

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: Feb 07, 2019
To: "Ronald Augustine Sancetta" [REDACTED]
From: "The Green Journal" em@greenjournal.org
Subject: Your Submission ONG-19-69

RE: Manuscript Number ONG-19-69

The Shoulder Shrug Maneuver- a new technique to facilitate delivery during Shoulder Dystocia

Dear Dr. Sancetta:

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 Feb 28, 2019, we will assume you wish to withdraw the manuscript from further consideration.

REVIEWER COMMENTS:

Reviewer #1: ONG-19-69

TITLE: The Shoulder Shrug Maneuver- a new technique to facilitate delivery during Shoulder Dystocia

Article type: Procedures and Instruments.

Precis: The shoulder shrug maneuver is a simple technique to learn that can be utilized by the obstetrician to aid in the management of shoulder dystocia.

Overall:

Shoulder dystocia is a potential complication of vaginal delivery that increases the chances of injury to the infant and mother. The authors present three case studies of shoulder dystocia unresolved by McRoberts maneuver, which utilize a new technique that has been proven useful when encountering shoulder dystocia. When performed properly, the shoulder shrug maneuver decreases the likelihood of morbidity of the infant. Provided that the posterior shoulder can be shrugged, the technique has shown to be successful.

Other: No mention of IRB review

Disclosures: None listed.

Abstract

1. It seems uncommon to include a reference in the abstract. Perhaps this should be done in main portion of the paper.
2. Line 47: What is severe shoulder dystocia?

Procedures:

Nicely described.

Experience:

3. Line 96: Was the posterior shoulder the left or the right infant shoulder?

Discussion:

Thoughtful discussion of why Case 2 developed the Erb's palsy complication.

4. Line 141: Can a reference be provided for the Rubin's and Wood's maneuvers?
5. Line 163: Is the Sandberg reference intended to support this statement?
6. Does the lead author have any intention to evaluate this new procedure in a more rigorous manner?

References:

7. Please number the references and indicate in the text where references are applicable.
8. Possible additional reference to consider:

Gilstrop M, Hoffman MK
An Update on the Acute Management of Shoulder Dystocia.
Clin Obstet Gynecol (United States), Dec 2016, 59(4) p813-819

FIGURES:

Inclusion of pictures are very helpful.

Video:

Well done video - excellent support to the paper.

Reviewer #2: While I applaud the authors for their innovation and dedication to patient care, the manuscript contains some areas that require further consideration.

- 1) Since this is a case series, IRB approval is required. Although it would be deemed exempt, it is important to go through the process and state in the text.
- 2) Based upon this small case, is it appropriate to recommend that this maneuver be introduced into clinical practice? Is further study required for validation of this maneuver. Would simulation study and training be advised. As an example, prevention of shoulder dystocia using the "push back maneuver" was studied in a randomized trial of over 1000 patients to evaluate an obstetric maneuver for prevention of shoulder dystocia published by Poujade et al. Eur J Obstet Gynecol Rep Biol 2018.
- 3) Your commentary regarding the clinical utility of delivery of the posterior shoulder/ arm appears to be different from the conclusions of Hoffman et al. Obstet Gynecol 2011 entitled "A comparison of obstetric maneuvers for the acute management of shoulder dystocia." Please add your commentary of this article to your manuscript and bibliography. This was a required ABOG MOC reading in 2011
- 4) Citations: Please see author instructions. I would remove footnotes and cite references numerically in the bibliography

Reviewer #3: Description of study: This paper is a description of a new maneuver for the resolution of shoulder dystocia.

Overall: This paper effectively describes the maneuver and its utilization. While comparisons are made between this maneuver and existing maneuvers, no effort is given to characterizing the efficacy of existing maneuvers or to describing how the existing maneuvers came to be recommended (ie, data to support use and in what order). This would provide the necessary background for providers to understand how new maneuvers are introduced into practice and where these new maneuvers fall in relation to traditionally recommended maneuvers.

1. Title and Precis: The title and precis are clearly written and effectively summarize the main supposition of the paper.
2. Abstract: The "Background" section is clearly written and applicable. The "Technique" section should briefly summarize the technique and not restate the "Experience" section. The "Experience" section is clearly written and applicable. The "Conclusion" section has a typo in line 52. The conclusion of decreasing morbidity to the infant is overstated, and the last two sentences could be consolidated.
3. Technique: The technique is well-described and illustrated by the accompanying figure.
4. Experience: The three cases described simply restate the technique. The cases would be more impactful if they described patient cases in which maneuvers beyond McRoberts maneuver failed to resolve the dystocia. In the discussion, the authors discuss instances in which the Shoulder Shrug maneuver may be superior to delivery of the posterior arm or the Woods' or Rubin maneuvers. Cases demonstrating these points are recommended over the current cases.

5. Discussion:
 - a. Paragraph 2 is not necessary as the issue of brachial plexus injury is addressed in Paragraph 3.
 - b. There is a typo in Paragraph 4, Line 136.
 - c. Paragraph 5 and Paragraph 8 detail circumstances in which the Shoulder Shrug maneuver may be superior to delivery of the posterior arm or the Woods' or Rubin maneuvers. This should be expanded upon in a step-wise fashion for each maneuver and use cases from the experience section for examples.
 - d. Discussion of use of a catheter technique does not add greatly to the manuscript as this is not one of the traditionally recommended maneuvers.
 - e. Discussion of clavicular fracture and the Zavanelli maneuver should be moved to the end of this section as these are viewed as more extreme rescue maneuvers.
6. References: More references detailing the efficacy of existing maneuvers and how the existing maneuvers came to be recommended (ie, data to support use and in what order) are needed.

Reviewer #4: This is an interesting case series using a novel technique to help resolve shoulder dystocia. I think the video and description images are very helpful in allowing the reader to better visualize the technique. My concern with publishing this article at this time is that it is just 3 cases (though admittedly, this is likely something the author has used over the years of his career) and 1/3 did show at least mild nerve stretch. I would be concerned that with only 3 specific cases cited, there is not a large enough sample size. I would like to see a larger case series or cohort group and outcomes before publishing and recommending it as a new/safe tool to employ during shoulder dystocia.

EDITOR 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. Are any of your figures, or images from your video, published already in another source?

Tables, figures, and supplemental digital content should be original. The use of borrowed material (eg, lengthy direct quotations, tables, figures, or videos) is discouraged, but should it be considered essential, written permission of the copyright holder must be obtained. Permission is also required for material that has been adapted or modified from another source. Both print and electronic (online) rights must be obtained from the holder of the copyright (often the publisher, not the author), and credit to the original source must be included in your manuscript. Many publishers now have online systems for submitting permissions request; please consult the publisher directly for more information.

4. 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.

5. 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.

6. Titles in Obstetrics & Gynecology are limited to 100 characters (including spaces). Do not structure the title as a declarative statement or a question. Introductory phrases such as "A study of..." or "Comprehensive investigations into..." or "A discussion of..." should be avoided in titles. Abbreviations, jargon, trade names, formulas, and obsolete terminology also should not be used in the title. Titles should include "A Randomized Controlled Trial," "A Meta-Analysis," or "A Systematic Review," as appropriate, in a subtitle. Otherwise, do not specify the type of manuscript in the title.

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 American College of Obstetricians and Gynecologists' (ACOG) documents are frequently updated. These documents may be withdrawn and replaced with newer, revised versions. If you cite ACOG 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 (exceptions could include manuscripts that address items of historical interest). 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 an ACOG document has been withdrawn, it should not be referenced in your manuscript (exceptions could include manuscripts that address items of historical interest). All ACOG documents (eg, Committee Opinions and Practice Bulletins) may be found via the Clinical Guidance & Publications page at <https://www.acog.org/Clinical-Guidance-and-Publications/Search-Clinical-Guidance>.

12. 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).

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.

13. The current video may be resubmitted. Please check to make sure that the captions are free of spelling errors.

14. 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.

15. 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 Feb 28, 2019, we will assume you wish to withdraw the manuscript from further consideration.

Sincerely,

Nancy C. Chescheir, MD
Editor-in-Chief

2017 IMPACT FACTOR: 4.982
2017 IMPACT FACTOR RANKING: 5th out of 82 ob/gyn journals

In compliance with data protection regulations, please contact the publication office if you would like to have your personal information removed from the database.

Dear Reviewers and Editor,

Firstly, I wish to thank the reviewers for taking the time to provide thoughtful comments which have definitely allowed us to structure our manuscript more cohesively and ultimately polishing some areas that needed clarification. I also wish to OPT-IN in the responses to the revision process for the supplemental digital content. We have used these responses as an opportunity to discuss some of the points which might not be as extensively discussed in the modified manuscript due to size limitations. The following is a point-by-point response to each reviewer and editor.

Reviewer #1:

1. It seems uncommon to include a reference in the abstract. Perhaps this should be done in main portion of the paper.

We will remove the reference in the abstract on line 42

2. Line 47: What is severe shoulder dystocia?

Regarding line 47 what is severe shoulder dystocia, we agreed to rephrase it as persistent shoulder dystocia.

3. Line 96: Was the posterior shoulder the left or the right infant shoulder?

Regarding the clarification on line 96 this was the right infant shoulder, we will correct it in the text.

4. Line 141: Can a reference be provided for the Rubin's and Wood's maneuvers?

Regarding line 141, we will provide an original reference for both of those articles and also historical references and descriptions for both.

5. Line 163: Is the Sandberg reference intended to support this statement?

Regarding line 163, the answer would be yes. We intend to include additional Sandberg reference regarding a ten year review of Zavanelli cases in the bibliography.

6. Does the lead author have any intention to evaluate this new procedure in a more rigorous manner?

Hopefully publication of this article will share the technique to allow for further evaluation of the techniques success in the broader population for this relatively rare event of persistent shoulder dystocia after McRoberts and suprapubic pressure fails to resolve dystocia. We are seeking IRB approval for further evaluation of the technique and welcome other investigators to do the same.

7. Please number the references and indicate in the text where references are applicable.

The references will be numbered in the text where applicable.

8. Possible additional reference to consider:
Gilstrap M, Hoffman MK. An Update on the Acute Management of Shoulder Dystocia. Clin Obstet Gynecol (United States), Dec 2016, 59(4) p813-819

We will include the additional reference of Gilstrap and Hoffman that was suggested.

Reviewer #2:

1. Since this is a case series, IRB approval is required. Although it would be deemed exempt, it is important to go through the process and state in the text.

Regarding points made by reviewer number two we are in the process of obtaining IRB approval, however these cases were all emergency cases being performed under duress. The first part of the maneuver was focused on delivery of the posterior shoulder which is already an acceptable described technique in the management of shoulder dystocia. The second part of the technique involves a rotation maneuver which is also previously described and acceptable technique to relieve shoulder dystocia (Woods, Rubin maneuvers). The only unique part of our technique involves the grasping of the axilla and holding together to the head as a unit prior to rotation which we believe will improve the success of delivery after rotation. Nevertheless we will make mention in the text that we are seeking IRB approval for further study as well as the informed consent obtained from the patients although they will remain anonymous for the manuscript.

2. Based upon this small case, is it appropriate to recommend that this maneuver be introduced into clinical practice? Is further study required for validation of this maneuver. Would simulation study and training be advised? As an example, prevention of shoulder dystocia using the "push back maneuver" was studied in a randomized trial of over 1000 patients to evaluate an obstetric maneuver for prevention of shoulder dystocia published by Poujade et al. Eur J Obstet Gynecol Rep Biol 2018.

I believe that is appropriate to introduce this technique due to its simplicity. Rotations maneuvers are already in use (Woods corkscrew maneuver), the only addition is shrugging the posterior shoulder which is does not stretch to brachioplexus and is frequently performed in the process of posterior shoulder delivery procedures which are currently approved. I believe further study should be welcomed however the technique needs to be shared with other providers. Due to the rarity of shoulder dystocia most studies are retrospective in nature. Prospective studies would need to be performed in multicenter trials which I would welcome.

I believe simulation study and training would be a great platform to learn this technique.

I have reviewed the pushback technique and we will include it in our bibliography. It makes sense that the commonly performed Ritgen maneuver may predispose to an impending shoulder dystocia. The pushback technique may help to prevent anterior shoulder impaction. This theory is also consistent with the difficult cases of shoulder dystocia that can result with operative vaginal delivery in the presence of macrosomia. Hastening delivery can impair descent of the shoulders.

3. Your commentary regarding the clinical utility of delivery of the posterior shoulder/ arm appears to be different from the conclusions of Hoffman et al. Obstet Gynecol 2011 entitled "A comparison of obstetric maneuvers for the acute management of shoulder dystocia." Please add your commentary of this article to your manuscript and bibliography. This was a required ABOG MOC reading in 2011.

We will re-state the language regarding our position on posterior shoulder and arm delivery in reference to the obstetrics and gynecology article of Hoffman. I agree that posterior shoulder delivery is one of the most successful procedures to perform once significant difficulty is encountered after the initial failure of McRobert's and superpubic pressure.

4. Citations: Please see author instructions. I would remove footnotes and cite references numerically in the bibliography

We will remove footnotes and cite references numerically in the manuscript and bibliography.

Reviewer #3:

1. Title and Precis: The title and precis are clearly written and effectively summarize the main supposition of the paper.

Remain in original form.

2. Abstract: The "Background" section is clearly written and applicable. The "Technique" section should briefly summarize the technique and not restate the "Experience" section. The "Experience" section is

clearly written and applicable. The "Conclusion" section has a typo in line 52. The conclusion of decreasing morbidity to the infant is overstated, and the last two sentences could be consolidated.

We have re-stated the technique section in the abstract according to recommendation. We have corrected the typo on line 52. We have consolidated the last two sentences of the conclusion as recommended.

3. Technique: The technique is well-described and illustrated by the accompanying figure.

Remain in original form.

4. Experience: The three cases described simply restate the technique. The cases would be more impactful if they described patient cases in which maneuvers beyond McRoberts maneuver failed to resolve the dystocia. In the discussion, the authors discuss instances in which the Shoulder Shrug maneuver may be superior to delivery of the posterior arm or the Woods' or Rubin maneuvers. Cases demonstrating these points are recommended over the current cases.

We currently have performed a successful shoulder shrug maneuver in only these three cases. All cases were preceded by the McRoberts maneuver and suprapubic pressure. The author has not experienced success with the Rubin's or Wood's maneuver over the years and because of this tends to go directly to posterior shoulder delivery. Occasionally the Rubin's maneuver will be attempted with rotation of the anterior shoulder to oblique angle to retry the McRoberts maneuver. However after this, attention is paid to delivery of the posterior shoulder.

5. Discussion:

- a. Paragraph 2 is not necessary as the issue of brachial plexus injury is addressed in Paragraph 3.

As per recommendation of reviewer number three we have deleted paragraph number two.

- b. There is a typo in Paragraph 4, Line 136.

We have corrected the typo on paragraph 4 line 136.

- c. Paragraph 5 and Paragraph 8 detail circumstances in which the Shoulder Shrug maneuver may be superior to delivery of the posterior arm or the Woods' or Rubin maneuvers. This should be expanded upon in a step-wise fashion for each maneuver and use cases from the experience section for examples.

We have expanded our discussion in paragraph five and eight.

- d. Discussion of use of a catheter technique does not add greatly to the manuscript as this is not one of the traditionally recommended maneuvers.

We have eliminated the paragraph regarding the catheter technique.

- e. Discussion of clavicular fracture and the Zavanelli maneuver should be moved to the end of this section as these are viewed as more extreme rescue maneuvers.

We also have moved the discussion of clavicular fracture, Zavanelli and symphysiotomy to the end of the article.

6. References: More references detailing the efficacy of existing maneuvers and how the existing maneuvers came to be recommended (ie, data to support use and in what order) are needed.

We have included a short historical presentation and explanation of how existing maneuvers were introduced. We have addressed the success rate in the individual maneuvers including the current recommendation of order of utilization of each technique during management of shoulder dystocia by the American College of Obstetrics and Gynecology in the Discussion section. We have added additional references and discussion of techniques at the end of the article including a brief discussion regarding the approach to delivery of the macrosomic infants.

Reviewer #4:

This is an interesting case series using a novel technique to help resolve shoulder dystocia.

I think the video and description images are very helpful in allowing the reader to better visualize the technique.

My concern with publishing this article at this time is that it is just 3 cases (though admittedly, this is likely something the author has used over the years of his career) and 1/3 did show at least mild nerve stretch. I would be concerned that with only 3 specific cases cited, there is not a large enough sample size. I would like to see a larger case series or cohort group and outcomes before publishing and recommending it as a new/safe tool to employ during shoulder dystocia.

Regarding the critique of reviewer number four, and referring to the second case, during the process of attempted delivery by McRoberts maneuver, the patient did move back away from the operator. It is possible that the mild nerve stretch could've preceded the shoulder shrug maneuver. Because the McRoberts maneuver almost always precedes subsequent maneuvers, it is not possible to ascribe causation to the subsequent maneuver. In addition the brachial plexus palsy was mild and completely resolved by the second week. Likewise the shrug technique was begun initially as an attempt to deliver the posterior shoulder. This is an accepted procedure currently being performed and recommended after failed McRobert's maneuver. The rotation maneuver after the presentation of the shoulder is not a dramatic variance from currently accepted techniques and I believe that the currently described Wood's maneuver would have the same likelihood to stretch to the brachio-plexus during rotation due to the direction of movement of the shoulder (abduction). In addition I believe it is important to offer this procedure for further analysis and evaluation by other physicians in the circumstances of persistent shoulder dystocia. Description of this new technique is informative in nature and is designed to present three cases with good long term outcome. The utilization of the technique is solely up to the operator however having this technique as a possible procedure to try only exists if the procedure is published. In contrast the Zavanelli technique was published after only one case, however having it as a possible procedure to attempt only exists with learning about the procedure itself. Sometimes cases are so rare that it is unlikely to have a large number before presenting. This should not stop us from describing these cases for others to review. Some doctors may never need these unique techniques because they simply perform a cesarean section on all patients with the hint of macrosomia. For doctors who are proponents of vaginal delivery and occasionally in the face of severe macrosomia in excess of 5000 g, knowing all techniques that have been tried in extreme cases would be a great asset to their management, not hindrance. In 38 years of practice, I personally have had experience with 3 Zavanelli maneuvers two of which were in excess of 5000 g. All three of these had excellent outcome. All were performed quickly under emergency cesarean midline vertical with local anesthesia. None had brachio-plexus palsy or hypoxic encephalopathy. Had I not heard about the Zavanelli maneuver and been trained in emergency cesarean under local anesthesia, I doubt that the outcome would've been as good.

In Regards to the Editor 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:

OPT-IN: Yes, please publish my response letter and subsequent email correspondence related to author queries.

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

OPT-IN: Yes, please 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.

Reviewed.

3. Are any of your figures, or images from your video, published already in another source? Tables, figures, and supplemental digital content should be original. The use of borrowed material (eg, lengthy direct quotations, tables, figures, or videos) is discouraged, but should it be considered essential, written permission of the copyright holder must be obtained. Permission is also required for material that has been adapted or modified from another source. Both print and electronic (online) rights must be obtained from the holder of the copyright (often the publisher, not the author), and credit to the original source must be included in your manuscript. Many publishers now have online systems for submitting permissions request; please consult the publisher directly for more information.

All the figures and the video presented as supplemental digital content are the original work of Ricardo Leante. It is based on the description of the Shoulder Shrug maneuver by Ronald Sancetta, and knowledge of maternal and fetal anatomy pertinent to the delivery.

4. 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.

We reviewed the reVITALize definitions for the Obstetrics link and Gynecology link.

5. 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.

We contacted the editorial board via phone call on 2/25/2019 to explain that we had to expand the Discussion section of the article. This was due to the suggestions of the reviewers to provide a historical account with descriptions of previous shoulder dystocia techniques. We also briefly expanded on some other topics which became relevant during the review process and removed others as suggested as well. The finalized revision of the article currently contains 2468 words from Title to Figure Legend, excluding the References. If the board requests additional reduction we can accommodate although we believe that the current manuscript reads well and satisfies the requested changes.

6. Titles in Obstetrics & Gynecology are limited to 100 characters (including spaces). Do not structure the title as a declarative statement or a question. Introductory phrases such as "A study of..." or "Comprehensive investigations into..." or "A discussion of..." should be avoided in titles. Abbreviations, jargon, trade names, formulas, and obsolete terminology also should not be used in the title. Titles should include "A Randomized Controlled Trial," "A Meta-Analysis," or "A Systematic Review," as appropriate, in a subtitle. Otherwise, do not specify the type of manuscript in the title.

Reviewed.

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).

Only the listed authors contributed to the work in the manuscript. The patients whose cases are described in the manuscript have provided their informed consent which was submitted with the manuscript. This paper has never been presented at any meeting before.

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.

Reviewed. The Abstract word count was 153.

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.

Reviewed.

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.

Reviewed.

11. The American College of Obstetricians and Gynecologists' (ACOG) documents are frequently updated. These documents may be withdrawn and replaced with newer, revised versions. If you cite ACOG 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 (exceptions could include manuscripts that address items of historical interest). 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 an ACOG document has been withdrawn, it should not be referenced in your manuscript (exceptions could include manuscripts that address items of historical interest). All ACOG documents (eg, Committee Opinions and Practice Bulletins) may be found

via the Clinical Guidance & Publications page at <https://www.acog.org/Clinical-Guidance-and-Publications/Search-Clinical-Guidance>.

All citations and references to ACOG's Practice Bulletins have been reviewed to be current.

12. 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). 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.

Reviewed.

13. The current video may be resubmitted. Please check to make sure that the captions are free of spelling errors.

Reviewed.

14. 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/ifaauth.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.

Reviewed.

15. 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.

Once again we hope that the responses provided answer the points made by the four reviewers. We certainly hope that this technique allows further research in the management of this complicated obstetrician emergency and serves as an additional tool to aid in shoulder dystocia deliveries. With best regards to the reviewers that contributed their comments and the editor, cordially,

Ronald Sancetta, MD FACOG
February 25, 2019

From: M [REDACTED]
To: [Randi Zung](#)
Subject: Re: Final changes - 16-69R1
Date: Friday, March 22, 2019 1:54:25 PM
Attachments: [video authorization.pdf](#)

We agree with the proposed changes and agree with the title of the video. Attached please find the authorization from the video creator. Please note correct spelling of his first name is Ricardo. If you have any further questions please contact me at [REDACTED]

[REDACTED] Thank You
Ronald Sancetta, MD

From: Randi Zung <RZung@greenjournal.org>
Sent: Friday, March 22, 2019 2:04 PM
To: [REDACTED]
Subject: RE: Final changes - 16-69R1

Dear Dr. Sancetta:

The Editors have discussed your revised manuscript. There are two minor deletions that have been made in the Experience section on Lines 80-81. Please review these changes in the attached version of your manuscript (v4). If you have any additional changes at this time, please make them directly in the file.

Regarding your accompanying video, we will need the following:

- A completed copy of the Video Permission form signed by the video's creator. This form is attached.
- Please confirm that the title of the video should be displayed as, "The Shoulder Shrug Maneuver."
- Please confirm that the caption for the video should be displayed as, "The video highlights a new technique to facilitate delivery during shoulder dystocia. Video created by Ricard Leante, MS. Used with permission."

If you have any further edits to the manuscript file, please send back an updated version.

Thank you,
Randi

From: [REDACTED]
Sent: Tuesday, March 19, 2019 8:15 PM
To: Randi Zung <RZung@greenjournal.org>
Subject: Fwd: Final changes - 16-69R1

Sent from my iPhone

Subject: Final changes

Good evening,

Here's the revised manuscript. As far as addressing the editorial points here's the response based on the current modifications:

1. General: The Manuscript Editor and Dr. Chescheir have made edits to the manuscript using track changes. Please review them to make sure they are correct.

All changes tracked.

2. Corresponding Author Information: If your paper is accepted, is this the correct contact information to print?

Corrected in Manuscript

3. Precis: Do you agree with the precis edits?

Agreed

4. Line 44: Your paper is missing an Introduction section. According to our Instructions for Authors, the Introduction "Outlines the need for the new development." Please add this section.

Introduction added with corresponding references.

5. Please add an in-text citation for your video. ("Video 1 is available online at <http://links.lww.com/xxx>").

Video in-text citation added with the link that is provided by the EditorialManager, however we do not have any link with the format <http://links.lww.com/xxx> but i can be easily substituted.

6. Line 67-68: Rather than telling us about the IRB for future studies, what is needed is a statement from your IRB that you either have approval from the IRB to publish this case series or that your IRB does not require such consent.

The IRB review and approval exemption was written as requested. If the response letter from the BHSF IRB is required we can email it as well.

7. Line 71: Please edit this statement so that it is accurate to the case.

Corrected

8. Line 117: For any of the cases, do you have head to shoulder or head to body intervals?

Case #1, the head had been delivered prior to obstetrician's arrival and attempt for delivery was made by 2 neonatologists and one nurse for approximately 3-4 minutes. Upon Obstetrician arrival, the delivery of the body was completed less than 90 seconds.

Case #2, the patient moved backwards away from the obstetrician once shoulder dystocia was encountered. Head to body interval was approximately 3-4 minutes.

Case #3, the head to body delivery was approximately 2 minutes.

The above are estimates based upon physician memory but no personnel was logging those specific time intervals.

9. Discussion: Your paper is about 400 words over the recommended limit for a Procedures and Instruments article (without the Introduction). Please shorten the Discussion to about 750 words.

We made the suggested changes and shortened the Discussion section and shifted some of the background content the Introduction section. The Discussion section is now 716 words. The current article length excluding the References section is 1,994 words (less than the 2000 word limit).

10. Line 146-147: You can't really make this statement on the basis of a case series of

3. You could state something like “Alternatives to these historic approaches with the goal of minimizing neonatal and maternal injury are important when the routine approach fails. Delivery of the posterior shoulder if the McRobert’s procedures and suprapubic fail to result in neonatal delivery requires that the infant’s hand be accessible to sweep across the chest. This can be very difficult with a large infant or constricted maternal anatomy (10). As well, aggressive attempts can lead to humeral or clavicular fractures.”

The shoulder shrug technique advances the posterior shoulder to the introitus, reducing the transverse diameter of the shoulders. The posterior had does not need to be manipulated. As well, by moving the shoulder and head as a single unit, additional traction forces on the brachial plexus are avoid.

Corrected to be more concise.

11. Line 174-198: This highlighted text is not necessary. Your paper is not a review of all the techniques described to relieve a shoulder dystocia.

We agree regarding the object of the article not being a comprehensive review of all techniques used to relieve shoulder dystocia. At the same time, the reviewers suggested that some relevant techniques be mentioned for completeness. We synthesized the extent of the Discussion section to reflect those suggestions as well.

These responses along with the actual changes made should satisfy the inquiries and suggestions made by the Editorial board.

Regards,

Eileen Chang (Temp)

From: [REDACTED]
Sent: Tuesday, March 12, 2019 2:34 PM
To: Eileen Chang (Temp)
Subject: Re: O&G Figure Revision: 19-69

I have reviewed the legend and figures. All looks perfect for publication. Are we confirmed for publication? If so when might that be?

Ronald Sancetta, MD

Sent from my iPhone

On Mar 12, 2019, at 11:49 AM, Eileen Chang (Temp) <echang@greenjournal.org> wrote:

Hello,

Thank you for the clarification. If you could also get back to us on your approval of the figure and legend (or if there are any additional edits to be made) that would be great!

Best,
Eileen

From: [REDACTED]
Sent: Tuesday, March 12, 2019 11:41 AM
To: Eileen Chang (Temp) <echang@greenjournal.org>
Subject: Re: O&G Figure Revision: 19-69

D arrow represents movement of the posterior shoulder to the shrug position
E arrow represents counterclockwise rotation of the head/ shoulder unit
F arrow represents delivery of the infant

Sent from my iPhone

On Mar 12, 2019, at 11:11 AM, Eileen Chang (Temp) <echang@greenjournal.org> wrote:

Hello,

In addition, we have an author query for the figure legend. Please see below:

In parts D, E, and F, would you mention what the black arrow represents?

Thank you!

Eileen

From: Eileen Chang (Temp)
Sent: Tuesday, March 12, 2019 9:50 AM
To: [REDACTED]
Subject: O&G Figure Revision: 19-69

Good Morning,

Your figure and legend have been edited and they have been attached for your review. Please review the attachments CAREFULLY for any mistakes.

PLEASE NOTE: Any changes to the figure or legend 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 appreciate a reply no later than Thursday, 3/14. Thank you for your help.

Best,

Eileen