Revised November 2021

UC Previable PROM Protocol

The following protocol is intended for patients presenting with previable prelabor rupture of membranes less than 20w0d that are stable and without signs of chorioamnionitis.

Per UC MFM PROM Protocol[1], for any evidence of chorioamnionitis or maternal compromise, deliver regardless of gestational age. For patients with previable PPROM less than 20w0d immediate delivery should be offered. For patients dated 20w0d to 25w6d, consult MFM for individualized care counseling and recommendations.

Please refer to UC Health Abortion Policy (UCH-PCS-ADMIN-007-02)[2] for further policies regarding pregnancy termination.

Rationale: Previable prelabor rupture of membranes (PROM) is associated with maternal and perinatal morbidity and mortality[3-7]. Previable PROM may endanger the life of the mother due to complications that include intra-amniotic infection or endometritis leading to sepsis (1%), placental abruption leading to hemorrhage, or retained placenta. In some cases, there may be more serious risks such as loss of uterus or maternal life (< 0.5%). A recent study comparing expectant management of previable PROM versus pregnancy termination found that there was significantly increased risk of composite maternal morbidity (3.47 times the odds) in the expectantly managed group. Women pursuing expectant management had 4.1 times odds of developing chorioamnionitis and 2.44 times the odds of postpartum hemorrhage[6]. Given this risk, ACOG and SMFM recommend offering pregnancy termination in the setting of previable PPROM to mitigate the potential for maternal and perinatal morbidity and mortality[7].

In compliance with Ohio state laws and the UC Health Abortion Policy, pregnancy termination can be performed when a medical emergency exists[2,8,9]. Medical emergency is defined as “a condition that in the physician’s reasonable medical judgment, based on the facts known to the physician at the time, so complicates the woman’s pregnancy as to necessitate the immediate performance or inducement of an abortion in order to prevent the death of the pregnant woman or to avoid a serious risk of the substantial and irreversible impairment of a major bodily function of the pregnant woman that delay in the performance or inducement of the abortion would create.” Ohio law further defines “serious risk of the substantial and irreversible impairment of a major bodily function” as “any medically diagnosed condition that so complicates the pregnancy of the woman as to directly or indirectly cause the substantial and irreversible impairment of a major bodily function. A medically diagnosed condition that constitutes a serious risk of the substantial and irreversible impairment of a major bodily function includes pre-eclampsia, inevitable abortion, and premature rupture of the membranes, but does not include a condition related to the woman’s mental health.”

Diagnosis and Management:

1. **OB ED triage**
   - The patient is roomed and vital signs taken per RN protocol.
   - Physician evaluates patient, including physical exam.
   - Rupture of membranes is confirmed by at least one of the following: physical exam, microscopy, Amnisure.
   - Ultrasound is performed to assess fetal biometry, documentation of presence/absence of fetal heart tones, placental location, AFI or DVP.

2. **Confirmed previable PROM**
   - Physician counsels patient on management options, including expectant management versus pregnancy termination.
   - If patient elects expectant management, consult MFM. Consider NICU consult if patient desires.
   - If patient elects termination, consult one of the members of the Section of Family Planning.
     - Under the rare circumstances that none of Family Planning providers trained to perform D&E are physically available, medically stable patients can be referred to Planned Parenthood for care.

3. **Patient desires pregnancy termination**
   - Physician counsels patients thoroughly on D&E versus IOL, documents the discussion, and obtains written informed consent.
   - In compliance with UC Health Abortion Policy: the physician performing the termination is responsible for the following:
     - Informing the pregnant woman of the medical indications supporting the physician's judgment that an immediate abortion is necessary. This information shall be provided prior to the performance or inducement of the abortion whenever possible.
       - The reasons supporting the conclusion of medical necessity shall be fully documented in the patient's medical record.
       - A concurring opinion from a second attending is needed if there is fetal cardiac activity. This concurring opinion should be documented in the patient’s medical record.
     - Consulting ODA (Office of Decedent Affairs) to facilitate disposition of fetal remains (burial/cremation). ODA is available 24 hours/day.
     - Offering patient genetic studies including karyotype and microarray.
     - Discussing return of fertility and offering contraception.

4. **If patient desires D&E**
   - Obtain labs: CBC, T&S, consider coags, CMP.
   - Start IV fluids, make patient NPO.

- Add on to OR schedule (L&D vs main OR). Notify OR staff that this case is for pregnancy termination due to medical necessity.
- Admit to antepartum until OR time.
- Consider inpatient Anesthesia consult if indicated.
- Cervical prep (subject to change pending physician preference and clinical picture):
  - Patients ≤ 14 weeks: no cervical prep is needed, and can proceed directly with procedure.
  - Patients 14w0d - 16w6d weeks: cervical prep with buccal misoprostol approximately 2 hours prior to procedure
  - Patients ≥ 17 weeks: overnight (at least 12 hours) of cervical prep with Dilapan or laminaria
- Dilator supplies:
  - Sterile metal speculum
  - Single tooth tenaculum
  - Ring forceps
  - Gauze
  - 10 cc syringe with 22-gauge spinal needle
  - 10-20 cc 1% lidocaine
  - Order antibiotic prophylaxis
- Doxycycline 200mg PO on call to OR
- If allergy to doxycycline, azithromycin 500mg PO on call to OR
- If procedure scheduled for main OR, transfer to SDS/PACU pre-procedure
- Transfer back to antepartum after procedure (if previously admitted), or discharge directly home
- Discharge instructions
- Use D&E postop smart phrase for patients over 14 weeks. These include the state mandated postop instructions patients must receive.
- Follow-up: if patient is UCMC patient, follow up in 2-4 weeks for postop visit with provider that did D&E. If patient is not UCMC patient, offer follow up at UCMC if patient desires.

5. If patient desires IOL

- Admit to L&D with standard induction orders.
- Fetal monitoring is not necessary.
- Per ACOG protocol:
  - Vaginal or buccal loading dose of 600-800 mcg misoprostol followed by 400 mcg every 3-4 hours.
  - OR misoprostol 400 mcg vaginally or buccally q 3-4 hours for up to 5 doses.
  - If not delivered after 5 doses allow for 12-hour break prior to starting again.

6. **Paperwork**
   - Use smartphrases in EPIC for standard documentation ".fp"
   - Operative notes should be signed by the attending physician.
   - All patients require an ODH abortion reporting form (Confidential Abortion Report) filled out and faxed or mailed to ODH within 2 weeks of the procedure. A copy should be given to the Family Planning Section Director.
   - Copies of the H&P and additional attending progress notes need to be printed and given to the Family Planning Section Director for submission to the Ethics Committee within 48 hours.

References

1. UC MFM PROM Protocol, revised 10/2021, section IIn.
2. UC Health Abortion Policy (UCH-PCS-ADMIN-007-02).
3. Prelabor rupture of membranes. ACOG Practice Bulletin No. 188. American College of Obstetricians and Gynecologists. Obstet Gynecol 2018;131:e1–14.
4. Second-trimester abortion. Practice Bulletin No. 135. American College of Obstetricians and Gynecologists. Obstet Gynecol 2013;121:1394–1406.
5. Dotters-Katz SK, Panzer A et al. Maternal Morbidity After Previable Prelabor Rupture of Membranes. Obstet Gynecol. 2017 Jan;129(1):101-106. doi: 10.1097/AOG.0000000000001803.
6. Sklar AS, Sheeder J, Davis AR, Wilson C, Teal SB. Maternal morbidity after preterm premature rupture of membranes at <24 week's gestation. Am J Obstet Gynecol. 2021 Nov;205(4):340.e1-340.e5.
7. American College of Obstetricians and Gynecologists; Society for Maternal-Fetal Medicine. Obstetric Care consensus No. 6: Periviable Birth. Obstet Gynecol. 2017 Oct;130(4):e187-e199. doi: 10.1097/AOG.0000000000002352. PMID: 28937572.
8. Ohio SB 127 (131st General Assembly, 2017).
9. Ohio HB 153 (129th General Assembly, 2011).