COMPLICATIONS OF PREGNANCY

PRELABOUR RUPTURE OF THE MEMBRANES AT TERM

AIM

- The appropriate management of prelabour rupture of membranes at term.

DEFINITION

Term Prelabour Rupture of Membranes is defined as 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 OF CONFIRMED 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.
- Up to 24 hours of expectant management, in selected cases may be considered at the patient’s or clinician’s 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**

<table>
<thead>
<tr>
<th>MEDICATION</th>
<th>DOSE</th>
<th>ROUTE</th>
<th>FREQUENCY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benzyl penicillin</td>
<td>3g then 1.8g</td>
<td>IV</td>
<td>4 hourly</td>
</tr>
<tr>
<td>Clindamycin (if sensitive to penicillin)</td>
<td>900mg</td>
<td>IV</td>
<td>8 hourly</td>
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</tbody>
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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.

- **Unknown Group B Streptococcal Status**
  Clinical Guidelines, Section [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.

- **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.
FLOW CHART FOR THE MANAGEMENT OF SUSPECTED PROM AT TERM

Woman presents to the Maternal Fetal Assessment Unit with suspected SROM at term

Midwife/ resident takes a history and performs a physical examination and acts upon findings as outlined in the Quick Reference Guide

Are there any antenatal risk factors?

NO

Arrange obstetric registrar review and continue to follow flow chart

YES

Is PROM confirmed?

NO

If very convincing history of PROM
• repeat speculum after 2 hours

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• repeat speculum after 2 hours

YES

Is PROM confirmed?

NO

Arrange USS

YES

Is GBS screen positive or unknown?

NO

Is PROM >24 hours?

YES

Discuss options with woman

NO

Arrange obstetric registrar or above review

NO

Are there any antenatal risk factors?

YES

Follow Expectant Management Plan and perform CTG

NO

Arrange obstetric registrar or above review

YES

Transfer to Labour & Birth Suite for IOL

• Admit to Antenatal Ward or allow home
• Give date and time for IOL within 24 hours of PROM

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产妇出现宫内膜破裂

助产士/住院医师应获取病史并进行体格检查，并根据检查结果参照快速参考指南采取相应措施。

是否存在孕期风险因素？

否

安排产科住院医师审查并继续按照流程图管理。

是

是否存在宫内膜破裂？

否

安排超声。

是

是否GBS筛选结果呈阳性的或未知的？

否

宫内膜破裂超过24小时？

是

与产妇讨论选择。

否

安排产科住院医师或以上级别的会诊。

是

决定活动管理方案？

否

安排产科住院医师或以上级别的会诊。

是

转至产房以进行IOL。
REFERENCES (STANDARDS)

National Standards – 1- Care provided by the clinical workforce is guided by current best practice
Legislation – Nil
Related Policies -
Other related documents –

RESPONSIBILITY
Policy Sponsor | Nursing & Midwifery Director OGCCU
Initial Endorsement | September 2002
Last Reviewed | September 2014
Last Amended |
Review date | September 2017

Do not keep printed versions of guidelines as currency of information cannot be guaranteed. Access the current version from the WNHS website.