

OBSTETRICS & GYNECOLOGY



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

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

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obgyn@greenjournal.org.

Date: Nov 06, 2020
To: "Moti Gulersen" [REDACTED]
From: "The Green Journal" em@greenjournal.org
Subject: Your Submission ONG-20-2907

RE: Manuscript Number ONG-20-2907

Multisystem Inflammatory Syndrome: Atypical Presentation of Coronavirus Disease 2019 in Pregnancy

Dear Dr. Gulersen:

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 Nov 27, 2020, we will assume you wish to withdraw the manuscript from further consideration.

REVIEWER COMMENTS:

Reviewer #1:

The authors present their experience of a rare presentation of MIS-A associated with COVID-19 in a viable pregnancy. This is a well written report.

1. Line 147: what is the range for the SARS-CoV-2 IgG index to better understand this result from your laboratory? Is there an IgM value as well?
2. Line 155: what "broad spectrum antibiotics" did you use and what organisms were you considering treating?
3. Line 166+ please consider a table with comparison of the laboratory values which would be easier for the reader to interpret.
4. Line 174: with your multidisciplinary management planning group, was hospital ethics involved? You state that the patient did not wish to be monitored if it would threaten her health (line 177): It seems as if you could develop how you determined not monitoring a 28 week viable fetus: how was this decision achieved and how was she counseled?
 - a. During her intubation and course, what was the plan for fetal monitoring?
 - b. Line 186: fetal monitoring was deferred but, when was this initiated with respect to delivery?
5. Line 194: You state preeclampsia with severe features was suspected. Is there more pertinent information that contributes to her clinical presentation at that time? Did she have HELLP syndrome with low platelets for example?
6. Line 202: you mean to say that trans-esophageal echocardiography was utilized during her cesarean delivery? Please clarify.
7. Line 203: when was magnesium sulfate initiated?
8. Given this course with her diagnosis of preeclampsia, when was fetal monitoring initiated or resumed?
9. Line 210, aside from prematurity, does the newborn have any other complications?
10. Line 230: please refrain from using the word "case" to describe a patient's course. It is also used multiple times in other areas of this manuscript (such as line 262 and in your table); please replace with a more descriptive term.
11. Line 234: "all three patients who died" is confusing to the reader: do you mean, in the subset of these affected patients, three died?
12. Line 252: please replace the term "clinical picture" with a term such as "clinical presentation".

Reviewer #2:

The authors present a case report of a woman with multisystem inflammatory syndrome from COVID in pregnancy. I have several questions for the authors:

1. The title and the Precis do not match. Is the main point that she had an atypical presentation, or that IVIG/steroids are a potential therapeutic? One suggestion might be "Coronavirus-Related Multisystem Inflammatory Syndrome in a Pregnant Woman"
2. Please provide more details about the three weeks between the resolution of her initial COVID illness and presentation to labor and delivery. Did she have any tests done (ultrasound, for example)? did she have any symptoms prior to the day she came to L&D?
3. was a lactate level checked on admission?
4. line 156. how was the dexamethasone (for pericarditis) given, and at what dose?
5. line 189, please define therapeutic anticoagulation (IV UFH to maintain a specific PTT?)

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. 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 data definitions at <https://www.acog.org/practice-management/health-it-and-clinical-informatics/revitalize-obstetrics-data-definitions> and the gynecology data definitions at <https://www.acog.org/practice-management/health-it-and-clinical-informatics/revitalize-gynecology-data-definitions>. If use of the reVITALize definitions is problematic, please discuss this in your point-by-point response to this letter.

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

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

- * All financial support of the study must be acknowledged.
- * Any and all manuscript preparation assistance, including but not limited to topic development, data collection, analysis, writing, or editorial assistance, must be disclosed in the acknowledgments. Such acknowledgments must identify the entities that provided and paid for this assistance, whether directly or indirectly.
- * All persons who contributed to the work reported in the manuscript, but not sufficiently to be authors, must be acknowledged. Written permission must be obtained from all individuals named in the acknowledgments, as readers may

infer their endorsement of the data and conclusions. Please note that your response in the journal's electronic author form verifies that permission has been obtained from all named persons.

* If all or part of the paper was presented at the Annual Clinical and Scientific Meeting of the American College of Obstetricians and Gynecologists or at any other organizational meeting, that presentation should be noted (include the exact dates and location of the meeting).

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

7. 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.

8. 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.

9. 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.

10. In your Abstract, manuscript Results sections, and tables, the preferred citation should be in terms of an effect size, such as odds ratio or relative risk or the mean difference of a variable between two groups, expressed with appropriate confidence intervals. When such syntax is used, the P value has only secondary importance and often can be omitted or noted as footnotes in a Table format. Putting the results in the form of an effect size makes the result of the statistical test more clinically relevant and gives better context than citing P values alone.

If appropriate, please include number needed to treat for benefits (NNTb) or harm (NNTh). When comparing two procedures, please express the outcome of the comparison in U.S. dollar amounts.

Please standardize the presentation of your data throughout the manuscript submission. For P values, do not exceed three decimal places (for example, "P = .001"). For percentages, do not exceed one decimal place (for example, 11.1%).

11. Your manuscript contains a priority claim. 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 it is not based on a systematic search but only on your level of awareness, it is not a claim we permit.

12. Please review the journal's Table Checklist to make sure that your tables conform to journal style. The Table Checklist is available online here: http://edmgr.ovid.com/ong/accounts/table_checklist.pdf.

13. Please review examples of our current reference style at <http://ong.editorialmanager.com> (click on the Home button in the Menu bar and then "Reference Formatting Instructions" document under "Files and Resources"). Include the digital object identifier (DOI) with any journal article references and an accessed date with website references. Unpublished data, in-press items, personal communications, letters to the editor, theses, package inserts, submissions, meeting

presentations, and abstracts may be included in the text but not in the reference list.

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

14. 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 <https://wkauthorservices.editage.com/open-access/hybrid.html>.

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

If you choose to revise your manuscript, please submit your revision 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. Do not omit your responses to the Editorial Office or Editors' comments.

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 Nov 27, 2020, we will assume you wish to withdraw the manuscript from further consideration.

Sincerely,

Torri Metz, MD
Associate Editor, Obstetrics

2019 IMPACT FACTOR: 5.524

2019 IMPACT FACTOR RANKING: 6th out of 82 ob/gyn journals

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

Dear Dr. Metz,

Thank you for your willingness to give further consideration to our manuscript. We addressed all of the comments made by the reviewers and Editorial Office and have revised the manuscript accordingly.

Reviewer #1:

1. Line 147: what is the range for the SARS-CoV-2 IgG index to better understand this result from your laboratory? Is there an IgM value as well?

1. A positive SARS-CoV-2 IgG result from our institution's laboratory is when the antibody index is greater than or equal to 1.40. As suggested, we included this information in the revised manuscript, lines 161-162: "The patient's SARS-CoV-2 PCR was positive, and her SARS-CoV-2 immunoglobulin G (IgG) index was positive at 6.89 AU/mL (≥ 1.40 AU/mL)". Testing for SARS-CoV-2 IgM antibodies is not available at our institution.

2. Line 155: what "broad spectrum antibiotics" did you use and what organisms were you considering treating?

2. Our initial choice of broad-spectrum antibiotics was ceftriaxone, targeted toward gram positive and negative aerobic bacteria. As suggested, we revised our manuscript to clarify this point, lines 167-169: "Due to concern for sepsis and the low likelihood of recurrent COVID-19 infection,¹² broad-spectrum antibiotic coverage with ceftriaxone, targeted toward gram positive and negative aerobic bacteria, were initiated".

3. Line 166+ please consider a table with comparison of the laboratory values which would be easier for the reader to interpret.

3. We thank the reviewer for their comment. Due to space limitations and length restrictions by manuscript type provided by the journal, we are unable to include a second table.

4. Line 174: with your multidisciplinary management planning group, was hospital ethics involved? You state that the patient did not wish to be monitored if it would threaten her health (line 177): It seems as if you could develop how you determined not monitoring a 28 week viable fetus: how was this decision achieved and how was she counseled?

4. We thank the reviewer for their comment. Hospital ethics was not involved in the patient's care, as she demonstrated capacity to consent to treatment and participate in shared-decision making. As stated in our manuscript, the patient expressed clearly that she wished for all possible interventions to prioritize her own health and that she wanted to avoid any intervention that would increase her personal risk, even if that decision would increase the risk for the fetus. The patient was counseled that evidence suggesting delivery for maternal benefit was lacking. The issue of fetal monitoring in critically ill patients had been addressed in multidisciplinary meetings that included a specialist in obstetrical ethics, and agreement had been made to individualize and use shared-decision making with this patient. As delivery in her immediate condition could be life threatening, delivery for fetal indication was not being considered and fetal monitoring was deferred. We revised our manuscript to clarify the decision-making process, lines 201-212: "The patient was counseled that evidence suggesting delivery for maternal benefit was lacking. The issue of fetal monitoring in critically ill patients had been addressed in multidisciplinary meetings that included a specialist in obstetrical ethics, and agreement had been made to individualize and use shared-decision making with this patient. As delivery in her immediate condition could be life threatening, delivery for fetal indication was not being

considered and fetal monitoring was deferred”.

a. During her intubation and course, what was the plan for fetal monitoring?

a. As stated above, fetal monitoring was deferred as the patient expressed interest in avoiding any intervention that would increase personal risk and delivery for fetal indication may have been life threatening to her in her condition.

b. Line 186: fetal monitoring was deferred but, when was this initiated with respect to delivery?

b. The patient remained critically ill while receiving treatment for MIS-A and her clinical course was unpredictable despite the overall reassuring outcomes in the limited data reported in nonpregnant patients with MIS-A. Thus, the plan was to continue to reassess her clinical state and discuss routine fetal assessments on the day of her extubation. However, preeclampsia with severe features had developed on that same day, which was unexpected, and delivery was indicated for maternal benefit. A fetal heart rate of 144 bpm was confirmed by transabdominal ultrasound prior to delivery. As suggested, we revised our manuscript to clarify this point, lines 227-231: “In the absence of MIS-A or other pathology to explain these new findings, the diagnosis of preeclampsia with severe features was suspected and delivery was indicated for maternal benefit. Intravenous magnesium was initiated for seizure prophylaxis and fetal neurological benefit. Transabdominal ultrasound confirmed a fetal heart rate of 144 bpm prior to delivery”.

5. Line 194: You state preeclampsia with severe features was suspected. Is there more pertinent information that contributes to her clinical presentation at that time? Did she have HELLP syndrome with low platelets for example?

5. We thank the reviewer for their comment. The platelet count at the time was 290,000 μ /L, and thus HELLP syndrome was not suspected.

6. Line 202: you mean to say that trans-esophageal echocardiography was utilized during her cesarean delivery? Please clarify.

6. Transesophageal echocardiography was utilized throughout the patient's cesarean birth. As suggested, we revised our manuscript to clarify this point, lines 243-244: "Transesophageal echocardiography to evaluate cardiac function was utilized throughout the cesarean birth and mechanical support options were available if needed".

7. Line 203: when was magnesium sulfate initiated?

7. Intravenous magnesium was initiated for seizure prophylaxis and fetal neurological benefit once the decision was made to proceed with delivery. We revised our manuscript to clarify this point, lines 227-230: "In the absence of MIS-A or other pathology to explain these new findings, the diagnosis of preeclampsia with severe features was suspected and delivery was indicated for maternal benefit. Intravenous magnesium was initiated for seizure prophylaxis and fetal neurological benefit".

8. Given this course with her diagnosis of preeclampsia, when was fetal monitoring initiated or resumed?

8. As stated in response to reviewer #1's comment 4b, the plan was to continue to reassess her clinical state and discuss routine fetal assessments on the day of her extubation. However, preeclampsia with severe features had developed on that same day, which was unexpected, and delivery was indicated for maternal benefit. A fetal heart rate of 144 bpm was confirmed by transabdominal ultrasound prior to delivery.

9. Line 210, aside from prematurity, does the newborn have any other complications?

9. Since admission to the neonatal ICU, newborn complications have been exclusively related to prematurity (i.e. respiratory distress syndrome, apnea of prematurity, immature feeding and

temperature regulation). As suggested, we clarified this point in our revised manuscript, lines 251-253: “Newborn SARS-CoV-2 PCR testing via nasopharyngeal swab specimen was negative and he remains in the neonatal ICU with complications exclusively related to prematurity”.

10. Line 230: please refrain from using the word "case" to describe a patient's course. It is also used multiple times in other areas of this manuscript (such as line 262 and in your table); please replace with a more descriptive term.

10. We thank the reviewer for their comment. We replaced the word case with patient wherever applicable.

11. Line 234: "all three patients who died" is confusing to the reader: do you mean, in the subset of these affected patients, three died?

11. Of the 27 patients included, three died. We revised our manuscript to clarify this point, lines 280-282: “Six patients (6/27, 22%) required mechanical ventilation, and the three patients that died had comorbid conditions such as obesity, hypertension and diabetes, a previous respiratory illness, and significant radiographic lung disease on presentation”.

12. Line 252: please replace the term "clinical picture" with a term such as "clinical presentation".

12. We thank the reviewer for their comment and rephrased the sentence. See lines 312-313: “At that time the patient was otherwise clinically improving, suggesting her inflammatory syndrome responded appropriately to therapy”.

Reviewer #2:

1. The title and the Precis do not match. Is the main point that she had an atypical presentation, or that IVIG/steroids are a potential therapeutic? One suggestion might be "Coronavirus-Related Multisystem Inflammatory Syndrome in a Pregnant Woman"

2. We thank the reviewer for their comment. Our main point was to illustrate that intravenous immunoglobulin and high-dose corticosteroids are a potential therapeutic option for pregnant women presenting with MIS-A. As suggested, we changed the title of our manuscript.

2. Please provide more details about the three weeks between the resolution of her initial COVID illness and presentation to labor and delivery. Did she have any tests done (ultrasound, for example)? did she have any symptoms prior to the day she came to L&D?

2. We thank the reviewer for their comment. The patient had received her prenatal care with a provider outside of our institution and did not have any recent ultrasounds or testing performed prior to presenting to our labor and delivery. As stated in our original manuscript, the patient had presented with a one-day history of fever and chest pain and did not report any other symptoms.

3. was a lactate level checked on admission?

3. A lactate was ordered on admission and was within normal limits (1.0 mmol/L). We revised our manuscript to include the normal lactate on admission, lines 158-159: "Serum coagulation studies, a complete metabolic panel, cardiac enzymes, lactate, ferritin, and procalcitonin were within normal limits".

4. line 156. how was the dexamethasone (for pericarditis) given, and at what dose?

4. Dexamethasone for treatment of pericarditis was initially prescribed as intravenous at a dose of 6 mg daily. The dose and frequency increased once the diagnosis of MIS-A was suspected. As suggested, we added these details to the revised manuscript, lines 169-171: "The Cardiology team suspected the diagnosis of pericarditis, and the patient was treated with pain medication and

dexamethasone (intravenous 6mg daily)", and lines 218-219: "Intravenous immunoglobulin and high-dose dexamethasone (intravenous 10mg every 6 hours) therapy were initiated".

5. line 189, please define therapeutic anticoagulation (IV UFH to maintain a specific PTT?)

5. As suggested, we defined therapeutic anticoagulation used for our patient as intravenous unfractionated heparin to maintain a partial thromboplastin time of 60-80 seconds. Please see lines 220-222: "Therapeutic anticoagulation with intravenous unfractionated heparin to maintain a partial thromboplastin time of 60-80 seconds was initiated given her multiple risk factors for venous thromboembolism".

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.

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.

2. I will ensure all coauthors disclosures listed in their eCTA will be correctly disclosed on the manuscript's title page.

3. Standard obstetric and gynecology data definitions have been developed through the reVITALize initiative, which was convened by the American College of Obstetricians and Gynecologists and the members of the Women's Health Registry Alliance. Obstetrics & Gynecology has adopted the use of the reVITALize definitions. Please access the obstetric data definitions at <https://www.acog.org/practice-management/health-it-and-clinical-informatics/revitalize-obstetrics-data-definitions> and the gynecology data definitions at <https://www.acog.org/practice-management/health-it-and-clinical-informatics/revitalize-gynecology-data-definitions>. If use of the reVITALize definitions is problematic, please discuss this in your point-by-point response to this letter.

3. We replaced the term cesarean delivery with cesarean birth in accordance with the revitalize initiative.

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

4. We made every effort to shorten the manuscript length while incorporating the additional information requested by the reviewers.

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

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

5. We thank the Editorial Office for clarifying the details regarding acknowledgements.

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

6. MIS-A in pregnancy.

7. 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.

7. The abstract word count is 123 words.

8. Only standard abbreviations and acronyms are allowed. A selected list is available online at <http://edmgr.ovid.com/ong/accounts/abbreviations.pdf>. Abbreviations and acronyms cannot be used in the title or précis. Abbreviations and acronyms must be spelled out the first time they are used in the abstract and again in the body of the manuscript.

8. We ensured that abbreviations and acronyms were not used in the title or précis, and spelled out for the first time when used in the abstract and body of the manuscript.

9. The journal does not use the virgule symbol (/) in sentences with words. Please rephrase your text to avoid using "and/or," or similar constructions throughout the text. You may retain this symbol if you are using it to express data or a measurement.

9. We revised the manuscript so that the virgule symbol is only used to express data or a measurement.

10. In your Abstract, manuscript Results sections, and tables, the preferred citation should be in terms of an effect size, such as odds ratio or relative risk or the mean difference of a variable between two groups, expressed with appropriate confidence intervals. When such syntax is used, the P value has only secondary importance and often can be omitted or noted as footnotes in a Table format. Putting the results in the form of an effect size makes the result of the statistical test more clinically relevant and gives better context than citing P values alone.

If appropriate, please include number needed to treat for benefits (NNTb) or harm (NNTh).

When comparing two procedures, please express the outcome of the comparison in U.S. dollar

amounts.

Please standardize the presentation of your data throughout the manuscript submission. For P values, do not exceed three decimal places (for example, "P = .001"). For percentages, do not exceed one decimal place (for example, 11.1%).

10. There were no P values used in this manuscript. Percentages did not exceed one decimal place.

11. Your manuscript contains a priority claim. 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 it is not based on a systematic search but only on your level of awareness, it is not a claim we permit.

11. We thank the Editorial Office for their comment. As suggested, we removed this claim.

12. Please review the journal's Table Checklist to make sure that your tables conform to journal style. The Table Checklist is available online

here: http://edmgr.ovid.com/ong/accounts/table_checklist.pdf.

12. We reviewed the Table Checklist to ensure our table conforms to journal style.

13. Please review examples of our current reference style

at <http://ong.editorialmanager.com> (click on the Home button in the Menu bar and then

"Reference Formatting Instructions" document under "Files and Resources"). Include the digital object identifier (DOI) with any journal article references and an accessed date with website references. Unpublished data, in-press items, personal communications, letters to the editor, theses, package inserts, submissions, meeting presentations, and abstracts may be included in the text but not in the reference list.

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

13. We revised our references in accordance with journal guidelines.

14. 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 <https://wkauthorservices.editage.com/open-access/hybrid.html>.

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.

14. We thank the Editorial Office for providing us with this information.