Introduction

Induction of labor is indicated in about 20% of term pregnancies and is associated with a Cesarean delivery rate of about 20% ***(NHS Maternity, 2004)***.

The Bishop score ***(Bishop, 1964)***, since its description in 1964, remains the gold standard for assessing favorability for induction of labor ***(Crane, 2006)***.

Transvaginal sonographic cervical length has been shown, by a number of studies ***(Daskalakis, 2006)***, to be a better predictor of Cesarean delivery than Bishop score in women undergoing induction of labor, but this finding has not been reported consistently ***(Rozenberg, 2005)***.

A recent meta- analysis concluded that transvaginal sonography has not been shown to be superior to Bishop score and calls for further research ***(Crane, 2006)***.

Previous studies ***(Chandra, 2001)***, with limited numbers of women (40 and 50 women, respectively) have indicated that transvaginal sonography is less painful than digital examination for Bishop score The timing of labor induction for common indications such as diabetes in pregnancy, prolonged pregnancy ***(Rand, 2000)***, and hypertension in pregnancy remains controversial ***(Boulvain, 2001)***.

If a high risk of failed labor induction can be predicted reliably, the timing of labor induction can be reconsidered in many cases with soft indications. Therefore, a reliable and better tolerated method of preinduction assessment than the Bishop score would be a helpful tool in the assessment and counseling of women planned for labor induction ***(Heard et al., 2004)***.