

OBSTETRICS & GYNECOLOGY



NOTICE: This document contains correspondence generated during peer review and subsequent revisions but before transmittal to production for composition and copyediting:

- 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 30, 2018
To: "Lynn M. Yee" [REDACTED]
From: "The Green Journal" em@greenjournal.org
Subject: Your Submission ONG-18-1426

RE: Manuscript Number ONG-18-1426

Daytime versus nighttime differences in management and outcomes of postpartum hemorrhage

Dear Dr. Yee:

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 20, 2018, we will assume you wish to withdraw the manuscript from further consideration.

REVIEWER COMMENTS:

Reviewer #1: The authors present a retrospective review of outcomes of women who had postpartum hemorrhage comparing outcomes of day versus night delivery. This is a reasonably important topic given that PPH is a potentially disastrous complication delivery and outcomes are thought to be better during the day given that other services are present. While I appreciate the work here there are substantial issues with this work. These should be addressed and considered in review of this paper.

1) How did the authors define night versus day delivery and is this appropriate? You mention this in the M and M section but given the variability of shift changes do you think this is appropriate and why?

2) What are the confounders in this data set that predispose patients to delivering at night? Given that most inductions begin in during the day statistically more deliveries would likely occur at night. Does this skew your data in anyway and how do you account for this?

3) While your work does describe the issue I dont see alot of description of the why? Why do you think that you needed to do this study in the respect of why do you think there are worse outcomes at night? Statistically there is no reason for this and in large hospitals which provide high-level OB services such as those cited, should have appropriate services to assist. I am curious as to what your premise is for thinking that there are worse outcomes at night?

4) Power analysis: Your study does not include a defined number of patients by which to power and thus simply looks at a large cohort (basically large data base study). As a result you show no difference between daytime and night time delivery- do you have enough patients to really detect a difference. I concede that your N is large but is this really enough to answer your question?

5) The discussion is reasonably well written with appropriate concern for significant weaknesses to this study.

Reviewer #2: This is a clearly written analysis of a large multicenter observational obstetric cohort, assessing the relationship between time of delivery and postpartum hemorrhage management and subsequent morbidity. It adds to a small literature on an important question, and findings generally contrast what has been reported to date. Addressing a few issues would strengthen the paper further.

1. As the authors note, a limitation of this analysis is that it reports on data from academic medical centers, in which I would imagine staffing and other systems issues are likely to differ least profoundly over time, compared to the private

practice setting. This seems particularly important because it is the systems (and not the physiology) which are at issue. It would be important for the authors to make very clear that their findings are specific to these academic settings, perhaps even by changing the title and precis by adding "in academic medical settings."

2. It is not clear why the authors report on the findings of the unadjusted analysis in the abstract. If interesting, they did not persist in the multivariable analysis and were not discussed substantively in the paper.

3. It would be helpful if the authors made more explicit, in the introduction, discussion, or both why we care about timing of delivery. Obviously, many deliveries can't be timed. How -- besides individuals *in academic medical centers* feeling somewhat reassured by these data, should we think about the question of timing (obviously, this study is not the last word on the subject) as it relates to systems of care as well as practice patterns, including (perhaps?) discussions around induction or cesarean, hospitalist practices, etc.

Reviewer #3:

Abstract

- 1- The Objective and Methods to approach its evaluation are very well stated.
- 2- The modality of estimation for blood loss should be presented, i.e. was it by subjective visual assessment and/or more objective measure, such as volumetric drapes or weighing blood containing items.
- 3- The Results are easy to understand and assimilate; well done.
- 4- The Conclusion is reasonable based upon the reported findings.

Introduction

- 5- The clinical question is thoughtfully presented.
- 6- The background literature is well summarized.
- 7- The objective is clear and straightforward.

Materials and Methods

- 8- Overall, the methods are sound and well described; nicely done.
- 9- The idea to restrict "night time" deliveries to the shorter time period of 8 PM to 6 AM may have impacted the results. An alternative way to have approached this dichotomy might be to take equally long periods of time from the mid-portion of a "day time" shift and compare them to a "night time" counterpart, both of which could be several hours long yet also a few hours removed from the common shift change times. This should eliminate the time difference as well as the potential impact of shift change/staffing.
- 10- How estimated blood loss was determined must be specifically stated in this section. As this is the clinical outcome upon which the majority of such cases rely, the veracity of the assessment is of paramount importance. Even if this is a combination of several modalities, e.g. visual assessment, volumetric drapes, weighing, etc., or unknown from the study cohort, this should be stated clearly.
- 11- The statistical approach and testing is appropriate.

Results

- 12- The results are well presented and easy to understand.
- 13- The confounders that were adjusted for should be delineated when the term is utilized.

Discussion

- 14- The summation is reasonable given the results.
- 15- How this information compares and contrasts with other research is well reported.
- 16- The discussion regarding the possible mitigation of the findings due to the cohort being from tertiary care, academic institutions is thoughtful and appropriate.
- 17- The strengths and limitations are well reasoned.

18- The conclusion of the final paragraph is fitting with the study's findings, and does not overreach nor understate.

Figures and Tables

19- These are well done in general and present a large amount of information in ways that are easy to understand.

20- As Tables 1 and 2 report comparisons of characteristics with several subset characteristics, though with only one p-value for these, the type of statistical tests employed should be mentioned in the footnotes for these tables.

21- The footnotes in Table 3 are excellent, though any ability to edit them to conserve space would be beneficial.

References

22- A thorough resource for the interested reader.

STATISTICAL EDITOR'S COMMENTS:

1. Tables 1 and 2: Given the large number of baseline factors which were different for the two cohorts and the large samples, it would be useful to corroborate the analysis with propensity score matching or some other algorithm to determine whether the crude, albeit slight difference in the primary outcome was/was not also valid after matching.

2. Table 3: Most of the adverse outcomes have large numbers and multiple adjustment modeling is justified. However, some have relatively modest counts among the nighttime delivery cohort (eg, hysterectomy, β -lynch procedure, uterine artery ligation or uterine balloon packing). So those comparisons not only have limited power, but are likely over fitted models. Should cite those comparisons as having less generalizability and less confidence than the other comparisons.

ASSOCIATE EDITOR-GYN's COMMENTS:

1. Please corroborate the analysis with propensity score matching as requested by the statistical reviewer

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: Original Research reports should not exceed 22 typed, double-spaced pages (5,500 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: Original Research articles, 300 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. Please review the journal's Table Checklist to make sure that your tables conform to journal style. The Table Checklist is available online here: http://edmgr.ovid.com/ong/accounts/table_checklist.pdf.

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). 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>.

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 20, 2018, we will assume you wish to withdraw the manuscript from further consideration.

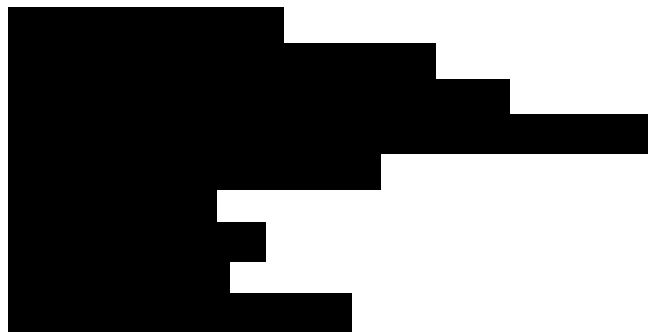
Sincerely,

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.



Editor
Obstetrics and Gynecology

10/1/18

Dear Editor,

We are resubmitting this revised manuscript entitled “Daytime versus nighttime differences in management and outcomes of postpartum hemorrhage” as an Original Research Article to Obstetrics and Gynecology. Authorship is unchanged. All authors have approved this version of the manuscript for submission.

We have replied to the Reviewers and Editors below and have made changes in the manuscript as requested. Please find in this upload the manuscript with three tables.

Please do not hesitate to contact us with any additional questions or concerns.

Thank you for your consideration,

Lynn M. Yee
On behalf of all authors

REVIEWERS’ COMMENTS

Reviewer #1

The authors present a retrospective review of outcomes of women who had postpartum hemorrhage comparing outcomes of day versus night delivery. This is a reasonably important topic given that PPH is a potentially disastrous complication delivery and outcomes are thought to be better during the day given that other services are present. While I appreciate the work here there are substantial issues with this work. These should be addressed and considered in review of this paper.

1) How did the authors define night versus day delivery and is this appropriate? You mention this in the M and M section but given the variability of shift changes do you think this is appropriate and why?

We agree that there are differences in shift change at each institution, both with regard to the precise time of shift change and which health care providers change shifts at which times. It is for precisely this reason that we chose a conservative definition of “night” (8pm to 6am) that encompasses the “night shift” for the majority of institutions. By choosing this definition, at the

vast majority of institutions, for all providers and for all days of the week, both the morning and evening shift changes would occur during the time frame designated as “daytime” for this analysis. Thus, we believe this choice is appropriate for this analysis. A clarifying sentence has been added to the methods.

2) What are the confounders in this data set that predispose patients to delivering at night? Given that most inductions begin in during the day statistically more deliveries would likely occur at night. Does this skew your data in anyway and how do you account for this?

Thank you for this question. In this cohort, in fact, a minority of women delivered at night; as stated in the 3rd sentence of the Results, 34.2% of women delivered at night. Additionally, the proportion of women who had induction of labor did not differ substantially during the day versus night (31% vs 36%, respectively, Table 2). However, there were other potential confounders that we noted. Potential confounders associated with delivery at night were described in the first paragraph of the Results. These included age, BMI, insurance, parity, hypertension, and gestational age (also in Table 1). These factors, and other clinical factors (Table 2), were accounted for in the multivariable regression analysis.

3) While your work does describe the issue I don't see a lot of description of the why? Why do you think that you needed to do this study in the respect of why do you think there are worse outcomes at night? Statistically there is no reason for this and in large hospitals which provide high-level OB services such as those cited, should have appropriate services to assist. I am curious as to what your premise is for thinking that there are worse outcomes at night?

Thank you for this opportunity for additional clarification. In the 2nd paragraph of the Introduction, we stated, “Hemorrhage management and subsequent morbidity may differ at night because of potentially less robust physician and nurse staffing, which could result in delays in care; in addition, providers may be cognizant of the possibility of delay and thus could choose to perform interventions earlier when hemorrhages occur at night.” We have expanded the Introduction to additionally state, “We hypothesized that differences in resource availability that occur at night may be associated with greater frequency of adverse maternal outcomes and differential management of hemorrhage.”

4) Power analysis: Your study does not include a defined number of patients by which to power and thus simply looks at a large cohort (basically large data base study). As a result you show no difference between daytime and night time delivery- do you have enough patients to really detect a difference. I concede that your N is large but is this really enough to answer your question?

We appreciate this comment and agree that the restrictions of this cohort mean that we have limited power to address differences in infrequent outcomes. A comment on this limitation is in the Discussion section.

5) The discussion is reasonably well written with appropriate concern for significant weaknesses to this study.

Thank you for this comment.

Reviewer #2:

This is a clearly written analysis of a large multicenter observational obstetric cohort, assessing the relationship between time of delivery and postpartum hemorrhage management and subsequent morbidity. It adds to a small literature on an important question, and findings generally contrast what

has been reported to date. Addressing a few issues would strengthen the paper further.

1. As the authors note, a limitation of this analysis is that it reports on data from academic medical centers, in which I would imagine staffing and other systems issues are likely to differ least profoundly over time, compared to the private practice setting. This seems particularly important because it is the systems (and not the physiology) which are at issue. It would be important for the authors to make very clear that their findings are specific to these academic settings, perhaps even by changing the title and precis by adding "in academic medical settings."

We agree with the Reviewer that the performance of APEX at largely academic medical centers may make the data less generalizable. We discussed this challenge in paragraph 2 of the Discussion and in our discussion of the limitations. We have added a sentence to the limitations, stating, "Finally, as discussed above, as the deliveries in this cohort largely occurred at academic medical centers which may have different systems in place from community hospitals, the findings may not be generalizable to other settings." We have also added the phrase "in academic medical centers" to the Precis. We have not changed the title due to length, but are happy to do so if the Editor requests.

2. It is not clear why the authors report on the findings of the unadjusted analysis in the abstract. If interesting, they did not persist in the multivariable analysis and were not discussed substantively in the paper.

We have edited the Abstract to deemphasize the unadjusted findings.

3. It would be helpful if the authors made more explicit, in the introduction, discussion, or both why we care about timing of delivery. Obviously, many deliveries can't be timed. How -- besides individuals *in academic medical centers* feeling somewhat reassured by these data, should we think about the question of timing (obviously, this study is not the last word on the subject) as it relates to systems of care as well as practice patterns, including (perhaps?) discussions around induction or cesarean, hospitalist practices, etc.

We appreciate this opportunity for expansion and have discussed this topic in both the Introduction and Discussion. We have added the statement, "Understanding such potential temporal differences may shed light on areas for potential systems improvements that are essential to improving quality of care for all patients" to the Introduction. In the Discussion, we stated, "Although it is not generally possible to time delivery for the majority of women, understanding associations between timing of delivery and patient outcomes is an important component of understanding if and how health care systems may be optimized to provide high quality care to all patients." We are happy to expand further on this topic if requested but have not done so due to length restrictions.

Reviewer #3:

We thank Reviewer 3 for multiple favorable comments and have responded below to only those requiring changes.

2- The modality of estimation for blood loss should be presented, i.e. was it by subjective visual assessment and/or more objective measure, such as volumetric drapes or weighing blood containing items.

EBL was determined based on local protocol and thus may have differed according to site. We have added this comment to the Methods section of the text (rather than the Abstract) due to

word count restrictions.

9- The idea to restrict "night time" deliveries to the shorter time period of 8 PM to 6 AM may have impacted the results. An alternative way to have approached this dichotomy might be to take equally long periods of time from the mid-portion of a "day time" shift and compare them to a "night time" counterpart, both of which could be several hours long yet also a few hours removed from the common shift change times. This should eliminate the time difference as well as the potential impact of shift change/staffing.

We appreciate this suggestion for an alternative way to examine provider factors. Our intent was to examine night as a period of time in which resources and staff may be less readily available, rather than to examine the concept of shift change and provider fatigue with regard to time until next shift change. We agree that examining factors related to shift change may be an interesting and important analysis to better understand how provider cognitive factors, fatigue, or distraction may influence care. However, we believe such an analysis may address a different question from the one we posed, and thus no changes have been made.

10- How estimated blood loss was determined must be specifically stated in this section. As this is the clinical outcome upon which the majority of such cases rely, the veracity of the assessment is of paramount importance. Even if this is a combination of several modalities, e.g. visual assessment, volumetric drapes, weighing, etc., or unknown from the study cohort, this should be stated clearly.

The Reviewer raises an important point about the potential variability in estimated blood loss measurements. Institutions participating in APEX were not required to adhere to a standardized protocol for determination of EBL, and thus the abstracted data were the clinically recorded EBL as determined by local protocol. We are unable to report on the specific measurement technique, which could have varied by institution or even by provider. We have added to the methods, "Estimated blood loss was determined according to each hospital's local protocol." We have also added to the Discussion a statement that, "Additionally, estimated blood loss was determined according to local protocol and not according to one standardized technique."

13- The confounders that were adjusted for should be delineated when the term is utilized.
This information has been added as a parenthetical.

20- As Tables 1 and 2 report comparisons of characteristics with several subset characteristics, though with only one p-value for these, the type of statistical tests employed should be mentioned in the footnotes for these tables.

The tests in which one p-value was reported for a variable with multiple categories are chi-squared tests. We have added a footnote to Tables 1 and 2 explaining the statistical tests.

21- The footnotes in Table 3 are excellent, though any ability to edit them to conserve space would be beneficial.

We do not believe any of these footnotes can be removed without compromising clarity and thus no changes have been made.

STATISTICAL EDITOR'S COMMENTS:

1. Tables 1 and 2: Given the large number of baseline factors which were different for the two cohorts and the large samples, it would be useful to corroborate the analysis with propensity score matching or

some other algorithm to determine whether the crude, albeit slight difference in the primary outcome was/was not also valid after matching.

We appreciate this feedback and have performed the requested analyses. We performed propensity score matching on daytime versus nighttime delivery to get a better balance of the baseline factors. The match factors included all the variables we adjusted for in the primary outcome model. After performing this procedure, the unadjusted p-value for the maternal morbidity outcome is 0.235, compared with the observational analysis p-value of 0.031, and the adjusted OR is nearly identical in strength and direction as the observed data results (aOR 0.88, 95% CI 0.75-1.03). Thus, we have expanded the text of the Methods and Results to state that we have performed a sensitivity analysis using propensity score matching to corroborate the results for the primary outcome. We have also added a comment on this issue in the Discussion.

2. Table 3: Most of the adverse outcomes have large numbers and multiple adjustment modeling is justified. However, some have relatively modest counts among the nighttime delivery cohort (eg, hysterectomy, β -lynch procedure, uterine artery ligation or uterine balloon\packing. So those comparisons not only have limited power, but are likely over fitted models. Should cite those comparisons as having less generalizability and less confidence than the other comparisons.

We agree with this assessment that one limitation of our analysis is relatively small frequency of some secondary outcomes. We have added a statement of this limitation to the Discussion.

ASSOCIATE EDITOR'S COMMENTS:

1. Please corroborate the analysis with propensity score matching as requested by the statistical reviewer

This information has been added, please see above response.

RESPONSE TO EDITORIAL OFFICE COMMENTS:

- OPT-IN: Yes, please publish my response letter and subsequent email correspondence related to author queries.
- The transparency statement was uploaded with the original submission.
- Standard obstetric and gynecology data definitions have been used, where appropriate.
- The acknowledgements have been written per guidelines. All financial support has been stated. No manuscript preparation assistance was utilized outside of the author group. All persons in the acknowledgments have agreed to be acknowledged. The presentation of this abstract was noted.
- Only standard acronyms and abbreviations were utilized. The virgule was removed.
- The Abstract word count is 282.

Daniel Mosier

From: Lynn M Yee [REDACTED]
Sent: Monday, October 22, 2018 4:46 PM
To: Daniel Mosier
Subject: Re: Manuscript Revisions: ONG-18-1426R1
Attachments: 18-1426R1 ms (10-19-18v2) LY.docx

Hi,

My minor edits/responses are attached! There were no big issues, and I have a few comment bubbles and deletions of the virgule included.

Lynn

Lynn M. Yee, MD, MPH
Assistant Professor, Division of Maternal-Fetal Medicine
Department of Obstetrics and Gynecology
Northwestern University Feinberg School of Medicine

From: Lynn M Yee
Sent: Saturday, October 20, 2018 3:21 PM
To: Daniel Mosier
Subject: Re: Manuscript Revisions: ONG-18-1426R1

Daniel,

It looks like Dr Leveno may not have responded because the email address is slightly off. It should be:

[REDACTED]

I will work on the other parts ASAP.

Lynn

Lynn M. Yee, MD, MPH

From: Daniel Mosier <dmosier@greenjournal.org>
Sent: Friday, October 19, 2018 10:13 AM
To: Lynn M Yee
Subject: Manuscript Revisions: ONG-18-1426R1

Dear Dr. Yee,

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 5: Please ask the following authors to respond to their authorship confirmation email. We emailed them at the email addresses below. The email contains a link that needs to be clicked on. The sender of the email is EM@greenjournal.org.
Kenneth J Leveno: [REDACTED]
3. LINE 74: Please revise "and/or" to mean either "and" or "or." Be sure this is done throughout your paper.
4. LINE 173: Should the virgule (/) be deleted here?

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 **Tuesday, October 23rd**.

Sincerely,
-Daniel Mosier

Daniel Mosier

Editorial Assistant
Obstetrics & Gynecology
The American College of Obstetricians and Gynecologists
409 12th Street, SW
Washington, DC 20024
Tel: 202-314-2342
Fax: 202-479-0830
E-mail: dmosier@greenjournal.org
Web: <http://www.greenjournal.org>