Management of Pre-labour Spontaneous Rupture of the Membranes (PROM) at Term

Speciality:	Maternity
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Definition: Rupture of amniotic membrane after ≥ 37 weeks of gestation prior to labour.

Diagnosis of PROM: either in community or hospital setting within preferably 4 hours of initial report:

1. Convincing history can lead to an accurate diagnosis

If doubt remains:

2. Speculum examination by experienced midwife or doctor – draining / pooling of amniotic fluid in the vagina (woman must lie down for 20 minutes prior to speculum examination to avoid missing the diagnosis). If no liquor seen draining to use AmniSure to aid diagnosis.

3. Ultrasound scan is **NOT** used as a diagnostic tool for PROM as there is no evidence to support this.

Negative results to steps 1-2 would suggest it is unlikely that her waters have broken and the woman should be reassured.

NOTE

- Digital vaginal examination must be avoided unless there is strong evidence that the woman may be in active labour.
- Do not carry out a speculum examination if the diagnosis is certain.
- There is no convincing evidence of benefit for mothers or neonates from the routine use of antibiotics for PROM at or near term (≥37 weeks of gestation) even intrapartum unless signs of infection or meets the GBS criteria for intrapartum antibiotic prophylaxis (see below).

Background

The risk of serious neonatal infection goes from 0.5% to 1% in comparison with women with intact membranes. It is reported that 60% of women with pre-labour rupture of membranes will go into labour within 24 hours and 94% within 96 hours.

Women who opt for planned early birth are at reduced risk of chorioamnionitis, postpartum septicaemia (an absolute risk reduction of 5 per cent in the planned early birth) and their neonates are less likely to go on antibiotics (1 per cent reduction in actual risk). There is also evidence with planned early birth that women had a shorter stay in hospital, shorter duration from rupture to birth and less neonatal admissions to neonatal special or intensive care unit.

It is also noted that women reported more positive experiences than those who had expectant management.

Management of confirmed PROM:

1. **Low risk women** could have conservative management for at least 24 hours in the community provided:

- Liquor draining is clear.
- Fetal heart rate is normal - usually through auscultation, CTG only if indicated (NICE 2017).
- No abnormal vaginal bleeding.
- Singleton, cephalic presentation, head fixed in pelvis.
- No evidence of infection
- No h/o GBS in this pregnancy

2. Women should be provided with information on PROM and induction of labour (IOL) - given both verbally and via information leaflet. Women should be advised to check their temperature every 4 hours whilst awake. Information provided and consent for IOL must be documented in the maternity notes.

3. Contact phone numbers should be provided.

4. Women who are not in spontaneous labour within 24 hours of PROM , should be offered IOL. This should be booked through Labour Ward approximately 24 hours following PROM.

5. Low risk women with PROM and in spontaneous labour within 24 hours of PROM are suitable for intrapartum care in a midwifery led setting.

Women may choose not to take up the recommendation of IOL (see "Wait and See" section).

6. Women undergoing conservative management should be advised to telephone the maternity unit/community midwife for if:

- She feels unwell and has symptoms suggestive of a temperature.
- Any change in fetal movements.
- Liquor becomes offensive smelling or becomes green, brown or significantly blood stained.
- Any other concerns.

PROM with Maternal Group B Strep

Women who have tested positive to Group B Strep (rectal swab, urine sample, low vaginal swab) or previous baby with early onset neonatal Group B Strep disease **should be offered induction of labour as soon as reasonably possible and intrapartum antibiotic prophylaxis recommended**. IOL could be started with PV prostaglandin (prostin) or IV Syntocinon based on Bishop Score. IV antibiotics should be started irrespective of the method of IOL.

For intrapartum antibiotic regime please refer to local Group B Strep guidelines.

Management of High Risk Women with PROM:

- Their management plan should be decided and documented by a senior obstetrician (usually consultant).
- Women with meconium stained liquor would usually be advised to consider immediate induction of labour.

Method of Induction (NICE 2008):

1. Immediately prior to induction a normal CTG should be obtained.

2. Vaginal examination undertaken and Bishop Score assessed.

3. Unfavourable cervix (Bishop Score <7) 3mg PGE tablet or 2mg PGE gel given followed by the commencement of IV oxytocin as per regime after 6 hours .

4. Favourable cervix (Bishop Score ≥7) commences IV oxytocin as per regime.

5. Women should have CTG in labour

Women declining induction of labour after 24 hours of PROM - "Wait and See":

In the absence of signs of maternal or fetal infection, inform women who are GBS negative and choosing to decline IOL after 24 hours of PROM (which current evidence supports):

- That it is reasonable to wait for a period of up to 96 hours before induction of labour.
- Inform women that the rates of maternal and neonatal infection increase beyond 24 hours after PROM.
- However, avoiding vaginal examinations until active labour occurs, appears to minimise this risk and is therefore an important part of an expectant management approach.

- There are no differences in the rates of assisted birth (ventouse and forceps) or caesarean section between induction of labour after 24 hours and expectant management for up to 96 hours (4 days).
- Expectant management of more than 96 hours has no evidence base however, women may still choose this type of care, but should have clear documentation of a discussion with a senior obstetrician or consultant midwife.

Monitoring of Maternal & Fetal Well-being (NICE 2013)

For women choosing expectant management following PROM at term, remaining at home during the latent period is recommended.

Daily assessment should be conducted by the midwife either in the woman's home, in the MLU / ADAU or AAU. This assessment should include:

- monitoring maternal vital signs (temperature, pulse, respiratory rate and blood pressure)
- assessment of uterine activity
- assessing fetal movement and heart rate (CTG)
- examination of the amniotic fluid
- discussion of the woman's emotional well-being.

Do not offer lower vaginal swabs or maternal C-reactive protein.

Digital vaginal examination should not be performed, as it is strongly associated with increased rates of chorioamnionitis. Advise the woman to record her temperature every 4 hours during waking hours and to report immediately:

- a temperature of over 37.5 C or below 36 C, or if feeling unwell
- any change in the colour or smell of her vaginal loss
- any decrease/change in fetal movements.

Inform her that bathing or showering are not associated with an increase in infection, but that having sexual intercourse may be.

If any contraindications to expectant management are noted on physical examination, or for any other emotional or psychological reasons, women should be strongly recommended induction of labour.

Ensure that women with PROM, choosing expectant management, are aware of when and how to contact their midwife for support, should complications develop.

References:

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

Middleton P et al. (2017) Planned Early Birth Versus Expectant Management (Waiting) for Prelabour Rupture of Membranes at Term (37 Weeks or More). The Cochrane Database of Systematic Reviews 2017

NICE Intrapartum care for healthy women and babies Clinical guideline (Published 2014; Updated 2017)

NICE Induction of Labour Guideline (Published 2008; Reviewed 2017)

Group B Streptococcal Disease, Early-onset (Green-top Guideline No. 36) (Published: 2017)

Wojcieszek AM, Stock OM, Flenady V. Antibiotics for prelabour rupture of membranes at or near term. Cochrane Database of Systematic Reviews 2014, Issue 10

Maternity Services

Checklist for Clinical Guidelines being Submitted for Approval

Title of Guideline:	Management of Pre-labour Spontaneous Rupture of the Membranes (PROM) at Term
Name(s) of Author:	Labour Ward Forum
Chair of Group or Committee approving submission:	Madhu Dey / Dawn Apsee
Brief outline giving reasons for document being submitted for ratification	Updated Version
Details of persons included in consultation process:	Labour Ward Forum
Name of Pharmacist (mandatory if drugs involved):	
Issue / Version No:	2
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Date approved by Group:	September 15th 2021
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Please indicate key words you wish to be linked to document	SROM, Rupture, Spontaneous, membrane
File Name: Used to locate where file is stores on hard drive	Z:\npt_fs2\Maternity Incidents Stats\WISDOM POLICIES\Ratified-Policies & Procedures – Obs