HUTT maternity
Hutt Valley Maternity Care

HUTT VALLEY DHB

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Pre – Labour Spontaneous Rupture of Membranes at Term

Hutt Maternity Policies provide guidance for the midwives and medical staff working in Hutt Maternity Services. Please discuss policies relevant to your care with your Lead Maternity Carer.

Definition

Pre-labour 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.
Pre-labour spontaneous rupture of the membranes (SRM) at term occurs in 8-10% of births (NICE, 2008). PROM is associated with increased maternal and neonatal morbidity.

Purpose

This guideline outlines the practice that relates to the management of pre-labour spontaneous rupture of membranes at ≥ 37 weeks gestation.

Scope

All medical and midwifery staff employed by Hutt Valley DHB.
All Hutt Valley DHB Maternity access holders.

Guideline

The clinical significance of SRM varies with the gestational age and the time interval between the SRM and birth. Prolonged SRM intervals increase the risk of complicating chorioamnionitis / perinatal morbidity and mortality.

Optimal clinical management needs to factor into account the full clinical presentation, results of investigations and ongoing clinical developments. Hopes to avoid an intervention cascade following induction of labour, must be balanced with the need to avert significant perinatal sepsis.

Principles of care for pre-labour SRM include

A comprehensive assessment of all women with pre-labour ROM at term, to check maternal and foetal wellbeing, is recommended.

- Establish a diagnosis of ruptured membranes
  If SROM is not obvious then a sterile speculum is advisable to confirm membrane rupture
  - Sterile speculum (After a woman has rested for 20 – 30 minutes to allow any leakage of liquor to pool in posterior vaginal fornix).
  - Look for liquor
  - Low vaginal and rectal swab – Group B Streptococcus.
  - Avoid digital examination

- Exclude underlying infection i.e. Chorioamnionitis by monitoring maternal Temperature and pulse rate, Respiration, Blood pressure,
- If SRM associated with PV bleeding: vasa praevia must be considered.
- Exclude Malpresentation
- Exclude cord prolapse if in doubt perform digital examination
- An obstetric consultation is recommended for women with PROM. (The referral guidelines,2012).
- Fetal wellbeing Assessment including foetal heart rate and maternal report of foetal movements. Ascertain whether there is meconium stained liquor.

Indications for offering intrapartum antibiotics and augmentation/induction as soon as practical.

- If GBS detected on vaginal swab in current pregnancy between 35-37 weeks (RCOG, 2012). See MATY030
- History of early onset GBS in a sibling at birth (MATY 030).
- GBS bacteruria during the current pregnancy (MATY 030).
- Intrapartum fever > 38°C (Referral guidelines, code 5024: consultation)
- If women do not go into labour and give birth before 18 hours has elapsed they have developed a risk factor for GBS (MATY 030).
  (NZCOM Consensus guideline, 2014)
- Women with signs of chorioamnionitis require immediate treatment i.e. broad spectrum antibiotics and an induction of labour as soon as possible. (MATY 030).
- If meconium stained liquor is present an obstetric review is required and induction of labour is expedited unless there is an indication for a caesarean section.

For women who decline the recommendation for augmentation the criteria for expectant management include:

- Baby with fixed cephalic presentation.
- There are no indications for C/S (e.g. malpresentation, two previous scars etc)
- No digital vaginal exam has been performed
- 4 - 8 hourly maternal temperature and pulse remain within normal parameters
- Daily CTG
- Mother reports no reduction in fetal movements
- There are no other indications for induction or augmentation of labour

Plan and document care in discussion with the woman. The woman can change her mind and be augmented earlier if she chooses.

This guideline is related to the GBS Policy MATY030.

References

Bramberger, P. & Lawrence, J., Braun, D. & Saunders, B., Contreras, R. & Petitti, D. (2000). The influence of intrapartum antibiotics on the clinical spectrum of early onset Group B Streptococcal infection in term infants. *Pediatrics,* (106) 244-250.

Campbell, N., Eddy, A., Darlow, B., Stone, P. & Grimwood, K. (2004). The prevention of early-onset neonatal group B streptococcus infection: technical report from the New Zealand GBS Consensus Working Party. *The New Zealand Medical Journal.* 117 (1200). URL: http://www.nzma.org.nz/journal/117-1200/1023/

Consensus Guideline. (2013). The prevention of early-onset neonatal Group B Streptococcus infection.

Dare, M.R., Middleton, P., Crowther, C. A., Flenady, V., Varatharaju, B. (2006). Planned early birth versus expectant management (waiting) for prelabour rupture of membranes at term (37 weeks or more). *Cochrane Database of Systematic Reviews* 2006, Issue 1. Art. No.: CD005302. DOI: 10.1002/14651858.CD005302.pub2.

Duff, P. (2010). Preterm premature rupture of membranes. http://www.uptodate.com/online/content/topic.

Flenady, V. & Jenkins-Manning, S. (2007). For the Queensland Clinical Practice Guidelines Working Party on the prevention of early onset Group B Streptococcal Disease, Centre for Clinical Studies, Mater Health Services: Brisbane

Howarth, G., Botha, D. J. (2001). Amniotomy plus intravenous oxytocin for induction of labour. *Cochrane Database of Systematic Reviews 2001, Issue 3. Art No.:* CD003250.DOI:10.1002/14651858.CD003250.

Maternity Services Notice Pursuant to Section 88 of the NZ Public Health and Disability Act. 2000

Stutchfield, P., Whitaker, R., Russell, I. (2005). Antenatal betamethasone and incidence of neonatal respiratory distress after elective caesarean section; Pragmatic randomised trial. http://www.bmj.com/cgi/content/full/331/7518/662

National Institute Clinical Exellence (2012). CG55 Intrapartum care: NICE guideline

Royal College of Obstetricians and Gynaecologists (2012). The prevention of early-onset neonatal Group B Streptococcal disease. Green-top guideline No. 36

Informed Consent

The right of a consumer to make an informed choice and give informed consent, including the right to refuse medical treatment, is enshrined in law and in the Code of Health and Disability Consumers' Rights in New Zealand. This means that a woman can choose to decline treatment, referral to another practitioner, or transfer of clinical responsibility. If this occurs follow the process map on page 18 of the Referral Guidelines (Ministry of Health, 2012).

Appendix 4

Antibiotic Guidelines for Suspected Chorioamnionitis needs neonatal and obstetric consultation
FOR THOROUGH POST PARTUM REVIEW
NO
Add Clindamycin 900mg IV or Metronidazole 500mg IV before skin incision

Is patient going for C/Section?

Give broad spectrum antibiotics:
 Cefuroxime 1.5 gm IV 8 hourly

and
 Metronidazole 500mg IV 8 hourly

If not improving add
 Gentamicin 5mg/kg IV daily

NO
NO
YES
YES
Collect the following before starting treatment:
 HVS, GBS swab
 Urine culture
 Blood cultures
 CBC, CRP

Is patient in labour?
Chorioamnionitis
Not Chorioamnionitis
YES
Does patient have Fever ≥38°C and 2 of the following?
 Maternal leukocytosis
 Maternal tachycardia (pulse >100)
 Fetal tachycardia (FHR >160)
 Uterine tenderness
 Foul vaginal discharge