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)*

**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: Apr 18, 2019
To: "Lisa Haddad" [redacted]
From: "The Green Journal" em@greenjournal.org
Subject: Your Submission ONG-19-463

RE: Manuscript Number ONG-19-463

Hormonal contraception does not increase the risk of vaginal infections among a cohort of HIV serodiscordant couples in Lusaka, Zambia

Dear Dr. Haddad:

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 May 09, 2019, we will assume you wish to withdraw the manuscript from further consideration.

REVIEWER COMMENTS:

Reviewer #1: Authors sought to evaluate the relationship between use of hormonal contraception and vaginal infections in a longitudinal cohort of HIV discordant couples in Zambia. They reported use of depo medroxyprogesterone (DMPA) was associated with reductions in rates of bacterial vaginosis, vaginal candidiasis and trichomoniasis.

Germane research question, tidy methodology and a very well written manuscript.

1. Precis & abstract conclusions (lines, 41-42 62-66) need revising; first, DMPA was associated with reductions in rates of BV, candidiasis and trichomoniasis and OCP was associated with reduced rates of candidiasis. Use of "hormonal contraception" lacks specificity in light of the study's findings. Also, authors cannot imply causality (rather, associations), thus, statement "we confirm a protective effect…" overstates their findings and should be revised accordingly. Also, what do authors mean by "genital inflammation"? (line 63)

2. Introduction; very well articulated, but will suggest editing further for brevity.

3. Data Analysis; how did authors deal with women who changed methods of contraception or started or stopped HC during the course of their study? Were these censored?

4. Discussions; Authors appropriately recognized the limitations of their diagnostic methods of vaginal infections (lines 327-328); however, it will be useful for readers to understand who (personnel) read the wet preps/interpreted results, what their training was and if they were blinded to exposure of interest?

Reviewer #2: This is an interesting study that utilizes the data from a well organized long term cohort study of HIV serodiscordant couples in Zambia.

However, I have a few questions regarding the study background, justification and analysis:

1. Line 73- Can you explain the Prong II approach?

2. Line 86- You mention that a concern is that hormonal contraception may disrupt the vaginal microenvironment, leading to increased risks of BV and susceptibility to HIV. However, the work you cite postulates the opposite.

3. Line 133- Please discuss the secondary analysis

4. Line 157- I would be interested in how this was managed statistically

5. Line 164- Please elaborate on what you mean by a modified Amsel's criteria. Please further explain your wet-mount procedure

6. Line 181- This is not clear as it was previously stated that these were the primary outcomes of interest for this study.

7. Line 220- This is an important point.

8. Line 247- Please elaborate

9. Line 289- This is not well supported. Please elaborate.

10. Line 295- I am not sure that this is well supported by the data

Reviewer #3: Manuscript presents results of a secondary analysis of prospective cohort study looking at impact of hormonal contraception in the rate/risk of developing vaginitis in serodiscordant HIV couples in Lusaka, Zambia. You outline an excellent rationale in the introduction in that the presence of vaginitis increases the rate of HIV transmission and there is limited data that that suggests that hormonal contraception increases the rate of vaginitis or specifically bacterial vaginosis, candidiasis, and trichomonas.

The importance of further understanding of this subject is critical; particularly in a low resource setting, to ensure that we as providers who are encouraging and distributing methods for family planning are not causing harm.
One of the strengths of this study is that it incorporates a large cohort with long-term longitudinal follow up. The analyses however are very complex and confusing. I defer to the statistics review as to the appropriateness of the model and approach; however as part of the general readership population it is difficult to extrapolate the results as they are reported as a hazard ratio for a binary likely recurrent outcome (vaginitis) during a period of time when participants were not continuously using the exposure of interest (hormonal contraception).

However, conversely one of this study's strengths is its rigorous design. Compared to available literature; these authors were able to control for many confounders that could impact the rate and risk of developing vaginitis including diet, environment, access to hygiene, and sexual practices.

Although you state that HIV status was not found to be an effect measure modifier (lines 216 - 217), as a provider of women's health I would be interested to see the comparison in women who were HIV positive versus those who were not.

One of the limitations is the exclusion and/or censorship of couples who were started on ART(Lines 199 - 200). Given one of the covariates assessed was viral load; and it is possible that couples that were censored were likely to be a higher risk of transmission and possibly vaginitis.

This is a well-designed trial to look at a very specific and interesting question.

STATISTICAL EDITOR'S COMMENTS:

1. Table 1: For many of these row entries, the counts for the # of events and for the couple-yrs of follow up, ie, the numerator and denominators for rates are so sparse that there is no justification for estimation of rates to nearest .01 per 100 couple years. Should simply round all entries and the CIs to nearest integer value. Although these are crude rates, might consider statistical comparison of rates within each category (BV, Candida, Trichomoniasis) by contraception method.

2. Table 2: The number of events for the implant subset for BV are too few too allow for adjustment for 5 variables. Should omit aHR for that row.

3. Table 3: Same comment for Candidiasis intervals for implant row entry and adjustment in aHR for 4 variables.

4. Table 4: Same comment for Trichomoniasis aHR for implant subset. N = 2 and 6 adjustment variables.

5. Suppl Tables 1, 2, 3: There are multiple hypotheses tested in each table, with no adjustment of the inference threshold. Use of p < 05 will likely include many spurious associations. Should only cite as significant those with p values < .01 or < .001

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: Original Research reports should not exceed 22 typed, double-spaced pages (5,500 words). Stated page limits include all numbered pages in a manuscript (i.e., title page, précis, abstract, text, references, tables, boxes, figure legends, and print appendixes) but exclude references.

5. 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.

6. 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).

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: Original Research articles, 300 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 review the journal's Table Checklist to make sure that your tables conform to journal style. The Table Checklist

is available online here: http://edmgr.ovid.com/ong/accounts/table_checklist.pdf.

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.

***

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 May 09, 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

_____

May 19, 2019

Obstetrics & Gynecology
409 12th Street, SW
Washington, DC 20024-2188

Re: revision of manuscript: **Hormonal contraception and vaginal infections among HIV serodiscordant couples in Lusaka, Zambia**

Dear Editors and Reviewers,

Thank you for your thoughtful review of our manuscript. A detailed response to each reviewer comment is provided below in red.

This study was approved by the institutional review board (IRB) at Emory University and the University of Zambia. All authors have participated substantially in the work, and have met the criteria for authorship established by the International Committee of Medical Journal Editors. The lead author affirms that this manuscript is an honest, accurate, and transparent account of the study being reported; that no important aspects of the study have been omitted; and that any discrepancies from the study as planned (and, if relevant, registered) have been explained.

The content of this manuscript has not been previously published nor is being considered for publication elsewhere. The authors will not submit the manuscript elsewhere until a final decision is made by the editors of *Obstetrics & Gynecology*. All authors declare that they have no competing interests.

We thank you again for your consideration and look forward to hearing from you.

Sincerely,

Lisa Haddad, MD MS MPH
[redacted]

Reviewer #1: Authors sought to evaluate the relationship between use of hormonal contraception and vaginal infections in a longitudinal cohort of HIV discordant couples in Zambia. They reported use of depo medroxyprogesterone (DMPA) was associated with reductions in rates of bacterial vaginosis, vaginal candidiasis and trichomoniasis.

Germane research question, tidy methodology and a very well written manuscript.

1. Precis & abstract conclusions (lines, 41-42 62-66) need revising; first, DMPA was associated with reductions in rates of BV, candidiasis and trichomoniasis and OCP was associated with reduced rates of candidiasis. Use of "hormonal contraception" lacks specificity in light of the study's findings. Also, authors cannot imply causality (rather, associations), thus, statement "we confirm a protective effect…" overstates their findings and should be revised accordingly. Also, what do authors mean by "genital inflammation"? (line 63)

We have revised precis to the following: “Depot medroxyprogesterone acetate use was associated with reduced rates of BV, candidiasis, and trichomoniasis; oral contraception use was associated with reduced rates of candidiasis.” We have similarly revised causal language throughout the text.

In the abstract, we have clarified the associations between hormonal contraceptives and vaginitis and removed the sentence referring to our prior paper noting the association between inflammation and HIV transmission. Lines 63-65: “We confirm that DMPA use was associated with reduced rates of the three most common causes of vaginitis and OCP use was associated with reduced rates of candidiasis among women in HIV-discordant couples.”

2. Introduction; very well-articulated, but will suggest editing further for brevity.

Thank you for suggestion. We have condensed introduction accordingly.

3. Data Analysis; how did authors deal with women who changed methods of contraception or started or stopped HC during the course of their study? Were these censored?

Our primary exposures of interest were time varying hormonal contraception use that was recorded at each visit. We used Anderson-Gill models which can accommodate both time-varying exposures and time-varying outcomes, and have added a sentence to the methods section to highlight that this allowed us to account for method starting, stopping and switching.

4. Discussions; Authors appropriately recognized the limitations of their diagnostic methods of vaginal infections (lines 327-328); however, it will be useful for readers to understand who (personnel) read the wet preps/interpreted results, what their training was and if they were blinded to exposure of interest?

We have added the following text to the methods section for clarification: “Certified biomedical laboratory technicians with additional training by the site senior technologist performed wet-prep evaluations following standardized study procedures. This laboratory team was responsible for interpretation of results, quality control and release of those results to the clinic and had no access to the participant clinical data.”

Reviewer #2: This is an interesting study that utilizes the data from a well organized long term cohort study of HIV serodiscordant couples in Zambia.

However, I have a few questions regarding the study background, justification and analysis:

1. Line 73- Can you explain the Prong II approach?

The WHO has presented a 4-prong strategy for prevention of perinatal HIV transmission. These prongs are (1) the primary prevention of HIV among women of childbearing age; (2) the prevention of unintended pregnancies among women living with HIV; (3) the prevention of the transmission of HIV infection from HIV-positive pregnant women to their children; and (4) the provision of appropriate care, treatment and support for women living with HIV, as well as their children and families. The details of this approach seem beyond the scope of this paper. We have revised the sentence to gain the same insight without needing to define the WHO strategy as: "Providing safe contraceptive care for women at-risk or living with HIV is essential to adequately address their family planning needs and is primary strategy recognized by the WHO to reduce perinatal transmission of HIV via prevention of unintended pregnancy."

2. Line 86- You mention that a concern is that hormonal contraception may disrupt the vaginal microenvironment, leading to increased risks of BV and susceptibility to HIV. However, the work you cite postulates the opposite.

We have added a clarification to this point and added the following sentence: "Current data, however, suggest that hormonal contraception would not increase HIV susceptibility through this mechanism."

3. Line 133- Please discuss the secondary analysis
We have added to methods section a sentence to highlight that this analysis is a secondary analysis thus the study aims were not the intent of the primary study, which was to evaluate correlates of HIV acquisition and transmission.

4. Line 157- I would be interested in how this was managed statistically
We have added details to clarify the methods for how intervals with IUD use were excluded from our primary analysis. "Given relatively infrequent IUD use, intervals with IUD use were excluded from our primary analysis with person-time during IUD use removed from the analysis."

5. Line 164- Please elaborate on what you mean by a modified Amsel's criteria. Please further explain your wet-mount procedure

We have expanded our methods section to include details on the collection methods for the wet prep. Additionally we have added the following sentence to highlight how we have modified the Amsel's criteria: "Vaginal pH, which is part of Amsel's criteria, was not consistently available and thus not included in our determination of BV."

6. Line 181- This is not clear as it was previously stated that these were the primary outcomes of interest for this study. "

Our intent here was to highlight that there were 3 separate outcomes of interest. For analyses where a specific vaginal infection (BV, vaginal candidiasis, or trichomoniasis) was not the outcome of interest, those vaginal infections were evaluated as potential covariates.
We have clarified the sentence to state: "As we had three distinct outcomes of interest, BV, vaginal candidiasis, and trichomoniasis were each evaluated as a potential covariate in models where they were not the primary outcome of interest."

7. Line 220- This is an important point.

Thank you for highlight this. We have added the following to our limitations section: "HSV-2 status was only available for a subset of our cohort, thus our ability to evaluate the influence of HSV-2 status on study findings is reduced."

8. Line 247- Please elaborate

We have removed any reference to bivariate associations in the text at <0.05 given the statistical editors suggestion that these findings may be spurious due to multiple comparisons. In this process, the sentence referred to in line 247 has been removed.

9. Line 289- This is not well supported. Please elaborate.

We have changed the text to clarify our intent: "While our current study findings do not indicate an increase in vaginal infections with hormonal contraceptive use, our prior study findings highlight the need for ongoing consideration of these vaginal infections as potential modifiers of the association between hormonal contraception and HIV."

10. Line 295- I am not sure that this is well supported by the data

We recognize that our study did not systematically evaluate the influence of endogenous hormones on vaginitis. We have removed this sentence accordingly.

Reviewer #3: Manuscript presents results of a secondary analysis of prospective cohort study looking at impact of hormonal contraception in the rate/risk of developing vaginitis in serodiscordant HIV couples in Lusaka, Zambia. You outline an excellent rationale in the introduction in that the presence of vaginitis increases the rate of HIV transmission and there is limited data that that suggests that hormonal contraception increases the rate of vaginitis or specifically bacterial vaginosis, candidiasis, and trichomonas.

The importance of further understanding of this subject is critical; particularly in a low resource setting, to ensure that we as providers who are encouraging and distributing methods for family planning are not causing harm.
One of the strengths of this study is that it incorporates a large cohort with long-term longitudinal follow up. The analyses however are very complex and confusing. I defer to the statistics review as to the appropriateness of the model and approach; however as part of the general readership population it is difficult to extrapolate the results as they are reported as a hazard ratio

for a binary likely recurrent outcome (vaginitis) during a period of time when participants were not continuously using the exposure of interest (hormonal contraception).

However, conversely one of this study's strengths is its rigorous design. Compared to available literature; these authors were able to control for many confounders that could impact the rate and risk of developing vaginitis including diet, environment, access to hygiene, and sexual practices.

Although you state that HIV status was not found to be an effect measure modifier (lines 216 - 217), as a provider of women's health I would be interested to see the comparison in women who were HIV positive versus those who were not.

Thank you for this suggestion. While we recognize that HIV status is interesting, we did not find any statistical or meaningful differences in the associations when we stratified by HIV status. Thus, we continue to present unstratified results and consider HIV as a covariate in the evaluation. We feel that presentation of the stratified evaluation would provide unnecessary additional data for the reader and complicate our results, especially as the tables are already long and we have multiple outcomes.

One of the limitations is the exclusion and/or censorship of couples who were started on ART(Lines 199 - 200). Given one of the covariates assessed was viral load; and it is possible that couples that were censored were likely to be a higher risk of transmission and possibly vaginitis.

Thank you for this suggestion. We have added the following sentence: “As couples were no longer included in this cohort when the HIV-positive partner initiated antiretroviral therapy, our findings may lack generalizability to women in discordant couples with sicker index partners or those with greater access to treatment.”

STATISTICAL EDITOR'S COMMENTS:

1. Table 1: For many of these row entries, the counts for the # of events and for the couple-yrs of follow up, ie, the numerator and denominators for rates are so sparse that there is no justification for estimation of rates to nearest .01 per 100 couple years. Should simply round all entries and the CIs to nearest integer value. Although these are crude rates, might consider statistical comparison of rates within each category (BV, Candida, Trichomoniasis) by contraception method.
We have made these changes as requested

2. Table 2: The number of events for the implant subset for BV are too few too allow for adjustment for 5 variables. Should omit aHR for that row.
We have made these changes as requested

3. Table 3: Same comment for Candidiasis intervals for implant row entry and adjustment in aHR for 4 variables.

We have made these changes as requested.

4. Table 4: Same comment for Trichomoniasis aHR for implant subset. N = 2 and 6 adjustment variables.
We have made these changes as requested.

5. Suppl Tables 1, 2, 3: There are multiple hypotheses tested in each table, with no adjustment of the inference threshold. Use of p < 05 will likely include many spurious associations. Should only cite as significant those with p values < .01 or < .001

We understand that we have multiple comparisons here and thus variables significant at 0.05 may be spurious. We have removed the reference to these associations in the supplementary table, which is a combined table of supplementary table 1,2 and 3. We have also removed any reference in the text to these <0.05 associations.

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 are happy 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.
Thank you. We have removed.

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 have reviewed and do not believe there are any definitions that we have that are inconsistent with the reVITALize definition

4. Because of space limitations, it is important that your revised manuscript adhere to the following length restrictions by manuscript type: Original Research reports should not exceed 22 typed, double-spaced pages (5,500 words). Stated page limits include all numbered pages in a manuscript (i.e., title page, précis, abstract, text, references, tables, boxes, figure legends, and print appendixes) but exclude references.
We have combined our appendix tables to now ensure we are within the space limitations

5. 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.
These changes have been made

6. 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).

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: Original Research articles, 300 words. Please provide a word count.
The abstract has been reviewed carefully and the words count is included.

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.
These changes have been made to ensure all abbreviations are spelled out the first time they are use both for the abstract and 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.
These changes have been made.

10. Please review the journal's Table Checklist to make sure that your tables conform to journal style. The Table Checklist is available online here: http://edmgr.ovid.com/ong/accounts/table_checklist.pdf.
These changes have been made.

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.