**A Retrospective Study of Feto –Maternal Outcome in Premature Rupture of Membranes at Aswan University Hospital**

Laila Ezzat

Department of Obstetrics and Gynecology, Faculty of Medicine, Aswan University, Aswan, Egypt

[lailaezzat972000@gmail.com](mailto:lailaezzat972000@gmail.com)

**Abstract: Background:** Premature rupture of membranes (PROM) is a challenging problem to the obstetricians. In the last three decades it has taken a new dimension because of identification of clinical risk factors and improved fetomaternal outcome due to better management. Premature rupture of membranes is a common and important event in obstetrics. It has a major impact on fetal and maternal outcome, complicating the pregnancy leading to maternal and fetal complications, immediate risks such as cord prolapse, cord compression and placental abruptions, and later risks such as maternal or neonatal infection, as well as the use of interventions such as caesarean section and its complications. **Material and Methods:** A list of patients that had PROM admitted to Aswan University Hospital from January 1/2013 to December 31/2013. Diagnosed by history clinical examination and investigations. The case notes was retrieved from the medical records department. The data was entered in the computer for statistical analysis using one proprietary statistical package which is Statistical Packages for the Social Science (SPSS). **Results:** incidence 10.85%, the average age 28.5 year. The patient's parity primigravida (25.47%), multiparas patients (52.47%) and grand multi-paras represent (22.05%) patients. Average gestational age 34 weeks. Caesarean section (38.27%) vaginal delivery61.72%. About the indications for caesarean section fetal distress 25.28%, failure to progress (40.4%) and previous caesarean section (s) (34.2%) Fetal complications, (NICU) admission 10.07%, respiratory distress (RD) 2.28%, and neonatal sepsis 5.13%. maternal complications, Chorioamnitis 0.57%, postpartum heamorrage 11.59%, Puerperal pyrexia 8.55%. **Conclusions:** Individualized management of cases with Premature rupture of membranes depending on the gestational age and risk of complications is the best way to achieve a good fetomaternaloutcome.

**[**Laila Ezzat. **A Retrospective Study of Feto –Maternal Outcome in Premature Rupture of Membranes at Aswan University Hospital.** *Cancer Biology* 2018;8(2):110-113]. ISSN: 2150-1041 (print); ISSN: 2150-105X (online). <http://www.cancerbio.net>. 15. doi:[10.7537/marscbj080218.15](http://www.dx.doi.org/10.7537/marscbj080218.15).

**Keywords**: PROM, PPROM, Gestational age, Prematurity, chorioamionitis.

**1. Introduction**

A challenging problem to the obstetricians is Premature rupture of membranes (PROM). In the last three decades it has taken a new dimension because of identification of clinical risk factors and improved fetomaternal outcome due to better management.

PROM at term is defined as spontaneous rupture of the membranes after 37 weeks of the gestation before the onset of regular painful uterine contractions. (1)

When PROM occurs before 37 completed weeks of gestation it is termed as preterm premature rupture of membranes (P PROM). (2)

Premature rupture of membranes occurs in approximately 10-20 % of all pregnancies, of which approximately 80% occur at term pregnancy. (1)

PROM at tearm usually 70-80% goes into spontaneous onset of labor within 12 to 24 hours, and 95% within 48 to 72 hours. If the latent period exceeds 24 hours, the chances of increase rate of complications (3).

Premature rupture of membranes is a common and important event in our field. Because It has a major impact on fetal and maternal outcome, complicating the pregnancy leading to maternal and fetal complications, immediate risks such as cord prolapse, cord compression and placental abruptions, and later risks such as maternal or neonatal infection, as well as the use of interventions such as caesarean section and its complications. (3)

Pathophysiology is multifactorial and complex. One of the main role is the failure integrity of chorioamniotic membrane, Also reported that prematurely ruptured membranes have less collagen content and hence less tension resistance. (4)

Compact layer of stromal matrix forms the main fibrous integrity of the amniotic membrane.

Collagen contents are secreted by mesenchymal cells in the layer of fibroblast. The interstitial collagens (types I and III) predominate and form parallel bundles that maintain the amniotic membrane mechanical integrity. (5)

PROM occurs when intrauterine pressure overcomes membrane resistance. It happens due to weakening of membranes either congenital or acquired (smoking and vitamin C deficiency), also because of damaging factors either mechanical during amniocentesis or damage by infection (*Trichomonas* infection, group B *streptococci*, bacterial vaginosis). The failure of mechanical support such as cervical dilatation can lead to premature rupture of membranes of the fetus. (6) Alsoother etiological factors are over distended uterus, big baby, polyhydramnios and multiple gestation. (7)

Latent period (time interval between rupture of membranes and onset of labor) is inversely proportional to the gestational age and directly proportional to the incidence of infection rate. Many of the problems of PROM are infection related and also due to premature delivary. (2)

**2. Material and Methods**

A list of patients that had PROM admitted to Aswan University Hospital from Jan-uary 1/2013 to December 31/2013. Diagnosed by history clinical examination and investigations. The case notes was retrieved from the medical records department in the form of data relating to the age, parity, gestational age, method of termination, perinatal outcomes, and related maternal complications. The data was entered in the computer for statistical analysis using one proprietary statistical package which is Statistical Packages for the Social Science (SPSS).

**3. Results**

There were 4284 deliveries during the period. Under review among them 526 cases premature rupture of membranes with incidence 10.85%, the age of the patients ranged from 20-37 years with average age 28.5 year.

As regard the patient's parity primigravida represents 134 patients with incidence (25.47%), multiparas patient represent 276 patients with incidence (52.47%) and grand multi-paras (delivered five times or more) were 116 patients represent (22.05%) patients.

The gestational age were ranged from 28 weeks to 40 weeks with average gestational age 34 weeks.

About the methods of termination 178 patients were delivered by caesarean section with incidence (38.27%) and 287 patients terminated by vaginal delivery with incidence 61.72%. About the indications for caesarean section fetal distress 45 patients with incidence 25.28%, failure to progress 72 patients with incidence (40.4%) and previous caesarean section (s) 61 patients with incidence (34.2%).

About the complications of premature rupture of membranes. Fetal complications, admission to neonatal intensive care unit (NICU) 53 cases with incidence 10.07%, respiratory distress (RD) 12 cases with incidence 2.28%, and neonatal sepsis 27cases with incidence 5.13%.

About maternal complications, Chorioamnitis 3 cases with incidence 0.57%, postpartum heamorrage61 cases with incidence 11.59%, Puerperal pyrexia 45 cases with incidence 8.55%.

**Table (1): Patients age**

|  |  |  |
| --- | --- | --- |
| Variables | Range | Average |
| Patients age | 20-37 | 28.5 |

**Table (2): Patient parity.**

|  |  |  |
| --- | --- | --- |
| Parity | Number | Incidence |
| Primigravida\* | 134 | 25.47% |
| Multipara\*\* | 276 | 52.47% |
| Grand multipara\*\*\* | 116 | 22.05% |
| Total | 526 | 100% |

\*: First pregnancy

\*\*: Delivered 2 to 4 times.

\*\*\*.: Delivered 5 times or more.

**Table (3): Gestational age**

|  |  |  |
| --- | --- | --- |
| Variables | Range | Average |
| Gestational age | 28-40 | 34 |

**Table (4): Indications for caesarean section**

|  |  |  |
| --- | --- | --- |
| Indications for caesarean section | Number | Incidence |
| fetal distress | 45 | 25.28%, |
| failure to progress | 72 | 40.4% |
| previous caesarean section | 61 | 34.2% |
| Total | 178 | 100% |

**Table (4): Fetal complications**

|  |  |  |
| --- | --- | --- |
| complication | Number | Incidence |
| NICU admission | 53 | 10.07%, |
| respiratory distress | 12 | 2.28% |
| neonatal sepsis | 27 | 5.13% |

**Table (5): Maternal complications**

|  |  |  |
| --- | --- | --- |
| complication | Number | Incidence |
| , Chorioamnitis | 3 | 0.57% |
| postpartum hemorrhage | 61 | 11.59% |
| Puerperal pyrexia | 45 | 8.55% |

**4. Discussion**

Premature rupture of membranes is not uncommon yet the management, even at term, the management is controversial. When a pregnancy reaches term, women normally expect labour to begin spontaneously, without medical or surgical assistance. However, for approximately more than 8% ofwomen, the membrane ruptures but labour does not begin spontaneously within the next few hours. Because the risk of maternal and fetal infection is known to increase risk of maternal and fetal infection is known to increase risk of maternal and fetal infection is known to increase with increasing duration. In majority of the reports, where immediate induction with misoprostol was done, the latency period was significantly shorter, hence the duration of labor and hospitalization period were reduced. However, expectant management was another approach used where in, the operative intervention rate was lesser, without rise in the perinatal and maternal complications. (8)

The results of the present study showed the age of the patients ranged from 20-37 years with average age 28.5 year, This was comparable to the study done by Rajanietal (9) who found that The mean age of PROM patients was 24.00±2.77 years. As regard the parity of the patients 25.47% were primigravida this results is less than results reported by Rajanietal (9) who found that 54% were primigravida. In the present study, vaginal deliveries were noted in 61.72%. cases. Sanyal MK et al reported 87% vaginal deliveries in PROM cases. (10)

In the present study, caesarean section incidence (38.27%), this incidence is high in relation to the caesarean section rates reported by different authors in PROM patients which are as follows: Schreiber J et al-24% (11), Spinnato JA-15.4%(12), Egan et al-8% in primigravida, 2% in multigravida. (13) may be due to increase incidence of caesarean section. In the present study, the indications for caesarean section were fetal distress with incidence 25.28%, failure to progress with incidence (40.4%) and previous caesarean section (s) with incidence (34.2%) This was comparable to the study done by Rajanietal (9) who found that most common indication of caesarean section was meconium stained liquor/nonreassuringfoetal heart rate.

In this study NICU admission was seen in 10.07%, this results in agree with Rajanietal (9) who found that NICU admission was seen in 10% neonates of expectant management of PROM patients.

**Conclusion:**

PROM once has occurred, controversy lies regarding whether or not to deliver the baby at that particular gestational age. The concern is that, not delivering the baby exposes the fetus to the risk of infection. Alternately, delivering the baby increases the risk of prematurity and its risk. So careful identification of present or impending complications, and individualizing the management based on gestational age and the presence or likelihood of these complications currently holds best hopes for optimizing fetomaternal outcome in PROM patients.

**References**

1. Duff P. Premature rupture of membranes in term patients: induction of labour versus expectant management. Clin Obstet Gynecol. 1998; 41:883-91.
2. McParland PC, Taylor DJ, Bell SC. Mapping of zones of altered morphology and choriodeciduaic connective tissue cellular phenotype in human fetal membranes (amnion and deciduas) overlying the lower uterine pole and cervix before labor at term. Am J Obstet Gynecol. 2003Nov;189(5):1481-8.
3. Bennett KA, Butt K, Crane JM, Hutchens D, Young DC. A masked randomized comparison of oral and vaginal administration of misoprostol for labour induction. Obstet Gynecol. 1998;92 (4 pt 1):48-6.
4. Tejero E, Perichart O, Pfeffer F, Casanueva E, Vadillo-Ortega F. Collagen synthesis duringpregnancy, vitamin C availability, and risk of premature rupture of fetal membranes. Int JGynaecol Obstet. 2003;81(1):29-34.
5. Niknejad H, Peirovi H, Jorjani M, Ahmadiani A, Ghanavi J, Sefalian M. Properties Of The amniotic membrane for potential use in tissue engineering. European Cells and Materials. 2008; 15:88-9.
6. Larranaga-Azcarate C, Campo-Molina G, Perez- Rodriguez AF. Dinoprostone vaginal slow release system compared to expectant management in the active treatment of PROM at term: impact on maternal and foetal outcome. Actaobstetrica. 2008; 87:195-200.
7. Ozden S, Delikara MN, Avci A. Intravaginal misoprostol vs expectant management in PROM with low Bishop scores at term. Int J obstet. 2002;77:109-15.
8. Savitha T. S., Pruthvi S., Sudha C. P., Vikram S. Nadig A comparative study of feto-maternal outcome in expectant management versus active management in pre-labor rupture of membranes at term *Int J Reprod Contracept Obstet Gynecol. 2018 Jan;7(1):146-151.*
9. Rajani Rawat, Pragati Divedi\*, Sukla Debbarma, Soniya Vishwakarma, Nupur Mitta A comparative study between active and expectant management of premature rupture of membranes at term on fetomaternal and perinatal outcome in rural population *Int J Reprod Contracept Obstet Gynecol. 2018 Jun;7(6):2393-2398.*
10. Sanyal MK, Mukherjee TN. Premature rupture of membranes an assessment from a rural medical college of West Bengal. J Obstet Gynaecol India. 1990; 40(5):623-8.
11. Schreiber J, Benedetti T. Conservative management of preterm premature rupture of the fetal membranes in a low socioeconomic population. Am J Obstet Gynecol. 1980 Jan;136(1):92-6.
12. Spinnato JA, Shaver DC, Bray EM, Lipshitz J. Preterm premature rupture of the membranes with fetal pulmonary maturity present: A prospective study. Obstet Gynecol. 1987 Dec;25(6):489.
13. Egan D, O’hlerlihy C. Expectant management of spontaneous rupture of membranes at term. J Obstet Gynaecol. 1988 Jan;8(3):243-7.

6/25/2018