STANDARD OPERATING PROCEDURE

Premature Pre-Labour Rupture of Membranes

Special Region (1)

Union of Myanmar

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Approved by: Internal Medicine Unit

Premature Pre-Labour Rupture of Membranes

Premature Pre-Labour Rupture of Membranes (PPROM) PROM (prelabour rupture of membranes) Rupture of membrane after 37 weeks before the onset of labour. PPROM (preterm prelabour rupture of membranes) Rupture of membrane between 24 and 37 weeks gestation. Predisposing factors

- Infection (majority) e.g., bacterial vaginosis
- Cervical weakness to keep internal os closed till the onset of labour
- Manipulation
- Most of the risk factors for preterm labour

Major complications

- Infection (Chorioamnionitis)
- Abruptio placenta
- Preterm delivery
- Cord prolapse
- Reduced liquor leading to pressure effects or pulmonary hypoplasia on fetus

Diagnosis History - complaint of gush of fluid vaginally or leaking in dribbles. Examination Sterile speculum examination under strict aseptic precautions

- To confirm the diagnosis (fluid escaping from Cervix or presence of liquor pool in posterior

fornix) or Nitrazine test (use of a nitrazine stick to define the presence of amniotic fluid by turning yellow to blue) (false positive with blood, semen & even urine)

- To exclude cord prolapse
- To take high vaginal swab for infection (HVS) for C & S

Management This depends on gestation and the presence or absence of infection (Chorioamnionitis). Confirm maturity by history, examination, AN Record, and USG (Earliest USG)

I. PPROM

- Admission to hospital
- Explain the Diagnosis

- Counsel the risk and benefit of conservative management versus those of active

management (Delivery)

- Explain the management plan

Conservative plan in the absence of infection

- Do not do Vaginal examination (VE)
- Antibiotics - Erythromycin 250 mg qid for a maximum of 10 days or until the woman is in

established labour whichever is sooner

- Antenatal corticosteroids
- IM Dexamethasone 6 mg 12 hourly for 4 doses or IM betamethasone 12 mg 24 hr

apart for 2 doses to promote fetal lung maturity should be offered between 24+0 weeks and 33+6 weeks, and can be considered up to 35+6 weeks gestation.

- Role of $MgSO_4$ for neuroprotection
- In women who have PPROM and are in established labour or having a planned

preterm birth within 24 hours, intravenous magnesium sulfate should be offered between 24+0 and 29+6 weeks of gestation

- Tocolytics
- Routinely not recommended unless to buy the time to get effect of steroid action on

surfactant production and to facilitate in utero transfer to tertiary center

- Initial oral dose of Nifedipine 20 mg followed by 10 - 20 mg three to four times

daily, adjusted according to uterine activity for up to 48 hrs.

- Monitoring for sign & symptom of infection (Chorioamnionitis)
- Daily Temperature, Pulse Rate 4 hourly
- Daily FHR and uterine tenderness and foul-smelling discharge
- Blood investigation T & DC and C reactive protein (CRP)
- Observe for fetal well-being and growth potential
- Daily Fetal Kick count Chart, Fetal heart rate monitoring, Cardiotocography

monitoring (CTG) twice weekly

- Weekly USG for liquor index, Two weekly USG for fetal growth
- Neonatologist involvement

- Neonatologists should be informed once the diagnosis of PPROM has been made

and delivery is anticipated to ensure that the neonatal unit has the appropriate staff and facilities to care for the neonate should delivery occur.

- Where possible, once the diagnosis has been confirmed, women with PPROM and

their partners should be offered the opportunity to meet with a neonatologist to discuss their baby's care

- Delivery of baby
- Delivery should be expedited when sign and symptoms of infection occur (or)
- Presence of suspicious fetal well-being
- Induction of labour at 37 completed weeks or presence of fetal compromise

II. PROM

- Admission
- Confirm maturity
- Assess signs of labour and take pain note
- Exclude infection
- Assess fetal wellbeing

Treatment will depend on whether patient is in labour or not, duration of PROM and presence or absence of chorioamnionitis.

If patient is in labour

- do VE and take HVS to identify evidence of infection
- partograph for progress of labour
- parenteral antibiotics
- CTG
- Augmentation if necessary

If patient is not in labour symptom and sign of chorioamnionitis is absent

- wait for 24 hours of conservative management
- During waiting period assess labour pain, fetal wellbeing, and monitor signs and symptoms
- f infection
- Plan Induction of labour 24 hours after PROM
- Bishop scoring of cervix for favorability of induction
- Induction of labour according to hospital protocol
- If patient went into labour, manage accordingly.

If patient is not is labour after 24 hours or if sign of chorioamnionitis present

- induction of labour according to hospital guideline

References

1. Obstetrics and Gynaecology Myanmar management Guidelines, 2024

2. National Institute of Clinical Excellence (2015). Preterm labour and birth. NICE clinical guideline, 25.

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4. Willekes C (2018). Prelabour Rupture of the Membranes. In: James D, Steer PJ, Weiner CP, Gonik B and Robson SC (eds). High-Risk Pregnancy: Management Options, 5th edition, Cambridge University Press, 1654 - 1673.