this & that

02

OBSTETRIC QUICK GUIDES · IF THIS, THEN THAT

NO.

Preterm Prelabour Rupture of Membranes

& periviable rupture

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Obstetrics & Gynaecology

Diagnosis & management

Verified against ACOG · SMFM · RCOG · SOGC — October 2026

Preterm prelabour rupture of membranes

At a glance: the numbers to remember

No VE	<34^{+0} wk	24^{+0}–33^{+6}	<32^{+0} wk	37^{+0} wk
digital exams shorten latency (3 vs 5 days)	expectant care + latency antibiotics	one steroid course: every society agrees	$MgSO_4$ if birth is imminent (ACOG)	the latest point to deliver

Where societies disagree, each position carries the society name; follow your local protocol. Doses are for singleton pregnancies unless stated.

01 Definitions and natural history

Term	Meaning
PROM	Rupture of the membranes before the onset of labour, at any gestation.
PPROM	PROM before 37^{+0} wk. Early PPROM 24^{+0}–33^{+6} wk; late-preterm PPROM 34^{+0}–36^{+6} wk (Obstetric EBG).
Previable / periviable PPROM	Rupture before about 24^{+0} wk. Periviable birth is birth at 20^{+0}–25^{+6} wk (ACOG/SMFM OCC 6). Managed with the counselling in Section 10.
Latency	Time from rupture to birth. It shortens as gestational age at rupture rises.

How long until birth?

GA at PPROM	Mean latency	Birth <48 h	Birth <7 days	Birth <14 days
<24 wk	~7 days	20%	40–50%	70%
24^{+0}–33^{+6} wk	3–6 days	50%	70–80%	90%
34^{+0}–36^{+6} wk	~24 h	70–80%	90%	>95%

Obstetric EBG 4e, Table 20.4. Median latency at 24–28 wk is about 9 days; above 30 wk it is usually 2–4 days.

What drives the risk

- PPROM complicates 1–3% of pregnancies at 24–33 wk and 3–5% at 34–36 wk, and precedes 25–30% of preterm births.
- **Infection** limits latency: chorioamnionitis complicates about 40% of mid-trimester PPROM, mostly in the first week.
- **Abruption** both causes PPROM (10–15% of cases) and follows it. **Cord prolapse** about 2%, and 11% with a non-cephalic fetus.
- **Pulmonary hypoplasia** 13–28% after mid-trimester rupture; 50–60% if rupture is at ≤20 wk. Risk rises with persistent oligohydramnios.
- Prognosis depends on GA at rupture, residual liquor, latency and GA at birth, not on the rupture itself.

02 Diagnosis and triage

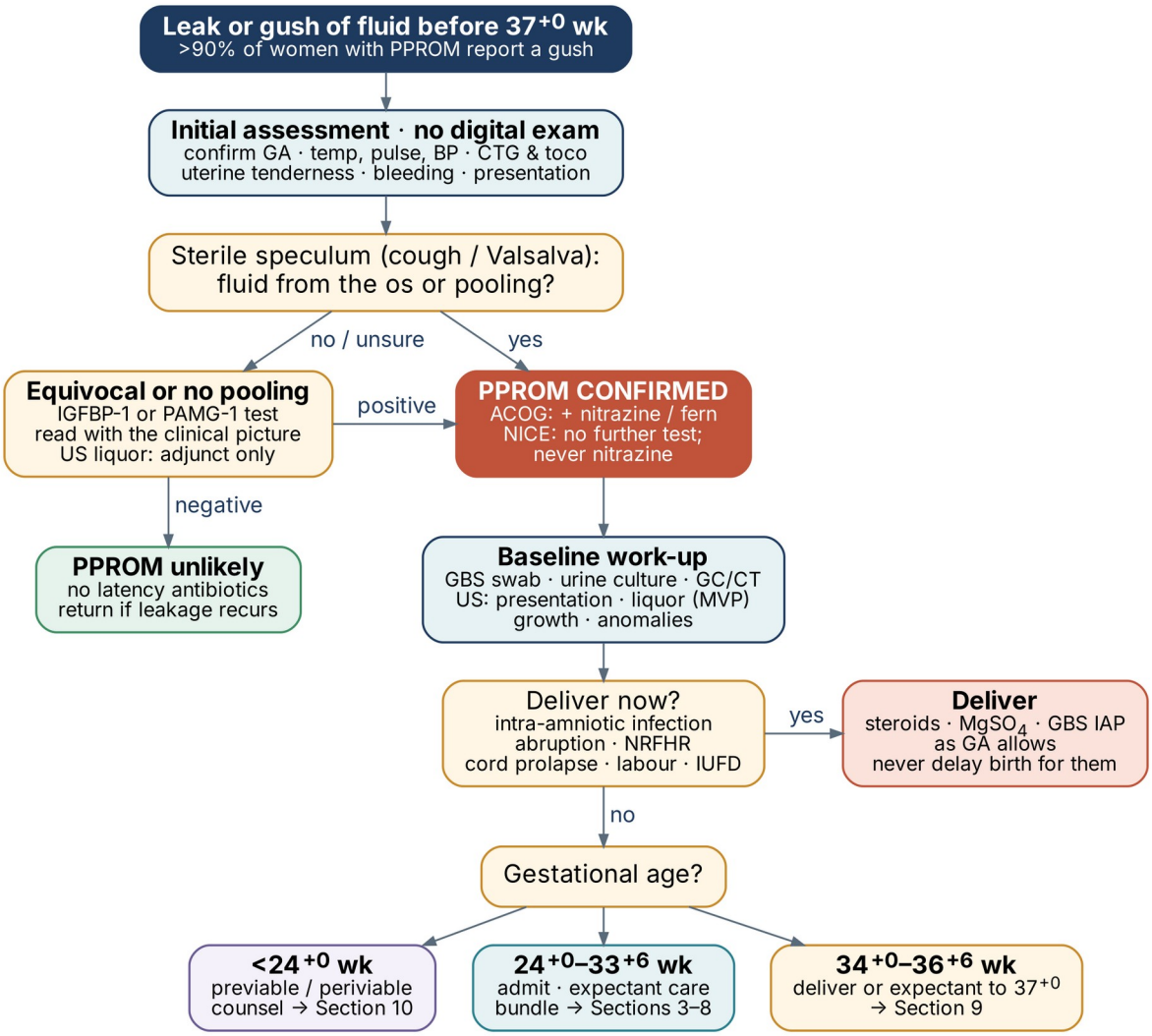


Figure 1. *From a reported leak to a management pathway.*

IF	THEN
Leak or gush of fluid	• Sterile speculum; ask her to cough or bear down • **No digital examination** unless she is in active labour or birth is imminent (ACOG). One or two exams cut latency from 5 to 3 days
Fluid seen draining from the os or pooling	• PPROM is diagnosed • ACOG: confirm with nitrazine (amniotic fluid pH 7.1–7.3) and/or ferning • NICE: no further test needed; **do not use nitrazine**
No pooling, or unsure	• IGFBP-1 or PAMG-1 test of vaginal fluid (NICE) • Read any amniotic-protein test with the clinical picture: false-positive rates 19–30% (FDA 2018, ACOG) • Ultrasound liquor supports but does not make the diagnosis
Test negative and no pooling	PPROM unlikely. **No antibiotics** (NICE). Safety-net: return if leakage recurs.
Still unsure at a low GA	Ultrasound-guided amnioinfusion of indigo carmine or fluorescein; a stained tampon or pad confirms. **Never methylene blue** (fetal methaemoglobinaemia).

IF	THEN
Rupture confirmed	• Rectovaginal GBS swab, urine culture, gonorrhoea/chlamydia NAAT • Ultrasound: presentation, deepest pool, growth, anomalies • Look for infection, abruption, labour, cord prolapse and fetal compromise before choosing expectant care
Bleeding with the leak	Consider abruption. Exclude placenta praevia on ultrasound before any digital exam.
Low liquor on the first scan	Common (50–70%). It predicts shorter latency and cord compression but is **not** by itself a reason to deliver.

How good are the tests?

Test	Sensitivity	Specificity	Notes
Nitrazine (pH)	85%	40%	False positives: blood, semen, antiseptics, BV, Trichomonas. NICE: do not use
Fern	84%	79%	False positives: cervical mucus, semen, fingerprints
PAMG-1 (AmniSure)	93%	100%	Unaffected by semen, urine, blood or infection; no speculum needed
IGFBP-1 (Actim PROM)	88%	94%	Blood contamination can alter the result
Fetal fibronectin	95%	89%	Not recommended for diagnosing rupture

Obstetric EBG 4e, Table 20.1. All tests lose accuracy when more than an hour has passed since rupture.

03 Management by gestational age

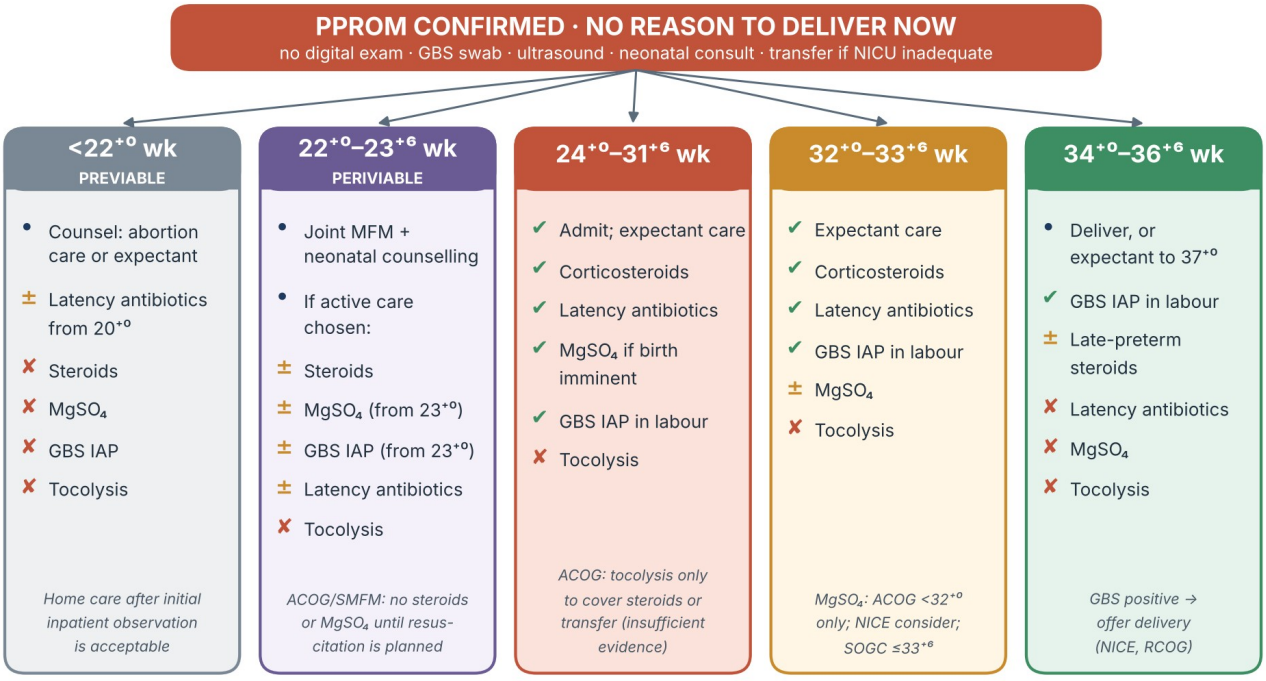


Figure 2. *What to give once PPROM is confirmed and there is no reason to deliver now.*

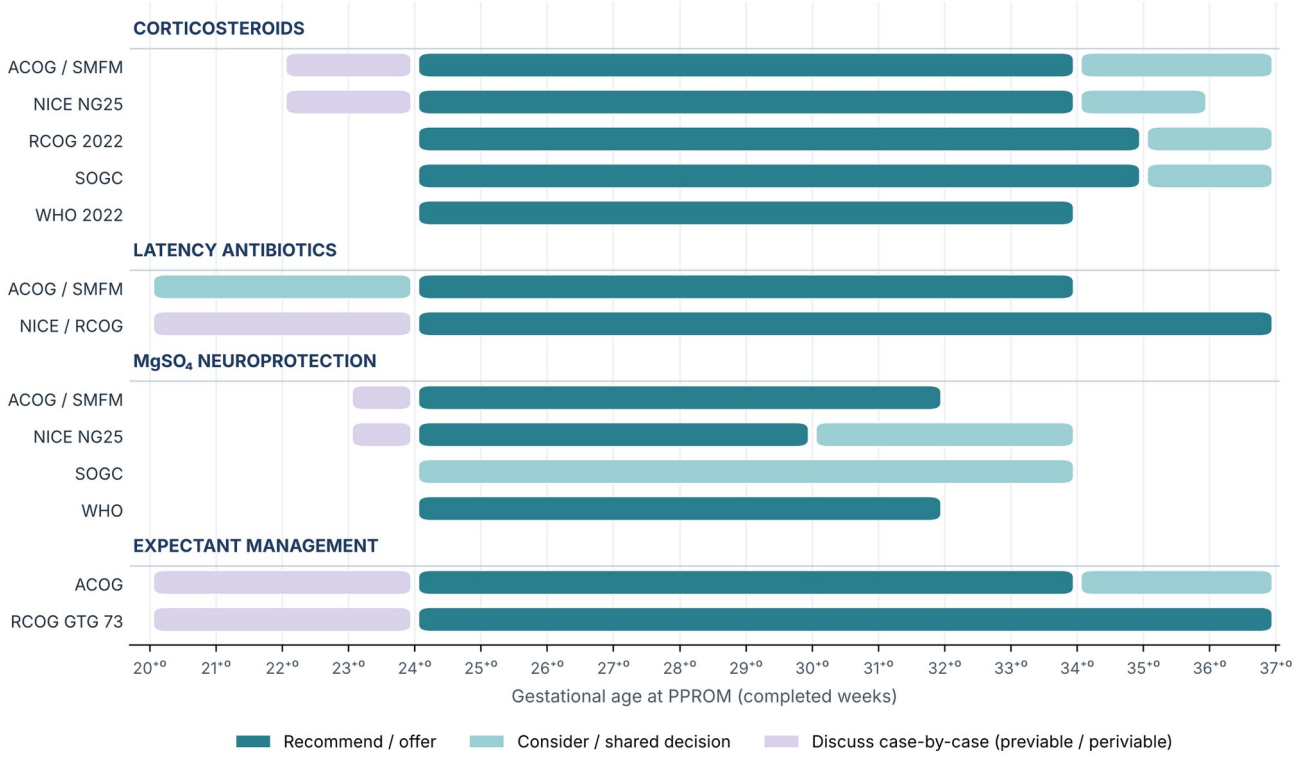


Figure 3. *Gestational-age windows for steroids, latency antibiotics, $MgSO_4$ and expectant management, by society.*

Expectant care bundle at 24^{+0}–33^{+6} wk

- Admit; ACOG does not recommend outpatient care once the fetus is viable. Notify neonatology and agree the plan.
- If the unit cannot care for a baby of this gestation, arrange in-utero transfer.
- Corticosteroids (Section 5) and latency antibiotics (Section 4) on admission.
- $MgSO_4$ when birth becomes imminent before 32^{+0} wk (Section 6). GBS prophylaxis in labour.
- Surveillance for infection, abruption, labour and fetal compromise (Section 8). Plan birth by 34^{+0}–37^{+0} wk (Section 9).

04 Latency antibiotics

IF	THEN
PPROM <34^{+0} wk, expectant care	• Give a course of latency antibiotics (ACOG Level A; NICE; RCOG; SOGC; WHO) • Benefit: ↓ chorioamnionitis 34%, ↓ birth within 48 h 29% and within 7 d 21%, ↓ neonatal infection 33%, ↓ abnormal cranial ultrasound 19% (Cochrane, in Obstetric EBG)
34^{+0}–36^{+6} wk	ACOG: latency antibiotics are not appropriate; give GBS prophylaxis only. RCOG/NICE give erythromycin regardless of GA once PPROM is diagnosed.
20^{+0}–23^{+6} wk, expectant care chosen	Consider a 7-day course (SMFM #71, 2C). Recommended from 24^{+0} wk.
Penicillin allergy	• ACOG: no well-studied alternative; choose an agent active against GBS according to the severity of the reaction, with the macrolide • Low anaphylaxis risk: cefazolin. High risk: clindamycin if the GBS isolate is susceptible, otherwise vancomycin (doses in Section 9) • NICE: if erythromycin cannot be used, an oral penicillin for up to 10 days
Any regimen	**Never co-amoxiclav** (amoxicillin-clavulanate): ↑ neonatal NEC (RR 4.72).
Cerclage left in place	Do not extend antibiotics beyond 7 days (ACOG).

IF	THEN
Diagnosis uncertain	Do not start. With intact membranes, antibiotics gave no benefit and more cerebral palsy at 7 years (ORACLE II).
Labour, birth or infection	Stop the latency course. Switch to GBS prophylaxis in labour, or to treatment for intra-amniotic infection (Section 8).

Regimens

Society	Drugs and doses	Duration	Notes
ACOG / SMFM (NICHD trial)	**Ampicillin 2 g IV q6h + erythromycin 250 mg IV q6h** for 48 h, then **amoxicillin 250 mg PO q8h + erythromycin base 333 mg PO q8h** for 5 days	7 days	Azithromycin (e.g. 1 g PO once) may replace erythromycin if it is unavailable or not tolerated. The ampicillin phase also covers GBS
NICE / RCOG	**Erythromycin 250 mg PO four times daily**	10 days, or until established labour if sooner	If erythromycin cannot be used: an oral penicillin
WHO	Erythromycin as the antibiotic of choice (250 mg PO four times daily)	10 days or until birth	Amoxicillin if erythromycin is unavailable
SOGC 430	Macrolide alone (erythromycin, azithromycin or clarithromycin) plus 48 h of GBS cover if GBS positive or unknown; **or** ampicillin/amoxicillin plus a macrolide	Up to 10 days	Doses not specified in the summary available to us (secondary source)

05 Antenatal corticosteroids

IF	THEN
24^{+0}–33^{+6} wk	• **Betamethasone 12 mg IM, 2 doses 24 h apart** (or dexamethasone 6 mg IM q12h ×4) • Single course, all societies; RCOG 2022 and SOGC offer to 34^{+6} • Benefit holds with ruptured membranes: ↓ perinatal death (RR 0.72), RDS (RR 0.66), IVH (RR 0.55), NEC (RR 0.50)
Birth expected within 24 h	Give the first dose anyway. **Never delay an indicated delivery** to complete the course.
23^{+0}–23^{+6} wk	ACOG: may be considered, depending on the family's decision about resuscitation. NICE: discuss case-by-case.
22^{+0}–22^{+6} wk	• ACOG 2021 Practice Advisory: may be considered **only if neonatal resuscitation is planned**, after counselling • SMFM #71: no steroids until resuscitation is appropriate and desired • RCOG SIP 76: only if birth is likely within 7 days and survival-focused care is planned
<22^{+0} wk	Not recommended.
34^{+0}–36^{+6} wk, no prior course	• **ACOG/SMFM:** betamethasone only if birth is planned in ≥24 h and ≤7 days, singleton, no pregestational diabetes, no chorioamnionitis • No tocolysis to complete the course; warn the neonatal team about hypoglycaemia • NICE: consider at 34^{+0}–35^{+6} · RCOG 2022: consider at 35^{+0}–36^{+6} after discussion · SOGC: individualise · WHO: not recommended outside research

IF	THEN
Course given >7 days ago, still <34^{+0}, birth expected again	• ACOG: insufficient evidence for or against a rescue course in PPROM • NICE: consider one repeat course if birth is very likely within 48 h • Never more than 2 courses; serial weekly courses shorten latency and ↑ chorioamnionitis
Diabetes (any type)	Not a contraindication before 34 wk. Expect hyperglycaemia for about 5 days and step up glucose monitoring and insulin.
Chorioamnionitis	Deliver. Do not hold birth for steroids.

06 Magnesium sulphate for fetal neuroprotection

IF	THEN
<32^{+0} wk and birth imminent	• PPROM in labour, or planned birth within 24 h (ACOG Level A) • ↓ cerebral palsy; women with PPROM were close to 90% of the largest trial (BEAM) • Give in singletons and twins; never delay delivery to give it
Dose (one protocol per unit)	• **ACOG:** no set dose; follow a trial protocol, e.g. BEAM 6 g IV over 20–30 min then 2 g/h, or ACTOMgSO$_4$ 4 g then 1 g/h • **NICE:** 4 g IV over 15 min, then 1 g/h until birth or for 24 h • **SOGC:** 4 g IV over 30 min, then 1 g/h until birth or for 24 h
30^{+0}–33^{+6} wk	NICE: consider (offer at 24^{+0}–29^{+6}). SOGC: consider up to 33^{+6}. ACOG and WHO: not routine at ≥32 wk.
23^{+0}–23^{+6} wk	ACOG/SMFM: consider only if resuscitation is planned. NICE: discuss case-by-case. Not recommended before 23^{+0}.
Not delivered and birth no longer imminent	Stop the infusion; reload if it is restarted later.
On infusion	• Respiratory rate, reflexes, urine output and SpO$_2$ at least 4-hourly • Toxicity: stop; **calcium gluconate 1 g IV** over 10 min
Myasthenia gravis	Contraindicated.

07 Tocolysis, cerclage and other adjuncts

IF	THEN
Contractions with PPROM <34^{+0} wk	• ACOG: insufficient evidence; a short course may be considered only to complete steroids or allow transfer, never with infection or abruption • RCOG: not recommended · WHO 2022: nifedipine can be considered with ruptured membranes and no infection • Cochrane: 73 h more latency but ↑ chorioamnionitis <34 wk, ↑ 5-min Apgar <7 (RR 6.05), no perinatal benefit
≥34^{+0} wk, previable PPROM, or any infection or abruption	**No tocolysis.** No maintenance tocolysis at any GA.
Cerclage in place and infection, labour or bleeding	Remove it now.

IF	THEN
Cerclage in place, none of the above	• ACOG and SMFM #71: removal or retention are both reasonable after shared decision-making • RCOG GTG 75: at 24–34 wk, deferring removal for 48 h for steroids or transfer can be considered • Obstetric EBG: remove in most cases, especially once steroids are given and after 32 wk • Retention: more births delayed beyond 48 h, but ↑ chorioamnionitis (OR 1.78) with no proven neonatal benefit
On vaginal progesterone	Stop it: no benefit after rupture and a possible ascending-infection risk (Obstetric EBG). ACOG: no data on its use after PPROM.
Amnioinfusion or membrane sealing (amniopatch)	Research only (SMFM #71; RCOG SIP 76). Serial amnioinfusion did not reduce perinatal mortality in PPROMEXIL-III.
Bed rest, fetal lung maturity testing, routine amniocentesis	Not recommended. None improves outcome.

08 Surveillance and intra-amniotic infection

IF	THEN
Where to manage once viable	• ACOG: hospitalise; outpatient care with a viable fetus is not recommended • RCOG: individualise after initial inpatient observation; home care is riskier with rupture <26 wk, non-cephalic presentation or oligohydramnios • Only about 18% of women meet strict outpatient criteria (Obstetric EBG)
Maternal checks	• Temperature, pulse, uterine tenderness, offensive or purulent discharge, contractions • NICE: diagnose infection from clinical assessment plus CRP, white cell count and CTG together; never one test alone • Steroids raise the white cell count for about 3 days
Fetal checks	• CTG: ACOG has no set frequency; Obstetric EBG suggests continuous for the first 24 h, then 30–60 min up to 3 times a day • Fetal tachycardia may be the first sign of infection • Ultrasound for growth and presentation at intervals; Doppler if growth restricted
Fever with no other source	Treat as intra-amniotic infection until proven otherwise.
Suspected intra-amniotic infection (ACOG)	• Temperature ≥39.0 °C, or 38.0–38.9 °C plus maternal leukocytosis, purulent cervical discharge or fetal tachycardia (ACOG CO 712, criteria updated 2024) • Obstetric EBG: two or more of fever, maternal or fetal tachycardia, uterine tenderness, purulent discharge
Infection diagnosed	• **Deliver**, vaginally if possible; no tocolysis; do not wait for steroids • ACOG: **ampicillin 2 g IV q6h + gentamicin 2 mg/kg then 1.5 mg/kg q8h** (or 5 mg/kg once daily) • Mild penicillin allergy: cefazolin 2 g IV q8h + gentamicin · severe: clindamycin 900 mg IV q8h or vancomycin + gentamicin • NICE NG195: benzylpenicillin + gentamicin + metronidazole
After birth with infection	Vaginal birth: no further doses needed (ACOG). Caesarean: one more dose plus **clindamycin 900 mg or metronidazole 500 mg IV**.

09 Timing and mode of birth

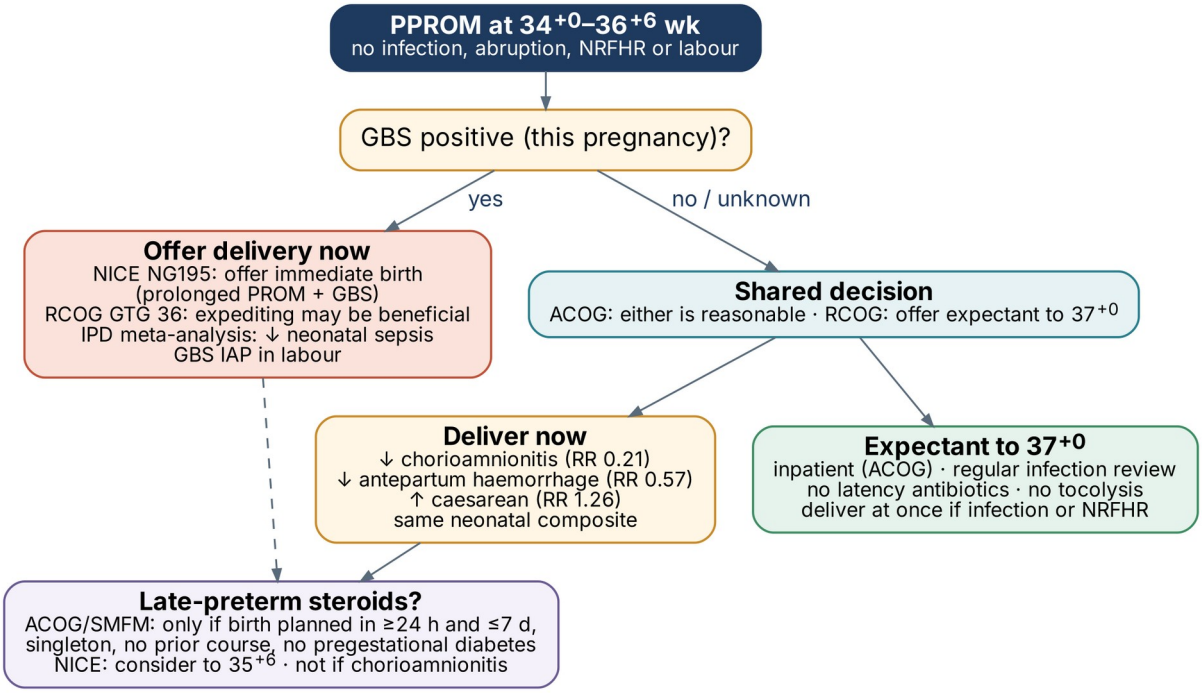


Figure 4. *Deliver or wait at 34+0–36+6 weeks.*

IF	THEN
<34+0 wk, mother and fetus well	Expectant care (ACOG Level A; all societies). Planned early birth ↑ neonatal death (RR 2.55) and RDS (RR 1.26) without less neonatal sepsis (Cochrane, 12 trials, 3617 women).
34+0–36+6 wk	• ACOG: expectant care or delivery are both reasonable after shared decision-making; never beyond 37+0 • RCOG: offer expectant care to 37+0 • Immediate birth: same neonatal composite (RR 1.20, NS), ↓ chorioamnionitis (RR 0.21) and antepartum haemorrhage (RR 0.57), ↑ caesarean (RR 1.26)
34+0–36+6 wk and GBS positive	Offer delivery. NICE NG195: offer immediate birth with prolonged rupture and GBS; RCOG GTG 36: expediting may help; immediate birth ↓ neonatal sepsis in women with a positive vaginal culture.
≥37+0 wk	Deliver; induce if there is no contraindication.
Labour or planned birth: GBS prophylaxis	• ACOG: give IAP in labour if GBS positive or unknown, whatever antibiotics came before • **Penicillin G 5 MU IV, then 2.5–3 MU q4h**, or ampicillin 2 g, then 1 g q4h • Allergy, low risk: cefazolin 2 g, then 1 g q8h · high risk: clindamycin 900 mg q8h if susceptible, otherwise vancomycin 20 mg/kg q8h (max 2 g per dose) • RCOG/NICE: benzylpenicillin for women in preterm labour; RCOG does not test for GBS after PPROM
Mode of birth	• PPROM is not an indication for caesarean; use the usual obstetric indications • Malpresentation is common at early GA; a classical incision may be needed with oligohydramnios and a poorly formed lower segment • Birth before 32–34 wk belongs in a unit with a NICU

IF	THEN
Non-cephalic presentation during expectant care	Higher risk of cord prolapse (about 11% vs 2%), especially before 26 wk. Keep her in hospital and examine promptly if contractions start.

10 Previable and periviable PPROM

Spontaneous rupture before viability complicates about 0.5–0.6% of pregnancies. Counsel jointly with neonatology using local outcome data, and record the family's choice on resuscitation; it decides every intervention below.

Intervention	20^{+0}–21^{+6}	22^{+0}–22^{+6}	23^{+0}–23^{+6}	24^{+0}–25^{+6}
Neonatal assessment for resuscitation	Not recommended	Consider	Consider	Recommended
Corticosteroids	Not recommended	Consider (if resuscitation planned)	Consider	Recommended
Latency antibiotics	Consider	Consider	Consider	Recommended
$MgSO_4$ neuroprotection	Not recommended	Not recommended	Consider	Recommended
GBS prophylaxis in labour	Not recommended	Not recommended	Consider	Recommended
Caesarean for fetal indication	Not recommended	Not recommended	Consider	Consider at 24; recommended from 25

ACOG/SMFM OCC 6 (2017) as updated by the 2021 steroid advisory and SMFM Consult #71 (2024). Tocolysis is not recommended before viability (ACOG PB 217).

IF	THEN
Any PPROM before 24 wk	• Offer abortion care (induction or D&E) and, when there is no contraindication, expectant management (SMFM #71) • ACOG 2025: maternal morbidity is higher than previously reported; be ready to provide abortion care before she is critically ill
Infection, heavy bleeding, labour or IUFD	Empty the uterus promptly; do not wait for sepsis. Give treatment-dose antibiotics (RCOG SIP 76: 94% have histological chorioamnionitis).
Expectant care chosen	• Initial inpatient observation; home if no bleeding, cramping or fever (Williams: after about 24 h) • Teach temperature checks, no intercourse; return for fever, bleeding, contractions or discharge • RCOG SIP 76: very low threshold for admission (complications OR 6.2 with home care before 26 wk) • Readmit at the agreed viability GA, usually 23–24 wk
Antibiotics	Consider a 7-day course from 20^{+0} wk; recommended from 24^{+0} wk.
Steroids, $MgSO_4$, GBS prophylaxis, caesarean for the fetus	Only once resuscitation is planned and wanted (table above).
Rupture after amniocentesis	Much better outlook: 91–99% perinatal survival; leaks often reseal. Outpatient care with serial liquor checks and temperature monitoring.

IF	THEN

Counselling numbers

- **Latency:** 40–50% deliver within a week; average about 2 weeks (Williams). Up to 14% stop leaking and do as well as intact pregnancies (Obstetric EBG).
- **Survival after expectant care of PPROM <24 wk:** 38.8% to discharge (SMFM #71). By GA at rupture (PPROMEXIL-III): about 20% at 16–19 wk, 30% at 20–21 wk, 41% at 22–23 wk.
- **UK data (RCOG SIP 76, rupture <23^+0^):** live birth in 44% of continuing singleton pregnancies; survival without severe morbidity 18%; maternal sepsis 13% with expectant care vs 10% after termination.
- **Maternal risk (SMFM #71):** composite morbidity 60.2% with expectant care vs 33.0% with abortion care; intra-amniotic infection 38% vs 13%; postpartum haemorrhage 23.1% vs 11.0%; sepsis up to 6.8%. Retained placenta 9–18%.
- **Pulmonary hypoplasia:** 13–28%, with 50–95% mortality; 43% with severe oligohydramnios, 21% with moderate, 7% with mild or none.

11 Special situations

IF	THEN
Twins	• Same steroids, latency antibiotics and $MgSO_4$ as singletons (Obstetric EBG) • Latency is shorter (median often <24 h); the presenting sac ruptures in about 90% • Obstetric and Maternal-Fetal EBG: deliver by 34^{+0} wk; no ACOG/SMFM twin-specific advice • No late-preterm steroids in ongoing twins (excluded from ALPS)
Recurrent genital HSV, PPROM <34^{+0} wk	Expectant care with antiviral treatment (ACOG). Caesarean if lesions or prodrome are present in labour.
Primary HSV	Higher transmission risk and less clear management: antivirals, senior and MFM input; caesarean if lesions at birth.
HIV	• Individualise with the HIV team by GA, antiretroviral regimen and viral load (ACOG) • Maternal-Fetal EBG: <34 wk expectant care with steroids and antibiotics; ≥34 wk deliver, mode by viral load; transmission is not tied to the duration of rupture on effective therapy
After fetoscopic surgery	PPROM is common (PPROM <32 wk in up to 40% after laser for TTTS). Sealing procedures are investigational.
Growth restriction	Doppler surveillance and delivery by the FGR protocol.
Meconium-stained liquor	Linked with infection; not by itself an indication to deliver (Obstetric EBG).
Gonorrhoea, chlamydia or UTI found	Treat with the appropriate regimen in addition to the latency course.

12 After birth and the next pregnancy

IF	THEN
After birth	• Send the placenta for histology (RCOG SIP 76: in every case <24 wk) • Watch for endometritis (about 13% after mid-trimester PPROM) and retained placenta • Debrief: what happened and the recurrence risk
Recurrence risk	• PPROM again in 16–32% vs 4% after an uncomplicated term birth; preterm birth in 20–30% (Obstetric EBG) • After previable PPROM: 46% delivered before 37 wk and 17% before 24 wk in the next pregnancy (Williams) • Higher with earlier rupture and an interpregnancy interval <6 months
Next pregnancy	• Manage as a prior spontaneous preterm birth (SMFM #71) • Serial TVUS cervical length from 16 wk; vaginal progesterone or cerclage by the usual criteria (see No. 01) • Stop smoking; treat genital tract infection

13 Do not

- Do a digital examination before active labour.
- Rely on nitrazine alone (NICE: never use it), or on a protein test without the clinical picture.
- Give co-amoxiclav, or latency antibiotics when the diagnosis is uncertain.
- Give latency antibiotics at ≥34^{+0} wk (ACOG) or extend them beyond 7 days because a cerclage is in place.
- Use tocolysis at ≥34^{+0} wk, before viability, with infection or abruption, or as maintenance.
- Give serial steroid courses, more than 2 courses, or steroids and $MgSO_4$ before viability when resuscitation is not planned.
- Hold birth for steroids when there is chorioamnionitis.
- Continue expectant management beyond 37^{+0} wk.
- Offer amnioinfusion, amniopatch or other sealants outside a trial, or prescribe bed rest.
- Use methylene blue for a dye test.

14 Where the guidelines differ

Topic	ACOG / SMFM	RCOG / NICE	SOGC	WHO
Diagnosis	Pooling + nitrazine and/or fern; protein tests only with clinical assessment	Speculum; IGFBP-1 or PAMG-1 if no pooling; never nitrazine	—	—
Latency antibiotics	Ampicillin + erythromycin (or azithromycin) ×7 d, <34 wk	Erythromycin ×10 d; no GA cut-off stated	Macrolide ± ampicillin/amoxicillin, ≤10 d, GBS cover	Erythromycin; amoxicillin if unavailable
Steroid window	Recommend 24^{+0}–33^{+6}; consider 22^{+0}–23^{+6}	NICE offer 24^{+0}–33^{+6}; RCOG 2022 to 34^{+6}	24^{+0}–34^{+6}	24–34 wk with conditions
Late-preterm steroids	Only if birth planned in 24 h–7 d; singleton	NICE consider to 35^{+6}; RCOG consider 35^{+0}–36^{+6}	Individualise (TU 439)	Not recommended outside research
Rescue course	Insufficient evidence in PPROM	NICE: one, >7 d, birth likely in 48 h	—	One repeat 7–14 d later if still at risk

Topic	ACOG / SMFM	RCOG / NICE	SOGC	WHO
$MgSO_4$	<32^{+0} wk	Offer 24^{+0}–29^{+6}; consider to 33^{+6}	≤33^{+6}	<32 wk
Tocolysis	Insufficient evidence <34; not ≥34	Not recommended	—	Can be considered if no infection
Birth at 34–37 wk	Deliver or expectant, never beyond 37^{+0}	Expectant to 37^{+0}; offer birth if GBS positive	—	—
GBS	Swab on admission; IAP in labour regardless of prior antibiotics	RCOG: no GBS swab after PPROM; IAP in preterm labour	—	—
Cerclage	Remove or retain	Removal may be deferred 48 h at 24–34 wk	—	—
Outpatient care	Not once viable	Individualise	—	—

A dash means no verified position. The SOGC PPROM guideline (No. 430) full text could not be accessed; SOGC cells rest on secondary summaries.

15 Sources

Textbooks

- Cunningham FG et al. Williams Obstetrics, 26th ed. Ch. 11 (previable PPROM); Ch. 22 (ruptured membranes); Ch. 45 Preterm Birth.
- Berghella V (ed). Obstetric Evidence Based Guidelines, 4th ed. Ch. 20 Preterm Prelabor Rupture of Membranes.
- Berghella V (ed). Maternal-Fetal Evidence Based Guidelines, 4th ed. GBS; HIV; herpes; multiple gestation.

Guidelines checked (October 2026)

- ACOG Practice Bulletin 217, Prelabor Rupture of Membranes (2020); current, not replaced as of Oct 2026.
- ACOG Committee Opinion 713, Antenatal Corticosteroid Therapy (2017, reaffirmed 2020); ACOG Practice Advisory, Antenatal Corticosteroids at 22 Weeks (2021).
- ACOG Committee Opinion 455, $MgSO_4$ for Neuroprotection (2010, reaffirmed 2023).
- ACOG/SMFM Obstetric Care Consensus 6, Periviable Birth (2017, reaffirmed); ACOG Practice Advisory on maternal morbidity with previable and periviable PPROM (2025).
- ACOG Committee Opinion 712, Intraamniotic Infection (2017); ACOG Clinical Practice Update on suspected intraamniotic infection criteria (2024). ACOG Committee Opinion 797, GBS (2020).
- SMFM Consult Series #71, Previable and Periviable PPROM (2024); #58, Late-preterm Corticosteroids (2021).
- NICE NG25, Preterm Labour and Birth (2015; updated 2019, 2022); NICE NG195, Neonatal Infection (2021; updated 2024, 2026).
- RCOG Green-top 73, PPROM from 24^{+0} Weeks (2019); RCOG Scientific Impact Paper 76, PPROM before 24^{+0} Weeks (2025); RCOG Antenatal Corticosteroids guideline (2022); Green-top 75, Cerclage (2022); Green-top 36, GBS (2017); BAPM Extreme Preterm Framework (2026).
- SOGC Guideline 430, PPROM (2022); 364, Antenatal Corticosteroids (2018); Technical Update 439, Late-preterm Corticosteroids (2023); 376, $MgSO_4$ (2019); 298, GBS (2013).
- WHO recommendations on antenatal corticosteroids (2022) and tocolysis (2022); WHO PPROM antibiotic and $MgSO_4$ recommendations (2015, maintained). FIGO Prep-for-Labor good practice recommendations (2023).
- Kua S et al. Systematic review of 17 PPROM guidelines. Am J Obstet Gynecol 2025.

Decision aid only: it does not replace clinical judgement or local protocols. Verify drug doses against your formulary.