

Term prelabour rupture of membranes

Clinical Guideline Presentation v2.0



45 minutes

Towards CPD Hours

References:

Queensland Clinical Guideline: Term prelabour rupture of membranes is the primary reference for this package.

Recommended citation:

Queensland Clinical Guidelines. Term prelabour rupture of membranes clinical guideline education presentation E23.47-2-V2-R28. Queensland Health 2023.

Disclaimer:

This presentation is an implementation tool and should be used in conjunction with the published guideline. This information does not supersede or replace the guideline. Consult the guideline for further information and references.

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Abbreviations

CS	Caesarean section
GBS	Group B <i>Streptococcus</i>
EOGBSD	Early onset Group B Streptococcal disease
HVS	High vaginal swab
IOL	Induction of labour
NICU	Neonatal intensive care unit
PROM	Prelabour rupture of membranes
SCN	Special care nursery

Objectives

- Identify management options following term PROM
- Identify risks and benefits of management options



Term PROM

What is term PROM?

Term PROM refers to women who:

- Have ruptured membranes
- Are equal to or greater than 37+0 weeks gestation
- Are not in labour



Prelabour
Rupture
Of
Membranes

Occurs in around 8% of pregnancies

- Approximately 85% of women will spontaneously establish labour by 24–48 hours after term PROM

Diagnosis

Avoid digital vaginal examinations as may increase risk of infection

How is the diagnosis of PROM made?

- History:
 - Sudden gush or continued leakage of fluid from vagina
- Sterile speculum:
 - Pooling of amniotic fluid or leakage from cervical os with coughing
- Test vaginal secretions:
 - Immunoassay (e.g. Amnisure®)
 - pH stick (e.g. Nitrazine)

Conduct a clinical assessment

- Review history
- Maternal vital signs
- General physical exam
- Abdominal palpation
- Fetal heart rate

During sterile speculum exam

- Exclude cord prolapse
- Visualise cervical length and dilatation
- Test vaginal secretions, if required
- HVS for GBS, if not previously collected

If unable to confirm diagnosis

- Ultrasound for liquor volume



Management options

Yasmin is 38 weeks pregnant with her second baby. Her membranes have ruptured and she is not in labour. She presents to hospital.

What are the clinical indications for active management of PROM?

- Signs of maternal infection
- Meconium/blood stained liquor
- Concern for maternal or fetal wellbeing
- Maternal choice
- High head
- GBS positive



Expectant management

- Waiting for the spontaneous onset of labour

Active management

- Planned intervention intended to lead to birth by:
 - Induction of labour or
 - Caesarean section (CS)

Indications for CS

- Vaginal birth contraindicated
- Consider CS if non-cephalic presentation
- Maternal choice

Outcomes of management

Yasmin would like to have expectant management but is worried that it might not be best for her baby.

What can you advise Yasmin about active compared to expectant care?

With active management decreased:

- Chorioamnionitis (suspected or proven)
- Admission to NICU/SCN
- Neonatal sepsis (definite or probable)

With active management:

- Increased IOL
- No significant difference in caesarean section

Active versus expectant care

No difference in:

Postpartum antibiotic use, pyrexia, endometritis, operative vaginal birth, primary postpartum haemorrhage, caesarean section for fetal distress, uterine rupture, epidural analgesia, cord prolapse, stillbirth, Apgar < 7 at 5 minutes, definite neonatal sepsis, perinatal mortality

No data about:

Breastfeeding, postnatal depression, meningitis, respiratory distress syndrome, necrotising enterocolitis, neonatal encephalopathy, disability at childhood follow-up

Antibiotics

Yasmin asks whether she will need to have antibiotics.

Are antibiotics recommended?

Routine prophylactic antibiotics are not recommended for women with term PROM.

When are antibiotics indicated?

- If PROM of 18 hours or more prior to birth (a risk factor for EGOBDS), recommend intrapartum antibiotic prophylaxis for GBS
- If chorioamnionitis or other infection

Risk factors for GBS

- GBS colonisation in current pregnancy
- GBS bacteriuria in current pregnancy
- Preterm labour at less than 37+0 weeks
- Previous baby with EGOBDS
- PROM longer than 18 hours
- Intrapartum temperature 38 °C or higher



Expectant management

After a thorough discussion about the risk and benefits, Yasmin decides she will 'wait and see' if labour starts.

What is the maximum time recommended for Yasmin wait?

- There is limited high level evidence about the maximum duration
- The risk of chorioamnionitis is increased after 24 hours

Consensus recommendation in QLD

- If labour not established by 24 hours of ROM, offer IOL

Maternal choice

Offer complete and unbiased information

Respect a woman's right to choose

Spontaneous labour

Most women will establish spontaneous labour by 24–48 hours after term PROM

Risk of infection

Yasmin decides to go home. She asks you if there is anything she should look out for or be worried about?

What advice do you give Yasmin?

- Return to hospital if any concerns
- Be alert for signs of infection
- Change pad regularly and note changes in colour, amount, odour
- Risk of infection is:
 - Possibly increased with vaginal sex
 - Not affected by showering or bathing



Signs of infection

- Feeling unwell or flu-like symptoms
- Maternal temperature greater than 37.5 °C
- Offensive vaginal discharge
- Uterine tenderness
- Fetal tachycardia
- Change in fetal movements