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

**Date:** Feb 25, 2021
**To:** "Moeun Son" [redacted]
**From:** "The Green Journal" em@greenjournal.org
**Subject:** Your Submission ONG-21-92

RE: Manuscript Number ONG-21-92

High-Dose versus Standard-Dose Oxytocin Regimens to Augment Labor in Nulliparous Women: A Randomized Controlled Trial

Dear Dr. Son:

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 Mar 18, 2021, we will assume you wish to withdraw the manuscript from further consideration.

REVIEWER COMMENTS:

Reviewer #1:

Precis - in nulliparas who were augmented - high dose oxytocin did not affect c/s or delivery but decreased labor duration and incidence of chorio
Abstract - Objective - to determine whether high dose oxytocin decreased risk of primary c/s when compared to standard dosing
Methods - double blined RCT - nulliparous 36 wk labor augmentation; high dose - initial and incremental 6mU/min or standard - initial and incremental 2mU/min
primary outcome - c-section, secondary outcome - labor duration, chorio, PPE, PPH, Apg <3 at 5 minutes, umbilical artery acidemia, NICU, death, morbidity
Results - 1003 randomized - 502 - high dose and 501 - standard
primary outcome - 14.5% in high dose versus 14.4% in standard
high dose - shorter labor duration - 9.1 h vs 10.5 hours, lower horio rate 10.4% vs 15.6% - no other differences
Conclusions - high dose has no affect on c/s but decreases duration of labor and incidence of chorio

Intro - concerns about safety with high dose regiments but not well studied
hypothesis - high dose results in lower risk of c/s compared to standard dosing in nulliparas
Methods - parallel group, double blind, singl center RCT, computer generated random sequencing, primary outcome - c/s and secondary outcome - labor duration, chorio, PPEH, PPH, perinatal outcomes
data was extracted, blinded and unmasked after data base was secure
analyses by intent to treat and unblinded interim analysis for safety

Results - 1003 - 502 to high dose and 501 to standard
most stayed in assigned group, primary outcome - 14.5% vs 14.4 and no difference in distribution of indications for c/s
high dose had shorter labor duration - 9h vs 10.5 h and chorio decreased from 10.4 vs 15.6% - no difference in neonatal morbidities

Discussion - no difference in c/s rate or indication for c/s, decreased labor duration and chorio incidence
adherence to randomization was high but may be under powered for less frequent outcome

Comments -

This is a very well done double blind RCT comparing high dose to standard dose oxytocin. There seems to clearly be no

benefit to standard dose and a benefit to high dose with decreased duration and decreased chorio, with no increased risk. However, I do think it is important to emphasize that the incidence of the secondary outcomes, primarily the adverse neonatal outcomes, are too rare for this to be adequately powered to assess those.
Further data is needed to determine these risks.

Reviewer #2:

Summary of submission:
This is a double-blind randomized control study comparing the effect of a high-dose versus a standard-dose oxytocin regimen on the rate of cesarean section among nulliparous women undergoing labor augmentation.

Precis:
This is a well-written summary of study findings.

Abstract:
Summarizes study objective, design, results and conclusions effectively.

Intro:
The rationale for the study and the study's hypothesis are very clearly stated. The outline of the limitations of the 2013 Cochrane review is especially helpful in illustrating the urgency of and need for the research question at hand.

Line 89: Was reference 14 included in the Cochrane review? It is clear that reference 13 was included in the review, but it is not entirely clear if 14 was as well.

Methods:
The approach to answering the research question is overall thoroughly and clearly explained.

Line 106: Consider "affirm" instead of "vouch".

Line 109: What is meant by "who were planned for augmentation with oxytocin infusion"? Does this mean that, upon admission for spontaneous labor as defined, patients met some sort of criteria for oxytocin administration? For example, was it the case that if a patient was considered to be in spontaneous labor but contracting less than 3-4 contractions per 10 minutes, hypotonic labor, that the patient was counseled on starting Pitocin? To add clarity, consider rephrasing to "who were planned for augmentation with oxytocin infusion based determination from each patient's obstetrics-care team". Labor is classically defined as contractions that result in cervical change, how was 3cm cervical dilation or 80% effacement with or without SROM in the setting of at least 6 contractions per hour decided upon? Are there previous studies demonstrating specifically that this degree of dilation or effacement reliably optimizes the ability of Pitocin to lead to vaginal delivery? While the Bishop score was initially intended to guide providers on the use of Pitocin in the setting of induction of labor, was application of the bishop score (i.e. women with favorable Bishop scores would be eligible to participate) considered for the purposes of your study?

Were patients compared at all based on their membrane status? That is, was the data analyzed in such a way as to be able to compare women in the study who were admitted with SROM, those who spontaneously ruptured membranes during labor, and those who required AROM as per the determination of the OB care team?

Line 128: "labeled" spelling error
Results:
The results are well-organized and thorough.

Line 209: Were providers and/or patients required to provide an explanation as to why they requested the masked dosing regimen to be discontinued?

Discussion

Line 251: "the previous trial" is vague. Please characterize this reference more clearly. Was it one of the papers analyzed in the Cochrane review? This comment is similar to that for line 89.

Line 252: Did the Cochrane review include any trials that looked at choriamnionitis as an outcome?

Table 1. The patient population is quite homogenous—majority Caucasian, young (i.e. <35), with private insurance, and a BMI <30. This limits generalizability.

Reviewer #3:

The authors present a pragmatic double blind RCT hypothesizing that a high dose oxytocin regimen will reduce the risk of cesarean when compared to a standard dose oxytocin regimen. The study is well done and the manuscript is well written.

Intro - Authors do acknowledge the previous Cochrane Review but note that there are limitations due to the largest included study introducing bias which supports the need for additional data. Also important to note that although oxytocin is common, a recommended standard dosing regimen has not been determined.
Methods - Well done
Results - While there was no difference in the primary outcome, this alone is important. I often find that there may be resistance to high dose Pitocin protocols due to concern for causing fetal intolerance and leading to increase in cesarean delivery. Can the authors provide any data on duration of oxytocin received by participants in each group - to give the readers a sense of if oxytocin remained on during most of labor or was turned off for most of it?

STATISTICS EDITOR COMMENTS:

Abstract: Needs to conform to our RCT template for abstracts. Specifically, should include concise section re: power and sample size

Table 2: No need to include p-values for primary outcome, since CI is given. Should cite as formatted in Methods, that is, as difference in CD rates, with CI. Since the subsets have denominators = 73 and 72, the %s should all be rounded to nearest integer %, not cited to 0.1% precision.

Table 3: The rates of chorioamnionitis, endometritis or PPH are each small and there is low power to generalize the NS findings.

Table 4: Same issue with low power. Should include the result for UAC pH < 7.0 with multiple imputation, which then made the association NS.

For Tables 3,4: The column of p-values is redundant, since CIs are included. Could embolden or otherwise indicate the RRs that are statistically significant for the reader, if desired.

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. For studies that report on the topic of race or include it as a variable, authors must provide an explanation in the manuscript of who classified individuals' race, ethnicity, or both, the classifications used, and whether the options were defined by the investigator or the participant. In addition, the reasons that race/ethnicity were assessed in the study also should be described (eg, in the Methods section and/or in table footnotes). Race/ethnicity must have been collected in a formal or validated way. If it was not, it should be omitted. Authors must enumerate all missing data regarding race and ethnicity as in some cases, missing data may comprise a high enough proportion that it compromises statistical precision and bias of analyses by race.

Use "Black" and "White" (capitalized) when used to refer to racial categories. The nonspecific category of "Other" is a convenience grouping/label that should be avoided, unless it was a prespecified formal category in a database or research instrument. If you use "Other" in your study, please add detail to the manuscript to describe which patients were included in that category.

4. Clinical trials submitted to the journal as of July 1, 2018, must include a data sharing statement. The statement should indicate 1) whether individual deidentified participant data (including data dictionaries) will be shared; 2) what data in particular will be shared; 3) whether additional, related documents will be available (eg, study protocol, statistical analysis plan, etc.); 4) when the data will become available and for how long; and 5) by what access criteria data will be shared (including with whom, for what types of analyses, and by what mechanism). Responses to the five bullet points should be provided in a box at the end of the article (after the References section).

5. If an administrative database is used: In order for an administrative database study to be considered for publication in Obstetrics & Gynecology, the database used must be shown to be reliable and validated. In your response, please tell us who entered the data and how the accuracy of the database was validated. This same information should be included in the Materials and Methods section of the manuscript.

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 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.

7. Because of space limitations, it is important that your revised manuscript adhere to the following length restrictions by manuscript type: Original Research reports should not exceed 22 typed, double-spaced pages (5,500 words). Stated page limits include all numbered pages in a manuscript (i.e., title page, précis, abstract, text, 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 Original Research articles is 300 words. Please provide a word count.

10. Abstracts for all randomized, controlled trials should be structured according to the journal's standard format. The Methods section should include the primary outcome and sample size justification. The Results section should begin with the dates of enrollment to the study, a description of demographics, and the primary outcome analysis. Please review the sample abstract that is located online here: http://edmgr.ovid.com/ong/accounts/sampleabstract_RCT.pdf. Please edit your abstract as needed.

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

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

13. 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.

14. 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%").

15. 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.

16. 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).

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

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

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

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

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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 Mar 18, 2021, we will assume you wish to withdraw the manuscript from further consideration.

Sincerely,

Torri D. Metz, MD
Associate Editor, Obstetrics

2019 IMPACT FACTOR: 5.524
2019 IMPACT FACTOR RANKING: 6th out of 82 ob/gyn journals

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[redacted]

Torri D. Metz, MD
Associate Editor, Obsetrics
Obstetrics & Gynecology

Dear Dr. Metz,

Thank you for the opportunity to revise our manuscript titled "High-Dose versus Standard-Dose Oxytocin Regimens to Augment Labor in Nulliparous Women: A Randomized Controlled Trial" for review and reconsideration for publication in *Obstetrics & Gynecology*. We greatly appreciate the thoughtful insights from the reviewers, and we believe that we were able to address their comments and questions in our responses below.

We thank you for your consideration of our revised manuscript for publication. Please contact us if you have any questions or concerns.

Sincerely,

Moeun Son, MD, MSCI
On behalf of all co-authors

Response to Reviewers:

*Reviewer #1:*

*Precis - in nulliparas who were augmented - high dose oxytocin did not affect c/s or delivery but decreased labor duration and incidence of chorio*
*Abstract - Objective - to determine whether high dose oxytocin decreased risk of primary c/s when compared to standard dosing*

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*Results - 1003 randomized - 502 - high dose and 501 - standard*
*primary outcome - 14.5% in high dose versus 14.4% in standard*
*high dose - shorter labor duration - 9.1 h vs 10.5 hours, lower chorio rate 10.4% vs 15.6% - no other differences*
*Conclusions - high dose has no effect on c/s but decreases duration of labor and incidence of chorio*

*Intro - concerns about safety with high dose regiments but not well studied*
*hypothesis - high dose results in lower risk of c/s compared to standard dosing in nulliparas*
*Methods - parallel group, double blind, single center RCT, computer generated random sequencing, primary outcome - c/s and secondary outcome - labor duration, chorio, PPEH, PPH, perinatal outcomes*
*data was extracted, blinded and unmasked after data base was secure*
*analyses by intent to treat and unblinded interim analysis for safety*

*Results - 1003 - 502 to high dose and 501 to standard*
*most stayed in assigned group, primary outcome - 14.5% vs 14.4 and no difference in distribution of indications for c/s*
*high dose had shorter labor duration - 9h vs 10.5 h and chorio decreased from 10.4 vs 15.6% - no difference in neonatal morbidities*

*Discussion - no difference in c/s rate or indication for c/s, decreased labor duration and chorio incidence*
*adherence to randomization was high but may be under powered for less frequent outcome*

*Comments -*

*This is a very well done double blind RCT comparing high dose to standard dose oxytocin. There seems to clearly be no benefit to standard dose and a benefit to high dose with decreased duration and decreased chorio, with no increased risk. However, I do think it is important to emphasize that the incidence of the secondary outcomes, primarily the adverse neonatal outcomes, are too rare for this to be adequately powered to assess those.*
*Further data is needed to determine these risks.*

**Thank you for this comment. The manuscript has been revised to emphasize that the secondary outcomes should be interpreted with caution given some of their relatively low frequencies (Page 15).**

*Reviewer #2:*

*Summary of submission:*
*This is a double-blind randomized control study comparing the effect of a high-dose versus a standard-dose oxytocin regimen on the rate of cesarean section among nulliparous women undergoing labor augmentation.*

*Precis:*
*This is a well-written summary of study findings.*

*Abstract:*
*Summarizes study objective, design, results and conclusions effectively.*

*Intro:*
*The rationale for the study and the study's hypothesis are very clearly stated. The outline of the limitations of the 2013 Cochrane review is especially helpful in illustrating the urgency of and need for the research question at hand.*

*Line 89: Was reference 14 included in the Cochrane review? It is clear that reference 13 was included in the review, but it is not entirely clear if 14 was as well.*

**We have made the clarification that reference 14 was included in the Cochrane review, and the only included trial that assessed labor duration (Page 6).**

*Methods:*
*The approach to answering the research question is overall thoroughly and clearly explained.*

*Line 106: Consider "affirm" instead of "vouch".*

**We have made this correction (Page 7).**

*Line 109: What is meant by "who were planned for augmentation with oxytocin infusion"? Does this mean that, upon admission for spontaneous labor as defined, patients met some sort of criteria for oxytocin administration? For example, was it the case that if a patient was considered to be in spontaneous labor but contracting less than 3-4 contractions per 10 minutes, hypotonic labor, that the patient was counseled on starting Pitocin? To add clarity, consider rephrasing to "who were planned for augmentation with oxytocin infusion based determination from each patient's obstetrics-care team". Labor is classically defined as contractions that result in cervical change, how was 3cm cervical dilation or 80% effacement with or without SROM in the setting of at least 6 contractions per hour decided upon? Are there previous studies demonstrating specifically that this degree of dilation or effacement reliably optimizes the ability of Pitocin to lead to vaginal delivery? While the*
*Bishop score was initially intended to guide providers on the use of Pitocin in the setting of induction of labor, was application of the bishop score (i.e. women with favorable Bishop scores would be eligible to participate) considered for the purposes of your study?*

**We have revised the wording for clarification as requested (Page 7).**

**This was a pragmatic study, and the initiation of exogenous oxytocin was based on the clinical determination of each patient's obstetrics-care team, not based on a specific cervical exam. The purpose of the criteria for 3 cm dilation or 80% effacement or spontaneous rupture of membranes was to ensure that those who may have benefitted from cervical ripening agents were not included in this cohort.**

*Were patients compared at all based on their membrane status? That is, was the data analyzed in such a way as to be able to compare women in the study who were admitted with SROM, those who spontaneously ruptured membranes during labor, and those who required AROM as per the determination of the OB care team?*

**In Table 1, we present data on the frequencies of spontaneous rupture of membrane and amniotomy prior to trial entry for both intervention groups, and these were not significantly different. The timing of amniotomy was not prescribed in the protocol as this was not part of the study intervention and was instead left to the discretion of each patient's obstetrics care team given the pragmatic nature of the trial. Given the baseline similarities in membrane status between groups, we did not make further comparisons after trial entry.**

*Line 128: "labeled" spelling error*
**This has been revised (Page 8).**

*Results:*
*The results are well-organized and thorough.*

*Line 209: Were providers and/or patients required to provide an explanation as to why they requested the masked dosing regimen to be discontinued?*

**No, we unfortunately did not collect detailed records to document explanations when providers or patients requested discontinuation of masked dosing regimens. However, since all patients still continued oxytocin but at known dosing concentration rates, we suspect that they were uncomfortable with remaining blinded to dosing regimen.**

*Discussion*

*Line 251: "the previous trial" is vague. Please characterize this reference more clearly. Was it one of the papers analyzed in the Cochrane review? This comment is similar to that for line 89.*

**This has been revised for clarification (Page 14).**

*Line 252: Did the Cochrane review include any trials that looked at choriamnionitis as an outcome?*

**The Cochrane review did include two trials (n=404) that examined chorioamnionitis as a secondary outcome. The Discussion was revised to reflect this (Page 14).**

*Table 1. The patient population is quite homogenous—majority Caucasian, young (i.e. <35), with private insurance, and a BMI <30. This limits generalizability.*

**The Discussion was revised to include this limitation (Pages 15-16).**

*Reviewer #3:*

*The authors present a pragmatic double blind RCT hypothesizing that a high dose oxytocin regimen will reduce the risk of cesarean when compared to a standard dose oxytocin regimen. The study is well done and the manuscript is well written.*

*Intro - Authors do acknowledge the previous Cochrane Review but note that there are limitations due to the largest included study introducing bias which supports the need for additional data. Also important to note that although oxytocin is common, a recommended standard dosing regimen has not been determined.*
*Methods - Well done*
*Results - While there was no difference in the primary outcome, this alone is important. I often find that there may be resistance to high dose Pitocin protocols due to concern for causing fetal intolerance and leading to increase in cesarean delivery. Can the authors provide any data on duration of oxytocin received by participants in each group - to give the readers a sense of if oxytocin remained on during most of labor or was turned off for most of it?*

**The duration of oxytocin received by participants in each group was calculated and included in the Results (Page 12).**

*STATISTICS EDITOR COMMENTS:*

*Abstract: Needs to conform to our RCT template for abstracts. Specifically, should include concise section re: power and sample size*

**The abstract has been revised.**

*Table 2: No need to include p-values for primary outcome, since CI is given. Should cite as formatted in Methods, that is, as difference in CD rates, with CI. Since the subsets have denominators = 73 and 72, the %s should all be rounded to nearest integer %, not cited to 0.1% precision.*

**These revisions have been made.**

*Table 3: The rates of chorioamnionitis, endometritis or PPH are each small and there is low power to generalize the NS findings.*

**This limitation has been included in the Discussion (Page 16).**

*Table 4: Same issue with low power. Should include the result for UAC pH < 7.0 with multiple imputation, which then made the association NS.*

**This modification has been made in Table 4.**

*For Tables 3,4: The column of p-values is redundant, since CIs are included. Could embolden or otherwise indicate the RRs that are statistically significant for the reader, if desired.*

**The p-value was included in Table 3 for the outcome of time interval since the RR does not apply. If the editor would still like us to remove this column and to leave it to the text, we can remove this column.**

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.**

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

**It has been confirmed that my coauthors and I do not have any disclosures to report.**

*3. For studies that report on the topic of race or include it as a variable, authors must provide an explanation in the manuscript of who classified individuals' race, ethnicity, or both, the classifications used, and whether the options were defined by the investigator or the participant. In addition, the reasons that race/ethnicity were assessed in the study also should be described (eg, in the Methods section and/or in table footnotes). Race/ethnicity must have been collected in a formal or validated way. If it was not, it should be omitted. Authors must enumerate all missing data regarding race and ethnicity as in some cases, missing data may*

*comprise a high enough proportion that it compromises statistical precision and bias of analyses by race.*

*Use "Black" and "White" (capitalized) when used to refer to racial categories. The nonspecific category of "Other" is a convenience grouping/label that should be avoided, unless it was a prespecified formal category in a database or research instrument. If you use "Other" in your study, please add detail to the manuscript to describe which patients were included in that category.*

**Race and ethnicity is included as a baseline variable characteristic, in addition to other demographic variables, to provide descriptive information to the readers about our hospital patient population to aid them in their interpretation of our study's generalizability to their practices. The non-specific category of "Other" was a prespecified formal category in our database instrument. Table 1 and its footnote have been revised to provide more clarity about this variable.**

*4. Clinical trials submitted to the journal as of July 1, 2018, must include a data sharing statement. The statement should indicate 1) whether individual deidentified participant data (including data dictionaries) will be shared; 2) what data in particular will be shared; 3) whether additional, related documents will be available (eg, study protocol, statistical analysis plan, etc.); 4) when the data will become available and for how long; and 5) by what access criteria data will be shared (including with whom, for what types of analyses, and by what mechanism). Responses to the five bullet points should be provided in a box at the end of the article (after the References section).*

**This has been included after the References section.**

*5. If an administrative database is used: In order for an administrative database study to be considered for publication in Obstetrics & Gynecology, the database used must be shown to be reliable and validated. In your response, please tell us who entered the data and how the accuracy of the database was validated. This same information should be included in the Materials and Methods section of the manuscript.*

**This is not applicable to our trial.**

*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 data definitions at https://nam12.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.acog.org%2Fpractice-management%2Fhealth-it-and-clinical-informatics%2Frevitalize-obstetrics-data-definitions&data=04%7C01%7Cmoeun.son%40yale.edu%7C127b19042b9441f51b8708d8d9a4a2d5%7Cdd8cbebb21394df8b4114e3e87abeb5c%7C0%7C1%7C637498648422526414%7CU*

*nknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C1000&sdata=3epi4PeAE%2B5uWJY2Bgza%2F5lV9iHuqeO7pvdQXBkz5dA%3D&reserved=0and the gynecology data definitions at https://nam12.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.acog.org%2Fpractice-management%2Fhealth-it-and-clinical-informatics%2Frevitalize-gynecology-data-definitions&data=04%7C01%7Cmoeun.son%40yale.edu%7C127b19042b9441f51b8708d8d9a4a2d5%7Cdd8cbebb21394df8b4114e3e87abeb5c%7C0%7C1%7C637498648422526414%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C1000&sdata=Jlx7wVYZCzUQ7FUU09J0%2BfRRv1KlQnj9idYb9j5u5Go%3D&reserved=0. If use of the reVITALize definitions is problematic, please discuss this in your point-by-point response to this letter.*

**We have modified the text to only include standard abbreviations in the above list.**

7. Because of space limitations, it is important that your revised manuscript adhere to the following length restrictions by manuscript type: Original Research reports should not exceed 22 typed, double-spaced pages (5,500 words). Stated page limits include all numbered pages in a manuscript (i.e., title page, précis, abstract, text, 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:*

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** 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).*

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