CATEGORY: CLINICAL GUIDANCE STATEMENT

Term Prelabour Rupture of Membranes (Term PROM)

Objectives: To provide advice on the management of Term (≥37 weeks gestation) Prelabour Rupture of

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1. Plain language Summary

In about one in 12 pregnancies, after 37 weeks, the fetal membranes around the baby will break before labour begins (breaking of the waters). Sometimes it is not clear that the waters have actually broken, and additional tests might have to be done to find the answer. Many women will start labour on their own after the waters break, but if not, induction of labour within 24 hours reduces infections for the woman and her baby.

3. Introduction

Term Prelabour Rupture of Membranes (term PROM) is defined as rupture of the membranes prior to the onset of labour at or beyond 37 weeks gestation.

The incidence of term PROM is 8%. Most women (70%) will commence labour spontaneously within 24 hours, but some women will have significant latency from PROM to delivery if managed expectantly. 85% of women with term PROM will labour spontaneously within 48 hours while 95% will labour spontaneously within 96 hours.

The immediate, but uncommon, risks of rupture of membranes include cord prolapse, cord compression and placental abruption.

Delayed risks include maternal and neonatal infection. Neonatal infection can result in devastating sequelae including death, chronic lung disease and cerebral palsy. Chorioamnionitis has been implicated as a cause of cerebral palsy in term infants[5].

4 How should women with term PROM be assessed?

Initial assessment of women presenting with term PROM should include confirmation of the diagnosis, of gestation, of presentation and assessment of maternal and fetal wellbeing. Where there is diagnostic uncertainty, a sterile speculum examination should be performed. If uncertainty remains regarding the diagnosis, tests for the presence of amniotic fluid proteins in vaginal fluid (e.g. Amnisure) may be used. Clinicians must be aware that false-positive test results may occur in the presence of blood or semen, alkaline antiseptics, certain lubricants, trichomonas, or bacterial vaginosis. Alternatively, false-negative test results may occur with prolonged membrane rupture and minimal residual fluid. False-positive test result rates of 19-30% have also been reported in women with clinically intact membranes and symptoms of labour[6].

All biochemical tests to confirm or refute the presence of ruptured membranes have a low but measurable false positive and false negative rate, and test findings should be inter

5. *Management*

5.1 How should women with term PROM be managed ?

Management of term PROM requires discussion between the woman, her partner and caregivers regarding the benefits and risks of expectant management versus active management with induction of labour.

5.2 What are the differences in outcome between expectant management and induction of labour?

Recommendation 3	Grade
In women with ruptured membranes at term, induction of labour within 24 hours is recommended.	Grade A

5.2.2 Expectant management

Some women may choose expectant management, after counselling regarding the increased risks of this decision. Routine antibiotic prophylaxis may reduce rates of maternal infection in these women[4]. Ideally, these women would be/have:

- Fixed cephalic presentation.
- Negative Group B streptococcus (GBS) status and no prior history of a baby with EOGBS infection.
- No signs of infection (maternal tachycardia, fever, uterine tenderness).
- Normal CTG and fetal movements.
- Clear

5.4 Should induction of labour be undertaken with oxytocin or prostaglandins?

The usual method of induction of labour in Australia is with oxytocin. Oxytocin or oral prostaglandins are used in New Zealand[10]. Prostaglandins were used in the TermPROM trial and, in this trial and a number of further small trials, including Australian data, there was no difference in outcome compared to the use of oxytocin for induction of labour. In women with an unfavourable cervix, the use of prostaglandins may have a role. Mechanical methods of induction eg. balloon catheters, are associated with an increased risk of infection, however the data is limited.

Recommendation 5	Grade and reference
Induction of labour with oxytocin is the usual method in Australia but oxytocin or oral prostaglandins are used in New Zealand. Prostaglandins may also be used in women with an unfavourable cervix.	Grade B[3]

6. Conclusion

Planned early birth leads to reduced maternal infections, reduced neonatal infections and greater maternal satisfaction without an increase in caesarean section.

Appendices

Appendix A Women's Health Committee Membership

Name	Position on Committee
Professor Yee Leung	Chair and Board Member
Dr Gillian Gibson	Deputy Chair, Gynaecology
Dr Scott White	Deputy Chair, Obstetrics
Dr Jared Watts	Membe92.06625.2 7.1992229922 62(r)

ii. Declaration of interest process and management

Declaring interests is essential in order to prevent any potential conflict between the private interests of members, and their duties as part of the Women's Health Committee.

A declaration of interest form specific to guidelines and statements was developed by RANZCOG and approved by the RANZCOG Board in September 2012. The Women's Health Committee members were required to declare their relevant interests in writing on this form prior to participating in the review of this statement.

Members were required to update their information as soon as they become aware of any changes to their interests and there was also a standing agenda item at each meeting where declarations of interest were called for and recorded as part of the meeting minutes.

There were no significant real or perceived conflicts of interest that required management during the process of updating this statement.

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Appendix D Full Disclaimer

Purpose

This Statement has been developed to provide general advice to practitioners about women's health issues concerning term prelabour rupture of membranes and should not be relied on as a substitute for proper assessment with respect to the particular circumstances of each case and the needs of any person with a term prelabour rupture of membranes. It is the responsibility of each practitioner to have regard to the particular circumstances of each case. Clinical management should be responsive to the needs of the individual person with a prelabour rupture of membranes at term and the particular circumstances of each case.