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: Jul 01, 2019
To: "Mackenzie N Naert" [redacted]
From: "The Green Journal" em@greenjournal.org
Subject: Your Submission ONG-19-965

RE: Manuscript Number ONG-19-965

Association between first trimester subchorionic hematomas and adverse pregnancy outcomes after 20 weeks in singleton pregnancies

Dear Dr. Naert:

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 22, 2019, we will assume you wish to withdraw the manuscript from further consideration.

REVIEWER COMMENTS:

Reviewer #1: Thank you for your work. Specific comments:

1. Abstract: can you specify here the size range of bleeds in the study. Was there any attempt to look at bleed volume vs outcome?

2. Introduction: Can you end this section with a hypothesis rather than "objective".

3. Methods: You need to present your power / sample size calculation in this section, not just the abstract. Did you check for normal distributions of your data before using parametric univariate tests? If a multivariable analysis was planned it should be done. Also it is unclear what your main and secondary outcomes were (lines 98-9).

4. Results: line 133-4 is not really appropriate (if planned, should be done and may see interactions not plain in univariate analyses), and should be explained in methods, not results.

5. Lines 135-7 belong in methods. And why was this done post hoc and not pre-study?

6. Lines 145-6 you can check if you are powered, "likely" isn't helpful.

7. Discussion: lines 169-72 you know you aren't powered to make this statement.

8. I would add to limitations that you likely have a baseline higher risk population (MFM practice) so may "drown out" the effect of SCH if you are seeing women with a higher risk of poor outcome at baseline. Was this accounted for and controlled?

Reviewer #2: This well written manuscript reports data from a cohort of 2172 singleton pregnancies who had an ultrasound scan before 14 weeks over a three-year period at a single obstetric practice. Of these, 389 (17.9%) had a subchorionic hematoma documented. The Authors' findings suggest that the presence of SCH in the first trimester was not associated with adverse pregnancy outcomes >20 weeks.

Data are interesting and of some relevance for counseling. However, the effect on clinical practice is modest.
The manuscript could be improved is some ways:

1) Data are available on first trimester bleeding. It could be useful to analyse pregnancy outcomes separately for pregnancy with SCH according to presence or absence of first trimester bleeding.

2) The Authors made an attempt to correlate persistence of the SCH with pregnancy outcomes. They careful interpreted their data as they are aware of the limitations given by small numbers. However, previous literature has associated adverse outcomes with persistent bleeding. If they have clinical information on bleeding after 14 weeks they should report it.

3) As indicated by the Authors, this study is based on the same cohort as Naert MN, Khadraoui H, Rodriguez AM, Naqvi M, Fox NS. Association between first trimester subchorionic hematomas and pregnancy loss in singleton pregnancies. Obstet Gynecol 2019 (in press). The article is not yet available online, so I am not able to assess the degree of overlap with the current paper. However, I wonder why the Authors did not report outcomes before and after 20 weeks in the same paper.

Reviewer #3: General Comments
The investigators describe the outcomes during the second half of pregnancy after having an identified first trimester subchorionic hemorrhage. Prior reports have been conflicting and have various limitation. The study is well written. The study is retrospective from a single institution. The authors comment on the frequency of this diagnosis and use a definition of subchorionic hemorrhage as a crescent shaped sonolucent echo free area between the chorion and the myometrium. It is likely this definition overcalls actual hemorrhages although this is the most common definition used. You would expect actual hemorrhages with areas of sonolucency to have a retracted clot or internal echoes. The authors do not review the images of the cases even though this is a single institution. Since the definition used is the most commonly used definition it makes it possible to compare to previous studies.

Specific Comments:

1. Methods: Pg 5 Paragraph 2, ln 84-86: The authors should reference their prior published study.

2. Discussion: Pg 10, Ln 186-189: In addition to ascertainment bias it may explain the difference in gestational age when the SCH was identified. Probably worth a comment.

3. Table 3: The investigators report volume. It is not clear how volume is calculated or if it is routinely reported.

4. Methods: Various diagnoses are abstracted from the medical record such as preeclampsia, gestational hypertension, and placental abruption. It would be worthwhile to know how the authors confirmed these diagnoses and how they defined the diagnosis.

STATISTICAL EDITOR'S COMMENTS:

1. lines 93-94 and Tables: Many of the comparisons involve counts of characteristics that were ≤ 5, so should not use Chis-square, but rather, Fisher's exact test for p-value. Need to amend Methods, Tables and re-do some stats.

2. Table 2 and lines 40-43, 129-133: Many of the comparisons have low counts and should use Fisher's test. Also, those with low counts (eg, PTB < 34 wks, Gest HTN, Pre-eclampsia, IUFD, Blood transfusion or antepartum depression have low stats power to discern a difference and therefore the negative associations cannot be generalized. Also, since the purpose of the study was to evaluate outcomes > 20 wks, need to verify that IUFD occurred after 20 wks, or include that phrase in the Table Title.

3. lines 43-44 170-172 and Table 3: The counts of SCH in the 18 0/7 to 21 6/7 week category number only 17. There is insufficient power to generalize any NS conclusion regarding adverse outcomes in this small subset.

4. lines 138-142 and 169-170: The results section shows that the SCH at later GAs were larger in max diameter and in volume, but no data are shown to demonstrate that those with larger diameter/volumes at earlier GAs were the ones that persisted. The statement that those with larger volume initially were the ones that persisted needs further analysis of serial measurements. That is, did those that persisted have consistently larger initial volumes or did they simply increase in size, while others resolved?

5. Tables 4, 5 and lines 143-146: Again, should use Fisher's test for comparing the proportions. The NS difference in rates of pre-eclampsia, placental abruption or IUFD are low, have low power and the NS differences cannot be generalized.

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

10. 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.

11. 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.

12. 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.

13. 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.

14. The American College of Obstetricians and Gynecologists' (ACOG) documents are frequently updated. These documents may be withdrawn and replaced with newer, revised versions. If you cite ACOG documents in your manuscript, be sure the reference you are citing is still current and available. If the reference you are citing has been updated (ie, replaced by a newer version), please ensure that the new version supports whatever statement you are making in your manuscript and then update your reference list accordingly (exceptions could include manuscripts that address items of historical interest). If the reference you are citing has been withdrawn with no clear replacement, please contact the editorial office for assistance (obgyn@greenjournal.org). In most cases, if an ACOG document has been withdrawn, it should not be referenced in your manuscript (exceptions could include manuscripts that address items of historical interest). All ACOG documents (eg, Committee Opinions and Practice Bulletins) may be found via the Clinical Guidance & Publications page at https://www.acog.org/Clinical-Guidance-and-Publications/Search-Clinical-Guidance.

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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 22, 2019, we will assume you wish to withdraw the manuscript from further consideration.

Sincerely,

The Editors of Obstetrics & Gynecology

2018 IMPACT FACTOR: 4.965
2018 IMPACT FACTOR RANKING: 7th out of 83 ob/gyn journals

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

RE: Manuscript Number ONG-19-965, entitled, "Association between first trimester subchorionic hematomas and adverse pregnancy outcomes after 20 weeks in singleton pregnancies

Reviewer #1:

Thank you for your work. Specific comments:

1. Abstract: can you specify here the size range of bleeds in the study. Was there any attempt to look at bleed volume vs outcome?
-The SCH sizes (mean largest diameter and standard deviation) were added to the abstract as requested.
-Bleed size/volume vs. outcome were added (Results-Lines 161-162 and Table 6). There was no correlation.

2. Introduction: Can you end this section with a hypothesis rather than "objective".
-Thank you for this suggestion. This was added (Lines 77-78).

3. Methods: You need to present your power / sample size calculation in this section, not just the abstract. Did you check for normal distributions of your data before using parametric univariate tests? If a multivariable analysis was planned it should be done. Also it is unclear what your main and secondary outcomes were (lines 98-9).
-Since this was a large retrospective study, we did our power analysis post-hoc and therefore included it in the Results section.
-As requested by the Statistical Editor as well, we did certain statistical calculations with nonparametric testing.
-We did not originally perform the regression analysis because there were no significant differences at baseline, as described in the Results. However, we added a regression analysis in the Results section (Lines 146-149) and only found an association between bleeding and certain outcomes.

4. Results: line 133-4 is not really appropriate (if planned, should be done and may see interactions not plain in univariate analyses), and should be explained in methods, not results.
-Thank you for pointing this out. The regression analysis was added (Lines 146-149).

5. Lines 135-7 belong in methods. And why was this done post hoc and not pre-study?
-See comment above (#3). The power analysis was conducted post-hoc because in this retrospective study, we included all of the patients available to us during the study period who met inclusion criteria for the study.

6. Lines 145-6 you can check if you are powered, "likely" isn't helpful.

-This was corrected, thank you.

7. Discussion: lines 169-72 you know you aren't powered to make this statement.
-We added: "However we were underpowered for this analysis, so it remains possible that persistence of SCH is associated with pregnancy outcomes." (Lines 203-204)

8. I would add to limitations that you likely have a baseline higher risk population (MFM practice) so may "drown out" the effect of SCH if you are seeing women with a higher risk of poor outcome at baseline. Was this accounted for and controlled?
-We added: "It is also possible that results would be different in a practice setting other than Maternal-Fetal Medicine." (Lines 216-218)

Reviewer #2:
This well written manuscript reports data from a cohort of 2172 singleton pregnancies who had an ultrasound scan before 14 weeks over a three-year period at a single obstetric practice. Of these, 389 (17.9%) had a subchorionic hematoma documented. The Authors' findings suggest that the presence of SCH in the first trimester was not associated with adverse pregnancy outcomes >20 weeks. Data are interesting and of some relevance for counseling. However, the effect on clinical practice is modest. The manuscript could be improved is some ways:

1. Data are available on first trimester bleeding. It could be useful to analyze pregnancy outcomes separately for pregnancy with SCH according to presence or absence of first trimester bleeding.
-This was added to the Results (Lines 146-149). Bleeding was independently associated with preterm birth and IUGR, but SCH was not.

2. The Authors made an attempt to correlate persistence of the SCH with pregnancy outcomes. They careful interpreted their data as they are aware of the limitations given by small numbers. However, previous literature has associated adverse outcomes with persistent bleeding. If they have clinical information on bleeding after 14 weeks they should report it.
-We did not collect data on second trimester bleeding in women without SCH, and our sample size was small, so we were unable to perform this analysis.

3. As indicated by the Authors, this study is based on the same cohort as Naert MN, Khadraoui H, Rodriguez AM, Naqvi M, Fox NS. Association between first trimester subchorionic hematomas and pregnancy loss in singleton pregnancies. Obstet Gynecol 2019 (in press). The article is not yet available online, so I am not able to assess the degree of overlap with the current paper. However, I wonder why the Authors did not report outcomes before and after 20 weeks in the same paper.
-Given the differences in outcomes between the two studies, we felt the combined manuscript would have been too long.

Reviewer #3:

The investigators describe the outcomes during the second half of pregnancy after having an identified first trimester subchorionic hemorrhage. Prior reports have been conflicting and have various limitations. The study is well written. The study is retrospective from a single institution.

The authors comment on the frequency of this diagnosis and use a definition of subchorionic hemorrhage as a crescent shaped sonolucent echo free area between the chorion and the myometrium. It is likely this definition overcalls actual hemorrhages although this is the most common definition used. You would expect actual hemorrhages with areas of sonolucency to have a retracted clot or internal echoes. The authors do not review the images of the cases even though this is a single institution. Since the definition used is the most commonly used definition it makes it possible to compare to previous studies.

1. Methods: Pg 5 Paragraph 2, ln 84-86: The authors should reference their prior published study.
-Thank you for this suggestion. The reference has been added.

2. Discussion: Pg 10, Ln 186-189: In addition to ascertainment bias it may explain the difference in gestational age when the SCH was identified. Probably worth a comment.
-This was added as suggested (Line 222).

3. Table 3: The investigators report volume. It is not clear how volume is calculated or if it is routinely reported.
-Thank you for pointing this out. We added a note to Table 3 that volume in cm^3 was calculated by length x width x height. We also added this explanation to Methods (Line 114).

4. Methods: Various diagnoses are abstracted from the medical record such as preeclampsia, gestational hypertension, and placental abruption. It would be worthwhile to know how the authors confirmed these diagnoses and how they defined the diagnosis.
-The outcomes were defined clinically at the time of diagnosis according to contemporary guidelines. This was added to the Methods section (Lines 106-107).

STATISTICAL EDITOR'S COMMENTS:

1. lines 93-94 and Tables: Many of the comparisons involve counts of characteristics that were ≤ 5, so should not use Chis-square, but rather, Fisher's exact test for p-value. Need to amend Methods, Tables and re-do some stats.
--This is actually how we did the statistics, but did not indicate this as well as we could have. The Methods and Tables were amended to reflect this testing.

2. Table 2 and lines 40-43, 129-133: Many of the comparisons have low counts and should use Fisher's test. Also, those with low counts (eg, PTB < 34 wks, Gest HTN, Pre-eclampsia, IUFD, Blood transfusion or antepartum depression have low stats power to discern a difference and therefore the negative associations cannot be generalized. Also, since the purpose of the study was to evaluate outcomes > 20 wks, need to verify that IUFD occurred after 20 wks, or include that phrase in the Table Title.
-Fisher's exact test was used for the outcomes with counts <6.
-We added to the Discussion the limitation in power for the infrequent outcomes (Lines 225-226).

-We added ">20 weeks" throughout the manuscript and in Tables 2, 4, and 5 for the outcome IUFD.

3. lines 43-44 170-172 and Table 3: The counts of SCH in the 18 0/7 to 21 6/7 week category number only 17. There is insufficient power to generalize any NS conclusion regarding adverse outcomes in this small subset.
-We added to the Results and the Discussion that we were underpowered for the analyses of SCH persistence and adverse outcomes.

4. lines 138-142 and 169-170: The results section shows that the SCH at later GAs were larger in max diameter and in volume, but no data are shown to demonstrate that those with larger diameter/volumes at earlier GAs were the ones that persisted. The statement that those with larger volume initially were the ones that persisted needs further analysis of serial measurements. That is, did those that persisted have consistently larger initial volumes or did they simply increase in size, while others resolved?
-We did not do this analysis, so those statements were removed.

5. Tables 4, 5 and lines 143-146: Again, should use Fisher's test for comparing the proportions. The NS difference in rates of pre-eclampsia, placental abruption or IUFD are low, have low power and the NS differences cannot be generalized.
-This was done as suggested, and the limitation in power was added to the Results and Discussion.

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: We chose to 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.

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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.

A completed STROBE statement checklist with the page numbers is included with the re-submission.

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

10. 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.

11. 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.

12. 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.

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