Term prelabour rupture of membranes

Clinical Guideline Presentation v1.0

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 E18.47-1-V1-R23. Queensland Health 2018.

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

Prelabour

Rupture

Of

Membranes

Occurs in around 8% of pregnancies

- Estimates vary but around 60−95% of women will establish in spontaneous 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 speculum exam

- Exclude cord prolapse
- Visualise cervical length and dilatation

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

Indications for CS

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

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:

- Time from ROM to birth
- Chorioamnionitis
- Maternal length of stay
- Admission to NICU/SCN
- Neonatal sepsis (definite or probable)

With active management:

- Maternal satisfaction – mixed reports
- No 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 should have antibiotics.

Should you recommend antibiotics?

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 EOGBSD), 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 EOGBSD
- PROM longer than 18 hours
- Temperature 38 ^{o}C or higher intrapartum

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 you should recommend Yasmin wait?

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

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 in 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 ^{o}C
- Offensive vaginal discharge
- Uterine tenderness
- Fetal tachycardia
- Change in fetal movements

Risk of infection

Lucy is 39 weeks pregnant. She initially presented 24 hours ago with PROM and then went home. No swabs were collected at the initial presentation.

Should Lucy have had swabs collected at her initial presentation?

- High vaginal swabs are not *routinely* indicated following PROM at term
- Recommend low vaginal and anal swab for GBS if GBS status unknown at presentation

Initial presentation

- Clinical assessment
- Review history and time of fluid loss
- Sterile speculum
- Test vaginal secretions if required
- Low vaginal and anal swab for GBS