73.3	< .001	1.15 (1.12-1.18)
Intrauterine pressure catheter	41.8	36.6	< .001	1.14 (1.07-1.21)
Labor and delivery duration, d	0.83 (0.53, 1.2)	0.57 (0.37, 0.85)	< .001	
Magnésium sulfate infusion	1.9	2.9	0.02	0.67 (0.48-0.92)
Antibiotic infusion	42.7	45.8	0.02	0.93 (0.88-0.99)
LOS after delivery >2 days	20.9	23.1	< .001	0.86 (0.79-0.94)

Antepartum

Accouchement

Post partum

**TABLE 5****Proportion (percentage) of women and neonates, after discharge from the delivery admission, with at least 1 encounter with the health care system, stratified by randomized group assignment**

Variables	Induction of labor (n = 3059)	Expectant management (n = 3037)	<i>P</i> value	RR (95% CI)
<b>Maternal</b>				
<b>Ambulatory</b>				
Office visit, unanticipated	5.8	6.2	.48	0.93 (0.76–1.13)
Urgent care visit	1.3	1.3	1.00	1.02 (0.66–1.58)
Emergency department visit	6.6	6.8	.76	0.97 (0.80–1.17)
<b>Inpatient</b>				
Hospital admission	2.3	2.4	.67	0.93 (0.67–1.28)
<b>Neonatal</b>				
<b>Ambulatory</b>				
Office visit, unanticipated	15.3	13.5	.04	1.14 (1.01–1.29)
Urgent care visit	2.0	1.7	.57	1.12 (0.78–1.62)
Emergency department visit	8.5	8.7	.82	0.98 (0.83–1.15)
<b>Inpatient</b>				
Hospital admission	3.1	2.6	.22	1.21 (0.90–1.62)

# Différences absolues significatives pour 1000

patientes

Déclenchement vs expectative

Variables	Difference
<b>Antepartum</b>	
Ambulatory visits	-1206
Office visit, routine prenatal care	-751
Office visit, unanticipated	-24
Urgent care/emergency department/obstetric triage visit	-432
Inpatient days	-13
Tests prior to delivery admission	-698
Nonstress test	-334
Sonogram <sup>a</sup>	-183
Laboratory test <sup>b</sup>	-118
Urinalysis	-63
Treatments	-59
Analgesic	-22
IV hydration	-14
Antibiotic	-4
Other medication <sup>c</sup>	-20

<b>Delivery admission</b>	
Labor and delivery (patient days)	250
Ripening agent	476
Balloon catheter	218
Laminaria	1
Cervidil	39
PGE1 or gel	218
Oxytocin infusion	112
Intrauterine pressure catheter	52
Magnesium sulfate infusion	-10
Antibiotic infusion	-31

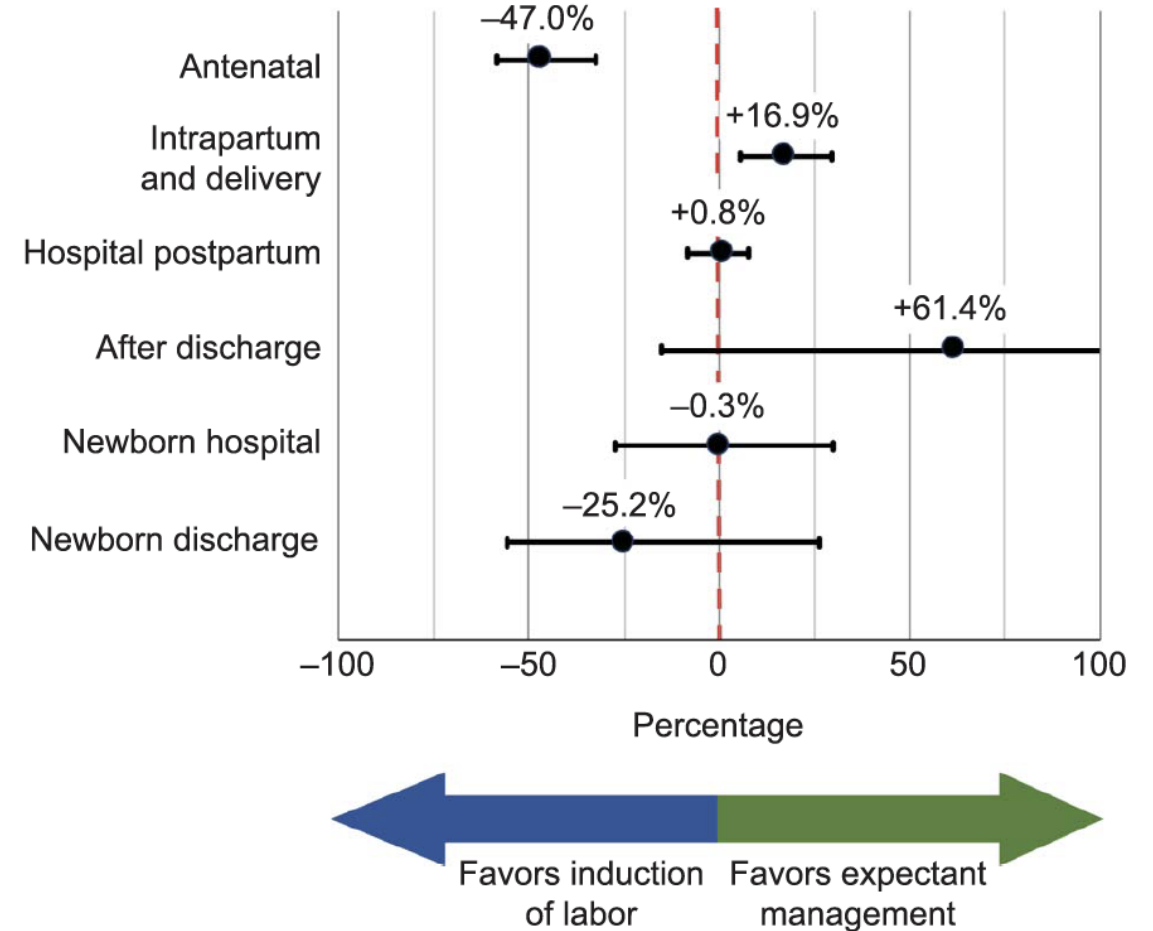
<b>Maternal postpartum LOS, d</b>	-45
Postpartum unit	-41
Intensive care unit	-4
CPAP/high-flow oxygen	-11
<b>Neonatal LOS, d</b>	-113
Well-baby unit	-24
Intermediate or ICU	-89

# Cost of Elective Labor Induction Compared With Expectant Management in Nulliparous Women

*Einerson et al., Obstet, 2020*

We performed an economic analysis of Utah participants in the ARRIVE trial. The ARRIVE trial was

Our primary outcome, the mean total cost of induction, was not significantly different than that of expectant management (adjusted mean difference +4.7%, 95% CI -2.1% to +12.0%,  $P=.18$ ; unadjusted mean difference +5.0%, 95% CI -2.1% to +12.5%).



Quel impact de ces modifications de pratique ?

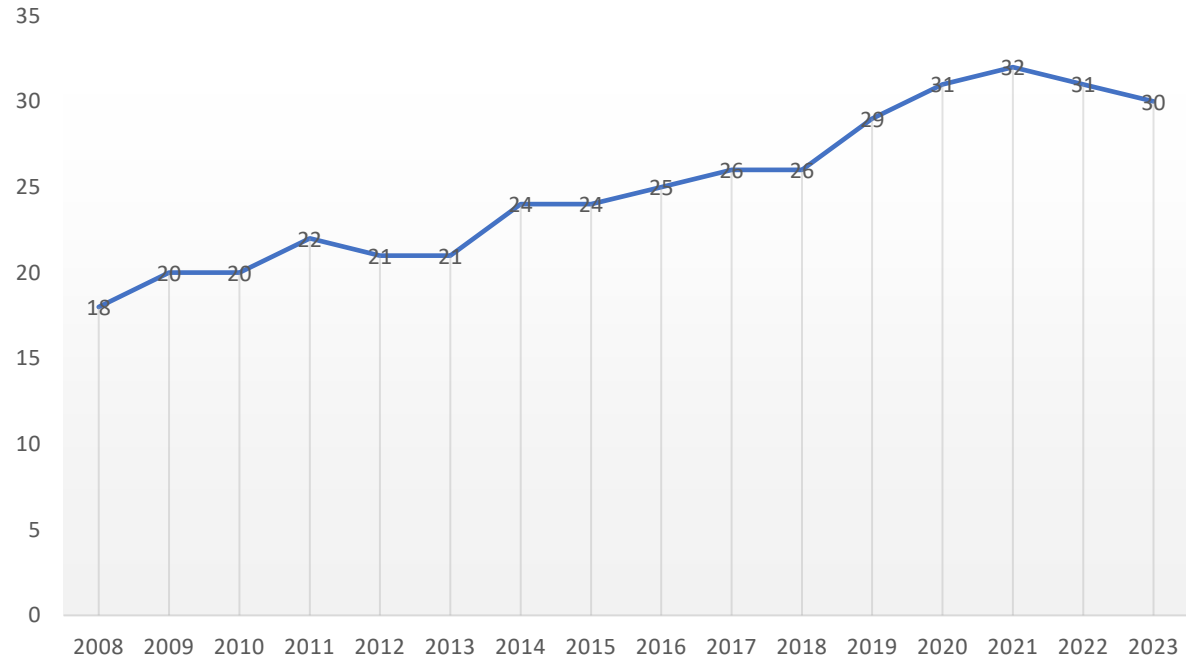
Notre expérience



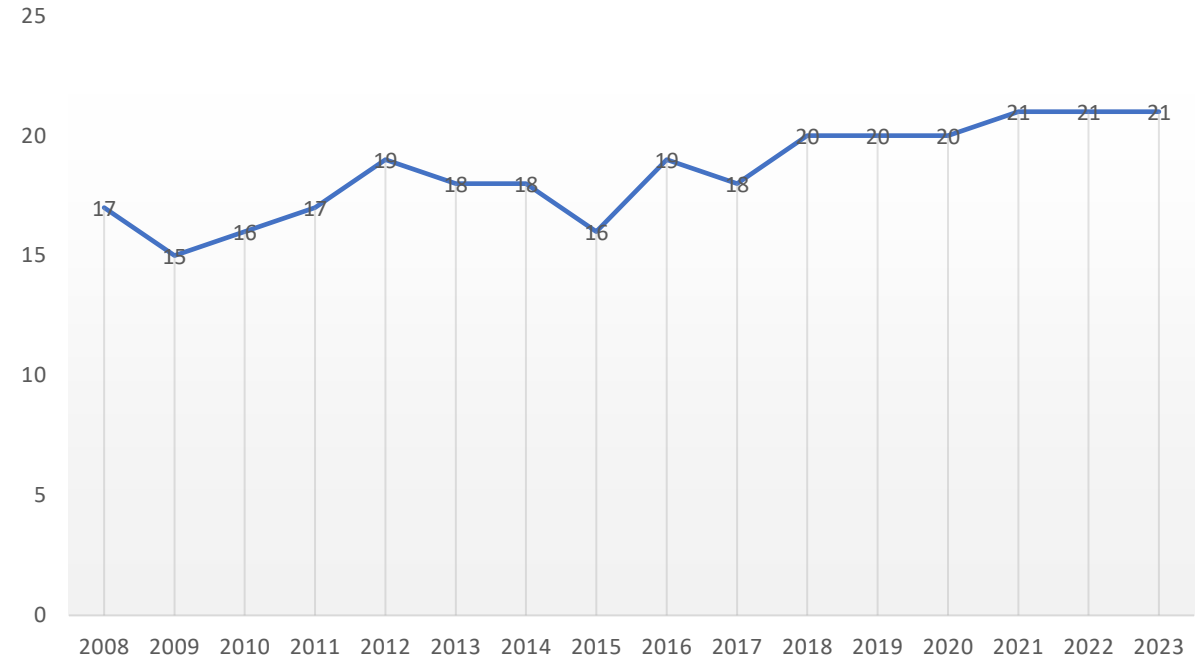
# Evolution du taux de déclenchement et de césarienne



## Evolution du taux de déclenchement



## Evolution du taux de césarienne



Janv-Août 2024

Motifs de déclenchement	Total	
	Nb	%
Anomalie du rythme cardiaque foetal	88	6.34%
Cholestase gravidique	20	1.44%
Convenance personnelle	40	2.88%
Diabète antérieur à la grossesse	33	2.38%
Diabète gestationnel	57	4.11%
Diminution mvts actifs	8	0.58%
HTA ou PE	75	5.41%
Hyperthermie	1	0.07%
Macrosomie	114	8.22%
Pas de précision	42	3.03%
Pathologie foetale	88	6.34%
Pathologie maternelle	58	4.18%
RCIU ou PAG	137	9.88%
RMTAT	267	19.25%
RPM < 37 SA	43	3.10%
Diminution mvts actifs	56	4.04%
Terme dépassé	260	18.75%
Total	1387	100.00%



Peu d'impact du déclenchement sur demande maternelle.  
Déclenchement plus facile?  
Mêmes résultats que ARRIVE dans ces populations?

### Ressenti des équipes

- Durée de travail plus longue
- « Embolisation » des salles de naissance
- Obligé de limiter le nombre de déclenchements (8 max)
- Décalage de situations non urgentes (macrosomie, demande maternelle...)

# Quelles solutions?

## Contrôle du taux

### Suivi des indications

- Réunion de programmation des déclenchements (échec à JDF ! )
- Utilisation de classifications comme celle de Grenoble = Robson du déclenchement?

## Architecture

### Repenser nos secteurs

- Expérience du secteur « Pré naissance » du CHU de Toulouse
- Plan architectural de « JDF Demain »: 10 chambres dans un secteur dédié avec lieux de déambulation et baignoire

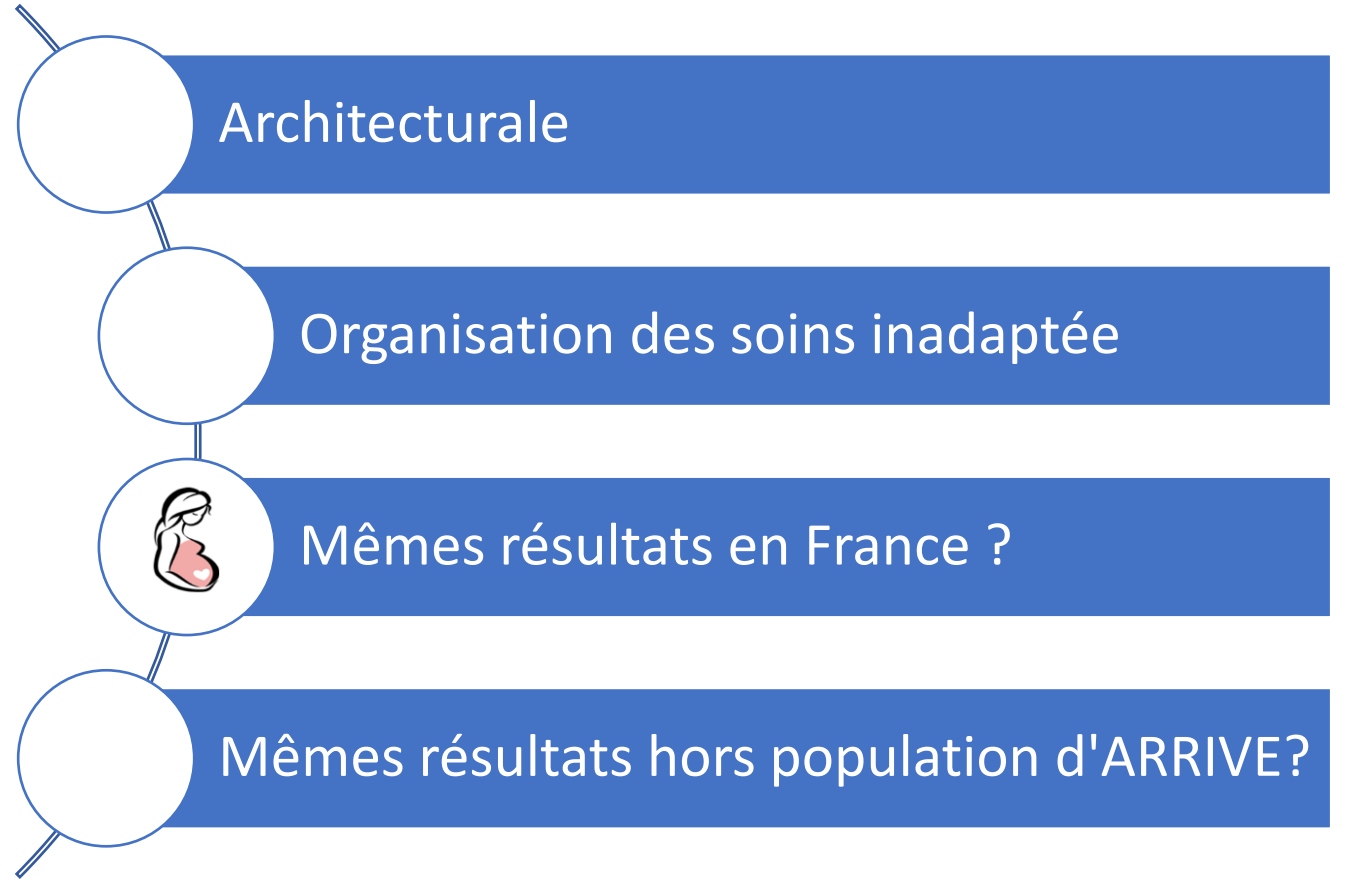
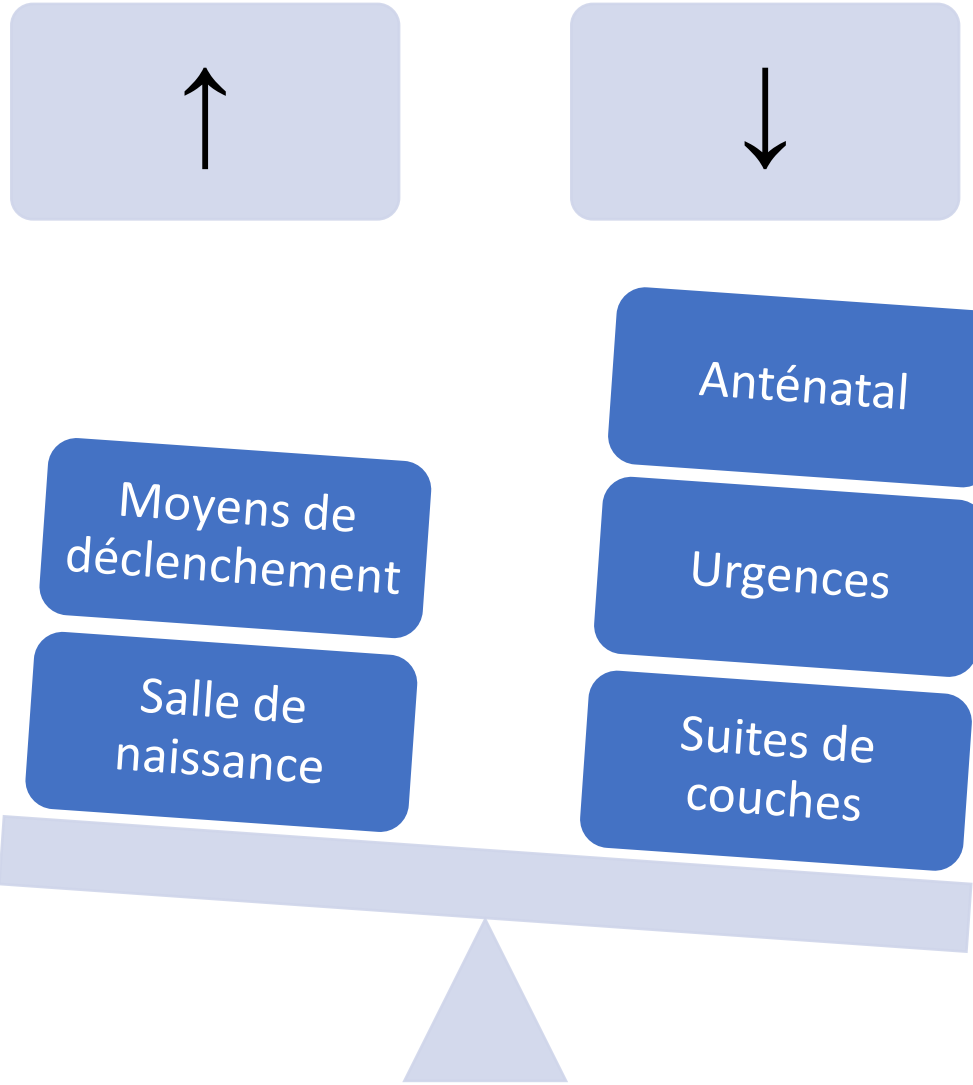


## Ressources

### Utilisation différente des ressources

- Sous réserve des mêmes résultats
- Réorganisation des ressources humaines

# Conclusion – Quel impact sur l'organisation?



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