Document Control

Title			
PRE-LABOUR RUPTURE OF MEMBRANES AT TERM (PROM) Guideline			
Author			Author's job title Consultant Obstetrician& Gynaecologist
Directorate Acute Surgery			Department Maternity
Version	Date Issued	Status	Comment / Changes / Approval
1.0	May 2005	Final	Initial version published on Tarkanet
1.1	Jul 2010	Revision	New guideline in Trust template for midwifery staff to supersede previous document. New title
2.0	Aug 2011	Final	Revised for the whole maternity team. Approved at Maternity Services Patient Safety Forum on 19th October and the Lead Clinician for Obstetrics and Gynaecology on 25th October 2011.
2.1	Nov 2011	Revision	Minor amendments by Corporate Governance to document control report, headers and footers, and formatting for document map navigation.
2.2	Jan 2016	Revision	Circulated by email for comments
3.0	Feb 2016	Final	Approved at the Maternity Services Guideline Group 03/02/16
3.1	Jan 2017	Revision	Minor amendments so that they are all consistently giving the same message
4.0	Sept 2018	Final	Minor changes to align with Royal Devon and Exeter NHS foundation trust
Main Contact Consultant Obstetrics & Gynaecology North Devon District Hospital Raleigh Park Barnstaple, EX31 4JB			Tel: Direct Dial – 01271370251 Tel: Internal – 3251
Lead Director Medical Director			
Superseded Documents Nil			
Issue Date September 2018	Review Date September 2021		Review Cycle Three years

Consulted with the following stakeholders: (list all) • Senior Obstetricians • Senior Midwives • Paediatricians • Microbiologists
Approval and Review Process • Maternity Specialist Governance Forum
Local Archive Reference G:/maternity&midwifery Local Path Acute surgery/Children&women/Maternity/Guidelines 2018 Filename Pre-labour rupture of membranes at term V4 October 2018

Policy categories for Trust's internal website (Bob)	Tags for Trust's internal website (Bob)
Maternity/midwifery	PROM

CONTENTS

KEY POINTS OF THE GUIDELINES

- **When advising women with suspected PROM to come to hospital for assessment, ask them to bring sanitary towels or underwear for evidence of liquor, its colour and odour.**

- **A speculum examination is not required if there is obvious liquor is draining from the introitus.**

- **In low risk pregnancies, where the head is engaged the clinician should auscultate the fetal heart for 2 minutes and throughout a contraction if there is any uterine activity, or perform a cardiotocograph if reduced fetal movements reported or other risk factors are present**

- **Digital vaginal examinations must be avoided in the absence of good contractions.**
  If a patient has *a digital vaginal examination* but is not in established labour, the woman may be discharged home (if all observations are normal) with a plan to return to commence induction of labour *at 24 hours* following SROM. However, if a vaginal examination is undertaken on *more than one occasion*, infectious morbidity is increased, and *active management* should be instituted.

- **Induction of labour is advised approximately 24 hours after rupture of membranes unless immediate induction is indicated.**

- **Women with known Group B strep should be commenced on IV antibiotics and induction of labour commence immediately.**

- **Women with meconium stained liquor should be transferred to labour ward for continuous monitoring and induction with Oxytocin (Syntocinon).**

- **Intrapartum antibiotics is not required for women with pre-labour rupture of membranes at term with no other risk factors.**

- **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 birth.**

1. Purpose

1.1. Pre-labour Rupture of Membranes (PROM) at term 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.

1.2. Infection of the lower genital tract and/or amniotic cavity is one of the most important aetiologies of pre-labour rupture of membranes at term.

1.3. 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.

1.4. 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. The reason for noncompliance must be documented clearly in the patient's notes.

2. 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

3. Responsibilities

3.1. All clinicians (both obstetric and midwifery staff) are responsible for care of women presenting with PROM or suspected PROM.

3.2. Timing and the place (DAU or labour ward) for inducing labour should depend on the clinical need, unit activity and should be agreed between labour ward co-ordinator and consultant on-call.

3.3. Consultant on-call is responsible for choosing the appropriate method for induction of labour.

4. General Principles of Pre-labour Rupture of Membranes at Term

4.1. Initial Assessment of Women with PROM

4.1.1. 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 if there are no other risk factors.

4.1.2. When advising women to come to hospital prior to assessment, ask them to bring sanitary towels or underwear for evidence of liquor, including colour and odour**.**

4.1.3. Take as thorough history as possible regarding the episode of vaginal loss, fetal movements and history of contractions. Check maternal temperature, respirations and pulse. Ascertain presentation of fetus abdominally; if uncertain check with ultrasound scans.

4.1.4. In low risk pregnancies, where the head is engaged the clinician should auscultate the fetal heart for 2 minutes and throughout a contraction if there is any uterine activity or perform a cardiotocograph if reduced fetal movements reported or other risk factors are present.

4.1.5. Women with an uncertain history of PROM should be offered a speculum examination. Verbal consent should be obtained and then a sterile speculum should be inserted into the vagina to observe whether there is evidence of membrane rupture and to visualize cervical dilatation. A speculum examination is not required if there is obvious liquor is draining from the introitus. A high vaginal swab (HVS) should be taken at the same time as the sterile speculum examination.

4.1.6. Low vaginal swab should be taken if speculum not indicated.

4.2. Vaginal examinations

4.2.1. **Digital vaginal examinations must be avoided in the absence of good contractions.**

4.2.2. A vaginal examination in the presence of SROM increases the risk of ascending infection. If a patient is contracting regularly and thought to be in labour, a speculum examination should be performed first to assess if there are cervical changes. If unsure of speculum findings, please ask for senior obstetric assistance.

4.2.3. If a patient is seen with SROM and contractions and has a digital vaginal examination but is not in established labour, the woman may be discharged home (if all observations are normal) with a plan to return to commence induction of labour **at 24 hours following SROM**. However, if a vaginal examination is undertaken on more than one occasion, infectious morbidity is increased, and **active management should be instituted**. If IOL declined or delayed please liaise with the Consultant on call.

4.3. Management and induction of labour

4.3.1. Women presenting with pre-labour rupture of membranes at term should be advised that:

- The risk of serious neonatal infection is 1% rather than 0.5% for woman with intact membranes. Risk of infection (neonatal and maternal) increases as the time between PROM and labour increases.
- 60% of women with pre-labour rupture of membranes will go into labour within 24 hours
- Induction of labour is advised approximately 24 hours after rupture of membranes unless immediate induction is indicated.

4.3.2. 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. Women should be advised to monitor fetal movements, colour of liquor and to monitor their temperature every 4 hours during waking hours. They should report immediately any change in the colour or smell of their vaginal loss.

4.3.3. Where the woman chooses immediate induction, the timing will depend upon clinical need and unit activity.

4.3.4. If woman declines induction of labour - **see expectant management section 4.4.**

4.3.5. Women **with known Group B strep** should be commenced on IV antibiotics and induction of labour commence immediately – **see IOL guideline**.

4.3.6. Women with **meconium stained liquor** should be transferred to labour ward for continuous monitoring and induction with Oxytocin (Syntocinon).

4.3.7. IAP is not required for women with pre-labour rupture of membranes at term with no other risk factors.

4.4. Women who decline induction of labour and choose expectant management

4.4.1. A small number of women may decline induction of labour and wait for labour to occur naturally. Women opting for **expectant management for longer than 24 hours** may choose to await spontaneous labour at home. These women should be informed of the increased risk of infection associated with prolonged ruptured membranes and be offered daily assessment of fetal wellbeing in DAU. Clinical review includes maternal temperature, pulse, respiration, and colour of liquor, swab results, fetal movements and fetal heart rate monitoring.

4.4.2. All women choosing expectant management must be advised to monitor fetal movements, colour of liquor and to monitor their temperature every 4 hours 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.

4.4.3. 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

4.4.4. 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.

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

4.4.6. **The expectant management approach does not apply to**:

- Suspicion of infection such as maternal pyrexia, tachycardia, persistent fetal tachycardia
- Known Carrier of Strep B
- Meconium or blood-stained liquor
- High Presenting Part or Abnormal Lie
- Obstetric/Medical Complications

- Previous LSCS

Women with contra-indications to expectant management at home must be admitted to the Antenatal Ward. These women must be reviewed by senior obstetrician (on-call staff grade or consultant) and formulate further management plan.

5. Monitoring Compliance with and the Effectiveness of the Guideline

5.1. 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. The reason for noncompliance must be documented clearly in the patient's notes.

5.2. Any concern or non-compliance with this guideline that is identified through the investigation of clinical incidents, claims or complaints will be reviewed as per the Trust Policies regarding Incidents, Claims and Complaints, and may result in an audit and/or amendment to the guideline.

6. References

6.1. *Induction of labour*. National Institute for Health and Care Excellence. London: NICE; July 2008

6.2. *Intra-partum care for healthy women and babies (CG190)*. National Institute for Health and Care Excellence. London: NICE; 2014

6.3. *Prevention of early onset neonatal group B streptococcal disease*. Royal College of Obstetricians and Gynaecologists: RCOG; Guideline No. 36. September 2017.

6.4. *Induction of labour compared with expectant management for pre-labour rupture of the membranes at term*. Hannah M.E. et al. The New England Journal of Medicine 1996, 334: 1005-1110.

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

6.6. *Clinical guideline on "Management of pre-labour rupture of membranes(PROM) at term".* Royal Devon& Exeter NHS Foundation Trust. July 2017.

7. Associated Documentation

7.1. "Prevention of early onset neonatal Group B Streptococcal Infection "guideline

7.2. "Induction of labour" guideline