CLINICAL GUIDELINE

Prelabour Rupture of Membranes at Term

A guideline is intended to assist healthcare professionals in the choice of disease-specific treatments.

Clinical judgement should be exercised on the applicability of any guideline, influenced by individual patient characteristics. Clinicians should be mindful of the potential for harmful polypharmacy and increased susceptibility to adverse drug reactions in patients with multiple morbidities or frailty.

If, after discussion with the patient or carer, there are good reasons for not following a guideline, it is good practice to record these and communicate them to others involved in the care of the patient.

Version Number:	2
Does this version include changes to clinical advice:	Yes
Date Approved:	26th October 2017
Date of Next Review:	1st October 2022
Lead Author:	Julie Murphy
Approval Group:	Obstetrics Clinical Governance Group

Important Note:

The Intranet version of this document is the only version that is maintained.
Any printed copies should therefore be viewed as 'Uncontrolled' and as such, may not necessarily contain the latest updates and amendments.

Greater Glasgow & Clyde Obstetric Guidelines

Prelabour Rupture of Membranes at Term

***Applicable Unit Policies**

- **Group B Strep prophylaxis**
- **Early onset sepsis (neonatal guideline)**
- **Maternal sepsis**
- **Antibiotic policy for obstetric patients**

Definition

Spontaneous rupture of membranes after 37+0 gestation and before the onset of regular uterine contractions. Complicates 5-10% of all pregnancies.

It is associated with increased incidence of malpresentation (eg breech) and malpositions (eg OP)

Initial Assessment

On initial telephone contact with the woman a history should be taken, including date and time of the suspected ruptured membranes.
If the woman reports any of the following she should be advised to attend hospital for assessment as soon as possible:

Vaginal bleeding
Green or offensive liquor
She feels unwell or has a raised temperature
The fetal movements have changed
The fetal position was not cephalic at last antenatal visit
She has a history of group B Streptococcus (GBS) this pregnancy or a past history of a neonate affected by GBS
Previous Caesarean section
Multiple pregnancy
There are maternal complications

All other women with suspected prelabour rupture of membranes at term should be seen by a midwife within 12 hours.

Diagnosis

- Perform an abdominal examination and confirm lie and presentation and auscultate fetal heart.
- Speculum examination IF required to make Diagnosis
- Sterile speculum examination, after the mother has adopted the left lateral position for 20 mins. A low vaginal swab should be sent to bacteriology, together with a sample of amniotic fluid if a pool is demonstrated. Ultrasound scan is **not routinely required.**
- All non-Green Pathway cases should have a CTG performed.
- A digital examination should not be performed unless active labour is suspected or CTG abnormalities are present.

Management

Neither the Term PROM study (Hannah et al. NEJM 1996 334; 16:1005-10) nor a meta-analysis (Mozurkewich & Wolf. Obstet Gynecol 1997 89; 6:1035-43) showed any significant difference in neonatal infection or caesarean section rates between those women who were induced immediately and those who were managed expectantly. The 2006 Cochrane review by Dare and colleagues confirmed these findings. Active management however was

associated with a significant reduction in maternal infection (chorioamnionitis and endometritis).

Therefore the woman should be given 3 options:

1. Expectant management at home and readmittance 24-48 hours later, if she has not laboured, for induction.
2. Expectant management in hospital and induction 24-48 hours later if she has not laboured.
3. "Immediate" induction with Syntocinon (Labour Ward permitting).

Expectant management at home should only be offered if the woman meets the following criteria:

- Not in labour
- Singleton pregnancy
- Cephalic presentation with head fixed in pelvis
- Clear liquor
- Apyrexial
- Previously uncomplicated antenatal history
- No evidence of being a carrier for Group B Strep.
- No geographical issues

NICE (2007) advise: 'Assess fetal movement and heart rate at initial contact and then every 24 hours after rupture of membranes while the woman is not in labour, and advise the woman to report immediately any decrease in fetal movements.' Therefore, if IOL is being delayed more than 24 hours then the woman should be reassessed by a midwife every 24 hours to assess maternal and fetal wellbeing.

If an inpatient admission is indicated a MEWS chart should be commenced and an individual plan of ongoing care discussed and documented in the maternal records.

If IOL is delayed more than 48 hours then maternal observations and the fetal heart rate should be recorded every 4 hours.

Prelabour Rupture of Membranes at term is no longer an indication for intrapartum antibiotic prophylaxis for Group B Streptococcus (see Group B Strep Prophylaxis guideline)

If the diagnosis of PROM is not confirmed, clinically the liquor volume is normal and the fetal heart / CTG satisfactory, the woman should be discharged home.

If there is any suspicion that the patient may be in labour then vaginal assessment should be performed and management plan agreed with woman.

See Patient leaflet on following page.

Lead Author

Dr. F. Mackenzie, Consultant Obstetrician, PRM on behalf of the GGC Obstetric Guidelines Group

Title

Prelabour Rupture of Membranes at Term_Obstetrics Version 3

Implementation / review Dates

Implementation 18/10/17 Review date 01/10/2022

Approval

Obstetric Guideline Group and Obstetric Governance, GGC Date: 12th October 2017

Patient information leaflet - What to look for after your waters have broken.

GREATER GLASGOW & CLYDE

WHAT TO LOOK FOR AFTER YOUR WATERS HAVE BROKEN

We have confirmed that the bag of water in front of your baby's head has burst. We would plan to induce labour 24 – 48 hours from now unless you go into labour yourself.

While you are waiting for labour to start you must watch for any signs of infection.

Infection is a rare complication.

If you notice any of the following please contact the labour ward midwife immediately on following telephone number depending on where you are booked:

Site	Location	Telephone number
Princess Royal Maternity	**Maternity Assessment**	**0141 211 0753** **0141 211 5276** **0141 211 5352**
Royal Alexandra Hospital	**Labour Ward**	**0141 314 6743**
Queen Elizabeth University Hospital	**Maternity Assessment**	**0141 232 4677** **0141 232 4363**

1. If you think you are in labour.
2. Pain in your abdomen (tummy)
3. The water draining changes colour or becomes smelly
4. Your baby doesn't move around as much
5. If you feel unwell, shivery or similar to having the 'flu

If you have not experienced any of the above and have not gone into labour then please

return to……..on:

……at……for induction of labour.

Information issued by……

Print Name & Grade……

Date & Time……

It is hospital policy for all babies born to women whose waters have broken prior to labour to be observed on the postnatal wards for 24-36 hours for any signs of infection.