

# 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](mailto:obgyn@greenjournal.org).

**Date:** Aug 16, 2018  
**To:** "Mark A. Turrentine" [REDACTED]  
**From:** "The Green Journal" em@greenjournal.org  
**Subject:** Your Submission ONG-18-1425

RE: Manuscript Number ONG-18-1425

Antepartum Testing for the prevention of stillbirth: Where do we go from here?

Dear Dr. Turrentine:

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 Sep 06, 2018, we will assume you wish to withdraw the manuscript from further consideration.

#### REVIEWER COMMENTS:

##### REVIEWER #1:

##### Overall Comment:

The authors provide a clinical commentary on the use of antenatal fetal testing and current clinical practice and its expansion into other potential identified high-risk groups. The authors essentially restate the clinical importance of prevention of fetal demise. They state that as additional high-risk groups of women are identified, indications for antenatal testing continue to expand despite quality data linking such testing to improved outcomes for women and their pregnancies who have these additional risk factors.

A review of the literature is performed with respect to the development of the antenatal testing and the risks and benefits of the various tests such as contraction, stress test, non-stress test, biophysical profile and they do not directly comment on the use of Doppler. They discuss the risks and benefits of the respective tests as well as those groups in which positive predictive value have been noted. Further, it is evident from the discussion that those women of higher socio-economic status receiving an increased number of prenatal visits, a population in which stillbirth deaths are reduced. It is unclear whether the authors are trying to project that there are women that are of a status with increased surveillance and have a decreased risk of stillbirth versus those that in general are managed by an algorithm of evaluations and treatments based on current best evidence. This is overtly noted where the authors state that the implementation of any scheme of antenatal assessment will by virtue of an increased rate of delivery avoid some stillbirths.

Most of the commentary is reflected in a previous executive summary of the Eunice Kennedy Shriver National Institute of Child Health and Human Development Workshop that was published in Obstetrics and Gynecology in 2009. They note the same frustrations with respect to the application of these tests identification of high risk groups in which to implement these tests and further identification of new groups including women with advanced maternal age and obesity.

The authors of the NICHD workshop describe well the need for continued study in this area and the importance of randomized clinical trials. Future directions as noted in the current clinical commentary overall reflect that currently accepted approaches to antenatal testing should not be abandoned and they also state that properly constructed randomized clinical trials of the potential newer indications in maternal age and obesity should be more strongly considered. These sentiments are in alignment with the previous NICHD review which states that conducting well-designed randomized trials can be challenging especially as despite weaknesses in evidence with respect as to who should receive the antenatal testing, this testing has become an accepted and expected component of prenatal care making it difficult to design definitive trials. They further state that even among pregnancies at increased risk stillbirth is an outcome. As many of late fetal deaths occur in women without an identifiable noted risk factor that is especially difficult to design

strategies for using antenatal testing to prevent unexpected losses.

In summary, the authors of the current commentary express an opinion that I believe already understood and accepted in the area of management of high risk births and, thus, I feel this commentary does not add to the current literature except for more strongly advocating for the study of antenatal testing in women of advanced maternal age and obesity.

#### REVIEWER #2:

Johnson, et al present a Clinical Commentary about expanding indications for antepartum testing (AT). This is certainly a timely and important topic that warrants discussion. I have several comments:

1. The historical section is important for context but much too long. It should be shortened to a page at most and some of the information could be condensed to a table.
2. For the paragraph starting line 135, this is an important concept that needs to be stated more clearly in plain English: Any test or intervention that results in more deliveries at or after 39 weeks will reduce the stillbirth rate. The impact on other outcomes (health care costs, Cesarean rate, downstream impacts such as morbidly adherent placentation, etc.) also need to be considered.
3. The first sentence of line 144 warrants expansion: what are the potential/likely pros and cons of "repetitive provider-performed testing"??
4. Perhaps most importantly, some outline of what increased testing might reasonably be expected to accomplish is needed to make this commentary useful. Simply stating "RCTs should be done" is too superficial. What OR/RR of stillbirth is likely to be a reasonable target for intervention? For example, a JAMA article by Aune, et al (JAMA. 2014 Apr 16;311(15):1536-46. doi: 10.1001/jama.2014.2269) showed a statistically significant RR of IUFD of 1.21 for a 5 unit increase in BMI. Is this a likely target for AT? How many women would need to be studied given the rate of IUFD and an expected effect size of AT? As the authors have (appropriately) selected obesity and AMA as "new" targets for AT, some examples of what an RCT to study the impact of AT for these indications. Without drilling down on such issues in more depth I'm afraid this commentary doesn't add much.

#### REVIEWER #3:

This review of antepartum testing by Johnson et al is well written and describes a concern that most obstetricians have of the continued escalation of the use of antepartum testing for questionable indications. I completely agree with the authors' premise that little data supports the increasing use of antepartum testing and more so the marked increase in frequency of testing. It is common to see patients having daily or twice daily NST with absolutely no data to support this type of use. I have a concern that the authors state at the end of the article to continue the current practice of antepartum testing even though their data does not support this. They need to be more definitive in their recommendation instead of taking the easy way of saying to leaving things unchanged. They should comment on why they have decided to support the use of antepartum testing to remain unchanged. They need to be much stronger in discussing the frequency of testing and its current abuse. Is there a financial concern that affects its current usage? Also, they need to discuss the legal liability of not doing antepartum testing with an ensuing poor outcome. Are they willing to testify for the defense when the testing was not performed because there are plenty of physicians who will. Their statement about performing randomized trials in the current clinical and legal environment is truly a fantasy. The same has been suggested about intrapartum fetal monitoring for 30 years yet no new studies will ever be performed.

I do believe in the message that the authors present but I am completely pessimistic that anything will change.

#### ASSOCIATE EDITOR'S COMMENTS:

Excellent written commentary but it ultimately fails to satisfy re: the vague ending call for randomized trials. We would be willing to consider a revision that addresses in a more specific way how a randomized trial would be conducted and the feasibility of such an endeavor.

Things to think about:

- 1) Sample size
- 2) Design: Individual randomization, cluster randomization, stepped wedge evaluation? Something else?
- 3) Testing modality?
- 3) Feasibility and costs

As written, I don't think this offers as much as it could to our predominantly clinician audience as it provides no real specifics on a potential way forward.

## 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. Each author on this manuscript must submit a completed copy of our revised author agreement form (updated in the August 2014 issue). Please note:

a) Any material included in your submission that is not original or that you are not able to transfer copyright for must be listed under I.B on the first page of the author agreement form.

b) All authors must disclose any financial involvement that could represent potential conflicts of interest in an attachment to the author agreement form.

c) All authors must indicate their contributions to the submission by checking the applicable boxes on the author agreement form.

d) The role of authorship in Obstetrics & Gynecology is reserved for those individuals who meet the criteria recommended by the International Committee of Medical Journal Editors (ICMJE; <http://www.icmje.org>):

\* Substantial contributions to the conception or design of the work;

OR

the acquisition, analysis, or interpretation of data for the work;

AND

\* Drafting the work or revising it critically for important intellectual content;

AND

\* Final approval of the version to be published;

AND

\* Agreement to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

The author agreement form is available online at <http://edmgr.ovid.com/ong/accounts/agreementform.pdf>. Signed forms should be scanned and uploaded into Editorial Manager with your other manuscript files. Any forms collected after your revision is submitted may be e-mailed to [obgyn@greenjournal.org](mailto:obgyn@greenjournal.org).

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: Current Commentary articles should not exceed 12 typed, double-spaced pages (3,000 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. Specific rules govern the use of acknowledgments in the journal. Please edit your acknowledgments or provide more information in accordance with the following guidelines:

\* All financial support of the study must be acknowledged.

\* Any and all manuscript preparation assistance, including but not limited to topic development, data collection, analysis, writing, or editorial assistance, must be disclosed in the acknowledgments. Such acknowledgments must identify the entities that provided and paid for this assistance, whether directly or indirectly.

\* All persons who contributed to the work reported in the manuscript, but not sufficiently to be authors, must be acknowledged. Written permission must be obtained from all individuals named in the acknowledgments, as readers may infer their endorsement of the data and conclusions. Please note that your signature on the journal's author agreement form verifies that permission has been obtained from all named persons.

\* If all or part of the paper was presented at the Annual Clinical and Scientific Meeting of the American College of Obstetricians and Gynecologists or at any other organizational meeting, that presentation should be noted (include the exact dates and location of the meeting).

6. 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: Current Commentary articles, 250 words. Please provide a word count.

7. 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.

8. 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.

9. We discourage claims of first reports since they are often difficult to prove. How do you know this is the first report? If this is based on a systematic search of the literature, that search should be described in the text (search engine, search terms, date range of search, and languages encompassed by the search). If on the other hand, it is not based on a systematic search but only on your level of awareness, it is not a claim we permit.

10. The American College of Obstetricians and Gynecologists' (College) documents are frequently updated. These documents may be withdrawn and replaced with newer, revised versions. If you cite College documents in your manuscript, be sure the reference you are citing is still current and available. If the reference you are citing has been updated (ie, replaced by a newer version), please ensure that the new version supports whatever statement you are making in your manuscript and then update your reference list accordingly. If the reference you are citing has been withdrawn with no clear replacement, please contact the editorial office for assistance ([obgyn@greenjournal.org](mailto:obgyn@greenjournal.org)). In most cases, if a College document has been withdrawn, it should not be referenced in your manuscript (exceptions could include manuscripts that address items of historical interest). All College documents (eg, Committee Opinions and Practice Bulletins) may be found via the Resources and Publications page at <http://www.acog.org/Resources-And-Publications>.

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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 Sep 06, 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

August 28, 2018

Editor

Obstetrics & Gynecology

RE: Manuscript ID ONG-18-1425

Dear Editor,

We wish to thank the Editor and Reviewers for their comments. We also want to thank you for the opportunity to do the revisions. The suggestions were fantastic and the manuscript is stronger from them. We will address each comment individually. We have attached a manuscript version with the Track Changes as well as a “clean version” with the Track Changes accepted for ease of readability. The line numbers refer to the revised Track Changes version. 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. Finally, regarding the inquiry of transparency around peer-review. Yes, please publish our response letter and subsequent email correspondence related to author queries.

Best regards,

Mark Turrentine, MD

REVIEWER #1:

Overall Comment:

The authors provide a clinical commentary on the use of antenatal fetal testing and current clinical practice and its expansion into other potential identified high-risk groups. The authors essentially restate the clinical importance of prevention of fetal demise. They state that as additional high-risk groups of women are identified, indications for antenatal testing continue to expand despite quality data linking such testing to improved outcomes for women and their pregnancies who have these additional risk factors.

A review of the literature is performed with respect to the development of the antenatal testing and the risks and benefits of the various tests such as contraction, stress test, non-stress test, biophysical profile and they do not directly comment on the use of Doppler. They discuss the risks and benefits of the respective tests as well as those groups in which positive predictive value have been noted. Further, it is evident from the discussion that those women of higher socio-economic status receiving an increased number of prenatal visits, a population in which stillbirth deaths are reduced. It is unclear whether the authors are trying to project that there are women that are of a status with increased surveillance and have a decreased risk of stillbirth versus those that in general are managed by an algorithm of evaluations and treatments based on current best evidence. This is overtly noted where the authors state that the implementation of any scheme of antenatal assessment will by virtue of an increased rate of delivery avoid some stillbirths.

Most of the commentary is reflected in a previous executive summary of the Eunice Kennedy Shriver National Institute of Child Health and Human Development Workshop that was published in Obstetrics and Gynecology in 2009. They note the same frustrations with respect to the application of these tests identification of high risk groups in which to implement these tests and further identification of new groups including women with advanced maternal age and obesity.

The authors of the NICHD workshop describe well the need for continued study in this area and the importance of randomized clinical trials. Future directions as noted in the current clinical commentary overall reflect that currently accepted approaches to antenatal testing should not be abandoned and they also state that properly constructed randomized clinical trials of the potential newer indications in maternal age and obesity should be more strongly considered. These sentiments are in alignment with the previous NICHD review which states that conducting well-designed randomized trials can be challenging especially as despite weaknesses in evidence with respect as to who should receive the antenatal testing, this testing has become an accepted and expected component of prenatal care making it difficult to design definitive trials. They further state that even among pregnancies at increased risk stillbirth is an outcome.

As many of late fetal deaths occur in women without an identifiable noted risk factor that is especially difficult to design strategies for using antenatal testing to prevent unexpected losses.

In summary, the authors of the current commentary express an opinion that I believe already understood and accepted in the area of management of high risk births and, thus, I feel this commentary does not add to the current literature except for more strongly advocating for the study of antenatal testing in women of advanced maternal age and obesity.

While we appreciate the NICHD document (Signore 2009) and have referenced it in our manuscript, we, as well as the other Reviewers, disagree that our review adds nothing new to the literature. While the NICHD document did discuss the paucity of good data supporting the efficacy of antenatal testing, the main points of our discussion were not addressed at all by the NICHD document. These include:

1. The fallacy of assuming that all causes of stillbirth are similar and involve a slow, gradual decline in fetal oxygenation.
2. The common error deriving from point 1, i.e. assuming that testing methods presumable of value in post-date and hypertensive pregnancies will be of value in other groups at risk for stillbirth.
3. The concept, appreciated by the other Reviewers that any test leading to more intervention will lead to fewer stillbirth, regardless of the actual efficacy of the test itself, and a discussion of intervention effect.
4. The fallacy in assuming that when a test fails, performance that is more frequent is the answer.
5. A detailed discussion of the unique problems of using historical controls in this specific setting.

Thus, we agree with the other Reviewers that our manuscript does have potential added value to the current literature.

REVIEWER #2:

Johnson, et al present a Clinical Commentary about expanding indications for antepartum testing (AT). This is certainly a timely and important topic that warrants discussion. I have several comments:

1. The historical section is important for context but much too long. It should be shortened to a page at most and some of the information could be condensed to a table.

We have shortened this section, and moved some of the material to sections that are more appropriate. We believe that further reductions would materially weaken the manuscript, described by two Reviewers as well written or excellently written. However, we defer to the Editor and will be happy to shorten further if requested.

2. For the paragraph starting line 135, this is an important concept that needs to be stated more clearly in plain English: Any test or intervention that results in more deliveries at or after 39 weeks will reduce the stillbirth rate. The impact on other outcomes (health care costs, Cesarean rate, downstream impacts such as morbidly adherent placentation, etc.) also need to be considered.

We have expanded upon this in the new lines 145-150 of the revised Track Changes manuscript.

3. The first sentence of line 144 warrants expansion: what are the potential/likely pros and cons of "repetitive provider-performed testing"??

The pros are outlined in lines 154-156 of the Track Changes manuscript. The cons are outlined in lines 152-153 of the Track Changes manuscript.

4. Perhaps most importantly, some outline of what increased testing might reasonably be expected to accomplish is needed to make this commentary useful. Simply stating "RCTs should be done" is too superficial. What OR/RR of stillbirth is likely to be a reasonable target for intervention? For example, a JAMA article by Aune, et al (JAMA. 2014 Apr 16;311(15):1536-46. doi: 10.1001/jama.2014.2269) showed a statistically significant RR of IUFD of 1.21 for a 5 unit increase in BMI. Is this a likely target for AT? How many women would need to be studied given the rate of IUFD and an expected effect size of AT? As the authors have (appropriately) selected obesity and AMA as "new" targets for AT, some examples of what an RCT to study the impact of AT for these indications. Without drilling down on such issues in more depth I'm afraid this commentary doesn't add much.

This point was also brought up by the Associate Editor and has been addressed in detail in response to the Associate Editor's comments below.



REVIEWER #3:

This review of antepartum testing by Johnson et al is well written and describes a concern that most obstetricians have of the continued escalation of the use of antepartum testing for questionable indications. I completely agree with the authors premise that little data supports the increasing use of antepartum testing and more so the marked increase in frequency of testing. It is common to see patients having daily or twice daily NST with absolutely no data to support this type of use. I have a concern that the authors state at the end of the article to continue the current practice of antepartum testing even though their data does not support this. They need to be more definitive in their recommendation instead of taking the easy way of saying to leaving things unchanged.

In lines, 232-235 (Track Changes manuscript) we make it clear that we are advocating no change to those specific testing indications recommended by ACOG and SMFM, rather than a wholesale support of “current practices.”

They should comment on why they have decided to support the use of antepartum testing to remain unchanged.

We have already done this on lines 235 – 236 in the Track Changes manuscript.

They need to be much stronger in discussing the frequency of testing and its current abuse.

We have strengthened lines 176-178 in the Track Changes manuscript to reflect this.

Is there a financial concern that affects it current usage?

We have added lines 148-150 that comment on this aspect.

Also, they need to discuss the legal liability of not doing antepartum testing with an ensuing poor outcome. Are they willing to testify for the defense when the testing was not performed because there are plenty of physicians who will.

As a matter of fact, yes, any of the authors would be willing to testify for the defense when practice is supported by data, or lack of data. However, we believe such a statement is not appropriate in an article such as this and do not feel this was a serious recommendation.

Their statement about performing randomized trials in the current clinical and legal environment is truly a fantasy. The same has been suggested about intrapartum fetal monitoring for 30 years yet no new studies will ever be performed.

As outlined in response to Reviewer #2, this has been addressed at length in response to the Associate Editor’s comments below.

I do believe in the message that the authors present but i am completely pessimistic that anything will change.

While we are empathetic with this Reviewer’s pessimism, we just could not sit on the sidelines knowing that ACOG and SMFM are developing new guidelines for antepartum fetal testing that potentially may embrace these new indications for fetal surveillance.

## ASSOCIATE EDITOR'S COMMENTS:

Excellent written commentary but it ultimately fails to satisfy re: the vague ending call for randomized trials. We would be willing to consider a revision that addresses in a more specific way how a randomized trial would be conducted and the feasibility of such an endeavor.

Things to think about:

1) Sample size

2) Design: Individual randomization, cluster randomization, stepped wedge evaluation?  
Something else?

3) Testing modality?

3) Feasibility and costs

As written, I don't think this offers as much as it could to our predominantly clinician audience as it provides no real specifics on a potential way forward

We greatly appreciate these insightful comments, which led us to perform a power analysis with sample size estimate and consider as well a stepped wedge cluster evaluation. Indeed, we were wrong in our sanguine assessment of the potential for the construction of a randomized controlled trial. As outlined in the revised manuscript, a randomized controlled trial is not feasible.

However, as we reflected upon these results, and considered our review in light of the new ARRIVE trial data; a more important conclusion became evident (at least to us). While much of the official response to the ARRIVE trial data derives from considerations involving the wholesale induction of the population at 39 weeks and implications for workflow, little has been written about the significance of the ARRIVE trial for women at high risk of stillbirth beyond 39 weeks and the issue of induction versus delivery. We feel this may ultimately be a more important impact of the ARRIVE trial. In addition, your comments provoked a deeper analysis on our part of the existing data regarding the reported underlying rates of stillbirth for women with obesity or AMA prior to 39 weeks versus the stillbirth rates achieved with current antepartum testing modalities. Such considerations make the use of antepartum testing for these new indications even less rational.

All of the above has been added to a heavily revised conclusion section of our manuscript. Our analysis, coupled with the ARRIVE trial results suggest that antepartum testing for any high risk condition beyond 39 weeks makes very little sense. We believe this is a far more impactful conclusion than was our previous one and request you review in this light. Again, our faith in the peer review process was strengthened as your comments dramatically improved the manuscript.

## Daniel Mosier

---

**From:** [REDACTED]  
**Sent:** Wednesday, September 5, 2018 5:42 PM  
**To:** Daniel Mosier  
**Subject:** Re: Manuscript Revisions: ONG-18-1425R1  
**Attachments:** 18-1425R1 ms (9-5-18v2) MT.docx; Box 1.docx

Daniel,

Attached is the revised, revised version. I have put the changes in Track Changes as requested. Here is our response to the queries:

1. Please note the minor edits and deletions throughout. Please let us know if you disagree with any of these changes.  
*We agree with the minor edits and deletions throughout. Thank you for the wordsmithing.*
2. LINE 35: What do you think of this since validating expanded testing is not feasible?  
*We like the suggestion and agree to change to this. The is a better "bottom line."*
3. LINE 76: Please here and throughout replace with FGR  
*Thank you for catching this. The correction has been made throughout the document.*
4. LINE 224: Please add Table or Box from ACOG Practice Bulletin on Antepartum Fetal Surveillance with indications for testing  
*I have attached a Word version of the Box from the Practice Bulletin. Do we need to request permission to use this from ACOG?*

Thank you again,

Mark T.

-----Original Message-----

From: Daniel Mosier <dmosier@greenjournal.org>  
To: Mark Turrentine [REDACTED]  
Sent: Wed, Sep 5, 2018 11:18 am  
Subject: RE: Manuscript Revisions: ONG-18-1425R1

Apologies, the correct file is attached.

**Daniel Mosier**  
Editorial Assistant  
*Obstetrics & Gynecology*  
Tel: 202-314-2342

**From:** [REDACTED]  
**Sent:** Wednesday, September 5, 2018 12:15 PM  
**To:** Daniel Mosier <[dmosier@greenjournal.org](mailto:dmosier@greenjournal.org)>  
**Subject:** Re: Manuscript Revisions: ONG-18-1425R1

Hi Daniel,

The only attachment was the revision check list. Do you send us the manuscript with the edits you have suggested or is it through the editorial manager?

Mark T.

-----Original Message-----

From: Daniel Mosier <[dmosier@greenjournal.org](mailto:dmosier@greenjournal.org)>

To: Mark Turrentine [REDACTED]

Sent: Wed, Sep 5, 2018 9:35 am

Subject: Manuscript Revisions: ONG-18-1425R1

Dear Dr. Turrentine,

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 35: What do you think of this since validating expanded testing is not feasible?
3. LINE 76: Please here and throughout replace with FGR
4. LINE 224: Please add Table or Box from ACOG Practice Bulletin on Antepartum Fetal Surveillance with indications for testing

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, September 7<sup>th</sup>**.

Sincerely,

-Daniel Mosier

**Daniel Mosier**

Editorial Assistant

*Obstetrics & Gynecology*

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