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:** May 26, 2020
**To:** "Suzanne Denise Slayton-Milam" [redacted]
**From:** "The Green Journal" em@greenjournal.org
**Subject:** Your Submission ONG-20-1424

RE: Manuscript Number ONG-20-1424

Induction of Labor and Vaginal Birth of an Intubated COVID-19 Patient

Dear Dr. Slayton-Milam:

Your manuscript has been reviewed by the Editorial Board and by special expert referees. Dr. Chescheir is interested in potentially publishing your revised manuscript in a timely manner. In order to have this considered quickly, we need to have your revision documents submitted to us as soon as you are able. I am tentatively setting your due date to May 28, 2020, but please let me know if you need additional time.

The standard revision letter text follows.

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).

REVIEWER COMMENTS:

Reviewer #1: The value of this report is to remind readers that mechanical ventilation in general, and for COVID-19 specifically, is not an indication for cesarean delivery and that vaginal delivery, as you say in your Precis, should be considered in appropriately selected candidates.

That said, it is far too long and could be shortened by at least 2/3. How?
1) Much if not all of the COVID specific management could be deleted, especially since a lot of it is now looking dubious if not dangerous (viz, hydroxychloroquine, azithro). The point of this case report is the decision to attempt (and succeed in) vaginal delivery.

2) Even the induction and delivery aspects of this case report are too excessively detailed and could be greatly shortened. Readers don't need a blow by blow of procedures with which they are familiar.

3) I think the entire case report could be in narrative form, with no need for tables, figures, etc. These are peripheral to your report. If they are kept, should go in Appendix

Essentially, a pregnant patient developed COVID, became progressively ill, got intubated and the decision was made to delivery her. After consideration of the pros and cons of mode, she was induced and had a successful vaginal delivery. I suggest framing your report in these turns, focusing on what was essential to her labor management, and strip away the excessive detail about her medical treatment.

Minor Issues
Title: She is a patient with COVID-19, not a COVID-19 patient.

Introduction could start with the line that begins "Currently.. and would not say "is" by cesarean but "has been predominantly been by.." If you say this elsewhere, should also correct.

It is strange to start the case with "healthy" when was clearly ill.

Would avoid the use "required" as often as possible. She didn't necessarily "require" mechanical ventilation for 9 days (maybe she could have come off on day 8). Rather, she "received" or "underwent...

Cesarean section should be cesarean delivery.

Reviewer #2: The authors have submitted a COVID-19 case of a critically ill woman wherein IOL with operative forceps allowed for safe delivery of infant.

Precis
1 - The novelty of this submission is IOL in tenuous clinical circumstances (as stated in the title) - the forceps delivery was just an add-on

Intro
2 - It is stated very matter-of-factly (line 97) that these patients are delivered by c-section - this broad statement warrants a supportive citation

3 - The last couple sentences here are illuminating in feeling as if the authors are tackling way too much in what is supposed to be a brief CR submission

Case
4 - Line 103 presumably a prior uncomplicated vaginal delivery (?)

5 - 5 chest x-ray images are too much for any journal other than a pulmonary journal - one should suffice

6 - The authors spend far too much space describing the nuances of her pulmonary status - that is why they consulted IM (line 112) right at the beginning. None of the OBGYN readership is going to be managing the O2 or vent and as a result much of this can be considerably shortened. What the reader cares about is whether there are any contraindications to IOL?

7 - Once she arrives in the ICU it is not necessary to know whether she is on SQ heparin, or famotidine, how the consent process went for remdesivir, etc.

8 - Yet another example of too much detail is Lines 132-134

9 - Finally, in line 149 the topic of IOL is raised. Did the authors decide this was necessary for maternal reasons? What the reader cares about is what were the considerations around this, what medications were planned, would any of this worsen her pulmonary status? None of these items are addressed. Does misoprostol have adverse effects? Apparently so, as uterine tachysystole occurred.

10 - It is not explained why the authors chose to do a forceps delivery. The patient appeared to be stable; why did they not simply allow routine delivery?

11 - Another example of too much info is describing her postpartum ECHO and adding its parameters (line 175)

Discussion
12 - Important point, well presented about non-use of steroids

13 - It seems some of the info about breastfeeding belongs in the case itself - with an explanation in Discussion

14 - At least a mention of the decision-making (line 220) belongs in the case itself. Yet it is curious, how long did it take from IOL to delivery? How long were the authors willing to wait?

15 - Are there any adverse outcomes for 'elective' operative delivery in a preterm infant?

Tables
16 - Neither Table 1 or 2 add value

References
17 - The authors have exceeded the recommended number

EDITOR'S COMMENTS:

We no longer require that authors adhere to the Green Journal format with the first submission of their papers. However, any revisions must do so. I strongly encourage you to read the instructions for authors (the general bits as well as those specific to the feature-type you are submitting). The instructions provide guidance regarding formatting, word and reference limits, authorship issues and other relevant topics. Adherence to these requirements with your revision will avoid delays during the revision process by avoiding re-revisions on your part in order to comply with formatting.

Numbers below refer to line numbers.

31 and your abstract: it's not clear why you are emphasizing the instrumental delivery. Presumably it is due to a passive second stage in a patient who is unable to valsalva? Would you consider emphasizing first and foremost that vaginal delivery is an option and it may be by a second stage instrumental delivery if patient unable to push?

77. Was it a planned forceps assisted vaginal birth? Please mention the outcome of the neonate.

86. Please substitute cesarean delivery or cesarean birth for cesarean section throughout your paper.

87. Delete the teaching point on remdesivir and focus on teaching points relevant to the major point of your paper—the vaginal birth. You didn't implement a cesarean in the ICU and so that should be deleted.

92-100: I'd recommend focusing on 3 things in your introduction: that the majority of deliveries reported so far have been by Cesarean although from countries with widely different practice patterns from the US pre-COVID-19 (provide reference) and that vaginal delivery is possible even in patients without the ability to add any effort for expulsion of the baby (example: women w/ paraplegia or spina bifida, for instance) and that these might require (but don't always) instrumental assistance. As such, vaginal birth should be considered an option for patients ill with SARS-CoV-2. Lastly, the importance of limiting transport of patients out of the ICU.

106. The test is for the virus, COVID-19. The disease is called SARS-CoV-2.
107. spell out ED.

I totally agree with both of your reviewers that you should drastically shorten your case presentation as they have described. Focus the majority of it on your thought processes about deciding first that she needed to be delivered and then on your thought processes about selecting a vaginal birth. You should mention somewhere that she had had a prior vaginal birth. Part of the reason for writing this, and its importance, is to reassure ICU staff and administrators that this is doable in an ICU. Include in your discussion of the case pertinent steps you put in place (I know a lot of detail is in the appendix, so limit this to key issues—you might describe the document in the appendix a bit). Was the husband allowed to be present?

You could limit the description of her labor a lot:

At the beginning of the induction, her cervical examination (don't use CE) showed her to be 3cm dilated, 50% effaced and a minus 2 station, with a vertex presentation confirmed by ultrasound. Intravaginal 25 mcg of misoprostol was followed 5 hours later by dinoprostone as she had experienced tachysystole with the misoprostol without cervical change. The ability to remove the dinoprostone in the event of recurrent tachysystole or fetal intolerance of labor was considered a benefit. During the latent phase, she had had variable decelerations which responded to position changes.

Seven hours after dinoprostone placement, amniotomy was performed when she was 5 cm dilated, 80% effaced and 1 cm dilated. This was done by pudendal tray syringe to obtain a clean sample of amniotic fluid for COVID-19 testing. An internal pressure catheter [what about an FSE?] was placed. She made progress without needing oxytocin augmentation and 3.5 hours later was 9 cm dilate, 90% effaced and 0 station with fetal variable decelarations. [please tell us a little bit about her respiratory status during her labor. Did she require ventilator changes? What about pain relief? Did she respond to her contractions? How many L&D nurses were there? Was the father allowed in? Had you held her heparin? When you say you put her in frog leg, I responded to this thinking how would you do any posterior traction on the bed. Did you elevat her buttocks at all to allow room for required manuvers? Please explain why you felt it necessary to do a high forceps delivery at station +1? Why didn't you wait? "Baby simpsoms" is colloquial. Please replace. You could collapse the delivery note a lot : " A newborn weighing 2430 grams was easily delivered with a single pull over an intact perineum. Apgar scores of 3 at 1 minute, 5 at 5 minutes and 5 and 10 and 15 minutes were assigned by the neonatal team in attendance." [ we don't really need to know about foley catheters and nuchal cords here)

Collapse lines 173-180 to a simple statement that she had 4 more days of ventilation support, was discharged on hospital day 16 on enoxaparin prophylaxis for 4 weeks.

186: How comfortable was NICU with negative test in mother? She cleared her swab within 16 days?

186: You already told us the EGA at birth.

189, 190. The name of her disease is SARS-Cov-2 (See WHO for this)

Discussion should be focused on the purpose of your case report. Delete extraneous information.

230: first time you've told us this was a short interval pregnancy. Perhaps mention.

Delete tables 1 and 2.

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. Obstetrics & Gynecology uses an "electronic Copyright Transfer Agreement" (eCTA). 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.

3. You note in table 2 that the data were provided from Gilead Sciences. Would you add that to the acknowledgment on the title page? "Gilead Sciences provided the data in Table 2." Also, please add text describing whether Gilead was involved in the study.

4.Reference 10 should be cited in the text only and removed from the References list.

5. Each figure and table in the supplementary file should be labeled an "Appendix." Do not use the words "table" or "figure" in the appendix file. For example, there should not be an Appendix 1 with a figure 1, 2, 3, etc. These should be Appendixes 1, 2, and 3. Please be sure to update your text to reflect the changes. Remove the table of contents from the supplemental file.

6. 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.

7. Because of space limitations, it is important that your revised manuscript adhere to the following length restrictions by manuscript type: Case Reports should not exceed 8 typed, double-spaced pages (2,000 words). Stated page limits include all numbered pages in a manuscript (i.e., title page, précis, abstract, text, references, tables, boxes, figure legends, and print appendixes) but exclude references.

8. Specific rules govern the use of acknowledgments in the journal. Please note the following guidelines:

* All financial support of the study must be acknowledged.
* Any and all manuscript preparation assistance, including but not limited to topic development, data collection, analysis, writing, or editorial assistance, must be disclosed in the acknowledgments. Such acknowledgments must identify the entities that provided and paid for this assistance, whether directly or indirectly.
* All persons who contributed to the work reported in the manuscript, but not sufficiently to be authors, must be acknowledged. Written permission must be obtained from all individuals named in the acknowledgments, as readers may infer their endorsement of the data and conclusions. Please note that your response in the journal's electronic author form verifies that permission has been obtained from all named persons.
* If all or part of the paper was presented at the Annual Clinical and Scientific Meeting of the American College of Obstetricians and Gynecologists or at any other organizational meeting, that presentation should be noted (include the exact dates and location of the meeting).

9. The most common deficiency in revised manuscripts involves the abstract. Be sure there are no inconsistencies between the Abstract and the manuscript, and that the Abstract has a clear conclusion statement based on the results found in the paper. Make sure that the abstract does not contain information that does not appear in the body text. If you submit a revision, please check the abstract carefully.

In addition, the abstract length should follow journal guidelines. The word limit for Case Reports is 125 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. ACOG is moving toward discontinuing the use of "provider." Please replace "provider" throughout your paper with either a specific term that defines the group to which are referring (for example, "physicians," "nurses," etc.), or use "health care professional" if a specific term is not applicable.

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. Each supplemental file in your manuscript should be named an "Appendix," numbered, and ordered in the way they are first cited in the text. Do not order and number supplemental tables, figures, and text separately. References cited in appendixes should be added to a separate References list in the appendixes file.

15. 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.

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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.

Sincerely,

Nancy C. Chescheir, MD
Editor-in-Chief

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.

Nancy C. Chescheir, MD
Editor-in-Chief, *Obstetrics & Gynecology*

Dear Dr. Chescheir,

We are very pleased to submit our revised manuscript entitled "*Induction of Labor and Vaginal Birth of an Intubated Patient with COVID-19*", for consideration of publication in *Obstetrics & Gynecology.*

The dates of this case were not included to protect patient confidentiality, but we would like to note that this occurred early in the COVID pandemic when literature was just evolving.

We do not intend to submit this manuscript elsewhere, and it will not be submitted elsewhere until a final decision regarding publication in *The Green Journal* is made. Of note, this manuscript was previously rejected by the New England Journal of Medicine. Approval for this case report was granted by Legacy Research Institute and was exempt from IRB review. Signed consent for publication of this case report from the patient has been obtained and a copy of this consent form will be attached with our submission.

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.

Please find our manuscript revisions and a point-by-point response below. Our responses have been bolded for ease of viewing.

Reviewer Comments and Manuscript Revisions:

Reviewer #1: The value of this report is to remind readers that mechanical ventilation in general, and for COVID-19 specifically, is not an indication for cesarean delivery and that vaginal delivery, as you say in your Precis, should be considered in appropriately selected candidates.

**Line 35-36: Precis was clarified, added that mechanical ventilation is not an indication for cesarean delivery specifically.**

That said, it is far too long and could be shortened by at least 2/3. How?
1) Much if not all of the COVID specific management could be deleted, especially since a lot of it is now looking dubious if not dangerous (viz, hydroxychloroquine, azithro). The point of this case report is the decision to attempt (and succeed in) vaginal delivery.

**Lines 78-80; 111-119: The case edited and COVID specific management as well as comments on ventilator status prior to induction of labor were removed. The mention of her treatment with hydroxychloroquine, remdesivir, and azithromycin was removed from the abstract and case.**

2) Even the induction and delivery aspects of this case report are too excessively detailed and could be greatly shortened. Readers don't need a blow by blow of procedures with which they are familiar.

**Lines 132-143: Discussion of the induction and delivery in the case were modified. Routine delivery information was removed and additional questions posed by the reviewers and editors were addressed.**

3) I think the entire case report could be in narrative form, with no need for tables, figures, etc. These are peripheral to your report. If they are kept, should go in Appendix.

**Tables that were included in the manuscript were removed. It is noted that the Appendix was also edited and laboratory tables and imaging were removed as the information referencing this in the case was also taken out.**

Essentially, a pregnant patient developed COVID, became progressively ill, got intubated and the decision was made to delivery her. After consideration of the pros and cons of mode, she was induced and had a successful vaginal delivery. I suggest framing your report in these turns, focusing on what was essential to her labor management, and strip away the excessive detail about her medical treatment.

**The report was edited throughout (see lines above regarding the case) to removed many of the details about medical treatment.**

Minor Issues
Title: She is a patient with COVID-19, not a COVID-19 patient.

**Line 1: Title was changed to " Induction of Labor and Vaginal Birth of an Intubated Patient with COVID-19"**

Introduction could start with the line that begins "Currently.. and would not say "is" by cesarean but "has been predominantly been by.." If you say this elsewhere, should also correct. See line 78 and 104

**Line 74, 97: Changes were made to correct "is by cesarean" to "has predominantly been by..". citation was also provided for this statement in the introduction per reviewer request.**

It is strange to start the case with "healthy" when was clearly ill.

**Line 111: This was removed and the case now begins with " A 27 year old ...".**

Would avoid the use "required" as often as possible. She didn't necessarily "require" mechanical ventilation for 9 days (maybe she could have come off on day 8). Rather, she "received" or "underwent...

**Line 114-115: Statement was changed to "underwent intubation". Statements that previously used "required" were changed.**

Cesarean section should be cesarean delivery.

**This was addressed throughout.**

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Reviewer #2: The authors have submitted a COVID-19 case of a critically ill woman wherein IOL with operative forceps allowed for safe delivery of infant.

Precis
1 - The novelty of this submission is IOL in tenuous clinical circumstances (as stated in the title) - the forceps delivery was just an add-on

**Line 35-36: Precis was modified and now reads "Critically ill patients who are on mechanical ventilation may undergo induction of labor and vaginal delivery in carefully selected patients. "**

Intro
2 - It is stated very matter-of-factly (line 97) that these patients are delivered by c-section - this broad statement warrants a supportive citation

**Lines 97-98: Supportive citations for prevalence of cesarean delivery in COVID-19 patients was added.**

3 - The last couple sentences here are illuminating in feeling as if the authors are tackling way too much in what is supposed to be a brief CR submission

**Lines 105-109:** The Introduction has been edited overall. The editor recommended that introduction focus on prevalence of cesarean section, potential for vaginal delivery in patients without ability to push in second stage of labor and that vaginal birth should be considered for critically ill patients, and the importance of limiting transport out of the ICU.

Case
4 - Line 103 presumably a prior uncomplicated vaginal delivery (?)

**Line 130: The patient's previous delivery was uncomplicated, and this was added to case discussion of induction of labor.**

5 - 5 chest x-ray images are too much for any journal other than a pulmonary journal - one should suffice

**Appendix- Chest x ray images were removed from the appendix and are no longer cited in the case, as much of the discussion of pulmonary status, COVID management was removed per reviewer and editor request.**

6 - The authors spend far too much space describing the nuances of her pulmonary status - that is why they consulted IM (line 112) right at the beginning. None of the OBGYN readership is going to be managing the O2 or vent and as a result much of this can be considerably shortened. What the reader cares about is whether there are any contraindications to IOL?

**Lines 129-136: Please see the above comments regarding removal of pulmonary status details. More details regarding the patient being a favorable candidate for induction of labor and decision to deliver were added.**

7 - Once she arrives in the ICU it is not necessary to know whether she is on SQ heparin, or famotidine, how the consent process went for remdesivir, etc.

**Lines 121-124: Famotidine, remdesivir information was removed aside from the patient being on subcutaneous heparin. This was included per the editors request, as she was interested in whether heparin was held during delivery. See Lines 121-124 for shortened details regarding ICU admission prior to induction of labor.**

8 - Yet another example of too much detail is Lines 132-134

**This was removed**

9 - Finally, in line 149 the topic of IOL is raised. Did the authors decide this was necessary for maternal reasons? What the reader cares about is what were the considerations around this, what medications were planned, would any of this worsen her pulmonary status? None of these items are addressed. Does misoprostol have adverse effects? Apparently so, as uterine tachysystole occurred.

**Lines 122-124; 128-132: Details regarding the decision to proceed with induction of labor for maternal indications was expanded.**

**Lines 180-184: Further discussion of misoprostol and adverse affects was added in the discussion.**

10 - It is not explained why the authors chose to do a forceps delivery. The patient appeared to be stable; why did they not simply allow routine delivery?

**Lines 127-132; 145-148; 171-172: Detail was added describing the plan for induction of labor, potential use of forceps, and indication for forceps delivery.**

11 - Another example of too much info is describing her postpartum ECHO and adding its parameters (line 175)

**This was removed from the case and ECHO results were removed from the Appendix.**

Discussion
12 - Important point, well presented about non-use of steroids

**Lines 188-191: This point was kept in the discussion.**

13 - It seems some of the info about breastfeeding belongs in the case itself - with an explanation in Discussion

**Information regarding breastfeeding, remdesivir was removed from the article as it felt it distracted from the main point and COVID treatment had also been removed at reviewer request.**

14 - At least a mention of the decision-making (line 220) belongs in the case itself. Yet it is curious, how long did it take from IOL to delivery? How long were the authors willing to wait?

**Line 158: The length of the induction of labor was added to the case.**

15 - Are there any adverse outcomes for 'elective' operative delivery in a preterm infant?

**Lines 173-179: Discussion of risks of operative delivery was added to the discussion.**

Tables
16 - Neither Table 1 or 2 add value

**Table 1 and Table 2 were removed at reviewer and editor request.**

References
17 - The authors have exceeded the recommended number

**Number of references now is 6.**

EDITOR'S COMMENTS:

We no longer require that authors adhere to the Green Journal format with the first submission of their papers. However, any revisions must do so. I strongly encourage you to read the instructions for authors (the general bits as well as those specific to the feature-type you are submitting). The instructions provide guidance regarding formatting, word and reference limits, authorship issues and other relevant topics. Adherence to these requirements with your revision will avoid delays during the revision process by avoiding re-revisions on your part in order to comply with formatting.

Numbers below refer to line numbers.

31 and your abstract: it's not clear why you are emphasizing the instrumental delivery. Presumably it is due to a passive second stage in a patient who is unable to valsalva? Would you consider emphasizing first and foremost that vaginal delivery is an option and it may be by a second stage instrumental delivery if patient unable to push?

**Lines 35-36: Precis changed to emphasize that vaginal delivery is possible in carefully selected patient's.**

**Lines 73-86: Abstract edited to place more emphasis on vaginal delivery vs. instrumented delivery.**

77. Was it a planned forceps assisted vaginal birth? Please mention the outcome of the neonate.

**Line 78-79: The forceps assisted birth was not planned but it was known that she could require forceps assistance. Thus, in the abstract it does not state that this was a planned forceps assisted delivery.**

**Line 82: Neonatal outcome added to the abstract.**

86. Please substitute cesarean delivery or cesarean birth for cesarean section throughout your paper.

**This has been done throughout**

87. Delete the teaching point on remdesivir and focus on teaching points relevant to the major point of your paper—the vaginal birth. You didn't implement a cesarean in the ICU and so that should be deleted.

**Line 91-94: The teaching point on remdesivir and breastfeeding as well as mention of cesarean in the ICU was deleted. Noted that mention of breastfeeding and remdesivir in the discussion was also removed.**

92-100: I'd recommend focusing on 3 things in your introduction: that the majority of deliveries reported so far have been by Cesarean although from countries with widely different practice patterns from the US pre-COVID-19 (provide reference) and that vaginal delivery is possible even in patients without the ability to add any effort for expulsion of the baby (example: women w/ paraplegia or spina bifida, for instance) and that these might require (but don't always) instrumental assistance. As such, vaginal birth should be considered an option for patients ill with SARS-CoV-2. Lastly, the importance of limiting transport of patients out of the ICU.

**Lines 97-100: A reference for incidence of cesarean section in other countries as well as the United States was added to the Introduction.**

**Lines 97-108: Introduction was edited to reflect recommendations on focus of the introduction (incidence of cesarean delivery, vaginal delivery is possible though may require assistance- w/ example, and lastly that transport of patient's in the ICU should be limited.**

106. The test is for the virus, COVID-19. The disease is called SARS-CoV-2.

**Details of her COVID testing was removed, as we condensed the case presentation.**

107. spell out ED.

**This was removed as we condensed the case presentation.**

I totally agree with both of your reviewers that you should drastically shorten your case presentation as they have described. Focus the majority of it on your thought processes about deciding first that she needed to be delivered and then on your thought processes about selecting a vaginal birth.

**Lines 118-126; 127-131: The case presentation was shortened (details of COVID treatment, ventilator management) and additional details regarding decision making and through process regarding induction of labor and vaginal birth.**

You should mention somewhere that she had had a prior vaginal birth.

**Lines 110-111; 130: The patient's prior successful vaginal birth and short interval history was added to case presentation and discussion of decision to induce.**

Part of the reason for writing this, and its importance, is to reassure ICU staff and administrators that this is doable in an ICU. Include in your discussion of the case pertinent steps you put in place (I know a lot of detail is in the appendix, so limit this to key issues—you might describe the document in the appendix a bit).

**Lines 122-126: Details regarding preparation of ICU for delivery and a brief description of the appendix was added to the case.**

Was the husband allowed to be present?

**Lines 157-158: No, the husband was not allowed to be present. This was added at the end of the case presentation.**

You could limit the description of her labor a lot:

At the beginning of the induction, her cervical examination (don't use CE) showed her to be 3cm dilated, 50% effaced and a minus 2 station, with a vertex presentation confirmed by ultrasound. Intravaginal 25 mcg of misoprostol was followed 5 hours later by dinoprostone as she had experienced tachysystole with the misoprostol without cervical change. The ability to remove the dinoprostone in the event of recurrent tachysystole or fetal intolerance of labor was considered a benefit. During the latent phase, she had had variable decelerations which responded to position changes.

Seven hours after dinoprostone placement, amniotomy was performed when she was 5 cm dilated, 80% effaced and 1 cm dilated. This was done by pudendal tray syringe to obtain a clean sample of amniotic fluid for COVID-19 testing. An internal pressure catheter [what about an FSE?] was placed.

**Lines 131-142: These above descriptions were utilized and the description of labor and the routine aspects of delivery were shortened.**

**Line 141: An FSE was not placed during delivery and this was added to the case.**

She made progress without needing oxytocin augmentation and 3.5 hours later was 9 cm dilate, 90% effaced and 0 station with fetal variable decelerations. [please tell us a little bit about her respiratory status during her labor. Did she require ventilator changes?

**Lines 166-168: A brief description of the patient's respiratory status and ventilator status during the induction ad labor were added.**

What about pain relief? Did she respond to her contractions?

**Lines 138-139: The patient was heavily sedated during delivery due to being on mechanical ventilation. She did not require additional sedation for delivery or respond to her contractions. This was added to the case.**

**Lines 150-152: The patient did respond with forceps delivery per nurses in attendance for delivery. This was added to the details of the delivery**

How many L&D nurses were there? Was the father allowed in?

**Lines 151-152: one L&D RN and one ICU RN was present for delivery.**

**157-158: The father was not allowed to be present for delivery. It is mentioned later that he was allowed to visit the infant in the NICU (lines 161-162).**

Had you held her heparin?

**Line 185-187: It was clarified that heparin was low dose and was not held for delivery.**

When you say you put her in frog leg, I responded to this thinking how would you do any posterior traction on the bed. Did you elevate her buttocks at all to allow room for required maneuvers?

**Line: 147-149: It was clarified that elevation was not required due to maternal habitus and there being ample room for maneuvers, but a wedge pillow was available if needed.**

Please explain why you felt it necessary to do a high forceps delivery at station +1?

**Lines 147: It was clarified that station was between +1 and +2 with occiput engaged.**

Why didn't you wait?

**Lines 144-145: Clarification and more detail regarding variable decelerations (indicating cord compression) was added.**

"Baby simpsoms" is colloquial. Please replace.

**Line 50: Simpson forceps were 12-inch Simpson's.**

You could collapse the delivery note a lot : " A newborn weighing 2430 grams was easily delivered with a single pull over an intact perineum. Apgar scores of 3 at 1 minute, 5 at 5 minutes and 5 and 10 and 15 minutes were assigned by the neonatal team in attendance."

**Lines 151-155: Delivery note was condensed.**

[ we don't really need to know about foley catheters and nuchal cords here)

**Lines 153-154: Information from the foley catheter was removed from the case. The presence of a nuchal cord was kept in the case but clarified that it was a tight nuchal cord and added greater detail to the severity of the variable decelerations that occurred.**

Collapse lines 173-180 to a simple statement that she had 4 more days of ventilation support, was discharged on hospital day 16 on enoxaparin prophylaxis for 4 weeks.

**Line 167-169: This was condensed.**

186: How comfortable was NICU with negative test in mother? She cleared her swab within 16 days?

**Lines 163-165: The NICU was comfortable with the negative testing in the mother, once she had subsequent negative tests 24 hours apart. This was clarified.**

**Line 165: The date of the patient's negative swab was clarified.**

186: You already told us the EGA at birth.

**Line 165: EGA was removed here.**

189, 190. The name of her disease is SARS-Cov-2 (See WHO for this)

**Lines 163-164: SARS-CoV-2 testing of the neonate was not changed in the revised manuscript in reference to neonatal testing. This may be confusion on our part, but per the WHO:**

**"COVID-19: The name of the disease caused by the novel coronavirus, SARS-CoV-2, and is short for "Coronavirus Disease 2019." (Source: WHO)**

**SARS-CoV-2: The name of the novel coronavirus that causes COVID-19 disease. (Source: WHO) "**

Discussion should be focused on the purpose of your case report. Delete extraneous information.

**Information regarding remdesivir and breastfeeding was deleted from the discussion.**

230: first time you've told us this was a short interval pregnancy. Perhaps mention.

**Lines 110-111; 129-130: The patient's prior successful vaginal birth and short interval history was added to case presentation and discussion of decision to induce.**

Delete tables 1 and 2.

**Tables were deleted.**

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.**

2. Obstetrics & Gynecology uses an "electronic Copyright Transfer Agreement" (eCTA). 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.

**Author disclosures were correctly disclosed on the manuscript's title page. There were no disclosures.**

3. You note in table 2 that the data were provided from Gilead Sciences. Would you add that to the acknowledgment on the title page? "Gilead Sciences provided the data in Table 2." Also, please add text describing whether Gilead was involved in the study.

**Table 2 was removed at reviewer and editor request, and all information regarding breastfeeding and remdesivir was removed from the case, thus this acknowledgement was not added.**

4.Reference 10 should be cited in the text only and removed from the References list.

**This reference was removed, in addition to references that had been citing pharmacology information on remdesivir, as this was removed from the case.**

5. Each figure and table in the supplementary file should be labeled an "Appendix." Do not use the words "table" or "figure" in the appendix file. For example, there should not be an Appendix 1 with a figure 1, 2, 3, etc. These should be Appendixes 1, 2, and 3. Please be sure to update your text to reflect the changes. Remove the table of contents from the supplemental file.

**The appendix has been edited and now only includes one Appendix and the table of contents was removed.**

6. 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.

**These definitions were used reviewed and adhered to, to the best of our knowledge.**

7. Because of space limitations, it is important that your revised manuscript adhere to the following length restrictions by manuscript type: Case Reports should not exceed 8 typed, double-spaced pages (2,000 words). Stated page limits include all numbered pages in a manuscript (i.e., title page, précis, abstract, text, references, tables, boxes, figure legends, and print appendixes) but exclude references.

**The revised manuscript does not exceed 8 pages and is less than 2000 words. However, the appendix is 3 pages in total. This was designed to be a supplemental appendix for interested readers to be able to access when viewing the article online, not necessarily a print appendix.**

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).

**There were two additional acknowledgements made on this revised manuscript. Two of the authors (Bashar Alkinj and Dominic Chan) had contributed to the manuscript previously in the areas of their expertise only, pulmonology, pharmacology, respectively. However, when making revisions requested by the reviewers and editors, their contributions have been removed. They did not contribute to this final manuscript. Thus, they were not felt to meet criteria for authorship, and were instead mentioned in the acknowledgements.**

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 limit for Case Reports is 125 words. Please provide a word count.

**The word count of the abstract is 125 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.

**Only standard abbreviations and acronyms were used.**

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.

**This did not apply.**

12. ACOG is moving toward discontinuing the use of "provider." Please replace "provider" throughout your paper with either a specific term that defines the group to which are referring (for example, "physicians," "nurses," etc.), or use "health care professional" if a specific term is not applicable.

**This has been done.**

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.

**Tables have been removed.**

14. Each supplemental file in your manuscript should be named an "Appendix," numbered, and ordered in the way they are first cited in the text. Do not order and number supplemental tables, figures, and text separately. References cited in appendixes should be added to a separate References list in the appendixes file.

**Please see comments regarding supplemental Appendix above.**

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We confirm that all authors have read the Instructions for Authors.

Thank you for considering our revised manuscript for publication in *Obstetrics & Gynecology.* We look forward to hearing your feedback.

Sincerely, on behalf of all authors,

Suzanne D. Slayton-Milam MD, FACOG

Signed by: