CTM Obs 139

Management of Pre-labour Spontaneous Rupture of Membranes (SROM) at term (≥37+0 gestation)

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Approval Group	Labour Ward Forum
Distribution	Midwifery, Medical and Neonatal staff within Cwm Taf Morgannwg University Health Board (via email)
Archiving	Directorate secretary will be responsible for archiving all versions
Document Location	Health Board intranet Wisdom
Freedom of Information	Open

CHANGE HISTORY

Version	Date	Author Job Title	Reasoning
2	June 2024	Bryany Tweedale	update

AUTHORSHIP, RESPONSIBILITY AND REVIEW

Authors	Bryany Tweedale	Ratification Date	June 2024
Job Title	Consultant Midwife	Review Date	June 2027

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Contents

Definition

Pre-labour spontaneous rupture of membranes (SROM) at term is defined as rupture of the fetal amniotic membrane prior to the onset of regular, painful contractions in women ≥37 weeks' gestation.

Aim

The aim of this guideline is to:

- Support consistent care and ongoing care planning for women and pregnant people who report or present with pre-labour spontaneous rupture of membranes (SROM) ≥37+0 weeks.
- Support information provision and informed decision-making in partnership with women and pregnant people.

Background

Pre-labour spontaneous rupture of membranes (SROM) at term (≥37 weeks gestation), is a fairly common occurrence, with an incidence of 8-10% of pregnancies. It is reported that approximately 60% of women with pre-labour rupture of membranes will go in to labour within 24 hours. Up to 94% of women with pre-labour rupture of membranes will go in to labour within 96 hours, with around 6% remaining pregnant beyond 96 hours. In women with pre-labour rupture of membranes at term, the likelihood of serious neonatal infection goes from 0.5% to 1% in comparison with women with intact membranes at the onset of labour (NICE, 2023).

Women who opt for planned early birth have a reduced likelihood of chorioamnionitis, postpartum septicaemia (and absolute risk reduction of 5% in the planned early birth) and their babies are less likely to commence antibiotic therapy (1% reduction in actual risk). There is also evidence with planned early birth, that women have a shorter stay in hospital, a shorter duration from rupture of membranes, to birth, and less neonatal admissions to neonatal special care unit or intensive care unit.

Initial assessment of rupture of membranes

1. The woman should be advised to contact her midwife or maternity priority unit where she suspects rupture of membranes ≥37 weeks' gestation to receive an initial triage assessment over the telephone.

2. This initial telephone triage should include ascertaining when the membranes ruptured and an assessment of the presence of any risk factors:
    - Meconium stained liquor
    - Blood stained liquor or vaginal bleeding
    - Reduced or altered fetal movements
    - Continuous abdominal pain
    - Unpleasant or offensive smelling liquor (or any change in the colour or smell of vaginal loss)
    - Known Group B Streptococcus (GBS) carriage or infection in the current pregnancy, or where there a plan has been made for the woman to receive intrapartum antibiotic prophylaxis in her current pregnancy.
    - The woman is feeling unwell in herself
    - The baby has an abnormal lie or presentation (for example, transverse lie or breech presentation)
    - There is fetal growth restriction
    - There is a low-lying placenta

If any of these factors are present, or if there is any uncertainty, the woman should be advised to immediately attend the maternity priority unit for an urgent in-person review.

For women ≥37+0 weeks, with suspected rupture of membranes, but no risk factors identified during the initial telephone triage assessment:

- Offer to see the woman in person as soon as possible if she has any concerns or wishes to discuss or undergo induction of labour immediately
- Or, within 12 hours.
- And, the woman should be advised that if anything changes, or she has any concerns, she should be advised to call the midwife or maternity unit back sooner than the planned review.

A speculum examination is not required and should not be carried out where it is certain that the membranes have ruptured.

Ongoing assessment of rupture of membranes

The midwife should offer the woman a review at her home, in a midwife-led unit, or within the maternity priority unit. The following assessment should be undertaken:

1) Review the woman's maternity notes.
2) Confirm the pregnancy gestation and EDD with the woman.
3) Review fetal growth surveillance by Gap/Grow customised growth chart (standardised fundal height (SFH) measurement should be undertaken if no measurement has been undertaken in the previous 2 weeks, in line with Perinatal Institute guidance.
4) Perform an abdominal palpation, confirming presentation and engagement of the presenting part.
5) Auscultate the fetal heart rate with a Pinnard stethoscope or hand-held Doppler.
6) Ask about (and document) the presence of a normal pattern of fetal movements.
7) If there is any alteration or reduction in the woman's normal pattern of fetal movements, a Cardiotocograph (CTG) should be recommended.
8) Any woman suitable for the All Wales Clinical Pathway for Normal Labour (AWCPNL) should not have a CTG undertaken as a routine/without a clinical indication as per their initial assessment.
9) For women not suitable for the All Wales Clinical Pathway for Normal Labour (AWCPNL), a CTG should be considered as part of this initial assessment, with reference to the Cwm Taf Morgannwg UHB Fetal Monitoring guideline: wisdom.nhs.wales/health-board-guidelines/cwm-taf-maternity-file/fetal-monitoring-guideline/
10) Perform maternal observations; including temperature, pulse, blood pressure and respiratory rate. If the woman is not suitable for assessment on the All Wales Clinical Pathway for Normal Labour (AWCPNL), observations should be recorded on a MEWS chart.
11) **Do not carry out a speculum examination if it is certain that the membranes have ruptured.**
12) If it is uncertain whether pre-labour rupture of membranes have occurred, offer the woman a sterile speculum examination. During speculum examination, inspect for:

- Presence of amniotic fluid passing through the cervix/pooling in the vagina
- Amount/colour of amniotic fluid
- Signs of infection
- Cervical changes/dilatation

13) Where there is no pooling of amniotic fluid observed, AmniSure testing can be used to support diagnosis/exclusion of rupture of membranes.

14) If there is no amniotic fluid observed on speculum examination and/or Amnisure testing is negative, it is highly unlikely that pre-labour rupture of membranes has occurred and the woman should be discharged home with advice to return if she has any further vaginal loss or any other concerns.

15) **Digital vaginal examination should be avoided in the absence of regular contractions likely to be indicative of active labour**. Digital examination increases the risk of ascending infection and poor outcome, and will not add any helpful information to the speculum examination if the woman is not in labour.

Informed Decision Making

The following principles around informed decision making Shared decision making (nice.org.uk) should be used during counselling, including:

- Encouraging the woman to talk about what is important to her
- Communicating with the woman in a way that she can understand
- Using clear language, avoiding jargon and explaining technical terms
- Sharing and discussing the information needed to make informed decisions
- Making sure that the woman understands the choices available to her (including the choice of doing nothing or not changing her current plan)
- Accept and acknowledge that women may vary in their views about the balance of risks, benefits and consequences of treatments, and that they may differ from those of their healthcare professionals.

- Explore risks/benefits/alternatives using the B.R.A.I.N pneumonic:
  Benefits - What are the perceived benefits of the proposed plan?
  Risks - What are the risks/disadvantages associated with the proposed plan?
  Alternatives - What are the alternatives to the proposed plan?
  Intuition - What does the woman feel about what is right for her, knowing her body and any previous birth experience?
  Nothing - What could happen if the woman does nothing, or says 'not now' and takes some time to think?

Ongoing management following confirmation of pre-labour rupture of membranes

Advise the woman that with confirmed pre-labour rupture of membranes at term (≥37+0 weeks) that:

- The risk of serious neonatal infection is 1% (1:100) rather than 0.5% (1:200) for women with intact membranes, and that the likelihood of serious neonatal infection may increase over time.
- If digital examination is performed and the woman is not in active labour, she should be offered discussion with a senior obstetrician to offer and arrange induction of labour.
- Intrapartum antibiotic prophylaxis is recommended where:
  The woman is known to have GBS colonisation, bacteriuria or infection during the current pregnancy, or.
  Have had a previous baby with an invasive GBS infection, or
  Have a clinical diagnosis of chorioamnionitis.

For women with pre-labour rupture of the membranes at term (≥37+0 weeks), offer a choice of:

- Expectant management for up to 24 hours.
- Induction of labour as soon as possible

If a woman has pre-labour rupture of membranes at term (≥37+0 weeks) and **has had a positive GBS test at any time in the current pregnancy, or a previous pregnancy where her baby developed GBS infection, immediate induction of labour should be offered** (or caesarean birth, if this is the planned mode of birth).

Discuss the benefits and risks of these options with the woman, and take into account her individual circumstances and preferences. For women who choose expectant management after pre-labour rupture of the membranes at term (≥37+0 weeks):

- Recommend induction of labour if labour has not started spontaneously after approximately 24 hours.
- Offer a further period of expectant management, ensuring that the woman is aware of the increasing likelihood of serious neonatal infection with pre-labour rupture of membranes over 24 hours, and further increasing over a longer period of time.

Until induction of labour is commenced, or if expectant management beyond 24 hours is chosen by the woman:

- **Do not offer** low vaginal swabs (LVS) or maternal FBC/CRP levels.
- Advise the woman to record her temperature every 4 hours during waking hours to detect any infection that may be developing, and to report immediately any change in colour or small of vaginal loss.
- Inform the woman that bathing and/or showering is not associated with an increase in infection, but that sexual intercourse may be associated with an increase in infection.
- Arrange to assess fetal movements and fetal heart rate at every contact, and then a minimum of every 24 hours after rupture of membranes while the woman is not in labour.
- Advise the woman to immediately report any alteration or decrease in fetal movements.
- Advise the woman to immediately report if she is feeling unwell.
- If labour has not started spontaneously 24 hours after rupture of membranes, advise the woman to give birth where there is access to neonatal services and advise her to remain in hospital for at least 12 hours after birth for the baby to receive a period of neonatal observation/s.
- Women who are planning a vaginal birth after caesarean section (VBAC) who attend with pre-labour rupture of membranes should have an opportunity to discuss and agree a plan with a senior obstetrician following their initial assessment.

References

- National Institute for Health and Care Excellence (NICE) Intrapartum Care, NICE Guideline [NG235], Published: 29 September 2023
- National Institute for Health and Care Excellence (NICE) Inducing Labour, NICE Guideline [NG207], Published: 04 November 2021
- National Institute for Health and Care Excellence (NICE) Inducing Labour, NICE Guideline [NG195], Published: 20 April 2021
- Royal College of Obstetricians & Gynaecologists (RCOG) Prevention of Early-onset Group B Streptococcal Disease, Green-top Guideline No.36, Published 13 September 2017
- Dare MR et al. (2006) Planned early birth versus expectant management for prelabour rupture of membranes at term. The Cochrane Database of Systematic Reviews 2006; Issue 2
- Tan BP and Hannah ME (2001). Prostaglandins for prelabour rupture of membranes at or near term. The Cochrane Database of Systematic Reviews 2001; Issue 2

Appendix One- Information Leaflet

Information for women whose waters have broken and who are staying at, or going home.

Once your waters have broken and you and baby have been checked over by a midwife, it is often safe to remain at or go home to wait for labour to start. The risk of your baby having an infection goes from 0.5% (1:200) to 1% (1:100) when your waters have broken over 24 hours. 6 out of every 10 women (60%) whose waters break without contractions will go in to labour within the next 24 hours.

Whilst at home, we advise you to:

- Record your temperature every **4 hours** during waking hours

Phone for further advice if:

- There is any change in the colour or smell of the amniotic fluid (waters) coming away from around the baby
- Your temperature goes over 37.5^0C
- You feel unwell, such as feeling flu-like symptoms
- There is a change in the pattern of your baby's movements
- You are having regular, painful contractions

Maternity Priority Unit, Princess of Wales Hospital, Bridgend: 01656
Maternity Priority Unit, Prince Charles Hospital, Merthyr Tydfil:
Tirion Birth Centre, Royal Glamorgan Hospital, Llantrisant: 01443443524

You may go about normal activities whilst waiting for labour to start, including bathing and showering.

Sexual intercourse is not advised as it may increase the risk of infection.

If labour has not started in the 24 hours after your waters have broken, you are advised you give birth in hospital, and induction of labour is offered.

If labour has not started before, you have been asked to return to the ward on

……/……/…..…. at…….:…….

to discuss whether you would like to continue with induction of labour.