

OBSTETRICS & GYNECOLOGY



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- 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 30, 2019
To: "juhua luo" [REDACTED]
From: "The Green Journal" em@greenjournal.org
Subject: Your Submission ONG-19-527

RE: Manuscript Number ONG-19-527

Associations between parity, breastfeeding, and risk of maternal type 2 diabetes among postmenopausal women

Dear Dr. luo:

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 21, 2019, we will assume you wish to withdraw the manuscript from further consideration.

REVIEWER COMMENTS:

Reviewer #1: In this manuscript, the authors present secondary analysis of WHI data. The study seeks to clarify what is the contribution of parity and breastfeeding on the eventual development of Type II diabetes. Apparently the WHI study captured self-reported data on the initiation of Type II medications (how diabetes was defined for the study) and breastfeeding outcomes. The authors point out that the definition of diabetes has proven to be reliable but this issue is not said of the breastfeeding outcomes. Given, there is some stigma associated with breastfeeding (as in no or less breastfeeding is "bad"), it could be imagined these self-reported outcomes are over-reported. There are some curious findings that are hard to physiologically reconcile - why would race matter with respect to how parity or breastfeeding impact the acquisition of diabetes? I have the following specific questions/comments:

- 1) The introduction is perfect - concise yet informative to the study question(s).
- 2) It would be nice if in the discussion there was something said about how accurate are self-reported breastfeeding parameters. There is a study that shows women do not particularly recall birth outcomes very well. It seems hard to imagine women clearly recall how long they breastfed and as noted above they might be biased to overstate this duration and that could vary by race insofar as it is a proxy for cultural perspectives on the activity. In that light, the study conclusion that focuses on non-Hispanic white women seems at odds with the sentence at 280 - "few significant differences...stratified by race and ethnicity."
- 3) Are the waist circumferences, BMI, healthy eating habits all self-report? If not then when were these data collected?
- 4) It seems a stretch to say you adjusted for psychosocial stress particularly after you say that family size isn't necessarily the risk factor. How do you adjust for low parenting support? While poor eating/exercise habits could be logically linked to diabetes, are there any studies directly linking stress and diabetes? Just seems kind of squishy. Overall, the study appears to ask a reasonable question and given obvious limitations w/ the analyzed data, adds some clarity to what is the relationship between parity, breastfeeding and the onset of Type II diabetes.

Reviewer #2: I have reviewed this paper and have the following comments:

1. Adjusting for self-reported weight gain negates the parity finding, suggesting that weight gain, not parity is responsible for the development of T2DM. I don't see this emphasized in the conclusion as it should be.
2. What happens to the impact of breastfeeding on T2DM when self-report weight gain is adjusted for? My guess would

be that similar to parity, the impact would go away.

3. Breastfeeding is associated with better nutrition in the mother, greater caloric expenditure and a quicker and increased likelihood of returning to pre pregnancy weight. All of these factors could explain the study findings and should be discussed.
4. Was any effort made to estimate how many calories were burned by the breastfeeding mothers based on how long they breastfed?
5. The overall impact of parity and breastfeeding on the developments of T2DM is very marginal. This is not mentioned in the paper.

Reviewer #3: The authors present an effort designed to examine the associations between parity and breastfeeding with risk for development of diabetes later in life.

Readers will be familiar with the Women's Health Initiative- the large, US prospective study from which this data was obtained

The large number of patients studied over such an extended period of time permitted the authors an attempt at isolating the impact of parity upon diabetes risk, demonstrating an association between parity and risk for diabetes later in life.

The data suggests that breastfeeding duration - as defined in several ways- appears to generally mitigate this risk.

Differential effects were noted in different ethnic groups- a finding that will likely be of great interest to readers

The authors report that the association between parity/breastfeeding was not modified by baseline obesity status. They acknowledge however, that these associations were attenuated after controlling for lifetime weight gain- Supplemental data is provided in support of this finding. Readers will be most interested in this important finding- which is addressed only briefly in the Discussion

STATISTICAL EDITOR'S COMMENTS:

1. Precis, Abstract and main text: Causal language should be avoided, since this study design can only assess associations, it cannot prove that any intervention or change in behavior would reduce risk of DM.
2. lines 250-252: Should show this analysis, could be in supplemental.
3. Table 1: Need to enumerate all missing data.
4. Table 2: Need to include a column of crude OR to contrast with aORs.
5. Table 3: Not clear why parity was aggregated into none, 1-4 and ≥ 5 , when the previous tables analyzed as binary 0 vs any or had multiple levels of parity, not just 1-4 and ≥ 5 .
6. Table 4: Many of the subsets (esp for higher number of months breast fed or for ≥ 6 months breastfeeding duration per child) would have low counts of diabetics among the Asian or Hispanic groups. Therefore adjustment with the large number of variables cited in Table 4 footnote likely has resulted in an overfitted model with spurious associations. On the other hand, the low counts of adverse outcomes have low stats power and make generalization of the NS findings (only 3 of 28 comparisons were statistically significant). Too few adverse outcomes to adequately test for interaction terms.
7. lines 254-259 and Table S2: Unfortunately, the important finding re: maternal wgt gain is in supplement, when it should be in the main text. After considering wgt gain from age 18-50, the associations of development of diabetes with parity, breastfeeding lose statistical significance. That is, maternal wgt gain from age 18-50 appears to be the factor most associated with development of diabetes.

EDITORIAL OFFICE COMMENTS:

1. The Editors of Obstetrics & Gynecology are seeking to increase transparency around its peer-review process, in line with efforts to do so in international biomedical peer review publishing. If your article is accepted, we will be posting this revision letter as supplemental digital content to the published article online. Additionally, unless you choose to opt out, we will also be including your point-by-point response to the revision letter, as well as subsequent author queries. If you opt out of including your response, only the revision letter will be posted. Please reply to this letter with one of two responses:

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

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

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

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

3. Our journal requires that all evidence-based research submissions be accompanied by a transparency declaration statement from the manuscript's lead author. The statement is as follows: "The lead author* affirms that this manuscript is an honest, accurate, and transparent account of the study being reported; that no important aspects of the study have been omitted; and that any discrepancies from the study as planned (and, if relevant, registered) have been explained."

*The manuscript's guarantor.

If you are the lead author, please include this statement in your cover letter. If the lead author is a different person, please ask him/her to submit the signed transparency declaration to you. This document may be uploaded with your submission in Editorial Manager.

4. Responsible reporting of research studies, which includes a complete, transparent, accurate and timely account of what was done and what was found during a research study, is an integral part of good research and publication practice and not an optional extra. Obstetrics & Gynecology supports initiatives aimed at improving the reporting of health research, and we ask authors to follow specific guidelines for reporting randomized controlled trials (ie, CONSORT), observational studies (ie, STROBE), meta-analyses and systematic reviews of randomized controlled trials (ie, PRISMA), harms in systematic reviews (ie, PRISMA for harms), studies of diagnostic accuracy (ie, STARD), meta-analyses and systematic reviews of observational studies (ie, MOOSE), economic evaluations of health interventions (ie, CHEERS), quality improvement in health care studies (ie, SQUIRE 2.0), and studies reporting results of Internet e-surveys (CHERRIES). Include the appropriate checklist for your manuscript type upon submission. Please write or insert the page numbers where each item appears in the margin of the checklist. Further information and links to the checklists are available at <http://ong.editorialmanager.com>. In your cover letter, be sure to indicate that you have followed the CONSORT, MOOSE, PRISMA, PRISMA for harms, STARD, STROBE, CHEERS, SQUIRE 2.0, or CHERRIES guidelines, as appropriate.

5. Standard obstetric and gynecology data definitions have been developed through the reVITALize initiative, which was convened by the American College of Obstetricians and Gynecologists and the members of the Women's Health Registry Alliance. Obstetrics & Gynecology has adopted the use of the reVITALize definitions. Please access the obstetric and gynecology data definitions at <https://www.acog.org/About-ACOG/ACOG-Departments/Patient-Safety-and-Quality-Improvement/reVITALize>. If use of the reVITALize definitions is problematic, please discuss this in your point-by-point response to this letter.

6. Because of space limitations, it is important that your revised manuscript adhere to the following length restrictions by manuscript type: 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.

7. 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.

8. 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).

9. 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.

10. 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.

11. 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.

12. 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.

13. 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.

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 21, 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

In compliance with data protection regulations, you may request that we remove your personal registration details at any time. (Use the following URL: <http://ong.edmgr.com/login.asp?a=r>) Please contact the publication office if you have any questions.

RE: Manuscript No. Manuscript Number ONG-19-527, entitled "Associations between parity, breastfeeding, and risk of maternal type 2 diabetes among postmenopausal women".

Dear Editor,

We would like to thank you for the opportunity to revise the manuscript, and thank the editor and the reviewers for their constructive comments. We have carefully read all comments and have revised our manuscript accordingly. Please see our detailed response to the reviewers for one-by-one replies to all comments below. We hope that the revised manuscript is now suitable for publication in Obstetrics & Gynecology.

Juhua Luo, 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 following is our point-by point responses to all the comments:

REVIEWER COMMENTS:

Reviewer #1: In this manuscript, the authors present secondary analysis of WHI data. The study seeks to clarify what is the contribution of parity and breastfeeding on the eventual development of Type II diabetes. Apparently the WHI study captured self-reported data on the initiation of Type II medications (how diabetes was defined for the study) and breastfeeding outcomes. The authors point out that the definition of diabetes has proven to be reliable but this issue is not said of the breastfeeding outcomes. Given, there is some stigma associated with breastfeeding (as in no or less breastfeeding is "bad"), it could be imagined these self-reported outcomes are over-reported. There are some curious findings that are hard to physiologically reconcile - why would race matter with respect to how parity or breastfeeding impact the acquisition of diabetes? I have the following specific questions/comments:

1) The introduction is perfect - concise yet informative to the study question(s).

Response: We appreciate the reviewer's positive comment on the introduction.

2) It would be nice if in the discussion there was something said about how accurate are self-reported breastfeeding parameters. There is a study that shows women do not particularly recall birth outcomes very well. It seems hard to imagine women clearly recall how long they breastfed and as noted above they might be biased to overstate this duration and that could vary by race insofar as it is a proxy for cultural perspectives on the activity. In that light, the study conclusion that focuses on non-Hispanic white women seems at odds with the sentence at 280 - "few significant differences...stratified by race and ethnicity."

Response: Based on our data, the self-reported breastfeeding was highest in Asia/Pacific Islanders (61%), and lowest among Blacks (47%). These differences in the proportion of self-reported breastfeeding may relate to cultural differences in the acceptability of this practice.

We have de-emphasized race differences and have added discussion on the accuracy of history of self-reported breastfeeding as follows:

Most studies of the accuracy of long-term maternal recall of breastfeeding practice have shown that breastfeeding initiation and duration were accurate even 20 years after mothers gave birth ^{(1, 2), (3)}. A few studies have examined the sociodemographic factors that affect recall accuracy, and the results are inconclusive. ^{(4, 5), (1, 2)}. If appreciable non-differential misclassification exists, this would underestimate a true dose-response association between duration of a breastfeeding event and risk of diabetes. However, if the misclassification is differential, then the impact of this type of bias may be unpredictable.

3) Are the waist circumferences, BMI, healthy eating habits all self-report? If not then when were these data collected?

Response: Waist circumferences and BMI were measured objectively at baseline by trained clinic staff, not self-report. Total HEI-2005 score was based on self-report from the Food Frequency Questionnaire at baseline and was a measure of diet quality that assesses conformance to the 2005 dietary guidelines for Americans. We have made this clearer in the text.

4) It seems a stretch to say you adjusted for psychosocial stress particularly after you say that family size isn't necessarily the risk factor. How do you adjust for low parenting support? While poor eating/exercise habits could be logically linked to diabetes, are there any studies directly linking stress and diabetes? Just seems kind of squishy.

Response: There is some evidence in the literature showing that stressful life events, lack of social support and social strain may be associated with increased risk of diabetes. We have added a statement about this and cited a new reference in the discussion.

In this study, we speculated that psychosocial stress may partially contribute to the observed parity-diabetes relationship. We adjusted for lifestyle factors such as diet and exercise that are affected by stress; however, we did not specifically adjust for psychosocial stress or parenting support. We have revised the text to make this clearer.

Overall, the study appears to ask a reasonable question and given obvious limitations w/ the analyzed data, adds some clarity to what is the relationship between parity, breastfeeding and the onset of Type II diabetes.

Response: We appreciate the reviewer's overall positive comment.

Reviewer #2: I have reviewed this paper and have the following comments:

1. Adjusting for self-reported weight gain negates the parity finding, suggesting that weight gain, not parity is responsible for the development of T2DM. I don't see this emphasized in the conclusion as it should be.

Response: We have moved the results that adjust for self-reported weight gain from Supplementary Table 2 to the main text as new columns in Table 2, and have emphasized the finding in the text.

2. What happens to the impact of breastfeeding on T2DM when self-report weight gain is adjusted for? My guess would be that similar to parity, the impact would go away.

Response: Most of the impact of breastfeeding on T2DM became non-significant except that women who breastfed 3 or more children had significantly lower risk of diabetes compared with women who breastfed no child. These results are now presented in a revised Table 2.

3. Breastfeeding is associated with better nutrition in the mother, greater caloric expenditure and a quicker and increased likelihood of returning to pre pregnancy weight. All of these factors could explain the study findings and should be discussed.

Response: We have added these points in the discussion.

4. Was any effort made to estimate how many calories were burned by the breastfeeding mothers based on how long they breastfed?

Response: Unfortunately, we did not have information on calories burned by breastfeeding.

5. The overall impact of parity and breastfeeding on the developments of T2DM is very marginal. This is not mentioned in the paper.

Response: We agree with the reviewer that the overall impact of parity and breastfeeding is marginal, and the association between parity and T2DM went away after further adjusting for adult weight gain. We have modified the interpretation of our findings.

Reviewer #3: The authors present an effort designed to examine the associations between parity and breastfeeding with risk for development of diabetes later in life.

Readers will be familiar with the Women's Health Initiative- the large, US prospective study from which this data was obtained

The large number of patients studied over such an extended period of time permitted the authors an attempt at isolating the impact of parity upon diabetes risk, demonstrating an association between parity and risk for diabetes later in life.

The data suggests that breastfeeding duration - as defined in several ways- appears to generally mitigate this risk.

Differential effects were noted in different ethnic groups- a finding that will likely be of great interest to readers

The authors report that the association between parity/breastfeeding was not modified by baseline obesity status. They acknowledge however, that these associations were attenuated after controlling for lifetime weight gain- Supplemental data is provided in support of this finding. Readers will be most interested in this important finding- which is addressed only briefly in the Discussion

Response: We appreciate the reviewer's positive comments on our study. As suggested, we have moved the results that control for lifetime weight gain from Supplementary Table 2 to the main text and have emphasized the finding in the text.

STATISTICAL EDITOR'S COMMENTS:

1. Precis, Abstract and main text: Causal language should be avoided, since this study design can only assess associations, it cannot prove that any intervention or change in behavior would reduce risk of DM.

Response: We have modified the language where appropriate.

2. lines 250-252: Should show this analysis, could be in supplemental.

Response: We have provided p values for all the interaction tests in the text.

3. Table 1: Need to enumerate all missing data.

Response: We have added all missing data in Table 1.

4. Table 2: Need to include a column of crude OR to contrast with aORs.

Response: We have added a column of age-adjusted ORs in Table 2.

5. Table 3: Not clear why parity was aggregated into none, 1-4 and ≥ 5 , when the previous tables analyzed as binary 0 vs any or had multiple levels of parity, not just 1-4 and ≥ 5 .

Response: Since the HRs for women with parity=1-4 were similar, we collapsed them to improve study power for the analysis of joint associations of parity and breastfeeding with risk of diabetes.

6. Table 4: Many of the subsets (esp for higher number of months breast fed or for ≥ 6 months breastfeeding duration per child) would have low counts of diabetics among the Asian or Hispanic groups. Therefore adjustment with the large number of variables cited in Table 4 footnote likely has resulted in an overfitted model with spurious associations. On the other hand, the low counts of adverse outcomes have low stats power and make generalization of the NS findings (only 3 of 28 comparisons were statistically significant). Too few adverse outcomes to adequately test for interaction terms.

Response: The following is the number of cases for Table 4 for Asian and Hispanic groups. We agree the number of cases for the higher number of months breastfed or months breastfed per child was not very high for the Asian group, and some of these findings may be a chance finding given multiple tests. Although we tried to remove some covariates with minor impacts on the model and observed similar results, we have de-emphasized the findings by race/ethnicity.

	Asian	Hispanic
Lactation history		
No of months breastfed		
Never breastfed	128	340
1-6	137	229
7-12	76	104
13-23	41	82
24 or more	35	88
No of months breastfed per child		
Never breastfed	128	340
1-3	164	277

4-6	62	105
6 or more	63	121

7. lines 254-259 and Table S2: Unfortunately, the important finding re: maternal wgt gain is in supplement, when it should be in the main text. After considering wgt gain from age 18-50, the associations of development of diabetes with parity, breastfeeding lose statistical significance. That is, maternal wgt gain from age 18-50 appears to be the factor most associated with development of diabetes.

Response: We have integrated Supplementary Table 2 into a revised Table 2 and emphasized the finding in the text.

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.

Response: OPT-IN

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.

Response: Will follow the instructions.

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.

Response: We will remove these PDFs.

3. Our journal requires that all evidence-based research submissions be accompanied by a transparency declaration statement from the manuscript's lead author. The statement is as follows: "The lead author* affirms that this manuscript is an honest, accurate, and transparent account of the study being reported; that no important aspects of the study have been omitted; and that any discrepancies from the study as planned (and, if relevant, registered) have been explained." *The manuscript's guarantor.

If you are the lead author, please include this statement in your cover letter. If the lead author is a different person, please ask him/her to submit the signed transparency declaration to you. This document may be uploaded with your submission in Editorial Manager.

Response: [We have added the statement in the cover letter.](#)

4. Responsible reporting of research studies, which includes a complete, transparent, accurate and timely account of what was done and what was found during a research study, is an integral part of good research and publication practice and not an optional extra. Obstetrics & Gynecology supports initiatives aimed at improving the reporting of health research, and we ask authors to follow specific guidelines for reporting randomized controlled trials (ie, CONSORT), observational studies (ie, STROBE), meta-analyses and systematic reviews of randomized controlled trials (ie, PRISMA), harms in systematic reviews (ie, PRISMA for harms), studies of diagnostic accuracy (ie, STARD), meta-analyses and systematic reviews of observational studies (ie, MOOSE), economic evaluations of health interventions (ie, CHEERS), quality improvement in health care studies (ie, SQUIRE 2.0), and studies reporting results of Internet e-surveys (CHERRIES). Include the appropriate checklist for your manuscript type upon submission. Please write or insert the page numbers where each item appears in the margin of the checklist. Further information and links to the checklists are available at <http://ong.editorialmanager.com>. In your cover letter, be sure to indicate that you have followed the CONSORT, MOOSE, PRISMA, PRISMA for harms, STARD, STROBE, CHEERS, SQUIRE 2.0, or CHERRIES guidelines, as appropriate.

Response: [We have followed the STROBE guidelines.](#)

5. Standard obstetric and gynecology data definitions have been developed through the reVITALize initiative, which was convened by the American College of Obstetricians and Gynecologists and the members of the Women's Health Registry Alliance. Obstetrics & Gynecology has adopted the use of the reVITALize definitions. Please access the obstetric and gynecology data definitions at <https://www.acog.org/About-ACOG/ACOG-Departments/Patient-Safety-and-Quality-Improvement/reVITALize>. If use of the reVITALize definitions is problematic, please discuss this in your point-by-point response to this letter.

Response: [The definitions are fine with us.](#)

6. 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.

Response: [Our revised manuscript is within the limits.](#)

7. 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.

Response: [Guidelines are followed.](#)

8. 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).

Response: Guidelines are followed.

9. 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.

Response: Guidelines are followed.

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.

Response: Our abstract is within limit.

10. 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.

Response: Guidelines are followed.

11. 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.

Response: Guidelines are followed.

12. 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.

Response: We reviewed the journal's Table Checklist to make sure that the tables conform to journal style.

13. 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>.

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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.

Response: Will do.