OBSTETRICS & GYNECOLOGY

NOTICE: This document contains correspondence generated during peer review and subsequent revisions but before transmittal to production for composition and copyediting:

- Comments from the reviewers and editors (email to author requesting revisions)
- Response from the author (cover letter submitted with revised manuscript)*

**The corresponding author has opted to make this information publicly available.*

Personal or nonessential information may be redacted at the editor's discretion.

Questions about these materials may be directed to the *Obstetrics & Gynecology* editorial office: obgyn@greenjournal.org.

Date: Aug 30, 2019
To: "Sophie DELPLANQUE" [redacted]
From: "The Green Journal" em@greenjournal.org
Subject: Your Submission ONG-19-1442

RE: Manuscript Number ONG-19-1442

Vaginal cesarean section: operative technique and experience of one referral center

Dear Dr. DELPLANQUE:

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 Sep 20, 2019, we will assume you wish to withdraw the manuscript from further consideration.

REVIEWER COMMENTS:

Reviewer #1: This very interesting paper provides a case series of seven patients who underwent delivery of nonviable or dead fetuses before 32 weeks by vaginal approach via hysterotomy (vaginal cesarean section). This procedure has been credited to Duhrssen as early as 1890. A US case review was published in JAMA in 1915. The selection criteria and surgical technique were well articulated. The accompanying video was well-produced and practical.

Many of the alarming complications cited in these patients were due to or exacerbations of their respective preoperative morbidities. Two cases of postoperative infection (29%, one a result of uterine artery embolization) are higher than data from other second trimester abortion techniques, however these women were no longer candidates for these techniques due to their advanced morbidity, and the low number of subjects overall make extrapolation of these data to a larger context impractical.

I did not see mention of the use of preoperative antibiotics. I believe substantial clarification of informed consent by the subjects and IRB pre-approval should be furnished and reviewed before publication. It is apparent that these very ill patients benefited from care at a tertiary hospital with urgent access to interventional radiology, blood and blood products, and critical care. This technique is likely to be much more problematic if performed at most community hospitals. Moreover, the implication that this is a relatively easy procedure to use and teach residents is belied by the mean length of the procedure (71 minutes) and the long mean hospital stay. These reservations should be included in the article.

These were very ill patients with medical and obstetric comorbidities who had limited safe options for delivery, thus qualifying them for this procedure. Given the mean EGA of 21 weeks the option of second trimester dilatation and evacuation would be limited and had been exhausted for many of them. With that in mind the outcomes presented here were quite good and would have likely been worse, maybe much worse, had open hysterotomy been employed. This is a procedure of long if not frequent use, and clearly has a place in the armory of our specialty.

Reviewer #2: This is a technique paper including a video and report on 7 cases describing a vaginal approach for Cesarean delivery from a tertiary center in France.

Main issues:
1- Many procedures that was done in the past goes out of favor! Having this procedure as a backup technique for specific indications might be important. What specific situations that this procedure is less morbid than a standard

C-section and why? I like to see more discussion on that!

2- I see that the main complication would be bleeding whether atonic or due to extension to the right or left potentially affecting a large branch of the uterine artery or both. What is the plan for addressing this potentially life threatening complication? Is that procedure limited to second trimester pregnancies termination!

Specific issues:
1- Introduction:
a. Please define "maternal salvage"

2- Cases:
a. Authors included 7 patients, please identify if the video was for one of those patients or not and which patient!
b. Line 154: "peripheral hospital" consider changing to "were referred to our hospital"
c. Line 157" "The gestational term" Please change to "gestational age"

3- Discussion:
a. Line 202: "effective and safe": not sure that we can have any conclusion about safety from this limited number of patients. Feasibility is the only reasonable conclusion!
b. Line 226 :"on live fetuses" please change to "living" . I believe a better approach to this part of the discussion is to conduct a systematic search to allow more accurate presentation of the prior literature. The discussion of the indication of this procedure is very important and has several aspects including clinical, ethical and legal!
c. Line 251: "Dilaceration" please clarify!
d. Line 257: "Can be considered as less-hemorrahgic procedure than abdominal cesarean section" please modify or remove, there is no data to support this claim!

4- Tables, Figures, and Video:
a. Table 2: please consider adding estimated blood loss and hemoglobin before and after the procedure for each of the included patients.
b. Table 3: "Cardiopulomnary arrest" is that a maternal death?
c. Figure 4, Picture not very clear!
d. Video: Nice presentation of the procedure!

Reviewer #3: This case series describes the technique of vaginal cesarean section and a series of 7 cases performed over a 17 year period. I have some concern that the authors minimize the risks associated with this procedure, especially risk of bladder injury and risk of infection. In addition, it's not clear that VCS allows for recovery similar to a vaginal delivery as the average length of stay was 7 days, however this could be skewed by comorbid conditions leading to needing delivery. Furthermore, my impression is that this procedure would require a practitioner comfortable with vaginal surgery (especially vaginal hysterectomy). I doubt that most physicians in the United States would choose this procedure over a cesarean delivery or D&E. This all being said, I could see a role for VCS in the setting where cesarean delivery poses significant maternal morbidity (i.e severe adhesive disease) and there is urgent need for delivery (I.e. heart failure) where cervical prep for D&E is not feasible. I do not think most practitioners in the U.S. are aware of the availability of VCS. Furthermore, the authors suggest that this procedure may afford women a vaginal delivery in future pregnancies although these were not the outcomes of the 7 deliveries documented here.

General comments:
—Please make it clear from the beginning (Introduction) that this procedure is intended for situations of a non-viable fetus

—We generally do not use hysterosalpingogram to assess for cervical incompetence. What is meant by this?

—The maximum gestational age of fetuses in this series was 24 weeks and the authors raise concerns that cephalopelvic disproportion could be an issue. It's fine to cite other work where VCS has been performed up to 32 weeks but I would refrain from stating this in the conclusions

—D&E is a safe procedure and most data suggest that it is not associated with preterm delivery. I would not discuss this association.

STATISTICAL EDITOR COMMENTS:

The Statistical Editor makes the following points that need to be addressed:

Tables 1 and 2: Since there were n = 7 subjects, no need to cite %s to nearest 0.1%, should round to nearest whole %. Tobacco, not Tabaco; gestation, not gestity.

lines 302-303: A series of n = 7 is insufficient to make any conclusion re: safety.

EDITOR'S COMMENTS:

1. Please format your revision as a "Procedures and Instruments" paper (See the Information for Authors for details (http://edmgr.ovid.com/ong/accounts/authors.pdf). It is important to make it clear from the beginning of your paper that the procedure is limited to those pregnancies with a non-viable pregnancy and is done entirely for maternal benefit. You need also to make it very clear that these are very sick mothers and that it is difficult to predict what their outcomes would have had either an abdominal CS or D&E have been performed, or an induction of labor.

The term "Vaginal Cesarean Section" is a bit unclear early in your paper. In your introduction and abstract, please describe the procedure in general terms. Something like "Vaginal Cesarean Section, the transvaginal incision of the anterior cervix after development of a bladder flap, is performed for maternal-indications in the setting of a stillborn fetus or expected neonatal death." In the discussion of your paper, please mention that this is an alternative to D&E. Although you mention that D&E specimens are not useful for anatomic evaluation, there are some papers which suggest that they can be useful. As well, cytogentic and genetic evaluation is possible off of both.

2. 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.

3. 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.

Please check with your coauthors to confirm that the disclosures listed in their eCTA forms are correctly disclosed on the manuscript's title page.

4. 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.

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: Procedures and Instruments articles should not exceed 8 typed, double-spaced pages (2,000 words). Stated page limits include all numbered pages in a manuscript (i.e., title page, précis, abstract, text, references, tables, boxes, figure legends, and print appendixes) but exclude references.

7. 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).

8. Provide a short title of no more than 45 characters, including spaces, for use as a running foot.

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: Procedures and Instruments, 200 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. Line 299: We discourage claims of first reports since they are often difficult to prove. How do you know this is the first report? If this is based on a systematic search of the literature, that search should be described in the text (search engine, search terms, date range of search, and languages encompassed by the search). If on the other hand, it is not based on a systematic search but only on your level of awareness, it is not a claim we permit.

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. Figures 1–4: Please provide figures without any arrows or text. These will be added back per journal style. Were the drawing created by an illustrator or previous used?

15. Video: Please resubmit your video file with the revision.

16. Authors whose manuscripts have been accepted for publication have the option to pay an article processing charge and publish open access. With this choice, articles are made freely available online immediately upon publication. An information sheet is available at http://links.lww.com/LWW-ES/A48. The cost for publishing an article as open access can be found at http://edmgr.ovid.com/acd/accounts/ifauth.htm.

Please note that if your article is accepted, you will receive an email from the editorial office asking you to choose a publication route (traditional or open access). Please keep an eye out for that future email and be sure to respond to it promptly.

17. If you choose to revise your manuscript, please submit your revision through Editorial Manager at http://ong.editorialmanager.com. Your manuscript should be uploaded in a word processing format such as Microsoft Word. Your revision's cover letter should include the following:
    * A confirmation that you have read the Instructions for Authors (http://edmgr.ovid.com/ong/accounts/authors.pdf), and
    * A point-by-point response to each of the received comments in this letter.

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 Sep 20, 2019, we will assume you wish to withdraw the manuscript from further consideration.

Sincerely,

Nancy C. Chescheir, MD
Editor-in-Chief

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

RESPONSES TO REVIEWERS COMMENT

First of all, we would like to thank the Editor in Chief and the Reviewers for their comments which have greatly contributed to improving our manuscript. We have responded to all the comments and hope that the new revised version of the study will now be suitable for publication in the green journal.

REVIEWER COMMENTS:

Reviewer #1: This very interesting paper provides a case series of seven patients who underwent delivery of nonviable or dead fetuses before 32 weeks by vaginal approach via hysterotomy (vaginal cesarean section). This procedure has been credited to Duhrssen as early as 1890. A US case review was published in JAMA in 1915. The selection criteria and surgical technique were well articulated. The accompanying video was well-produced and practical.

Many of the alarming complications cited in these patients were due to or exacerbations of their respective preoperative morbidities. Two cases of postoperative infection (29%, one a result of uterine artery embolization) are higher than data from other second trimester abortion techniques, however these women were no longer candidates for these techniques due to their advanced morbidity, and the low number of subjects overall make extrapolation of these data to a larger context impractical.

I did not see mention of the use of preoperative antibiotics.
Thank you for this comment.
In the Methods section (Step-by-step description of the VCS procedure), we have added "**The protocol included antibioprophylaxis with cefazolin 2 grams before induction of anesthesia.**" (Methods section, line 65-66)

I believe substantial clarification of informed consent by the subjects and IRB pre-approval should be furnished and reviewed before publication.
We agree with this comment. All the patients gave their consent to participate in the study before inclusion.
We have added the IRB pre-approval. We have now added the following sentence: **"All included patients gave their consent to participate in the study. The study was approved by the Ethics Committee of the National College of French Gynaecologists and Obstetricians (reference number: CEROG 2019-GYN-0901)."** (section Methods, line 61-63).

It is apparent that these very ill patients benefited from care at a tertiary hospital with urgent access to interventional radiology, blood and blood products, and critical care. This technique is likely to be much more problematic if performed at most community hospitals. Moreover, the implication that this is a relatively easy procedure to use and teach residents is belied by the mean length of the procedure (71 minutes) and the long mean hospital stay. These reservations should be included in the article.

We agree with this comment.
We have added the following sentence in the Discussion section.
« Patients should be managed in a reference center and the VCS should be performed by a fully trained surgeon. » (discussion section line 123)

These were very ill patients with medical and obstetric comorbidities who had limited safe options for delivery, thus qualifying them for this procedure. Given the mean EGA of 21 weeks the option of second trimester dilatation and evacuation would be limited and had been exhausted for many of them. With that in mind the outcomes presented here were quite good and would have likely

been worse, maybe much worse, had open hysterotomy been employed. This is a procedure of long if not frequent use, and clearly has a place in the armory of our specialty.

Thank you for this comment.

Reviewer #2: This is a technique paper including a video and report on 7 cases describing a vaginal approach for Cesarean delivery from a tertiary center in France.

Main issues:

1- Many procedures that was done in the past goes out of favor! Having this procedure as a backup technique for specific indications might be important. What specific situations that this procedure is less morbid than a standard C-section and why? I like to see more discussion on that!

Thank you for the comment. In our opinion, **VCS has two principal advantages over abdominal CS for women with a coagulation disorder and before 24 GW: the extraperitoneal approach may induce less bleeding, and there is no contraindication for a vaginal delivery for subsequent pregnancies.** We have now included this sentence in the text (Discussion section, line 162-164)

2- I see that the main complication would be bleeding whether atonic or due to extension to the right or left potentially affecting a large branch of the uterine artery or both. What is the plan for addressing this potentially life-threatening complication?

Thank you for the comment. Following sentences have been added to the text (discussion section, line 146-149): "**In the present study, two patients experienced intraoperative hemorrhage secondary to hemostatic abnormalities. They were managed by medical treatment alone. If the bleeding is uncontrolled during the surgery, ligature of the uterine artery via the vaginal is possible. If necessary, laparotomy with ligature of pedicle vessels or uterine artery embolization should be performed.**"

Is that procedure limited to second trimester pregnancies termination!

Thank you for this comment. We think that VCS is particularly interesting for termination of second trimester pregnancies even if it can be performed at later stages.
We have added the following sentences in the Discussion, lines 165-167.
"**Based on the experience of obstetricians performing abdominal cesarean and VCS, we believe that VCS is a less interesting option for third trimester pregnancy termination: incision in the lower uterine segment during abdominal surgery at this stage, and the fetus is heavier.**"

Specific issues:

1- Introduction:

a. Please define "maternal salvage"

We defined it in the text.
We have added the following sentence in the Introduction section, line 52-53: "**defined as emergency treatment when there is a risk for the patient's life in the event of continued pregnancy**".

2- Cases:

a. Authors included 7 patients, please identify if the video was for one of those patients or not and which patient!

The operative technique is explained in an educational video **(featuring Patient 1, Appendix 1)**. We have added this information in the Methods section, line 65.

b. Line 154: "peripheral hospital" consider changing to " were referred to our hospital "

We have changed the sentence tor "Seven patients underwent VCS during the study period, **five of whom (71.4%) were referred to our hospital**" in the Experience section, line 94-95.

c. Line 157" "The gestational term" Please change to "gestational age"
We have changed the sentence accordingly "**The mean gestational age of pregnancy was of 21 GW and 2 days."** in the Experience section, line 96.

3- Discussion:
a. Line 202: "effective and safe": not sure that we can have any conclusion about safety from this limited number of patients. Feasibility is the only reasonable conclusion!
We agree with this comment. We have changed the sentence to "**This retrospective study shows that VCS is feasible and that the procedure is well standardized**. "in the Discussion section, line 121.

b. **Line 226:"on live fetuses" please change to "living". I believe a better approach to this part of the discussion is to conduct a systematic search to allow more accurate presentation of the prior literature. The discussion of the indication of this procedure is very important and has several aspects including clinical, ethical and legal!**
We agree that a systematic approach will be better. However, most studies are retrospective and old with lack of clear information about the indications especially for living fetuses. Moreover, in order to follow editor instructions, we reduced the number of references (10) and words (2000).
We change the sentence for the following one: We have changed this sentence to: "**According to some old previous retrospective studies, VCS can be practiced up to 32 GW for fetuses with a fetal weight under 2500 grams and with living fetuses (5). However, the neonatal mortality rate was ranged from 24 to 33% (6). Khadel et al. performed VCS in a living fetus with umbilical cord prolapse and anoxia. The fetus died two days after (2)**" in the Discussion section, line 133-135.

c. **Line 251: "Dilaceration" please clarify!**
We have changed this term to "**non-controlled extension of the incision and injury**" in the Discussion section, line 144-146.
« **Hemorrhage can be due either to non-controlled extension of the incision and injury of the cervico-vaginal pedicles when the incision is not median or when the lower uterine segment is poorly amplified, or to hemostatic disorders.** »

d. **Line 257: "Can be considered as less-hemorrahgic procedure than abdominal cesarean section" please modify or remove, there is no data to support this claim!**
We understand this comment. However, as the VCS technique does not involve effraction of the peritoneal cavity and is associated with few dissection spaces, it may be a less-hemorrhagic procedure than abdominal cesarean section. We have altered the sentence to: "**However, as the VCS technique does not involve effraction of the peritoneal cavity and requires few dissection spaces, it may be a less-hemorrhagic procedure than abdominal CS** » in the Discussion section, line 149-151.

4- **Tables, Figures, and Video:**
a. Table 2: please consider adding estimated blood loss and hemoglobin before and after the procedure for each of the included patients.
We agree with this comment and have now added these data in Appendix 1 and 3.

b. Table 3: "Cardiopulomnary arrest" is that a maternal death?
No, the patient was resuscitated after cardiac massage and extracorporeal circulation. We now clarify this point in the Table.
We add in appendix 1: "**Cardio respiratory arrest resuscitated by cardiac massage and extracorporeal circulation**"

c. **Figure 4, Picture not very clear!**
We have changed and added notes to Figure 4 to make it more comprehensive.

d. Video: Nice presentation of the procedure!

Thank you for this comment.

Reviewer #3: This case series describes the technique of vaginal cesarean section and a series of 7 cases performed over a 17-year period. I have some concern that the authors minimize the risks associated with this procedure, especially risk of bladder injury and risk of infection. In addition, it's not clear that VCS allows for recovery similar to a vaginal delivery as the average length of stay was 7 days, however this could be skewed by comorbid conditions leading to needing delivery. Furthermore, my impression is that this procedure would require a practitioner comfortable with vaginal surgery (especially vaginal hysterectomy). I doubt that most physicians in the United States would choose this procedure over a cesarean delivery or D&E. This all being said, I could see a role for VCS in the setting where cesarean delivery poses significant maternal morbidity (i.e severe adhesive disease) and there is urgent need for delivery (I.e. heart failure) where cervical prep for D&E is not feasible. I do not think most practitioners in the U.S. are aware of the availability of VCS. Furthermore, the authors suggest that this procedure may afford women a vaginal delivery in future pregnancies although these were not the outcomes of the 7 deliveries documented here.

General comments:
—Please make it clear from the beginning (Introduction) that this procedure is intended for situations of a non-viable fetus

We agree with this comment and have added the following sentence accordingly: "**It should be stressed that VCS is not intended for viable fetal extraction in modern obstetrics**." (Introduction section, lines (53-54).

—We generally do not use hysterosalpingogram to assess for cervical incompetence. What is meant by this?

We have changed the sentence as follows: "**Some authors recommend cervical incompetence assessment after VCS**." (Discussion section, line 161)

—The maximum gestational age of fetuses in this series was 24 weeks and the authors raise concerns that cephalopelvic disproportion could be an issue. It's fine to cite other work where VCS has been performed up to 32 weeks but I would refrain from stating this in the conclusions

We agree with your comments. We have removed the term "**before 32 GW**" from the abstract.

—D&E is a safe procedure and most data suggest that it is not associated with preterm delivery. I would not discuss this association.
We have removed the association between D&C and pre-term delivery in the Discussion as follows, lines 168-171: "**Dilatation and curettage (D&C) seems to be an interesting alternative option because it is well controlled by most obstetrician gynecologists and can provide tissue for cytogenetic and genetic evaluation. However, more advanced pregnancy, D&C can be complicated by bleeding or uterine perforation. In addition, the clinical situation of patients may require surgery in extreme urgency, making it impossible to perform the cervical preparation necessary for D&C.**"

STATISTICAL EDITOR COMMENTS:

The Statistical Editor makes the following points that need to be addressed:

Tables 1 and 2: Since there were n = 7 subjects, no need to cite %s to nearest 0.1%, should round to nearest whole %. Tobacco, not Tabaco; gestation, not gestity.

lines 302-303: A series of n = 7 is insufficient to make any conclusion re: safety.

Thank you for these comments.
We have made the corrections accordingly.
We removed "safe" from the conclusion with the following sentences: "**This retrospective study shows that VCS is feasible** » (Discussion section, line 121)

EDITOR'S COMMENTS:

1. **Please format your revision as a "Procedures and Instruments" paper (See the Information for Authors for details (http://edmgr.ovid.com/ong/accounts/authors.pdf). It is important to make it clear from the beginning of your paper that the procedure is limited to those pregnancies with a non-viable pregnancy and is done entirely for maternal benefit. You need also to make it very clear that these are very sick mothers and that it is difficult to predict what their outcomes would have had either an abdominal CS or D&E have been performed, or an induction of labor.**

We have formatted the manuscript as a Procedures and instruments paper in order to follow the instructions we have submit tables as supplemental digital content.

We agree with your comments and have made the following additions and changes:
"**It should be stressed that VCS is not intended for viable fetal extraction in modern obstetrics" (**Introduction section, lines 53-54)
And "The main indications cited in literature are always for maternal salvage (defined as emergency treatment when there is a risk for the patient's life in the event of continued pregnancy)." (Introduction section, lines 51-53)

"In addition, based on this series of seven patients, it is impossible to predict what their outcomes would have been had either an abdominal CS or D&C been performed "(Discussion section, lines 170-171)

The term "Vaginal Cesarean Section" is a bit unclear early in your paper. In your introduction and abstract, please describe the procedure in general terms. Something like "Vaginal Cesarean Section, the transvaginal incision of the anterior cervix after development of a bladder flap, is performed for maternal-indications in the setting of a stillborn fetus or expected neonatal death."
Thank you for this comment. We have added the following sentence: "**Vaginal Cesarean Section is a transvaginal incision of the anterior cervix after creating a bladder flap to extract the fetus. The main indications cited in literature are for maternal salvage (defined as emergency treatment when there is a risk for the patient's life in the event of continued pregnancy) in the setting of a dead fetus or expected neonatal death. It should be stressed that it is not intended for viable fetal extraction in modern obstetrics**." (Introduction section, lines 50-54).

In the discussion of your paper, please mention that this is an alternative to D&E. Although you mention that D&E specimens are not useful for anatomic evaluation, there are some papers which

suggest that they can be useful. As well, cytogentic and genetic evaluation is possible off of both. We agree your comments and we add as following: "**Dilatation and curettage (D&C) seems to be an interesting alternative option because it is well controlled by most obstetrician gynecologists and can provide tissue for cytogenetic and genetic evaluation. However, in more advanced pregnancy, D&C can be complicated by bleeding or uterine perforation. In addition, the clinical situation of patients may require surgery in extreme urgency, making it impossible to perform the cervical preparation necessary for D&C.** » (Discussion section, lines 168-171)

2. **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.

We opt for the option A.

3. **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.**

Please check with your coauthors to confirm that the disclosures listed in their eCTA forms are correctly disclosed on the manuscript's title page.

We have checked with our coauthors and confirm that the disclosures listed in their eCTA forms appear correctly on the manuscript's title page.

4. 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.

We have now included this statement in the cover letter.

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: Procedures and Instruments articles should not exceed 8 typed, double-spaced pages (2,000 words). Stated page limits include all numbered pages in a manuscript (i.e., title page, précis, abstract, text, references, tables, boxes, figure legends, and print appendixes) but exclude references.

We have followed your instructions.

7. 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).**

We have respected these rules.

8. Provide a short title of no more than 45 characters, including spaces, for use as a running foot.

We have added the short title: “Vaginal cesarean section”

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: Procedures and Instruments, 200 words. Please provide a word count.

We have formatted the manuscript as a Procedures and Instruments paper with an abstract not exceeding 200 words.

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.**

Done.

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.

Done**.**

12. Line 299: We discourage claims of first reports since they are often difficult to prove. How do you know this is the first report? If this is based on a systematic search of the literature, that search should be described in the text (search engine, search terms, date range of search, and languages encompassed by the search). If on the other hand, it is not based on a systematic search but only on your level of awareness, it is not a claim we permit.
Thank you for these comments, we have removed the sentence" in the Discussion section, line 172

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.

We follow your instructions.

14. Figures 1–4: Please provide figures without any arrows or text. These will be added back per journal style. Were the drawing created by an illustrator or previous used?

We now provide figures without arrows or text.
We confirm that the drawings were created by the author.

15. Video: Please resubmit your video file with the revision.
We are resubmitting our video file with the revision

16. Authors whose manuscripts have been accepted for publication have the option to pay an article processing charge and publish open access. With this choice, articles are made freely available online immediately upon publication. An information sheet is available at http://links.lww.com/LWW-ES/A48. The cost for publishing an article as open access can be found at http://edmgr.ovid.com/acd/accounts/ifauth.htm.

Please note that if your article is accepted, you will receive an email from the editorial office asking you to choose a publication route (traditional or open access). Please keep an eye out for that future email and be sure to respond to it promptly.

We noticed it.

17. If you choose to revise your manuscript, please submit your revision through Editorial Manager at http://ong.editorialmanager.com. Your manuscript should be uploaded in a word processing format such as Microsoft Word. Your revision's cover letter should include the following:
*** A confirmation that you have read the Instructions for Authors (http://edmgr.ovid.com/ong/accounts/authors.pdf), and**
*** A point-by-point response to each of the received comments in this letter.**

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 Sep 20, 2019, we will assume you wish to withdraw the manuscript from further consideration.

Date: Oct 17, 2019
To: "Sophie DELPLANQUE" [redacted]
From: "The Green Journal" em@greenjournal.org
Subject: Your Submission ONG-19-1442R1

RE: Manuscript Number ONG-19-1442R1

Vaginal cesarean section: operative technique and experience of one referral center

Dear Dr. Delplanque:

Thank you for your first revision of this manuscript and for changing the format to be that of a Procedures and Instruments submission. As your manuscript was more the 600 words over the word limit and there were instances of some French-English issues, I've suggested extensive edits, particularly in the Discussion section. It is very important that you confirm that I've not altered your meaning or emphasis. I could never write a manuscript in a language other than English, and I hope my edits are acceptable to you. The current word count is just at 1990 words (exclusive of References). The maximum word count for this article type is 2000 words.

Queries from the Manuscript Editor and myself appear as follows in the version of the manuscript being sent back to your Author account in Editorial Manager (file name is 19-1442R1 ms (10-17-19v2). This is uploaded to your account and can be found under Attachments for this submission. Please email Randi Zung (rzung@greenjournal.org) directly if you cannot locate the file.

Please retain the tracked changes from our office, and track your new edits on top of them. Please make all of your edits directly to the text. Your next revised version should be submitted to the Editorial Office via the Editorial Manager website.

Your next version will be due November 1, 2019.

Queries in manuscript file:

1. General: The Manuscript Editor and Dr. Chescheir have made edits to the manuscript using track changes. Please review them to make sure they are correct.

2. Copyright Transfer Agreement: Vincent Lavoué and Krystel Nyangoh Timoh will need to complete our electronic Copyright Transfer Agreement, which was sent to them through EM@greenjournal.org. Once the form is complete, please add their disclosures to the "Financial Disclosure" section.

3. Acknowledgements: Please confirm that you approve of the edits made to this sentence.

4. Precis: Please note the Editor's suggested Precis below. Do you approve?

5. Line 48: Since there are only 7 patients, percentages don't really make sense here. Just delete the percentages. What is a "cardiovascular infarction"? Is this an MI or a stroke or something else?

6. Line 49: Is a cerebrovascular infarction the same as a stroke? If so, please substitute that language. I've removed all percentages as with these small numbers, they really don't add much.

7. Line 54 ("maternal salvage"): Please substitute something like "for maternal indications" throughout the submission.

8. Line 63-64: Please note the recommended change in definitions which I believe are consistent with the meaning of your suggested changes.

9. Line 75: Please confirm that you included women 18 years of age.

10. Line 81: As you are > 600 words over the limit for this paper, I'm making some suggestions for editing of your paper. It is critical that you affirm that I have not altered your meaning or emphasis. Please confirm your acceptance of these changes or make appropriate changes.

11. Line 83: Were these performed under general or regional anesthesia?

12. Line 103: What is the operator checking for with their fingers? Length of incision?

13. Line 124: Please make sure I've edited the surgical procedures accurately.

14. Line 125: What do you mean by "Copohoraphy can then be performed."

15. Line 141: Were the same 5 who had coagulation disorders the same 5 who needed transfusion? If so, please state: "All five of the patients who had coagulation disorders required transfusions."

16. Lines 143-146: Please confirm that this sentence is rephrased appropriately.

17. Line 151: Epidural or spinal or combined spinal-epidural?

18. Line 165: Please add the information about follow up here.

19. Line 166: Were these in women who had follow up pregnancies? How many were there who had deliveries/pregnancies after index pregnancies?

20. Line 169: What was gestational age at delivery of the deliveries?

21. Line 171: If she has delivered in the intervening time period since submission, please provide delivery information.

22. Line 172 (Discussion): I recommend starting the discussion w/ something like this:
"In some cases of severe and deteriorating maternal conditions with a nonviable or dead fetus , rapid fetal delivery with a minimum additional surgical stress may be a critical intervention. In settings in which dilation and evacuation is unavailable, vaginal cesarean delivery is a reasonable option. These patients should ideally be cared for at a tertiary obstetrical center with a skilled vaginal surgeon and anesthesia team.

By avoiding an intraperitoneal approach, the extrafascial vaginal cesarean delivery technique offers a rapid option with potentially lower risk of immediate maternal risks. "

This recommended edit is to shorten your discussion somewhat and to avoid making statements for which you have no supporting data given your small number of cases and the small number in the literature. This would replace everything from "This study shows….an absence of abdominal scarring".

23. Line 172 (Discussion): Please read the discussion carefully as I have made many suggested edits. These are in part to add some clarity around word choice, grammar and organization for an English language journal and partly to shorten the discussion due to word limits. It is critically important that you are comfortable with these suggestions and that I have not suggested any changes that alter your meaning.

24. Line 210: Of what gestational age? Please add that.

25. Line 212: Do you mean dystocia in the course of term labor? Please clarify.

26. Line 218: By corporeal incision do you mean an incision into the lower uterine segment? Please so state here and in the case description above what you mean by "corporeal" incision.

27. Line 240: By "instrumental fetal extraction" do you mean D&E or forceps or both? Please be clear.

28. Line 258: I removed statement suggesting that prior abdominal cesarean is a contraindication to vaginal birth.

29. Line 259: Please confirm this statement.

30. Line 265: Do you recommend monitoring cervical lengths in the subsequent pregnancies even if no interval assessment for cervical insufficiency is done?

Sincerely,

Nancy C. Chescheir, MD
Editor-in-Chief

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

Queries in manuscript file:

We want to thank the Manuscript Editor and Dr. Chescheir for all these comments that enhance the manuscript.

1. General: The Manuscript Editor and Dr. Chescheir have made edits to the manuscript using track changes. Please review them to make sure they are correct.

The review is correct.

2. Copyright Transfer Agreement: Vincent Lavoué and Krystel Nyangoh Timoh will need to complete our electronic Copyright Transfer Agreement, which was sent to them through EM@greenjournal.org. Once the form is complete, please add their disclosures to the "Financial Disclosure" section.

Done

3. Acknowledgements: Please confirm that you approve of the edits made to this sentence.

Yes, we approved the modification.

4. Precis: Please note the Editor's suggested Precis below. Do you approve?

Yes, we approved the modification.

5. Line 48: Since there are only 7 patients, percentages don't really make sense here. Just delete the percentages. What is a "cardiovascular infarction"? Is this an MI or a stroke or something else?

Thank you for the comment. It is a stroke, we made the modification in the text: "Seven patients with maternal indications for urgent premature delivery who underwent vaginal cesarean delivery were included. Indications were severe bleeding (3), severe previable preeclampsia (2), severe heart failure (1), and stroke (1)."

6. Line 49: Is a cerebrovascular infarction the same as a stroke? If so, please substitute that language. I've removed all percentages as with these small numbers, they really don't add much.

Thank you for the comment. It is a stroke, we made the modification in the text: "Seven patients with maternal indications for urgent premature delivery who underwent vaginal cesarean delivery were included. Indications were severe bleeding (3), severe previable preeclampsia (2), severe heart failure (1), and stroke (1)."

7. Line 54 ("maternal salvage"): Please substitute something like "for maternal indications" throughout the submission.
Thank you for this comment, we agreed the modification:" severe maternal indications."

8. Line 63-64: Please note the recommended change in definitions which I believe are consistent with the meaning of your suggested changes.
Yes, we confirmed that the modifications are consistent with the meaning of our suggested changes.

9. Line 75: Please confirm that you included women 18 years of age.

Yes, we confirmed.

10. Line 81: As you are > 600 words over the limit for this paper, I'm making some suggestions for editing of your paper. It is critical that you affirm that I have not altered your meaning or emphasis. Please confirm your acceptance of these changes or make appropriate changes.

We made some appropriate changes and accept some changes in the manuscript.

11. Line 83: Were these performed under general or regional anesthesia?
The two options are possible. We have changed the sentence: "Surgery was generally performed under general anesthesia but regional anesthesia is a possible option after preoperative antibiotic prophylaxis with 2 gram cefazoline »

12. Line 103: What is the operator checking for with their fingers? Length of incision?
Length of the incision to be sure that the incision is still in the lower segment.

13. Line 124: Please make sure I've edited the surgical procedures accurately.
We confirmed that you've edited the surgical procedures accurately.

14. Line 125: What do you mean by "Colpohoraphy can then be performed."
By colporrhaphy, we mean vaginal suture.
We agree that this sentence can be deleted.

15. Line 141: Were the same 5 who had coagulation disorders the same 5 who needed transfusion? If so, please state: "All five of the patients who had coagulation disorders required transfusions."
Yes, it is, we have made the correction.

16. Lines 143-146: Please confirm that this sentence is rephrased appropriately.
We confirmed that this sentence is rephrased appropriately.

17. Line 151: Epidural or spinal or combined spinal-epidural?
It was an epidural anesthesia.

18. Line 165: Please add the information about follow up here.
We changed the sentence: "Follow up was available for 5 of the 7 women. There were no identified cases of post-procedure cervical stenosis or vesico-uterine fistula."

19. Line 166: Were these in women who had follow up pregnancies? How many were there who had deliveries/pregnancies after index pregnancies?
All patients had a consultation at 2 months of vaginal cesarean section in our center. None of them had any complications like cervical stenosis or vesico-uterine fistula.
In the long term, only 5 patients were followed in our center and two of them had subsequent pregnancies.

20. Line 169: What was gestational age at delivery of the deliveries?
We added the information: 'Both deliveries were by cesarean delivery due to a history of two previous cesarean deliveries at 38 GW ».

21. Line 171: If she has delivered in the intervening time period since submission, please provide delivery information.
We added the information: "The other patient had an uneventful physiological course and had a spontaneous vaginal delivery at 41 weeks".

22. Line 172 (Discussion): I recommend starting the discussion w/ something like this: "In some cases of severe and deteriorating maternal conditions with a nonviable or dead fetus, rapid fetal delivery with a minimum additional surgical stress may be a critical intervention. In settings in which dilation and evacuation is unavailable, vaginal cesarean delivery is a reasonable option. These patients should ideally be cared for at a tertiary obstetrical center with a skilled vaginal surgeon and anesthesia team.

By avoiding an intraperitoneal approach, the extrafascial vaginal cesarean delivery technique offers a rapid option with potentially lower risk of immediate maternal risks. "

This recommended edit is to shorten your discussion somewhat and to avoid making statements for which you have no supporting data given your small number of cases and the small number in the literature. This would replace everything from "This study shows….an absence of abdominal scarring".

Thank you for these modifications we made the changes.

23. Line 172 (Discussion): Please read the discussion carefully as I have made many suggested edits. These are in part to add some clarity around word choice, grammar and organization for an English language journal and partly to shorten the discussion due to word limits. It is critically important that you are comfortable with these suggestions and that I have not suggested any changes that alter your meaning.

In France, when patient had a prior cesarean section with an hyterotomy in the upper segment, the recommendations are to make an iterative cesarean because of the risk of uterine rupture during the term labor. We made the modification: "For instance, the hysterotomy needed for abdominal cesarean delivery in pregnancies prior to 24 weeks are typically in the upper segment which would require an iterative abdominal cesarean section at term".

24. Line 210: Of what gestational age? Please add that.

We added the information: "Khadel et al. performed vaginal cesarean delivery in a living fetus at 26 weeks with umbilical cord prolapse and anoxia. **»**

25. Line 212: Do you mean dystocia in the course of term labor? Please clarify.

Yes, we mean cervical dystocia in course of labor for therapeutic abortion. We made the modification as follow: "Furthermore, vaginal cesarean delivery may be practiced in the event of cervical dystocia for therapeutic abortion"

26. Line 218: By corporeal incision do you mean an incision into the lower uterine segment? Please so state here and in the case description above what you mean by "corporeal" incision.

By corporeal incision we meant incision up to the lower uterine segment in the body of the uterus. We made the modification: "Two cases required an extension of the incision of the uterus' body to enable fetal extraction." (experience section); "No extraction difficulties were found in the present study though an extension of the incision to the body of the uterus was required in two cases » (discussion section).

27. Line 240: By "instrumental fetal extraction" do you mean D&E or forceps or both? Please be clear.

By instrumental fetal extraction, we mean forceps. We changed the sentence: "The postoperative period is comparable to that of a forceps fetal extraction."

28. Line 258: I removed statement suggesting that prior abdominal cesarean is a contraindication to vaginal birth.

Thank you for the modification.

29. Line 259: Please confirm this statement.

Yes, we confirm this statement

30. Line 265: Do you recommend monitoring cervical lengths in the subsequent pregnancies even if no interval assessment for cervical insufficiency is done?

Thank you for this comment, we changed the sentence: "at least, a monitoring cervical length in the subsequent pregnancies could be done". (discussion section)

Sincerely,