THE IMPACT OF PREMATURE RUPTURE OF MEMBRANES ON MATERNAL AND FETAL OUTCOME DURING LABOUR

THESIS

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of Ain Shams University in Partial Fulfillment
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and Gynecological Nursing

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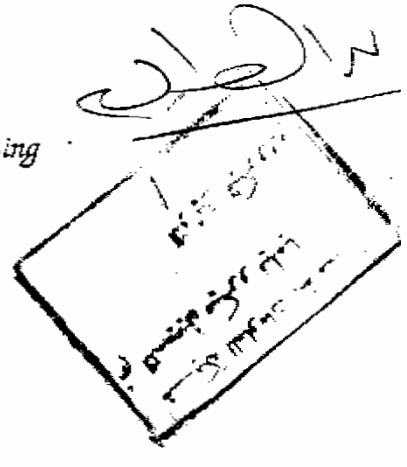

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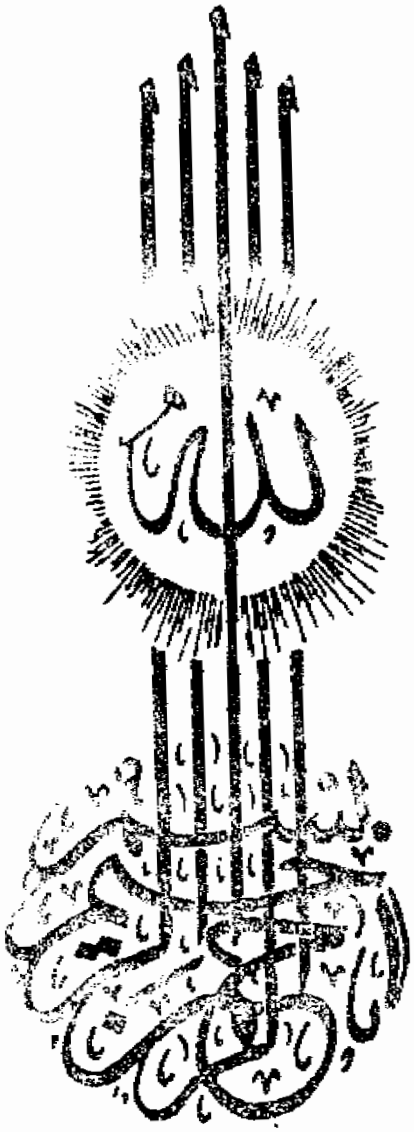

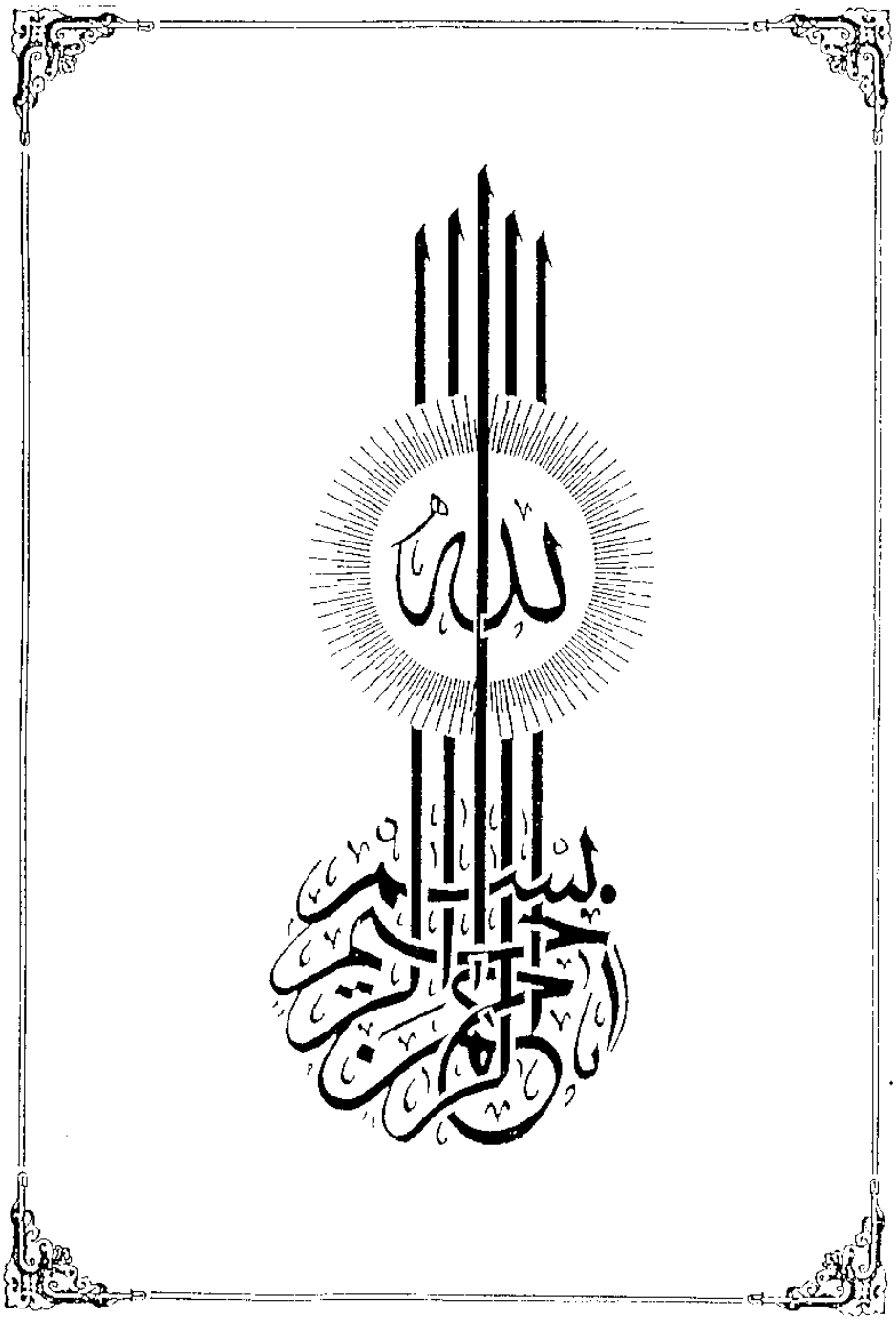

بسم الله الرحمن الرحيم

اللَّهُ لَا إِلَٰهَ إِلَّا هُوَ الْحَيُّ الْقَيُّومُ ۚ لَا تَأْخُذُهُ سِنَةٌ وَلَا نَوْمٌ ۚ
لَهُ مَا فِي السَّمَاوَاتِ وَمَا فِي الْأَرْضِ ۗ مَنْ ذَا الَّذِي يَشْفَعُ عِنْدَهُ
إِلَّا بِإِذْنِهِ ۚ يَعْلَمُ مَا بَيْنَ أَيْدِيهِمْ وَمَا خَلْفَهُمْ ۖ وَلَا يُحِيطُونَ
بِشَيْءٍ مِنْ عِلْمِهِ إِلَّا بِمَا شَاءَ ۚ وَسِعَ كُرْسِيُّهُ السَّمَاوَاتِ وَالْأَرْضَ ۖ
وَلَا يَئُودُهُ حِفْظُهُمَا ۚ وَهُوَ الْعَلِيُّ الْعَظِيمُ

صدق الله العظيم
سورة البقرة - الآية ٢٥٥

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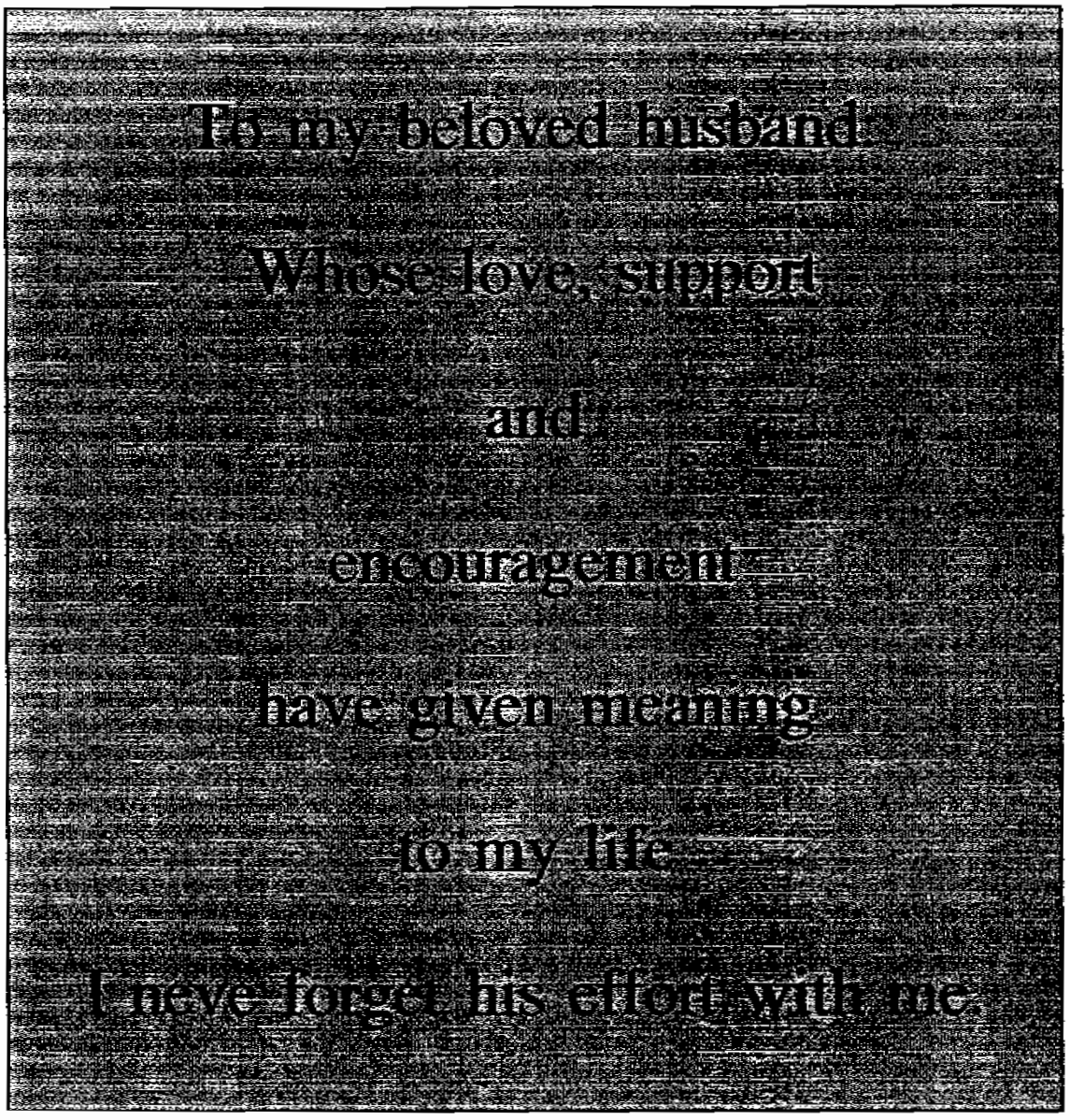
Soad Abd El Salam


To my beloved husband
Whose love, support
and
encouragement
have given meaning
to my life
I never forget his effort with me.

CONTENTS

INTRODUCTION

Introduction

Preterm premature rupture of membranes is an obstetrics emergency, which is defined as the disruption of the amnion and chorion with resultant leakage of the amniotic fluid prior to the onset of labour at gestational age < 37 completed weeks (Oddilon, 1984). The incidence of preterm premature rupture of membranes ranges from (4.5 to 7.6 %) of total deliveries in U.S.A. as stated by (Sweet and Gibbs, 1985), but according to recent reports, the incidence of preterm premature rupture of membranes occurs in approximately 1% of all pregnancies and it is associated with 30 to 40 % of preterm births and perinal death *(Ohlsson and wang, 1990).*

When preterm premature rupture of the membranes is associated with prolonged latent period, both maternal and fetal welfare are endangered (Grum, 1980). The major maternal dangerous, that associated with preterm premature rupture of membranes, are the development of choriomnionitis with subsequent pelvic inflammatory disease. The possibility of peritonitis and maternal sepsis. (Lawersen, 1983).

(Levine CD; 1991) done analysis revealed that pretrerm births are complicated by preterm premature rupture of membranes were at significantly higher risk of neonatal sepsis and infection.

Although, preterm premature rupture of membranes is considered as one of the most common obstetrics emergency, there is limited understanding of that basic patho physiology of preterm premature rupture of membranes and little certainly for the most favorable course of action. Despite, there is for from unanimity of though concerning optiomal management of pregnancies complicated by rupture of membranes, standard management is aimed to preventing neonatal and maternal infection. (Gibbs et.al., 1982).

The intact membranes are considered to be a barrier to infection of amniotic fluid. (Nelsen and Hokegard, 1983).

The current management protocols for preterm premature rupture of membranes adopt a conservative and expectant approach to allow fetal maturity unless evidence of maternal or fetal infection dictetes delivery. (Rotchild, 1990). The use of antibiotics in the management of preterm premature rupture of membranes remains controversial, by use of prospective randomized double-blind design. They investigated the maternal fetal benefits associated with antibiotics therapy in 85 women with preterm premature rupture of membranes at 34 weeks estimated gestational age. In the treatment group 40 patients received intravenous mezlocillin until delivery. In the control group 45 patients received intravenous and oral placebo, patients, who received antibiotics had choriommnionities and endometritis less frequently than the control group (Johnston, 1990). The nurse plays as prominent role in the treatment of preterm premature

rupture of membranes, so once, the diagnosis of preterm pre mature rupture of membranes is made. An initial evaluation must be done to accertain the optional nursing care of patient should start immediately to avoid risk of infection from both foetus and mother which include sterile cotton pads is applied after perineal care is carried out, and offer comfortable measures for mother with monitoring to maternal and fetal condition as reported by (Keneth 1980).

Vaginal examination was avoided before labour to minimize the risk of infection. Oxytocin was not used for induction, and the spontaneous onset of labour was awaited. They suggested that a waiting the spontaneous ouset of labour can, safely, achieve a high rate of vaginal delivery and avoid the need to induce labour with oxytocin. (Carroll et. al., 1990). The management of patients with preterm premature rupture of membranes, therefore, should start with a speculum examination to document the diagnosis and rule out cord prolapse. patients should, then, be studied continuously with external electronic F.H.S. monitoring and observed for 24 hours. If she becomes infected during that interval labour must be induced immediately. (Thomas, 1985).

AIM OF THE STUDY

Aim of the Study

1. To estimate the effect of preterm premature rupture of membranes on maternal out come.

2. To estimate the effect of preterm premature rupture of membranes on fetal out come.

3. To identify the causes of preterm premature rupture of membranes.

Hypothesis:

The present study is built upon the following assuptions and hypothesis:

1. Preterm premature rupture of membranes will be expected to cause low "Apgar Score" in one minute.

2. The mother with preterm premature rupture of membranes will be expected elevation of maternal temperature with long time of rupture of membranes..

3. The most of pregnant mother with pre term premature rupture of membranes will be delivered by C.S.