Prelabour Rupture of Membranes at Term - Full Clinical Guideline

Reference no.: Obst/03:18/L3

Contents

1. Introduction

The incidence of Prelabour Rupture Of Membranes (PROM) at term is about 8-10% of pregnancies. Prolonged rupture of membranes increases the risk of infection and therefore a correct diagnosis followed by a plan of care is essential, based on the individual risks.

2. Aim and Purpose

To provide guidance on the appropriate care that needs to be provided to women that are ≥37 weeks pregnant and report with prelabour rupture of the membranes. To provide information on how to support parents to make an informed choice of Induction of Labour or expectant management.

3. Definitions

Prelabour rupture of membranes at term is defined as spontaneous rupture of the amniotic membranes after 37 completed weeks of gestation prior to labour.

4. Abbreviations

CLC	-	Consultant Led Care
CRP	-	C-Reactive Protein
CTG	-	Cardiotocograph
FBC	-	Full Blood Count
IOL	-	Induction of Labour
GBS	-	Group B Beta Haemolytic Streptococcus
HVS	-	High vaginal Swab
IUGR	-	Intra Uterine Growth Retardation
MLC	-	Midwife Led Care
PROM	-	Premature Rupture of Membranes
SGA	-	Small for Gestational Age
SROM	-	Spontaneous Rupture of Membranes

5. Initial contact with suspected PROM

For women after 37+0 weeks with suspected rupture of the membranes but no risk factors on initial phone triage assessment:

- see the woman in person as soon as possible if she has any concerns or wishes to be induced immediately or within 12 hours.
- if anything changes or the woman has any concerns, advise her to call her midwife or maternity unit back sooner than the planned review.

Offer to carry out the review at the woman's home, in a midwifery-led unit, or an assessment centre at an obstetric unit as appropriate.

6. Diagnosis of PROM

Women will usually call to report the rupture of the membranes. During this phone call it is essential to take a history including:

- Date and time of suspected ruptured membranes
- Amount and colour of fluid lost
- MLC or CLC (please ask for risk factors)
- Perception of fetal movements
- History of GBS in this pregnancy
- Vaginal bleeding
- Presentation of baby on last visit
- Overall wellbeing
- Presence or absence of contractions

Advise the woman to use a fresh maternity pad so it can be inspected on arrival (and/or ask her to bring in a wet pad if she has just changed). Invite the woman in to the Pregnancy Assessment Unit (PAU). Alternatively, she may be invited directly into the birth centre or if a woman is planned for a home birth a home visit from a community midwife needs to be arranged. Assessment should be identical regardless of the place that she is being seen. Advise a woman to come in as soon as possible to assess maternal and fetal wellbeing and confirm SROM.

6.1. Initial Assessment

Initial assessment can be carried out by a midwife and should consist of the following:

- Full antenatal check including auscultation of the fetal heart
- Confirmation of PROM based on history given by the woman and visualisation of liquor. A speculum examination should ***NOT*** be carried out if it is certain that the membranes have ruptured
- If there is uncertainty, ask the woman to lie on her left side for half an hour. If liquor can be visualised, a speculum examination should not be carried out. If liquor cannot be visualised, confirm diagnosis with a sterile speculum examination

- In case of strong history of PPROM but NO liquor visible in the posterior fornix, carry out an Amnisure test
- Avoid digital vaginal examination in the absence of contractions suggestive of labour
- Maternal observations including temperature, pulse and respiratory rate
- Auscultation of the fetal heart should be carried out following speculum examination. This should be followed by a CTG monitoring for women with risk factors identified in pregnancy or during assessment (i.e. for all women that are suitable for CTG monitoring during labour under consultant led care)

Once ruptured membranes have been confirmed, complete a labour risk assessment form including the advised plan for fetal monitoring in labour/active labour management/planned induction of labour. Discuss these with the woman.

If a woman is under consultant led care a medical review is required to plan care.

6.2. Risk Factors for Immediate Induction of Labour

Risk factors that prompt a medical review (Registrar ST3 or higher) to discuss the appropriate timing of induction of labour and possible admission include:

- Signs of infection (e.g. maternal pyrexia, maternal or fetal tachycardia etc)
- GBS positive during this pregnancy (please see GBS guideline)
- Meconium stained liquor
- Altered fetal movements
- IUGR/SGA
- Abnormal CTG
- Other identified risk factors (see IOL guideline)

6.3. Low Risk Pregnancy or No Risk Factors Identified

In case of a low risk pregnancy under midwifery led care or no other complications requiring immediate induction of labour have been identified, women should be informed that:

- The risk of serious neonatal infection is 1% (in comparison to a 0.5% risk in the presence of intact membranes)
- 60% of women with PROM at term will go into spontaneous labour within 24 hours of the event
- IOL is appropriate approximately 24 hours after rupture of the amniotic membranes

Women should be supported if they make an informed choice for immediate induction of labour without delay or for expectant management beyond 24 hours.

Until IOL takes place, the following are advised:

- For the woman to contact the hospital immediately if:
    - starts to feel unwell (including symptoms of a raised temperature)
    - any change to the features of vaginal loss (e.g. odour, colour, presence of blood or meconium)
    - Any decrease in fetal movements or change in fetal movement pattern.

- For the woman to be advised to avoid sexual intercourse and to be aware that bathing and showering does not increase the risk of infection
- In the presence of any signs of infection (e.g. maternal pyrexia, maternal or fetal tachycardia.or feeling unwell), delivery should be expedited.
- FBC, CRP or HVS are not routinely recommended.

6.4 Expectant management beyond 24 hours

It the woman chooses not to accept induction of labour at 24 hours, she should be informed of the increased risk of infection if IOL is delayed for more than 24 hours. She should be advised that delivery should take place at RDH/QHB with neonatal services on site and that she will be advised to remain in hospital for 12 hours post-delivery for maternal and newborn observation

- If you plan to discharge the woman from the hospital setting please check the time of the previous set of full observations. If four hours or more have lapsed undertake a further full set of observations prior to discharge. All maternal observations should be documented onto MEOWS chart and escalated as appropriate

- To be aware of any infection that may be developing. The woman should be advised to record her temperature every 4 hours during waking hours, monitor for a change in colour or smell of her vaginal loss and contact the maternity unit immediately if any concerns.

- Contact the maternity unit immediately if she has any concerns about her fetal movement pattern

- Advised that a fetal heart rate (CTG monitoring) and fetal movement assessment should be undertaken by a midwife, every 24 hours.

- Advised that a date and time for induction of labour can be arranged, by her midwife, should she request it

- Advised that if induction of labour is not requested by 72 hours, she should be reviewed by a senior obstetrician for further discussion

- Provide information leaflet to support discussion (information is included in the Induction of labour patient information)

7. Monitoring Compliance and Effectiveness

Monitoring compliance with this guideline will be as agreed as part of the business unit audit forward programme.

8. References (including any links to NICE Guidance etc.)

NICE Feb 2017. Intrapartum care for healthy women and babies. Section 1.11

Documentation Control

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