University Hospitals Sussex
NHS Foundation Trust

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TRUST CLINICAL GUIDELINE

Pre-labour rupture of membranes at term (over 37 weeks)

Overview

This guideline outlines the diagnosis and management of pre-labour spontaneous rupture of membranes (SROM) at 37+0 weeks and over.

See maternity guidance on preterm birth for SROM at 36+6 or earlier.

Owner	S. Adamson
Author/further information	Z. Brice, Guideline & Audit Midwife
Guideline version	v1.0
Related policies	None
Related protocols/procedures	**SRH&WH:** Care in Labour GBS Preterm Risk Pathway **PRH&RSCH:** Care in labour Infections in pregnancy Pre-term and term pre-labour rupture of membranes **UHSx:** Induction of labour
Standards	NICE 2023 NG235: Intrapartum Care
Superseded documents	**This guideline replaces sections on term ROM in the following clinical documents -** • CG1119 IOL (SRH&WH)

	• CG1196 Care in Labour (SRH&WH) • MP032 Pre-term and term pre-labour rupture of membranes. (PRH&RSCH)
Review due	July 2028
Date uploaded	02/07/25

Approval		
JOGG	Date approved	09/04/2025
Women & Children's Clinical Effectiveness Meeting	Date approved	15/05/2025
Consultation		
	Date approved	
Ratification		
Clinical Document Approval Group	Date approved	02/07/25

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Pre-labour rupture of membranes at term (over 37 weeks)

1.0 Introduction

Term prelabour rupture of membranes is defined as the rupture of fetal membranes before the onset of labour at a gestational age over 37 weeks. The global incidence of term prelabour rupture of membranes is approximately 8% (Dayal et al 2024). Spontaneous onset of labour after term prelabour rupture of membranes usually follows within 24 hours (NICE 2023). Prelabour rupture of membranes at term may be managed expectantly or by elective birth, usually by induction of labour.

Spontaneous rupture of membranes (SROM) may result in immediate risks such as cord prolapse, cord compression and placental abruption; and later problems including maternal or birthing parent, or neonatal infection (Middleton *et al.*, 2017).

2.0 Scope

This guideline applies to the following:

- Midwives
- Obstetricians

3.0 Responsibilities

Midwives & obstetricians:

- To access, read, understand and follow this guidance.
- To use their professional judgement in application of this guideline.

Management:

- To ensure the guideline is reviewed as required in line with Trust and National recommendations.
- To ensure the guideline is accessible to all relevant staff.

4.0 Definitions and abbreviations used within this guideline

ARM Artificial rupture of membranes	**CTG** Cardiotocography
GBS Group B streptococcus	**IOL** Induction of labour
MAU Maternity Assessment Units	**PROM** Prolonged rupture of membranes
SROM Spontaneous rupture of membranes	**VE** Vaginal examination

5.0 Telephone triage

Advise women and birthing people with suspected rupture of membranes after 37+0 weeks to call Telephone Triage to have an initial triage assessment over the phone with a midwife. This should include when the membranes ruptured and an assessment of any risk factors, such as:

- Meconium-stained liquor
- Vaginal bleeding
- blood-stained liquor
- Reduced fetal movements
- Continuous abdominal pain
- Unpleasant smelling liquor, or any change in the colour or smell of her vaginal loss
- The woman or birthing person is feeling unwell
- Group B streptococcus carriage or infection in this or a previous pregnancy where a plan has been made for intrapartum antibiotic prophylaxis in this pregnancy
- The baby has abnormal lie or presentation (for example, transverse lie or breech)
- Fetal growth restriction
- Polyhydramnios/oligohydramnios
- Multiple pregnancy
- Low-lying placenta

If there are any relevant risk factors or if there is any uncertainty, the woman or birthing person should be advised to immediately attend the maternity unit for an urgent in-person review.

For women and birthing people after 37+0 weeks with suspected rupture of the membranes but no risk factors on initial telephone triage assessment:

- Offer to see the woman or birthing person in person as soon as possible on MAU if they have any concerns or wishes to be induced immediately **or**
- Within 12 hours on MAU, at home or on the birth centre. Women and birthing people who have a SROM check at home should be advised that if SROM cannot be confirmed they will be offered to attend MAU for a diagnostic test.

If anything changes or the woman or birthing person has any concerns, advise them to call telephone triage back sooner than the planned review. If a woman or birthing person chooses to wait for assessment on MAU, advise them to ring telephone triage when they would like to be assessed or as they are approaching 12 hours following SROM to ensure MAU are aware they will be attending.

6.0 Assessment of membrane rupture

Vaginal examinations should not be performed to ascertain whether membranes have ruptured due to the increased risk of infection, unless assessing for labour. In this case, a vaginal examination may be indicated but they should be kept to a minimum.

If there is clear evidence of SROM on inspection of sanitary towel/underwear and the baby's head is engaged, a speculum should not be performed.

If it is uncertain whether prelabour rupture of the membranes has occurred or the baby's head is high (not engaged), offer the woman or birthing person a speculum examination to determine whether the membranes have ruptured.

Ensure verbal informed consent is obtained if a speculum examination is required - confirm pooling of liquor in vagina and check for meconium or cord prolapse. If there is no liquor evident on speculum, further diagnostic testing should be offered to exclude SROM. (See **Error! Reference source not found.**).

Diagnostic tests are not available in the community. If a SROM assessment is performed at home and SROM cannot be confirmed, the option of attending the hospital for a diagnostic test should be offered.

If SROM is excluded, the woman or birthing person can be discharged from the hospital with safety netting advice.

6.1 Use of diagnostic tests

Diagnostic tests such as those that can detect insulin-like growth factor-binding protein 1 (IGFBP-1, Actim® PROM) or placental alpha microglobulin-1 (PAMG-1, AmniSure®) in vaginal fluid can be used to confirm if membranes have ruptured. These tests should not be used routinely at term but should be used if speculum examination is unable to confirm SROM. It can also be offered if there are repeated attendances for suspected rupture of membranes which are not confirmed on speculum examination. Diagnostic tests should not be used in labour.

If diagnostic tests are not available, a personalised care plan should be made in conjunction with the woman or birthing person and labour ward coordinator or obstetrician. This plan may include presuming SROM has occurred or inviting the woman or birthing person back for further review in the subsequent 48 hours.

6.1.1 Limitations of testing

There are limitations to the use of diagnostic tests. Manufacturer's instructions should always be adhered to. In particular:

- Contaminants (e.g. lubricants) may affect absorption of the specimen onto the swab and/or affect the test performance.

- When there is a significant presence of blood on the swab, the test can malfunction and is not recommended.
- Vaginal infections, urine and sperm do not interfere with the results of the AmniSure® or Actim® PROM Test.

See Appendix 2 and Appendix 3 for more information.

A false negative may occur if more than 12 hours has elapsed between reported SROM or reported cessation of fluid loss and the diagnostic test.

If a test result is negative in this situation, this should be discussed with the labour ward coordinator or registrar on-call and a personalised plan made with the woman or birthing person. It may be appropriate to invite the woman or birthing person back for further review in the subsequent 48 hours if there is any doubt. If SROM is excluded and the woman or birthing person is discharged, they should be informed that if they have any further symptoms or concerns that they should return for assessment.

7.0 Management of confirmed prelabour rupture of membranes

The pregnant woman or birthing person should be informed that:

- 60% of pregnant women and birthing people with SROM labour within 24 hours.
- The risk of serious neonatal infection doubles from 1 in 200 to 1 in 100 after 24 hours of ruptured membranes (i.e. from 0.5% to 1%).

Recommend that pregnant women and birthing people have:

- Expectant management for up to 24 hours **or**
- Induction of labour as soon as possible.

Discuss the benefits and risks of these options with the pregnant woman or birthing person and take into account their individual circumstances and preferences. If women or birthing people choose to decline induction of labour, see 7.2.

7.1 Expectant management of lower risk SROM

Until IOL is commenced or if expectant management beyond 24 hours is chosen by the pregnant woman or birthing person:

- Lower vaginal swabs and maternal or birthing parent C-reactive protein are not indicated.
- Pregnant women and birthing people should be informed that bathing or showering is not associated with an increase in infection, but that having sexual intercourse may be.
- Fetal movement and fetal heart rate should be monitored at initial contact and offered every 24 hours following SROM until established labour. Pregnant women and birthing

people should be advised to report any decrease or change in fetal movements immediately.

- Pregnant women and birthing people should be advised to record their temperature every 4 hours during waking hours and to report immediately any developing pyrexia (37.5 °C and above), feeling unwell or change in the colour or smell of their vaginal loss to detect any infection that may be developing.

Midwives should direct women and birthing people to patient information on pre-labour rupture of membranes at term.

If labour has not started 24 hours after rupture of the membranes, advise the woman or birthing person to give birth where there is access to neonatal services (this may be in an obstetric unit or an alongside midwifery unit) and to stay in hospital for at least 12 hours after the birth.

7.2 Declining IOL

If the woman or birthing person declines IOL after 24 hours of rupture of membranes:

- 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.

If the woman or birthing person wants to continue expectant management for more than 72 hours after rupture of membranes or declines IOL after SROM in the presence of other risk factors, this should be discussed with either a consultant midwife or consultant obstetrician.

7.3 SROM with meconium-stained liquor

Where there is any meconium-stained liquor, the pregnant woman or birthing person should be reviewed as soon as possible by an Obstetrician for an individualised plan of care. IOL should be offered to expedite the birth.

7.4 SROM with Group B streptococcus (GBS)

Pregnant women and birthing people with a history of GBS in current pregnancy, or a previous pregnancy where the baby developed GBS infection, should be asked to come to Labour Ward and be offered an induction as soon as possible, or caesarean birth if it had been planned. See Maternity guidance on GBS.

7.5 IOL for confirmed SROM

On admission, an assessment should be carried out as per IOL guideline. Please see IOL guidance for further guidance.

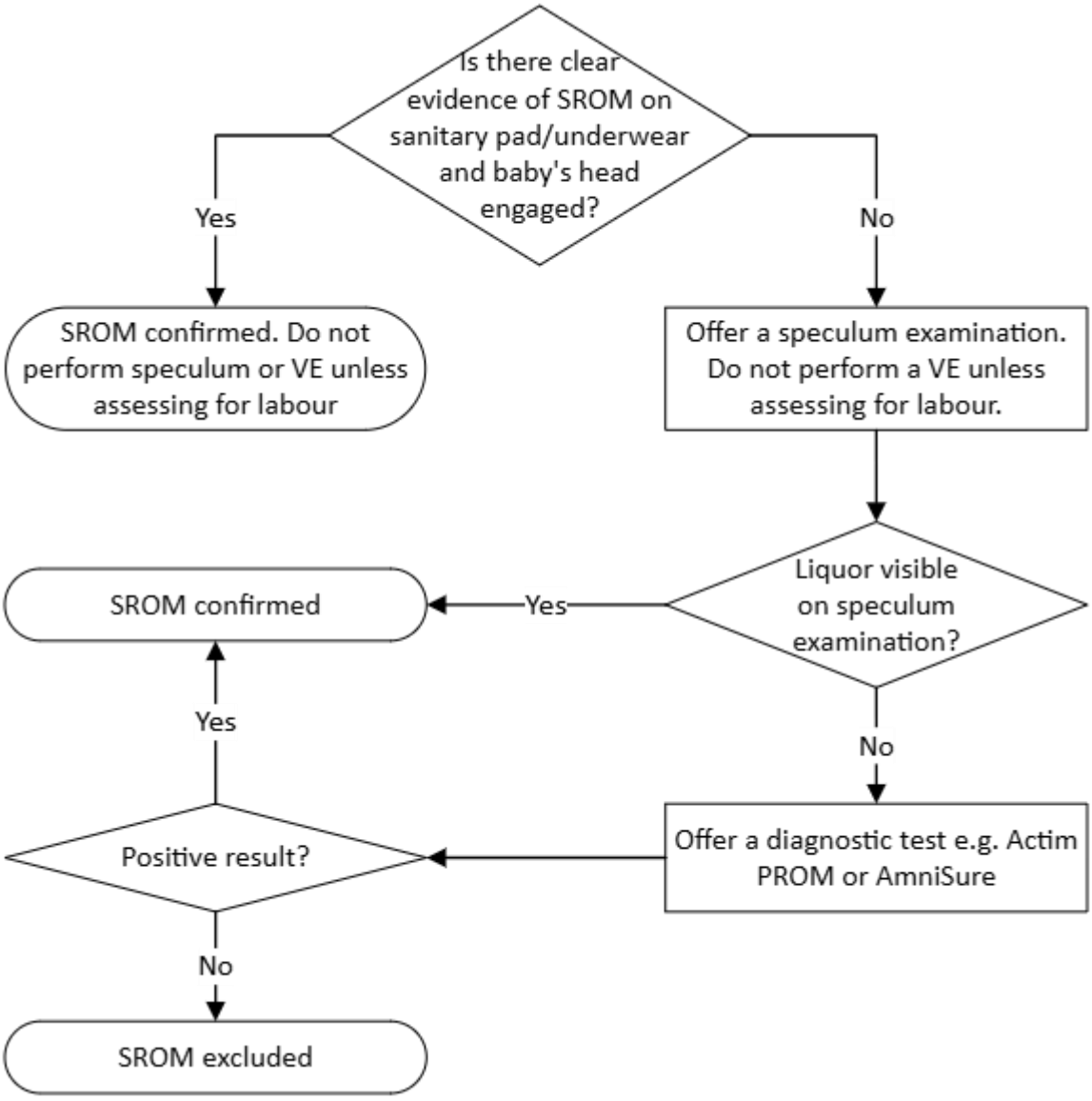
7.6 Confirmed SROM and planned elective

If SROM is confirmed when an elective caesarean birth is planned, the woman or birthing person should be referred to the obstetric registrar. An individualised plan should be made, which may include expediting planned caesarean or IOL.

8.0 Monitoring

Issue being monitored	**Monitoring method**	**Responsibility**	**Frequency**	**Reviewed by and actions arising followed up by**
Management and identification of Pre-labour rupture of membranes	Patient notes review	Maternity Patient Safety Team	Case by case	Any themes identified will be escalated through Maternity Quality and Safety meeting to agree appropriate actions

Appendix 1: SROM assessment flowchart

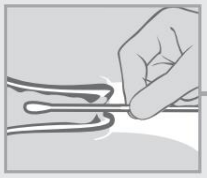


Appendix 2: AmniSure® Test instructions and limitations

[AmniSure® ROM test instructions for use]

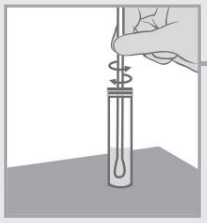
TEST PROCEDURE

NOTE: You must follow all directions carefully to get an accurate reading of the results.
Do not use the Test earlier than 6 hours after the removal of any disinfectant solutions or medicines from the vagina.
Placenta previa and performing digital exams prior to sample collection can lead to inaccurate test results.



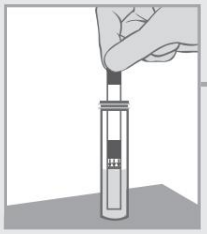
1. Take the solvent vial by its cap and shake well to make sure all liquid in the vial has dropped on the bottom. Open the solvent vial and put it in a vertical position.

2. To collect a sample from the surface of the vagina use the sterile polyester swab provided with the AmniSure ROM Test. Remove the sterile swab from its package following instructions on the packaging. The polyester tip of the swab should not touch anything prior to insertion into vagina. Hold the swab in the middle of its shaft and, while a patient is lying on her back, carefully insert the polyester tip of the swab into the vagina until the fingers contact the skin (no more than 2-3 inches or 5-7 cm deep). Withdraw the swab from the vagina **after one minute**.



3. After the swab has been removed from the vagina, immediately place the polyester tip into the provided solvent vial and rinse by rotating for one minute.

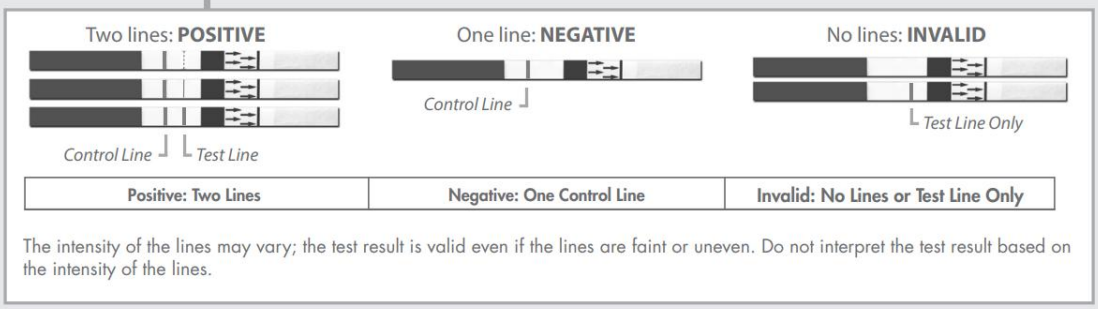
4. Remove the swab from the vial and dispose of it. Test the patient sample within 4 hours after collection. If the patient sample is not tested within 4 hours and sample storage is necessary, tightly close the sample vial and place in a refrigerator. Do not test the sample after more than 6 hours have passed since sample collection.



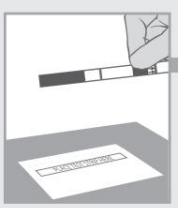
5. Tear open the foil pouch at the tear notches and remove the AmniSure ROM Test strip.

6. Dip the white end of the test strip (marked with arrows facing downward) into the vial with solvent. Strong leakage of amniotic fluid may make the results visible early, while a very small leak will take the full 10 minutes.

7. **Remove the test strip from the vial if two lines are clearly visible in the test region or after 10 minutes sharp.** Do not read or interpret the results after 15 minutes have passed since dipping the test strip in the vial. Read the results by placing the test strip on a clean, dry and flat surface in a well-lit environment via either natural or fluorescent lighting. A positive result is indicated by two lines in the test region, while a negative result is indicated by the presence of a control line and no test line. Please note that the presence of no lines or only a test line indicates an invalid test result. DO NOT interpret this as a negative test result. Invalid results require a retest. To properly distinguish between the test and control lines, please see Step 8.



The intensity of the lines may vary; the test result is valid even if the lines are faint or uneven. Do not interpret the test result based on the intensity of the lines.



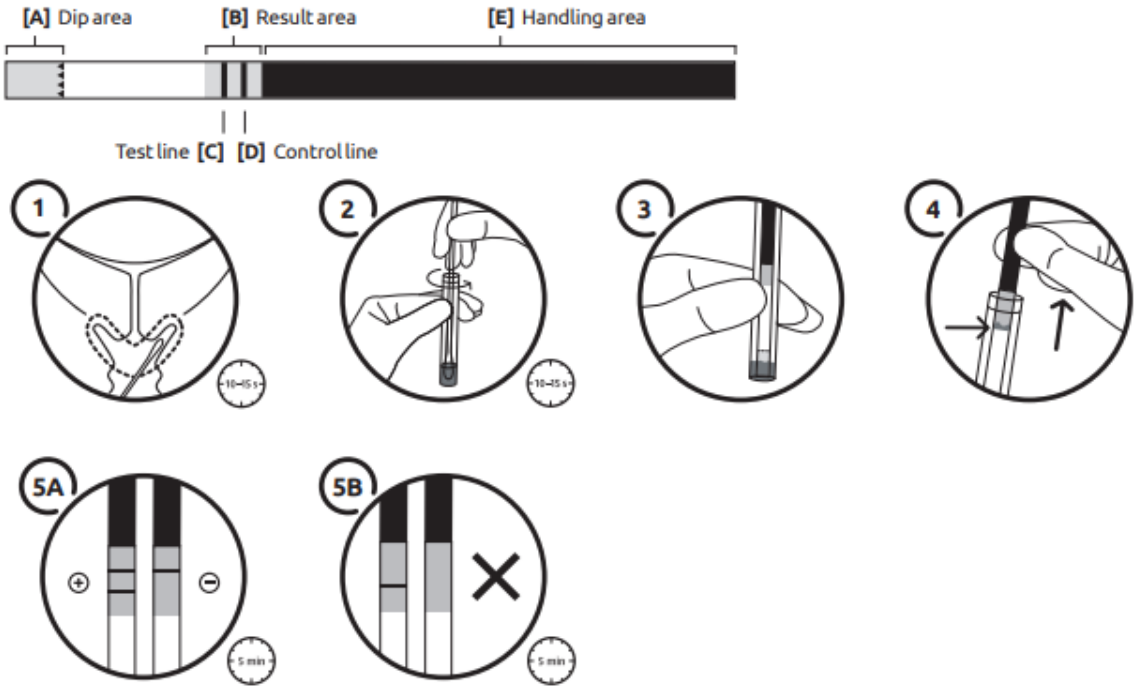
8. To ensure correct identification of test and control line locations, compare the test strip to the graphics on the outer kit bag or foil pouch, as indicated. This will help confirm result interpretation.

Limitations of the use of AmniSure®

- When there is a significant presence of blood on the swab, the test can malfunction and is not recommended. In cases of only trace amounts of blood on the swab, the test still functions properly.
- The performance of the AmniSure® ROM Test has **not** been established in the presence of the following contaminants:
  - anti-fungal creams or suppositories
  - K-Y® Jelly
  - Monistat® Yeast Infection Treatment
  - Baby Powder (Starch and Talc)
  - Replens® Feminine Moisturizer
  - Baby Oil.
- The performance of the AmniSure® ROM Test has not been established in the presence of meconium in the amniotic fluid.
- Vaginal infections, urine and sperm do not interfere with the results of the AmniSure® ROM Test.

Appendix 3: Actim® Prom Instructions for use and limitations

Actim® PROM Instructions for Use



The specimen should be collected prior to performing digital examination and/or transvaginal ultrasound. Take care not to touch anything with the swab before taking the specimen. Specimens should be tested as soon as possible after they have been extracted, and no later than 4 hours following the specimen extraction.

1. Separate the labia and carefully insert the tip of the swab into the vagina toward the posterior fornix until resistance is met. Alternatively, the specimen can be taken from the posterior fornix during a sterile speculum examination. The swab should be held in **the posterior fornix for 10–15 seconds** to allow it to absorb the cervicovaginal secretion.

2. Open the extraction buffer tube and extract the specimen immediately from the swab by swirling the swab vigorously in **the extraction buffer for 10–15 seconds**. Press the swab against the wall of the extraction buffer tube to remove any remaining liquid from the swab. Discard the swab after extraction. **NOTE!** Do not leave the swab in the tube.

3. Open the foil pouch containing the dipstick by tearing. Do not touch the yellow dip area at the lower part of the dipstick. Identifying marks may be written on the upper turquoise part of the dipstick. The dipstick must be used shortly after its removal from the foil pouch. Place the yellow dip area into the extracted specimen.

4. Hold the dipstick in the tube **until you see the liquid front enter the result area**. Remove the dipstick from the buffer and place it horizontally on a clean surface.

5. The result can be interpreted as positive as soon as two blue lines become visible in the result area. Negative result should be read at **5 minutes**. **Do not pay attention to any lines appearing later than 5 minutes**. If **two blue lines, the test line and the control line**, appear,

the test result is **positive** (5A). Any faint but continuous line should be interpreted as positive. If **only the control line appears**, the test result is **negative** (5A). If **the control line does not appear**, the test is **invalid** (5B).

Limitations of Actim® PROM

- Do not contaminate the swab or cervicovaginal specimen with lubricants or creams, as they may physically interfere with absorption of the specimen onto the swab and/or affect the test performance.
- Large amounts of meconium causing green staining of the amniotic fluid may interfere with the detection of IGFBP-1 with Actim® PROM.
- The following substances, conditions and micro-organisms were tested with Actim® PROM test and were found not to affect Actim® PROM test performance, when tested at the concentrations shown:

Substance/Condition/ Micro-organism	Tested concentration
Whole blood	100% v/v
Semen	100% v/v
Urine	100% v/v
pH 3.5-8.5	N/A
Surgical lubricant water-based (Aquasoniq 100, Optilube, Surgilube, HR Lubricating Jelly)	50% w/v
Skin oil (Ceridal Lipolotion)	50% v/v
Pevaryl (active ingredient: econatzol.nitras)	30 mg/ml
Gyno-Trosyd (tioconazol)	20 mg/ml
Flagyl (metronidazole)	100 mg/ml
Canesten (clotrimazol) capsule	40 mg/ml
Personal lubricant water-based (K-Y Jelly, Klick)	25% w/v
Personal lubricant silicone-based (Magic Glide)	3% w/v
Baby oil (Natusan)	50% v/v
Baby powder (Natusan)	50% w/v
Feminine deodorant (Vagi-Gard)	50% w/v
Vaginal film (VCF Dissolving Vaginal Cleansing Film)	0.1% w/v
Vaginal gel (Represh)	25% w/v
Shower and bath products (Rexona, Dove, Palmolive, Adidas, Daily)	0.1% w/v
Candida albicans	$11.2 * 10^8$ CFU/ml
Gardnerella vaginalis	$8.6 * 10^8$ CFU/ml
Neisseria gonorrhea	$10.6 * 10^8$ CFU/ml

Chlamydia trachomatis	5.0 * 10^3 $TCID_{50}$
HSV-1	5.0 * 10^3 $TCID_{50}$
HSV-2	5.0 * 10^3 $TCID_{50}$

Appendix 4: Guideline Version Control Log

Version	Date	Author	Status	Comment
1.0	December 2025	Z. Brice, Guideline & Audit Midwife	DRAFT	New cross site maternity guideline. This guideline replaces sections on term ROM in the following clinical documents - • CG1119 IOL (SRH&WH) • CG1196 Care in Labour (SRH&WH) • MP032 Pre-term and term pre-labour rupture of membranes. (PRH&RSCH)

Appendix 5: Due Regard Assessment Tool

To be completed and attached to any guideline when submitted to the appropriate committee for consideration and approval.

		Yes/No	Comments
1.	**Does the document/guidance affect one group less or more favourably than another on the basis of:**		
	Age	*No*	
	· Disability	*No*	
	· Gender (Sex)	*No*	
	· Gender Identity	*No*	
	· Marriage and civil partnership	*No*	
	· Pregnancy and maternity	*No*	
	· Race (ethnicity, nationality, colour)	*No*	
	· Religion or Belief	*No*	
	· Sexual orientation, including lesbian, gay and bisexual people	*No*	
2.	**Is there any evidence that some groups are affected differently and what is/are the evidence source(s)?**	*No*	
3.	**If you have identified potential discrimination, are there any exceptions valid, legal and/or justifiable?**	*NA*	
4.	**Is the impact of the document likely to be negative?**	*No*	
5.	**If so, can the impact be avoided?**	*NA*	
6.	**What alternative is there to achieving the intent of the document without the impact?**	*NA*	
7.	**Can we reduce the impact by taking different action and, if not, what, if any, are the reasons why the guideline should continue in its current form?**	*NA*	
8.	**Has the document been assessed to ensure service users, staff and other stakeholders are treated in line with Human Rights FREDA principles (fairness, respect, equality, dignity and autonomy)?**	*Yes*	

If you have identified a potential discriminatory impact of this guideline, please refer it to [Insert Name], together with any suggestions as to the action required to avoid/reduce this impact. For advice in respect of answering the above questions, please contact uhsussex.equality@nhs.net 01273 664685).

Appendix 6: Template Dissemination, Implementation and Access Plan

To be completed and attached to any guideline when submitted to Corporate Governance for consideration and TMB approval.

	Dissemination Plan	**Comments**
1.	Identify:	
	Which members of staff or staff groups will be affected by this guideline?	Midwives and obstetricians
	How will you confirm that they have received the guideline and understood its implications?	Dissemination through the usual communication channels and highlighted at Safety Huddles.
	How have you linked the dissemination of the guideline with induction training, continuous professional development, and clinical supervision as appropriate?	All new members of staff are shown where to access Clinical documents that are relevant to their area of practice.
2.	How and where will staff access the document (at operational level)?	Accessed by staff via Sharepoint.

		Yes/No	**Comments**
3.	Have you made any plans to remove old versions of the guideline or related documents from circulation?	Yes	Previous versions will be archived as part of the uploading onto sharepoint process.
4.	Have you ensured staff are aware the document is logged on the organisation's register?	Yes	Dissemination plan includes notifying staff via email, departmental noticeboards, and safety huddles.

Appendix 7: Additional guidance and information

Middleton P, Shepherd E, Flenady V, McBain RD, Crowther CA. Planned early birth versus expectant management (waiting) for prelabour rupture of membranes at term (37 weeks or more).Cochrane Database of Systematic Reviews 2017, Issue 1. Art. No.: CD005302.DOI: 10.1002/14651858.CD005302.pub3.

D'Ambrosi F, Cesano N, Iurlaro E, Ronchi A, Ramezzana IG, Di Maso M, Pietrasanta C, Ronchi A, Pugni L, Ferrazzi E. Prelabor rupture of membranes at term: A possible hematological triage in addition to vagino-rectal beta-hemolytic streptococcus screening for early labor induction. PLoS One. 2022 Jan 13;17(1):e0261906. doi: 10.1371/journal.pone.0261906. PMID: 35025890; PMCID: PMC8757946.

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Shailja Dayal; Suzanne M. Jenkins; Peter L. Hong. (2024) Preterm and Term Prelabor Rupture of Membranes (PPROM and PROM). Available at: https://www.ncbi.nlm.nih.gov/books/NBK532888/