



POSITION STATEMENT

Prelabor Rupture of Membranes at Term

Consistent with the philosophy of the American College of Nurse Midwives (ACNM) that women have the right to self-determination in their health care, ACNM affirms the following:

- Using the principles of shared decision making, midwives should provide counseling regarding management options for prelabor rupture of membranes (PROM) at term and offer expectant management for women with uncomplicated pregnancies and without risk factors for infection.
- When PROM occurs at term (≥ 37 weeks gestation), expectant management (no planned induction within 24 hours) decreases the likelihood of intervention and promotes the physiologic process of birth. Physiologic labor and birth has health benefits for both mothers and newborns. Expectant management will result in spontaneous labor and birth for most women.¹
- Planned early birth (induction of labor) following PROM may reduce the risk of maternal infection; however, evidence does not indicate that planned early birth reduces rates of serious maternal morbidity, maternal mortality, or neonatal mortality.¹
- Risk of infection with expectant management can be reduced by avoiding digital vaginal examinations, including the baseline, vaginal examination.²

Background

Prelabor rupture of membranes at term, formerly referred to as premature rupture of membranes, affects 8%-10% of pregnant women.³ In most cases, spontaneous onset of labor will occur soon after PROM, and 95% of births will occur within 28 hours with expectant management.⁴ Management approaches are classified as planned early birth, which involves induction of labor with oxytocin; cervical ripening with prostaglandins or mechanical methods; and expectant management in hospital or at home, typically for 24 hours. When onset of labor is delayed, the primary concern is risk of infection, including chorioamnionitis, endometritis, and neonatal sepsis.

In a recent meta-analysis of 23 trials involving 8615 women, reviewers assessed the effects of planned early birth (defined as immediate intervention or intervention within 24 hours) compared

with expectant management for women with PROM at term on maternal, fetal, and neonatal outcomes.¹ They found that women who had planned early births were at a reduced risk for chorioamnionitis and/or endometritis, and their newborns were less likely to have definite or probable early-onset neonatal sepsis. No clear differences were observed between groups for the risk of cesarean, serious maternal morbidity or mortality, and definite early-onset neonatal sepsis.¹ The effect of the management plan on breastfeeding outcomes, postpartum depression, or long term childhood outcomes is unknown.¹ The reviewers concluded that the quality of the trials and evidence was not high overall because of a lack of standard definitions and inconsistent study protocols and outcomes, particularly parameters for diagnosing and treating infection. In most of the studies, baseline, digital vaginal examinations were performed in the expectant management groups, which potentially contributed to risk of infection.¹

Management of PROM at term varies widely across providers and practice settings. The optimal course of action involves risk assessment and shared decision making within the context of established protocols and capabilities of the setting. The following conditions support offering expectant management as a safe alternative to planned early birth under the following conditions:

- A term, uncomplicated, singleton, pregnancy with fetus in vertex position and clear amniotic fluid, and
- Absence of fever or infection, and
- Reassuring fetal status.

During expectant management, digital, vaginal examinations should be avoided. Women who are carriers for Group B streptococcus should be advised of the increased risk of infection with expectant management. If they choose this option, antibiotic prophylaxis should be initiated.⁵ The optimal duration of expectant management has not been determined.

Some women may choose planned early birth, particularly because of the shorter duration from time of rupture to birth.¹ Consensus regarding an optimal method for induction (oxytocin vs. cervical ripening agents) does not exist; therefore, the management plan should be determined on an individual, case-by-case basis with frequent and ongoing assessment of fetal status and labor progress. Adequate time must be allowed for labor to commence and progress before diagnosis of failed induction.

In summary, management of PROM at term is a complex issue that requires a balanced and individualized approach based on discussion of risks and benefits and shared decision making. ACNM recommends that further, well designed studies be conducted to compare planned early birth to expectant management, including women colonized with Group B streptococcus. In addition, studies on approaches to expectant management, for example, optimal time parameters and optimal setting (home vs. hospital), are needed.

REFERENCES

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Note. Midwifery as used throughout this document refers to the education and practice of certified nurse-midwives (CNMs) and certified midwives (CMs) who have been certified by the American Midwifery Certification Board (AMCB).

Source: Division of Standards and Practice, Clinical Practice Section

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