Worcestershire Acute Hospitals NHS Trust

Spontaneous rupture of membranes (SROM) NOT in labour after 37+0 and up to 42+0 weeks gestation

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Key Amendments

Date	Amendments	Approved by

Introduction Epidemiological data on time interval from rupture of membranes to spontaneous labour suggests that 60% women go into spontaneous labour within 24 hours of rupturing their membranes. The rate of labour after this is about 5% per day. The risks of prelabour rupture of membranes at term relate to maternal/neonatal infection and prolapsed cord.

Patients covered

Women with ruptured membranes (cephalic presentation) not in labour ≥37^{+0} completed weeks and up to 42^{+0} completed weeks gestation.

Advice on receipt of telephone call

If a woman reports ruptured membranes with no contractions she should be offered an appointment in DAU within 12 – 18 hours, providing she feels well, the liquor is clear, fetal movements are normal, no vaginal bleeding present, and it is a single fetus in cephalic presentation. If she has any concerns before this she should be advised to telephone again and advised accordingly.

On admission

- Obtain maternal history including past medical and obstetric history and confirm gestational age/ dates.
- Full antenatal assessment in, including fetal and maternal observation and abdominal palpation to confirm lie and presentation. SFH measured if appropriate.
- Assess fetal wellbeing
- Speculum examination should be performed to confirm rupture of membranes / liquor pooling. If liquor is seen then treat as SROM. If liquor is not evident then perform ROM Plus. If positive then treat as SROM. If negative then assume membranes are still intact. On the rare occasion that ROM Plus is negative but the history is very suggestive of SROM, discuss with the registrar/Consultant on call regarding an on-going plan..
- Vaginal examination should be minimised unless really indicated (e.g. If woman appears to be in labour)
- Women should have electronic fetal monitoring 24hrs after SROM or earlier if indicated e.g reduced fetal movements

Indications for immediate IOL

- Maternal Pyrexia
- Fetal distress
- Significant meconium stained liquor
- Blood stained liquor
- Group B Streptococcus

- HIV positive mother
- Unstable presenting part
- Maternal choice
- 42+0

Evidence of infection in mother

If infection/ chorio-amnionitis is clinically suspected commence antibiotics (If not already on antibiotics) and make plans for delivery by most appropriate route depending on clinical situation. See Suspected Chorioamniotis guideline. Inform NICU before delivery.

Risk factors for intrauterine infection

- Maternal group B streptococcus
- Presence of meconium in amniotic fluid
- Increased time from rupture
- Number of vaginal examinations
- Use of internal monitoring
- Length of labour and mode of delivery

Expectant management

Until IOL commences or woman chooses expectant management beyond 24hrs, care can be inpatient or outpatient: If woman wishes to be managed as an outpatient she should have clear liquor, have a singleton pregnancy, cephalic presentation, stable observations and normal fetal heart.
Women should be advised

- 60% of women with PROM will go on to labour within 24hrs
- The risk of serious neonatal infection is 1% rather than 0.5% for women with intact membranes

- Induction of labour is appropriate approximately 24hrs after rupture of membranes(RCOG and NICE recommendations are for augmentation/IOL of labour after 24 hours)
- If a woman chooses immediate IOL it should be booked with the antenatal ward for the first available slot.
- If labour has not started after 24hrs of rupture of membranes arrange for Induction/augmentation if this is what the woman chooses after discussion

Until Induction of labour or if woman choses expectant management beyond 24hrs, assess fetal heart rate at initial contact and then every 24hrs. Do not offer lower vaginal swabs and maternal CRP.

Women should be advised

- Bathing or showering is not contraindicated
- To avoid sexual intercourse
- Record temperature 4hrly during waking hours
- To report to Maternity Triage **immediately** any changes is:
  Colour or smell of vaginal loss
  Any changes in fetal movement patterns
  If labour begins

If any fever or change in colour or order of amniotic fluid commence CTG and full assessment to determine best mode of birth
If labour has not started 24hrs after rupture of membranes women should give birth where there is access to neonatal services and stay in hospital > 12hrs after birth (see Group B strep guideline, and neonatal observations guidline)

There is no evidence to suggest that routine use of antibiotics in the absence of an indication for group B streptococcus prophylaxis improves neonatal outcomes (Cochrane review).

Intrapartum antibiotic prophylaxis should be considered if there is increased risk of neonatal GBS disease. Risk factors as follows.

- Previous infant with early onset GBS disease
- GBS bacteriuria in current pregnancy or GBS colonization at term
- Maternal temperature > 38 C in labour
- Prolonged rupture of membranes >24 hours (this might cause confusion of the 18 hours is in there)

Method of IOL (See Induction of Labour guideline)

Discuss with women and explain procedure with benefits and risks all pathways clearly discussed and documented

- On admission perform digital vaginal examination using aseptic technique, If cervix is unfavourable and there is no evidence of infection/ chorioamnionitis Propess 10 mg PV may be considered after discussing with the consultant on-call.

- Either prostaglandins (PGE2) pessary or oxytocin may be used when induction of labour is undertaken in nulliparous or multiparous women who have ruptured membranes, regardless of cervical status, as they are equally effective. (Cochrane review)
- There is evidence to suggest that Prostaglandins compared with oxytocin are associated with increased risk of chorioamnionitis (odds ratio of 1.49, 95% confidence interval 1.07 to 2.09) and maternal nausea/vomiting.
- If Prostaglandin is used for IOL the woman should be observed for signs and symptoms of infection/ chorioamnionitis.
- After 24hrs from membrane rupture if not already in labour perform EFM
- Perform EFM in labour