Background
In the last decades, evidence has shown that misoprostol is safe and effective in labor induction. In our environment, in absence of contraindications for vaginal delivery or induction of labor, and according to cervical conditions, usually with a Bishop score of less than 7 points, misoprostol, a PGE1 analogue, is used for labor induction.

Objectives
To recognize labor induction results with misoprostol, to analyze perinatal results and type of delivery in labor induction with misoprostol, to characterize the group of woman with vaginal delivery, including time to delivery since induction of labor.

Methods
Retrospective and descriptive analysis of labor induction with misoprostol carried out in Santiago Oriente Hospital, between September 1st, 2015 and February 29th, 2016, according to local guidelines. Misoprostol was administered in doses of 25 to 50 mcg, oral or vaginal, every 4 to 6 hours according to uterine contractions and cervical changes. Analyzed variables were: age, parity, weight, height, BMI, obstetric condition for labor induction indication, gestational age, Bishop score, type of delivery, birth weight, Apgar score at 1 and 5 minutes and neonatal results. The statistical analysis was performed with Stata 10.0.

Results
We collected data of 322 clinical charts. Clinical characteristics are shown in Table 1. In the period analyzed 50.6% were nulliparous women, 50.9% were 20 to 30 years old, and 10.2% were 40 years old or older. The most frequent indications for labor induction were pregnancies of 41 weeks of gestational age or above (26%), premature rupture of membranes (22.3%), gestational or pregestational diabetes (16.1%) and hypertensive pregnancy disorders (13.9%). Type of delivery: 79.2% vaginal in the whole group (6.2% assisted vaginal delivery), while it was 91.8% in multiparous women (2.5% assisted vaginal delivery) and 66.9% in nulliparous women (9.8% assisted vaginal delivery).

Conclusions
Our data reflects that misoprostol is safe in its usual indication, both in nulliparous and multiparous women, when patients are properly chosen, excluding those with contraindications, and when its administration is followed by strict surveillance, in a similar way as has been described in international literature. In our study misoprostol administration was not associated to low Apgar score and did not increased the cesarean section rate, both in multiparous and nulliparous women.