Worcestershire Acute Hospitals NHS Trust

Management of suspected chorioamnionitis

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Key Amendments

Date	Amendments	Approved by

Introduction

Chorioamnionitis is infection of the fetal membranes and amniotic cavity. Evidence is emerging that chorioamnionitis is a significant contributor to permanent neurological damage and cerebral palsy. The relative risks for periventricular leucomalacia and cerebral palsy are 3.0 and 1.9 respectively when a pre term birth is complicated by chorioamnionitis.
Remember that fetus will have a temperature of 1-1.5ºC higher than maternal core temperature.
Maternal temperature > 37.8ºC in labour due to infection combined with hypoxia may increase the risk of cerebral palsy by 80 fold**.**

Clinical findings of chorioamnionitis

- Increased fetal or maternal heart rate (remember that each may happen in isolation)
- Abdominal pain
- Altered vaginal loss (blood/meconium/offensive discharge)
- Pyrexia
- Uterine pain and tenderness

Symptoms can vary from a non-specific feeling of being unwell to those of overwhelming sepsis.

Investigation

- FBC - rising WCC with neutrophilia
- CRP (serial values may be useful)
- MSSU for culture
- Low vaginal swab for culture and sensitivity
- Peripheral blood cultures

Management

On suspicion of a diagnosis of chorioamnionitis:

- Maternal observations - pulse every 15 minutes, temperature hourly
- Control maternal pyrexia:
  - Prescribe regular paracetamol.
  - Fan/cool sponging for maternal comfort
- Maintain maternal hydration (IV fluids may be required)
- Maternal Antibiotics:

  IV Cefuroxime 750mg TDS and IV Metronidazole 500mg TDS
  (Cefuroxime can be reconstituted as directed on packaging and given as a slow IV bolus over 3-5 minutes or added to the metronidazole 500mg in 100ml bag and infused over 20mins.)

  If there is a true allergy to Penicillin, consult Consultant Microbiologist.

In the absence of retained products and as long as symptoms have resolved, antibiotics can be discontinued 48 hours after delivery. If converting to oral antibiotics co-amoxiclav 625mg TDS is appropriate if not penicillin allergic.

- Fetal Observation - continuous CTG. NB: Fetal blood sampling contra-indicated.
- Consider delivery by the best possible route - discuss with consultant on call
- Always inform neonatal unit staff
- Paediatrician should be present at delivery
- Send placental swabs post delivery for MC&S (Include clinical history and antibiotic use)
- Send swabs from the infant as requested by the paediatrician