

OBSTETRICS & GYNECOLOGY



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- Comments from the reviewers and editors (email to author requesting revisions)
- Response from the author (cover letter submitted with revised manuscript)*
- Email correspondence between the editorial office and the authors*

**The corresponding author has opted to make this information publicly available.*

Personal or nonessential information may be redacted at the editor's discretion.

Questions about these materials may be directed to the *Obstetrics & Gynecology* editorial office:

obgyn@greenjournal.org.

Date: Aug 09, 2018
To: "Janie Pak"
From: "The Green Journal" em@greenjournal.org
Subject: Your Submission ONG-18-1245

RE: Manuscript Number ONG-18-1245

Retroperitoneal Ectopic Pregnancy

Dear Dr. Pak:

Your manuscript has been reviewed by the Editorial Board and by special expert referees. Although it is judged not acceptable for publication in Obstetrics & Gynecology in its present form, we would be willing to give further consideration to a revised version.

If you wish to consider revising your manuscript, you will first need to study carefully the enclosed reports submitted by the referees and editors. Each point raised requires a response, by either revising your manuscript or making a clear and convincing argument as to why no revision is needed. To facilitate our review, we prefer that the cover letter include the comments made by the reviewers and the editor followed by your response. The revised manuscript should indicate the position of all changes made. We suggest that you use the "track changes" feature in your word processing software to do so (rather than strikethrough or underline formatting).

Your paper will be maintained in active status for 21 days from the date of this letter. If we have not heard from you by Aug 30, 2018, we will assume you wish to withdraw the manuscript from further consideration.

REVIEWER COMMENTS:

REVIEWER #1:

This is an interesting manuscript with a purpose to "present a case of a retroperitoneal ectopic pregnancy in a woman who spontaneously conceived with no history of surgery." This is a case report.

1. In Figure 1 the authors demonstrate that "the retroperitoneal hematoma is seen extending into the left broad ligament and mesosalpinx." Could this have been an ampullary ectopic gestation that ruptured into the mesosalpinx and extended into the broad ligament and retroperitoneum? Was the left fallopian tube completely intact?

2. The authors noted that when they evacuated the retroperitoneal hematoma at the second laparotomy there was no source of bleeding identified. How did they inspect the retroperitoneal space? Did they open the retroperitoneum along the entire length of the hematoma, including the broad ligament and mesosalpinx? Without identifying a clear source of bleeding, how did they determine when to discontinue and close the abdomen?

3. The authors note that transabdominal ultrasound demonstrated a "mild" amount of free fluid so the diagnosis of ruptured ectopic gestation was made and patient taken emergently to the operating room. Were they able to visualize a mass in the retroperitoneum with ultrasound? Were they concerned that there was only a "mild" amount of fluid in this patient who was hypotensive and tachycardic? What was their differential diagnosis? Could the authors develop an algorithm for evaluation and management of a patient who presents with a positive urine hCG, hypotension, tender abdomen but only a small amount of fluid in the peritoneal cavity on ultrasound? With the flank pain, when would they do an ultrasound of the kidneys and flank? When would they consider doing a culdocentesis? When would they consider a CT scan of the abdomen and pelvis? What type of incision did they make for the laparotomy? How long did they observe the hematoma to see if it was expanding before closing at the first laparotomy?

4. The authors note that after the first laparotomy "a few hours later the patient clinical decompensated requiring a repeat laparotomy." Could the authors please expand on what they mean by clinically decompensated? As they now had blood products did they attempt to stabilize the patient with more blood products prior to returning to the operating room? Do the authors have the patients hemoglobin, hematocrit, Prothrombin time, and partial thromboplastin time? Did they repeat an ultrasound?

5. Line 91 & 92: "hypotensive and tachycardic". What was the patient's blood pressure and pulse? What was her hemoglobin?

6. The authors note that the "management of a retroperitoneal ectopic pregnancy requires a multi-disciplinary approach

given their propensity to implant along major vessels." The authors did not identify an implantation site close to a major vessel in this case report. Have there been other case reports of implantation on or close to a major vessel in a retroperitoneal ectopic?

REVIEWER #2:

I have reviewed this interesting case of a retroperitoneal ectopic pregnancy. The authors provide detailed clinical information regarding a 30 yo female who presented in hypovolemic shock. They are complete in their description of the surgical findings and include photographs for the readers. More information could be included regarding her postoperative course including transfusion and hemoglobin. This is an interesting case, in part because of the setting in a low resource area with minimal access to blood products.

1. line 49 "Retroperitoneal ectopic pregnancy is a rare", remove "a"
2. line 110 "we searched through the clots" should be re-worded into a statement about examining the hematoma or blood products

EDITORIAL OFFICE COMMENTS:

1. The Editors of Obstetrics & Gynecology are seeking to increase transparency around its peer-review process, in line with efforts to do so in international biomedical peer review publishing. If your article is accepted, we will be posting this revision letter as supplemental digital content to the published article online. Additionally, unless you choose to opt out, we will also be including your point-by-point response to the revision letter, as well as subsequent author queries. If you opt out of including your response, only the revision letter will be posted. Please reply to this letter with one of two responses:

1. OPT-IN: Yes, please publish my response letter and subsequent email correspondence related to author queries.
2. OPT-OUT: No, please do not publish my response letter and subsequent email correspondence related to author queries.

2. Our journal requires that all evidence-based research submissions be accompanied by a transparency declaration statement from the manuscript's lead author. The statement is as follows: "The lead author* affirms that this manuscript is an honest, accurate, and transparent account of the study being reported; that no important aspects of the study have been omitted; and that any discrepancies from the study as planned (and, if relevant, registered) have been explained."

*The manuscript's guarantor.

If you are the lead author, please include this statement in your cover letter. If the lead author is a different person, please ask him/her to submit the signed transparency declaration to you. This document may be uploaded with your submission in Editorial Manager.

3. Standard obstetric and gynecology data definitions have been developed through the reVITALize initiative, which was convened by the American College of Obstetricians and Gynecologists and the members of the Women's Health Registry Alliance. Obstetrics & Gynecology will be transitioning as much as possible to use of the reVITALize definitions, and we encourage authors to familiarize themselves with them. The obstetric data definitions are available at <http://links.lww.com/AOG/A515>, and the gynecology data definitions are available at <http://links.lww.com/AOG/A935>.

4. Because of space limitations, it is important that your revised manuscript adhere to the following length restrictions by manuscript type: Case Reports should not exceed 8 typed, double-spaced pages (2,000 words). Stated page limits include all numbered pages in a manuscript (i.e., title page, précis, abstract, text, references, tables, boxes, figure legends, and appendices).

Please limit your Introduction to 250 words and your Discussion to 750 words.

5. The most common deficiency in revised manuscripts involves the abstract. Be sure there are no inconsistencies between the Abstract and the manuscript, and that the Abstract has a clear conclusion statement based on the results found in the paper. Make sure that the abstract does not contain information that does not appear in the body text. If you submit a revision, please check the abstract carefully.

In addition, the abstract length should follow journal guidelines. The word limits for different article types are as follows: Case Reports, 125 words. Please provide a word count.

6. Only standard abbreviations and acronyms are allowed. A selected list is available online at <http://edmgr.ovid.com/ong/accounts/abbreviations.pdf>. Abbreviations and acronyms cannot be used in the title or précis. Abbreviations and acronyms must be spelled out the first time they are used in the abstract and again in the body of the manuscript.

7. The journal does not use the virgule symbol (/) in sentences with words. Please rephrase your text to avoid using "and/or," or similar constructions throughout the text. You may retain this symbol if you are using it to express data or a measurement.

If you choose to revise your manuscript, please submit your revision via Editorial Manager for Obstetrics & Gynecology at <http://ong.editorialmanager.com>. It is essential that your cover letter list point-by-point the changes made in response to each criticism. Also, please save and submit your manuscript in a word processing format such as Microsoft Word.

If you submit a revision, we will assume that it has been developed in consultation with your co-authors, that each author has given approval to the final form of the revision, and that the agreement form signed by each author and submitted with the initial version remains valid.

Again, your paper will be maintained in active status for 21 days from the date of this letter. If we have not heard from you by Aug 30, 2018, we will assume you wish to withdraw the manuscript from further consideration.

Sincerely,

The Editors of Obstetrics & Gynecology

2017 IMPACT FACTOR: 4.982

2017 IMPACT FACTOR RANKING: 5th out of 82 ob/gyn journals

If you would like your personal information to be removed from the database, please contact the publication office.

19 August 2018

Re: Revision of Manuscript Number ONG-18-1245, Retroperitoneal Ectopic Pregnancy

The Editors^[1] Obstetrics & Gynecology
409 12th Street, SW
Washington, DC 20024-2188

Dear Editors:

My co-authors and I thank you for reviewing our manuscript (ONG-18-1245) submitted on June 25, 2018 and providing valuable feedback. This letter is in response to the reviewers' comments provided via email on August 8, 2018. We greatly appreciate your willingness to consider a revised version.

Each of the reviewers' points is copied below followed by our written responses and manuscript revisions. The "track changes" feature was used to track all changes. The lines of the edited phrases in the new draft are included.

The revised version meets the case report word count requirements as follows:

- Abstract: 117
- Introduction: 167
- Discussion: 495
- Total Manuscript: 1906 words, 8 pages

Additionally, We opt-in to increasing transparency of the peer-review process and agree to have our response letter and subsequent email correspondences published.

The co-authors have reviewed and agree with the responses and revisions made to the original manuscript. As the lead author, I affirm that this manuscript is an honest, accurate, and transparent account of the case being reported and that no important aspects of the case have been omitted to the best of my ability.

I am glad to address any questions regarding the manuscript and thank you for your time and consideration.

Sincerely,



Janie Pak

REVIEWER #1:

1. In Figure 1 the authors demonstrate that "the retroperitoneal hematoma is seen extending into the left broad ligament and mesosalpinx." Could this have been an ampullary ectopic gestation that ruptured into the mesosalpinx and extended into the broad ligament and retroperitoneum? Was the left fallopian tube completely intact?

Both fallopian tubes, particularly the left side, were inspected from the uterine cornua to the fimbriae and were found to be intact, including the ampullary region. The word "intact" was added to clarify that there was no adnexal involvement.

- Lines 80-81: "An exploratory laparotomy via a Pfannenstiel incision revealed minimal hemoperitoneum and a normal uterus with intact bilateral adnexa (Fig. 1)."

- Line 174-175 (Figure legend): "Intraoperative findings of a normal uterus and bilateral adnexae that were completely intact."

2. The authors noted that when they evacuated the retroperitoneal hematoma at the second laparotomy there was no source of bleeding identified. How did they inspect the retroperitoneal space? Did they open the retroperitoneum along the entire length of the hematoma, including the broad ligament and mesosalpinx? Without identifying a clear source of bleeding, how did they determine when to discontinue and close the abdomen?

The following additional details of the surgery have been added in to clarify intraoperative findings and procedures:

- Lines 96-102: "General surgery opened and evaluated the retroperitoneal space along the entire length of the hematoma including the broad ligament with particular attention to the vasculature. There was no evidence of trauma, tumors, or vascular malformations but a gestational sac with chorionic villi (Fig. 3) was identified within the evacuated hematoma and confirmed on histopathology. Despite extensive inspection, no sites of implantation or active bleeding were identified and the abdomen was closed."

3. The authors note that transabdominal ultrasound demonstrated a "mild" amount of free fluid so the diagnosis of ruptured ectopic gestation was made and patient taken emergently to the operating room.

a) Were they able to visualize a mass in the retroperitoneum with ultrasound? Were they concerned that there was only a "mild" amount of fluid in this patient who was hypotensive and tachycardic?

Thank you for this feedback. We apologize for this error as the "mild" amount of fluid was actually an intraoperative, not preoperative, finding. The quantity of free fluid seen on a limited bedside ultrasound was not quantified and there was no mention of a retroperitoneal mass. What was reported was the presence free fluid with no intrauterine

pregnancy. Thus, given the hypovolemic shock with a positive pregnancy test and no intrauterine pregnancy, the patient was taken for an emergent surgery for a presumed ruptured ectopic pregnancy. Corrections were made to clarify reported findings on ultrasound:

- Lines 73-75: “A bedside transabdominal ultrasound showed free fluid with no intrauterine pregnancy. An adnexal or retroperitoneal mass was not reported.”

b) What was their differential diagnosis?

The differential diagnosis was added to the following lines:

- Line 98-100: “There was no evidence of trauma, tumors, or vascular malformations but a gestational sac with chorionic villi (Fig. 3) was identified within the evacuated hematoma and confirmed on histopathology.”

- The differential diagnosis is also mentioned in lines 125-130:

“While a retroperitoneal ectopic pregnancy was on the differential, other causes of a retroperitoneal hematoma were considered. There was an attempt to medically terminate the pregnancy but there was no evidence of cervico-vaginal trauma or uterine perforation to suggest a complication of an unreported surgical abortion. Additional differential diagnoses included vascular malformation, bleeding of an hCG-producing tumor, and trauma in the setting of a complete abortion or an early pregnancy.”

c) Could the authors develop an algorithm for evaluation and management of a patient who presents with a positive urine hCG, hypotension, tender abdomen but only a small amount of fluid in the peritoneal cavity on ultrasound? With the flank pain, when would they do an ultrasound of the kidneys and flank? When would they consider doing a culdocentesis? When would they consider a CT scan of the abdomen and pelvis?

Given the wide spectrum of available resources and accessible expertise influencing management decisions, we feel it would be difficult to structure a practical, useful algorithm that can be widely used for a patient with a positive urine hCG, hypotension, tender abdomen but only a small amount of fluid in the peritoneal cavity on ultrasound. While additional imaging is useful in a hemodynamically stable patient, we would not generally recommend further imaging or a culdocentesis in a patient with a positive urine hCG, hypotension, and an acute abdomen, even in the absence of significant free fluid on initial ultrasound. We are concerned that doing so may significantly delay a necessary surgical intervention. Delays are often greatly magnified in low resource settings as barriers to urgent mobilization to the operating room may already exist. Additional challenges include delays in obtaining and reporting of tests, limited access to advanced or urgent imaging, and lack of workforce to appropriately monitor a patient.

We do agree that additional imaging in a hemodynamically stable patient with a pregnancy of unknown location and flank pain should be considered to avoid missing this rare, but life-threatening, condition. As such, the following was added:

- Line 140-142: "In hemodynamically stable patients with predominant flank pain and a pregnancy of unknown location, imaging of the retroperitoneum with an ultrasound or computed tomography scan should be considered."

d) What type of incision did they make for the laparotomy?

Clarification on the type of incision was made as follows:

- Line 80-81: "An exploratory laparotomy via a Pfannenstiel incision revealed minimal hemoperitoneum and a normal uterus with intact bilateral adnexa (Fig. 1)."

- Line 84-85: "General surgery was consulted and a midline vertical incision was made."

e) How long did they observe the hematoma to see if it was expanding before closing at the first laparotomy?

The hematoma was constantly re-assessed (both visually and by palpation) as the abdomen and pelvis were being explored. This was clarified as follows:

- Line 88-90: "Given the hematoma did not expand during the two-hour surgery and the lack of blood products, we decided to leave the retroperitoneum intact due to the risk of hemorrhage upon releasing the tamponade."

4. The authors note that after the first laparotomy "a few hours later the patient clinical decompensated requiring a repeat laparotomy."

a) Could the authors please expand on what they mean by clinically decompensated? As they now had blood products did they attempt to stabilize the patient with more blood products prior to returning to the operating room?

To clarify the patient's clinical deterioration, her postoperative vitals and findings after the first laparotomy were added. Blood products were requested and transfused as they became available in ICU, prior to the patient's second laparotomy, but the patient's condition continued to decline. Moreover, the supply of blood products remained limited and unpredictable. The detail of an abdominal drain placed at the first laparotomy was added as it factored into decision to return to the operating room for the second laparotomy:

- Lines 90-92: "The abdomen was closed after placing an intraperitoneal drain to help identify post-operative bleeding given limitations on obtaining rapid imaging and laboratory results."

- Lines 92-96: "A few hours later, despite ongoing transfusions as blood products became available, the patient became hypotensive (66-94/43-64 mm Hg), tachycardic (heart rate 113-119 beats per minute) with increased blood draining from the intraperitoneal drain. Due to concern for ongoing bleeding, the patient was emergently taken for a second laparotomy."

b) Do the authors have the patient's hemoglobin, hematocrit, Prothrombin time, and partial thromboplastin time?

While hemoglobin levels were reported, hematocrit levels were not. Prothrombin time (PT) and partial thromboplastin time (PTT) were not performed as results usually take

several days to return from an outside lab, and thus, would not have been available to guide acute management. At the time of the second laparotomy, only the admission hemoglobin was available. A hemoglobin was repeated during surgery. The following lines were added to clarify the above details:

- Line 75-76 (Admission hemoglobin): "Hemoglobin was 10.1 grams/dL but was not felt to reflect the acute blood loss. Coagulation labs were unavailable."
- Line 102: "An intraoperative hemoglobin was 6.6 grams/dL."

c) Did they repeat an ultrasound?

A repeat ultrasound was not repeated as attempting to get imaging would have significantly delayed surgery. There are no emergency radiology services. Moreover, a strict emergency department policy prohibited removal of the portable ultrasound machine from the emergency room where the patient had her initial bedside ultrasound.

- Line 95-96: "Due to concern for ongoing bleeding, the patient was emergently taken for a second laparotomy. No additional imaging was done."

5. Line 91 & 92: "hypotensive and tachycardic". What was the patient's blood pressure and pulse? What was her hemoglobin?

Details of patient's vitals on presentation were added:

- Lines 71-72: "On admission, the patient was hypotensive with a blood pressure of 57/33 mm Hg and a heart rate of 108 beats per minute."
- Line 75 (Admission hemoglobin): "Hemoglobin was 10.1 grams/dL but was not felt to reflect the acute blood loss."

6. The authors note that the "management of a retroperitoneal ectopic pregnancy requires a multi-disciplinary approach given their propensity to implant along major vessels." The authors did not identify an implantation site close to a major vessel in this case report. Have there been other case reports of implantation on or close to a major vessel in a retroperitoneal ectopic?

Numerous case reports of retroperitoneal ectopic pregnancies have reported implantation sites over or immediately adjacent to major vessels, including five of the references cited in this manuscript. Superscripts were added to reference these citations:

- Line 49-50 (Teaching Points): "Management of a retroperitoneal ectopic pregnancy requires a multi-disciplinary approach given their propensity to implant along major vessels^{3,4,5,7,8}."
- Line 113-115: "Given their propensity to implant along major vessels^{3,4,5,7,8}, retroperitoneal ectopic pregnancies pose a significant risk of life-threatening hemorrhage."

REVIEWER #2:

I have reviewed this interesting case of a retroperitoneal ectopic pregnancy. The authors provide detailed clinical information regarding a 30 yo female who presented in hypovolemic shock. They are complete in their description of the surgical findings and include photographs for the readers.

1. More information could be included regarding her postoperative course including transfusion and hemoglobin. This is an interesting case, in part because of the setting in a low resource area with minimal access to blood products.

Additional details regarding the patient's postoperative course were added as follows:

- Lines 102-105: "The patient received a total of 7 units of packed red blood cells, 8 units of fresh frozen plasma and 3 units of cryoprecipitate. Her hemoglobin was 7.6 grams/dL immediately after the second surgery and 10.7 grams/dL by day of discharge on postoperative day 10."

2. line 49 "Retroperitoneal ectopic pregnancy is a rare", remove "a"

The "a" was deleted and line 33-34 (previously line 49) now reads: "Retroperitoneal ectopic pregnancies are rare and have a tendency to implant along major vessels of the abdomen and pelvis."

3. line 110 "we searched through the clots" should be re-worded into a statement about examining the hematoma or blood products

The above phrase was edited as follows:

- Lines 98-100: "There was no evidence of trauma, tumors, or aneurysms but a gestational sac with chorionic villi (Fig. 3) was identified within the evacuated hematoma and confirmed on histopathology."

EDITORIAL OFFICE COMMENTS:

1. The Editors of Obstetrics & Gynecology are seeking to increase transparency around its peer-review process, in line with efforts to do so in international biomedical peer review publishing. If your article is accepted, we will be posting this revision letter as supplemental digital content to the published article online. Additionally, unless you choose to opt out, we will also be including your point-by-point response to the revision letter, as well as subsequent author queries. If you opt out of including your response, only the revision letter will be posted. Please reply to this letter with one of two responses:

We opt in and included this statement in cover letter above.

2. Our journal requires that all evidence-based research submissions be accompanied by a transparency declaration statement from the manuscript's lead author. The statement is as follows: "The lead author* affirms that this manuscript is an honest, accurate, and transparent account of the study being reported; that no important aspects of the study have been omitted; and that any discrepancies from the study as planned (and, if relevant, registered) have been explained." *The manuscript's guarantor. If you are the lead author, please include this statement in your cover letter. If the lead author is a different person, please ask him/her to submit the signed transparency declaration to you. This document may be uploaded with your submission in Editorial Manager.

The above statement was included in the cover letter replacing the word "study" with "case" to indicate this was a case report. The phrase, "and that any discrepancies from the study as planned (and, if relevant, registered) have been explained," was not included as it did not apply to case reports.

3. Standard obstetric and gynecology data definitions have been developed through the reVITALize initiative, which was convened by the American College of Obstetricians and Gynecologists and the members of the Women's Health Registry Alliance. Obstetrics & Gynecology will be transitioning as much as possible to use of the reVITALize definitions, and we encourage authors to familiarize themselves with them. The obstetric data definitions are available at <http://links.lww.com/AOG/A515>, and the gynecology data definitions are available at <http://links.lww.com/AOG/A935>.

No inconsistencies between this manuscript and the reVITALize initiative were identified.

4. Because of space limitations, it is important that your revised manuscript adhere to the following length restrictions by manuscript type: Case Reports should not exceed 8 typed, double-spaced pages (2,000 words). Stated page limits include all numbered pages in a manuscript (i.e., title page, précis, abstract, text, references, tables, boxes, figure legends, and appendixes). Please limit your Introduction to 250 words and your Discussion to 750 words.

The manuscript complies with page and word limits. Word count is provided in cover letter above.

5. The most common deficiency in revised manuscripts involves the abstract. Be sure there are no inconsistencies between the Abstract and the manuscript, and that the Abstract has a clear conclusion statement based on the results found in the paper. Make sure that the abstract does not contain information that does not appear in the body text. If you submit a revision, please check the abstract carefully. In addition, the abstract length should follow journal guidelines. The

word limits for different article types are as follows: Case Reports, 125 words. Please provide a word count.

Abstract was reviewed and is consistent with the manuscript and has a clear conclusion statement. It does not contain any information that does not appear in the body of the text. It has less than 125 words and the word count is provided in cover letter above.

6. Only standard abbreviations and acronyms are allowed. A selected list is available online at <http://edmgr.ovid.com/ong/accounts/abbreviations.pdf>. Abbreviations and acronyms cannot be used in the title or précis. Abbreviations and acronyms must be spelled out the first time they are used in the abstract and again in the body of the manuscript.

Only standard abbreviations and acronyms are included in the manuscript.

7. The journal does not use the virgule symbol (/) in sentences with words. Please rephrase your text to avoid using "and/or," or similar constructions throughout the text. You may retain this symbol if you are using it to express data or a measurement.

The virgule symbol is only used to present data or measurements.

Daniel Mosier

From: Janie Pak [REDACTED]
Sent: Wednesday, August 29, 2018 5:19 PM
To: Daniel Mosier
Subject: Re: Manuscript Revisions: ONG-18-1245R1
Attachments: 18-1245R1 ms (8-28-18v2).docx

Dear Daniel,

Thank you very much for this email. Here is a point-by-point response to each of the inquiries below. The revised manuscript is attached with all changes tracked.

1. Please note the minor edits and deletions throughout. Please let us know if you disagree with any of these changes.

Thank you for the edits throughout the manuscript. I agree with all the edits.
I made a minor edit as follows:

- Line 206: I added “trauma” to the differential an unreported trauma, especially intimate partner violence, is common and can be a potential cause of a retroperitoneal hematoma.

2. LINE 19: We noticed you removed Lucio Pedro as a coauthor. We need written consent from all of the individuals on your manuscript. Please fill out our authorship change form, which we will send to you via email. The form is attached to this message.

Thank you for catching this error. Dr. Lucio Pedro is a coauthor of this paper and approved most recent submission of the manuscript. His name, however, was mistakenly combined with the last line of Dr. John Durfee’s information making it appear as if his name was deleted. Thus, I corrected the spacing error such that Dr. Lucio Pedro’s name is now separate and appears in line 9.

3. LINE 58: It’s not clear what gen surg contributed – at minimum, does not seem to be an important point

Thank you very much for the changes to the teaching points. I agree the changes better reflect lessons learned from this particular case.

We do, however, feel it is important to mention general surgery’s involvement, even if briefly. When the retroperitoneal hematoma was discovered, we recognized our limitations and felt it was important to involve a specialty with more experience operating on retroperitoneal vessels/organs and ability to do vascular repairs. Given the risk of rapid blood loss, all providers agreed that general surgery should be the primary surgeons for the second surgery as they were the subspecialty best equipped to address these issues in Guyana. While skills and experience of OB/GYN generalists do vary, we do feel it is important to involve other specialties with these skills (ie: vascular repair) early on in these complicated cases. For these reasons, the following phrases in bold were added as follows:

- Lines 132-133: “Due to the unexpected findings, the incision was converted to a midline vertical laparotomy **and general surgery was consulted.**”

- Lines 239-240: "Given the propensity of retroperitoneal ectopic pregnancies to implant along great vessels, a **multi-disciplinary approach**, adequate exposure and preparation for a massive transfusion **are** essential."

4. LINE 59: The Teaching Points are part of the abstract, and we can't cite references in the abstract, so theses were removed.

Thank you. I agree with this edit.

5. LINE 145: Did the 2nd operation take place in the 'main OR'? – it would be important to mention this if true.

Thank you for this feedback. I agree this is important and have added "main operating room" to lines 164-165 to clarify the location of the second operation.

Thank you very much,
Janie

On Wed, Aug 29, 2018 at 7:50 AM Daniel Mosier <dmosier@greenjournal.org> wrote:

Dear Dr. Pak,

Thank you for submitting your revised manuscript. It has been reviewed by the editor, and there are a few issues that must be addressed before we can consider your manuscript further:

1. Please note the minor edits and deletions throughout. Please let us know if you disagree with any of these changes.
2. LINE 19: We noticed you removed Lucio Pedro as a coauthor. We need written consent from all of the individuals on your manuscript. Please fill out our authorship change form, which we will send to you via email. The form is attached to this message.
3. LINE 58: It's not clear what gen surg contributed – at minimum, does not seem to be an important point
4. LINE 59: The Teaching Points are part of the abstract, and we can't cite references in the abstract, so theses were removed.
5. LINE 145: Did the 2nd operation take place in the 'main OR'? – it would be important to mention this if true.

Each of these points are marked in the attached manuscript. Please respond point-by-point to these queries in a return email, and make the requested changes to the manuscript. When revising, please leave the track changes on, and do not use the "Accept all Changes" function in Microsoft Word.

Please let me know if you have any questions. Your prompt response to these queries will be appreciated; please respond no later than COB on **Friday, August 31st**.

Sincerely,

-Daniel Mosier

Daniel Mosier

Editorial Assistant

Obstetrics & Gynecology

The American College of Obstetricians and Gynecologists

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From: [REDACTED]
To: [Stephanie Casway](#)
Cc: [REDACTED]
Subject: Fwd: O&G Figure Revision: 18-1245
Date: Wednesday, September 5, 2018 10:55:57 AM

Hi Stephanie!

Thank you very much for this follow up email. I thought I had responded the morning I received your email. I am very very sorry if the email did not go through.

But regardless, I do not have any objections to the edits and agree with the changed made.

Thank you so much,
Janie
[REDACTED]

Sent from my iPhone

Begin forwarded message:

From: Janie Pak [REDACTED]
Date: August 29, 2018 at 7:22:52 AM PDT
To: SCasway@greenjournal.org
Subject: Re: O&G Figure Revision: 18-1245

Good morning, Stephanie!

These edits look great to me. I have no objections or additional changes to add.

Thank you so much,
Janie Pak
[REDACTED]

On Wed, Aug 29, 2018 at 5:41 AM Stephanie Casway
<SCasway@greenjournal.org> wrote:

Good Morning Dr. Pak,

Your figures and legend have been edited, and PDFs of the figures and legend are attached for your review. Please review the figures CAREFULLY for any mistakes. Note that Figure 3 is not attached, as no edits were made.

PLEASE NOTE: Any changes to the figures must be made now. Changes at later stages are expensive and time-consuming and may result in the delay of

your article's publication.

To avoid a delay, I would be grateful to receive a reply no later than Friday, 8/31. Thank you for your help.

Best wishes,

Stephanie Casway, MA
Production Editor

Obstetrics & Gynecology
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