

POSITION STATEMENT

Prelabor Rupture of Membranes at Term

Consistent with the philosophy of the American College of Nurse-Midwives (ACNM) that individuals 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 options for individuals with uncomplicated pregnancies and no risk factors for infection.
- When PROM occurs at term (≥ 37 weeks' gestation), expectant management (ie, no planned induction within 24 hours) decreases the likelihood of intervention and promotes the physiologic process of birth. Physiologic labor and birth have health benefits for both pregnant individuals and newborns. Expectant management will result in spontaneous labor and birth for most people.¹
- Planned early birth (induction of labor) following PROM may reduce the risk of chorioamnionitis/endometritis, but evidence does not indicate that planned early birth reduces rates of serious morbidity or mortality for the birthing person 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 (PROM) at term, formerly referred to as *premature rupture of membranes*, affects 8% to 10% of pregnant individuals.³ In many cases, spontaneous onset of labor will occur soon after PROM, with 60% to 75% of pregnant individuals initiating spontaneous labor within 24 hours.⁴ According to Hannah et al⁵ in a large randomized controlled trial, the duration of PROM to birth without intervention occurs at a mean 33 hours, with 95% of parturient individuals giving birth 95 to 107 hours after PROM. 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 participants, reviewers assessed the effects of planned early birth (defined as immediate intervention or intervention within 24 hours) compared with expectant management for PROM at term on parturient, fetal, and neonatal outcomes.¹ They found that parturient individuals who had planned early births were at a reduced risk for chorioamnionitis and 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 parturient morbidity or mortality, or 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 the 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 the capabilities of the setting. The following conditions support offering expectant management as a safe alternative to planned early birth: a term, uncomplicated, singleton pregnancy with the fetus in the vertex position and clear amniotic fluid; absence of fever or infection; and reassuring fetal status.

During expectant management, avoid digital vaginal examinations. Individuals 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.⁶ The optimal duration of expectant management has not been determined.

Some individuals 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 based on a case-by-case basis, with frequent and ongoing assessment of fetal status and labor progress. Allow adequate time for labor to commence and progress before diagnosing failed induction.

Management of PROM at term is a complex issue that requires a balanced and individualized approach based on discussion of risks and benefits as well as shared decision-making. ACNM recommends that additional well-designed studies be conducted to compare planned early birth with expectant management, including individuals 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 AMCB.

Source: Division of Standards and Practice, Clinical Practice Section

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