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# When your waters break early (preterm prelabour rupture of membranes) - information for you

This information is also available as a pdf: [When your waters break early \(preterm prelabour rupture of membranes\): Information for you](#) <sup>[1]</sup>.

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## How will I know if my waters have broken?

You may notice a 'gush' of fluid or you may feel damp. The fluid (known as amniotic fluid) is a clear or pinkish colour. It may be slightly blood stained. The amount of fluid you lose may vary from a trickle to a gush. This usually happens once labour has started. If it happens between 24 weeks and 37 weeks, it means that your waters have broken earlier than normal. Two out of every 100 women (2%) experience this during pregnancy.

Breaking of the waters is also known as rupture of the membranes. If your waters break early, it is also referred to as preterm prelabour rupture of membranes.

## What should I do?

If you think that you are leaking fluid from the vagina, it is advisable to wear a sanitary pad (not a tampon) and monitor the colour and smell of the fluid, as well as how much is leaking. Sometimes the leaking fluid is urine. Leaking urine can be normal during pregnancy. Leaking amniotic fluid smells different from the smell of urine. If you think the fluid is amniotic fluid, contact your local hospital.

## What happens at the hospital?

You will have a careful check-up which may include:

- a discussion with your doctor or midwife about whether you have experienced this in a previous pregnancy (if it has happened before, it is more likely to happen again)
- a vaginal inspection. Your doctor or midwife will use a speculum to look at your cervix (entrance to the uterus) and see if the leaking fluid is amniotic fluid. Your doctor will also be able to see if the cervix is changing in preparation for labour
- a specific test of the fluid to help decide if the waters have broken. These tests are not 100% accurate
- an ultrasound scan to see the amount of fluid around the baby

- a check of the baby's heartbeat.

If your waters have not broken, you may be able to go home. If only a very small amount of amniotic fluid leaks at first, it is not always easy to confirm that your waters have broken. If you continue to leak fluid at home, you should return to the hospital for a further check-up.

If the check-up shows that your waters have broken, you may be advised about:

- admission into hospital
- regular monitoring of the baby
- regular monitoring for signs of labour
- regular tests and monitoring for infection including having your temperature and pulse taken
- a blood test
- a vaginal swab (the results of your swab may indicate the presence of a common vaginal infection called group B streptococcus or GBS (see [RCOG Patient Information Preventing Group B streptococcus ? information for you](#) <sup>[2]</sup>).

## What caused it?

For most women, the reason their waters have broken early is not known.

The baby is surrounded by fluid within a bag of membranes. The vagina is not sterile and always contains healthy bacteria. There is a link between waters breaking and the growth of certain types of bacteria in the vagina. These bacteria produce enzymes that can weaken the membranes and cause the waters to break too soon and fluid to leak out.

It is unlikely that:

- anything you did caused your waters to break early
- anything could have been done to prevent this from happening.

## What could this mean for me and for my baby?

### Spontaneous vaginal delivery (preterm birth)

Most women go into labour spontaneously within 24 to 48 hours of their waters breaking. However, the chance of this happening is increased when infection is present.

### Infection

The membranes form a protective barrier around the baby and after these have broken, there is a risk of bacteria and infection getting into the uterus (womb). When infection gets into the uterus it is known as chorioamnionitis and this can trigger a preterm birth.

The symptoms of infection may include a raised temperature, an unusual vaginal discharge with an unpleasant smell, a fast pulse rate and/or abdominal (uterine) pain. Your baby's heart rate may be faster than normal.

Once you have an infection, your baby may need to be born soon to prevent a more serious infection.

### Lung development

The amniotic fluid which surrounds the baby is needed for the baby's lungs to develop. If the waters break

very early, there may not be enough fluid for your baby's lungs to develop normally.

## **Prematurity**

If your baby is likely to be born early, you should be given full information about what this might mean for your baby's health and development.

Premature babies (born before 37 weeks) can have an increased risk of health problems, particularly with breathing, feeding and infection.

Babies born before 34 weeks tend to have a higher risk of severe breathing problems, which may require intensive support.

Problems are even more severe when a baby is born before 28 weeks of pregnancy. Those premature babies with a problem will be cared for in hospital. In some cases the hospital might move you and/or your baby to a special care baby unit in a different hospital to give your baby more specialist care.

## **What if my waters have broken before 24 weeks?**

If your waters have broken before 23 to 24 weeks of pregnancy and you give birth, sadly, it is unlikely that your baby will survive. Babies who do survive are likely to have serious health problems. The possible treatment and outcomes for your baby will be discussed with you by an experienced paediatrician (a doctor specialising in the care of babies and children).

## **What treatment can I have?**

There is no treatment that can replace the fluid or repair the hole in the membranes of the amniotic sac. The baby's kidneys will continue to produce amniotic fluid even if the waters are broken. You may leak fluid for the rest of the pregnancy.

The purpose of treatment is to monitor for signs of infection and help get ready for birth. You may be offered:

- a course of antibiotics to treat and/or lower the risks of infection and the associated problems. These antibiotics will not harm your baby
- steroid injections (corticosteroids) to help the baby's lungs mature for breathing
- medication (tocolysis) to stop contractions and reduce the risk of the baby being born too early. Tocolysis is not routinely given. It is used if you need to be transferred to a hospital where there is a cot on a neonatal intensive care unit. It may also be used if more time is needed for the steroids to work.

## **When can I go home?**

If your waters have broken, you may be advised that you need to stay in hospital until the baby is born. However, going home may be an option if you can return to the hospital easily. You will need to check for signs of infection at home.

## **What should I do at home?**

Your doctor will have a full discussion about the signs of infection to watch for. It is very important that you:

- check that your temperature is normal twice daily (a normal temperature is 37.0 degrees Celsius or less)
- check the colour of the fluid does not change (see below). You should wear a sanitary pad rather than a tampon
- avoid vaginal intercourse.

You will be asked to come to the hospital at least once a week for a check-up. This may involve:

- a blood test to measure white cell count (white cells fight infection and increase if infection is developing)
- a vaginal swab to see if any unhealthy bacteria are present
- monitoring the baby's heart rate
- depending on your hospital, an ultrasound scan to look at the amount of amniotic fluid around the baby and the blood flow to the baby (Doppler scan).

## When should I call for help?

Contact your doctor and/or return to the hospital immediately if you experience any of the following:

- raised temperature (more than 37°C)
- if you are worried that the baby is not moving as normal
- flu-like symptoms (feeling hot and shivery and achy)
- vaginal bleeding
- if the leaking fluid becomes greenish or smelly
- abdominal pain
- contractions.

## What are my options for giving birth?

Your doctors should discuss your options for giving birth. Continuing with the pregnancy may increase the risk of infection (chorioamnionitis). However, it reduces the risk of problems relating to a premature baby.

Depending on your situation, your choices may include:

- continued monitoring of you and the baby until you give birth naturally
- being induced at between 34 and 37 weeks of pregnancy. You will be given pessaries (vaginal tablets) or a drip to start your labour. Being induced increases your chance of needing a caesarean section.

A [glossary of all medical terms is available](#) <sup>[3]</sup>.

## Sources and acknowledgements

This information is based on the Royal College of Obstetricians and Gynaecologists (RCOG) guideline Preterm Prelabour Rupture of Membranes (published by the RCOG in November 2006). This information will also be reviewed, and updated if necessary, once the guideline has been reviewed. The guideline contains a full list of the sources of evidence we have used. You can find it [online here](#) <sup>[4]</sup>.

Clinical guidelines are intended to improve care for patients. They are drawn up by teams of medical professionals and consumer representatives who look at the best research evidence available and then make recommendations based on this evidence. This information has been developed by the Patient Information Subgroup of the RCOG Guidelines and Audit Committee, with input from the Consumers? Forum and the authors of the clinical guideline. It was reviewed prior to publication by women attending clinics in London, Dublin and Brighton. The final version is the responsibility of the Guidelines and Audit Committee of the RCOG.

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## **A final note**

The Royal College of Obstetricians and Gynaecologists produces patient information for the public. This is based on guidelines which present recognised methods and techniques of clinical practice, based on published evidence. The ultimate judgement regarding a particular clinical procedure or treatment plan must be made by the doctor or other attendant in the light of the clinical data presented and the diagnostic and treatment options available. The RCOG consents to the reproduction of this document provided that full acknowledgement is made.

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