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: Jun 17, 2019
To: "Katie Lynn Westerfield" [redacted]
From: "The Green Journal" em@greenjournal.org
Subject: Your Submission ONG-19-770

RE: Manuscript Number ONG-19-770

A rare cause of respiratory collapse in a non-laboring patient

Dear Dr. Westerfield:

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

REVIEWER COMMENTS:

Reviewer #1: Thank you for your case report

Specific comments:

1. Short title needs to be a bit longer.

2. Precis: I would leave out the excess modifying words and put the actual cause in.

3. Case description: your case description is clear and succinct. I would include in the case if she was on any anti-reflux medications during pregnancy or the admission and if reflux had been a chronic symptomatic problem for her. I would also note if the event occurred daytime or while recumbent, perhaps while sleeping.

4. Line 123: are gastric secretions sterile? I don't think of any part of the GI system as sterile.

5. Lines 127-8: you had not previously mentioned her history of symptoms.

6. Line 137: again, a detail that should be in the case description.

7. Line 156-7 I would suggest that if a history of reflux had been elicited on admission these medications might have been onboard.

8. Line 160: but this was not " the labor process" you were prespping for possible cesarean, so this is a different situation. How would clears or food change the anesthesia process and risks at induction?

Reviewer #2: The authors present a case report of aspiration pneumonitis in an atypical setting and review the need to revisit guidelines for contemporary management of oral intake during labor. The topic is of interest in a climate interested in preventing severe maternal morbidity and enhanced recovery after surgery pathways and provides a platform to discuss these emerging issues as well as review clinical management of high-risk patients. I have a few comments and questions for these authors:

1. Precis: I would encourage including the word patient. It seems a little strange to have "gestation" be the subject of the sentence.

2. Line 98: Any other data about her respiratory alkalosis (i.e. pH and PO2).

3. Line 102: More objective data about the ABG and other data prompting intubation would be interesting if available (i.e. ABG information, AA gradient to understand the degree of ARDS, etc). Why intubate instead of other noninvasive ventilation? Also, how did you confirm this diagnosis and not other etiologies (her CT has a somewhat abnormal pattern for aspiration with the LUL involvement). Were there other micro studies sent?

4. Line 103: Any more data you could provide about her ICU course? How she was managed from an obstetric perspective and a high level overview of her ICU management.

5. Lines 102-107: More information about the timeline would also be instructive for the clinician. Similarly, more data on the timeline of her recovery could be instructive.

6. Line 115: Is it truly unprovoked? Or is there a more accurate term that could be used to describe this.

7. Line 147: I think this is one of the most clinically actionable items from the case report. Elaborating a bit more on ways to do this safely such as ERAS protocols, etc, would be of interest to the clinician.

8. Line 153: Is there other data that can be extrapolated from the general population to support use of H2 blockers or PPIs in this population? I might elaborate a bit more on this given it is a teaching point of your case and a conclusion.

Overall this is an interesting case with impressive imaging findings that provides a chance to review complex clinical management of a critically ill patient as well as current obstetric management paradigms. I imagine the clinician reading the case report may want a few more details of her presentation and management which is a nice opportunity for education. And reviewing the evidence informing the teaching points with a bit more granularity may help make a more convincing argument that could motivate the clinician to change management going forward.

Associate Editor's Comments:

Please address treatment of aspiration pnemonitis-? Antibiotics?

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. 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:
A. OPT-IN: Yes, please publish my point-by-point response letter.
B. OPT-OUT: No, please do not publish my point-by-point response letter.

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, 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. 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.

7. 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.

8. 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.

9. The Journal's Production Editor had the following comments about the figures in your manuscript:

"FIGURE 1: Please upload this figure as a separate file into Editorial Manager"

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

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

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

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

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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.

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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 Jul 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

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From: Katie L. Westerfield D.O., MAJ, MC, USA

To: Editorial Board, Obstetrics & Gynecology

Subject: Editorial Revision Manuscript Number ONG-19-770

Please accept our re-submission as we have addressed the following points of feedback:

Reviewer #1: Thank you for your case report

1. Short title needs to be a bit longer.
-Short title changed.

2. Precis: I would leave out the excess modifying words and put the actual cause in.
-Addressed and changed Precis.

3. Case description: your case description is clear and succinct. I would include in the case if she was on any anti-reflux medications during pregnancy or the admission and if reflux had been a chronic symptomatic problem for her. I would also note if the event occurred daytime or while recumbent, perhaps while sleeping.
-We have addressed all three parts of this comment. The patient was not on medications for GERD when admitted. The patient had only complained of occasional postprandial symptoms for which she occasionally took antacids 1-2 times per month. She was not having any symptoms or taking any medications at the time of admission.

4. Line 123: are gastric secretions sterile? I don't think of any part of the GI system as sterile.
-Addressed

5. Lines 127-8: you had not previously mentioned her history of symptoms
-Addressed

6. Line 137: again, a detail that should be in the case description
-This detail was already included in the original draft on line 91. (now line 102) Did not make changes.

7**. Line 156-7 I would suggest that if a history of reflux had been elicited on admission these medications might have been onboard.**
-History was elicited, but it was elicited to be occasional provoked with eating and not occurring at the time of admission. Patient was not started on medications at the time of admission. Had it been a more significant history, if patient had complained of symptoms at time of admission or if she had been receiving pharmacologic management this would have been continued on admission

8. **Line 160: but this was not " the labor process" you were prepping for possible cesarean, so this is a different situation. How would clears or food change the anesthesia process and risks at induction**?

-Thank you for your comment. After discussion, we feel that further research regarding diet during the labor process is still an area worthy of further exploration particularly when it is unclear if vaginal or cesarean birth will be undertaken.

- Current ASA guidelines, recommend no solid food for at least 4 hours prior to induction of anesthesia and no clears for at least 2 hours prior to induction. Providing food or clear liquids may have complicated the anesthesia induction because it was unknown whether she would labor and require additional intervention with possible cesarean birth or if preterm labor would be ruled out.

Reviewer #2: The authors present a case report of aspiration pneumonitis in an atypical setting and review the need to revisit guidelines for contemporary management of oral intake during labor. The topic is of interest in a climate interested in preventing severe maternal morbidity and enhanced recovery after surgery pathways and provides a platform to discuss these emerging issues as well as review clinical management of high-risk patients. I have a few comments and questions for these authors:

1. Precis: I would encourage including the word patient. It seems a little strange to have "gestation" be the subject of the sentence.

-Addressed.

2. **Line 98: Any other data about her respiratory alkalosis (i.e. pH and PO2).**

-Yes. Addressed.

3. Line 102: More objective data about the ABG and other data prompting intubation would be interesting if available (i.e. ABG information, AA gradient to understand the degree of ARDS, etc). Why intubate instead of other noninvasive ventilation? Also, how did you confirm this diagnosis and not other etiologies (her CT has a somewhat abnormal pattern for aspiration with the LUL involvement). Were there other micro studies sent?

-ABG data was added. Blood cultures were negative. Echocardiogram showed normal left ventricle function. Non-invasive ventilation was not performed because high-flow nasal canula was not available at our facility and non-invasive ventilation was not compatible with air-transport for higher level of care.

4. Line 103: Any more data you could provide about her ICU course? How she was managed from an obstetric perspective and a high level overview of her ICU management.

-Unfortunately this data is not available from the outside referral hospital

5. **Lines 102-107: More information about the timeline would also be instructive for the clinician. Similarly, more data on the timeline of her recovery could be instructive.**

-Unfortunately, no additional information is available from the outside referral hospital.

6**. Line 115: Is it truly unprovoked? Or is there a more accurate term that could be used to describe this.**

-Addressed

7. Line 147: I think this is one of the most clinically actionable items from the case report. Elaborating a bit more on ways to do this safely such as ERAS protocols, etc, would be of interest to the clinician.

-Thank you for your comment. Although we have considered your comment and agree with your conclusion that it would be helpful to the clinician we do not have any evidence base to recommend ERAS protocols during preterm labor rule outs with malpresentation that may necessitate cesarean birth.

8. Line 153: Is there other data that can be extrapolated from the general population to support use of H2 blockers or PPIs in this population? I might elaborate a bit more on this given it is a teaching point of your case and a conclusion.

-Unfortunately, there is not good literature available on whether or not H2 blockers, antacids, or PPIs should be given in NPO patients. There is limited evidence from the Anesthesia Society guidelines 2017 that state that for patients that are at risks for aspiration they should be given GI stimulants, PPI, H2 blocker or nonparticulate antacids prior to surgery and should be kept NPO for 2 hours prior to procedure. Unfortunately, this does not answer our question when we having a potential preterm laboring patient that we are trying to determine delivery method and is NPO due to possible cesarean, but definite time is not given.

Overall this is an interesting case with impressive imaging findings that provides a chance to review complex clinical management of a critically ill patient as well as current obstetric management paradigms. I imagine the clinician reading the case report may want a few more details of her presentation and management which is a nice opportunity for education. And reviewing the evidence informing the teaching points with a bit more granularity may help make a more convincing argument that could motivate the clinician to change management going forward.

-Agreed additional details added about her case presentation and management. Unfortunately, there is not good literature available on whether or not H2 blockers, antacids, or PPIs should be given in NPO patients. There is limited evidence from the Anesthesia Society guidelines 2017 that state that for patients that are at risks for aspiration they should be given GI stimulants, PPI, H2 blocker or nonparticulate antacids prior to surgery and should be kept NPO for 2 hours prior to procedure. Unfortunately, this does not answer our question when we having a potential preterm laboring patient that we are trying to determine delivery method and is NPO due to possible cesarean, but definite time is not given.

Associate Editor's Comments:

Please address treatment of aspiration pneumonitis-? Antibiotics?

-Addressed in separate paragraph in discussion.

* OPT-IN: Yes, please publish my point-by-point response letter.

Standard obstetric and gynecology data definitions developed through the reVITALize initiative were used in this manuscript.

Word count for manuscript 1410

Word count for abstract 81

Sincerely,

Katie L. Westerfield, D.O.