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EDİTÖRE MEKTUP/LETTER TO THE EDITOR

Successful treatment of preterm premature rupture of membranes

Preterm erken membran rüptürünün başarılı yönetimi

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Dear Editor,

Preterm premature rupture of membranes (PPROM) occurs in approximately 2% of all pregnancies and responsible for one third of all preterm births. PPROM is an important cause of prematurity and the reported recurrence rate ranges from 14% to 21%[1]. PPROM is associated with both maternal and neonatal infection. Although the management of PPROM remains undefined antimicrobial treatment in expectant mamagement is common. We report one case of treatment of PPROM at 25 weeks' gestation.

A- 30 year old woman G1P0 at 25 weeks of gestation admitted to our outpatient clinic for vaginal bleeding and rupture of membranes. Our ultrasound examination confirmed a vital fetus of 650 g in the 25 weeks of pregnancy, presence of oligohydramnios. Pooling of amniotic fluid was detected by sterile speculum examination. She had normal haematological and biochemical parameters with normal body temperature (36.6°C).

First of all we started prophylactic treatment of chorioamnionitis with ampicillin–sulbactam (1 g every 6 hours). Betamethasone was administered prophylactically in two doses 24 h apart to stimulate lung maturation in anticipation of possible preterm delivery. Complete blood count, routine biochemical investigation, C-reactive protein and sedimentation were carried out within following days. Uterine tenderness, elevated maternal temperature (≥°38C), fetal or maternal tachycardia, malodorous vaginal discharge and no other defined infection was not diagnosed within following days. No digital examination was made until active labor was suspected. 20 days after the consultation with the infectious diseases specialist oral treatment of amoxicillin/CA (1 g, two times per day) and vaginal treatment of 2% clindamycin phosphate (twice a day, vaginally) was applied. Fetal well-being with non-stress test was obtained daily. 56 days later, a cesarean section was performed onset of subfebrile fever that continued for 24 hours and elevated white blood count. The female newborn (APGAR 7/9; weight 1935g) was delivered.

Diagnosis and management of PPROM remains problematic for obstetricians as a significant portion of prematurity and perinatal mortality and other severe adverse pregnancy outcomes associated with infection[2]. PPROM occured in 2% of all pregnancies. PPROM can be diagnosed by if any two of the following items coexists: Positive nitrazine test, ferning or pooling of fluid[3]. Amniotic fluid volume assessment is important in the diagnosis of PPROM too. It is widely stated that PPROM is the most common cause of prematurity. Because of this importance, neonatal outcome remains closely dependent on the use of suitable antibiotics to prevent chorioamnionitis; corticosteroids for fetal lung maturity and tocolytics to delay delivery of the preterm infant[4]. The approach should be multidisciplinary with neonatologist, infectious diseases specialist according to the gestational age.

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