Date: Dec 21, 2018
To: "eddie HM sze" [redacted]
From: "The Green Journal" em@greenjournal.org
Subject: Your Submission ONG-18-2204

RE: Manuscript Number ONG-18-2204

An alternate approach to using candy cane stirrups in vaginal surgery

Dear Dr. sze:

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 Jan 11, 2019, we will assume you wish to withdraw the manuscript from further consideration.

REVIEWER COMMENTS:

Reviewer #1: This is a Procedures and Instruments article type reporting on a way to use candy cane stirrups safely for vaginal surgery.

1. Overall: The reader really needs another picture showing how the authors DON'T want you to use the candy cane stirrups so we can compare and contrast the positioning and how the candy cane stirrups are adjusted. The pictures provided of the author's way of doing things are great, we just need the comparison.

2. Introduction: Reference 8 in line 70 justifies the statement that boot or Allen stirrups have lower risk of neuropathy but there is nothing in the study referenced that speaks about better operative access. Is there something else that can be cited to show that everyone thinks operative access is better with candy cane stirrups vs. Allen/boot stirrups? Also, is operative access any better with the author's use of candy cane stirrups (given that the legs aren't that far apart) compared to Allen/boot stirrups?

3. Introduction: The study cited to say that Allen stirrups increase intracompartmental pressure in the lower extremities was done in unanesthetized women and pneumatic compression devices reduced the pressure measured...in other words, what is the clinical significance of these pressures and can we really know that the Allen stirrup increases risk of compartment syndrome? Have there been any studies on that? Have there been any studies comparing candy canes to boots and these outcomes of compartment syndrome and nerve injury?

4. Experience: For the report of cases in the last 10 years, we need more of a methods section as to how these cases were collected and tracked over time. How were the records retrieved and analyzed? Was there any loss to follow up? Also, this type of reporting requires IRB approval or assessment by an IRB that a waiver is appropriate.

5. Line 158 typo BMI of 3?

Reviewer #2: It was a pleasure to review this important paper about an issue regarding position during vaginal surgery, in particular alternate approach to using candy cane stirrups. The first important thing to avoid postprocedures problems to subjects in surgery is the correct position, the ergonomics, but it is true also for operators (see below).

Just few but important comments and improvements:

1- Add a drawn Picture (Figure 3) with the parallel and other comparative positions (perpendicular), evidencing the possible anatomical and neurological advantages (femoral, lateral femoral cutaneous, sciatic and common peroneal

nerves). Chose the best way to easily show the course of the nerves and their possible points at risk.

2- "easy access to the surgical site": what are the feelings of the two assistants with this new position? Please add a paragraph about this second important ergonomics issue, also for the all the helper surgeons and the assistant nurse.

3- This study lacks the comparative group in the same Institution, women in perpendicular approach group. It is just a retrospective cohort of one way, the parallel postion. It is just "Our impression", "based on our experience" as well-reported, not a reliable RCT. Please discuss this important limitation of the paper. We will need well-performed multi-centre RCTs about this issue to confirm this intersting report.

4- Please add a Table about the feautures of the 8 patients with type of complications, just to make them easier to understand.

Minor typos:

5. Page 9 line 158: "while the fifth patient had a BMI of 3". Please correct.

Reviewer #3: This manuscript by Sze describes implementation of a slight modification of candy cane stirrup positioning to minimize the incidence of pressure-induced peripheral sensory neuropathies of the lower extremities during vaginal surgery. He describes a neuropathy rate of about 0.5% in over 1,500 cases. Six were mild, and the others were associated with preexisting spinal pathology in patients with comorbidity that predisposed hem to injury.

The author's conclusion—that the hips should not be flexed beyond an axis 90 degrees from the plane of the operating table—is well-known. It is common knowledge that hyperflexion of the hip causes pressure on the femoral and genitofemoral nerves. Most surgeons who do much vaginal surgery also understand that obese and severely underweight patients are at greater risk. Admittedly, this precaution often is ignored in practice. The author also implies that he prefers not to use Allen stirrups because of the risk of compartment syndrome.

Comments regarding the text are as follows:

1. It is not clear whether this report describes the author's own cases only, or the work of multiple surgeons. It also is not clear what procedures are being performed, or of the distribution of operative times among these patients. We do not know what the BMI distribution was in this patient population.

2. In particular (and this is especially applicable to hysterectomies and to other operations on the upper vagina) the manuscript does not state how many of these patients were in steep Trendelenburg position, which can result in intraoperative shift in position. The author does not discuss this phenomenon, which has a potential effect on susceptibility to neuropathy.

3. Allen stirrups formerly referred to a device that essentially is a padded splint. Most surgeons now use a modified Allen stirrup called the Yellofins stirrup ™, also made by Allen. It is not clear whether correct positioning in Yellofins stirrups would produce a spectrum or incidence of complications different from what the author reports with regard to candy cane stirrups. In my own observation of gynecologists' practice as an administrator and intraoperative consultant, I have noticed many cases of poor positioning of the lower extremities in Yellofins stirrups. In any event, this study does not purport to offer a comparison. Rather, it seeks to demonstrate that attention to positioning nearly eliminates lower extremity neuropathy. This goal makes it all the more important to understand the length and nature of the cases included. Otherwise, this work will not be useful for historical comparisons.

4. Figure 2 is a photograph that shows minimal abduction of the thighs. It seems from this figure that assistants cannot comfortably work alongside the primary surgeon with this positioning.

5. In submitting photographs, has the author complied with his institutional and other relevant guidelines regarding consent and privacy?

In conclusion, if the point of the manuscript is to demonstrate that attention to positioning, he has done so, though it would be helpful to understand what procedures were being performed, duration of surgery, Trendelenburg, and BMI distribution. If this was the work of a single surgeon, it is not comparable to series reporting outcomes of multiple surgeons' procedures, because in the latter case, some may not be as attentive to correct positioning as was this author. Also, the author should be cautious in criticizing other devices unless he has reason to believe that they were used correctly and in comparable patient populations.

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. As of December 17, 2018, Obstetrics & Gynecology has implemented an "electronic Copyright Transfer Agreement" (eCTA) and will no longer be collecting author agreement forms. When you are ready to revise your manuscript, you will be prompted in Editorial Manager (EM) to click on "Revise Submission." Doing so will launch the resubmission process, and you will be walked through the various questions that comprise the eCTA. Each of your coauthors will receive an email from the system requesting that they review and electronically sign the eCTA.

Any author agreement forms previously submitted will be superseded by the eCTA. During the resubmission process, you are welcome to remove these PDFs from EM. However, if you prefer, we can remove them for you after submission.

3. 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.

4. All studies should follow the principles set forth in the Helsinki Declaration of 1975, as revised in 2013, and manuscripts should be approved by the necessary authority before submission. Applicable original research studies should be reviewed by an institutional review board (IRB) or ethics committee. This review should be documented in your cover letter as well in the Materials and Methods section, with an explanation if the study was considered exempt. If your research is based on a publicly available data set approved by your IRB for exemption, please provide documentation of this in your cover letter by submitting the URL of the IRB website outlining the exempt data sets or a letter from a representative of the IRB. In addition, insert a sentence in the Materials and Methods section stating that the study was approved or exempt from approval. In all cases, the complete name of the IRB should be provided in the manuscript.

5. 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 has adopted the use of the reVITALize definitions. Please access the obstetric and gynecology data definitions at https://www.acog.org/About-ACOG/ACOG-Departments/Patient-Safety-and-Quality-Improvement/reVITALize. If use of the reVITALize definitions is problematic, please discuss this in your point-by-point response to this letter.

6. Because of space limitations, it is important that your revised manuscript adhere to the following length restrictions by manuscript type: Procedures and Instruments articles 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 print appendixes) but exclude references.

7. Specific rules govern the use of acknowledgments in the journal. Please note 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 response in the journal's electronic author 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).

8. 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: Procedures and Instruments, 200 words. Please provide a word count.

9. 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.

10. 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.

11. The Journal's Production Editor had the following to say about this manuscript:

"Figures 1–2: Please upload as separate figure files on Editorial Manager."

When you submit your revision, art saved in a digital format should accompany it. If your figure was created in Microsoft Word, Microsoft Excel, or Microsoft PowerPoint formats, please submit your original source file. Image files should not be copied and pasted into Microsoft Word or Microsoft PowerPoint.

When you submit your revision, art saved in a digital format should accompany it. Please upload each figure as a separate file to Editorial Manager (do not embed the figure in your manuscript file).

If the figures were created using a statistical program (eg, STATA, SPSS, SAS), please submit PDF or EPS files generated directly from the statistical program.

Figures should be saved as high-resolution TIFF files. The minimum requirements for resolution are 300 dpi for color or black and white photographs, and 600 dpi for images containing a photograph with text labeling or thin lines.

Art that is low resolution, digitized, adapted from slides, or downloaded from the Internet may not reproduce.

12. Authors whose manuscripts have been accepted for publication have the option to pay an article processing charge and publish open access. With this choice, articles are made freely available online immediately upon publication. An information sheet is available at http://links.lww.com/LWW-ES/A48. The cost for publishing an article as open access can be found at http://edmgr.ovid.com/acd/accounts/ifauth.htm.

Please note that if your article is accepted, you will receive an email from the editorial office asking you to choose a publication route (traditional or open access). Please keep an eye out for that future email and be sure to respond to it promptly.

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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 and that each author has given approval to the final form of the revision.

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 Jan 11, 2019, 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

_____

Manuscript ONG-18-2204

Reviewer #1

1. Overall: The reader really needs another picture showing how the authors DON'T want you to use the candy cane stirrups so we can compare and contrast the positioning and how the candy cane stirrups are adjusted. The pictures provided of the author's way of doing things are great, we just need the comparison.
   Author's comment: I respectfully disagree. Every gynecologist knows the position of the patient's lower extremities when the candy cane stirrups are aligned perpendicular to the operating table. If needed, such picture is readily available on the internet.

   I am fairly certain that I will not get permission for such a picture. To be truthful, I have to inform the patient that I am going to put her in a positon that I do not want others to use because it causes excessive flexion, abduction, and external rotation of the lower extremities and possibly neuropathy in order to take a picture for a manuscript. Also, I am doubtful that IRB would approve such a request.

2. Introduction: Reference 8 in line 70 justifies the statement that boot or Allen stirrups have lower risk of neuropathy but there is nothing in the study referenced that speaks about better operative access. Is there something else that can be cited to show that everyone thinks operative access is better with candy cane stirrups vs. Allen/boot stirrups? Also, is operative access any better with the author's use of candy cane stirrups (given that the legs aren't that far apart) compared to Allen/boot stirrups?
   Author's comment: The suggested reference has been added. Gynecologic surgery in obese women. Committee Opinion Number 619. American College of Obstetricians and Gynecologists. Obstet Gynecol 2015;125:274-8.

   Based on my experience from more than 1,500 cases, the answer to the second part of the question is absolutely. I do not have a rigid boot and a long handle on each side to limit the assistants' access to the operative site. A common approach to perform vaginal surgery using Allen stirrups in my institution is to have the second assistant stand next to the patient as if the second assistant is participating in an abdominal laparotomy and hold the vaginal retractor from above.

   Patient's legs being close together do not reduce access to the surgical site. I am 67 inches tall, stand for all vaginal surgeries and usually need the operating table at maximum height to operate comfortably. When the patient is in dorsal lithotomy position

and her knees are flexed about 100 degrees, her legs are above my head, which allow unhindered access to the surgical site regardless of whether I am assisting or operating unless the patient is very short. In which case, I put her in slight Trendelenburg to further elevate her legs. My 71 inches tall resident can operate comfortably in this position, but does frequently have a foot near her face when she is assisting.

3. Introduction: The study cited to say that Allen stirrups increase intracompartmental pressure in the lower extremities was done in unanesthesized women and pneumatic compression devices reduced the pressure measured…in other words, what is the clinical significance of these pressures and can we really know that the Allen stirrup increases risk of compartmental syndrome? Have there been any studies on that? Have there been any studies comparing candy canes to boots and these outcomes of compartment syndrome and nerve injury?
   Author's response: Conclusion section of the abstract of reference 9 states "Therefore, increases in intraperitoneal pressures during surgery in the lithotomy position with the calf or knee supported may be one of the factors that contributes to the development of compartment syndrome". My reason for including this reference is that there is a clinical study, which suggests that Allen stirrups may predispose patients to developing compartment syndrome.

   The statement in question (line 70) and other sentences and sections were deleted in order to meet the 8 page limit.

4. Experience: For the report of cases in the past 10 years, we need more of a method section as to how these cases were collected and tracked over time. How were the records retrieved and analyzed? Was there any loss to follow-up? Also, this type of reporting requires IRB approval or assessment by an IRB that a waiver is appropriate.
   Author's response: The IRB at Upstate Medical University did evaluate and exempt this study from review. These cases were retrieved from my surgical log, which listed all intra- and post-operative complications. The relevant patient files were reviewed and summarized for this manuscript. This was added to line 101 in the manuscript.

   None of the postoperative neuropathy cases were lost to follow-up. Six of the 8 patients who developed postoperative neuropathy were discharged from my practice and referred back to their gynecologist for care because their neuropathy resolved spontaneously. The patient with anesthesia around both knees did not want to return for

follow-up after her one year postoperative visit because she lives a significant distance from my office. I still evaluate the patient with persistent meralgia paresthestica every 6 months. This was discussed in the manuscript.

Reviewer #2.

1. Add a draw picture (Figure 3) with the parallel and other comparative positions (perpendicular), evidencing the possible anatomical and neurological advantages (femoral, lateral femoral cutaneous, sciatic and common peroneal nerves). Choose the best way to easily show the course of the nerves and their possible points at risk.
   Author's response: I respectfully decline. The course of these nerves and their points at risk have been extensively discussed and illustrated in references 1 to 6. Placing candy cane stirrups parallel to the operating table does not change the course of these nerves or their possible points at risk. It avoids excessive flexion, abduction, and external rotation of the thigh and prevents compression and stretch injury to these nerves.

2. "easy access to the surgical site". What are the feelings of the two assistants with this new position? Please add a paragraph about this second important ergonomics issue, also for the all the helper surgeons and the assistant nurse.
   Author's response: The feeling of an assistant (the author) who has assisted (and operated) in more than 1,576 vaginal cases with patients in dorsal lithotomy using candy cane stirrups placed in parallel position is that this alignment provides easy access to the surgical site for the assistants.

   The second assistant is almost always a third year medical student. Most participated in 1 to 2 cases. I am not sure what their feelings are regarding this issue.

3. This study lacks the comparative group in the same institution, women in perpendicular approach group. It is just a retrospective cohort of one way, the parallel position. It is just "our impression", "based on our experience" as well-reported, not a reliable RCT. Please discuss this important limitation of the paper. We will need well-performed multi-center RCTs about this issue to confirm this interesting report.
   Author's response: I respectfully decline. This manuscript is submitted as a Procedures and Instruments article whose headings include Abstract, Background, Technique, Experience, and Conclusion. In the Experience section, the journal's

Instructions for Authors specifically states “Reports experience with the technique and what the general outcomes were”, which is exactly what I did.

My opinion is that investigators would have a difficult time recruiting patients for such a RCT since investigators have to truthfully tell potential subjects that their legs may be excessively flexed, abducted, and externally rotated, which may lead to compression and stretch injuries to the femoral, lateral femoral cutaneous, sciatic, and common peroneal nerves. Whether such a study will get IRB approval is also debatable.

4. Please add a Table about the features of the 8 patients with type of complication, just to make them easier to understand.
   Author’s response: I respectfully disagreed. The neuropathy in these 8 patients is clearly described in the text.

5. Page 9, line 158: “while the fifth patient had a BMI of 3”. Please correct.
   Author’s response: The fifth patient’s BMI has been corrected to 37.

Reviewer #3:

1. It is not clear whether this report described the author’s own cases only, or the work of multiple surgeons. It also is not clear what procedures are being performed, or of the distribution of operative time among these patients. We do not know what the BMI distribution was in this patient population.
   Author’s response: I was the surgeon in all these cases. Line 99 has been changed to “During the past 10 years, the author has used candy cane stirrups positioned in this parallel alignment in 1,576 consecutive vaginal cases performed mainly for urogynecologic indications”.

   The reviewer correctly pointed out that BMI and operative time have been cited as risk factor for lower extremity neuropathy. Other cited risk factors include diabetes, advanced age, and smoking cigarettes. As far as I know, type of surgery by itself has not been cited as a risk factor. I do not believe that this information is essential to this manuscript since the surgeon has little or no control over most of these risk factors. Putting patient’s lower extremities in an anatomically and neurologically neutral position allows the surgeon to do what is needed to correct the patient’s condition regardless of what risk factors are present, while minimizing her risk of developing postoperative

neuropathy. Plus, I do not have sufficient space to put these data in an 8 page manuscript.

2. In particular (and this is especially applicable to hysterectomies and to other operations on the upper vagina) the manuscript does not state how many of these patients were in steep Trendelenburg position, which can result in intraoperative shift in position. The author does not discuss this phenomenon, which has a potential effect on susceptibility to neuropathy.
   Author's response: The reason is that I do not put patient in steep Trendelenburg position. As stated in line 92, if needed, we place the patient in the desired degree of Trendelenburg preoperatively and tilt the candy cane stirrups toward the lower break of the operating table to compensate for the thigh flexion caused by the Trendelenburg. If repositioning is done intraoperatively, we always check to make sure that Trendelenburg did not cause excessive thigh flexion.

3. Allen stirrups formerly referred to a device that essentially is a padded splint. Most surgeons now use a modified Allen stirrups called the Yellowfins stirrup, also made by Allen. It is not clear whether correct positioning in Yellowfins stirrups would produce a spectrum or incidence of complications different from what the author reports with regard to candy cane stirrups. In my own observation of gynecologists' practice as an administration and intraoperative consultant, I have noticed many cases of poor positioning of the lower extremities in Yellowfins stirrups. In any event, this study does not purport to offer a comparison. Rather, it seeks to demonstrate that attention to positioning nearly eliminates lower extremity neuropathy. This goal makes it all the more important to understand the length and nature of the cases involved. Otherwise, this work will not be useful for historical comparisons.
   Authors' response: my response to this question is the same as my response to reviewer's question 1 and question 3 from reviewer #2.

4. Figure 2 is a photograph that shows minimal abduction of the thighs. It seems from this figure that assistants cannot comfortably work alongside the primary surgeon with this positioning.
   Author's response: My response to this question is the same as my response to question 2 from reviewer #1 and question 2 from #2. Assisting in vaginal surgery is

never very comfortable and patient safety is always more important than surgeon and assistants' comfort.

5. In submitting photographs, has the author compiled with his institutional and other relevant guidelines regarding consent and privacy?
   Author's response: Yes**.** The patient in the photographs signed the Upstate Medical University consent to be photographed while under anesthesia in the operating room and has reviewed the photographs and signed the consent from Obstetrics & Gynecology for allowing the photographs to be published.

   In conclusion, if the point of the manuscript is to demonstrate that attention to positioning, he has done so, though it would be helpful to understand what procedures were being performed, duration of surgery, Trendelenburg, and BMI distribution. If this was the work of a single surgeon, it is not comparable to series reporting to outcomes of multiple surgeons' procedures, because in the latter case, some may not be as attentive to correct positioning as was this author. Also, the author should be careful in criticizing other devices unless he has reasons to believe that they were used correctly and in comparable patient populations.
   Author's response: The point of the manuscript is changing the candy cane stirrups from a perpendicular to a parallel alignment allows the surgeon to place the patient's lower extremities in an anatomically and neurologically neutral position.

   I would not be able to put the patients lower extremities in an anatomically and neurologically neutral position with the candy cane stirrups placed in the perpendicular alignment no matter how careful I am.

   I read my manuscript again and did not find any criticism of other devices, which I assume is Allen stirrups. My comments on Allen stirrups are based on published work and ACOG Practice Bulletin. If the editor finds any critical comments on other devices or Allen stirrups, I will be happy to rephrase or delete them.

   Editorial Office Comments:

   1. OPT-IN: Yes, please publish my response letter and any subsequent email correspondence related to author queries.
   2. No response needed.

3. I, Eddie HM Sze, affirm 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.
4. IRB exempt statement is included in the cover letter and the manuscript.
5. No response needed.
6. When all the deleted sentences were removed, the manuscript, which includes the title page, precis, abstract, text, and figure legends, totaled exactly 8 pages.
7. No response needed.
8. Total word count for the abstract is 199.
9. This guideline was followed in the manuscript. The only abbreviation I used in the manuscript was BMI.
10. I did not use virgule symbol in the manuscript.
11. I will upload figure 1 and 2 as separate files.
12. No response needed at the present time.

Thank you for giving me the opportunity to revise my manuscript.

Daniel Mosier

From: Eddie Sze [redacted]
Sent: Wednesday, January 16, 2019 6:31 PM
To: Daniel Mosier
Subject: Re: (EXTERNAL) Manuscript Revisions: ONG-18-2204R1

Thank you for the email. I accept all changes.
Eddie Sze

>>> Daniel Mosier <dmosier@greenjournal.org> 01/16/19 3:38 PM >>>
Dear Dr. Sze,
Thank you for submitting your revised manuscript. It has been reviewed by the editor. Please note the minor edits and deletions throughout. Please let us know if you disagree with any of these changes. If you need to make changes, please use the attached version of the manuscript. Leave the track changes on, and do not use the "Accept all Changes" function prior to re-submission.
Your prompt response would be appreciated be appreciated; please respond no later than COB on **Friday, January 18th.**
Sincerely,
-Daniel Mosier

Daniel Mosier
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From: Stephanie Casway
To: [redacted]
Subject: RE: (EXTERNAL) FW: O&G Figure Revision: 18-2204
Date: Thursday, January 24, 2019 11:26:00 AM

Good Morning Dr. Sze,

Our editor would prefer to use the cropped version of Figure 2. He did mention that Figure 1 was excellent, and very complementary to the article.

If you have any concerns, please let me know.

Thank you so much!

From: [redacted]
Sent: Wednesday, January 23, 2019 1:14 PM
To: Stephanie Casway <SCasway@greenjournal.org>
Subject: Re: (EXTERNAL) FW: O&G Figure Revision: 18-2204

I like the original picture much better. The attached picture just does not provide a complete picture of how her legs and buttocks are placed. I understand why the editor may want to crop this picture, but OBGYN is a medical and specifically a GYN journal. The patient in the picture saw this photograph and she has no concern about publishing this picture in a medical journal. I would like ask the editor to think about using the original picture. Thank you.

Eddie Sze

>>> Stephanie Casway <SCasway@greenjournal.org> 1/23/2019 9:35 AM >>>
Good Morning Dr. Sze,

I just wanted to follow up on the email below. If you need additional time, just let me know.

Thanks so much!

From: Stephanie Casway
Sent: Wednesday, January 16, 2019 9:50 AM
To: [redacted]
Subject: O&G Figure Revision: 18-2204

Good Morning Dr. Sze,

Your figure has been edited, and a PDF of the figure is attached for your review. Please review the figure CAREFULLY for any mistakes.

Note that Figure 1 and the legend are not attached, as no edits were made. We did crop Figure 2, please let me know if this is a concern.

PLEASE NOTE: Any changes to the figures must be made now. Changes made 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, 1/18. Thank you for your help.

Stephanie Casway, MA
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