Date: Jan 31, 2019
To: "Leah Yieh" [redacted]
From: "The Green Journal" em@greenjournal.org
Subject: Your Submission ONG-18-2415

RE: Manuscript Number ONG-18-2415

Cost-Effectiveness of Resuscitation Strategies of Neonates at 22 Weeks' Gestational Age

Dear Dr. Yieh:

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 Feb 21, 2019, we will assume you wish to withdraw the manuscript from further consideration.

REVIEWER COMMENTS:

Reviewer #1: The authors present their work comparing cost-effectiveness for resuscitation compared to no resuscitation at 22 weeks gestation. They provide a thorough evaluation of the factors that contribute to the cost effectiveness of these options.

Reviewer #2: In the manuscript under review the authors analyzed cost effectiveness of three strategies regarding resuscitation of infant born at 22 to 22 6/7 week gestation. This is a very important paper from the health policy point of view. Given that there are limited resources mathematical modeling that is described in this paper is very important to consider what is best outcomes you can get for the amount of money that is available. National Institutes of Healthcare Excellence (NICE) in UK uses these types of modeling to decide what should be covered and what should not. I think with all assumptions that are make this paper supports that resuscitation at 22 weeks is no cost effective and should be discouraged (from healthcare economics point of view).

The following are my comments:

Abstract: Overall is well written and summarizes well the study. Please explain where numbers of 365 and 120, Table 1 and text mention different numbers (373 survivors and 123 with severe neurodevelopmental impairment). I think Table 1 explains the difference, however I would try to keep numbers in abstract and text the same (less confusion for reader).

Introduction:

1. Lines 114-115, the authors mention overall survival from 22-24 weeks infants, however since this paper is about 22 week infants, I would recommend to mention from Younge paper survival outcomes for 22 week infants.

2. Line: 144, again recommend to mention numbers.

Material and Methods:

3. The authors present many numbers and reader can get confused with numbers. I think Figure 1 can be enhanced by putting number on the lines.

For example there 5176 neonates born between 22-22'6 weeks gestation.

4. For universal resuscitation (all 5176 infants are attempted to be resuscitated), what percent (and number) is destines to

survive in delivery room and next node, what percent (and number) is destined to be discharge from NICU based on assumptions that authors made.

5. For selective resuscitation, from reading patient, only 21 % of hospital offer resuscitation, so we are starting with 1087 infants (21% from 5176 or assumption can be made that more will be attempted to be resuscitated) and then based on survival percentage the other numbers should be filled in.

6. Another strategy is to consider selective resuscitation for 22 week infants only whose who have completed steroids (some studies include steroids in 22 weeks infants).

7. Line 216 please list the numbers that authors used for maternal utilities of having child with mild, moderate and severe neurodevelopmental delays.

8. Line 220: Please list neonatal utility numbers used in the text. I would also suggest maybe a table with all maternal and neonatal utility numbers assumed in the text.

Results:

9. Lines 252-255: I think that the way numbers described in text are confusing. I think as I have suggested previous all these numbers can be placed on figure 1, then Table 1 may not be necessary.

10. Line 257 Universal resuscitation ……. Would start a new paragraph. The numbers in text not obvious from Table 2. Maybe explain to reader that 465mil (481 mil universal -16 mil no resuscitation).

11. Figure 2 is nice visualization of Monte Carlo trials. Please state what is represented by each dot. According to graph. All points are in quadrant one.

12. I am glad that authors did sensitivity analysis, and it is explained well.

Discussion:

13. Overall discussion is well written and reflecting information that is presented in paper. Since authors mention that currently universal resuscitation is practiced in Sweden and Japan, is there any information how much government is willing to pay for qaly in these countries. In this paper it is set for 100K/qaly. Maybe figure 2 can also plot WTP 50K/qaly and 30 K/qaly (used by NICE).

Reviewer #3: I reviewed the manuscript which entitled as "Cost-Effectiveness of Resuscitation Strategies of Neonates at 22 Weeks' Gestational Age ".

This manuscript evaluated the cost-effectiveness of different approaches to care of neonates born at 22 weeks (i.e. universal resuscitation, selective resuscitation, or no resuscitation).

The results stated that the universal resuscitation would result in 365 additional survivors and 120 more infants with severe disability compared to no resuscitation. The manuscript focuses on the edge-cut research area. it is very difficult to rescue 22 weeks infants, however the authors reviewed the theoretical cohort study and concluded that neither selective nor universal resuscitation of 22-week infants was a cost-effective strategy compared to no resuscitation. Thus, while resuscitation at 22 weeks' gestation was possible, its routine use may not be economically favorable.

This manuscript provided the information of the outcome of death and survival with and without neurodevelopment impairments in the infant that was born at 22 weeks with different resuscitation, it questions that if the resuscitation should be applied in the practice for the 22 weeks infants based onto economical plan and the infants' outcomes. It definitely requires further study to clarify this question.

STATISTICAL EDITOR'S COMMENTS:

1. lines 252-254: Wouldn't it be simpler to state the n(%) of survivors in the three scenarios, rather than citing incremental differences? Could then cite the n(%) within each category of normal/mild, moderate or severe sequelae.

2. Suggest defining the term "utility" for readers not accustomed to simulation models.

3. Table 2: Could round to less precision (total costs, total QALYs, total maternal and neonatal QALYs) without any loss of significant information for reader. Similarly, maternal and neonatal QALYs per infant could be rounded to nearest .01 without any significant loss of information.

4. Table 3: The calculation of ICER should be explained better to readers, since ΔC, ΔE are not defined. Is total cost in this Table indexed per survivor? (The Total maternal and neonatal QALYs in Table 3 are the sum of total neonatal and maternal QALYs per infant.) Since the values are quite different from total costs in Table 2, need to elaborate clearly for the reader and use consistent terminology in Tables 2 and 3. Also, the format for Table 2 and Table 3 would be easier for the reader to follow if the order were the same, that is, Table 2 has universal, selective and no resuscitation, while Table 3 has the reverse order.

5. Fig 3b: Do the Authors have an explanation for the abrupt change in ICER at the maternal utility for neonatal death at 0.69 specifically?

6. I think that the Appendix 1 Table is important enough to warrant placement in the main text. Admittedly, some subsets are small, but what if the assumption that survival to hospital discharge or outcome probabilities for sequelae were not the same for universal, selective or no resuscitation cohorts? It would seem that sensitivity analysis should explore those possibilities.

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, as well as subsequent author queries. 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:
1. OPT-IN: Yes, please publish my response letter and subsequent email correspondence related to author queries.
2. OPT-OUT: No, please do not publish my response letter and subsequent email correspondence related to author queries.

2. As of December 17, 2018, Obstetrics & Gynecology has implemented an "electronic Copyright Transfer Agreement" (eCTA) and will no longer be collecting author agreement forms. When you are ready to revise your manuscript, you will be prompted in Editorial Manager (EM) to click on "Revise Submission." Doing so will launch the resubmission process, and you will be walked through the various questions that comprise the eCTA. Each of your coauthors will receive an email from the system requesting that they review and electronically sign the eCTA.

Any author agreement forms previously submitted will be superseded by the eCTA. During the resubmission process, you are welcome to remove these PDFs from EM. However, if you prefer, we can remove them for you after submission.

3. 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.

4. 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 26 typed, double-spaced pages (6,500 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.

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 précis on the second page, for use in the Table of Contents. The précis is a single sentence of no more than 25 words that states the conclusion(s) of the report (ie, the bottom line). The précis should be similar to the abstract's

conclusion. Do not use commercial names, abbreviations, or acronyms in the précis. Please avoid phrases like "This paper presents" or "This case presents."

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 limits for different article types are as follows: Original Research articles, 300 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. 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.

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

12. The Journal's Production Editor had the following to say about the figures in this manuscript:

"Figure 3: Is this available at a higher resolution? Also, these 5 images will likely not fit in print as a single figure. Please consider breaking Figure 3 into Figures 3–7. "

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.

Art that is low resolution, digitized, adapted from slides, or downloaded from the Internet may not reproduce.

13. 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.

***

If you choose to revise your manuscript, please submit your revision via Editorial Manager for Obstetrics & Gynecology at

http://ong.editorialmanager.com. It is essential that your cover letter list point-by-point the changes made in response to each criticism. Also, please save and submit your manuscript in a word processing format such as Microsoft Word.

If you submit a revision, we will assume that it has been developed in consultation with your co-authors and that each author has given approval to the final form of the revision.

Again, your paper will be maintained in active status for 21 days from the date of this letter. If we have not heard from you by Feb 21, 2019, we will assume you wish to withdraw the manuscript from further consideration.

Sincerely,

The Editors of Obstetrics & Gynecology

2017 IMPACT FACTOR: 4.982
2017 IMPACT FACTOR RANKING: 5th out of 82 ob/gyn journals

_____

Leah Yieh, MD, MPH
Children's Hospital Los Angeles
4650 Sunset Blvd., MS #31
Los Angeles, CA 90027

Manuscript #: ONG-18-2415
Title: Cost-Effectiveness of Resuscitation Strategies of Neonates at 22 Weeks' Gestational Age

Dear Dr. Nancy Chescheir,

We thank the editors and reviewers for their generous comments on our manuscript. We have edited the paper to fully address the comments and concerns as listed below.

Reviewer #2 comments:

1. **Abstract: Overall is well written and summarizes well the study. Please explain where numbers of 365 and 120, Table 1 and text mention different numbers (373 survivors and 123 with severe neurodevelopmental impairment). I think Table 1 explains the difference, however I would try to keep numbers in abstract and text the same (less confusion for reader).**
   Thank you for suggestion. 365 and 120 represent the difference between universal resuscitation (373-8=365) and no resuscitation (123-3=120) in regards to survivors and infants with severe disability, respectively. Changed as suggested.

2. **Lines 114-115, the authors mention overall survival from 22-24 weeks infants, however since this paper is about 22 week infants, I would recommend to mention from Younge paper survival outcomes for 22 week infants.**
   Changed as suggested. "From 2008-2011, across 24 centers participating in the National Institute of Child Health and Human Development Neonatal Research Network, active treatment was provided for 22% of infants born at 22 weeks, of which only 5% survived without neurodevelopmental impairment at 18-22 months of corrected age."

3. **Line: 144, again recommend to mention numbers.**
   Thank you for your comment. Changed as suggested. "Since then, rates of active treatment at 22 weeks have increased, especially for those born on the last two days of the gestational week, to 30-50%, and data on neurodevelopmental outcomes has become more readily available."

4. **The authors present many numbers and reader can get confused with numbers. I think Figure 1 can be enhanced by putting number on the lines.**
   For example there 5176 neonates born between 22-22'6 weeks gestation.
   Thank you for your feedback. Given that we used a theoretical cohort, we did not include numbers on the figure in order to let different stakeholders input their own parameters. However, we have included additional details in the figure legend to walk the reader through the decision tree: "In our hypothetical cohort of 5,176 neonates born between 22

0/7 – 22 6/7 weeks' gestation, we applied three different resuscitation strategies. For the no resuscitation arm, 5,140 would not survive the delivery room. Of the 36 infants who would be admitted to the NICU, only 8 would survive to discharge. 3 of those infants would have severe impairments, 2 would be moderately delayed, and 3 would have little to no sequelae. For the selective resuscitation arm, 336 infants would survive to NICU admission, 78 of which would survive to discharge home. 26 neonates would be severely affected, 22 with moderate delays, and 30 with mild or no impairments. In the universal resuscitation branch, 3,561 infants would be expected to die in the delivery room. 373 infants would survive to discharge, of which 123 would have severe sequelae, 104 with moderate impairments, and 145 intact or mildly affected."

5. **For universal resuscitation (all 5176 infants are attempted to be resuscitated), what percent (and number) is destines to survive in delivery room and next node, what percent (and number) is destined to be discharge from NICU based on assumptions that authors made.**
   For universal resuscitation, 31.2% (1,615) will survive the delivery room, and 23.1% (373) of those infants will survive to discharge.
   The percentages are included in the Appendix Table whereas the actual numbers are included in Table 1.

6. **For selective resuscitation, from reading patient, only 21 % of hospital offer resuscitation, so we are starting with 1087 infants (21% from 5176 or assumption can be made that more will be attempted to be resuscitated) and then based on survival percentage the other numbers should be filled in.**
   We have modified the methods section to clarify that, "21% of infants are selectively resuscitated at 22 weeks' gestation."
   We used the probability of selective resuscitation (21%) to calculate the probability of delivery room survival (0.21x0.312 = 0.065) for that group.

7. **Another strategy is to consider selective resuscitation for 22 week infants only whose who have completed steroids (some studies include steroids in 22 weeks infants).**
   Thank you for your feedback. Yes, that is an excellent point. However, the data that we used from the literature did not stratify outcomes by antenatal steroid exposure though 27.8% of actively treated 22 week infants had a partial or full course of steroids (Rysavy MA, Li L, Bell EF, Das A, Hintz SR, Stoll BJ, et al. Between-hospital variation in treatment and outcomes in extremely preterm infants. N Engl J Med 2015;372:1801-11). Therefore, our model was not able to capture those who received steroids.

8. **Line 216 please list the numbers that authors used for maternal utilities of having child with mild, moderate and severe neurodevelopmental delays.**
   Changed as suggested.

9. **Line 220: Please list neonatal utility numbers used in the text. I would also suggest maybe a table with all maternal and neonatal utility numbers assumed in**

the text.
Thank you for your suggestion. Changed as suggested.
All maternal and neonatal utilities are listed in the Appendix table.

10. **Lines 252-255: I think that the way numbers described in text are confusing. I think as I have suggested previous all these numbers can be placed on figure 1, then Table 1 may not be necessary.**
Thank you for your comment. Please refer to comment #4.

11. **Line 257 Universal resuscitation ……. Would start a new paragraph. The numbers in text not obvious from Table 2. Maybe explain to reader that 465mil (481 mil universal -16 mil no resuscitation).**
Changed as suggested – new paragraph started, and derivation of numbers explained.

12. **Figure 2 is nice visualization of Monte Carlo trials. Please state what is represented by each dot. According to graph. All points are in quadrant one.**
Thank you for the suggestion. Figure legend has been edited to include that "each dot represents one infant born at 22 0/7 – 22 6/7 weeks' gestation." In addition, we have added that "all dots are located in quadrant I."

13. **I am glad that authors did sensitivity analysis, and it is explained well.**
Thank you for the comment.

14. **Overall discussion is well written and reflecting information that is presented in paper. Since authors mention that currently universal resuscitation is practiced in Sweden and Japan, is there any information how much government is willing to pay for qaly in these countries. In this paper it is set for 100K/qaly. Maybe figure 2 can also plot WTP 50K/qaly and 30 K/qaly (used by NICE).**
Thank you for the feedback. There is no official willingness to pay threshold in Sweden and Japan, but per review of the literature, it is approximately $130,000/QALY in Sweden (Hultkrantz L, Svensson M. The value of a statistical life in Sweden: a review of the empirical literature. Health Policy 2012;108: 302-310) and $60,000-$75,000/QALY in Japan (Shiroiwa T, et al. WTP for a QALY and health states: More money for severer health states? Cost Eff Resour Alloc 2013;11:22). We have edited the discussion to include this information.

In the UK, the commonly cited willingness to pay threshold is $25,000-$40,000/QALY (Appleby J, Devlin N, Parkin D. NICE's cost effectiveness threshold. BMJ 2007;335:358-9).

<u>Statistical editor's comments:</u>

15. **lines 252-254: Wouldn't it be simpler to state the n(%) of survivors in the three scenarios, rather than citing incremental differences? Could then cite the n(%) within each category of normal/mild, moderate or severe sequelae.**

Thank you for the suggestion. We stated the incremental differences in survivors to emphasize the additional number of lives that would result from different resuscitation strategies.
We have changed the neurodevelopmental outcomes to percentages as suggested.

16. **Suggest defining the term "utility" for readers not accustomed to simulation models.**
Thank you for the comment. In response to this suggestion, we have added the following, "Maternal preferences were derived from Carroll et al. in which parents or guardians were asked to provide utility values, or subjective, quantitative measures of a particular health state, for randomly chosen disease scenarios using the standard gamble technique."

17. **Table 2: Could round to less precision (total costs, total QALYs, total maternal and neonatal QALYs) without any loss of significant information for reader. Similarly, maternal and neonatal QALYs per infant could be rounded to nearest .01 without any significant loss of information.**
Changed as suggested.

18. **Table 3: The calculation of ICER should be explained better to readers, since ΔC, ΔE are not defined. Is total cost in this Table indexed per survivor? (The Total maternal and neonatal QALYs in Table 3 are the sum of total neonatal and maternal QALYs per infant.) Since the values are quite different from total costs in Table 2, need to elaborate clearly for the reader and use consistent terminology in Tables 2 and 3. Also, the format for Table 2 and Table 3 would be easier for the reader to follow if the order were the same, that is, Table 2 has universal, selective and no resuscitation, while Table 3 has the reverse order.**
Thank you for the comments.
We have included the definition of ICER in the figure legend for Table 3 as suggested.
Yes, total cost in Table 3 is per infant, and total QALYs are the sum of neonatal and maternal QALYs per infant.
In Table 3, we have changed the heading to "Incremental Cost-Effectiveness of Resuscitation Strategies with Extended Dominance Per Infant" for clarification.
We have changed the format in Table 2 to ensure consistency with Table 3.

19. **Fig 3b: Do the Authors have an explanation for the abrupt change in ICER at the maternal utility for neonatal death at 0.69 specifically?**
Thank you for the question. If you refer to Figure 2 with the ICER plot, as the ICER increases and eventually crosses over to quadrant II, the ICER becomes negative (higher costs, less effective).

20. **I think that the Appendix 1 Table is important enough to warrant placement in the main text. Admittedly, some subsets are small, but what if the assumption that survival to hospital discharge or outcome probabilities for sequelae were not the**

same for universal, selective or no resuscitation cohorts? It would seem that sensitivity analysis should explore those possibilities.
Thank you for the comment. We did not include the Appendix Table into the main text due to space constraints. If the editors would be open to allowing more than 22 pages, we would be happy to include it.
We performed sensitivity analysis on the probability of survival to discharge for universal resuscitation as demonstrated in Figure 3e. In response to the comments, we have added that, "Selective resuscitation becomes cost-effective from a neonatal perspective once the probability for survival to discharge exceeds 0.3. For the no resuscitation group, the number of infants who would actually survive the delivery room is so small that survival to discharge is insensitive to variation in the inputs."
Due to data constraints, we were not able to show all sensitivity analyses. However, our ICER plot encompasses all of the probabilistic sensitivity analyses in which we varied all inputs simultaneously across their respected distributions for each of the 100,000 runs.

Journal production editor's comments:

21. **"Figure 3: Is this available at a higher resolution? Also, these 5 images will likely not fit in print as a single figure. Please consider breaking Figure 3 into Figures 3–7. "**
Figures were exported from TreeAge software with the highest resolution possible. Figure headings changed as suggested.

We look forward to hearing from you regarding our submission. We would be glad to respond to any further questions and comments that you may have.

Sincerely,

Leah Yieh, MD, MPH

On behalf of all authors.

Daniel Mosier

From: Yieh, Leah [redacted]
Sent: Tuesday, March 5, 2019 5:26 PM
To: Daniel Mosier
Subject: Re: Manuscript Revisions: ONG-18-2415R1
Attachments: 18-2415R1 ms (3-1-19v2).docx; mg_info.txt

Hi Mr. Mosier,

Please find revisions attached.

Thanks,

Leah Yieh, MD, MPH
Assistant Professor of Clinical Pediatrics
USC Keck School of Medicine
Fetal and Neonatal Institute
Children's Hospital Los Angeles

From: Daniel Mosier <dmosier@greenjournal.org>
Sent: Friday, March 1, 2019 12:10:01 PM
To: Yieh, Leah
Subject: Manuscript Revisions: ONG-18-2415R1 (EXTERNAL EMAIL)

Dear Dr. Yieh,

Thank you for submitting your revised manuscript. It has been reviewed by the editor, and there are a few issues that must be addressed before we can consider your manuscript further:

1. Please note the minor edits and deletions throughout. Please let us know if you disagree with any of these changes.
2. LINE 1: Note edits to title.
3. LINE 27: Please add the exact dates of the meeting.
4. LINE 81:
   a. Please here give the survivors and severe disability for the other two strategies.
   b. Here please succinctly explain extended dominance for our clinical audience, e.g., it cost more per QALY and resulted in fewer survivors or whatever
5. LINE 99: Please shorten this introduction by half
6. LINE 145: Did you receive IRB approval or exemption? Please add information on the IRB in this section.
7. LINE 146: Please go through manuscript and use the active voice when possible and appropriate
8. TABLE 1: This row and the next are highly redundant since you repeat everything in triplicate-please find a way to not do this
9. FIGURES: The editor on your manuscript would like you to select 3 figures to appear in the text and move the rest of the supplemental digital content portion. Please rename the supplemental figures “Appendix X” (numbered based on their order of appearance within the text), and amend the in-text citations accordingly. Please also renumber the figures that will remain within the main text, and amend the citations.

When revising, use the attached version of the manuscript. Leave the track changes on, and do not use the "Accept all Changes"

Please let me know if you have any questions. Your prompt response to these queries will be appreciated; please respond no later than COB on **Tuesday, March 5th.**

Sincerely,
-Daniel Mosier

Daniel Mosier
Editorial Assistant
Obstetrics & Gynecology
The American College of Obstetricians and Gynecologists
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Washington, DC 20024
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Web: http://www.greenjournal.org

Eileen Chang (Temp)

From: Yieh, Leah [redacted]
Sent: Tuesday, March 12, 2019 1:56 PM
To: Eileen Chang (Temp)
Subject: Re: O&G Figure Revision: 18-2415
Attachments: 18-2415 Legend Revisions #2.docx; Yieh_Appendix_Revisions.docx; mg_info.txt

Hi Eileen,

Figures 1-3 look good. Minor edits to the legend and appendix attached.

Thank you!
Leah

From: Eileen Chang (Temp) <echang@greenjournal.org>
Sent: Monday, March 11, 2019 2:26:25 PM
To: Yieh, Leah
Subject: RE: O&G Figure Revision: 18-2415 (EXTERNAL EMAIL)

Hello,

We have moved figures 4-7 to the appendix (with the edits to Appendix 3-4) and the appendix file is attached for your review. We have also edited the legend, attached for your review.

If you could also get back to us on whether or not Figures 1-3 (attached as PDFs) need any edits, we would greatly appreciate it.

Best,
Eileen

From: Yieh, Leah [redacted]
Sent: Thursday, March 7, 2019 10:49 PM
To: Eileen Chang (Temp) <echang@greenjournal.org>
Subject: Re: O&G Figure Revision: 18-2415

Hi Eileen,

Figures 4-7 should be moved to the appendix and have been re-named as Appendix 1-4, respectively. Please see track changes attached.

Also, for Figures 6 and 7, the Y-axis should be labeled NEONATAL incremental cost-effectiveness.

Thanks for your help!

Leah Yieh, MD, MPH
Assistant Professor of Clinical Pediatrics
USC Keck School of Medicine
Fetal and Neonatal Institute
Children's Hospital Los Angeles

From: Eileen Chang (Temp) <echang@greenjournal.org>
Sent: Wednesday, March 6, 2019 11:08:45 AM
To: Yieh, Leah
Subject: O&G Figure Revision: 18-2415 (EXTERNAL EMAIL)

Good afternoon,

Your figures and legend have been edited and they have been attached for your review. Please review the attachments CAREFULLY for any mistakes.

PLEASE NOTE: Any changes to the figures must be made now. Changes made at later stages are expensive and time-consuming and may result in the delay of your article's publication.

To avoid a delay, I would appreciate a reply no later than Friday, 3/8. Thank you for your help.

Best,

Eileen