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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.

	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 blas. 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; $1au^2 = 0.19$; $l^2 = 72\%$;
	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 fisk of caesarean section (average RR 0.84; 0.50% CL 0.60 to 1.04; 2.2 trials. 9576 wereast Tau ² = 0.10, 1^2 = 55% how quality
	95% CI 0.09 to 1.04; 23 trials, 8576 women; Tau ² = 0.10; 1 ² = 55%; 10w-quality
	women very low quality ovidence), definite early encet neonatal concis (PR 0.57, 05%)
	CLO 24 to 1.22; civ trials, 1202 infants; yory low guality ovidence); or peripatal
	mortality (PP 0.47: 05% CL 0.13 to 1.66; eight trials, 6302 infants; moderate quality
	avidence) SECONDARY OUTCOMES: women who had a planned early hirth wore at a
	reduced risk of chorioampionitis (average RR 0.55: 05% CL 0.37 to 0.82: eight trials
	6874 women: Tau ² = 0.19; l ² = 73%) and nostnartum senticaemia (BB 0.26; 95% Cl
	0.07 to 0.96; three trials 263 women) and their neonates were less likely to receive
	antibiotics (average BB 0.61: 95% CI 0.44 to 0.84: 10 trials .6427 infants: $Tau^2 = 0.06$:
	$l^2 = 32\%$) Women in the planned early birth group were more likely to have their
Main results	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% Cl
	-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% Cl -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% Cl
	-21.96 to -0.04; one trial, 182 infants) or special or intensive care unit stay (RR 0.72;
	95% Cl 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.
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2. Clinical Practice Guidelines

 \oplus positive recommendation (regardless of the level of evidence reported) \emptyset 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)**.

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