University Hospitals Sussex
NHS Foundation Trust

# MP032(i):Pre-Labour Rupture of Membranes at Term (PROM)

# MP032(ii): Pre-Term Pre-Labour Rupture of Membranes (PPROM)

Maternity Protocol: MP032

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| **Guideline Reviewer:** | Katie Fraser / Giulia Lorina<br>Ryan Watkins |
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| **Cross reference:** | **MP008** Infections in pregnancy including GBS<br>**MP009** Guidelines for the Management of HIV in Pregnancy and Neonatal period<br>**MP026** BSOTS<br>**MP031** Pre-term Labour<br>**MP033** Induction of labour<br>**MP034** Vaginal Birth After Caesarean Section (VBAC)<br>**MP037** Fetal heart monitoring<br>**MP046** Breech & ECV<br>**MP045** Pyrexia in Labour and Sepsis |

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# Term Pre-Labour Rupture Of Membranes (PROM)

## 1 Definition

Rupture of membranes (RoM) after completed 37 weeks of gestation before the onset of labour (NICE)

## 2 Telephone assessment

2.1 When the pregnant woman / person phones into labour ward or triage a midwife or obstetrician should undertake a verbal risk assessment by asking for the following information in an open and sensitive manner:

- Routine demographics
- Gravida, parity and gestation (EDD by USS)
- Any relevant medical, social or previous pregnancy issues
- Wellbeing and issues throughout the current pregnancy
- Reason for call
- Fetal movements (before and since rupture of membranes)
- Presentation and engagement of the baby (at last appointment)
- Time of RoM, colour, consistency and volume
- Pain/contractions/uterine activity
- General health & wellbeing

2.2 For term **low risk pregnancies** with suspected pre labour rupture of membranes the midwife can give the following options:

2.2.1 To attend for immediate assessment in DAU if between 9-5pm or Triage (or labour ward) if out of hours.

2.2.2 To attend for a DAU/Triage appointment later that day (or the following morning if overnight), with the advice as per 2.6 and call labour ward if any concerns

2.3 For term **low risk pregnant women / people and their babies** with suspected pre labour rupture of membranes and **planning a home birth** the midwife should give them the following options:

2.3.1 To attend for immediate assessment in DAU if between 9-5pm or Triage (or labour ward) if out of hours.

2.3.2 The midwife to arrange for a community midwife to assess women at home as soon as possible (the following morning if overnight).

2.4 Pregnant women / people with **risk factors identified** and suspected pre labour rupture of membranes should be invited for immediate assessment in the maternity unit.

2.5 If women make an informed decision to decline to come into the unit the midwife should discuss this with the labour ward co-ordinator.

2.6 All discussions should include:

- Explanation of the importance of attending the unit in order to confirm the diagnosis and the subsequent care plan
- Risks of any missed diagnosis of meconium, malposition or infection and subsequent delay in treatment

2.7 For those not attending immediately, or declining to attend should be advised to monitor and call again if there is any change in the fetal movements, any vaginal bleeding, any change in the colour of the liquor.

2.8 All advice, discussions and decisions need to be clearly documented in the telephone log / on Badgernet.

## 3 Clinical Assessment

On presentation to the unit, the midwife providing initial care should undertake a risk assessment using BSOTS MP026 that includes:

3.1 Detailed history

3.1.1 Medical, social/lifestyle, psychological and previous obstetric history

3.1.2 Confirm gestation and EDD, any problems in the current pregnancy, planned place of birth

3.1.3 Confirm suspected time of RoM, colour of liquor, presence of fetal movements. Any other associated symptoms eg. pain.

3.1.4 Check Group B Strep status

3.1.5 For pregnant women/people with known blood born infectious diseases (HBV/HIV) and herpes refer to MP009 Guidelines for the Management of HIV in Pregnancy and Neonatal period / MP008 Infections in Pregnancy

3.2 After taking informed consent the midwife should:

3.2.1 Take parent observations pulse, blood pressure, temperature, respiratory rate

3.2.2 Perform full abdominal examination (SFH, fetal lie, presentation, engagement) noticing any palpable tightenings.

3.2.3 Confirm presentation - using ultrasound if unsure.

3.2.4 Confirm fetal wellbeing - intermittent auscultation for low risk pregnant women / people, or CTG for those with risk factors identified

3.3 Speculum examination if indicated:

3.3.1 A speculum is not necessary if there is a good history of PROM and there is clear evidence of RoM on inspection of sanitary towel/underwear and the baby's head is engaged

3.3.2 Ensure to take verbal informed consent if a speculum examination is required - confirm pooling of liquor in vagina and check for meconium or cord prolapse.

3.3.3 Only send an HVS or LVS for term PRoM if there are specific clinical concerns or risk factors for chorioamnionitis

3.4 Use of Amnisure ®

3.4.1 The Amnisure ® test should not be used routinely to assess for RoM at term. For the majority a speculum examination will be adequate to confirm or refute RoM.

3.4.2 Amnisure® can be used if the history given is strongly suggestive of RoM and despite no liquor being seen on speculum the clinician has a high suspicion that RoM has occurred; or if there are repeated attendances for suspected RoM not confirmed on speculum examination

3.4.3 No test is 100% sensitive or specific, so always use clinical judgement as to whether the use of Amnisure is appropriate.

3.4.4 The following specific factors may lead to an inaccurate result:

<u>POSSIBLE FALSE POSITIVE:</u>
Significant amounts of blood in the vagina (trace amounts are fine)
Vaginal medication use within last 6 hours eg. Canesten pessary
Vaginal examination prior to test
Placenta praevia

<u>POSSIBLE FALSE NEGATIVE:</u>
More than 12 hours has elapsed between reported SROM and Amnisure test, or from reported cessation of fluid loss.

If an Amnisure result is negative in this situation, please use clinical judgement based on the history. It would be appropriate to invite the woman back for further review in the subsequent 48 hours if there is any doubt, or to discuss with an obstetric consultant

3.5 Clinicians **should not** perform VE despite contractions unless:

3.5.1 The cervix is open on speculum examination and active labour is suspected, or

3.5.2 There are other risk factors which require immediate intervention such as meconium, abnormal FH or suspected chorioamnionitis

Clinical Features for Chorioamnionitis:
Feeling unwell
Raised temperature (2x >37.5-38c 1 hour apart or 30 minutes apart if meconium),
Maternal / parent tachycardia
Raised WBC and CRP
Uterine tenderness
Offensive liquor
Fetal tachycardia

NB: consider increased risk for chorioamnionitis if there have been repeated digital vaginal examinations.

## 4 Care Planning and Management after confirmation of PRoM

4.1 Pregnant women / people with PRoM and **no other risk factors**

4.1.1 All pregnant women / people with rupture of membranes at term should be offered induction of labour immediately, or at any time after confirmation of rupture of membranes.

4.1.2 Where the pregnancy is low risk and no other acute concerning features are identified, induction of labour is appropriate up to 24 hours after the rupture of membranes.

4.1.3 Conservative management can be offered upto 24 hours if:

- They are not in labour
- It is a singleton low risk pregnancy
- The fetal head engaged

- The liquor is clear
- The woman is apyrexial
- The fetal heart monitoring is normal
- No history of GBS
- There is no adverse past obstetric history

4.1.4 When making the decision about whether to consider immediate induction or conservative management pregnant women / people should be advised that:

- 60% of women with PROM will labour within 24 hours
- Risk of serious neonatal infection increases from 1 in 200, to 1 in 100 (doubles) after 24 hours of ruptured membranes (i.e. from 0.5% to 1%).

4.1.5 For those opting for conservative management, they should be asked to check their temperature 4 hourly when awake.

4.1.6 Inform the woman that bathing or showering is not associated with an increase in infection, but that having sexual intercourse may be.

4.1.7 Advise to contact delivery suite if:

- Temperature exceeds 37.5-38C (on 2 occasions, 1 hour apart)
- Liquor changes colour or becomes foul smelling
- Any bleeding
- Feels unwell
- Fetal movements are reduced
- Contractions or abdominal pain
- Any other concern

4.2 Pregnant women / people with PROM and **other risks** (as listed below) IOL should be advised **immediately** after review by the obstetric registrar or consultant:

- Meconium stained liquor
- Chorioamnionitis
- Concerns with fetal monitoring
- GBS positive - offer immediate induction and IV antibiotics

4.3 For pregnant women / people planning VBAC with pre-labour spontaneous rupture of membranes please refer to MP034 Vaginal Birth after Caesarean Section for details on care planning and processes.

4.4 If the pregnant woman / person declines IOL after 24 hours of RoM:

- Advise close observation of fetal movements
- Advise FHR monitoring every 24 hours with a CTG with the information that this does not guarantee fetal wellbeing outside of that monitoring window
- Advise a blood test (FBC and CRP)

4.5 If the pregnant woman / person wants to continue expectant management for more than 72 hours after RoM, this should be discussed with a consultant

## 5 Admission for Induction of Labour (IOL)

5.1 Where a pregnant woman / person has opted for conservative management they should be booked for IOL as close to 24 hours (ideally before 24-hours) from the time of RoM.

5.2 Where SRoM is overnight, book as close to 24-hours as possible – I,e, if at midnight consider admission for 10PM the following evening, if at 4AM can bring for 6AM the following day – or at 10PM same day as preferred by the pregnant woman / person.

5.3 If known to be GBS positive in this pregnancy – give IV antibiotics in labour. See maternity protocol MP008: Infections in pregnancy including GBS

5.4 Pregnant women / people with unknown GBS status and ROM > 24 hours, who have no signs of infection, should be advised that routine IV antibiotics are NOT required.

5.5 Pregnant women / people with ROM > 24 hours with no obvious signs of infection but with inadvertent VEs before IOL should be advised to have blood tests for FBC and CRP in case of subclinical chorioamnionitis

5.6 If there is clinical suspicion of sepsis, urgent bloods should be sent (FBC, CRP, G&S, U&Es, cultures) and broad spectrum IV antibiotics should be started immediately (Pyrexia in labour protocol) and refer to the on-call obstetric registrar

## 6 Process for Induction of Labour (IOL):

6.1 If Bishop score is <6 and mother and fetus are well, IOL management can allo 1 x Prostin PV (1 dose only) followed by Oxytocin augmentation

6.2 Bishop score is >6 – direct augmentation with Oxytoxin

6.3 For further information on IOL see Maternity Protocol MP033: Induction of Labour

## 7 References


- NICE guideline NG 207 : Inducing labour, November 2021
- NICE guideline CG 190: Intrapartum care for healthy women and babies, updated February 2017
- RCOG Green Top Guideline No.73 Care of Women Presenting with Suspected Preterm Prelabour Rupture of Membranes from $24^{+0}$ Weeks of Gestation, June 2019

# Pre-term Pre-Labour Rupture Of Membranes (PPRoM)

## 1 Definition and Background

1.1 Rupture of membranes (RoM) before 37 weeks gestation and prior to onset of labour

1.2 PPRoM complicates up to 3% of pregnancies and is associated with 30–40% of preterm births.

1.3 Risks associated with PPROM resulting in significant neonatal morbidity and mortality include

- Those associated with prematurity
- Sepsis
- cord prolapse
- pulmonary hypoplasia

1.4 Risks associated with poor maternal outcome including chorioamnioitis and sepsis.

1.5 The median latency after PPROM is 7 days and tends to shorten as the gestational age at PPROM advances.

## 2 Phone Assessment

2.1 When the pregnant woman / person phones into labour ward or triage a midwife or obstetrician should undertake a verbal risk assessment as per MP0032 (i) Section 2.

2.2 All pregnant women / people reporting suspected PPRoM should be invited in for assessment as soon as possible.

## 3 Clinical Assessment

3.1 On arrival the midwife should complete a thorough assessment using BSOTS MP026 including history, confirm gestation and presence of fetal movements.

3.2 The attending midwife should check all baseline observations, and start CTG monitoring if >26-weeks gestation

3.3 All pregnant women /people with suspected PPRoM should be reviewed by a member of the obstetric team.

3.4 After confirming the history, and gaining informed consent the reviewing obstetrician should

3.4.1 Undertake sterile speculum examination to confirm pooling of liquor in vagina and rule out meconium or cord prolapse.

3.4.2 If an obstetrician is unavailable despite request and a speculum is required urgently a senior midwife can undertake this procedure.

3.4.3 If on speculum examination, no amniotic fluid is observed, clinicians should consider performing an Amnisure® test should be used to guide further management
(the diagnosis of PPROM can be equivocal in 10–20% of cases)
Refer to MP032(i) section 3.4 for information in using Amnisure ®

3.4.4 The role of ultrasound assessment of amniotic fluid volume is unclear however persistent anhydramnios is associated with increaseed risk of severe pulmonary hypoplasia.

3.4.5 Do not perform digital vaginal examination despite contractions unless

- the cervix appears to be dilated on speculum examination or
- there is an indication to start immediate augmentation of labour i.e. meconium more than grade 1 or signs of chorioamnionitis

## 4 Initial Care Planning and Management (all gestations)

4.1 The ongoing care plan following the confirmation of PPRoM will depend on gestation.

4.2 In the immediate management, it is important to rule out any current infection.

4.3 A combination of clinical assessment, parental inflammatory and infection markers and fetal wellbeing should be used to diagnose chorioamnionitis:

4.3.1 Take FBC (WCC) and CRP *

4.3.2 Perform HVS

4.3.3 Review CTG assessment of fetus *

4.4 Where the situation is stable, there are no signs of infection or immediate delivery:

4.4.1 Admit to the ward for ongoing assessment for 48-72 hours.
During admission, vital signs, including pulse, blood pressure, respiratory rate and temperature, should be recorded on Badgernet.

4.4.2 Arrange fetal growth scan and assess liquor volume.

4.4.3 Inform neonatal team – all pregnant women / people with PPROM should have the opportunity to meet with a neonatologist to discuss their baby's care

*Do not use WCC, CRP or CTG in isolation - if the results of the clinical assessment or any of the tests are not consistent with each other, continue to observe the woman and consider repeating the tests

4.5 Antibiotics (antenatal)

4.5.1 Offer all pregnant women / people with confirmed PPROM oral erythromycin 250 mg 4 times a day for a maximum of 10 days or until in established labour (whichever is sooner).

4.5.2 For those with PPROM who cannot tolerate erythromycin or in whom erythromycin is contraindicated, use Amoxilciln 500mg TDS for a maximum of 10 days or until in established labour (whichever is sooner).

4.5.3 Do not offer co-amoxiclav as prophylaxis for intrauterine infection for PPROM.

4.6 Antibiotics (intrapartum)

4.6.1 Advise and prescribe IV benzylpenicillin to all women / people in established pre-term labour refer to MP031 Pre-Term Labour for regimes.

4.7 Antenatal corticosteroids

4.7.1 Refer to MP031 Pre Term Labour Guideline

4.7.2 A single course of corticosteroids can be given to any women with threatened pre-term labour from 23 - $34^{+6}$/40 gestation.

4.7.3 The recommended course of corticosteroids is:

Dexamethasone 12mg IM – 2 doses given 12 hours apart

OR

Betamethasone 12mg IM – 2 doses given 12 hours apart

4.7.4 Corticosteroids may sometimes be considered at gestations from 22+0 to 22+6, but this decision should be taken by the obstetric and neonatal consultants after consideration of active management in line with the BAPM framework

4.7.5 If antenatal corticosteroids have been given at gestations less than $26^{+0}$ weeks, then consideration should be given to a further course if there is another admission with suspected preterm labour under $32^{+0}$ weeks if delivery is considered highly likely to happen. More than 2 courses of steroids is not recommended

4.7.6 The optimum effect of a steroid course is seen if delivery occurs between 24 hours and 7 days after the last dose. A course of steroids can be initiated if delivery is anticipated within 24 hours as there is still a beneficial effect on neonatal death.

## 5 Magnesium Sulphate

Please refer to MP031 Pre-Term Labour
Administration of IV MgSO4 should be given to those in established preterm labour or where preterm birth is expected / being planned within the following 24 hours.

5.1 Magnesium sulphate reduces cerebral palsy and motor dysfunction in the baby - with greatest benefit before 30+0 weeks of gestation.

5.1.1 Offer MgSO4 to those between 24+0 and 29+6 weeks diagnosed with PPROM and in established labour

5.1.2 Offer MgSO4 to those between 24+0 and 29+6 weeks with PPROM and expecting / planning delivery within 24 hours

5.1.3 MGSO4 should be considered when preterm birth is anticipated between 30+0 and 33+6 weeks and should be discussed with the neonatal team and the parents.

5.2 Tocolysis is not recommended for cases with PPROM.

5.3 Amnioinfusion is not recommended as part of routine clinical practice.

## 6 Pre-Term Pre-Labour Rupture of Membranes between 34 - 36+6 Weeks

6.1 If cephalic presentation, and in the absence of concerns for infection, or meconium, discuss with the benefits and risks of induction of labour and conservative management beyond 37 weeks.

6.2 If breech presentation – recommend elective caesarean section at 37 weeks after discussing risks and benefits of both IOL and conservative management as well as options of LSCS and vaginal birth. See Breech Guideline MP046

6.3 Timing of birth and ongoing plan for care should be discussed with each pregnant woman / person on an individual basis and in conjunction with the neonatal team. It is important to consider the whole clinical picture including the level of liquor seen on the USS.

6.4 All discussions should be clearly documented. It should also be clear that the pathway may change in case of any deterioration in the clinical picture / fetal wellbeing.

6.5 Conservative management until 37-weeks, may reduce the risks of prematurity and reduce the risk of respiratory support for the newborn. It may also reduce the risk of caesarean section. However, there is increased risk of chorioamnionitis.

6.6 Conservative management beyond 37-weeks is not recommended. If a pregnant woman / person wishes to extend the pregnancy please refer to the obstetric consultant in ANC.

6.7 Expediting delivery – induction of labour reduces the risk of developing chorioamniotnitis, but does not reduce the risk of neonatal infection. Risks include increased risk of caesarean section.

6.8 For those opting to await delivery at 37-weeks, on discharge from the department:

6.8.1 Give Erythromycin TTO to continue for 10-days in line with Section,

6.8.2 Organise weekly DAU follow up for repeat infection markers and fetal monitoring

6.8.3 Fortnightly scans for fetal growth and assessment of amniotic fluid

6.8.4 Book a date for IOL – explain that date may be expedited if the clinical picture changes.

6.8.5 Observations at home and other advice should be same as for term PROM

6.8.6 Advise that deterioration in the clinical picture may require expediting delivery earlier than the planned 37-weeks

## 7 Pre-term Pre-labour Rupture of Membranes between 24 and 33+6 Weeks

7.1 Admission and investigations should be carried out as per Section 4.1 - 4.7.

7.2 Offer antibiotics as per section 4.8 (an alternative in case of allergy) for 10 days .

7.3 Offer a course of antenatal steroids as above Section 4.9 if labour appears likely or planned within the next 7-days.

7.4 6-hourly assessment of maternal observations, FHR monitoring as per the CTG guideline (CTG should be attempted from 26-weeks), colour of liquor and uterine tenderness

7.5 If there is meconium, signs of chorioamnionitis, fetal distress, or maternal sepsis delivery should be expedited with steroid, antibiotic and magnesium sulphate cover as per Section 4

7.6 Where there is no indication for immediate delivery, aim to manage the pregnant woman / person conservatively with regular reviews.

7.7 Upon discharge from the department:

7.7.1 Give Erythromycin TTO to continue for 10-days in line with Section,

7.7.2 Organise weekly DAU follow up for repeat infection markers and fetal monitoring

7.7.3 2-weekly scans for fetal growth / dopplers and assessment of amniotic fluid

7.7.4 Observations at home and other advice should be same as for term PROM

7.7.5 Advise that deterioration in the clinical picture may require expediting delivery

7.8 Timing of birth plans should be discussed with each pregnant woman / person on an individual basis:

7.8.1 Whilst aiming to reach 37-weeks of gestation, decisions around the timing of delivery should be dynamic - based around the clinical picture, fetal wellbeing and liquor volume.

7.8.2 Decisions around timing of delivery should involve the MDT with obstetric and neonatal input and review in the obstetric ANC at least every 4-weeks.

7.8.3 There is a recognised increased risk of lung hypoplasia where there is prolonged reduced liquor volume. For this reason, it may not be in the best interest of the baby to continue with conservative management even in the absence of infection.

7.8.4 All discussions must be clearly documented in Badgernet and the MDT be aware of the ongoing plan. Such patients may be referred to / discussed at the Complex Care Meeting

## 8 Pre-Term Pre-Labour Rupture of Membranes between 22 and 23+6

8.1 Please refer to the BAPM pathway and Pre-term pathway for decisions around management at this gestation. It is imperative that decisions at this gestation are made with complete involvement with the senior MDT and with involvement from the pregnant person.

8.2 Where appropriate steroids, magnesium sulphate and antibiotics may be offered and active management as per those with gestation >24-weeks in Section 6.

## 9 Extreme pre-term pre-labour rupture of membranes before 22-weeks

9.1 For those with PPRoM <24-weeks, discussions around the ongoing management must be based primarily on concerns for maternal wellbeing – eg. Signs of sepsis

9.2 Where there are concerns for maternal health, termination should be advised.

9.3 Where there are no concerns for maternal wellbeing, discussions with families must be open and clear regarding the unknown likelihood of survival and the likelihood of poor fetal / neonatal outcome.

9.4 In the absence of concerns for maternal wellbeing, options should still include termination of pregnancy, or conservative management as per those with PPRoM >24 weeks.

9.5 The pregnant woman / person must be informed that the clinical picture can change and there may be changes to management plans at short notice.

9.6 Evidence is lacking for outcomes of babies where PPRoM occurs at these early gestations and discussions should include:

- Increased risk of pulmonary hypoplasia – particularly where PPRoM occurs <20-weeks
- Increased risk of chorioamnionitis
- Low rates of neonatal survival (around 40%) for cases where PPRoM occurs before 20-weeks – irrespective of latency from RoM to delivery
- One study showed that 70% of pregnancies affected by PPROM prior to 24 weeks gestation resulted in live births with two-thirds of these live births surviving to over a year of age. Concluding that there is better prognosis than reported in similar literature.

## 10 References

**RCOG guideline No 73: Care of Women Presenting with Suspected Preterm Prelabour Rupture of Membranes from 24+0 Weeks of Gestation**

**RCOG guideline No. 7: Antenatal corticosteroids to reduce neonatal morbidity and mortality. October 2010**

http://labguide.fairview.org/showtest.asp?testid=4104

**NICE guideline CG 149: Neonatal infection (early onset): antibiotics for prevention and treatment**

**Pregnancy Outcome for Membrane Rupture Before 24 Weeks Gestational Age**
Newcastle University, Institute of Health and Society,
Anna Jackson*, Dr Martin Ward-Platt

**J Perinatology. 2004 Oct;24(10):611-6.Expectant management in spontaneous preterm premature rupture of membranes between 14 and 24 weeks' gestation**
Sandy J Falk[1], Laura J Campbell, Aviva Lee-Parritz, Amy P Cohen, Jeffrey Ecker, Louise Wilkins-Haug, Ellice Lieberman

**Appendix A**

**A Guide for DAU Follow Up for Pre-Term Pre-Labour Rupture of Membranes**

- Weekly review is advised but the pregnant woman / person must have open access to call in for review where they have any concerns for raised temperature, change in colour, odour, or consistency of PV loss, concerns for fetal movements, feeling unwell, experiencing pain, or other concern.
- Confirm history and plan from notes
- Ask for any new symptoms, colour and smell of liquor, fetal movements
- Check parental observations, perform abdominal palpation observing for any uterine tenderness
- CTG
- Check recent blood, swab and scan results
- Re-take FBC, CRP and organise a suitable time to speak to parent with results
- Discuss with doctor on call regarding ongoing plan.

**Appendix B :**
**Summary Table for management planning for conservative management PPROM and PROM**

| **Gestation at PPROM** | **Admission** | **Antbiotics**<br><br>**Erythromycin 10 days or until labour whichever sooner** | **Steroids**<br><br>**Dexamethasone 12mg 12-24hr apart** | **Scans**<br><br>**Growth, dopplers, LV** | **MDT review** |
|---|---|---|---|---|---|
| | | | | | |
| <22 weeks | RSCH | TBC following discussion with MDT / neonatal team (BAPM pathway) | TBC by MDT | At time or PPROM and 4-weekly thereafter unless concerns for fetal movements | At time of PPRoM and 4-weekly thereafter |
| 22-24+6 | RSCH | Recommended after discussion with neonatal team | Recommended after discussion with neonatal team<br><br>May consider second dose upto 32 weeks of suspected PTL | At time or PPROM and 4-weekly thereafter unless concerns for fetal movements | At time of PPRoM,<br><br>28-weeks<br><br>4-weekly thereafter. |
| 24+6 – 34-weeks | RSCH | Recommended | Recommended | At time or PPROM and 4-weekly thereafter unless concerns for fetal movements | |
| 34 | PRH / RSCH | Recommended | Recommended | 2- weekly scan until delivery | |

**Appendix C:**
**Summary Table for management planning for those in established labour, or where pre-term delivery planned within 24 hours (i.e. meconium, or concerns for infection)**

| **Gestation at PPROM** | **Admit** | **Antibiotics** | **Steroids**<br><br>**Dexamethasone 12mg 12-24hr apart** | **Scans** | **MgSO4** | **MDT review** |
|---|---|---|---|---|---|---|
| | | | | | | |
| <22 weeks | RSCH | | N/A | N/A | N/A | N/A |
| 22-24+6 | RSCH | Recommended after discussion with neonatal team where actively managing | Recommended after discussion with neonatal team where actively managing<br><br>May consider second dose | For EFW if possible Presentation | Recommend ed after discussion with neonatal team where actively managing | See BAPM pathway<br><br>To establish plans for intrapartum monitoring and resuscitation |
| 24+6 – 33+6 | RSCH | Recommended | Recommended | For EFW / presentation | Recommend ed | |
| 34 – 36+6 | PRH / RSCH | Recommended | Recommended upto 34+6 | EFW / Presentation | N/A | |