Plymouth Hospitals NHS
NHS Trust

Intrapartum Guidelines

No.22 Management of Pre - labour Rupture of Membranes at Term

1. Introduction

Prelabour rupture of membranes at term is defined as rupture of the membranes prior to the onset of labour in women at or over 37 weeks of gestation.
Incidence: 8-10% of all pregnancies.

2. History & Assessment

If PROM has occurred woman must be seen as soon as possible in order to confirm diagnosis and determine that the liquor is clear, there is a cephalic presentation and no other antenatal risk factors.

- Speculum examination: Not indicated with clinical evidence of liquor
- With uncertain history: either use the Amniotic leak detector (please refer to SOP for Amniotic Leak Detectors) or offer a speculum examination to determine whether membranes have been ruptured, take a HVS avoid digital vaginal examination in the absence of contractions
- Record fetal heart rate & fetal movements at initial contact

3. Management Options

- Immediate induction of labour
- Expectant management

60% will go into spontaneous labour within 24 hours
Risk of serious neonatal infection is 1% compared to 0.5% for women with intact membranes.

Women should be given the choice between immediate and expectant management which should include information about:

	Immediate management	***Expectant management***
Pain experienced	Increased	Decreased
Risk of infection (neonatal)	Decreased	Increased
Risk of LSCS or instrumental delivery	No difference	
Length of stay in hospital	If delivered within 24 hours can go home	If delivered after 24 hours of SRM will need to stay for neonatal NEW obs

3.1 Expectant management

- Up to 24 hrs

- Women should be warned of signs of infection & advised to record temperature every 4 hrs & report immediately any change in the colour/smell of their vaginal loss
- Fetal movements - report any decrease in FM.

Thick meconium stained liquor should be interpreted in the light of the CTG and other risk factors. If all else is normal, meconium alone is not an indication for immediate induction.

3.1.1 Contraindications:

- With history of GBS +ve in current pregnancy
- **Thick meconium stained liquor should be interpreted in the light of the CTG and other risk factors. If all else is normal, meconium alone is not an indication for immediate induction.**
- If vaginal examination has been done and woman is not in established labour, induction must start within 6 hours of VE.
- Suspicion of chorioamnionitis

4. Method of Induction

4.1 Favourable Cervix:

- Bishop score 6 or more, for Syntocinon as soon as feasible

4.2 Unfavourable Cervix:

- Routine FBC, CRP, LVS **not** indicated.
- Prescribe and administer Propess 24 hours slow release pessary
- Transfer to CDS 6 hours after insertion of Propess pessary and commence Syntocinon regime 30 min after removal of Propess pessary

NB. If CDS unable to take patient leave Propess pessary in situ and remove after 24 hours or as indicated in intrapartum care guideline 12: Induction of labour.

4.2.1 Unfavourable cervix with evidence of infection

If signs of infection present (maternal pyrexia, maternal & fetal tachycardia, uterine tenderness) call duty obstetrician to consider immediate delivery, ie C/S.

5. Antibiotics

- Not indicated if there are no signs of infection even with more than 24 hrs of membrane rupture
- If there is evidence of infection, broad spectrum IV antibiotics in labour followed by a full course postnatally.

Suspicion of Chorioamnionitis

Start broad spectrum IV antibiotics, followed by a full course postnatally

6. When to do a VE in PROM

- Prior to second dose of diamorphine
- A request for epidural
- Urge to push
- CTG abnormalities

7. Postnatal care

- Observe for signs & symptoms for infection (temperature, lower abdominal pain, offensive lochia) if PROM > 24 hours.

- To remain an inpatient for a minimum of 12 hours with 4 hourly observations.
- On transfer to community after at least 12 hours, warn women of these symptoms & to report to community midwife/GP if she develops them.

8. Record keeping and documentation

It is expected that every episode of care be recorded clearly, in chronological order and as contemporaneously as possible by all healthcare professionals as per Hospital Trust Policy. This is in keeping with standards set by professional colleges, i.e. NMC and RCOG. All entries must have the date and time together with signature and printed name.

Please document discussion re: active / expectant management of labour together with risks and benefits and the mother's decision.

Monitoring and Audit

Auditable standards:
See IOL audit tool – available from Risk Management office

Please refer to audit tool, location: 'Maternity on cl2-file11', Guidelines

Reports to:
Clinical Effectiveness Committee – responsible for action plan and implementation of recommendations from audit

Frequency of audit:
Annual

Responsible person:
Obstetric registrar

Cross references

Antenatal Guideline 31 - Maternity Hand Held Notes, Hospital Records and Record Keeping
Antenatal Guideline 44 – Guideline Development within the Maternity Services
Intrapartum Guideline 12 – Induction of labour

References

Intrapartum care – Clinical guideline, NICE, September 2007
Induction of Labour, NICE, July 2008

Author	Guideline Committee		
Work Address	Maternity Unit, Derriford Hospital, Plymouth, Devon, PL6 8DH		
Version	6		
Changes	Use of Propess Use of Amniotic Leak Detectors		
Date Ratified	Sep 13	**Valid Until Date**	Sep 16