**UC Preivable PPROM Protocol**

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

Per UC MFM PROM Protocol (Oct 2017): For any evidence of chorioamnionitis or maternal compromise, deliver regardless of gestational age. For patients with preivable PPROM less than 20w0d immediate delivery should be offered. For patients in the perivable period, 20w0d to 25w6d, consult MFM for individualized care counseling and recommendations.

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

**Rationale:** Preivable premature rupture of membranes (PPROM) is associated with maternal and perinatal morbidity and mortality. Preivable PPROM 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 found that expectant management of preivable PPROM is associated with significant morbidity in one in seven women. Given this risk, ACOG and SMFM recommend offering pregnancy termination in the setting of preivable PPROM to mitigate the potential for maternal and perinatal morbidity and mortality.

In compliance with Ohio state laws and the UC Health Abortion Policy, pregnancy termination can be performed when a medical emergency exists. 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**
   - Rooming and vital signs per RN protocol
   - Evaluation by triage resident including physical exam, cervical exam
   - Rupture of membranes confirmation: exam, microscopy, amnisure
   - Ultrasound: fetal biometry (BPD), placenta location, AFI
   - Cervical dilation

2. **Confirmed previable PPROM**
   - Thorough counseling by OB resident and attending on management options
   - Consultation from MFM and NICU depending on patient request

3. **Family Planning Consult**
   - For patients who desire pregnancy termination, please consult with Family Planning prior to offering D&E or IOL. If one of the physicians below is NOT on L&D, please call to see availability prior to offering services.
     - First call: Meredith Pensak (513-509-7246)
     - Second call: Priya Gursahaney (330-283-9509)
     - Third call: Marianne DiNapoli (518-588-2175)

4. **Patient desires pregnancy termination**
   - Thorough counseling on D&E versus IOL
     - Counseling note templates are available as EPIC smartphrases
   - Under the rare circumstances that none of Family Planning providers trained to perform D&E are physically available, patients can be referred to Planned Parenthood for care.
     - Sharon Liner, Medical Director
     - Vanessa Hinsdale, Surgery Manager

5. **Paperwork**
   - Use smartphrases in EPIC for standard documentation “.fp”
   - Operative notes should be done 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 administrator*
   - Copies of the H&P and additional attending progress notes need to be printed and given to the Family Planning administrator for submission to the Ethics Committee within 48 hours

*Contact information for Family Planning administrator forthcoming, for now please submit ALL paperwork to Meredith Pensak.
All Patients:

- In compliance with UC Health Abortion Policy: the medical staff 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.
  - Offer patient ODA consult if they desire social support or specific disposition of the remains such as private burial/cremation. ODA is available 24 hours/day
  - Offer patient genetic studies including karyotype and microarray
  - Discuss return of fertility and offer contraception

Patients that desire D&E:

- Obtain labs: CBC, T&S, place IV
- Add on to main OR, notify OR staff that this case is for pregnancy termination due to medical necessity
- Admit to antepartum until OR time
- NPO/IVF
- Consider inpatient Anesthesia consult if indicated
- Cervical prep (subject to change pending attending preference and clinical picture):
  - Patients < 13 weeks no cervical prep is needed and can proceed directly with procedure
  - Patients 13 > 16/17 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
    - Dilapan Supplies:
      - Sterile metal speculum
      - Single tooth Tenaculum
      - Ring forcep
      - Gauze
      - 20 cc syringe with 22-gauge spinal needle
      - 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

- Transfer to SDS/PACU pre-procedure
- Complete procedure in main OR. Have ultrasound available
- Transfer back to antepartum
- Discharge home
- Discharge Instructions
- Use Dr. Pensak’s 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 weeks for postop visit with provider that did D&E. If patient is not UCMC patient, offer follow up at UCMC if patient desires

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

References:

UC Health Abortion Policy (UCH-PCS-ADMIN-007-02)
Ohio SB 127 (enacted 2017)
Ohio HB 153 (Budget--2011)