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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.*

Personal or nonessential information may be redacted at the editor's discretion.

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

Date: Jul 07, 2022
To: "Braxton Forde" [redacted]
From: "The Green Journal" em@greenjournal.org
Subject: Your Submission ONG-22-988

RE: Manuscript Number ONG-22-988

Pregnancy outcomes following previable and periviable rupture of membranes after treatment of twin-twin transfusion syndrome

Dear Dr. Forde:

Thank you for sending us your work for consideration for publication in Obstetrics & Gynecology. Your manuscript has been reviewed by the Editorial Board and by special expert referees. The Editors would like to invite you to submit a revised version for further consideration.

If you wish to revise your manuscript, please read the following comments submitted by the reviewers and Editors. Each point raised requires a response, by either revising your manuscript or making a clear argument as to why no revision is needed in the cover letter.

To facilitate our review, we prefer that the cover letter you submit with your revised manuscript include each reviewer and Editor comment below, followed by your response. That is, a point-by-point response is required to each of the EDITOR COMMENTS (if applicable), REVIEWER COMMENTS, STATISTICAL EDITOR COMMENTS (if applicable), and EDITORIAL OFFICE COMMENTS below. Your manuscript will be returned to you if a point-by-point response to each of these sections is not included.

The revised manuscript should indicate the position of all changes made. Please use the "track changes" feature in your document (do not use strikethrough or underline formatting).

Your submission will be maintained in active status for 21 days from the date of this letter. If we have not heard from you by Jul 28, 2022, we will assume you wish to withdraw the manuscript from further consideration.

REVIEWER COMMENTS:

Reviewer #1: Membrane rupture is one of the most common complications of fetal therapy procedures and is a significant source of morbidity in TTTS. In this single-center retrospective review of pregnancies treated with SFLP for TTTS, the authors evaluated latency rates and loss rates following rupture of membranes at 16 to 26 weeks.

Comments and questions follow.
1. General comments.
a. The study has just 2 outcome variables: latency (from ROM to delivery) and neonatal survival to hospital discharge. It is anticipated that latency correlates with neonatal survival and presumably with various neonatal morbidities, and such information would be helpful for counseling. The paper would be strengthened by reporting fetal and neonatal death separately and by including selected morbidities such as RDS, BPD, IVH, or sepsis.
b. The authors have focused on rupture of membranes at 16-26 weeks, the same gestational age range at which SFLP for TTTS is generally offered, but they haven't considered disease severity. Guidelines recommend surveillance for TTTS at least every 2 weeks with the understanding that when SFLP is needed, it must be performed urgently. A pregnancy needing SFLP at 16 weeks is at greater risk than a pregnancy needing SFLP at e.g. 24 weeks (and presumably unlikely survive until 24 weeks had the procedure not been performed). PROM occurring earlier indicates an a-priori higher risk because the severity of TTTS required SFLP earlier in gestation. The gestational age at which SFLP is performed also affects the opportunity for PROM, because the authors only studied PROM following SFLP. Please address these confounding variables.

2. Abstract.
a. How did you handle fetal death when analyzing the data? Also applies to the body of the manuscript.
b. It is not necessary to list the gestational age intervals in the abstract methods, as you have listed them 3 times in the abstract results.
c. Rather than writing that eg 14 (2%) experienced PROM at 16-19 weeks, might express the % using for the denominator the number that underwent SPLC between 16 and 19 weeks and thus had an opportunity for post-procedure

PROM. This applies to the body of the manuscript as well.
d. If analyzing data according to whether a woman did or did not deliver within 48 hours of PROM as a function of gestational age, it would be helpful to report how many pregnancies did and did not deliver within 48 hours of PROM (overall), because you are presenting percentages without Ns. The reader has no basis to determine how small numbers are in each subset. This directly applies to the 2nd part of the conclusion.
e. The last sentence of the results is a comparison of percentages describing an increase in survival but without a p-value. Please include one. According to the data in Table 2, this comparison is not statistically significant. Thus it is not appropriate to report as an increase.

3. Introduction.
a. 2nd sentence. The diagnosis of TTTS is based on oligohydramnios in 1 sac and hydramnios in the other sac. The other criteria listed are relevant for staging only after the diagnosis has been made. This is described correctly in the methods but is confusing as presented here. May want to reference the ACOG Practice Bulletin or documents from SMFM or NAFTNet.
b. 3rd sentence. Would verify that the high mortality rate quoted is for all TTTS (as stated) rather than for severe TTTS.
c. Objective (2nd paragraph, last sentence). Suggest revising the objective to more explicitly convey what you studied. For example, might clarify e.g. that you studied pregnancies with rupture of membranes between 16 and 26 weeks and evaluated neonatal survival rates according to gestational age at membrane rupture. As stated the reader might think that you compared previable ROM with periviable ROM or that you studied other outcomes.

4. Methods.
a. Suggest defining previable and periviable (separately). This phrase is used throughout the manuscript.
b. Was it your practice to offer termination of pregnancy until 26 weeks? This appears to be what you are saying in the methods.
c. Were all procedures successful, or was procedural success an inclusion criterion? How did you address rupture of membanes in the setting of other complications such as fetal death, preterm labor prior to ROM, or placental abruption? Were pregnancies with these complications included or excluded? Did you look at disease progression?
d. In how many pregnancies did you perform an amnio-dye test after rupture of membranes? If none, suggest removing this statement with the understanding that this might confer increased risk in an already very-at-risk situation. What dye did you use?
e. As above (1b), would include something about why you performed SFLP when you did, considering the urgency at which affected pregnancies are often referred and the spectrum of presentation within the 10-week window at which SFLP was offered.

5. Results/Tables
a. One of the outcomes you describe in the 2nd paragraph of the results is PROM within 7 days of surgery. Would include this in the methods. What is the rationale for the 7-day cut-off?
b. Are you able to stratify by TTTS stage?
c. In the bottom section of Table 2 (latency > 48 hours), the mean gestational age at delivery was 26 weeks in those with PROM <23 weeks and was 31 weeks in those with PROM >=/26 weeks. This 5-week difference is clinically relevant, so if not statistically significant please address power.

6. Discussion.
a. Would avoid restating numerical results, e.g. in the opening paragraph of the discussion.
b. Do you have any counseling recommendations based on your findings?
c. The content of the discussion might be streamlined. The 2nd to last page is somewhat redundant.

Reviewer #2: Authors performed a retrospective cohort study over a 9+-year period (2010-2019) comparing pregnancy outcomes in patients who underwent SFLP for TTTS and experienced PROM < 26 weeks to PROM > 26 weeks. The primary outcome was infant survival to NICU discharge. Secondary outcomes included gestational age and delivery, and latency from rupture to delivery.

Title: Recommend authors consider a more specific in title about what "treatment" means. For example, Comparison of Pregnancy Outcomes of Pre- and Periviable Rupture of Membranes after Laser Photocoagulation for TTTS.

Precis: It is not clear what authors mean by "iatrogenic PROM", if this is an assumption that the surgery caused the PROM.

Abstract: Line 48 Recommend authors be clear on primary and secondary outcomes.
Recommend reporting result of primary outcome first (infant survival to NICU discharge between <26 weeks and >26 weeks). Authors can then report secondary outcomes. Line 49-50 Also include secondary outcome stratified by pregnant > 48 hours. Line 60-61 Recommend word smithing: "is associated with longer latency but lower rates of survival." Line 62 "or PROM less than 26 weeks" instead or "previable PROM" (to include peri- and previable).

Introduction: Line 78-79 Awkward start to the manuscript/wording. Recommend deleting "Due to shared placental

vasculature and imbalances in blood flow…" The authors do a good job of developing a sound introduction, defining why this research question is important to study given that the existing body of evidence clinical outcomes after pre and periviable PROM in this cohort.

Materials and Methods: Study design is appropriate to study associations between infant survival to NICU discharge and timing of premature rupture of membranes following laser photocoagulation for TTTS.

Line 105 Recommend defining limits of PROM, for example between >16+0 weeks to 33+6 weeks)

Line 108-112 Please comment whether there were any changes to "standard of care management" over the time period of this study

Line 112-114 At what lower gestational age limit is betamethasone offered in your institution, and has this changed over the study period?

Line 118-120 Did any of the patients reseal after PROM? If so, was this an exclusion criteria? Were patients excluded if one or both of the twins had anomalies or aneuploidy? Were they excluded if they had cervical cerclage? Please be very detailed about eligibility for laser photocoagulation. Where they excluded if there was a demise of one twin following laser?

Line 125-26 What multiples of the median cut-offs were used for abnormal?

Line 136-137 Recommend discussing secondary outcome of at least 48 hours of latency as well.

Line 139-140 Baseline demographics did not include history of spontaneous preterm birth or PPROM, other medical comorbidities other than BMI, socioeconomic status which could be confounders in this study.

For this type of clinical study, unadjusted estimates and, if applicable, confounder-adjusted estimates and their precision (eg, 95% confidence interval) would be more relevant to the reader.

Discuss if there a plan to adjust for confounders? If so make clear which confounders were adjusted for and why they were included.

Did any of the patients have delayed interval delivery of fetus B? If so, how did the authors handle these patients in the study?

Did any patients require more than one laser? If so, how were they handled in the study?

Were any patients treatment failures following laser, e.g. persistent TTTS? Did any develop TAPS following laser?

No STROBE checklist included.

Results:
Line 153-156 Recommend flow diagram

Line 177-178 I am confused why this was necessary if PROM definition is for prelabor patients? Did authors think some of these patients had intrapartum rupture of membranes that was misclassified?

Line 188-189 What are "patient-friendly graphs"?

Discussion:
Line 200, 201-202 The wording "labor-associated PROM" is confusing if authors are consistently defining PROM as prelabor rupture of membranes in their manuscript.

Line 216-218 Authors introduce new concepts of "iatrogenic PROM" and "PROM associated with preterm labor" in the discussion. If this is something they sought to differentiate, please distinguish these two entities very cleary in background and methods.

Line 219-220 Can authors find references to and compare rate for PROM in mo/di twins without TTTS instead?

Line 221-223 Maternal outcomes are not explored in this paper. I would caution authors to avoid concluding it is "reasonable" to offer expectant management based on this study without knowing more about maternal outcomes in this cohort.

Figures and Tables:
Table 1: are these standard deviations or 95% CI? If CI, why are the estimates not included?

Reviewer #3: Thank you for this important retrospective cohort of 250 patients with PPROM after laser photocoagulation for TTTS, with a focus on those with PROM < 26 weeks. This is an important contribution to literature and to patient care. I have minimal feedback. I especially find the graphical representations in Figures 1 and 2 useful for clinical practice.

Results, general feedback: at times, your many subdivisions of the patients became confusing. Consider a study flow diagram to ensure readers can keep up.

Line 172: suggest placing the R^2 = 0.26 in parentheses for readability

Line 245 and line 268: suggest avoiding first person use of "we"

Line 188: you high rates of survival of >= 1 neonate in all groups (circa 80-100%) except in patients who experienced PROM between 20w0d - 22w6d. Can you comment on this in your discussion? This may be related to bias from small sample size, or teams handling these cases differently.

Could you address the timing of steroid administration for cases admitted before 23 weeks? If you have this data, then the paper may be strengthened by mentioning any granular description of which twin pairs received BMZ and were steroid complete at delivery.

STATISTICAL EDITOR COMMENTS:

Table 1: Need units for BMI.

Table 2: Since the groups were defined by GA strata at PROM, should not statistically test for a non-random difference among GA at PROM. It is predetermined by the definition of the columns to be non-random. Therefore, should omit the p-value for that row. Also, should state in footnote to Table whether the p-value is evaluating a trend across PROM GA strata or simply evaluating whether the allocation of data is non-random, to avoid confusing the reader.

Tables 1, 2: Need to enumerate all missing data, either in Tables or in footnotes to Tables.

Figs 1, 2: Should include CIs for the histograms (survival of ≥1 vs 2 infants among each twin set).

General: Since this study includes births from 2010 to 2019, was there any association between year of study and survival rate? That is, what were the results of the linear regression analysis if year of study were included as a "predictor"?

EDITORIAL OFFICE COMMENTS:

1. If your article is accepted, the journal will publish a copy of this revision letter and your point-by-point responses as supplemental digital content to the published article online. You may opt out by writing separately to the Editorial Office at em@greenjournal.org, and only the revision letter will be posted.

2. 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:
* Funding information (ie, grant numbers or industry support statements) should be disclosed on the title page and at the end of the abstract. For industry-sponsored studies, describe on the title page how the funder was or was not involved in the study.
* 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.

3. Obstetrics & Gynecology's Copyright Transfer Agreement (CTA) must be completed by all authors. When you uploaded your manuscript, each coauthor received an email with the subject, "Please verify your authorship for a submission to Obstetrics & Gynecology." Please ask your coauthor(s) to complete this form, and confirm the disclosures listed in their CTA are included on the manuscript's title page. If they did not receive the email, they should check their spam/junk folder. Requests to resend the CTA may be sent to em@greenjournal.org.

4. 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, describe the reasons that race and ethnicity were assessed in the Methods section and/or in table footnotes. Race and 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.

List racial and ethnic categories in tables in alphabetic order. Do not use "Other" as a category; use "None of the above" instead.

Please refer to "Reporting Race and Ethnicity in Obstetrics & Gynecology" at https://edmgr.ovid.com/ong/accounts/Race_and_Ethnicity.pdf.

5. ACOG uses person-first language. Please review your submission to make sure to center the person before anything else. Examples include: "People with disabilities" or "women with disabilities" instead of "disabled people" or "disabled women"; "patients with HIV" or "women with HIV" instead of "HIV-positive patients" or "HIV-positive women"; and "people who are blind" or "women who are blind" instead of "blind people" or "blind women."

6. The journal follows ACOG's Statement of Policy on Inclusive Language (https://www.acog.org/clinical-information/policy-and-position-statements/statements-of-policy/2022/inclusive-language). When possible, please avoid using gendered descriptors in your manuscript. Instead of "women" and "females," consider using the following: "individuals;" "patients;" "participants;" "people" (not "persons"); "women and transgender men;" "women and gender-expansive patients;" or "women and all those seeking gynecologic care."

7. 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:

STROBE: observational studies

Include the appropriate checklist for your manuscript type upon submission, if applicable, and indicate in your cover letter which guideline you have followed. 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 www.equator-network.org/.

8. 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.

9. Make sure your manuscript meets the following word limit. The word limit includes the manuscript body text only (for example, the Introduction through the Discussion in Original Research manuscripts), and excludes the title page, précis, abstract, tables, boxes, and figure legends, reference list, and supplemental digital content. Figures are not included in the word count.

Original Research: 3,000 words

10. Specific rules govern the use of acknowledgments in the journal. Please review the following guidelines and edit your title page as needed:

* 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 or indicate whether the meeting was held virtually).
* 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]."

* Do not use only authors' initials in the acknowledgement or Financial Disclosure; spell out their names the way they appear in the byline.

11. Provide a short title of no more than 45 characters, including spaces, for use as a running foot. Do not start the running title with an abbreviation.

12. Be sure that each statement and any data in the abstract are also stated in the body of your manuscript, tables, or figures. Statements and data that appear in the abstract must also appear in the body text for consistency. Make 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 manuscript.

In addition, the abstract length should follow journal guidelines. Please provide a word count.

Original Research: 300 words

13. 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.

14. The journal does not use the virgule symbol (/) in sentences with words, except with ratios. 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.

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

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.

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

Express all percentages to one decimal place (for example, 11.1%"). Do not use whole numbers for percentages.

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

18. Please review examples of our current reference style at https://edmgr.ovid.com/ong/accounts/ifa_suppl_refstyle.pdf. 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 formal reference list. Please cite them on the line in parentheses.

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. In most cases, if an ACOG document has been withdrawn, it should not be referenced in your manuscript.

Please make sure your references are numbered in order of appearance in the text.

19. Figures 1 and 2 may be resubmitted with the revision as-is.

20. 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.

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

http://ong.editorialmanager.com. Your manuscript should be uploaded as a Microsoft Word document. Your revision's cover letter should include a point-by-point response to each of the received comments in this letter. Do not omit your responses to the EDITOR COMMENTS (if applicable), the REVIEWER COMMENTS, the STATISTICAL EDITOR COMMENTS (if applicable), or the EDITORIAL OFFICE COMMENTS.

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

Again, your manuscript will be maintained in active status for 21 days from the date of this letter. If we have not heard from you by Jul 28, 2022, we will assume you wish to withdraw the manuscript from further consideration.

Sincerely,

Torri D. Metz, MD, MS
Associate Editor, Obstetrics

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

_____

7/27/2022

Re: Submission of manuscript, "Comparison of Pregnancy Outcomes of Pre- and Periviable Rupture of Membranes after Laser Photocoagulation for TTTS"

The Editors
Obstetrics & Gynecology
409 12th Street, SW
Washington, DC 20024-2118

Dear Editors:

Thank you for the thought-provoking commentary and feedback. I have attempted to address this thoroughly. Please refer to my answers below in red as well as the updated manuscript. Thank you very much for your time.

Sincerely,

Braxton Forde, MD
Division of Maternal-Fetal Medicine
Department of Obstetrics and Gynecology, University of Cincinnati College of Medicine
[redacted]

REVIEWER COMMENTS:

Reviewer #1: Membrane rupture is one of the most common complications of fetal therapy procedures and is a significant source of morbidity in TTTS. In this single-center retrospective review of pregnancies treated with SFLP for TTTS, the authors evaluated latency rates and loss rates following rupture of membranes at 16 to 26 weeks.

Comments and questions follow.

1. General comments.

a. The study has just 2 outcome variables: latency (from ROM to delivery) and neonatal survival to hospital discharge. It is anticipated that latency correlates with neonatal survival and presumably with various neonatal morbidities, and such information would be helpful for

counseling. The paper would be strengthened by reporting fetal and neonatal death separately and by including selected morbidities such as RDS, BPD, IVH, or sepsis.

I will include rates of sepsis, RDS, IVH, NEC for all deliveries <26 weeks and attach as a supplement. Thank you. I will also report the fetal deaths in table 2.

b. The authors have focused on rupture of membranes at 16-26 weeks, the same gestational age range at which SFLP for TTTS is generally offered, but they haven't considered disease severity. Guidelines recommend surveillance for TTTS at least every 2 weeks with the understanding that when SFLP is needed, it must be performed urgently. A pregnancy needing SFLP at 16 weeks is at greater risk than a pregnancy needing SFLP at e.g. 24 weeks (and presumably unlikely survive until 24 weeks had the procedure not been performed). PROM occurring earlier indicates an a-priori higher risk because the severity of TTTS required SFLP earlier in gestation. The gestational age at which SFLP is performed also affects the opportunity for PROM, because the authors only studied PROM following SFLP. Please address these confounding variables.

Completely agree, however due to low N when each group is stratified, I hesitate to perform adjustment for stage at the time of surgery. Furthermore, as we hope this helps guide practice, we wanted to give the raw outcomes so that when a patient presents in those various settings, they could be counseled regarding neonatal management. For more clarity, in a supplemental table attached, I have listed more detail regarding the preoperative indication for surgery, cervical length preoperatively, etc. An interesting and ongoing study within our group is an evaluation of the latency from surgery to delivery in the setting of various gestational ages and preoperative considerations at those gestational ages which might contribute to prolonged latency so that we may better counsel patients preoperatively. I did change the discussion to include a discussion of TTTS severity and outcomes. Thank you.

2. Abstract.

a. How did you handle fetal death when analyzing the data? Also applies to the body of the manuscript.

Fetal death was factored into the survival data. For example, if a patient underwent FLP, had a donor demise postoperatively, and then subsequently experienced PROM, with a recipient survival to NICU discharge, the survival to NICU discharge was recorded 1 of 2 infants.

b. It is not necessary to list the gestational age intervals in the abstract methods, as you have listed them 3 times in the abstract results.

Changed, thank you.

c. Rather than writing that eg 14 (2%) experienced PROM at 16-19 weeks, might express the % using for the denominator the number that underwent SPLC between 16 and 19 weeks and thus had an opportunity for post-procedure PROM. This applies to the body of the manuscript as well.

Thank you for the suggestion but I hesitate to do this as it would only be accurate for the 16-19+6 group and changes the study design as this was a cohort study only of patients that experienced rupture of membranes after fetoscopic laser photocoagulation. This was why we included the number of cases in which rupture of membranes occurred within 1 week of surgery to give the reader an idea of the immediate postoperative risk. Expressing PROM as a rate relative to time of surgery is a somewhat different study, since as gestational ages progress in this study until delivery, the total number of patients able to break their water increases, thus presenting the data as a fraction of which patients have had their laser during that time window does not give an accurate risk of ruptured membranes. A different but interesting study would be to investigate the risk of rupture in a pregnancy when fetoscopy occurs at 16 weeks, 17 weeks, etc and to compare those risks, which I certainly will be doing after this very thought-provoking suggestion. I am happy however to give you the numbers for the lasers done in each group.

660 completed fetoscopic lasers completed in twins for TTTS. 7 documented cases of either significant fetal anomalies expected to severely impact postnatal outcomes (i.e. CDH, ductal dependent cardiac lesion, anencephaly) and aneuploidy. 250/653 lasers experienced rupture of membranes between 16-37 weeks.

Of the 653, 271 were performed between 16-19+6 weeks, 246 between 20-22+6, 114 between 23-25+6, and 22 at ≥ 26 weeks.

d. If analyzing data according to whether a woman did or did not deliver within 48 hours of PROM as a function of gestational age, it would be helpful to report how many pregnancies did and did not deliver within 48 hours of PROM (overall), because you are presenting percentages without Ns. The reader has no basis to determine how small numbers are in each subset. This directly applies to the 2nd part of the conclusion.

This has been changed, thank you.

e. The last sentence of the results is a comparison of percentages describing an increase in survival but without a p-value. Please include one. According to the data in Table 2, this comparison is not statistically significant. Thus it is not appropriate to report as an increase.

The test in Table 2 that does not reach significance is an analysis of survival of 2 infants specifically between groups with rupture of membranes at the various gestational age categories when latency lasted > 48 hours. Differences were statistically significant between all 4 groups in all other survivor categories.

To fix this and present the data as objectively as possible, I have removed the word increase. My reasoning is as follows: The comment regarding increase is that the survival in each group increased when latency was at least 48 hours. I hesitate to place a p value here as this is not a fair comparison for tests of significance because there is bias in the fact that the second group is the first group, however with a smaller denominator and the benefit of time. For example, as latency must be > 48 hours in the 16-19+6 group for survival to even be possible, it is biased to compare outcomes such as survival between the two groups.

3. Introduction.

a. 2nd sentence. The diagnosis of TTTS is based on oligohydramnios in 1 sac and hydramnios in the other sac. The other criteria listed are relevant for staging only after the diagnosis has been made. This is described correctly in the methods but is confusing as presented here. May want to reference the ACOG Practice Bulletin or documents from SMFM or NAFTNet.

This has been corrected for clarity. Thank you.

b. 3rd sentence. Would verify that the high mortality rate quoted is for all TTTS (as stated) rather than for severe TTTS.

Some of the notation for outcomes regarding TTTS depends upon the study quoted and the time of presentation. I am happy to amend the comment for clarity. For furth discussion regarding outcomes: The seminal paper in TTTS, by Senat et al in NEJM in 2004 does quote previous studies showing 90% mortality in severe TTTS, citing a paper written by Haverkamp et al in 2001. That Haverkamp paper notes an overall mortality of 70% with TTTS in the literature, however in their study, they found with TTTS diagnosed at any point in a pregnancy, there was a 48% mortality rate and of survivors, 30% with significant neurological abnormality. When presenting in the mid trimester, however, Stage 1 TTTS is associated with a 30% regression. When presenting in the mid trimester, progressive TTTS untreated carries a 90-100% mortality. I have attached an additional reference below with 75% fetal/neonatal death with expectant management (including no amnioreduction) of TTTS. I have changed the documentation to hopefully make the introduction more clear.

Berghella V, Kaufmann M. Natural history of twin-twin transfusion syndrome. *J Reprod Med*. 2001;46(5):480-484.

c. Objective (2nd paragraph, last sentence). Suggest revising the objective to more explicitly

convey what you studied. For example, might clarify e.g. that you studied pregnancies with rupture of membranes between 16 and 26 weeks and evaluated neonatal survival rates according to gestational age at membrane rupture. As stated the reader might think that you compared previable ROM with periviable ROM or that you studied other outcomes.

Corrected, thank you.

4. Methods.
a. Suggest defining previable and periviable (separately). This phrase is used throughout the manuscript.

Done, thank you.

b. Was it your practice to offer termination of pregnancy until 26 weeks? This appears to be what you are saying in the methods.

Sorry, this was unclear. As per Ohio law at that time, termination was offered up to 21 weeks, 6 days, and this has been corrected in the manuscript.

c. Were all procedures successful, or was procedural success an inclusion criterion? How did you address rupture of membanes in the setting of other complications such as fetal death, preterm labor prior to ROM, or placental abruption? Were pregnancies with these complications included or excluded? Did you look at disease progression?

Only cases in which laser was completed were included in the analysis. Cases in which diagnostic fetoscopy was performed and laser deemed un-feasible were excluded. Any cases with fetal death, either at the time of surgery or subsequently, were included in the analysis. As this was a retrospective review with documents often provided by outside hospitals, it was sometimes difficult to adequately capture preterm labor prior to rupture of membranes. This is why the separate analysis of patients with latency of a minimum of 48 hours after PROM was performed, as we suspected that labor proceeding rupture of membranes would be a progressive process. All cases with abruption were included. As placental abruption cannot be diagnosed via imaging and the confirmation of the presence or absence of placental abruption is noted at the time of delivery we could not exclude any cases in which a placental abruption occurred. As PROM would have occurred prior to documentation of abruption and because PROM itself is a very significant risk factor for abruption, it is not clear if the laser led to abruption which led to PROM, or the PROM itself led to abruption. Interestingly, in the cases with PROM prior to 26 weeks, the rate of placental abruption was 9/81, 11%, which is higher than what is reported in the literature (<5%) and higher than in our referent group with PROM ≥26 weeks (abruption was noted in 11/169, 6.5% of cases). I am happy to include this in the final manuscript, please let me know. Any case with progression or recurrence of TTTS was still included in the analysis, though no cases of TTTS recurrence were noted in the cases in which PROM occurred prior to 26 weeks.

Regarding repeat procedures, there was 1 repeat laser for TAPS. There was 1 additional case of postoperative TAPS which did not undergo laser. There was 1 case with inability to complete the laser, with subsequent follow up laser and completion. There was 1 case with progressive TTTS after laser but this occurred at 28 weeks and the patient was managed with amnioreduction and subsequently experienced rupture of membranes. Patients that underwent diagnostic fetoscopy alone were not included in the analysis as this was a study of patients that underwent laser photocoagulation.

d. In how many pregnancies did you perform an amnio-dye test after rupture of membranes? If none, suggest removing this statement with the understanding that this might confer increased risk in an already very-at-risk situation. What dye did you use?

I apologize, this was not clear and has been fixed in the methods. At our institution, patients in which rupture of membranes was not clear by exam was offered the option of inpatient monitoring with observation of leaking vs an amnio-dye test with 1 ampule of fluorescein diluted into 10 cc crystalloid. In our review, only one patient, with rupture of membranes after 26 weeks, elected for this test. It is possible that given that this study was only of patients with documented rupture of membranes that more amnio-dye tests were performed but the patients were not included in the analysis as they did not receive the diagnosis of PROM with a negative test.

e. As above (1b), would include something about why you performed SFLP when you did, considering the urgency at which affected pregnancies are often referred and the spectrum of presentation within the 10-week window at which SFLP was offered.

SFLP was offered to any case of stage II or greater disease. Risks and benefits of surgery vs expectant management of Stage I disease with recipient cardiomyopathy were discussed and patient centered counseling. This has been added to the manuscript.

5. Results/Tables

a. One of the outcomes you describe in the 2nd paragraph of the results is PROM within 7 days of surgery. Would include this in the methods. What is the rationale for the 7-day cut-off?

As mentioned above, we included the number of cases in which rupture of membranes occurred within 1 week of surgery to give the reader an idea of the immediate postoperative risk from surgery. If you feel this is confusing to the reader, we can remove. I have added this to the methods.

b. Are you able to stratify by TTTS stage?

I have included an additional table with stratification by stage of disease, though I worry interpretation of this data of this may be problematic as we are only looking at patients that experienced PROM. An interesting question (which I am happy to investigate but may be beyond the scope of this study) is to evaluate the risk and timing of PROM and the subsequent pregnancy outcomes in all patients that underwent SFLP at stage I, II, III, IV.

c. In the bottom section of Table 2 (latency > 48 hours), the mean gestational age at delivery was 26 weeks in those with PROM <23 weeks and was 31 weeks in those with PROM >=/26 weeks. This 5-week difference is clinically relevant, so if not statistically significant please address power.

This was underpowered in table 2 due to testing all groups relative to each other and would have required 27 per group at an alpha of 0.05 and a power of 0.8. In a direct comparison between two groups, PROM < 23 and PROM ≥ 26 weeks, that difference is statistically significant (26.1 vs 31.4 weeks, p < 0.001). I have now commented regarding PROM at the various gestational ages. Power is addressed.

6. Discussion.

a. Would avoid restating numerical results, e.g. in the opening paragraph of the discussion.

Thank you.

b. Do you have any counseling recommendations based on your findings?

Honestly, we feel that it is most important the decisions regarding pregnancy management in a difficult situation like previable and periviable PROM be chosen by the pregnant patients and that a very detailed and informed conversation should take place in a patient-centered manner. We hope this data will aide in that conversation.

c. The content of the discussion might be streamlined. The 2nd to last page is somewhat redundant.

The discussion has been revised. Thank you!

Reviewer #2: Authors performed a retrospective cohort study over a 9+-year period (2010-2019) comparing pregnancy outcomes in patients who underwent SFLP for TTTS and experienced PROM < 26 weeks to PROM > 26 weeks. The primary outcome was infant survival to NICU discharge. Secondary outcomes included gestational age and delivery, and latency from rupture to delivery.

Title: Recommend authors consider a more specific in title about what "treatment" means. For

example, Comparison of Pregnancy Outcomes of Pre- and Periviable Rupture of Membranes after Laser Photocoagulation for TTTS.

This has been changed, thank you for the suggestion.

Precis: It is not clear what authors mean by "iatrogenic PROM", if this is an assumption that the surgery caused the PROM.

This has been corrected for clarity. Thank you.

Abstract: Line 48 Recommend authors be clear on primary and secondary outcomes. Recommend reporting result of primary outcome first (infant survival to NICU discharge between <26 weeks and >26 weeks). Authors can then report secondary outcomes. Line 49-50 Also include secondary outcome stratified by pregnant > 48 hours. Line 60-61 Recommend word smithing: "is associated with longer latency but lower rates of survival." Line 62 "or PROM less than 26 weeks" instead or "previable PROM" (to include peri- and previable).

Corrected, thank you.

Introduction: Line 78-79 Awkward start to the manuscript/wording. Recommend deleting "Due to shared placental vasculature and imbalances in blood flow…" The authors do a good job of developing a sound introduction, defining why this research question is important to study given that the existing body of evidence clinical outcomes after pre and periviable PROM in this cohort.

Corrected, thank you.

Materials and Methods: Study design is appropriate to study associations between infant survival to NICU discharge and timing of premature rupture of membranes following laser photocoagulation for TTTS.

Line 105 Recommend defining limits of PROM, for example between >16+0 weeks to 33+6 weeks)

Addressed, thank you.

Line 108-112 Please comment whether there were any changes to "standard of care management" over the time period of this study

Addressed, thank you.

Line 112-114 At what lower gestational age limit is betamethasone offered in your institution, and has this changed over the study period?

This answer is a bit complicated as it was an evaluation of all patients referred to our fetal center. At the University of Cincinnati, we offered betamethasone at 22 weeks, 0 days for the duration of the study. However, not all the patients which experienced PROM < 26 weeks) presented to our institutions as we have a fetal referral base that stretches across multiple states and our affiliated level III NICU's were not always the closest to patients. Many of the patients that experienced PROM > 26 weeks did not present to our institution. Thus there is some variability regarding the institutional management of PROM. I have adjusted our methods section to make this clear.

Line 118-120 Did any of the patients reseal after PROM? If so, was this an exclusion criteria? Were patients excluded if one or both of the twins had anomalies or aneuploidy? Were they excluded if they had cervical cerclage? Please be very detailed about eligibility for laser photocoagulation. Where they excluded if there was a demise of one twin following laser?

Any patient that was diagnosed with rupture of membranes at any point was considered to be ruptured and included in the study. Twins with aneuploidy were excluded. Anomalies incompatible with life or carrying significantly poor prognosis (anencephaly, CDH, ductal dependent cardiac lesion) were excluded. Cerclage was NOT an exclusion. Postoperative demise of a twin was NOT an exclusion and was factored into the postnatal survival (for example if a patient underwent FLP, had a donor demise postoperatively, and then subsequently experienced PROM, with a recipient survival to NICU discharge, the survival to NICU discharge was recorded 1 of 2 infants). I have re-written the methods to be clearer regarding inclusion/exclusion.

Line 125-26 What multiples of the median cut-offs were used for abnormal?

As per the Leiden staging for TAPS, > 1.5 MoM and < 1 was considered abnormal. However, as I have included more analysis per editorial request and we are not directly evaluating TAPS in this study, I have removed this due to word count constraints.

Line 136-137 Recommend discussing secondary outcome of at least 48 hours of latency as well.

This is addressed further down in the methods, in the same paragraph, I have fixed it for clarity. Thank you.

Line 139-140 Baseline demographics did not include history of spontaneous preterm birth or PPROM, other medical comorbidities other than BMI, socioeconomic status which could be confounders in this study.

I have added to the table a row with history of prior spontaneous preterm birth. We do not have the other medical comorbidities in our database, however if the editors would prefer we

complete this, we can extract this data from the medical record

For this type of clinical study, unadjusted estimates and, if applicable, confounder-adjusted estimates and their precision (eg, 95% confidence interval) would be more relevant to the reader.

95% CI have been added to tables, thank you. As we did not perform relative risk calculations of the various cohorts, we did not perform adjust between groups.

Discuss if there a plan to adjust for confounders? If so make clear which confounders were adjusted for and why they were included.

Groups did not have significantly different preoperative characteristics which would allow for adjustment. The planned sub analysis of PROM with latency of at least 48 hours was done in an attempt to eliminate the confounder of cases which were actually preterm labor, but were reported as PROM.

Did any of the patients have delayed interval delivery of fetus B? If so, how did the authors handle these patients in the study?

In our study there were no delayed interval deliveries for greater than 24 hours between delivery of A and B.

Did any patients require more than one laser? If so, how were they handled in the study?

Please see the below answer.

Were any patients treatment failures following laser, e.g. persistent TTTS? Did any develop TAPS following laser?

There was 1 repeat laser for TAPS. There was 1 additional case of postoperative TAPS which did not undergo laser. There was 1 case with inability to complete the laser, with subsequent follow up laser and completion. There was 1 case with progressive TTTS after laser but this occurred at 28 weeks and the patient was managed with amnioreduction and subsequently experienced rupture of membranes. Patients that underwent diagnostic fetoscopy alone were not included in the analysis as this was a study of patients that underwent laser photocoagulation.

No STROBE checklist included.

Completed and included.

Results:
Line 153-156 Recommend flow diagram

Completed and included, thank you.

Line 177-178 I am confused why this was necessary if PROM definition is for prelabor patients? Did authors think some of these patients had intrapartum rupture of membranes that was misclassified?

Yes. As a number of patients presented both with the complaint of leaking as well as cramping, and as preterm labor can cause rupture of membranes that likely represents a different pathway than prelabor rupture of membranes, we wished to understand what true prelabor rupture of membranes represented and thus is why we did the latency > 48 hours analysis. We expected that the presence of labor would be our greatest confounder in this study and is why we did this.

Line 188-189 What are "patient-friendly graphs"?

Apologies. The hope is that the graphs would be both comprehensive and easy to interpret and potentially even show to patients when they present in this setting, however we can remove this wording.

Discussion:
Line 200, 201-202 The wording "labor-associated PROM" is confusing if authors are consistently defining PROM as prelabor rupture of membranes in their manuscript.

This has been corrected and addressed, thank you.

Line 216-218 Authors introduce new concepts of "iatrogenic PROM" and "PROM associated with preterm labor" in the discussion. If this is something they sought to differentiate, please distinguish these two entities very cleary in background and methods.

This section of the discussion has been changed, thank you.

Line 219-220 Can authors find references to and compare rate for PROM in mo/di twins without TTTS instead?

Reports of only mo-di are primarily limited to case reports. However when twin data has both mo-di and di-di pooled together, the best study is likely the following: In a retrospective study of multifetal pregnancies with PV-PPROM (defined up to 26 weeks, overall neonatal survival at discharge was 43%, and only 17% survived without significant neonatal morbidity, however when stratified by gestational age, PROM < 19+6 was associated with 25% survival and PROM 20-22+6 was associated with 10% survival. (. Wong L F, Holmgren C M, Silver R M, Varner M W, Manuck T A. Outcomes of expectantly managed pregnancies with multiple gestations and preterm premature rupture of membranes prior to 26 weeks. Am J Obstet Gynecol. 2015;212(2):2150–2.15E11.). I have added this to the discussion.

Line 221-223 Maternal outcomes are not explored in this paper. I would caution authors to avoid concluding it is "reasonable" to offer expectant management based on this study without knowing more about maternal outcomes in this cohort.

Corrected, thank you.

Figures and Tables:
Table 1: are these standard deviations or 95% CI? If CI, why are the estimates not included?

We have included both the SD as well as the 95% CI below the mean and SD. Apologies, I am a bit confused by this question. The estimate of the confidence interval with a confidence of 95% is the same as the 95% CI which is listed below the mean and SD in Table 1.

Reviewer #3: Thank you for this important retrospective cohort of 250 patients with PPROM after laser photocoagulation for TTTS, with a focus on those with PROM < 26 weeks. This is an important contribution to literature and to patient care. I have minimal feedback. I especially find the graphical representations in Figures 1 and 2 useful for clinical practice.

Results, general feedback: at times, your many subdivisions of the patients became confusing. Consider a study flow diagram to ensure readers can keep up.

Added, thank you.

Line 172: suggest placing the R^2 = 0.26 in parentheses for readability

Corrected, thank you.

Line 245 and line 268: suggest avoiding first person use of "we"

Corrected, thank you.

Line 188: you high rates of survival of >= 1 neonate in all groups (circa 80-100%) except in patients who experienced PROM between 20w0d - 22w6d. Can you comment on this in your discussion? This may be related to bias from small sample size, or teams handling these cases differently.

Done, thank you.

Could you address the timing of steroid administration for cases admitted before 23 weeks? If you have this data, then the paper may be strengthened by mentioning any granular description of which twin pairs received BMZ and were steroid complete at delivery.

Thank you and agree this would be quite interesting. Unfortunately, while we have steroid administration data for those which presented at our hospital, we have only the operative and neonatal records for those which presented to outside hospitals for rupture of membranes, thus we do not have the timing of steroid administration for all cases.

STATISTICAL EDITOR COMMENTS:

Table 1: Need units for BMI.

Corrected, thank you.

Table 2: Since the groups were defined by GA strata at PROM, should not statistically test for a non-random difference among GA at PROM. It is predetermined by the definition of the columns to be non-random. Therefore, should omit the p-value for that row. Also, should state in footnote to Table whether the p-value is evaluating a trend across PROM GA strata or simply evaluating whether the allocation of data is non-random, to avoid confusing the reader.

Corrected, thank you.

Tables 1, 2: Need to enumerate all missing data, either in Tables or in footnotes to Tables.

Corrected, thank you.

Figs 1, 2: Should include CIs for the histograms (survival of ≥1 vs 2 infants among each twin set).

Apologies. The CI's were not previously included in the graphs as it was data directly from the tables which included the CI's and our hope with the graph was it could both latency and survival data on the same graph. Also per the editorial office comments, Figure 1 and 2 are to be re-submitted as is, so I was not planning to change this. Please let me know if the editors change their mind and I can adjust the figure.

General: Since this study includes births from 2010 to 2019, was there any association between year of study and survival rate? That is, what were the results of the linear regression analysis if year of study were included as a "predictor"?

Thank you. There was no association between year of study and survival rate.

EDITORIAL OFFICE COMMENTS:

1. If your article is accepted, the journal will publish a copy of this revision letter and your point-by-point responses as supplemental digital content to the published article online. You may opt out by writing separately to the Editorial Office at em@greenjournal.org, and only the revision letter will be posted.

2. 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:

* Funding information (ie, grant numbers or industry support statements) should be disclosed on the title page and at the end of the abstract. For industry-sponsored studies, describe on the title page how the funder was or was not involved in the study.
* 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.

Completed, thank you.

3. Obstetrics & Gynecology's Copyright Transfer Agreement (CTA) must be completed by all authors. When you uploaded your manuscript, each coauthor received an email with the subject, "Please verify your authorship for a submission to Obstetrics & Gynecology." Please ask your coauthor(s) to complete this form, and confirm the disclosures listed in their CTA are included on the manuscript's title page. If they did not receive the email, they should check their spam/junk folder. Requests to resend the CTA may be sent to em@greenjournal.org.

I will confirm receipt of all authors.

4. 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, describe the reasons that race and ethnicity were assessed in the Methods section and/or in table footnotes. Race and 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.

Race was selected by the patient at the time of intake with evaluation at our Fetal center. We normally report this data in our demographical data, however we did not perform any specific analysis or risk adjustment related to race, therefore it has been removed.

Use "Black" and "White" (capitalized) when used to refer to racial categories.

List racial and ethnic categories in tables in alphabetic order. Do not use "Other" as a category; use "None of the above" instead.

Racial categories have been removed.

Please refer to "Reporting Race and Ethnicity in Obstetrics & Gynecology" at https://nam11.safelinks.protection.outlook.com/?url=https%3A%2F%2Fedmgr.ovid.com%2Fong%2Faccounts%2FRace_and_Ethnicity.pdf&data=05%7C01%7Cfordebn%40ucmail.uc.edu%7C7def9baaf2b741f6134e08da60506985%7Cf5222e6c5fc648eb8f0373db18203b63%7C1%7C0%7C637928195852181434%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=cmCJudu33vswQYtqBvpM2e4EhaOBgz5RjQQTClBIhY8%3D&reserved=0.

5. ACOG uses person-first language. Please review your submission to make sure to center the person before anything else. Examples include: "People with disabilities" or "women with disabilities" instead of "disabled people" or "disabled women"; "patients with HIV" or "women with HIV" instead of "HIV-positive patients" or "HIV-positive women"; and "people who are blind" or "women who are blind" instead of "blind people" or "blind women."

Manuscript reviewed, thank you.

6. The journal follows ACOG's Statement of Policy on Inclusive Language (https://nam11.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.acog.org%2Fclinical-information%2Fpolicy-and-position-statements%2Fstatements-of-policy%2F2022%2Finclusive-language&data=05%7C01%7Cfordebn%40ucmail.uc.edu%7C7def9baaf2b741f6134e08da60506985%7Cf5222e6c5fc648eb8f0373db18203b63%7C1%7C0%7C637928195852181434%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=mMuJadsNTTEHYGI1LXT5ExLeI8C5eR7ZIfKQEsJDglM%3D&reserved=0). When possible, please avoid using gendered descriptors in your manuscript. Instead of "women" and "females," consider using the following: "individuals;" "patients;" "participants;" "people" (not "persons"); "women and transgender men;" "women and gender-expansive patients;" or "women and all those seeking gynecologic care."

This manuscript has been written with inclusive language. We do refer to “maternal” data and would plan to keep that language unless the Green Journal would prefer we adjust this in some way.

7. 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:

STROBE: observational studies

Include the appropriate checklist for your manuscript type upon submission, if applicable, and indicate in your cover letter which guideline you have followed. 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 https://nam11.safelinks.protection.outlook.com/?url=http%3A%2F%2Fwww.equator-network.org%2F&data=05%7C01%7Cfordebn%40ucmail.uc.edu%7C7def9baaf2b741f6134e08da60506985%7Cf5222e6c5fc648eb8f0373db18203b63%7C1%7C0%7C637928195852181434%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=Rz8G0A3ceMNPYVwa3axYuc7mJi9HmV6MJurvt20cqyo%3D&reserved=0.

Apologies this was not included in error and has been included in this submission.

8. 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://nam11.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.acog.org%2Fpractice-management%2Fhealth-it-and-clinical-informatics%2Frevitalize-obstetrics-data-definitions&data=05%7C01%7Cfordebn%40ucmail.uc.edu%7C7def9baaf2b741f6134e08da60506985%7Cf5222e6c5fc648eb8f0373db18203b63%7C1%7C0%7C637928195852181434%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=faqmulqxenPhNI%2FgZhsB5WtkjsEtGV2XHGCZWtvM8YI%3D&reserved=0 and the gynecology data definitions at https://nam11.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.acog.org%2Fpractice-management%2Fhealth-it-and-clinical-informatics%2Frevitalize-gynecology-data-definitions&data=05%7C01%7Cfordebn%40ucmail.uc.edu%7C7def9baaf2b741f6134e08da60506985%7Cf5222e6c5fc648eb8f0373db18203b63%7C1%7C0%7C637928195852181434%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=mS2f4SczPg8pd564jmFB5ksB%2BrEvUasfxAQyrOh9bTk%3D&reserved=0. If use of the reVITALize definitions is problematic, please discuss this in your point-by-point response to this letter.

9. Make sure your manuscript meets the following word limit. The word limit

includes the manuscript body text only (for example, the Introduction through the Discussion in Original Research manuscripts), and excludes the title page, précis, abstract, tables, boxes, and figure legends, reference list, and supplemental digital content. Figures are not included in the word count.

Original Research: 3,000 words

10. Specific rules govern the use of acknowledgments in the journal. Please review the following guidelines and edit your title page as needed:

* 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 or indicate whether the meeting was held virtually).
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* Do not use only authors' initials in the acknowledgement or Financial Disclosure; spell out their names the way they appear in the byline.

11. Provide a short title of no more than 45 characters, including spaces, for use as a running foot. Do not start the running title with an abbreviation.

Done, thank you.

12. Be sure that each statement and any data in the abstract are also stated in the body of your manuscript, tables, or figures. Statements and data that appear in the abstract must also appear in the body text for consistency. Make 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 manuscript.

Done, thank you.

In addition, the abstract length should follow journal guidelines. Please provide a word count.

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