Date: Feb 15, 2019
To: "Sarah C. Lassey" [redacted]
From: "The Green Journal" em@greenjournal.org
Subject: Your Submission ONG-19-188

RE: Manuscript Number ONG-19-188

Hyponatremia in home birth transfers with prolonged labor

Dear Dr. Lassey:

Your submission is really not a case report or case series, as you have culled three cases from a larger cohort. Had you just submitted the 3 cases we would consider this a case series. Knowing that these cases come from a larger cohort, to consider your submission further we are asking that you format it as a cohort study of home birth transfers and resubmit it as original research. In that re-submission, please be responsive to the comments of the reviewers. Also, your revised manuscript would be sent out for further peer review which would be used in our further deliberations on your manuscript.

Thank you for considering Obstetrics & Gynecology for your work.

Sincerely,

-Dwight J. Rouse
Associate Editor, Obstetrics
Obstetrics & Gynecology

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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 Mar 08, 2019, we will assume you wish to withdraw the manuscript from further consideration.

REVIEWER COMMENTS:

Reviewer #1: This is a case report of three pregnancies with prolonged attempts at home delivery and associated hyponatremia. The report highlights several important teaching points including the physiologic changes in osmolality during pregnancy, etiologies, clinical presentation and management. I do think this is something of interest to the general obstetrician and should be on everyone's radar.

Abstract:

1. Line 48 In review of hyponatremia the literature seems to divide the etiologies into hypovolemic, euvolemic or hypervolemic. I would suggest using these terms instead of exertion, which presumptively would be hypovolemic.

Teaching points:

2. I would suggest making one of the teaching points the physiologic changes in pregnancy related to a baseline decrease in osmolality. This is important for blood volume expansion during pregnancy and directly impacts interpretation of any Na result.

3. The general length of labor and exposure to endogenous or exogenous oxytocin is a risk for hyponatremia. Although the cases were intended home births the wording sounds pejorative. The bigger risk may be the combined effects of ADH and excessive free water intake which was mentioned in the discussion section.

Introduction:

4. Line 74-76 The analogy used for a marathon runner is helpful, however the description of hyponatremia in labor not appropriately resuscitated is not specific. The key is the combined impacts of ADH on the collecting tubal to maintain euvolumia or resorb free H2O in extended aerobic activity and electrolyte repletion at the same time. It is the combined effect of excessive free water intake resuscitation and ADH that may exacerbate either scenario.

Cases

5. Line 87-88 I think there is general understanding of lay midwife and further description of lack of training is not needed and can be shortened.

6. Line 91 Is there more specifics of what liberal liquid intake was? Ie water vs. electrolyte or isotonic fluids. Also other than description of mucous membranes is there any information on general urine output over the home delivery time period?

7. Line 95 Was there further objective assessment of confusion in regards to mental status exam or neurologic exam?

8. Line 105 What was the preoperative diagnosis of chorioamnionitis based upon? Was there criteria for intra-amniotic infection and/or inflammation? If antibiotics were continued what was given and for how long?

9. For all cases was there more information on volume status reflected on urine Na, specific gravity or osmolality results?

Discussion:

10. Line 170 The reference Obstet Gynecol Surv. 2007;62:731-8 reports a similar case however the case report discussed the impact of possible black cohosh on mechanisms for hyponatremia. The case report did not implicate oxytocin use.

11. Line 192 Give a reference for pre eclampsia and hyponatremia. Physiologically these patients tend to be hemoconcentrated.

12. Line 205 The conclusion about home births and fluid intake should specify hypotonic fluid like water.

13. The rest of the discussion is well written with a thorough description of management and correction of hyponatremia.

Reviewer #2: I. Introductory Summary:

A high proportion of women planning home birth transferred to a tertiary care facility for prolonged labor were found to have moderate to severe hyponatremia. A series of three cases detail instances of presentation, management and clinical course of severe intrapartum hyponatremia.

II. Novelty:

The question of hyponatremia and its etiologies in labor have been investigated, as you note in your introduction. Yours is the largest case-study I am able to find looking specifically at the topic in women planning home birth that were subsequently transferred to inpatient management for prolonged labor.

1. A pair of papers do cover a somewhat similar question and are at least worth your consideration. First, Blitz et al (AJP Rep. 2016 Mar;6(1):e121-4) describes a single case report of home birth transfer with symptomatic severe hyponatremia that they attribute to Black Cohosh ingestion. In a prospective cross-sectional case study, Ekanem et al (ISRN Obstet Gynecol. 2012;2012:430265.) describe electrolyte anomalies in a population of rural women admitted for obstructed labor in Nigeria. That population had elevated levels of serum sodium that they attribute to dehydration.

III. Methodology:
Case report - although 6 were mentioned, only 3 were described.

IV. Significance:
As home-birth becomes more common, inpatient providers will expect to receive more transfers for prolonged labor. Screening for hyponatremia in these women is useful. Additionally, risk of excessive fluid consumption during labor is highlighted.

V. Presentation:
The paper clearly describes the intended topic and includes most information that a reader needs to consider. Please consider the following points.

1. The discussion of marathons in the first paragraph is distracting, particularly as marathons are not brought back into the conversation at any point. The paragraph could be replaced with one sentence stating that hyponatremia has been associated with excessive fluid consumption during extreme aerobic activity.

2. Insert a comma following "result" on line 78

3. The descriptors "home birth transfer" and "lay-midwife," while likely understandable to most readers, feel colloquial and pejorative. "Lay-midwife" is a non-specific term that could apply to those with or without certification. The preferred term certified professional midwife. Move this description to the introduction. A definition of home birth transfer should also be included early in the introduction, as well as some description of common experiences with such transfers in your institution as there is a wide practice variation among those attending home birth. Thirteen transfers over four full years is a relatively low number, and I suspect there are a small number of certified professional midwives sending their patients to your institution. Also, are there particular characteristics of these women or providers that are different than women planning hospital birth and choose to spend most of their labor at home?

4. A tone of condescension toward home birth permeates the paper (e.g. describing weeks of ROM [lines 89 & 146], 6 hour delay of pushing [148], extreme caput [159]), unnecessarily distracting from the pathology you are describing.

5. Work up for hyponatremia should include more objective data, particularly in regard to urine osmolality and sodium concentrations. Objective measures for UOP should replace subjective descriptors (line 132).

6. In line with the prior point, excessive fluid intake is purported to be the etiology of the hyponatremia in each of these patients, but other etiologies (particularly exposures) are not clearly ruled out. Apparently the medical record describes evidence of "liberal" fluid intake for cases 1 & 3, but this is not defined. Is this drinking to thirst or forced fluid intake? Were there objective measure of intake? The marathoners' intake in cited studies was quantified in liters as well as miles per cup.

7. Objective definitions and management of hyponatremia should be established in case one, and explanations for deviation in management (e. g. the use of desmopressin in the second patient) should be explained.

8. The differential diagnosis paragraph in the discussion (line 185) needs references.

9. Headache, lethargy, nausea and anorexia are symptoms, not signs, of hyponatremia (line 193)

10. In lines 98 and 156, was decision for emergent cesarean based on prolonged bradycardia (>10 mins) or prolonged deceleration?

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. 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.

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

5. 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).

6. Provide a short title of no more than 45 characters (40 characters for case reports), including spaces, for use as a running foot.

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

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

8. 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.

9. 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.

10. Please express outcome data as both absolute and relative effects since information presented this way is much more useful for clinicians. In both the Abstract and the Results section of the manuscript, please give actual numbers and percentages in addition to odds ratios (OR) or relative risk (RR). If appropriate, please include number needed to treat for benefits (NNTb) or harm (NNTh). When comparing two procedures, please express the outcome of the comparison in U.S. dollar amounts.

11. 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 Mar 08, 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

[redacted]

March 15, 2019

Nancy C. Chescheir
Editor in Chief
Obstetrics and Gynecology
The American College of Obstetricians and Gynecologists
409 12th St, SW
Washington, DC 20024

Dear Dr. Chescheir:

Please find enclosed our manuscript titled “Hyponatremia in home birth transfers with prolonged labor” which we are pleased to submit for publication as a case series in Obstetrics and Gynecology. The corresponding author of this manuscript is Dr. Sarah C. Lassey.

This case series was written after increase in awareness of hyponatremia following home birth transfers. This is the first case series of this complication from home birth transfers and we hope with publication of our series we are able to increase clinician awareness to this outcome and review management.

With the submission of this manuscript I would like to undertake that all authors have participated in the review of this case and have read and approved the final version submitted. I would also like to disclose that the contents of this manuscript are not under consideration for publication elsewhere and will not be submitted while acceptance is under consideration. The authors have no conflicts of interest to declare and no financial disclosures. We affirm that this manuscript is an honest, accurate, and transparent account of the event being reported.

These cases occurred at our institution between 2014-2017. This research was approved by the Partners IRB. Written permission was obtained from the cases presented in the manuscript. Brigham and Women’s Hospital is fully aware of this submission.

After initial submission, the reviewers and editors requested certain revisions. They are as follows with our responses by-line in bold and italics.

Reviewer #1: This is a case report of three pregnancies with prolonged attempts at home delivery and associated hyponatremia. The report highlights several important teaching points including

the physiologic changes in osmolality during pregnancy, etiologies, clinical presentation and management. I do think this is something of interest to the general obstetrician and should be on everyone's radar.

Abstract:

1. Line 48 In review of hyponatremia the literature seems to divide the etiologies into hypovolemic, euvolemic or hypervolemic. I would suggest using these terms instead of exertion, which presumptively would be hypovolemic.
This has been changed to "hypovolemic hyponatremia" in the text.

Teaching points:

2. I would suggest making one of the teaching points the physiologic changes in pregnancy related to a baseline decrease in osmolality. This is important for blood volume expansion during pregnancy and directly impacts interpretation of any Na result.
We did not include any of the normal physiologic changes of pregnancy in the manuscript or teaching points due to the word and length limitations of the paper. If the reviewers and editors overall feel this is important it can be added.

3. The general length of labor and exposure to endogenous or exogenous oxytocin is a risk for hyponatremia. Although the cases were intended home births the wording sounds pejorative. The bigger risk may be the combined effects of ADH and excessive free water intake which was mentioned in the discussion section.
Our intent was not to sound pejorative and we have edited the text in hopes that it does not. These cases however were identified as home birth transfers. When we evaluated all cases of severe hyponatremia at our center, very few were associated with prolonged labor, likely due to IV fluid resuscitation throughout. Yes, the physiologic mechanism is likely ADH and excessive free water intake and therefore our hope is to educate providers to check electrolytes when these patients present to their centers. We are happy to readdress if the editors think the text continues to sound pejorative.

Introduction:

4. Line 74-76 The analogy used for a marathon runner is helpful, however the description of hyponatremia in labor not appropriately resuscitated is not specific. The key is the combined impacts of ADH on the collecting tubal to maintain euvolumia or resorb free H2O in extended aerobic activity and electrolyte repletion at the same time. It is the combined effect of excessive free water intake resuscitation and ADH that may exacerbate either scenario.
This analogy to the marathon runner has been removed from the manuscript as it was distracting from the clinical presentation. A sentence about ADH's role in euvolemia has been added to the introduction to explain the physiologic mechanism.

Cases

5. Line 87-88 I think there is general understanding of lay midwife and further description of lack of training is not needed and can be shortened.
This has been shortened to eliminate the definition of a lay midwife.

6. Line 91 Is there more specifics of what liberal liquid intake was? Ie water vs. electrolyte or isotonic fluids. Also other than description of mucous membranes is there any information on general urine output over the home delivery time period?
This has been changed to free water as documented in the patient's chart. Unfortunately we do not have any other information regarding urine output at home prior to presenting to labor and delivery.

7. Line 95 Was there further objective assessment of confusion in regards to mental status exam or neurologic exam?
Further clarification regarding mental status exam has been added. When her mental status improved further objective assessment (ex. Imaging) was deferred.

8. Line 105 What was the preoperative diagnosis of chorioamnionitis based upon? Was there criteria for intra-amniotic infection and/or inflammation? If antibiotics were continued what was given and for how long?
She was febrile to 102 shortly following delivery and in the setting of prolonged rupture of membranes the diagnosis was consistent with chorioamnionitis. This was confirmed with placental pathology. This has now been added to the manuscript.

9. For all cases was there more information on volume status reflected on urine Na, specific gravity or osmolality results?
Unfortunately, urine osmolality and sodium concentration were not sent on these cases (reviewer 3 asked for similar objective parameters).

Discussion:

10. Line 170 The reference Obstet Gynecol Surv. 2007;62:731-8 reports a similar case however the case report discussed the impact of possible black cohosh on mechanisms for hyponatremia. The case report did not implicate oxytocin use.
This reference has now been removed. It pertained to another case that was not chosen for the manuscript.

11. Line 192 Give a reference for pre eclampsia and hyponatremia. Physiologically these patients tend to be hemoconcentrated.
This phenomenon has been described in multiple case reports. The most descriptive has now been included as a reference.

12. Line 205 The conclusion about home births and fluid intake should specify hypotonic fluid like water.
This has been changed to clarify hypotonic fluid consumption.

13. The rest of the discussion is well written with a thorough description of management and correction of hyponatremia.
We thank the reviewer for this feedback.

Reviewer #2: I. Introductory Summary:

A high proportion of women planning home birth transferred to a tertiary care facility for prolonged labor were found to have moderate to severe hyponatremia. A series of three cases detail instances of presentation, management and clinical course of severe intrapartum hyponatremia.

II. Novelty:

The question of hyponatremia and its etiologies in labor have been investigated, as you note in your introduction. Yours is the largest case-study I am able to find looking specifically at the topic in women planning home birth that were subsequently transferred to inpatient management for prolonged labor.

1. A pair of papers do cover a somewhat similar question and are at least worth your consideration. First, Blitz et al (AJP Rep. 2016 Mar;6(1):e121-4) describes a single case report of home birth transfer with symptomatic severe hyponatremia that they attribute to Black Cohosh ingestion. In a prospective cross-sectional case study, Ekanem et al (ISRN Obstet Gynecol. 2012;2012:430265.) describe electrolyte anomalies in a population of rural women admitted for obstructed labor in Nigeria. That population had elevated levels of serum sodium that they attribute to dehydration.
Thank you for these references as they certainly add to the literature around electrolyte abnormalities during labor. The ISRN Obstet Gynecol was added as a reference for the differential diagnosis, thank you for this input.

III. Methodology:
Case report - although 6 were mentioned, only 3 were described.
The structure of this paper has been changed to a case series without the further information regarding the larger cohort as per discussion with the editor. This has been changed in both the abstract and the text of the paper.

IV. Significance:
As home-birth becomes more common, inpatient providers will expect to receive more transfers for prolonged labor. Screening for hyponatremia in these women is useful. Additionally, risk of excessive fluid consumption during labor is highlighted.

V. Presentation:
The paper clearly describes the intended topic and includes most information that a reader needs to consider. Please consider the following points.

1. The discussion of marathons in the first paragraph is distracting, particularly as marathons are not brought back into the conversation at any point. The paragraph could be replaced with one sentence stating that hyponatremia has been associated with excessive fluid consumption during extreme aerobic activity.
This comparison and the associated reference have been removed from the manuscript as we agree with the editors it distracts from the text.

2. Insert a comma following "result" on line 78
This change has been made in the manuscript.

3. The descriptors "home birth transfer" and "lay-midwife," while likely understandable to most readers, feel colloquial and pejorative. "Lay-midwife" is a non-specific term that could apply to those with or without certification. The preferred term certified professional midwife. Move this description to the introduction. A definition of home birth transfer should also be included early in the introduction, as well as some description of common experiences with such transfers in your institution as there is a wide practice variation among those attending home birth. Thirteen transfers over four full years is a relatively low number, and I suspect there are a small number of certified professional midwives sending their patients to your institution. Also, are there particular characteristics of these women or providers that are different than women planning hospital birth and choose to spend most of their labor at home?

Home birth transfer is the terminology our center uses to describe intended home births that are delivered at the hospital. This definition has been added to the introduction. Upon review, this terminology is what is used in the literature to describe these deliveries. We are open to suggestion if there is another phrase the reviewer would like us to use. We agree that thirteen transfers over four full years is a relatively low number and in our state home birth transfers are quite rare (0.54% from CDC data). We also practice in a city with multiple tertiary academic centers and so the transfers are likely spread across multiple institutions.

The description of the planned delivering provider has been removed from the text because as mentioned by another reviewer, the point is to explain the physiologic mechanism of prolonged labor with free water intake.

4. A tone of condescension toward home birth permeates the paper (e.g. describing weeks of ROM [lines 89 & 146], 6 hour delay of pushing [148], extreme caput [159]), unnecessarily distracting from the pathology you are describing.
The language throughout the paper has been edited as a pejorative or condescending tone was not intended.

5. Work up for hyponatremia should include more objective data, particularly in regard to urine osmolality and sodium concentrations. Objective measures for UOP should replace subjective descriptors (line 132).
We agree with this sentiment of the editor. Urine osmolality and sodium concentration were available for case 2 and added to the manuscript. Her UOP has been changed to objective measures (500-700mL/hour). Objective measures unfortunately did not exist for the other two cases.

6. In line with the prior point, excessive fluid intake is purported to be the etiology of the hyponatremia in each of these patients, but other etiologies (particularly exposures) are not clearly ruled out. Apparently the medical record describes evidence of "liberal" fluid intake for cases 1 & 3, but this is not defined. Is this drinking to thirst or forced fluid intake? Were there objective measure of intake? The marathoners' intake in cited studies was quantified in liters as well as miles per cup.
Unfortunately, we do not have objective measures for fluid intake prior to presenting to the hospital. One patient commented that she was encouraged to drink frequently, implying more than drinking to thirst.

7. Objective definitions and management of hyponatremia should be established in case one, and explanations for deviation in management (e. g. the use of desmopressin in the second patient) should be explained.
Unfortunately we do not have urine studies for case 1. The rationale for DDAVP by nephrology has been added to case 2 to avoid rapid diuresis of free water in someone who had a rapid over-correction of hyponatremia.

8. The differential diagnosis paragraph in the discussion (line 185) needs references.
References have been added to the differential diagnosis.

9. Headache, lethargy, nausea and anorexia are symptoms, not signs, of hyponatremia (line 193)
This has been changed in the text to "symptoms."

10. In lines 98 and 156, was decision for emergent cesarean based on prolonged bradycardia (>10 mins) or prolonged deceleration?
The manuscript has been edited to clarify that case 1 had a prolonged bradycardia lasting 7 minutes (line 98) and case 3 had multiple prolonged decelerations.

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.
We choose to opt-in.

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. 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 to ensure our manuscript was in agreement.

4. Because of space limitations, it is important that your revised manuscript adhere to the following length restrictions by manuscript type: Case Reports should not exceed 8 typed, double-spaced pages (2,000 words. Stated page limits include all numbered pages in a manuscript (i.e., title page, précis, abstract, text, references, tables, boxes, figure legends, and print appendixes) but exclude references.
Currently, the manuscript with three cases is over the length restriction. If requested by the reviewers, we would remove case 2 from the series which would allow the manuscript to be less than 8 pages. Currently, the manuscript qualifies for word count <2000 words.

5. 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).

The rules regarding acknowledgements have been reviewed. There are no financial disclosures to report.

6. Provide a short title of no more than 45 characters (40 characters for case reports), including spaces, for use as a running foot.
The short title in the footer has been edited to 40 characters

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

In addition, the abstract length should follow journal guidelines. The word limits for different article types are as follows: Case Reports, 125 words;. Please provide a word count.
The abstract has been reviewed prior to submission. The word count is 125 words.

8. 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.
As requested, the abbreviations have been spelled out.

9. 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.
This symbol does not appear in the text with words.

10. Please express outcome data as both absolute and relative effects since information presented this way is much more useful for clinicians. In both the Abstract and the Results section of the manuscript, please give actual numbers and percentages in addition to odds ratios (OR) or relative risk (RR). If appropriate, please include number needed to treat for benefits (NNTb) or harm (NNTh). When comparing two procedures, please express the outcome of the comparison in U.S. dollar amounts.
This portion does not apply as our submission is a case report.

11. 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.

Sincerely,

Sarah C. Lassey, MD
Fellow, Maternal Fetal Medicine

Daniel Mosier

From: Lassey, Sarah C.,M.D. [redacted]
Sent: Friday, March 29, 2019 9:52 AM
To: Daniel Mosier
Subject: RE: Manuscript Revisions: ONG-19-188R1
Attachments: 19-188R1 ms (3-28-19v1v2).docx

Hi Daniel,
Thank you for your feedback. The edits below have been made (by line comments in bold below). I have attached the revision onto this email but please let me know if you prefer that it is uploaded onto the Green Journal website.
Let me know if you have any other questions.
Best,
Sarah Lassey

From: Daniel Mosier <dmosier@greenjournal.org>
Sent: Thursday, March 28, 2019 4:20 PM
To: Lassey, Sarah C.,M.D. [redacted]
Subject: Manuscript Revisions: ONG-19-188R1

External Email - Use Caution

Dear Dr. Lassey,

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.
   We note that case three has been removed from the manuscript and agree with this change (edits have not been made within the text of case three in this revision).
2. LINE 2: This wording may not be exactly right (modify if you wish) but it was made to indicate that "home transfer" shouldn't be used to describe a person and thus, a "home tranfer" can't be hyponatremic. Please carry this change (or your modification of it) throughout the manuscript and don't use "home birth transfer" to refer to these patients
   This change has been carried throughout the text.
3. LINE 28: Please modify as suggested above and throughout
   This change has been made
4. LINE 74: Partners IRB will not have meaning to many of our readers
   This has been changed to "institutional IRB"
5. LINE 90:
   a. This needs some sort of superscript
   Na has been changed to "sodium" throughout the text.
   b. Please give normal values here
   Reference ranges have been added
6. LINE 91: 26 what?
   A label has been added to her WBC count.
7. LINE 92: Same comment and please fix throughout with superscripts and "serum" everywhere you talk about "Na)

This has been changed to "serum sodium" throughout.

8. LINE 120: Please explain what this means
   < assay has been changed to "to low to be calculated"
9. LINE 121: Please explain this in a less jargony way
   This has been changed to "recommended serum sodium correction at a rate of…"
10. LINE 164: Isn't there a new term for this?
    This has been changed to "osmotic demyelination syndrome"
11. LINE 175: Please again serum and consistently report
    This has been revised to "serum sodium"

When revising, use the attached version of the manuscript. Leave the track changes on, and do not use the "Accept all Changes"

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 **Monday, April 1st.**

Sincerely,
-Daniel Mosier

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