Clinical Practice Guideline Pre-labour Rupture of Membranes at Term
Peninsula Care Goal Safe

Introduction

About 8% of women will have Pre-labour Rupture of Membranes at Term (Term PROM).
Rates of spontaneous onset of labour following term PROM are:

- 70% at 24 hours
- 85% at 48 hours
- 95% at 96 hours [1,2]

In most cases, term PROM occurs in the absence of any known risk factors.
However, some risk factors associated with term PROM include:

- Infection of urogenital tract
- Cigarette smoking
- Illicit drug use
- Previous PROM or preterm birth
- Polyhydramnios
- Antepartum haemorrhage

Management options in women with term PROM may be expectant or active.
Appropriate management options should be undertaken after careful evaluation of any risk factors, the ability of the unit to provide a safe level of care, and the woman's wishes.[3]

Purpose

- That women who experience pre-labour rupture of the membranes before the onset of labour where the gestation is greater than 37 weeks are offered appropriate treatment.
- To exclude and reduce the occurrence of recognised complications of term PROM:
    - Infection (Maternal/Fetal/Neonatal)
    - Placental abruption
    - Umbilical cord prolapse or cord compression
    - Respiratory distress syndrome in the newborn [3]

Definitions

Term	≥ 37 weeks Gestation
ROM	Rupture of membranes
SROM	Spontaneous rupture of membranes
PROM	Pre-labour rupture of membranes - not in established labour after a latent period of 4 hours following confirmed ROM
Latency	Period of time between ROM and onset of labour
Expectant Management	No planned intervention to precipitate birth within 24 hours of PROM
Active Management	Planned intervention to induce labour within 24 hours of PROM
IOL	Induction of labour
GBS	Group B Streptococcus
CTG	Cardiotocograph
APH	Ante-partum haemorrhage
Chorioamnionitis	Inflammation of the fetal membranes (amnion and chorion) due to a bacterial infection. It typically results from bacteria ascending into the

	uterus from the vagina and is most often associated with prolonged rupture of membranes.
Malpresentation	Abnormal (non-vertex) presentation e.g. breech or shoulder presentation.
Malaise	Feeling of general discomfort or uneasiness, an "out of sorts" feeling, often the first indication of an infection or other disease

Assessment of term PROM
Performed by:

- Registered Midwife
- Medical Officer
- Student Midwife/Medical Student (under the direct supervision of one of the above)

On the telephone

Careful history taking is essential to determine the possibility of PROM and assess the presence of any complicating risk factors. This assessment is often done over the phone.

Ask these questions:

- What time did membranes rupture?
- What is the amount, colour and odour of the fluid?
- Does the woman feel unwell?
- Is the baby moving normally?
- Does the woman know how her baby was presenting at the last antenatal visit?
- Are there any medical problems in pregnancy?
- Does the woman know her GBS status?
- Is this a singleton pregnancy?
- Has the woman had a previous Caesarean?

Advise the woman to present for assessment as soon as they are able to.
She should tell her midwife or doctor if contractions begin.

On presentation

- Perform a general and obstetric examination.
- Confirm the presence of liquor on the woman's pad, if relevant.
- If no evidence of liquor is present, a sterile speculum examination may be indicated.
- Perform high and low vaginal swab if GBS status unknown.
- If no liquor is visualised during the speculum examination, a diagnostic tool such as the Amnisure can be used.
- If no liquor is visualised and no diagnostic tools are available, admit the woman for ongoing observation and continue pad checks to confirm or rule out ROM.
- Digital vaginal examination should **NOT** be performed in women with ruptured membranes where conservative management is being considered.
- Vaginal examination should be considered if active labour is suspected, or at the commencement of induction.
- Electronic fetal monitoring to assess fetal wellbeing.

Management where term PROM is confirmed

- Women with term PROM, not in labour, and with no contraindications to expectant management should be offered a choice between **induction of labour** (IOL) at the earliest opportunity, or **expectant management**.

- To assist with this choice woman should be provided a copy of the Patient information leaflet from Safe care Victoria. All clinicians should be conversant with the pros and cons of these choices.

Factors contraindicating expectant management of term PROM:

- GBS positive status in current pregnancy
- Previous birth of a baby affected by GBS disease
- Evidence of chorioamnionitis (maternal pyrexia, offensive discharge, malaise)
- Meconium stained liquor
- Abnormal CTG
- Mal-presentation including Breech presentation
- Previous Caesarean section
- History of cervical cerclage
- Multiple pregnancy
- High head

Risk of sepsis associated with active and expectant management of term PROM*

	Early onset neonatal sepsis		Maternal chorioamnionitis or endometritis	
Active management	12 per 1000	1.2%	54 per 1000	5.4%
Expectant management	22 per 1000	2.2%	110 per 1000	11%

* Data from the 2017 Cochrane Review

Expectant management

In the absence of any complicating risk factors, women may be offered the option of expectant management. This may be as an inpatient or, if appropriate (based on individual circumstances such as travel requirements and support), at home.

- Discuss the management plan with the woman and her support person or family.
- Advise four-hourly observations of temperature, PV loss, fetal movement and uterine activity (during waking hours).
- Ensure the woman understands normal and abnormal parameters and knows to report any abnormal observations.
- Advise the woman to avoid vaginal intercourse.
- Offer active management if labour is not established by 24 hours after ROM (The timing of the induction may depend on the availability of staffing and a birth suite room. Women with ruptured membranes may need to take priority over other elective inductions. Prioritisation of inductions should be discussed between the ANUM and consultant in charge. Any issues causing delay must be clearly documented in the notes and on BOS).

- Recommend prophylactic intrapartum IV antibiotics as detailed below if onset of spontaneous labour or IOL > 18 hours
- Daily fetal and maternal assessment on ward until spontaneous labour or until labour is arranged.
- Women may choose to continue with expectant management for an additional period of time. The benefits and risks of prolonged expectant management should be discussed and documented, and daily review recommended to evaluate fetal and maternal wellbeing.

Spontaneous labour
Intrapartum CTG is required in spontaneous labour following PROM greater than 24 hours. (4)

Active management
- Active management is recommended for women with any risk factors or contraindications for expectant management, and for those women who prefer this option.
- **If the woman is GBS positive, prophylactic IV antibiotics should be commenced immediately and IOL commenced as soon as possible.**
- If chorioamnionitis is suspected, induction should be expedited with broad spectrum antibiotic cover and close fetal monitoring.
- Commencement of active management may be dependent on the availability of staff and a birth suite room.
- Oxytocin induction is advised for IOL

Choice of Antibiotics
Antibiotics for GBS+ve or ROM >18 hours
- IV Benzylpenicillin 3 g loading dose, continuing 1.8 g every four hours

(If the woman has a penicillin allergy)
- IV Clindamycin 900 mg every eight hours

Antibiotics for suspected sepsis/chorioamnionitis
- IV Amoxycillin 2 g loading dose, continuing 1 g every six hours
  AND
- IV Gentamycin 5 mg/kg daily
  AND
- IV Metronidazole 500 mg every 12 hours

If the woman has a penicillin allergy
- IV Clindamycin 900 mg every 8 hours (3)

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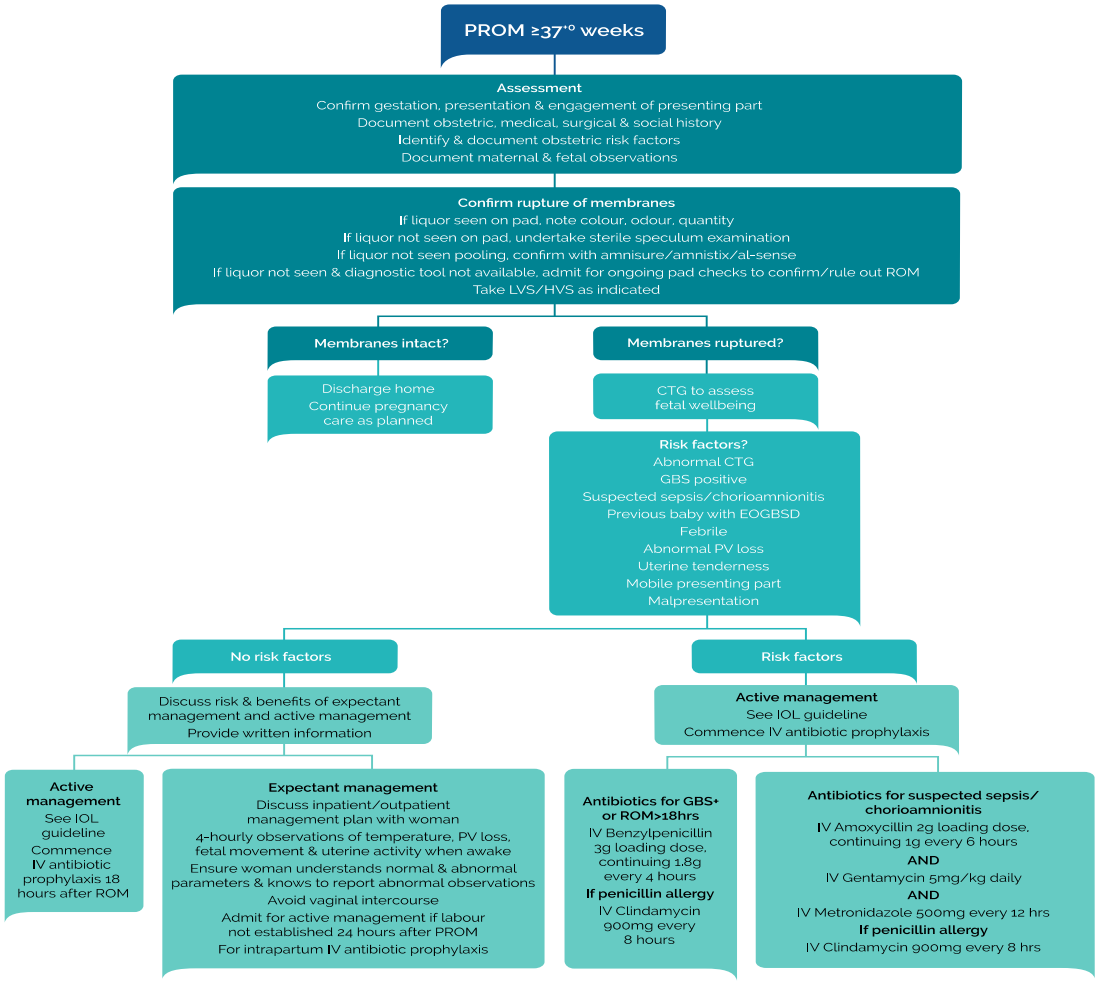
Term PROM



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This Algorithm is guidance from [Maternity e-handbook by Safer Care Victoria](#).

The precise timing of induction may depend on the availability of staff and a birth suite room.

Related Policies and Guidelines

- Hand Hygiene & Aseptic Technique
- Prolonged Pregnancy
- Induction and Augmentation of Labour with Oxytocin.

- Management of Meconium Stained Liquor (MSL)
- Neonatal Resuscitation
- Pathology Specimen Collection
- Blood and Body Substance Exposure Prevention and Management of Exposure
- Induction of Labour – Indications and Booking Process.

References

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2. Hannah ME, Ohlsson A, Farine D, Hewson SA, Hodnett ED, Myhr TL, et al. Induction of labor
3. https://www2.health.vic.gov.au/hospitals-and-health-services/safer-care-victoria/maternity-ehandbook/prom
4. The Royal Australian and New Zealand College of Gynaecologists (RANZCOG), 2006, *Intrapartum Fetal Surveillance, Clinical Guidelines – second edition, Melbourne, Australia.*http://www.ranzcog.edu.au/publications/pdfs/ClinicalGuidelines-IFSSecEd.pdf
5. National Institute for Health & Care Excellence. Clinical guideline [CG190] 1.11. Prelabour rupture of membranes at term. February 2017

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