# Document Control

## Title

**Pre-labour Rupture of Membranes (PROM) at Term Guidelines**

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<tr>
<th>Version</th>
<th>Date Issued</th>
<th>Status</th>
<th>Comment / Changes / Approval</th>
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<td>1.0</td>
<td>May 2005</td>
<td>Final</td>
<td>Initial version published on Tarkanet.</td>
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<td>1.1</td>
<td>Jul 2010</td>
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<td>New guideline in Trust template for midwifery staff to supersede previous document. New title.</td>
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<tr>
<td>2.1</td>
<td>Nov 2011</td>
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<td>Minor amendments by Corporate Governance to document control report, headers and footers, and formatting for document map navigation.</td>
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<td>2.2</td>
<td>Jan 2016</td>
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### Main Contact

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Medical Director

### Superseded Documents

Term Pre-labour Rupture of Membranes (Term PROM)

<table>
<thead>
<tr>
<th>Issue Date</th>
<th>Review Date</th>
<th>Review Cycle</th>
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<tr>
<td>January 2017</td>
<td>January 2020</td>
<td>Three years</td>
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Consulted with the following stakeholders: *(list all)*

- Senior Obstetricians
- Senior Midwives
- Paediatricians
- Microbiologists

Contact responsible for implementation and monitoring compliance:

- Clinician Lead for Labour Ward
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<td>• Practice Development Midwives</td>
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2. **Introduction**

This document sets out Northern Devon Healthcare NHS Trust’s best practice guidelines for pregnant women presenting with Pre-labour Rupture of Membranes (PROM) at Term.

3. **Purpose**

The following general principles can be applied in order to improve the diagnosis, investigation and management of women with pre-labour rupture of membranes at term in accordance with best practice guidance by:

- NICE ‘Induction of labour’ (2008)
- RCOG ‘Group B Streptococcal disease, Early onset’ (2012)
- NICE ‘Intrapartum care’ (2014)

This guideline applies to all members (obstetric and midwifery) of the maternity team and must be adhered to. Non-compliance with this guideline may be for valid clinical reasons only. The reason for non-compliance must be documented clearly in the patient’s notes.

4. **Definitions**

- **GBS**
  - Group B Streptococcal infection
- **NICE**
  - National institute for clinical excellence
- **PROM**
  - Pre-labour rupture of membranes
- **SROM**
  - Spontaneous rupture of membranes
- **DAU**
  - Day Assessment Unit
- **IAP**
  - Intra-partum antibiotic prophylaxis
- **EONGBS**
  - Early Onset Neonatal Group B Streptococcal infection

5. **Background**

PROM is defined as the rupture of the membranes prior to the onset of labour at or after 37 weeks of gestation. Incidence of PROM at term is 6 - 19%. The spontaneous labour rate following PROM is 60% within 24 hours, 94% within 96 hours.
Systematic review (2006) of 12 trials involving 6814 women compared the effects of planned early birth (immediate induction of labour or induction within 24 hours) with expectant management (no planned intervention within 24 hours). The study identified shorter time from rupture of membranes and delivery, less development of chorioamnionitis and endometritis, fewer admissions to special care baby unit or neonatal intensive care unit and higher women’s satisfaction rate in planned early birth group. There was no difference in mode of delivery in terms of caesarean section or instrumental vaginal delivery rate in both groups.

6. **General Principles of Pre-labour Rupture of Membranes at Term**

6.1 **Initial Assessment of Women with PROM**

- Women contacting the unit with a suspected history of PROM should be advised to attend the DAU for assessment and confirmation OR should be assessed by a midwife in a community setting within 12 hours, if there are no other risk factors.
- Check maternal temperature, respirations and pulse.
- Ascertain presentation of fetus abdominally; if uncertain check with ultrasound scans.
- Confirm PROM by history and examination (if necessary). If pooling of amniotic fluid is not observed, perform a diagnostic test for an insulin-like growth factor binding protein-1 of vaginal fluid (Actim-PROM). If the test is negative, P-PROM is very unlikely and if it is positive, offer care consistent with the woman having P-PROM.
- A digital examination should not be performed in the absence of good contractions.
- Low vaginal swab should not be routinely offered unless infection is suspected.
- Fetal monitoring – if the woman is low risk, auscultation of fetal heart is suitable. CTG should be performed if other risk factors are present.
- Women presenting with pre-labour rupture of the membranes at term should be advised that:

The majority (60%) of women go into labour within 24 hours spontaneously.

The risk of serious neonatal infection is 1% rather than 0.5% for women with intact membranes. Risk of infection (neonatal and maternal) increases as the time between PROM and labour increases.

Induction of labour is appropriate approximately 24 hours after rupture of the membranes.

Women should be offered a choice of induction of labour or expectant management. Women suitable for expectant management should be given the information leaflet to assist them in making a choice.
Where the woman chooses immediate induction, the timing will depend upon clinical need and unit activity.

6.2 Further management

Immediate induction is recommended to women with

- Known carrier of GBS in the current pregnancy.
- Meconium or blood-stained liquor
- Suspicion of infection, e.g. pyrexia, offensive liquor, fetal or maternal tachycardia.

Identifying infection
- Use a combination of clinical assessment and appropriate tests;
- Maternal observations including BP, pulse, respirations and temp, GCS and urinalysis,
- Fetal heart monitoring using CTG,
- Maternal blood tests including Lactate, C-reactive protein and white blood cell count.
- If abnormal findings are noted or infection is suspected;
  - Obstetric assessment and plan is required.
  - Follow ‘Maternal Sepsis’ guideline.

Women with contra-indications to expectant management at home (See Appendix A) must be admitted to the Antenatal Ward.

Women choosing expectant management up to 24 hours who are suitable can be sent home and advised to return to the Maternity Unit for induction. The time of readmission will be clearly documented in her notes and on the information leaflet.

If a vaginal examination is performed expectant management must not be longer than 24 hours.

Women choosing expectant management for longer than 24 hours must return to DAU for review every twenty four hours. Clinical review includes maternal temperature, pulse, respirations, and colour of liquor, swab results, fetal movements and fetal heart rate monitoring.

All women choosing expectant management must have their temperature recorded 4 hourly during waking hours. Women must also be informed that bathing or showering is not associated with an increase in infection, but that having sexual intercourse may be.

Women must be advised to contact the labour ward and return if:

- Feeling unwell or febrile
- Change in colour or odour of liquor
- Onset of labour
- Reduced fetal movements

If labour has not started 24 hours after rupture of the membranes, women must be advised to give birth where there is access to neonatal services and advised to stay in hospital for at least 12 hours following the birth.

Women who don’t go into labour and choosing to have expectant management beyond 72 hours must be reviewed by consultant on-call.

6.3 Induction of Labour following PROM

Admit women directly to Labour Ward. The timing of the readmission depends on the clinical assessment of maternal and fetal wellbeing, the workload on Delivery Suite and the woman’s wishes.

Either Prostaglandin or Oxytocin may be used in women who have ruptured membranes, regardless of cervical status, as they are equally effective.

Decision for IV antibiotics:

- follow Guideline ‘Indications for antibiotics in labour including GBS’.
- in cases of maternal pyrexia (temp ≥37.5°C on 2 occasions one hour apart OR one temp of ≥38°C) or suspected or confirmed maternal sepsis; follow Guideline ‘Maternal Sepsis’.
- IAP is not required for women with pre-labour rupture of membranes at term with no other risk factors.

6.4 Post-natal management

Babies born to mothers who should have received antibiotics but did not or the first dose was less than two hours prior to delivery require paediatric review.

If there are no signs of infection in the woman, antibiotics should not be given to the woman after delivery, even if the membranes have been ruptured for over 24 hours. However, the babies should be closely observed for the first 12 hours of life (at 1 hour, 2 hours and then 2 hourly for 10 hours) when the risk of neonatal infection is highest.

A baby with any symptom of possible sepsis, or born to a woman who has evidence of chorioamnionitis, should immediately be referred to a neonatal care specialist.

Women with prelabour rupture of the membranes should be asked to inform their healthcare professionals immediately of any concerns they have about their baby’s wellbeing in the first 5 days following birth, particularly in the first 12 hours when the risk of infection is greatest.
7. **Education and Training**

Responsibility for education and training lies with the Lead Clinician and Lead Midwife for labour ward. It will be provided through formal study days and informal training on the ward.

8. **Consultation, Approval, Review and Archiving Processes**

The author consulted with all relevant stakeholders. Please refer to the Document Control Report.

Approval was given by the Maternity Guidelines Group and Lead Clinician for Obstetrics and Gynaecology.

This guideline will be reviewed every 3 years. The author will be responsible for ensuring the guidelines are reviewed and revisions approved by the Maternity Guidelines Group in accordance with the Document Control Report.

All versions of these guidelines will be archived in electronic format by the author within the Maternity Team policy archive.

Any revisions to the final document will be recorded on the Document Control Report.

To obtain a copy of the archived guidelines, contact should be made with the author.

9. **Monitoring Compliance with and the Effectiveness of the Guideline**

Monitoring of implementation, effectiveness and compliance with these guidelines will be the responsibility of the lead clinician for labour ward.

10. **References**

Dare MR et al. (2006) Planned early birth versus expectant management (waiting) for pre-labour rupture of membranes at term (37 weeks or more). The Cochrane Database of Systematic Reviews 2006 Issue 2.


NICE Intrapartum Care Guideline (Care of healthy women and their babies during child birth) 2014.


11. **Associated Documentation**

Prevention of early onset neonatal Group B Streptococcal Infection (OBSTETRICS)

Prevention of early onset neonatal Group B Streptococcal Infection ( NOENATE)

Guidelines for the use of Antenatal and Intra-partum Fetal Monitoring in all Care Settings (including Management of Fetal Blood Sampling and Cord pH)

Use of Oxytocin for Augmentation/Induction

Maternal sepsis during pregnancy, labour and the post-labour period (including maternal fever, chorioamnionitis and endometritis following miscarriage)
Appendix A: Contra-indications to expectant management at home

- High head, i.e. non-engaged.
- Hypertension or pre-eclampsia.
- Previous caesarean section.
- Growth restriction.
- Other obstetric complications, e.g. polyhydramnios.