Approved by Quality & Patient Care Committee
21 September 2017

RUPTURE OF MEMBRANES – PRELABOUR AT TERM – ASSESSMENT AND MANAGEMENT

This LOP is developed to guide clinical practice at the Royal Hospital for Women. Individual patient circumstances may mean that practice diverges from this LOP.

1. AIM

- Accurate diagnosis, and appropriate management of Prelabour Rupture of Membranes (PROM)

2. PATIENT

- Woman with suspected/confirmed rupture of membranes (ROM) ≥37 weeks' gestation, who is not in labour

3. STAFF

- Medical and midwifery staff

4. EQUIPMENT

- Sterile speculum
- Liquor detection kit (e.g. Actim Prom)
- Sterile gloves
- Light source
- Cardiotocograph (CTG) machine

5. CLINICAL PRACTICE

- Perform midwifery admission
- Take and document history including:
    - Gestational age and method for dating pregnancy
    - Date and time of suspected ROM
    - Fluid volume, colour and odour
    - History, including uterine activity
    - Symptoms of infection e.g. fever, rigors, dysuria, malodourous vaginal discharge, uterine tenderness
    - Group B strep (GBS) status
    - Placental location
- Perform maternal observations
- Perform abdominal palpation and determine fetal lie, presentation, engagement and assess for any uterine activity and/or tenderness. Measure fundal height. Ultrasound may be needed to confirm presentation. This may be performed at the bedside by an appropriately trained clinician
- Perform CTG
- Confirm PROM by observing liquor draining from vagina and/or liquor on pad.
- Perform sterile speculum examination if diagnosis is uncertain or the presenting part is not fixed in the pelvis
- Take swabs for liquor detection test if diagnosis still uncertain, with direct visualisation of vagina and cervix

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RUPTURE OF MEMBRANES – PRELABOUR AT TERM – ASSESSMENT AND MANAGEMENT cont'd

- Perform sterile digital vaginal examination (if no contraindications exist) when cervix appears effaced or dilated on speculum, breech presentation, or immediately prior to commencing induction of labour
- Discuss findings with woman and record findings in integrated clinical notes
- Recommend immediate induction of labour (IOL) for woman with meconium stained liquor (MSL), or ROM > 24 hours
- Recommend and organise IOL for woman within 24 hours of ROM who is GBS positive, or has other risk factors for EOGBS sepsis
- Ensure criteria for expectant management are fulfilled before considering this as an option:
    - Fixed cephalic presentation
    - Singleton pregnancy
    - No signs of infection (maternal tachycardia, fever, uterine tenderness)
    - Reassuring CTG
    - No history of cervical suture this pregnancy
    - Adequate resource/staffing to provide support as an outpatient or inpatient
    - Commitment to 4 hourly maternal temperature, evaluation of vaginal loss and assessment of fetal wellbeing
    - Reliable transport to return to hospital quickly if needed
- Recommend medical admission for woman with confirmed PROM who does NOT fulfil criteria for expectant management and/or has a clinical/social scenario unsuitable to return home
- Discuss advantages/disadvantages of IOL vs expectant management with woman who is eligible to consider either option
- Give woman with confirmed PROM the following options, if she fulfils criteria, and has no other complications:
    - Immediate IOL, depending on Delivery Suite level of activity
    - Returning home to await spontaneous labour, with a recommendation for IOL within 24 hours if spontaneous labour does not ensue
    - Admission to antenatal ward to await spontaneous labour, with recommendation for IOL within 24 hours
- Ensure fetal presentation has been confirmed with bedside ultrasound as fixed and cephalic, for woman choosing to return home
- Advise the following for woman who chooses to return home, or woman who declines IOL:
    - Fourth hourly temperature, pad checks and changes during the day
    - Daily review in hospital and daily CTG
    - Clear instructions when to contact her midwife or Delivery Suite
- Give Patient Information Leaflet regarding PROM (Appendix 1) to woman undertaking expectant management and returning home, and ensure she understands all instructions
- Book IOL to commence the following morning, if spontaneous labour does not ensue, for woman not undertaking immediate IOL

6. DOCUMENTATION

- Integrated clinical notes
- Obstetric database
- CTG Stickers
- Antenatal Observation Chart
- Antenatal Short Stay Observation Chart
- Antenatal Card

RUPTURE OF MEMBRANES – PRELABOUR AT TERM – ASSESSMENT AND MANAGEMENT cont'd

7. EDUCATIONAL NOTES

- The incidence of term PROM is 8%. Spontaneous labour follows term PROM at 24, 48 and 96 hours in 70%, 85% and 95% of women, respectively. Thus, an important proportion of women have significant latency from PROM to delivery if managed expectantly, particularly nulliparous women. Management of term PROM requires a clear discussion with the woman, her partner and caregivers regarding the benefits and risks of expectant management versus active management with IOL.
- The immediate risks of ROM include cord prolapse, cord compression, and abruption.
- The 2017 Cochrane review by Middleton and colleagues provided information regarding 8615 women and their neonates in 23 trials with PROM $\geq$ 37 weeks gestation managed with planned early birth (IOL) or expectant management. Ten trials assessed intravenous oxytocin, and 12 trials assessed prostaglandins (six trials in the form of vaginal prostaglandin E2 and six as oral, sublingual or vaginal misoprostol). Most of the evidence is regarded by the author(s) as 'low quality'. The review showed:
    - No difference in:
        - caesarean section rate (RR 0.84, 95% CI 0.69-1.04)
        - serious maternal morbidity or mortality (although very low quality evidence)
        - definite early-onset neonatal sepsis (RR 0.57, 95% CI 0.24-1.33, very low quality evidence)
        - perinatal mortality (RR 0.47, 95% CI 0.13-1.66, moderate quality evidence)
    - IOL associated with reduction in:
        - maternal infectious morbidity (chorioamnionitis and/or endometritis) (RR 0.49, 95% CI 0.33-0.72, low quality evidence)
        - definite or probably early-onset neonatal sepsis (RR 0.73, 95% CI 0.58-0.92, low quality evidence)
    - Women in the planned early birth group (IOL) had more positive experiences compared with women in the expectant management group.
- The TERMPROM Study from 1996 had similar findings

8. RELATED POLICIES/ PROCEDURES/CLINICAL PRACTICE GUIDELINES

- Admission - Midwifery Guideline
- ACTIM PROM: Qualitative Diagnosis of Preterm Premature Rupture of Membranes
- Cardiotocography (CTG) – Antenatal
- Estimating Due Date (EDD)
- Syntocinon Induction or Augmentation of Labour
- Vaginal Examinations in Labour
- Group B Streptococcus (GBS) – Screening and Prophylaxis
- Cervical suture/cerclage – removal guideline

9. RISK RATING

- Low

LOCAL OPERATING PROCEDURE

CLINICAL POLICIES, PROCEDURES & GUIDELINES

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RUPTURE OF MEMBRANES – PRELABOUR AT TERM – ASSESSMENT AND MANAGEMENT cont'd

10. NATIONAL STANDARD

- CC – Comprehensive Care

11. REFERENCES

1. RANZCOG guidelines. Term Prelabour Rupture of Membranes (PROM). First endorsed by RANZCOG: July 2010 Current: March 2014
2. Hannah ME, Ohlsson A, Farine D, Hewson SA, Hodnett ED, Myhr TL, et al. Induction of labor compared with expectant management for prelabor rupture of the membranes at term. TERMPROM Study Group. N Engl J Med. 1996;334(16):1005-10.
3. Middleton P, Shepherd E, Flenady V, McBain RD, Crowther CA. Planned early birth versus expectant management (waiting) for prelabour rupture of membranes at term (37 weeks or more). Cochrane Database of Systematic Reviews 2017, Issue 1. Art. No.: CD005302

REVISION & APPROVAL HISTORY

Reviewed and endorsed Maternity Services LOPs 12/9/17
Title – *Rupture of Membranes – Preterm Prelabour – Assessment and Management*
Approved Quality & Patient Care Committee 6/10/16
Reviewed and endorsed Maternity Services LOPs 13/9/16
Title – *Preterm Premature rupture of Membranes (PPROM) – Assessment and Management Guideline*
Approved Quality & Patient Safety Committee 18/2/10
Obstetric Clinical Guidelines Group October 2009

FOR REVIEW : SEPTEMBER 2022

APPENDIX 1

RUPTURED MEMBRANES - PRELABOUR AT TERM - FOR WOMEN CHOOSING TO GO HOME

This information has been prepared for you as you have ruptured your membranes (broken your waters) before labour and you do not wish, or need, to stay in hospital. Most women (70%) will labour on their own within 24 hours of ruptured membranes.

If you are going home to await labour, we would want to confirm:

- You are pregnant with only ONE baby
- Your baby is in a 'head down' position
- Your baby is well grown
- You have no signs of infection
- You have reliable transport to return to hospital quickly if needed

If you choose to return home, it is important to take some basic precautions and know when to call and come in:

- Take your temperature every 4 hours during the day. If your temperature rises above 37.5^{o}C please contact your midwife or Delivery Suite
- You will need to wear a sanitary pad and change at least every 4 hours during the day. If you wake up during the night, please change your pad. The colour of the water (amniotic fluid) is normally clear. If the colour of the water changes to green, yellow or is blood stained, please contact your midwife or Delivery Suite.
- If the baby is quiet or not moving as your baby normally does, please contact your midwife or Delivery Suite.
- If you have regular, painful contractions, then please contact your midwife or Delivery Suite
- <u>If you are concerned for ANY reason or feel unwell in any way, please contact your midwife or Delivery Suite</u>

If any of these things happen, you will be asked to come in to the hospital for review.

What can you do to reduce the chance of infection?

- It is essential to maintain good hygiene by having twice daily showers and frequent pad changes as outlined above
- Do not use tampons
- Do not go swimming
- Do not have a bath
- Do not have sexual intercourse

As discussed, we recommended an induction of labour within 24 hours of ruptured membranes. Your induction of labour has been booked for:

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If you decline induction of labour, we recommend that you are reviewed daily to assess you and your baby

- Your appointment in Delivery Suite/Birth Centre has been booked for

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- If you are concerned at any time, or if you have any questions please contact your midwife or Delivery Suite

The direct telephone number to the Delivery Suite is 9382 6100 (24 hours).

Your midwife's telephone number is ……....