

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: Aug 12, 2021
To: "Jane Martin" [REDACTED]
From: "The Green Journal" em@greenjournal.org
Subject: Your Submission ONG-21-1555

RE: Manuscript Number ONG-21-1555

Cesarean postoperative complications and type of skin incision in morbidly obese patients

Dear Dr. Martin:

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).

Please be sure to address the Editor comments (see "EDITOR COMMENTS" below) in your point-by-point response.

Your paper will be maintained in active status for 21 days from the date of this letter. If we have not heard from you by Sep 02, 2021, we will assume you wish to withdraw the manuscript from further consideration.

REVIEWER COMMENTS:

Reviewer #1: This manuscript describes a retrospective cohort study comparing Pfannenstiel skin incision (PSI) to vertical skin incision (VSI) in morbidly obese patients. The primary outcome was a composite of wound morbidities, as one would expect. The primary outcome was more frequently found in patients with the VSI, with an aOR of 1.62. This was in contrast to the stated hypothesis. The authors also found that the VSI was associated with vertical hysterotomy.

The study was from a single center. Strengths included that the study is fairly large, including over 125 VSI cases. Another is that the patients are said to have been followed for 42 days postpartum.

1. Lines 88 through 91 indicate that data extraction from the data warehouse was not reliable for important components of the study. The authors, however, do not explain what they did to account for this, at least in this section of the Materials and Methods. I assume charts were manually reviewed, as suggested in lines 226-231. Do the authors mean to say that some 4,500 charts were reviewed? If not, how were charts selected for manual review to reduce bias? Please explain.
2. The authors should reference the "previous studies" used for the power calculation in the paragraph in which this is described.
3. Can the authors comment on, and perhaps adjust for, the duration of surgery?
4. In my experience certain physicians are more inclined to use a vertical incision. Can the authors comment on this with regard to practice at their institution.
5. I feel a bit unsettled regarding the inclusion of more than one cesarean in a given patient. In obese patients, repeat cesarean deliveries can be modestly difficult and lengthy. Are the authors able to stratify according to primary versus repeat cesareans? Why not do this?

Reviewer #2:

Summary: This retrospective study compares wound morbidity following cesarean delivery in obese women receiving Pfannenstiel (PSI) and two types of vertical skin incisions (VSIs). The authors hypothesized that PSI would incur more

wound complications. However, their results were contradictory to their hypothesis finding that there was an increase in composite wound morbidity among with who underwent VSI. Type of incision for obese patients may be challenging to study in a prospective fashion, therefore a retrospective review is relevant.

1. Interest and Relevance: With concurrently increasing rates of obesity and cesarean delivery in the United States, this article is timely and useful in assessing patient risk for wound complication. Choice of skin incision is important in obstetrical surgery and this article raises important considerations for obstetrical surgeons.
2. Readability/Grammar/Organization: In general, the paper is well written and supported by its references. There are some minor grammatical errors. Each section is well organized with minimal redundancy.
3. Introduction: This section is well written and referenced.
 - a. Line 68: Would remove "due to this uncertainty" when describing study.
4. Methods: Strengths of this study are found in the methods utilized, including following patients to 42 days postpartum, use of 2 reviewers for extraction of outcomes and exposures to limit collection biases.
 - a. The authors pointed out that diagnosis codes were missing for many of the women found to have wound complications through a chart review. (as detailed in lines 98-103). On the other hand, if the patient did not receive a diagnostic code is it possible that the authors are over-interpreting their chart review? This should be addressed in the Discussion.
 - b. Clarification should be provided as to why some secondary outcomes were selected (i.e. neonatal outcomes) which are seemingly not related to the study's exposures or outcomes.
 - c. Lines 111-115: Power analyses are not applicable in retrospective studies, this seems unnecessary. My understanding is that "ad hoc" power analyses should be included in the discussion.
 - d. Why were obese women with BMIs in the range of 30-40 not included?
5. Results: Overall, well described.
 - a. Line 151: Would remove "interestingly" from a results section.
6. Table 1 [line 290]:
 - a. What relevance does insurance type have on this study? This is not mentioned in the results or discussion and seems superfluous.
 - b. It is unclear to this reviewer why race is included in this analysis. Please discuss why this variable was included.
7. Table 2 [line 295]:
 - a. 5-minute APGAR and NICU admission do not seem like relevant data to this study's outcomes or exposures and needs further explanation in the manuscript.
 - b. The aOR did not consider gestational age which was significantly earlier in the VSI group. An explanation should be given of why this and other variables were or were not included in the adjusted analyses.
 - c. Vertical hysterotomy is typically a function of gestational age and may be confounded by the VSI study cohort where the gestational ages were lower.
 - d. A discussion of why vertical hysterotomy was associated with vertical skin incisions is warranted.
8. Table 4 [line 308]:
 - a. Again, despite being secondary outcomes, 5-minute APGARS and NICU admissions do not seem relevant to either the outcomes or exposures in this study. Furthermore, the sample size is small when stratifying based on BMI therefore conclusions are difficult to make despite statistical significance. Please indicate that small sample sizes in some of the cohorts limits the ability to draw conclusions about exposures.
9. Table 5 [line 312]:
 - a. Sample size is very small when stratified based on IUV/SUV so I would question the ability to make conclusions. Please comment.
10. Discussion: Appropriately points out that this study is unique in its methods and has one of the largest cohorts of patients studied. Limitations discussed are appropriate as are final discussion of outcomes. Given the small population with VSI it is difficult to draw conclusions regarding differences in the SUV and IUV groups.

Reviewer #3: In this original article, the authors evaluate the association of location of skin incision (Pfannensteil vs. vertical midline) and wound morbidity in women with severe obesity (BMI ≥ 40) undergoing cesarean delivery. While they hypothesize that PFI will have higher rates of wound morbidity, they actually find that PFI has a lower rate of wound morbidity; with vertical midline (both types) associated with increased wound morbidity, transfusion, and vertical hysterectomy. The study design is simple and well-executed and the study well-written. Minor comments are described below.

Abstract:

- Lines 31-33. It is unclear at first that this sentence is comparing the rates of vertical hysterectomy for each midline skin incision type. Please clarify

Introduction:

- The introduction is very brief and clear. Hypothesis and objectives are clearly stated.

Methods:

- Why did the authors choose pre-pregnancy BMI, given that the exposure (i.e. incision type) is actually at the time of delivery. Qualifications should include delivery BMI. While it is unlikely patients lost weight in pregnancy, the pre-pregnancy BMI choice is curious as it does not reflect the delivery timepoints where the exposure is made.

- Lines 81-83: I am unclear what this statement means

- Line 80: I am not sure in the instance of repeat cesarean and wound infection, individual pregnancies can be statistically treated as independent events. They are interrelated and should statistically be considered and treated as so. If not, further justification is required.

- In the methods, the authors report that data extraction was not valid for the primary outcomes and three important other variables. They thus relied on ICD coding for these variables it seems. This is problematic given the variety of data extraction methods which may not be internally consistent. Also for rare outcomes, ICD9/10 codes are notoriously inaccurate. The authors should report any manual validation to confirm the accuracy of their data extraction techniques. The authors also report in line 107 that there was manual chart review. It needs to be significantly clarified what was done via computer-based algorithmic extraction and what was performed manually; or if the manual chart review confirmed the extraction. As it stands, the data acquisition is unclear and therefore appears suspect.

- Line 122: Why are those variables considered and chosen as confounders?

- Why were not GEE models utilized given that observations may not be independent for a single individual

Results:

- Lines 142-146 are redundancy considering the statement immediately prior. Referencing the tables should suffice.

- I am unclear what to make of the BMI strata analysis. There was no significance in either the lower or upper strata and only the middle one (BMI 45-49.99). This could represent statistical error. Alternatively, this analysis could be reduced given the weak association and supplemented with tests of interaction to determine whether stratified analysis is even justified.

- I am unclear what Table 3 adds to the overall study findings

Discussions

- I am not sure if following patients through the PP period is unique as the majority of studies evaluate up to 6 weeks postpartum

- Given the accuracy or lack thereof described the methods, how accurate were locations of the VSI classified as SUV vs IUV. How were paramedic incisions classified?

- The limitations adequately address the limitations in the study

STATISTICAL EDITOR COMMENTS:

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

Table 1: Clearly, the women who had VSI were heavier, older, more likely smokers, have DM, so more risk factors for adverse outcomes. Given the large number of PSI women vs VSI, should have matched to verify the adjustment model.

Table 2: Need to round all %s to nearest 0.1% precision, not cite to 0.01% precision. The higher rates of NICU admission are likely related to the earlier delivery GAs. The p-values are redundant, since CIs are included for ORs and aORs.

Table 3: Need to clearly separate the primary from secondary outcomes. Need units for age. P-values are redundant, column should be omitted.

Table 4: Again, the primary should be separated clearly from the secondary outcomes, the columns of p-values are redundant and the counts in subsets and by outcomes become fewer, thus limiting stats power to discern and thus

generalize the NS comparisons. On the other hand, likely the multivariable adjustment models are over fitted as well.

Table 5: Same issues as with Table 4.

EDITOR COMMENTS:

1. We would be happy to consider a revised manuscript that uses matching to control for the imbalance in important characteristics between groups.

2. The Editors of Obstetrics & Gynecology have increased transparency around its peer-review process, in line with efforts to do so in international biomedical peer review publishing. If your article is accepted, we will be posting this revision letter as supplemental digital content to the published article online. Additionally, unless you choose to opt out, we will also be including your point-by-point response to the revision letter. If you opt out of including your response, only the revision letter will be posted. Please reply to this letter with one of two responses:

- A. OPT-IN: Yes, please publish my point-by-point response letter.
- B. OPT-OUT: No, please do not publish my point-by-point response letter.

3. When you submit your revised manuscript, please make the following edits to ensure your submission contains the required information that was previously omitted for the initial double-blind peer review:

- * Include your title page information in the main manuscript file. The title page should appear as the first page of the document. Add any previously omitted Acknowledgements (ie, meeting presentations, preprint DOIs, assistance from non-byline authors).
- * Funding information (ie, grant numbers or industry support statements) should be disclosed on the title page and in the body text. For industry-sponsored studies, the Role of the Funding Source section should be included in the body text of the manuscript.
- * Include clinical trial registration numbers, PROSPERO registration numbers, or URLs at the end of the abstract (if applicable).
- * Name the IRB or Ethics Committee institution in the Methods section (if applicable).
- * Add any information about the specific location of the study (ie, city, state, or country), if necessary for context.

4. Obstetrics & Gynecology uses an "electronic Copyright Transfer Agreement" (eCTA), which must be completed by all authors. When you uploaded your manuscript, each co-author received an email with the subject, "Please verify your authorship for a submission to Obstetrics & Gynecology." Please check with your coauthors to confirm that they received and completed this form, and that the disclosures listed in their eCTA are included on the manuscript's title page.

5. 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.

6. 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.

7. All studies should follow the principles set forth in the Helsinki Declaration of 1975, as revised in 2013, and manuscripts should be approved by the necessary authority before submission. Applicable original research studies should be reviewed by an institutional review board (IRB) or ethics committee. This review should be documented in your cover letter as well in the Methods section of the body text, with an explanation if the study was considered exempt. If your research is based on a publicly available data set approved by your IRB for exemption, please provide documentation of this in your cover letter by submitting the URL of the IRB website outlining the exempt data sets or a letter from a representative of the IRB. In addition, insert a sentence in the Methods section stating that the study was approved or exempt from approval. In all cases, the complete name of the IRB should be provided in the manuscript.

8. Please submit a completed STROBE checklist.

Responsible reporting of research studies, which includes a complete, transparent, accurate and timely account of what was done and what was found during a research study, is an integral part of good research and publication practice and not an optional extra. Obstetrics & Gynecology supports initiatives aimed at improving the reporting of health research, and we ask authors to follow specific guidelines for reporting randomized controlled trials (ie, CONSORT), observational studies (ie, STROBE), observational studies using ICD-10 data (ie, RECORD), meta-analyses and systematic reviews of randomized controlled trials (ie, PRISMA), harms in systematic reviews (ie, PRISMA for harms), studies of diagnostic accuracy (ie, STARD), meta-analyses and systematic reviews of observational studies (ie, MOOSE), economic evaluations of health interventions (ie, CHEERS), quality improvement in health care studies (ie, SQUIRE 2.0), and studies reporting results of Internet e-surveys (CHERRIES). Include the appropriate checklist for your manuscript type upon submission. Please write or insert the page numbers where each item appears in the margin of the checklist. Further information and links to the checklists are available at <http://ong.editorialmanager.com>. In your cover letter, be sure to indicate that you have followed the CONSORT, MOOSE, PRISMA, PRISMA for harms, STARD, STROBE, RECORD, CHEERS, SQUIRE 2.0, or CHERRIES guidelines, as appropriate.

9. Your study uses ICD-10 data, please make sure you do the following:

- a. State which ICD-10-CM/PCS codes or algorithms were used as Supplemental Digital Content.
- b. Use both the diagnosis and procedure codes.
- c. Verify the selected codes apply for all years of the study.
- d. Conduct sensitivity analyses using definitions based on alternative codes.
- e. For studies incorporating both ICD-9 and ICD-10-CM/PCS codes, the Discussion section should acknowledge there may be disruptions in observed rates related to the coding transition and that coding errors could contribute to limitations of the study. The limitations section should include the implications of using data not created or collected to answer a specific research question, including possible unmeasured confounding, misclassification bias, missing data, and changing participant eligibility over time.
- f. The journal does not require that the title include the name of the database, geographic region or dates, or use of database linkage, but this data should be included in the abstract.
- g. Include RECORD items 6.3 and 7.1, which relate to transparency about which codes, validation method, and linkage were used to identify participants and variables collected.

10. 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.

11. 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 5,500 words. Stated word limits include the title page, précis, abstract, text, tables, boxes, and figure legends, but exclude references.

12. 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).
- * If your manuscript was uploaded to a preprint server prior to submitting your manuscript to Obstetrics & Gynecology, add the following statement to your title page: "Before submission to Obstetrics & Gynecology, this article was posted to a preprint server at: [URL]."

13. 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.

14. Only standard abbreviations and acronyms are allowed. A selected list is available online at <http://edmng.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.

15. Line 100 and elsewhere: 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.

16. 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%).

17. Line 203: 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.

18. 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.

19. 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 references you are citing are still current and available. Check the Clinical Guidance page at <https://www.acog.org/clinical> (click on "Clinical Guidance" at the top). If the reference is still available on the site and isn't listed as "Withdrawn," it's still a current document.

If the reference you are citing has been updated and 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.

20. Figure 1: Please upload as a figure file on Editorial Manager.

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

22. 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>.

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 open access, you will receive an Open Access Publication Charge letter from the Journal's Publisher, Wolters Kluwer, and instructions on how to submit any open access charges. The email will be from publicationservices@copyright.com with the subject line, "Please Submit Your Open Access Article Publication Charge(s)." Please complete payment of the Open Access charges within 48 hours of receipt.

If you choose to revise your manuscript, please submit your revision through Editorial Manager at

<http://ong.editorialmanager.com>. Your manuscript should be uploaded as a Microsoft Word document. 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 Sep 02, 2021, we will assume you wish to withdraw the manuscript from further consideration.

Sincerely,

Dwight J. Rouse, MD, MSPH
Editor-in-Chief

2020 IMPACT FACTOR: 7.661
2020 IMPACT FACTOR RANKING: 3rd out of 83 ob/gyn journals

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REVIEWER COMMENTS:

Reviewer #1: This manuscript describes a retrospective cohort study comparing Pfannenstiel skin incision (PSI) to vertical skin incision (VSI) in morbidly obese patients. The primary outcome was a composite of wound morbidities, as one would expect. The primary outcome was more frequently found in patients with the VSI, with an aOR of 1.62. This was in contrast to the stated hypothesis. The authors also found that the VSI was associated with vertical hysterotomy.

The study was from a single center. Strengths included that the study is fairly large, including over 125 VSI cases. Another is that the patients are said to have been followed for 42 days postpartum.

1. Lines 88 through 91 indicate that data extraction from the data warehouse was not reliable for important components of the study. The authors, however, do not explain what they did to account for this, at least in this section of the Materials and Methods. I assume charts were manually reviewed, as suggested in lines 226-231. Do the authors mean to say that some 4,500 charts were reviewed? If not, how were charts selected for manual review to reduce bias? Please explain.

Thank you for this comment. In lines 108-114, the authors explained that charts were manually reviewed by two groups of research team members. This was also highlighted in lines 272-278.

2. The authors should reference the "previous studies" used for the power calculation in the paragraph in which this is described.

Thank you for this suggestion. The power calculation has been removed from the manuscript as explained below.

3. Can the authors comment on, and perhaps adjust for, the duration of surgery?

Thank you for this comment. Unfortunately, that data point cannot be reliably extracted from the electronic medical record in our system. The authors agree that this would have been an interesting addition to the study, as prolonged operative time could contribute to postoperative wound complications.

4. In my experience certain physicians are more inclined to use a vertical incision. Can the authors comment on this with regard to practice at their institution.

The authors agree with this observation. Our institution does not have a standard policy, type of skin incision is left up to the discretion of the individual physician. This was briefly mentioned in the discussion, but was added to in lines 233-236 and lines 262-267.

5. I feel a bit unsettled regarding the inclusion of more than one cesarean in a given patient. In obese patients, repeat cesarean deliveries can be modestly difficult and lengthy. Are the authors able to stratify according to primary versus repeat cesareans? Why not do this?

Thank you for this suggestion. The authors are unsure whether this reviewer meant that inclusion of a patient who underwent more than one cesarean during the study period could affect results, or whether stratifying all patients in the cohort by primary versus repeat cesarean could affect results. Either way, the authors agree that both could impact our results so both have been addressed below.

A test of interaction was performed to determine whether previous cesarean affected the primary outcome. The results were not statistically significant; therefore, the authors did not proceed with a stratified analysis according to history of previous cesarean. This is not included in the manuscript, however the authors would be happy to include this if the reviewers suggest this addition.

Composite wound morbidity and wound infection were evaluated using a generalized estimated equation to account for patients who underwent more than one cesarean during the study period. This has been included in the manuscript. Wound infection was included in the GEE model in addition to the primary outcome because it accounted for the majority of wound complications; therefore it was the component that was most likely to influence the primary composite outcome.

Reviewer #2:

Summary: This retrospective study compares wound morbidity following cesarean delivery in obese women receiving Pfannenstiel (PSI) and two types of vertical skin incisions (VSIs). The authors hypothesized that PSI would incur more wound complications. However, their results were contradictory to their hypothesis finding that there was an increase in composite wound morbidity among with who underwent VSI. Type of incision for obese patients may be challenging to study in a prospective fashion, therefore a retrospective review is relevant.

1. Interest and Relevance: With concurrently increasing rates of obesity and cesarean delivery in the United States, this article is timely and useful in assessing patient risk for wound complication. Choice of skin incision is important in obstetrical surgery and this article raises important considerations for obstetrical surgeons.

2. Readability/Grammar/Organization: In general, the paper is well written and supported by its references. There are some minor grammatical errors. Each section is well organized with minimal redundancy.

3. Introduction: This section is well written and referenced.

a. Line 68: Would remove "due to this uncertainty" when describing study.

Thank you for this suggestion. This phrase has been removed from the manuscript.

4. Methods: Strengths of this study are found in the methods utilized, including following patients to 42 days postpartum, use of 2 reviewers for extraction of outcomes and exposures to limit collection biases.

a. The authors pointed out that diagnosis codes were missing for many of the women found to have wound complications through a chart review. (as detailed in lines 98-103). On the other hand, if the patient did not receive a diagnostic code is it possible that the authors are over-interpreting their chart review? This should be addressed in the Discussion.

The authors agree that there could be some degree of bias due to assumption with these methods. Unfortunately, relying on diagnostic codes did not capture most of the wound complications; therefore, chart review was necessary. The research team made efforts to minimize bias by following the CDC definition of surgical site infection when reviewing charts to avoid overinterpretation of a chart. (For example: a patient presented to the emergency department with a complaint of abdominal pain. They were found to have a postoperative wound infection according to the CDC's definition, based on the description in the provider's note and they were prescribed antibiotics. The diagnosis code for the visit was "abdominal pain, unspecified". This is a scenario where the diagnosis code failed to capture a wound infection.)

This is discussed in lines 268-278.

b. Clarification should be provided as to why some secondary outcomes were selected (i.e. neonatal outcomes) which are seemingly not related to the study's exposures or outcomes.

Thank you for this comment. The authors selected 5-minute Apgar <7 and NICU admission as neonatal outcomes that act as surrogate markers for difficult delivery. These were selected to detect whether there was a difference in neonatal outcomes based on the type of skin incision at the time of delivery. Previously published studies suggest that, in patients with BMI $\geq 40\text{kg/m}^2$, umbilical artery pH is lower than in non-obese counterparts (ref: Powell MF, Morgan CJ, Cantu JA, Sakawi Y, Biggio JR, Tita ATN, Szychowski JM, Edwards RK. Obesity and Neonatal Cord Blood Gas Results at Cesarean: Effect of Intraoperative Blood Pressure. Am J Perinatol. 2017 Jun;34(7):716-721. doi: 10.1055/s-0036-1597847. Epub 2016 Dec 28. PMID: 28030871.). The authors would have liked to use umbilical artery pH as a surrogate marker for difficult delivery; however, their institution does not routinely collect umbilical cord gases in all deliveries.

c. Lines 111-115: Power analyses are not applicable in retrospective studies, this seems unnecessary. My understanding is that "ad hoc" power analyses should be included in the discussion.

Thank you for this suggestion. The power analysis was removed from the manuscript as it did not add anything for the reader and did not reflect the number of subjects in our study population.

- d. Why were obese women with BMIs in the range of 30-40 not included?

Thank you for this question. The authors did not include patients with BMI 30-40kg/m² because in this group, a Pfannenstiel skin incision is more likely than a vertical skin incision. The authors wanted to study a population that had a high rate of both exposure groups.

5. Results: Overall, well described.
a. Line 151: Would remove "interestingly" from a results section.

This word has been removed.

6. Table 1 [line 290]:
a. What relevance does insurance type have on this study? This is not mentioned in the results or discussion and seems superfluous.
b. It is unclear to this reviewer why race is included in this analysis. Please discuss why this variable was included.

Thank you for these comments. The authors agree that these (insurance status, race) are not variables that should be adjusted for in an analysis because they have no biologic basis to explain an effect on the outcome of interest. These variables have typically been used to describe our patient population and therefore were included in the demographic description of the study population. If the journal would like us to exclude these, we would be happy to remove them.

7. Table 2 [line 295]:
a. 5-minute APGAR and NICU admission do not seem like relevant data to this study's outcomes or exposures and needs further explanation in the manuscript.

Copied from above:

Thank you for this comment. The authors selected 5-minute Apgar <7 and NICU admission as neonatal outcomes that act as surrogate markers for difficult delivery. These were selected to detect whether there was a difference in neonatal outcomes based on the type of skin incision at the time of delivery. Previously published studies suggest that, in patients with BMI ≥ 40 kg/m², umbilical artery pH is lower than in non-obese counterparts (ref: Powell MF, Morgan CJ, Cantu JA, Sakawi Y, Biggio JR, Tita ATN, Szychowski JM, Edwards RK. Obesity and Neonatal Cord Blood Gas Results at Cesarean: Effect of Intraoperative Blood Pressure. Am J Perinatol. 2017 Jun;34(7):716-721. doi: 10.1055/s-0036-1597847. Epub 2016 Dec 28. PMID: 28030871.). The authors would have liked to use umbilical artery pH as a surrogate marker for difficult delivery; however, their institution does not routinely collect umbilical cord gases in all deliveries.

This was further explained in the manuscript in lines 127-130.

- b. The aOR did not consider gestational age which was significantly earlier in the VSI group.

An explanation should be given of why this and other variables were or were not included in the adjusted analyses.

Thank you for this suggestion. The authors have added a sentence to the manuscript regarding the variables that were chosen to adjust for in the adjusted analysis.

c. Vertical hysterotomy is typically a function of gestational age and may be confounded by the VSI study cohort where the gestational ages were lower.

d. A discussion of why vertical hysterotomy was associated with vertical skin incisions is warranted.

Thank you for this suggestion. Discussion of this topic was added to the manuscript in lines 221-228.

8. Table 4 [line 308]:

a. Again, despite being secondary outcomes, 5-minute APGARS and NICU admissions do not seem relevant to either the outcomes or exposures in this study. Furthermore, the sample size is small when stratifying based on BMI therefore conclusions are difficult to make despite statistical significance. Please indicate that small sample sizes in some of the cohorts limits the ability to draw conclusions about exposures.

The authors agree that the sample sizes were small with any stratification. As discussed below, the BMI stratification has been removed from the analysis.

9. Table 5 [line 312]:

a. Sample size is very small when stratified based on IUV/SUV so I would question the ability to make conclusions. Please comment.

Thank you for this comment. The authors agree that the sample size creates limitations. Limitations on the ability to draw conclusions in this stratified analysis are discussed in lines 282-283.

10. Discussion: Appropriately points out that this study is unique in its methods and has one of the largest cohorts of patients studied. Limitations discussed are appropriate as are final discussion of outcomes. Given the small population with VSI it is difficult to draw conclusions regarding differences in the SUV and IUV groups.

Reviewer #3: In this original article, the authors evaluate the association of location of skin incision (Pfannensteil vs. vertical midline) and wound morbidity in women with severe obesity (BMI > = 40) undergoing cesarean delivery. While they hypothesize that PFI will have higher

rates of wound morbidity, they actually find that PFI has a lower rate of wound morbidity; with vertical midline (both types) associated with increased wound morbidity, transfusion, and vertical hysterectomy. The study design is simple and well-executed and the study well-written. Minor comments are described below.

Abstract:

- Lines 31-33. It is unclear at first that this sentence is comparing the rates of vertical hysterectomy for each midline skin incision type. Please clarify

Thank you for drawing this to our attention. This has been removed from the abstract.

Introduction:

- The introduction is very brief and clear. Hypothesis and objectives are clearly stated.

Methods:

- Why did the authors chose pre-pregnancy BMI, given that the exposure (i.e. incision type) is actually at the time of delivery. Qualifications should include delivery BMI. While it is unlikely patients lost weight in pregnancy, the pre-pregnancy BMI choice is curious as it does not reflect the delivery timepoints where the exposure is made.

Thank you for this comment. The authors used prepregnancy BMI in this study as this is the measurement used by ACOG when making recommendations pertaining to pregnancy management and delivery timing (ref: ACOG Practice Bulletin #230, Obesity in Pregnancy, June 2021). Also, BMI at the time of delivery is not readily extractable from our electronic medical record as not all patients have a height, weight, and/or BMI recorded at the time of delivery.

- Lines 81-83: I am unclear what this statement means

Thank you for this comment. This sentence was removed.

- Line 80: I am not sure in the instance of repeat cesarean and wound infection, individual pregnancies can be statistically treated as independent events. They are interrelated and should statistically be considered and treated as so. If not, further justification is required.

The authors agree with this comment. As noted below, a GEE model was utilized to account for repeated measures throughout the study period.

- In the methods, the authors report that data extraction was not valid for the primary outcomes and three important other variables. They thus relied on ICD coding for these variables it seems. This is problematic given the variety of data extraction methods which may not be internally consistent. Also for rare outcomes, ICD9/10 codes are notoriously inaccurate. The authors should report any manual validation to confirm the accuracy of their data extraction techniques. The authors also report in line 107 that there was manual chart review. It needs to be significantly clarified what was done via computer-based algorithmic extraction and what was

performed manually; or if the manual chart review confirmed the extraction. As it stands, the data acquisition is unclear and therefore appears suspect.

Thank you for this comment. The authors agree that the way this was explained in the methods was confusing and it has been further clarified in the manuscript. Initially, all data points were extracted from the electronic medical record via computer-based algorithms. The algorithm included ICD-10 codes for each of the primary outcome components. Upon data validation, the research team noted that the algorithm did not correctly capture 3 independent variables and each of the primary outcome components (as the reviewer mentioned – relying on ICD10 codes proved to be very inaccurate). Charts were then manually reviewed by members of the research team to extract these specific variables. See the revised methods and discussion sections for the authors explanation.

- Line 122: Why are those variables considered and chosen as confounders?

Thank you for this question. The authors have added a sentence to the manuscript regarding the variables that were chosen to adjust for in the adjusted analysis.

- Why were not GEE models utilized given that observations may not be independent for a single individual

Thank you for this suggestion. A GEE model has been utilized to evaluate the primary outcome and this has been added to the manuscript.

Results:

- Lines 142-146 are redundancy considering the statement immediately prior. Referencing the tables should suffice.

Thank you for this suggestion. The authors have made changes to make this paragraph less redundant.

- I am unclear what to make of the BMI strata analysis. There was no significance in either the lower or upper strata and only the middle one (BMI 45-49.99). This could represent statistical error. Alternatively, this analysis could be reduced given the weak association and supplemented with tests of interaction to determine whether stratified analysis is even justified.

The authors agree. A test of interaction was performed to determine whether BMI strata affected the primary outcome. The results were not statistically significant; therefore, the authors removed the stratified analysis according to BMI strata.

- I am unclear what Table 3 adds to the overall study findings

Thank you for this comment. The authors feel that Table 3 is important because it represents the aORs for variables included in the traditional logistic regression model. If the journal prefers that we remove this table, the authors would be happy to do so.

Discussions

- I am not sure if following patients through the PP period is unique as the majority of studies evaluate up to 6 weeks postpartum

Thank you for this comment. While most studies do follow patients up to 6 weeks postpartum, some only followed patients during their hospital admission (3-5 days postpartum). The authors feel this study is unique due to its size, classification of VSI (IUV vs SUV), and the fact that patients were followed to 42 days postpartum.

- Given the accuracy or lack thereof described the methods, how accurate were locations of the VSI classified as SUV vs IUV. How were paramedic incisions classified?

There were a total of 139 VSI in the study. Of those, 28 were unknown whether they were IUV or SUV and they were excluded from the stratified analysis. This is noted in the caption of Table 4. Paramedian incisions were classified as SUV if they were documented in the operative note as such.

- The limitations adequately address the limitations in the study

STATISTICAL EDITOR COMMENTS:

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

Table 1: Clearly, the women who had VSI were heavier, older, more likely smokers, have DM, so more risk factors for adverse outcomes. Given the large number of PSI women vs VSI, should have matched to verify the adjustment model.

Thank you for this suggestion. Matching has been performed to verify the adjustment model and this has been included in the manuscript. Results for both matching and propensity score matching were similar.

Table 2: Need to round all %s to nearest 0.1% precision, not cite to 0.01% precision. The higher rates of NICU admission are likely related to the earlier delivery GAs. The p-values are redundant, since CIs are included for ORs and aORs.

Thank you for this comment. The table has been edited with the following: all %s rounded to 0.1% precision, p-values have been removed, primary and secondary outcomes have been more clearly separated. Please note that the tracked changes were removed from this table so that the reviewers could interpret the table more clearly, as the changes we made significantly affected the formatting of the table.

Table 3: Need to clearly separate the primary from secondary outcomes. Need units for age. P-values are redundant, column should be omitted.

Thank you for these comments. The table has been edited with the following: all %s rounded to 0.1% precision, p-values have been removed. Please note that the tracked changes were removed from this table so that the reviewers could interpret the table more clearly, as the changes we made significantly affected the formatting of the table.

Table 4: Again, the primary should be separated clearly from the secondary outcomes, the columns of p-values are redundant and the counts in subsets and by outcomes become fewer, thus limiting stats power to discern and thus generalize the NS comparisons. On the other hand, likely the multivariable adjustment models are over fitted as well.

Table 4 was removed as discussed above.

Table 5: Same issues as with Table 4.

Thank you for this comment. The table has been edited with the following: all %s rounded to 0.1% precision, p-values have been removed, primary and secondary outcomes have been more clearly separated. Please note that the tracked changes were removed from this table so that the reviewers could interpret the table more clearly, as the changes we made significantly affected the formatting of the table.

EDITOR COMMENTS:

1. We would be happy to consider a revised manuscript that uses matching to control for the imbalance in important characteristics between groups.

Thank you for this suggestion. Matching has been performed to verify the adjustment model and this has been included in the manuscript.

2. The Editors of Obstetrics & Gynecology have increased 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.

3. When you submit your revised manuscript, please make the following edits to ensure your

submission contains the required information that was previously omitted for the initial double-blind peer review:

- * Include your title page information in the main manuscript file. The title page should appear as the first page of the document. Add any previously omitted Acknowledgements (ie, meeting presentations, preprint DOIs, assistance from non-byline authors).
- * Funding information (ie, grant numbers or industry support statements) should be disclosed on the title page and in the body text. For industry-sponsored studies, the Role of the Funding Source section should be included in the body text of the manuscript.
- * Include clinical trial registration numbers, PROSPERO registration numbers, or URLs at the end of the abstract (if applicable).
- * Name the IRB or Ethics Committee institution in the Methods section (if applicable).
- * Add any information about the specific location of the study (ie, city, state, or country), if necessary for context.

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4. Obstetrics & Gynecology uses an "electronic Copyright Transfer Agreement" (eCTA), which must be completed by all authors. When you uploaded your manuscript, each co-author received an email with the subject, "Please verify your authorship for a submission to Obstetrics & Gynecology." Please check with your coauthors to confirm that they received and completed this form, and that the disclosures listed in their eCTA are included on the manuscript's title page.

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5. 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.

Thank you for drawing this to our attention. Race, as documented in our electronic medical record, is self-identified. This has been added to table 1. "Other" has been removed from table 1.

6. 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 study did not use a database. Data was extracted directly from the electronic medical record and entered into the study documents. The data that was extracted using computer-based algorithms was reviewed by members of the research team to determine whether the data points were extracted correctly.

7. All studies should follow the principles set forth in the Helsinki Declaration of 1975, as revised in 2013, and manuscripts should be approved by the necessary authority before submission. Applicable original research studies should be reviewed by an institutional review board (IRB) or ethics committee. This review should be documented in your cover letter as well in the Methods section of the body text, with an explanation if the study was considered exempt. If your research is based on a publicly available data set approved by your IRB for exemption, please provide documentation of this in your cover letter by submitting the URL of the IRB website outlining the exempt data sets or a letter from a representative of the IRB. In addition, insert a sentence in the Methods section stating that the study was approved or exempt from approval. In all cases, the complete name of the IRB should be provided in the manuscript.

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8. Please submit a completed STROBE checklist.

Responsible reporting of research studies, which includes a complete, transparent, accurate and timely account of what was done and what was found during a research study, is an integral part of good research and publication practice and not an optional extra. Obstetrics & Gynecology supports initiatives aimed at improving the reporting of health research, and we ask authors to follow specific guidelines for reporting randomized controlled trials (ie, CONSORT), observational studies (ie, STROBE), observational studies using ICD-10 data (ie, RECORD), meta-analyses and systematic reviews of randomized controlled trials (ie, PRISMA), harms in systematic reviews (ie, PRISMA for harms), studies of diagnostic accuracy (ie, STARD), meta-analyses and systematic reviews of observational studies (ie, MOOSE), economic evaluations of health interventions (ie, CHEERS), quality improvement in health care studies (ie, SQUIRE 2.0), and studies reporting results of Internet e-surveys (CHERRIES). Include the appropriate checklist for your manuscript type upon submission. Please write or insert the page numbers where each item appears in the margin of the checklist. Further information and links to the checklists are available at <http://ong.editorialmanager.com>. In your cover letter, be sure to indicate that you have followed the CONSORT, MOOSE, PRISMA, PRISMA for harms, STARD, STROBE, RECORD, CHEERS, SQUIRE 2.0, or CHERRIES guidelines, as appropriate.

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9. Your study uses ICD-10 data, please make sure you do the following:

- a. State which ICD-10-CM/PCS codes or algorithms were used as Supplemental Digital Content.
- b. Use both the diagnosis and procedure codes.
- c. Verify the selected codes apply for all years of the study.
- d. Conduct sensitivity analyses using definitions based on alternative codes.
- e. For studies incorporating both ICD-9 and ICD-10-CM/PCS codes, the Discussion section should acknowledge there may be disruptions in observed rates related to the coding transition and that coding errors could contribute to limitations of the study. The limitations section should include the implications of using data not created or collected to answer a specific research question, including possible unmeasured confounding, misclassification bias, missing data, and changing participant eligibility over time.
- f. The journal does not require that the title include the name of the database, geographic region or dates, or use of database linkage, but this data should be included in the abstract.
- g. Include RECORD items 6.3 and 7.1, which relate to transparency about which codes, validation method, and linkage were used to identify participants and variables collected.

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Please again note that this study did not rely on ICD10 codes to capture the outcomes of interest because it was recognized after data points were extracted from the chart that ICD10 codes were not reliable. If a patient had an ICD10 code consistent with the outcomes of interest (wound infection, separation, or dehiscence), that outcome was considered to be present. However, all charts were manually reviewed to determine whether the outcomes of interest were present and therefore the outcome data did not rely on ICD10 codes. The ICD10 codes used have been uploaded into the submission as a separate file, however the authors hope not to include them in publication of this manuscript because inclusion of this list of ICD10 codes could cause confusion to a reader about the methods of this study.

If the journal would rather the authors exclude any mention of ICD10 codes altogether because all charts were eventually manually reviewed, the authors would be happy to make those changes.

10. 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.

The authors have reviewed the obstetric reVITALize definitions and can confirm that they are consistent with the terminology used in the manuscript.

11. 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 5,500 words. Stated word limits include the title page, précis, abstract, text, tables, boxes, and figure legends, but exclude references.

The revised manuscript is less than 5,500 words.

12. 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.
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- * If your manuscript was uploaded to a preprint server prior to submitting your manuscript to Obstetrics & Gynecology, add the following statement to your title page: "Before submission to Obstetrics & Gynecology, this article was posted to a preprint server at: [URL]."

13. 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.

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In addition, the abstract length should follow journal guidelines. The word limit for Original Research articles is 300 words. Please provide a word count.

The abstract word count has been added to the end of the abstract.

14. 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.

15. Line 100 and elsewhere: The journal does not use the virgule symbol (/) in sentences with words. Please rephrase your text to avoid using "and/or," or similar constructions throughout the text. You may retain this symbol if you are using it to express data or a measurement.

This / has been removed.

16. 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%).

Thank you for this suggestion. The authors have standardized presentation of data. P-values were removed from tables when 95%CI was also presented to avoid redundancy. Throughout the abstract, manuscript, and tables, p-values do not exceed three decimal places and percentages do not exceed one decimal place.

17. Line 203: 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.

This has been changed in the manuscript.

18. 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.

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19. 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.

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If the reference you are citing has been updated and 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.

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20. Figure 1: Please upload as a figure file on Editorial Manager.

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

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