Vi□t b□i Biên t□p viên
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BS Nguy□n Th□ Ki□u Trinh -□

I.Đ□I C□□NG

1. Đ□nh nghĩa

□i v□ non (PROM: prelabor rupture of membranes) là □i v□ tr□□c khi chuy□n d□. □i v□ tr□□c khi chuy□n d□ x□y ra tr□□c tu□n th□ 37 c□a thai k□ đ□□c g□i là □i v□ non □ thai non tháng (PPROM: Preterm prelabor rupture of membranes). Qu□n lý PPROM và □i v□ non □ thai đ□ tháng ph□ thu□c vào tu□i thai, s□ hi□n di□n c□a các y□u t□ ph□c t□p nh□ nhi□m trùng lâm sàng, nhau bong non, chuy□n d□ ho□c xét nghi□m thai nhi b□t th□□ng. Đánh giá chính xác v□ tu□i thai, các y□u t□ c□a m□, thai nhi và nguy c□ s□ sinh là c□n thi□t đ□ đánh giá thích h□p, t□ v□n, chăm sóc b□nh nhân □i v□ non.

2. Nguyên nhân và các y□u t□ nguy c□

□i v□ non có th□ x□y ra vì nhi□u lý do. M□c dù màng □i v□ có th□ x□y ra do s□ suy y□u sinh lý bình th□□ng c□a màng □i k□t h□p v□i áp l□c c□n co t□ cung, PPROM có th□ là k□t qu□ c□a m□t lo□t các nguyên nhân c□ ch□ b□nh lý ho□t đ□ng riêng l□ ho□c ph□i h□p. Nhi□m trùng □i đã đ□□c ch□ng minh th□□ng liên quan đ□n PPROM đ□c bi□t là □ tu□i thai càng non tháng.

Ti□n s□ PPROM là y□u t□ nguy c□ chính c□a PROM ho□c sinh non. Các y□u t□ nguy c□ khác liên quan đ□n PPROM t□□ng t□ nh□ nh□ng tr□□ng h□p liên quan đ□n sinh non t□ phát và bao g□m chi□u dài c□ t□ cung ng□n, ra máu trong tam cá nguy□t th□ hai và th□ ba, ch□ s□ kh□i c□ th□ th□p, tình tr□ng kinh t□ xã h□i th□p, hút thu□c lá và s□ d□ng ma túy. Đôi khi PPROM cũng không bi□t đ□□c nguy c□ y□u t□ ho□c nguyên nhân rõ ràng.

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Prelabor Rupture of Membranes

Preterm birth occurs in approximately 10% of all births in the United States and is a major contributor to perinatal morbidity and mortality (1–3). Prelabor rupture of membranes (PROM) that occurs preterm complicates approximately 2–3% of all pregnancies in the United States, representing a significant proportion of preterm births, whereas term PROM occurs in approximately 8% of pregnancies (4–6). The optimal approach to assessment and treatment of women with term and preterm PROM remains challenging. Management decisions depend on gestational age and evaluation of the relative risks of delivery versus the risks (eg, infection, abruptio placentae, and umbilical cord accident) of expectant management when pregnancy is allowed to progress to a later gestational age. The purpose of this document is to review the current understanding of this condition and to provide management guidelines that have been validated by appropriately conducted outcome-based research when available. Additional guidelines on the basis of consensus and expert opinion also are presented. This Practice Bulletin is updated to include information about diagnosis of PROM, expectant management of PROM at term, and timing of delivery for patients with preterm PROM between 34 0/7 weeks of gestation and 36 6/7 weeks of gestation.

Background

The definition of *prelabor rupture of membranes* is rup-

tractions, preterm PROM can result from a wide array of pathologic mechanisms that act individually or in concert (7, 8). Intraamniotic infection has been shown to be com-

Box 1. Management of Prelabor Rupture of Membranes by Gestational Age Categories in Patients With Normal Antenatal Testing

Term (37 0/7 weeks of gestation or more)

- GBS prophylaxis as indicated
- Treat intraamniotic infection if present
- Proceed toward delivery (induction or cesarean as appropriate/indicated)

Late Preterm (34 0/7–36 6/7 weeks of gestation)

- Expectant management or proceed toward delivery (see text) (induction or cesarean as appropriate/indicated)
- Single-course of corticosteroids, if steroids not previously given, if proceeding with induction or delivery in no less than 24 hours and no more than 7 days, and no evidence of chorioamnionitis*
- GBS screening and prophylaxis as indicated
- Treat intraamniotic infection if present (and proceed toward delivery)

Preterm (24 0/7–33 6/7 weeks of gestation)

- Expectant management
- Antibiotics recommended to prolong latency if there are no contraindications
- Single-course of corticosteroids; insufficient evidence for or against rescue course
- Treat intraamniotic infection if present (and proceed to delivery)
- A vaginal–rectal swab for GBS culture should be obtained at the time of initial presentation and GBS prophylaxis administered as indicated.
- Magnesium sulfate for neuroprotection before anticipated delivery for pregnancies <32 0/7 weeks of gestation, if there are no contraindications†

Periviable (Less than 23–24 weeks of gestation)‡,§

- Patient counseling; consider neonatology and maternal–fetal medicine consultation
- Expectant management or induction of labor
- Antibiotics may be considered as early as 20 0/7 weeks of gestation
- GBS prophylaxis is not recommended before viability‖
- Corticosteroids are not recommended before viability‖
- Tocolysis is not recommended before viability‖
- Magnesium sulfate for neuroprotection is not recommended before viability†,‖

Abbreviation: GBS, group B streptococci.
*Do not delay delivery for steroids; steroids should not be administered for an imminent cesarean birth.
†Magnesium sulfate for neuroprotection in accordance with one of the larger studies.
‡The combination of birth weight, gestational age, and sex provide the best estimate of chances of survival and should be considered in individual cases.
§Periviable birth. Obstetric Care Consensus No. 6. American College of Obstetricians and Gynecologists. 2017;130:187–99.
‖May be considered for pregnant women as early as 23 0/7 weeks of gestation.

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