While the study authors advocate expectant management over immediate delivery, further study is needed before current recommendations are revised.

**Is expectant management a safe alternative to immediate delivery in patients with PPROM close to term?**

*Yes,* when there are no overt signs of infection or fetal compromise in singleton pregnancies, according to results of a large randomized trial that compared these 2 forms of accepted management of preterm premature rupture of membranes.


**EXPERT COMMENTARY**

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**WHAT THIS EVIDENCE MEANS FOR PRACTICE**

Few clinical studies have the potential to significantly change obstetric management. This report by Morris and colleagues is one such study. It was well designed, well executed, and powered to look at the most clinically relevant outcome, namely, neonatal sepsis. While these study results do call into question the current American College of Obstetricians and Gynecologists recommendations to electively deliver patients with PPROM at or after 34 weeks’ gestation, additional discussion is needed at the national level before these recommendations can be changed.

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ruptured membranes before the onset of labor between 34 and 37 weeks’ gestation.

**PPROMT study design**
Morris and colleagues present results of their multicenter, international, randomized controlled trial (RCT) of expectant management versus planned delivery in pregnancies complicated by PPROM at 34 0/7 through 36 6/7 weeks’ gestation carried out in 65 centers across 11 countries. A total of 1,839 women not requiring urgent delivery were randomly assigned to either immediate delivery (n = 924) or expectant management (n = 915).

No difference was noted in the primary outcome of neonatal sepsis between the immediate birth (n = 23 [2%]) and expectant management groups (n = 29 [3%]; relative risk [RR], 0.8; 95% confidence interval [CI], 0.5–1.3). This also was true in the subgroup of women who were colonized with group B streptococcus (RR, 0.9; 95% CI, 0.2–4.5).

There also was no difference in the secondary outcome measure, a composite metric including sepsis, ventilation for 24 or more hours, or death (73 [8%] in the immediate delivery group vs 61 [7%] in the expectant management group; RR, 1.2; 95% CI, 0.9–1.6). However, infants born to women randomly assigned to immediate delivery, versus expectant management, had a significantly higher rate of respiratory distress syndrome (RR, 1.6; 95% CI, 1.1–2.3) and mechanical ventilation (RR, 1.4; 95% CI, 1.0–1.8). In addition, the immediate-delivery infants had a longer median stay in the special care nursery/neonatal intensive care unit (4.0 days, interquartile range [IQR], 0.0–10.0 vs 2.0 days, IQR, 0.0–7.0) and total hospital stay (6.0 days, IQR, 3.0–10.0 vs 4.0 days, IQR, 3.0–8.0). As expected, women in the expectant management group had a significantly longer hospital stay than women in the immediate delivery group, because 75% (688/912) were managed as inpatients. Interestingly, women in the immediate delivery group had a higher cesarean delivery rate than those in the expectant management group (239 [26%] vs 169 [19%], respectively; RR, 1.4; 95% CI, 1.2–1.7), although no explanation was offered.

**Strengths and limitations**
Major strengths of this study include the large sample size and superior study design. It is by far the largest RCT to address this question. Because this was a pragmatic RCT, certain practices (such as the choice of latency antibiotic regimen) varied across centers, although randomization would be expected to minimize the effect of such variables on study outcome.

A major limitation is that participant recruitment occurred over a period of more than 10 years, during which time antenatal and neonatal intensive care unit practices likely would have changed.

References