2 COMPLICATIONS OF PREGNANCY

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2.8 Prelabour Rupture of the Membranes at Term
Section B
Clinical Guidelines
King Edward Memorial Hospital
Perth Western Australia

2.8 PRELABOUR RUPTURE OF THE MEMBRANES AT TERM

AIM

The appropriate management of prelabour rupture of membranes at term.

DEFINITION[1]

Term Prelabour Rupture of Membranes is defined a rupture of the membranes prior to the onset of labour at or beyond 37 weeks gestation.

The incidence of Term PROM is 8%.

ASSESSMENT

Initial assessment of women presenting with Term PROM should include

- Confirmation of the diagnosis
- Confirmation of gestation and presentation
- Assessment of maternal and fetal wellbeing.

Digital vaginal examination should be avoided unless immediate induction is planned as this has been shown to increase the rate of neonatal infection.

SPECULUM EXAMINATION

The speculum (lubricated with a sterile water-soluble lubricant) should not touch the cervix. The cervical dilatation and the presence or absence of a prolapsed umbilical cord should be noted. If there is any suspicion of sepsis, two swabs are taken from the cervix - one air-dried on a glass slide for Gram stain, and the other placed in a transport culture medium.

If amniotic fluid is obviously draining from the cervix, no further action regarding confirming PROM needs to be taken.

If there is no amniotic fluid visible, the patient can be discharged from hospital unless there is strong clinical suspicion of the diagnosis.

All non-cephalic presentations presenting with ruptured membranes at term must have a digital vaginal examination to exclude cord prolapse ***after discussion*** with the Senior Registrar/ Consultant for Labour and Birth Suite

ULTRASOUND EXAMINATION

An ultrasound examination may be a useful adjunct to diagnosis (an amniotic fluid index of 5 or more suggests that there is no PROM). Ultrasound examination showing a markedly reduced amniotic fluid volume in the presence of normal fetal kidneys and the absence of IUGR is highly suggestive of ruptured membranes, however normal amniotic fluid volume does not exclude the diagnosis.

MANAGEMENT OFCONFIRMED RUPTURE OF MEMBRANES

If PROM is confirmed:

- Active management of term PROM with induction is associated with reduced maternal infective morbidity without increasing the caesarean section or operative vaginal birth rates. Fewer infants are admitted to NICU and fewer infants require postnatal antibiotics.[1]
- Up to 24 hours of expectant management, in selected cases,may be considered at the patient's or clinicians discretion.
- Criteria for expectant management
    - Term PROM with fixed cephalic presentation
    - GBS negative
    - No signs of infection (maternal tachycardia, fever, uterine tenderness)
    - Normal CTG
    - No cervical suture

  Women choosing expectant management may be admitted to an antenatal Ward OR discharged home with clear instructions on the day and time to return.

UN-CONFIRMED RUPTURE OF MEMBRANES

If the diagnosis of PROM is in doubt, repeat the speculum examination, after a period of two hours lying down. The use of Amnicator ® swabs does not provide more accurate diagnosis than visualising amniotic fluid passing through the cervix. Amnicators may give false positives with alkaline vaginal discharge (bacterial vaginosis), semen and or blood.

In the event of the diagnosis of rupture of membranes being uncertain in either the presence of a cervical suture or known group B streptococcus carrier, a woman should not be discharged from hospital without review by a senior medical officer.

NO EVIDENCE OF RUPTURE OF MEMBRANES

If there is no definitive evidence of PROM and no other risk factors, the woman can be discharged home.

SPECIAL CASES

- ***Cervical suture***

  If a cervical suture is present, there is a very high risk of sepsis. The suture should be removed as soon as possible and prompt delivery must be considered.
- ***Positive Group B streptococcus***

MEDICATION	DOSE	ROUTE	FREQUENCY
Benzyl penicillin	1.2g stat then 600mg	IV	4 hourly
Clindamycin (if sensitive to penicillin)	600mg	IV	8 hourly

Known carriers of group B streptococcus who present with PROM should be treated with IV antibiotics, and have labour induced within 6 hours of rupture of the membranes[1]

- ***Unknown Group B Streptococcal Status***

  Clinical Guidelines, Section B1.4.1 Group B Streptococcal Disease . For women whose GBS status is unknown, the Cochrane Review found that antibiotic use significantly reduced the rate of chorioamnionitis and endometritis.[1]

- ***Management of Prolonged Ruptured Membranes at Term***

  Commence IV antibiotics once membranes have been ruptured for ≥ 24 hours.

- ***Women attending the Family Birth Centre***

  If the woman's membranes have been ruptured for ≥ 24 hours she may remain in the Family Birth Centre for continuing care so long as she is in active labour. IV antibiotics should be commenced as outlined above.

ACTIVE MANAGEMENT

- The KEMH preferred option at 37 weeks (or greater) is early induction of labour. However, a woman's informed choice to be treated expectantly should be respected. The length of expectant management needs to be discussed with the woman and a decision made on an individual basis.

- Induction of labour with vaginal prostaglandins is associated with an increased risk of chorioamnionitis and neonatal infection in comparison with an oxytocin induction.

- Oxytocin rather than vaginal prostaglandins is preferred for the induction of labour in the presence of term PROM.

REFERENCE

1. The Royal Australian and New Zealand College of Obstetricians and Gynaecologists. College Statement C-Obs 36. Term Prelabour Rupture of membranes. July 2010. Avail at http://www.ranzcog.edu.au/publications/

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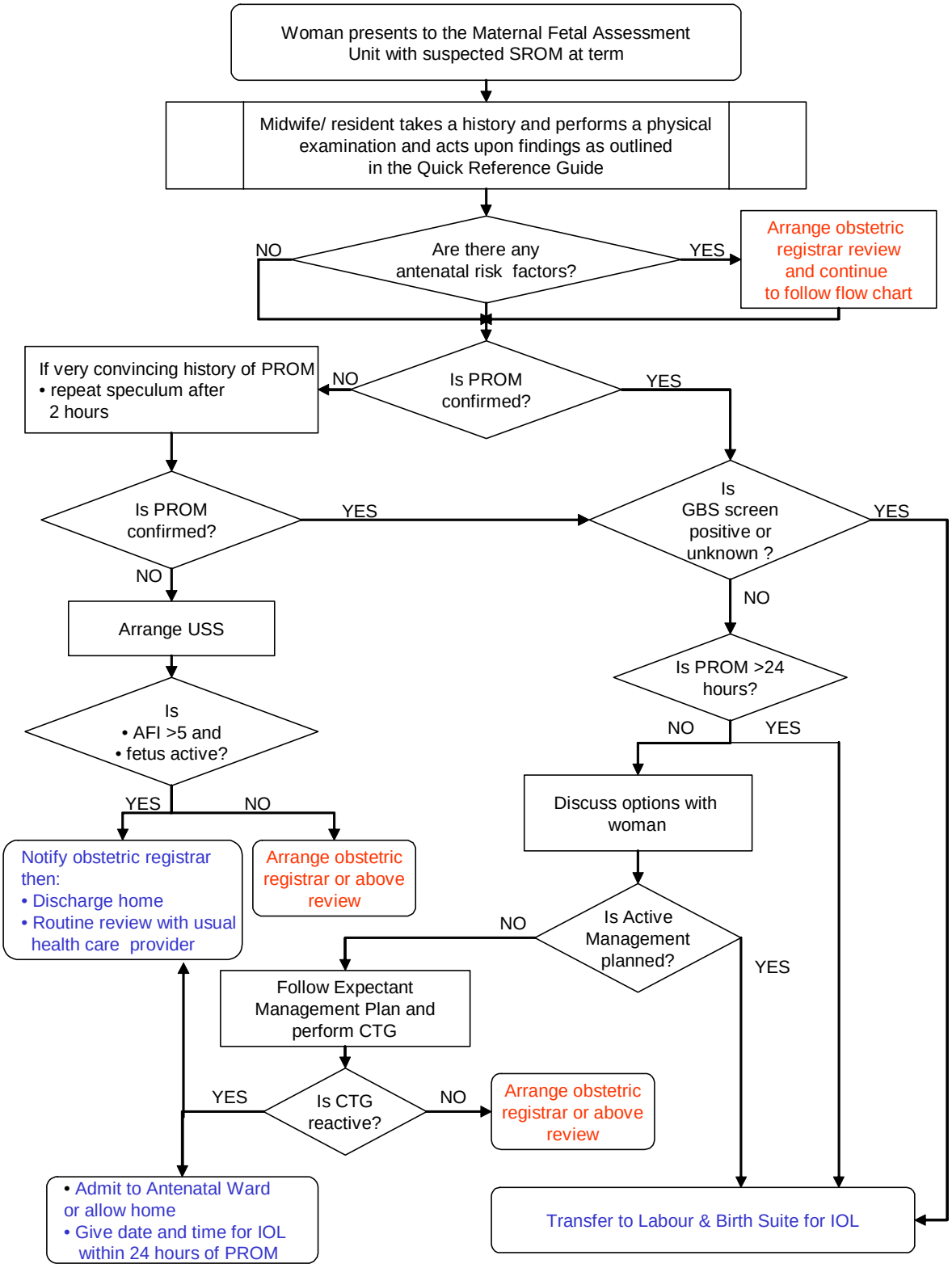
FLOW CHART FOR THE MANAGEMENT OF SUSPECTED PROM AT TERM