Suspected Preterm Labour and/or Premature Rupture of Membranes (PROM)

WAIT! INITIALLY DO NOT PERFORM A DIGITAL EXAM

The most experienced clinician in your community to assess patient

History
- Gestational age (LMP/US)
- EDD
- GTPAL
- Presenting symptoms:
  1) Vaginal bleeding
  2) Ruptured membranes
  3) Contractions
  4) Fetal movement

Physical
- Vital signs
- Fetal heart rate
- Fundal height
- Fetal position
- Assess contractions frequency and length
- Urinalysis
- Assess for vaginal/cervical infections

If Vaginal Bleeding Present

Check ultrasound report for placental placement and cervical length. If placental placement known to be normal, careful speculum exam to assess cause of bleeding.

Sterile speculum exam now

1) Assess for ruptured membranes
   - Pooling in posterior fornix
   - Fluid issues from cervical os
   - Actim PROM test (not affected by semen, urine, small amounts of blood)
   - Nitrazine status of fluid (**blood, semen, and urine can cause false positive**)
   - Ferning if possible (sample must be completely dry)

2) ActimPartus (22-34 weeks) Not affected by semen and urine
   - Must have **intact** membranes
   - No bleeding
   - Sterile speculum exam
   - Sample from cervix

3) If **NO** PROM, perform digital cervical assessment for dilation and effacement.
   If PROM, assess cervical dilation with speculum exam. **DO NOT PERFORM DIGITAL EXAM**

4) GBS swab (vaginal, anorectal: same swab)
   - Indicate penicillin allergy on requisition
   - Send with patient

NOW CONSULT WITH FINDINGS

To help avoid delivery while in transit ensure the following is completed just prior to transport:

a) Patients with PROM must have a speculum reassessment of cervical dilation

b) Patients with suspected preterm labour **without** PROM must have a digital reassessment of cervical dilation

Prepare for Birth

Equipment/Supplies Documentation

Newborn
- Resuscitation Station as per NRP
- Records

Mother
- Birth Kit
- L&D Records
- Active Management 3rd Stage
- Keep placenta to send w/medevac

Medications listed on reverse side

Suspected Preterm Labour and/or Premature Rupture of Membranes (PROM)

MEDICATIONS

Physician Order Required

	24-34 Weeks WITH PROM	24-34 Weeks NO PROM	34 to 36 Weeks with or without PROM

Antibiotics	• **Ampicillin** 2 g IV q6h and **Azithromycin** 1 gm IV
	
	If penicillin allergic, then use azithromycin only
		• **Penicillin G**, 5 million units IV then 2.5 million units IV q4h.
		  ○ If penicillin G is unavailable, use **ampicillin** 2 g IV then 1 g IV q6h
		
		• If the patient has had a non-anaphylactic allergic reaction to penicillin, give **cefazolin** 2 grams IV then 1 gram every 8 hours
		
		If the patient has had an anaphylactic allergic reaction to penicillin, give **clindamycin** 900 mg IV q8h
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			If the patient has had an anaphylactic allergic reaction to penicillin, give **clindamycin** 900 mg IV q8h

Corticosteroids	• **Betamethasone** 12 mg IM q24h X 2 doses **or** • **Dexamethasone** 6 mg IM q12h X 4 doses	• **Betamethasone** 12 mg IM q24h X 2 doses **or** **Dexamethasone** 6 mg IM q12h X 4 doses	**N/A**
Tocolysis	**Contraindicated if birth imminent, bleeding, chorioamnionitis, abnormal fetal heart rate** • **Nifedipine** 10 mg capsules. Must be swallowed whole. Ideal dosing unknown. ▪ Some suggest 10 mg po q1-2 h. ▪ Others use: a. ***Loading dose*** of 10 mg po q15-20 min until contractions stop, max 4 doses (40 mg) the first hour. b. ***Maintenance dose***: 10 mg q4-6 h, starting 6h post loading dose; may increase to 20 mg po q4-6 h prn. Suggest physician seek advice re: nifedipine dosing from (GP) obstetrician providing regional coverage. Watch maternal BP and fetal heart rate. • **Indomethacin** 100 mg suppository per rectum then 50 mg q6h per rectum prn; max dose 200 mg in the first 24 hr. <u>Avoid after 32 weeks gestation because of the risk of premature ductus closure</u>	**Contraindicated if birth imminent, bleeding, chorioamnionitis, abnormal fetal heart rate** • **Nifedipine** 10 mg capsules. Must be swallowed whole. Ideal dosing unknown. ▪ Some suggest 10 mg po q1-2 h. ▪ Others use: a. ***Loading dose*** of 10 mg po q15-20 min until contractions stop, max 4 doses (40 mg) the first hour. b. ***Maintenance dose***: 10 mg q4-6 h, starting 6h post loading dose; may increase to 20 mg po q4-6 h prn. Suggest physician seek advice re: nifedipine dosing from (GP) obstetrician providing regional coverage. Watch maternal BP and fetal heart rate. • **Indomethacin** 100 mg suppository per rectum then 50 mg q6h per rectum prn; max dose 200 mg in the first 24 hr. <u>Avoid after 32 weeks gestation because of the risk of premature ductus closure</u>	**N/A**