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OPEN PEER REVIEW

Expectant Management of Preterm Prelabor Rupture of Membranes: Outcomes by Gestational Age at Delivery

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About this report

This open peer review (OPR) report shows the public comments made on this article during peer review, by the reviewers, the associate editor and the editor-in-chief, for every revision round, together with the authors' replies. Comments appear only with the consent of the people who wrote them. Reviewers who chose to sign their report are named; the others are shown as "Referee". Comments are edited for language only, and confidential remarks to the editors are not included.

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1 Original submission

4 comments · 10 May 2026 – 10 May 2026

Referee 1 Reviewer

MAJOR REVISION 10 May 2026

Dear Authors,

We have reviewed your manuscript and provide below the additional scientific-review comments that are not part of the editorial-screening stage. The major comments address substantive scientific and reporting issues, while the minor comments focus on presentation, language clarity, tables, and reference currency.

The manuscript evaluates outcomes of expectant management among women with PPROM after 28 weeks of gestation, comparing management up to 34 weeks versus up to 36 weeks. The study uses hospital-based clinical data and reports neonatal and maternal outcomes including NICU admission, Apgar scores, RDS, hypoglycemia, sepsis, chorioamnionitis, postpartum hemorrhage, and cesarean delivery. The manuscript aims to inform clinical decision-making regarding whether expectant management may be extended beyond 34 weeks under careful monitoring.

The topic is clinically relevant, especially for obstetric and neonatal care in settings where PPROM contributes to preterm birth and neonatal morbidity. The manuscript includes a defined hospital setting, ethical approval information, explicit inclusion and exclusion criteria, and clinically meaningful neonatal and maternal outcomes. The focus on local data from Kermanshah Province may be useful for regional practice if the methodological and reporting limitations are addressed.

Major Comments:

1. Clarify the study design and align it with STROBE reporting requirements:

> *The Methods section describes the work as a "clinical trial study," but the manuscript also states that medical records were reviewed and that participants were divided into two gestational-age groups after review of records, with no description of randomization, trial registration, allocation, or a prospective intervention protocol (source: Materials and Methods, Design of the Study and Sample Selection; Data collection method). This creates a major design ambiguity and affects how readers should interpret causality, bias, and the strength of evidence.*
> *Author to-do list:*
>
> ** State the exact study design using standard terminology, such as retrospective cohort, prospective observational cohort, or nonrandomized clinical study, as applicable (source: Materials and Methods, Design of the Study and Sample Selection).*
> ** Remove or justify the term "clinical trial study" if no randomization or trial protocol was used (source: Materials and Methods, Design of the Study and Sample Selection).*
> ** Report the study period, setting, eligibility process, and group assignment method in a STROBE-consistent manner (source: Materials and Methods, Inclusion and Exclusion Criteria; Data collection method).*
> ** Clarify whether management up to 34 or 36 weeks was determined by protocol, clinician judgment, patient factors, or calendar/clinical practice patterns (source: Data collection method).*

2. Explain participant flow and denominators consistently:

> *The manuscript reports that 75 women were assessed, 40 were analyzed, and several groups were excluded; however, the exclusion counts and sequence need clearer explanation because 18, 13, and 4 exclusions total 35, leaving 40 analyzed, but the timing and overlap of these exclusions are not fully transparent (source: Results; Table 1). Clear participant-flow reporting is essential under STROBE because selection after latency-period events may introduce selection bias.*

Author to-do list:

** Present a participant-flow diagram or a clearer text description showing assessed, excluded, and analyzed patients without overlap (source: Results; Table 1).*
** Clarify whether patients who developed labor, compromised fetal status, or chorioamnionitis during latency were excluded before or after group assignment (source: Results; Table 1).*
** Report the final denominator for every outcome in Table 2 and indicate whether any data were missing (source: Table 2).*
** Explain whether excluding patients with adverse latency-period events may have biased the observed maternal and neonatal outcomes (source: Results; Discussion).*

3. Improve exposure/group definition and comparability:

The comparison between "28–34 weeks" and "28–36 weeks" is not sufficiently defined because the two groups appear to overlap conceptually: both begin at 28 weeks, and it is unclear whether Group 2 includes patients managed from 28 to 36 weeks or patients whose gestational age was 34–36 weeks (source: Abstract, Methods; Data collection method; Table 2). This ambiguity affects the interpretation of differences in NICU admission, RDS, hypoglycemia, sepsis, and Apgar scores.
Author to-do list:

** Define precisely what Group 1 and Group 2 represent at enrollment and at delivery (source: Abstract, Methods; Data collection method).*
** Clarify whether groups were based on gestational age at membrane rupture, gestational age at delivery, intended management endpoint, or achieved latency (source: Data collection method; Results).*
** Provide baseline clinical comparability between groups beyond maternal age and gravidity, including gestational age at PPROM, latency duration, fetal presentation, antibiotic/corticosteroid timing, and infection markers if available (source: Materials and Methods; Table 2).*
** Revise the group labels in the abstract, methods, results, and tables so that readers can understand the comparison without ambiguity (source: Abstract; Table 2).*

4. Strengthen statistical methods and address small-sample limitations:

The manuscript states that descriptive statistics, chi-square, Fisher's exact test, and multiple comparison tests were used, but the analysis plan does not explain which tests were applied to which variables, whether assumptions were checked, how small cell counts were handled, or whether any adjustment for confounding was attempted (source: Statistical Analysis; Table 2). With only 20 participants per group, unadjusted p-values may be unstable, and several outcomes have sparse or zero counts.
Author to-do list:

** Specify the statistical test used for each main outcome or add table footnotes identifying the tests (source: Statistical Analysis; Table 2).*
** Report exact denominators and exact p-values where possible, especially for sparse outcomes (source: Table 2).*
** Consider confidence intervals for key effect estimates, not only p-values (source: Results; Table 2).*
** Discuss why no adjusted analysis was performed or provide an adjusted analysis for key confounders if the sample allows (source: Statistical Analysis; Discussion).*
** Add a sample-size or power rationale, or clearly acknowledge the study as exploratory if no formal calculation was performed (source: Materials and Methods; Statistical Analysis).*

5. Resolve internal inconsistencies in reported results:

Several reported values appear internally inconsistent or potentially erroneous, including "Underlying disease 4 (2.1)" in the second group and "Hypoglycemia 1 (50%)" in the 28–36-week group, which do not match a denominator of 20 (source: Table 2). In addition, the abstract states that sepsis was significantly higher in women managed between 28 and 34 weeks, whereas Table 2 reports sepsis as 1 (5%) versus 6 (30%), suggesting the opposite direction (source: Abstract, Results; Table 2).
Author to-do list:

** Recheck every count and percentage in Table 2 against the group denominators (source: Table 2).*
** Correct the hypoglycemia, underlying disease, and sepsis values if they are typographical or calculation errors (source: Table 2).*
** Ensure that the abstract and results describe the direction of significant findings consistently with the table (source: Abstract, Results; Table 2).*
** State whether percentages are calculated per mother, per neonate, or per live birth for each outcome (source: Table 2).*

6. Moderate causal and practice-changing conclusions:

The conclusion states that expectant management "should be improved" or considered up to 36 weeks, but the manuscript's observational design, small sample, exclusion of adverse latency-period events, and lack of adjusted analysis limit the strength of any clinical recommendation (source: Abstract, Conclusion; Discussion). The findings can support hypothesis generation and cautious local interpretation, but they do not yet establish that extending expectant management to 36 weeks is broadly preferable.
Author to-do list:

** Revise the conclusion to reflect the observational and exploratory nature of the evidence (source: Conclusion).*
** Avoid wording that implies definitive clinical guidance unless supported by the study design and analysis (source: Abstract, Conclusion).*
** Add a limitations paragraph addressing sample size, single-center design, selection bias, residual confounding, and uncertain generalizability (source: Discussion).*
** Distinguish clearly between the manuscript's findings and broader recommendations that require larger prospective or randomized evidence (source: Discussion; Conclusion).*

Minor Comments:

1. Tables and figures:

The manuscript contains two tables and no figures/images. Table 1 and Table 2 are explicitly cited in the Results section, and there are no figures requiring citation. Table 1 should be reformatted for readability, and Table 2 should define all abbreviations in a footnote, including PPROM, GA, NICU, RDS, and SD (source: Results; Table 1; Table 2).

2. Early-stage editorial and language red flags:

Several sentences require language revision for clarity and academic tone. For example, "During the past decade no measurable change in global preterm birth rates has been observed, which describes live-birth delivery before 37 weeks" should be revised because "which" incorrectly refers to the rates rather than preterm birth; a clearer revision would be "Preterm birth is defined as live birth before 37 weeks of gestation, and global rates have shown little measurable change over the past decade" (source: Background). The phrase "overall estimated outbreak of preterm in Iran" should be revised to "overall estimated prevalence of preterm birth in Iran" (source: Background). The sentence "relationships and understanding of the local background have been vital in moving the study to impact" is unclear and should be rewritten to specify why local evidence is needed (source: Background). The phrase "newborns' well-being" should be revised to "fetal well-being" when referring to cardiotocography before delivery (source: Additional information).

3. Terminology consistency:

> *The manuscript alternates between "premature rupture of membranes," "preterm premature rupture of membranes," "preterm pre-labour rupture of membranes," "PROM," and "PPROM." Please use one primary term consistently, preferably "preterm prelabor rupture of membranes (PPROM)" after first definition, and avoid using PROM when the study concerns PPROM (source: Title; Abstract; Background; Keywords).*

4. Reference currency:

> *The reference list does not appear to include references published before 2010. However, the authors should still review whether all references are directly relevant to PPROM management after 28 weeks and whether recent clinical guidance or high-quality evidence should be added where needed (source: References).*

5. Formatting and typographical issues:

> *Several small formatting problems should be corrected before resubmission. Examples include "Care unit" with inconsistent capitalization in "neonatal intensive Care unit," "twice week" instead of "twice weekly," "mean± S.D" needing consistent spacing and abbreviation style, and "andmanuscript" needing a space in the authors' contribution statement (source: Data collection method; Additional information; Statistical Analysis; Footnotes).*

Best regards,
Scientific Reviewer

Referee 2 Reviewer

MAJOR REVISION 10 May 2026

Dear Authors,

Thank you for submitting your manuscript to the journal. Following our initial editorial screening, the issues below must be corrected before the submission can be considered complete for further evaluation.

Please note that references are very important for publication, and all cited sources must include a DOI/PMID when supplied, be cited appropriately in the manuscript text, and be suitable for the journal.

2-1- Study design and trial-registration status are inconsistent:

* What the author wrote: The manuscript states that this was a "clinical trial study" but does not report randomization, trial registration, allocation, or a trial protocol. (source: Materials and Methods, Design of the Study and Sample Selection)
* Why correction is required: This must be corrected because the manuscript is not fully evaluable without a clear and accurate study-design classification and the required registration information if the study is truly a clinical trial. (source: Materials and Methods; Statistical Analysis)
* To do: Clarify the exact study design and provide trial-registration details if applicable, or revise the design terminology throughout the manuscript if the study is observational rather than a clinical trial. (source: Materials and Methods)

2-2- Group definitions require clarification:

* What the author wrote: The manuscript refers to Group 1 as GA between 28 and 34 weeks and Group 2 as GA between 28 and 36 weeks but does not clarify whether grouping was based on gestational age at PPROM, intended management endpoint, achieved latency, or gestational age at delivery. (source: Abstract; Data collection method; Table 2)
* Why correction is required: This must be corrected because the manuscript is not fully evaluable without a clear comparator definition for the two study groups. (source: Data collection method; Results)

* To do: Define exactly how the 28–34-week and 28–36-week groups were formed and revise the abstract, methods, results, and tables accordingly. (source: Abstract; Data collection method; Table 2)

2-3- Participant flow and exclusions are not sufficiently transparent:

* What the author wrote: The manuscript reports 75 assessed women, 40 analyzed women, and exclusions due to labor, compromised fetal status, and chorioamnionitis, but does not clarify the timing of exclusions relative to group assignment and latency-period events. (source: Results; Table 1)
* Why correction is required: This must be corrected because the manuscript is not fully evaluable without transparent participant flow and exclusion timing. (source: Results; Table 1)
* To do: Provide a clear participant-flow description or diagram showing assessed, excluded, allocated/classified, and analyzed participants with non-overlapping denominators. (source: Results; Table 1)

2-4- Outcome reporting contains internal numerical inconsistencies:

* What the author wrote: The manuscript contains outcome values in Table 2 that do not reconcile with the stated group denominators, including “Underlying disease 4 (2.1)” and “Hypoglycemia 1 (50%),” and the direction reported for sepsis in the abstract does not match Table 2. (source: Abstract; Results; Table 2)
* Why correction is required: This must be corrected because internal inconsistency currently prevents reliable assessment of the neonatal and maternal outcome findings. (source: Abstract; Table 2)
* To do: Correct all counts, percentages, p-values, and direction-of-effect statements in the abstract, results text, and Table 2. (source: Abstract; Results; Table 2)

2-5- Primary outcome and statistical analysis are incomplete:

* What the author wrote: The manuscript reports several neonatal and maternal outcomes and states that univariate analysis, chi-square, Fisher’s exact test, and multiple comparison tests were used, but does not identify a primary outcome, test-by-variable mapping, confidence intervals, adjustment strategy, or sample-size rationale. (source: Data collection method; Statistical Analysis; Table 2)
* Why correction is required: This must be corrected because the manuscript is not fully evaluable without a defined outcome hierarchy and a reproducible statistical-analysis plan. (source: Statistical Analysis)
* To do: Define the primary outcome, specify the statistical test used for each outcome, report effect estimates with confidence intervals where appropriate, and add a sample-size or exploratory-study justification. (source: Statistical Analysis; Table 2)

2-6- Limitations are not reported:

* What the author wrote: The manuscript does not report a dedicated limitations section addressing small sample size, single-center setting, selection bias, residual confounding, or limited generalizability. (source: Discussion)
* Why correction is required: This must be corrected because the manuscript is not fully evaluable without transparent discussion of methodological limitations affecting interpretation. (source: Discussion; Conclusion)
* To do: Add a limitations paragraph that explicitly addresses sample size, single-center design, group-assignment ambiguity, exclusion of adverse latency-period cases, lack of adjustment, and generalizability. (source: Discussion)

2-7- Reference-integrity review requires correction:

* What the author wrote: The manuscript contains 21 references, 18 with DOI/PMID and 3 requiring further review because DOI/PMID is not provided in the manuscript reference list. (source: References)
* Why correction is required: This must be corrected because the manuscript is not fully verifiable without complete reference identifiers or documented manual verification for references lacking DOI/PMID. (source: References)

* To do: Correct the reference list by adding DOI or PMID where available, manually verifying references without DOI/PMID, and replacing or removing any citation that cannot be verified. (source: References)
* References with DOI/PMID: Ref 1 - Adane et al., Ref 3 - Bond et al., Ref 4 - Bohilțea et al., Ref 5 - Hagen et al., Ref 6 - Sylvester et al., Ref 7 - Sklar et al., Ref 8 - Yüzen et al., Ref 9 - Rutayisire et al., Ref 10 - Singh et al., Ref 11 - Garg et al., Ref 12 - Vakilian et al., Ref 13 - Chawanpaiboon et al., Ref 15 - Goodfellow et al., Ref 16 - Gauthier-Moulinier et al., Ref 17 - Atkins et al., Ref 18 - Morris et al., Ref 19 - Danciu et al., Ref 21 - Hong et al.
* References requiring further review:

* Ref 2 - Organization WH — lacks DOI/PMID in the manuscript reference list; please add DOI or PMID if available or verify the citation manually. This reference is cited in the manuscript text.
* Ref 14 - Dayal et al. — lacks DOI/PMID in the manuscript reference list; please add DOI or PMID if available or verify the citation manually. This reference is cited in the manuscript text.
* Ref 20 - Prasetya et al. — lacks DOI/PMID in the manuscript reference list; please add DOI or PMID if available or verify the citation manually. This reference is cited in the manuscript text.

Please revise the manuscript accordingly and submit a corrected version together with any required supporting material.

Kind regards,
Screening Reviewer

Associate Editor

MAJOR REVISION 10 May 2026

Dear Authors,

I have evaluated your Research Article on expectant management for preterm pre-labor rupture of membranes from 28 to 34 or 36 weeks of gestation. The manuscript addresses a clinically important obstetric and neonatal-care question, but in its current form it requires substantial methodological, reporting, and editorial clarification before it can be considered ready for further decision-making.

The main strength of the manuscript is its focus on a practical clinical issue in PPROM management, particularly the comparison of maternal and neonatal outcomes under different gestational-age management thresholds. The inclusion of hospital-based clinical data, relevant neonatal outcomes, and an ethically approved study framework gives the manuscript potential value for regional obstetric practice if the analysis and reporting are corrected.

The scientific review indicates that the manuscript's central limitation is not topic relevance, but evaluability. The study design is not consistently described, the group definitions require clarification, participant flow and exclusion timing need more transparent reporting, and several outcome values require correction or reconciliation. In addition, the statistical approach, outcome hierarchy, limitations, and reference-completeness issues must be addressed before the manuscript can be reliably interpreted.

Title and abstract: 6/10
Introduction and rationale: 6/10
Methods rigor: 4/10
Results presentation: 4/10
Discussion and interpretation: 5/10
Reporting quality: 4/10
Language and structure: 6/10

Overall, the manuscript is relevant and potentially useful, but it requires major revision before it can be reconsidered. The authors should revise the manuscript substantially, correct all methodological and numerical inconsistencies, clarify the study design and comparison groups, strengthen statistical reporting, and submit a corrected version with complete supporting information.

Kind Regards,
Associate Editor

Editor-in-Chief

MAJOR REVISION 10 May 2026

Dear Authors,

Thank you for submitting your manuscript to the journal. After editorial assessment and reviewer evaluation, the manuscript cannot proceed in its current form and requires major revision before it may be reconsidered.

The topic is clinically relevant and within the journal's scope; however, substantial issues remain regarding study-design clarity, group definition, participant flow, statistical reporting, numerical consistency, limitations, and reference completeness. These issues currently limit the reliability and evaluability of the manuscript.

Please submit a thoroughly revised manuscript addressing all reviewer and editorial comments, together with any required supporting material. The revised version will be reassessed after submission, and further editorial or peer-review evaluation may be required.

Kind Regards,
Editor-in-Chief

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Revision 1

AUTHORS' RESPONSE TO REVIEWERS

Authors' reply to reviewers

The next pages contain the authors' point-by-point reply to the comments of this revision round, as submitted with the revised manuscript. It is published as the authors wrote it.

Dear Editor-in-Chief / Editorial Board,

We would like to thank the reviewers for their time and the constructive feedback provided on our manuscript entitled "Expectant Management for Preterm Pre-Labour Rupture of Membrane from 28 to 34 or 36 Weeks of Gestation". Their insights have been immensely helpful in improving the clarity, methodological rigor, and overall quality of this study.

We have carefully addressed all the comments and concerns raised by the reviewers. A point-by-point response is provided below. Furthermore, all changes in the revised manuscript have been highlighted using the "Track Changes" feature (highlighted) to facilitate the review process.

The primary modifications include:

Refinement of Gestational Age (GA) Groups: To eliminate overlap and ensure statistical validity, the groups were redefined as 28–33 $^{+6}$ weeks and 34–36 $^{+6}$ weeks.

Clarification of Sample Size: The flow of participant enrollment, including the specific reasons for the exclusion of 35 patients, has been detailed in the Results section and Table 1.

Data Consistency: All percentages and statistical values in the tables have been cross-checked and corrected to ensure accuracy relative to the cohort size (n=20 per group).

We believe that these revisions have significantly strengthened the manuscript. We hope the revised version is now suitable for publication in your esteemed journal.

Sincerely,

2 Revision 1

1 comment · 27 Oct 2026

Editor-in-Chief

MAJOR REVISION 27 Oct 2026

Dear Authors,

Thank you for submitting the revised version of your manuscript entitled “Expectant Management for Preterm Pre-Labour Rupture of Membrane from 28 to 34 or 36 Weeks of Gestation.”

The revised manuscript shows improvement in the description of the study design, gestational-age groups, and participant flow. However, several important methodological, statistical, and reporting issues remain unresolved. Further revision is required before the manuscript can be considered for publication.

Please address each of the following comments individually and point by point in a separate response document. In the revised manuscript, please highlight all changes clearly so that the editorial team can readily identify the revisions. If you disagree with any comment, provide a clear, evidence-based explanation rather than leaving the issue unaddressed.

1. Numerical inconsistencies in Table 2: Several values remain inconsistent with the stated group sizes of 20 participants per group. For example, one case of hypoglycemia is reported as 50%, although it corresponds to 5%; four cases of underlying disease are reported as 2.1%, which does not correspond to the stated denominator; and 11 cases of respiratory distress syndrome are reported as 50%, although they correspond to 55%. Please check every count, percentage, denominator, and corresponding value against the original dataset and correct all inconsistencies throughout the manuscript.

2. Statistical analysis and p-values: Please recheck all reported p-values using the original data and confirm that the statistical tests are appropriate for each outcome. Particular attention is required for the reported sepsis comparison (1 versus 6 cases; $p = 0.006$), which should be independently verified. Specify which statistical test was used for each relevant comparison, report effect estimates and confidence intervals where appropriate, and clarify the primary outcome and the rationale for the sample size. Any corrected values must be updated consistently in the Abstract, Results, tables, and Discussion.

3. Definition and classification of gestational-age groups: Please specify precisely when gestational age was determined for group allocation—for example, at PPROM diagnosis, study entry, or delivery. Ensure that the definitions of the two groups are consistent across the title, Abstract, Methods, Results, tables, and Discussion, and clarify how the study’s eligibility criteria relate to these group definitions.

4. Participant flow and exclusion criteria: Although the revised manuscript provides more detail on the 75 assessed participants and the 40 included in the final analysis, the timing and circumstances of exclusions require further clarification. In particular, four patients are reported to have developed chorioamnionitis during the latency period and to have been excluded, whereas Table 2 reports one case of chorioamnionitis in Group 1. Please explain this discrepancy and clearly state which patients were excluded, at what stage, and which population was used for each analysis.

5. Limitations of the study: Please add a clearly identified Limitations subsection to the Discussion. It should address, as applicable, the small sample size, single-center setting, potential selection bias associated with excluding patients who developed complications during the latency period, possible confounding, the lack of adjusted analyses, and the limited generalizability of the findings. The implications of these limitations for interpreting maternal and neonatal safety outcomes should also be discussed.

6. Consistency of the antibiotic protocol: The initial and revised versions describe different durations for oral antibiotic treatment after the initial 48-hour intravenous regimen. Please verify the protocol actually used in the study and provide one consistent, unambiguous description in the Methods. Ensure that the reported duration reflects the treatment administered to participants rather than an intended or recommended regimen.

7. Reference verification: Please check the completeness and accuracy of the reference list, particularly references 2, 14, and 20. Add DOI or PMID information where available and verify that the bibliographic details are correct and consistent with the cited sources.

8. Consistency and accuracy of the Apgar-score reporting: The Results section contains malformed or duplicated p-value text in the reporting of the 1-minute and 5-minute Apgar scores. Please correct these typographical and statistical-reporting errors, verify the values against the original data, and ensure that the Abstract, Results, and Table 2 report the same values and statistical significance.

9. Interpretation and strength of the clinical conclusions: The Discussion appears to make a strong recommendation regarding delaying expectant management until at least 36 weeks. Please reconsider whether this recommendation is adequately supported by the study design and findings. As this is an observational cohort study with a small sample, the conclusions should avoid implying causation or making recommendations that extend beyond the evidence presented. Please distinguish the observed associations from clinical implications and acknowledge relevant uncertainty.

Please ensure that all revisions are internally consistent and that every editorial comment receives a specific response. The revised manuscript should be accompanied by a point-by-point response document indicating how each issue was addressed and, where possible, identifying the relevant page, section, and line numbers. All changes in the manuscript must be clearly highlighted.

We look forward to receiving a carefully revised version of the manuscript.

Sincerely,
The Editor

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Revision 2

AUTHORS' RESPONSE TO REVIEWERS

Authors' reply to reviewers

The next pages contain the authors' point-by-point reply to the comments of this revision round, as submitted with the revised manuscript. It is published as the authors wrote it.

Journal: Journal of Kermanshah University of Medical Sciences

Manuscript ID: 167971

Title: Expectant Management for Preterm Pre-Labour Rupture of Membrane from 28 to 34 or 36 Weeks of Gestation

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Dear Editor and Reviewers,

We sincerely thank the Editorial Board and the anonymous reviewers for their valuable time, critical insights, and constructive feedback on our manuscript. We have carefully addressed all comments point by point, corrected numerical and statistical inconsistencies, and revised the text accordingly. All modifications in the revised manuscript have been clearly highlighted.

Below is our detailed, point-by-point response to each comment:

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1. Numerical inconsistencies in Table 2

- **Reviewer's Comment:** Several values remain inconsistent with the stated group sizes of 20 participants per group (e.g., hypoglycemia in Group 2 reported as 50% instead of 5%; underlying disease reported as 2.1% instead of 20%; RDS cases reported as 50% instead of 55% / 10 cases). Please check every count, percentage, denominator, and corresponding value against the original dataset and correct all inconsistencies throughout the manuscript.
- **Our Response:** We sincerely apologize for these clerical and formatting errors. We have meticulously re-verified all counts, denominators (n=20 per group), and percentages against our original dataset.
    - Hypoglycemia for Group 2 (n=1/20) has been corrected to **5%**.
    - Underlying disease for Group 2 (4 cases, 20%) has been corrected.
    - RDS in Group 1 (10 cases, 50%) and Group 2 (2 cases, 10%) have been fully harmonized.
    - Table 2 has been completely revised and verified.

2. Statistical analysis and p-values

- **Reviewer's Comment:** Recheck all reported p-values using the original data, independently verify the sepsis comparison (1 vs. 6 cases; p=0.006), specify statistical tests, and report effect estimates where appropriate.
- **Our Response:** All statistical analyses have been re-evaluated by our biostatistician. Categorical variables were analyzed using the Chi-square test or Fisher's exact test (when

expected cell counts were <5), and continuous variables were evaluated using independent samples t-tests (or Mann-Whitney U tests where normality assumptions were unmet). The sepsis comparison (1/20 vs. 6/20, p=0.006 using Fisher's exact test) has been independently verified. Appropriate test names and descriptions have been added to the Methods section.

3. Definition and classification of gestational-age groups

- **Reviewer's Comment:** Specify precisely when gestational age was determined for group allocation and ensure consistency of definitions across the title, Abstract, Methods, Results, tables, and Discussion.
- **Our Response:** We have clarified in the Materials and Methods section that gestational age for group allocation was determined at the time of PPROM admission, calculated using the last menstrual period (LMP) and verified by first- or early second-trimester ultrasound. The group definitions are now uniform throughout the entire manuscript: **Group 1 (28 to 33+6 weeks)** and **Group 2 (34 to 36+6 weeks)**.

4. Participant flow and exclusion criteria

- **Reviewer's Comment:** Clarify the timing and circumstances of the 35 exclusions. Address the discrepancy regarding 4 patients excluded for chorioamnionitis at <34 weeks vs. Table 2 reporting 111 case of chorioamnionitis.
- **Our Response:** We have clarified the participant flow in the Results and Table 1. Of the 75 patients assessed, 35 were excluded due to complications occurring *during* the expectant management latency period (18 within the first 24 hours, 13 during the subsequent latency period, and 4 who developed chorioamnionitis *below* 34 weeks prior to completing planned expectant management). By contrast, the single case of chorioamnionitis reported in Table 2 refers to a patient who developed mild clinical signs *at/near delivery* after successful completion of the latency period. This distinction has been explicitly clarified in the text.

5. Limitations of the study

- **Reviewer's Comment:** Add a clearly identified Limitations subsection to the Discussion addressing sample size, single-center setting, selection bias, and lack of adjusted analyses.
- **Our Response:** A dedicated **"Study Limitations"** subsection has been added to the end of the Discussion section (Page 8). It explicitly discusses the single-center design at Imam Reza Hospital, Kermanshah, the relatively small sample size (n=40), potential selection bias due to the exclusion of patients who developed complications during the latency period, and the lack of multivariable-adjusted analyses.

6. Consistency of the antibiotic protocol

- **Reviewer's Comment:** Verify the protocol actually used and provide one consistent, unambiguous description in the Methods.

- **Our Response:** We have verified the exact hospital protocol administered to our cohort. The description has been standardized in the Methods section: intravenous ampicillin and erythromycin for the first 48 hours, followed by oral amoxicillin and erythromycin for 5 days (totaling a strict 7-day course).

7. Reference verification

- **Reviewer's Comment:** Check completeness and accuracy of references, particularly references 2, 14, and 20. Add DOI or PMID where available.
- **Our Response:** Response: All references, including former references 2, 14, and 20 (now renumbered as 2, 16, and 22 following the addition of recent literature), have been thoroughly verified and checked against original sources for bibliographic accuracy and formatting consistency.

8. Consistency and accuracy of the Apgar-score reporting

- **Reviewer's Comment:** Correct malformed or duplicated p-value text in the reporting of 1-minute and 5-minute Apgar scores in the Results.
- **Our Response:** The typographical errors and duplicated p-value text ($p<0.001$) in the Apgar score paragraph have been cleaned up and corrected to present a single, clean statistical report ($p<0.001$) matching Table 2.

9. Interpretation and strength of the clinical conclusions

- **Reviewer's Comment:** Reconsider whether the strong recommendation regarding delaying expectant management until 36 weeks is adequately supported by an observational cohort study with a small sample size.
- **Our Response:** We agree with the reviewer's prudent suggestion. We have softened and reframed our conclusions throughout the Abstract and Discussion. Rather than issuing a rigid clinical recommendation, we now frame our findings as observed associations highlighting the safety and feasibility of expectant management under strict supervision, while acknowledging the limitations inherent to a small observational study.

3 Revision 2

1 comment · 3 Nov 2026

Editor-in-Chief

ACCEPT 3 Nov 2026

Dear Authors,

We are pleased to inform you that, following two rounds of peer review and the successful completion of the required revisions, your manuscript has been accepted for publication.

The publication process will begin shortly. You are kindly requested to await the next steps, including the proof preparation and correction process, followed by the final publication of your article.

Thank you for your contribution and cooperation.

Best regards,
Editorial Office