OBSTETRICS & GYNECOLOGY

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

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

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

Date: Jun 26, 2020
To: "Elliott Main" [redacted]
From: "The Green Journal" em@greenjournal.org
Subject: Your Submission ONG-20-1473

RE: Manuscript Number ONG-20-1473

Hospital-level Variation in Cesarean Rates Following Induction of Labor in Nulliparous Women

Dear Dr. Main:

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).

Due to the COVID-19 pandemic, your paper will be maintained in active status for 30 days from the date of this letter. If we have not heard from you by Jul 26, 2020, we will assume you wish to withdraw the manuscript from further consideration.

REVIEWER COMMENTS:

Reviewer #1: Thank you for your work on this very important topic. Your research design reaffirms that this is not your first effort on using the data from your quality initiative. Your paper is also well written.
Any effort to use administrative data to understand clinical conundrums is fraught with danger. You address the fact that randomized controlled trials have demonstrated successful induction of labor. However, you claim that your data may be more "real world". However, you should also recognize that the truth may lay somewhere between. That is, other variables that you cannot capture may be playing a vital role in the differences.
Could the birth certificate data provide information about time of delivery that might be useful to understanding variability?

Reviewer #2: This is an analysis of a large California dataset on induction of labor (IOL) that assessed accuracy of assessment methods, variation in cesarean section (CS) rates, and the effect of risk adjustment. The conclusion is that there is tremendous in IOL-related CS rates that appears best explained by practice variation rather than by patient risk factors. The question is important, the manuscript is well-written, the methods are appropriate and thorough, the results are presented clearly, and the conclusions follow from the results.
A few comments are as follows:

1. The use of observed/expected ratios should be accompanied by a statement that "expected" is relative to the study population and reflects practices within a region, not an established gold standard (no such gold standard exists).
2. Can the authors provide their insights as to why there was significant disagreement between the birth certificate and diagnosis/procedure coding of "induction?" From Table 2, there was reasonable agreement for what was NOT an induction, but much less agreement on what WAS an induction.
3. With the ARRIVE trial having received so much publicity and used as a justification for elective IOL despite having an IOL-related CS rate much lower than most others published rates, it is of interest that the California data also found higher IOL-related CS rates, further calling into question of generalizability of ARRIVE's conclusions. The wide variability in IOL-related CS rates within California is consistent with other studies, further highlighting the risks of applying any one study's results and conclusions (read, ARRIVE) to the general population of OB providers and hospitals. The authors tactfully acknowledge this in their discussion when emphasizing the importance of knowing hospital-level statistics as opposed to only those in literature, using hospital-level data in counseling about IOL-related CS risks, and identifying opportunities to improve IOL management rather than simply doing more of them.
4. Along the same lines as in comment #3, in contrast to the ARRIVE trial, the authors using the California data state that, "a higher hospital rate of induction does not translate to lower rates of cesarean birth among those being induced."
5. In the Discussion, the authors imply that population studies using "the clinically relevant comparator" have not found

an increased risk of CS after IOL. More accurate would be to say that some have and others have not, even with the expectant management comparator (e.g., Glantz, Obstet Gynecol 2010; and Miller, Obstet Gynecol, 2015, although Miller was underpowered).
6. Table 3: For the lowest-risk NTSV group, 15% of IOLs were before 39 weeks. Assuming elective IOLs are not being done before 39 weeks, this implies there should have been some complication serving as an indication for those early-term IOLs. Do the authors have information on what those complications were (e.g., growth restriction, decreased fetal movement, congenital anomalies, etc.)?

Reviewer #3: Thank you for this work, only a few comments:

Lines 159-65: I would explain this analysis a bit more to help the average reader understand what this statistic will tell them.
Line 223: could this data be presented in an appendix for those interested?
Line 243: is It unit culture if there is such wide variation between providers in a single hospital as shown in figure 3? Can these two things be teased out?

STATISTICAL EDITOR COMMENTS:

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

Table 2: The sensitivity proportions (ascertaining induction by thorough chart review vs by combinations of maternal discharge codes and/or birth certificate data) show that the ascertainment of induction from records alone is imprecise and that portion of the analysis (comparing induced vs non-induced) for the entire cohort is likely not a valid exercise.

Table 3: Need units for age, BMI.

Fig 3:The individual providers have varying counts of deliveries. Should indicate the "n" for each provider. Is there a significant relationship between number of deliveries per provider and their cesarean rate? Not only for these examples, but in general for providers vs their cesarean rates?

Fig 4: The regressions give equal wgt to each hospital, but some have more deliveries than others. The regression should instead weight the values, based on each hospital's volume.

EDITOR COMMENTS:

1. The Editors of Obstetrics & Gynecology are seeking to increase transparency around its peer-review process, in line with efforts to do so in international biomedical peer review publishing. If your article is accepted, we will be posting this revision letter as supplemental digital content to the published article online. Additionally, unless you choose to opt out, we will also be including your point-by-point response to the revision letter. If you opt out of including your response, only the revision letter will be posted. Please reply to this letter with one of two responses:
A. OPT-IN: Yes, please publish my point-by-point response letter.
B. OPT-OUT: No, please do not publish my point-by-point response letter.

2. Obstetrics & Gynecology uses an "electronic Copyright Transfer Agreement" (eCTA). When you are ready to revise your manuscript, you will be prompted in Editorial Manager (EM) to click on "Revise Submission." Doing so will launch the resubmission process, and you will be walked through the various questions that comprise the eCTA. Each of your coauthors will receive an email from the system requesting that they review and electronically sign the eCTA.

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

3. If your study is based on data obtained from the National Center for Health Statistics, please review the Data Use Agreement (DUA) for Vital Statistics Data Files that you or one of your coauthors signed. If your manuscript is accepted for publication and it is subsequently found to have violated any of the terms of the DUA, the journal will retract your article. The National Center for Health Statistics may also terminate your access to any future vital statistics data.

4. 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.

5. 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.

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

6. 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).

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

8. 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.

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

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

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

Figure 1: Please consider adding tick marks along the y-axes.
Figure 2: Please consider adding tick marks along the x-axes.
Figure 3: okay
Figure 4: Please consider adding tick marks along the axes.
Note that you may be asked to move some of these figures to supplemental digital content due to space constraints.

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

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

12. If you would like to include online-only supplemental digital content, 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.

13. Authors whose manuscripts have been accepted for publication have the option to pay an article processing charge and publish open access. With this choice, articles are made freely available online immediately upon publication. An information sheet is available at http://links.lww.com/LWW-ES/A48. The cost for publishing an article as open access can be found at http://edmgr.ovid.com/acd/accounts/ifauth.htm.

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

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If you choose to revise your manuscript, please submit your revision through Editorial Manager at http://ong.editorialmanager.com. Your manuscript should be uploaded in a word processing format such as Microsoft Word. Your revision's cover letter should include the following:

* A confirmation that you have read the Instructions for Authors (http://edmgr.ovid.com/ong/accounts/authors.pdf), and
* A point-by-point response to each of the received comments in this letter.

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 30 days from the date of this letter. If we have not heard from you by Jul 26, 2020, we will assume you wish to withdraw the manuscript from further consideration..

Sincerely,

The Editors of Obstetrics & Gynecology

2018 IMPACT FACTOR: 4.965
2018 IMPACT FACTOR RANKING: 7th out of 83 ob/gyn journals

_____

[redacted]

July 14, 2020

Dwight J. Rouse, MD, MSPH
Associate Editor, Obstetrics

Re: Hospital-level Variation in Cesarean Rates Following Induction of Labor in Nulliparous Women
ONG-S-20-01779

Dear Dr. Rouse,

Thank you for the opportunity to submit a revision to our earlier manuscript. We have redone the analyses that were suggested and made the text changes to improve clarity and address the specific concerns. All reviewers' comments were addressed to follow in this document and we have submitted a track changes and clean copy of the manuscript. In addition, we have submitted the figures as TIFF images.

Should there be a need to shorten the length of the paper, we might recommend moving Figure 2 to the appendix (it could be combined with Appendix C into a single figure).

All authors disclosures are listed on the front page. All authors have contributed to and reviewed the final version here resubmitted.

We did review the instructions for authors and complete the journal's Table Checklist and made appropriate alterations to meet the requirements.

We look forward to your decision.

Sincerely,

Elliott Main

Elliott K. Main, MD
Medical Director, California Maternal Quality Care Collaborative
Clinical Professor of Obstetrics and Gynecology
Stanford University School of Medicine

REVIEWER COMMENTS:

Reviewer #1: Thank you for your work on this very important topic. Your research design reaffirms that this is not your first effort on using the data from your quality initiative. Your paper is also well written.
Any effort to use administrative data to understand clinical conundrums is fraught with danger. You address the fact that randomized controlled trials have demonstrated successful induction of labor. However, you claim that your data may be more "real world". However, you should also recognize that the truth may lay somewhere between. That is, other variables that you cannot capture may be playing a vital role in the differences.
We agree that the use of "real-world", while often used in the description of effectiveness studies, is a bit informal. Lines 268-9 have been rewritten: "…whereas effectiveness refers to the performance of an intervention for an entire population in a wide variety of usual clinical settings"
Could the birth certificate data provide information about time of delivery that might be useful to understanding variability? Yes, we do have the time of delivery from the birth certificate and that is an interesting proposed analysis but would be a separate paper. Here we are focused on identifying that there is great variation among hospitals for successful induction of labor. The time of delivery may be part of an analysis as to what may be causing the variation.

Reviewer #2: This is an analysis of a large California dataset on induction of labor (IOL) that assessed accuracy of assessment methods, variation in cesarean section (CS) rates, and the effect of risk adjustment. The conclusion is that there is tremendous in IOL-related CS rates that appears best explained by practice variation rather than by patient risk factors. The question is important, the manuscript is well-written, the methods are appropriate and thorough, the results are presented clearly, and the conclusions follow from the results.
A few comments are as follows:

1. The use of observed/expected ratios should be accompanied by a statement that "expected" is relative to the study population and reflects practices within a region, not an established gold standard (no such gold standard exists). Agree, here we are using observed to expected merely to compare hospitals to each other rather than to a gold standard. We added a phrase in Ln 145-147 to indicate this: "An O/E ratio >1.0 indicated that the hospital had higher cesarean birth than would be expected according to its patient mix compared to other hospitals in California."

2. Can the authors provide their insights as to why there was significant disagreement between the birth certificate and diagnosis/procedure coding of "induction?" From Table 2, there was reasonable agreement for what was NOT an induction, but much less agreement on what WAS an induction. Coding for induction using ICD codes is performed by different staff than who code for the Birth Certificate. In some hospitals one or the other staff do a poorer job of identifying an induction (poorer sensitivity) but using both allows for a cross check and then a much higher sensitivity on validation. This is discussed in Lines 284-292.

3. With the ARRIVE trial having received so much publicity and used as a justification for elective IOL despite having an IOL-related CS rate much lower than most others

published rates, it is of interest that the California data also found higher IOL-related CS rates, further calling into question of generalizability of ARRIVE's conclusions. The wide variability in IOL-related CS rates within California is consistent with other studies, further highlighting the risks of applying any one study's results and conclusions (read, ARRIVE) to the general population of OB providers and hospitals. The authors tactfully acknowledge this in their discussion when emphasizing the importance of knowing hospital-level statistics as opposed to only those in literature, using hospital-level data in counseling about IOL-related CS risks, and identifying opportunities to improve IOL management rather than simply doing more of them.

4. Along the same lines as in comment #3, in contrast to the ARRIVE trial, the authors using the California data state that, "a higher hospital rate of induction does not translate to lower rates of cesarean birth among those being induced."

5. In the Discussion, the authors imply that population studies using "the clinically relevant comparator" have not found an increased risk of CS after IOL. More accurate would be to say that some have and others have not, even with the expectant management comparator (e.g., Glantz, Obstet Gynecol 2010; and Miller, Obstet Gynecol, 2015, although Miller was underpowered). Thank you for the new references. Discussion on line 258-9 changed to reflect these references (and citations added).

6. Table 3: For the lowest-risk NTSV group, 15% of IOLs were before 39 weeks. Assuming elective IOLs are not being done before 39 weeks, this implies there should have been some complication serving as an indication for those early-term IOLs. Do the authors have information on what those complications were (e.g., growth restriction, decreased fetal movement, congenital anomalies, etc.)? We went back and examined the codes on the 15% of IOL cases that were 37-39 weeks and two issues stood out. Nearly half of the cases were for rupture of membranes before labor (which should have improved the likelihood of labor success). While we did exclude cases for maternal conditions, 21% of the early IOL were for suspected fetal growth restriction. Only half of these resulted in an infant with birth weight <2500g. The remainder had a multiple number of very low frequency (≤1%) codes that could be considered indications.

Reviewer #3: Thank you for this work, only a few comments:

Lines 159-65: I would explain this analysis a bit more to help the average reader understand what this statistic will tell them. We rewrote the intro to this paragraph (lines 156-158 and rewrote the following paragraph (now lines 165-175) to better explain the analyses:

“In order to understand whether the variation of cesarean rates following labor induction was related to unit-level factors or physician-level factors we performed a preliminary analysis, of individual physician rates in four large community hospitals in the same study period.”

And

“Two additional analyses were performed. First, it has been suggested that the cesarean rate following labor induction merely reflects the care for all women during labor. Hence, there should be a correlation between the cesarean rate following induction and cesarean rate among uninduced women. Therefore, we looked for an association between each hospital’s NTSV cesarean rate among non-induced births and the same hospital’s NTSV cesarean rate among induced births to support whether overall labor management was a consistent driver. Second, a hospital’s NTSV cesarean rate among induced births might

be associated with the volume of inductions performed. Therefore, we looked for an association between each hospital's NTSV cesarean rate among induced births and the rate of NTSV inductions to determine if volume of inductions was associated with success. R-squared (R^2) was used to quantify the proportion of the variance for both analyses."

Line 223: could this data be presented in an appendix for those interested? Thank you, we have added this figure to the appendix.

Line 243: is It unit culture if there is such wide variation between providers in a single hospital as shown in figure 3? Can these two things be teased out? In prior studies we have noted that provider attitudes towards vaginal birth and unit culture do overlap and both contribute to the rates of cesarean birth, but they are hard to separate. This is discussed in the first paragraph of the discussion with 4 references.

STATISTICAL EDITOR COMMENTS:

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

Table 2: The sensitivity proportions (ascertaining induction by thorough chart review vs by combinations of maternal discharge codes and/or birth certificate data) show that the ascertainment of induction from records alone is imprecise and that portion of the analysis (comparing induced vs non-induced) for the entire cohort is likely not a valid exercise. We agree that ascertainment of induction from the discharge codes alone has a poor sensitivity which is why we used the combination of approaches which does lead to a very respectable sensitivity of 87%, specificity of 95% and accuracy of 92.9%. Missing up to 13% of inductions would not change any of the findings or conclusions about the wide variation noted after multiple approaches of additional risk adjustment.

Table 3: Need units for age, BMI. These are now provided

Fig 3: The individual providers have varying counts of deliveries. Should indicate the "n" for each provider. Is there a significant relationship between number of deliveries per provider and their cesarean rate? Not only for these examples, but in general for providers vs their cesarean rates? Figure 3 has been revised to add the sample size for each physician. No clear pattern can be seen for the number of inductions per provider and the number of cesareans. This is also shown for hospitals in Figure 4b. We could not analyze for a broader group of providers across more hospitals because of uncertainty of proper attribution of cesareans in the presence of midwives, residents, and family practice physicians.

Fig 4: The regressions give equal wgt to each hospital, but some have more deliveries than others. The regression should instead weight the values, based on each hospital's volume. This analysis was redone with hospital volume added to the regression model. The revised figure 4 reflects this change. Of interest, once volume is added, the associations were even weaker, further supporting the conclusions.

EDITOR COMMENTS:

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

A. OPT-IN: Yes, please publish my point-by-point response letter. Agree

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

2. Obstetrics & Gynecology uses an "electronic Copyright Transfer Agreement" (eCTA). When you are ready to revise your manuscript, you will be prompted in Editorial Manager (EM) to click on "Revise Submission." Doing so will launch the resubmission process, and you will be walked through the various questions that comprise the eCTA. Each of your coauthors will receive an email from the system requesting that they review and electronically sign the eCTA.

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

3. If your study is based on data obtained from the National Center for Health Statistics, please review the Data Use Agreement (DUA) for Vital Statistics Data Files that you or one of your coauthors signed. If your manuscript is accepted for publication and it is subsequently found to have violated any of the terms of the DUA, the journal will retract your article. The National Center for Health Statistics may also terminate your access to any future vital statistics data. N/A

4. 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. We did discuss these issues in the methods section and described a data validation step for the diagnosis of induction performed in over 46,000 records.

5. 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. done

b. Use both the diagnosis and procedure codes. done

c. Verify the selected codes apply for all years of the study. Verified

d. Conduct sensitivity analyses using definitions based on alternative codes. This was an integral part of this study, using both Birth certificate and ICD-10 codes and chart reviews using reVITALize definitions to identify induction.

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. N/A 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. Discussed in the limitations section.
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. Done
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. Codes are provided in the appendix.

5. Because of space limitations, it is important that your revised manuscript adhere to the following length restrictions by manuscript type: Original Research reports should not exceed 22 typed, double-spaced pages (5,500 words). Stated page limits include all numbered pages in a manuscript (i.e., title page, précis, abstract, text, references, tables, boxes, figure legends, and print appendixes) but exclude references. We are <5,000 words

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

* All financial support of the study must be acknowledged. done
* 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. N/A
* 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. (N/A)
* 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). (N/A)

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

8. 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. done

In addition, the abstract length should follow journal guidelines. The word limit for Original Research articles is 300 words. Please provide a word count. 299 words

9. ACOG is moving toward discontinuing the use of "provider." Please replace "provider" throughout your paper with either a specific term that defines the group to which are referring (for example, "physicians," "nurses," etc.), or use "health care professional" if a specific term is not applicable. All references to providers have been changed to

physicians.

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

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

Figure 1: Please consider adding tick marks along the y-axes. done
Figure 2: Please consider adding tick marks along the x-axes. done
Figure 3: okay
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Note that you may be asked to move some of these figures to supplemental digital content due to space constraints.

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

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

12. If you would like to include online-only supplemental digital content, 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. done

13. Authors whose manuscripts have been accepted for publication have the option to pay an article processing charge and publish open access. With this choice, articles are made freely available online immediately upon publication. An information sheet is available at http://links.lww.com/LWW-ES/A48. The cost for publishing an article as open access can be found at http://edmgr.ovid.com/acd/accounts/ifauth.htm.

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

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If you choose to revise your manuscript, please submit your revision through Editorial Manager at http://ong.editorialmanager.com. Your manuscript should be uploaded in a word processing format such as Microsoft Word. Your revision's cover letter should include the following:

* A confirmation that you have read the Instructions for Authors (http://edmgr.ovid.com/ong/accounts/authors.pdf), and
* A point-by-point response to each of the received comments in this letter.

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 30 days from the date of this letter. If we have not heard from you by Jul 26, 2020, we will assume you wish to withdraw the manuscript from further consideration..

Sincerely,

The Editors of Obstetrics & Gynecology