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prelabour rupture of membranes

Rupture prématurée des membranes : évaluation de l'acupuncture

Systematic Reviews and Meta-Analysis

1.1. Generic Acupuncture

1.1.1. Middleton 2017

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 Syst Rev. 2017;:. [195003].

Background	Prelabour rupture of membranes (PROM) at term is managed expectantly or by planned early birth. It is not clear if waiting for birth to occur spontaneously is better than intervening, e.g. by inducing labour.
Objectives	The objective of this review is to assess the effects of planned early birth (immediate intervention or intervention within 24 hours) when compared with expectant management (no planned intervention within 24 hours) for women with term PROM on maternal, fetal and neonatal outcomes.
Methods	Search methods: We searched Cochrane Pregnancy and Childbirth's Trials Register (9 September 2016) and reference lists of retrieved studies. Selection CRITERIA: Randomised or quasi-randomised controlled trials of planned early birth compared with expectant management (either in hospital or at home) in women with PROM at 37 weeks' gestation or later. Data collection and analysis: Two review authors independently assessed trials for inclusion, extracted the data, and assessed risk of bias of the included studies. Data were checked for accuracy.

Main results	Twenty-three trials involving 8615 women and their babies were included in the update of this review. Ten trials assessed intravenous oxytocin; 12 trials assessed prostaglandins (six trials in the form of vaginal prostaglandin E2 and six as oral, sublingual or vaginal misoprostol); and **one trial each assessed Caulophyllum and acupuncture**. Overall, three trials were judged to be at low risk of bias, while the other 20 were at unclear or high risk of bias. Primary outcomes: women who had planned early birth were at a reduced risk of maternal infectious morbidity (chorioamnionitis and/or endometritis) than women who had expectant management following term prelabour rupture of membranes (average risk ratio (RR) 0.49; 95% confidence interval (CI) 0.33 to 0.72; eight trials, 6864 women; $Tau^2 = 0.19$; $I^2 = 72\%$; low-quality evidence), and their neonates were less likely to have definite or probable early-onset neonatal sepsis (RR 0.73; 95% CI 0.58 to 0.92; 16 trials, 7314 infants;low-quality evidence). No clear differences between the planned early birth and expectant management groups were seen for the risk of caesarean section (average RR 0.84; 95% CI 0.69 to 1.04; 23 trials, 8576 women; $Tau^2 = 0.10$; $I^2 = 55\%$; low-quality evidence); serious maternal morbidity or mortality (no events; three trials; 425 women; very low-quality evidence); definite early-onset neonatal sepsis (RR 0.57; 95% CI 0.24 to 1.33; six trials, 1303 infants; very low-quality evidence); or perinatal mortality (RR 0.47; 95% CI 0.13 to 1.66; eight trials, 6392 infants; moderate-quality evidence). SECONDARY OUTCOMES: women who had a planned early birth were at a reduced risk of chorioamnionitis (average RR 0.55; 95% CI 0.37 to 0.82; eight trials, 6874 women; $Tau^2 = 0.19$; $I^2 = 73\%$), and postpartum septicaemia (RR 0.26; 95% CI 0.07 to 0.96; three trials, 263 women), and their neonates were less likely to receive antibiotics (average RR 0.61; 95% CI 0.44 to 0.84; 10 trials, 6427 infants; $Tau^2 = 0.06$; $I^2 = 32\%$). Women in the planned early birth group were more likely to have their labour induced (average RR 3.41; 95% CI 2.87 to 4.06; 12 trials, 6945 women; $Tau^2 = 0.05$; $I^2 = 71\%$), had a shorter time from rupture of membranes to birth (mean difference (MD) -10.10 hours; 95% CI -12.15 to -8.06; nine trials, 1484 women; $Tau^2 = 5.81$; $I^2 = 60\%$), and their neonates had lower birthweights (MD -79.25 g; 95% CI -124.96 to -33.55; five trials, 1043 infants). Women who had a planned early birth had a shorter length of hospitalisation (MD -0.79 days; 95% CI -1.20 to -0.38; two trials, 748 women; $Tau^2 = 0.05$; $I^2 = 59\%$), and their neonates were less likely to be admitted to the neonatal special or intensive care unit (RR 0.75; 95% CI 0.66 to 0.85; eight trials, 6179 infants), and had a shorter duration of hospital (-11.00 hours; 95% CI -21.96 to -0.04; one trial, 182 infants) or special or intensive care unit stay (RR 0.72; 95% CI 0.61 to 0.85; four trials, 5691 infants). Women in the planned early birth group had more positive experiences compared with women in the expectant management group. No clear differences between groups were observed for endometritis; postpartum pyrexia; postpartum antibiotic usage; caesarean for fetal distress; operative vaginal birth; uterine rupture; epidural analgesia; postpartum haemorrhage; adverse effects; cord prolapse; stillbirth; neonatal mortality; pneumonia; Apgar score less than seven at five minutes; use of mechanical ventilation; or abnormality on cerebral ultrasound (no events).None of the trials reported on breastfeeding; postnatal depression; gestational age at birth; meningitis; respiratory distress syndrome; necrotising enterocolitis; neonatal encephalopathy; or disability at childhood follow-up. In subgroup analyses, there were no clear patterns of differential effects for method of induction, parity, use of maternal antibiotic prophylaxis, or digital vaginal examination. Results of the sensitivity analyses based on trial quality were consistent with those of the main analysis, except for definite or probable early-onset neonatal sepsis where no clear difference was observed.

Authors' conclusions	There is low quality evidence to suggest that planned early birth (with induction methods such as oxytocin or prostaglandins) reduces the risk of maternal infectious morbidity compared with expectant management for PROM at 37 weeks' gestation or later, without an apparent increased risk of caesarean section. Evidence was mainly downgraded due to the majority of studies contributing data having some serious design limitations, and for most outcomes estimates were imprecise. Although the 23 included trials in this review involved a large number of women and babies, the quality of the trials and evidence was not high overall, and there was limited reporting for a number of important outcomes. Thus further evidence assessing the benefits or harms of planned early birth compared with expectant management, considering maternal, fetal, neonatal and longer-term childhood outcomes, and the use of health services, would be valuable. Any future trials should be adequately designed and powered to evaluate the effects on short- and long-term outcomes. Standardisation of outcomes and their definitions, including for the assessment of maternal and neonatal infection, would be beneficial.

2. Clinical Practice Guidelines

⊕ positive recommendation (regardless of the level of evidence reported)
Ø negative recommendation (or lack of evidence)

2.1. Collège national des gynécologues et obstétriciens français (CNGOF, France) 2020 Ø

Sibiude J. Rupture des membranes à terme avant travail. Recommandations pour la pratique clinique du CNGOF — Faut-il déclencher ? [Term Prelabor Rupture of Membranes: CNGOF Guidelines for Clinical Practice - Timing of Labor Induction]. Gynecol Obstet Fertil Senol. 2020;48(1):35-47. [214606].

In case of term prelabor rupture of membranes, induction of labor is associated with shorter rupture of membranes to delivery intervals when compared to expectant management, if induction is conducted with oxytocin (LE2), prostaglandin E2 (LE2) or misoprostol (LE2), but not when induction is conducted with Foley® catheter (LE2), osmotic dilatator (LE2) or **acupuncture (LE2)**.