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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: Jun 30, 2022
To: "Ming Lim" [redacted]
From: "The Green Journal" em@greenjournal.org
Subject: Your Submission ONG-22-918

RE: Manuscript Number ONG-22-918

Differentiating and Managing Rare Thrombotic Microangiopathies During Pregnancy and Postpartum

Dear Dr. Lim:

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 21, 2022, we will assume you wish to withdraw the manuscript from further consideration.

REVIEWER COMMENTS:

Reviewer #1: 1. Your article on rare TMAs is impressively comprehensive and informative.
2. Given the rarity of these conditions, they are not likely at the forefront of providers' minds, and having a published reference like this would be helpful.
3. I appreciate the detailed headings that guide the reader and will make the article a useful clinical reference. Additionally, the tables complement the written material and provide a quick reference for clinicians.
4. The article was wordy and dense at times, making it unclear or difficult to read without rereading passages. For example, lines 60-63 are a single sentence with the phrase "as well as" used twice. Other examples include 98-102 and 255-258, which would flow easier if they were two sentences. This issue is likely an easy fix once it goes to an editor.
5. I found the "differentiating and making the diagnosis" section the hardest to follow; however, I am not an obstetrician. Perhaps the many acronyms were particularly challenging for someone unfamiliar with the terms.
6. On lines 301 and 516, American College of Obstetricians and Gynecologists is spelled out even though the familiar ACOG acronym was introduced on line 87. Conversely, I lost track of the meaning of some of the acronyms in the second half of the article. Consider spelling out and reintroducing some of the less common acronyms when transitioning to a discussion under a new heading.
7. Overall, I think it is well-written and thoroughly cited.

Reviewer #2: Clinical Expert Series are obviously reflecting the authors' high level of expertise but are intended for the wider Journal readership, mainly clinicians. Accent on practical applicability should therefore be observed. The submitted manuscript addresses the TMAs that can complicate pregnancy and is largely organized in two segments for each entity. First, pathophysiology and diagnosis, second, management. The management part is comprehensively and expertly written. The first part, however, leaves much to be desired. It is overburdened by too many complicated pathophysiologic details and, on the other hand, lacks a structured and easy to understand practical approach to the differential diagnosis. The clinician in the trenches needs guidance in reaching the correct diagnosis first. Management will logically follow. I am sure that the authors would be able to address this deficiency and rewrite from the perspective of a practical approach.

A few other observations:

- Line 205. I think that preeclampsia with severe features and other pregnancy complications are no longer among the obstetric clinical criteria for the diagnosis of APS.
- Line 215. Can catastrophic APS be "quiescent"?
- Line 243. Please make clear that summary cheat sheets as Table 1 are just orientative tools based on a most common scenario, but not absolute diagnostic criteria. We all know that HELLP, as an example, can be without hypertension in up to 30% of cases, that cases of HELLP with ADAMTS13 level even less than 10% have been reported and cases of preeclampsia/HELLP can occur even before 20 weeks.
- Line 245-246. This should be better explained. Can there be, let's say, TTP or HUS and HELLP at the same time? This would have major management implications.
- Lines 314-316. "In almost all cases of pregnancy-specific TMA's (preeclampsia and HELLP syndrome, and AFLP), the definitive management is delivery as soon as feasible, or expectant management with close maternal and fetal clinical monitoring". I disagree that expectant management is an option in HELLP and AFLP. Furthermore, why do you have to discuss, starting with line 251, AFLP? AFLP is not preeclampsia and not TMA.
- Line 574, and other places in the manuscript."…close obstetrical monitoring throughout pregnancy with serial growth scans and/or uterine artery Doppler scan…/". Please note that in the US, uterine artery Doppler assessment is not an accepted form of surveillance in pregnancy complications.

Reviewer #3: The authors set out to provide a contemporary review of the management of rare thrombotic microangiopathies during pregnancy and the postpartum period.

This is a comprehensive and thorough review that is well organized. Tables and figures are complementary. Congratulations on a well done article.

Reviewer #4: These authors offer a review of three rare but important TMA that may coincide with pregnancy. This is a dense, information-rich, well written article that summarizes a large amount of information. I have several specific comments:

1. Do the authors consider ADAMTS13 to be completely diagnostic for TTP? This is implied but not clearly stated. This has not necessarily been true in the past but may be now as disease understanding has progressed.
2. It might be worth stating the diagnostic accuracy of the PLASMIC and French scores in the text as well as table footnotes.
3. Page 11, line 258 - it might be worthwhile offering a level of renal impairment (SCr) at which preE becomes less likely and other TMAs more likely. It is common in my experience for Nephrologists or Hematologists to attribute a SCr or 2 or 3 to preE without understanding that this is actually very rare.
4. There is tension in an article like this between academic knowledge and clinical management. The flow charts on how to manage the different disease entities are very helpful, but initially the clinician needs to make management decisions before a diagnosis is made. Perhaps of most import is when empiric TPE should be started while awaiting test results. In my experience this is often a critical issue and one of contention. I often favor empiric TPE while waiting results. I think the authors should offer some "official" guidance on this issue.
5. Consider splitting Table 2 into three parts: Routine tests immediately available; routine tests that will come back after initial management decisions are made; tests that are not routine and/or are experimental.
6. Similar to point 4 above, regarding libe 322, what PLASMIC or French score qualifies as "a high clinical suspicion"?
7. A reference on the relative benefits of TPE vs plasma infusion (eg. Rock 1993 NEJM or newer if available) would be helpful. Also, a mention that if TPE is not available, patient transfer should be considered.

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. 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."

5. 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."

6. Standard obstetric and gynecology data definitions have been developed through the reVITALize initiative, which was convened by the American College of Obstetricians and Gynecologists and the members of the Women's Health Registry Alliance. Obstetrics & Gynecology has adopted the use of the reVITALize definitions. Please access the obstetric data definitions at https://www.acog.org/practice-management/health-it-and-clinical-informatics/revitalize-obstetrics-data-definitions and the gynecology data definitions at https://www.acog.org/practice-management/health-it-and-clinical-informatics/revitalize-gynecology-data-definitions. If use of the reVITALize definitions is problematic, please discuss this in your point-by-point response to this letter.

7. 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.

8. 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.

9. 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.

10. 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.

11. 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.

12. 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.

13. Figure 1: What is the source of this figure?
Figure 2: What is the source of this figure?
Figures 3-7: Is this figure original to the manuscript?

14. 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 21, 2022, we will assume you wish to withdraw the manuscript from further consideration.

Sincerely,

The Editors of Obstetrics & Gynecology

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

_____

July 13, 2022

To the Editors,

In response to your recommendations for revisions, we provide the following updated manuscript entitled “Differentiating and Managing Rare Thrombotic Microangiopathies During Pregnancy and Postpartum” for consideration for publication in the Clinical Expert Series in Obstetrics & Gynecology.

We appreciate the review and constructive suggestions. I can confirm that I have read the ‘Instructions for Authors.’ This revised manuscript was developed in consultation with all co-authors, and it is being submitted with each author giving approval for the final form of the revision. Both a track change, and a clean version of the manuscript are included in this response. Please note that line references for revisions are based on the clean version of the manuscript.

Sincerely,

Ming Y. Lim on behalf of the co-authors

REVIEWER COMMENTS:

Reviewer #1:
1. Your article on rare TMAs is impressively comprehensive and informative.
2. Given the rarity of these conditions, they are not likely at the forefront of providers' minds, and having a published reference like this would be helpful.
3. I appreciate the detailed headings that guide the reader and will make the article a useful clinical reference. Additionally, the tables complement the written material and provide a quick reference for clinicians.

Response: Thank you for the kind comments. No changes suggested.

4. The article was wordy and dense at times, making it unclear or difficult to read without rereading passages. For example, lines 60-63 are a single sentence with the phrase "as well as" used twice. Other examples include 98-102 and 255-258, which would flow easier if they were two sentences. This issue is likely an easy fix once it goes to an editor.

Response: We have revised lines 60-63, 98-102 and 273-276 accordingly to improve readability and flow.

5. I found the "differentiating and making the diagnosis" section the hardest to follow; however, I am not an obstetrician. Perhaps the many acronyms were particularly challenging for someone unfamiliar with the terms.

Response: We agree with the reviewer that there were a lot of acronyms used which can be challenging to follow. Regrettably, this was unavoidable as thrombotic microangiopathies can be due to many different diagnoses, of which some are specific to obstetrics (HELLP, AFLP), hematology (TTP, CM-HUS) or both (CAPS, aPL). To minimize the number of acronyms, we have removed a number of acronyms (cTTP, iTTP, MAHA, VWF, FVIII).

6. On lines 301 and 516, American College of Obstetricians and Gynecologists is spelled out even though the familiar ACOG acronym was introduced on line 87.

Response: We have revised this so that the acronym ACOG is used on lines 326 and 549.

Conversely, I lost track of the meaning of some of the acronyms in the second half of the article. Consider spelling out and reintroducing some of the less common acronyms when transitioning to a discussion under a new heading.

Response: We apologize for the number of acronyms which can be confusing to follow. We have removed the following acronyms, cTTP, iTTP, MAHA, VWF, FVIII, and spelled them out whenever used. Additionally, we reintroduced certain acronyms in the headings.

7. Overall, I think it is well-written and thoroughly cited.

Response: Thank you for the kind comments. No changes suggested.

Reviewer #2: Clinical Expert Series are obviously reflecting the authors' high level of expertise but are intended for the wider Journal readership, mainly clinicians. Accent on practical applicability should therefore be observed. The submitted manuscript addresses the TMAs that can complicate pregnancy and is largely organized in two segments for each entity. First, pathophysiology and diagnosis, second, management. The management part is comprehensively and expertly written. The first part, however, leaves much to be desired. It is overburdened by too many complicated pathophysiologic details and, on the other hand, lacks a structured and easy to understand practical approach to the differential diagnosis. The clinician in the trenches needs guidance in reaching the correct diagnosis first. Management will logically follow. I am sure that the authors would be able to address this deficiency and rewrite from the perspective of a practical approach.

Response: In response to other reviewers' comments, we have made edits to the sections on pathophysiology. Figure 1 and 2 were created to aid in understanding the pathophysiology of these rare TMAs. Similarly, we have made edits to the section on making the diagnosis based on other reviewers' comments.

A few other observations:
1. Line 205. I think that preeclampsia with severe features and other pregnancy complications are no longer among the obstetric clinical criteria for the diagnosis of APS.
Response: For obstetric APS, one of the criterion is, "One or more premature births of a morphologically normal neonate before the 34th week of gestation due to eclampsia and severe pre-eclampsia, or to recognised features of placental insufficiency." We have revised the sentence on lines 213-215 to clarify this.

2. Line 215. Can catastrophic APS be "quiescent"?
Response: We apologize for this error. The sentence should read, "…during the remission phase of CAPS" and has been corrected on line 224.

3. Line 243. Please make clear that summary cheat sheets as Table 1 are just orientative tools based on a most common scenario, but not absolute diagnostic criteria. We all know that HELLP, as an example, can be without hypertension in up to 30% of cases, that cases of HELLP with ADAMTS13 level even less than 10% have been reported and cases of preeclampsia/HELLP can occur even before 20 weeks.
Response: Thank you for this suggestion. We have added the following sentences in the manuscript on lines 252-256, "The typical features of TMAs occurring in pregnancy and postpartum are listed in Table 1. However, the clinician is reminded that no feature on its own is suffice to definitively confirm or exclude the diagnosis due to the possibility of atypical presentations of these TMAs. Clinical judgment with subspecialist input is imperative in making the final diagnosis."

4. Line 245-246. This should be better explained. Can there be, let's say, TTP or HUS and HELLP at the same time? This would have major management implications.
Response: Both preeclampsia and HELLP have been reported to occur concurrently or as a result of TTP and CM-HUS. We have revised the sentences on lines 259-261 to say, "Both preeclampsia and HELLP syndrome have also been reported to occur concurrently or as a result of TTP or CM-HUS, which adds to the complexity in diagnosis and management."

5. Lines 314-316. "In almost all cases of pregnancy-specific TMA's (preeclampsia and HELLP syndrome, and AFLP), the definitive management is delivery as soon as feasible, or expectant management with close maternal and fetal clinical monitoring". I disagree that expectant management is an option in HELLP and AFLP.
Response: We have removed the section on "expectant management…" from the manuscript.

6. Furthermore, why do you have to discuss, starting with line 251, AFLP? AFLP is not preeclampsia and not TMA.
Response: AFLP is briefly mentioned as AFLP can present with similar features as TTP or CM-HUS. We have revised the discussion on AFLP to clarify this on lines 267-270. We have also moved the sentence on AFLP to the next paragraph to avoid confusion with preeclampsia.

7. Line 574, and other places in the manuscript."…close obstetrical monitoring throughout pregnancy with serial growth scans and/or uterine artery Doppler scan…/". Please note that in the US, uterine artery Doppler assessment is not an accepted form of surveillance in pregnancy complications.
Response: We have removed, "uterine artery Doppler scan" and replaced it with "serial sonographic assessments" on lines 483, 608, and 673.

Reviewer #3: The authors set out to provide a contemporary review of the management of rare thrombotic microangiopathies during pregnancy and the postpartum period.

This is a comprehensive and thorough review that is well organized. Tables and figures are complementary. Congratulations on a well done article.
Response: Thank you for the kind comments. No changes suggested.

Reviewer #4: These authors offer a review of three rare but important TMA that may coincide with pregnancy. This is a dense, information-rich, well written article that summarizes a large amount of information. I have several specific comments:
1. Do the authors consider ADAMTS13 to be completely diagnostic for TTP? This is implied but not clearly stated. This has not necessarily been true in the past but may be now as disease understanding has progressed.
Response: The presence of severe ADAMTS13 deficiency in a patient with suspected TTP strongly supports the diagnosis. However, as with any laboratory test, ADAMTS13 deficiency, in itself, is insufficient to definitely establish or exclude the diagnosis of TTP. Clinical symptoms as well as clinical judgment is imperative in making the diagnosis.

We have revised the manuscript on line 298-299 to state that, "…ADAMTS13 testing is crucial to help distinguish the diagnosis of TTP from other TMAs".

We have added a paragraph on ADAMTS13 results on line 305-311, "When the result of ADAMTS13 activity is available, severe ADAMTS13 deficiency (<10%) confirms the diagnosis of TTP in patients with high clinical suspicion or an intermediate- to high-risk score. In those with low clinical suspicion or a low risk-score, severe ADAMTS13 deficiency strongly suggests the diagnosis but other clinical diagnoses should also be considered. An ADAMTS13 activity of >20% often rules out the diagnoses of TTP. If the ADAMTS13 activity is between 10-20% (an equivocal result), clinical judgment with hematologist input is required to guide diagnosis and treatment."

2. It might be worth stating the diagnostic accuracy of the PLASMIC and French scores in the text as well as table footnotes.
Response: We have included the diagnostic accuracy of the PLASMIC and French scores in the text at lines 146-152.

3. Page 11, line 258 - it might be worthwhile offering a level of renal impairment (SCr) at which preE becomes less likely and other TMAs more likely. It is common in my experience for Nephrologists or Hematologists to attribute a SCr or 2 or 3 to preE without understanding that this is actually very rare.
Response: We agree with the reviewer that severe renal impairment is rare in preeclampsia. Based on the study by Burwick et al, 2021, which found that a serum creatinine of >1.9 mg/dL was an optimal threshold for pregnancy-associated CM-HUS, we have used this threshold for severe renal impairment on lines 276-278, "Similarly, severe renal impairment (e.g. serum creatinine ≥1.9 mg/dL) is more suggestive of CM-HUS, may occur in CAPS, and is less likely in preeclampsia, HELLP syndrome or TTP.

4. There is tension in an article like this between academic knowledge and clinical management. The flow charts on how to manage the different disease entities are very helpful, but initially the clinician needs to make management decisions before a diagnosis is made. Perhaps of most import is when empiric TPE should be started while awaiting test results. In my experience this is often a critical issue and one of contention. I often favor empiric TPE while waiting results. I think the authors should offer some "official" guidance on this issue.

Response: We agree about the need for empiric management with TPE for suspected TTP before diagnosis is confirmed. This is stated on lines 349-350, "….daily therapeutic plasma exchange (TPE) should be initiated preemptively while awaiting confirmation of severe ADAMTS13 deficiency." The flow chart also lists empiric TPE prior to test results.

5. Consider splitting Table 2 into three parts: Routine tests immediately available; routine tests that will come back after initial management decisions are made; tests that are not routine and/or are experimental.
Response: Thank you for this suggestion. We have revised Table 2 accordingly.

6. Similar to point 4 above, regarding line 322, what PLASMIC or French score qualifies as "a high clinical suspicion"?
Response: A high clinical suspicion can be based on clinical assessment or using risk assessment models such as a PLASMIC high-risk score of 6-7 or at least 1 criterion met using the French score. This has been added to the manuscript on lines 347-348.

7. A reference on the relative benefits of TPE vs plasma infusion (eg. Rock 1993 NEJM or newer if available) would be helpful.
Response: We have included this reference on lines 354-356, "TPE is now the standard of care following the 1991 landmark trial demonstrating the superiority of TPE over plasma infusion for mortality and disease remission…"

Also, a mention that if TPE is not available, patient transfer should be considered.
Response: This is now included on lines 353-354, "If TPE is not available, transfer to a specialist center with TPE capabilities and specialist input is recommended."

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.
Response: Yes, please publish our point-by-point response letter.

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.
Response: There was no funding for this review paper. This information has been added to the title page and at the end of the abstract.

As this is a review paper, the information requested are not applicable for this manuscript.

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.
Response: This has been completed by all authors. Any disclosures have been included on the title page.

4. 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."
Response: The manuscript uses person-first language.

5. 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."
Response: The current manuscript has been revised to avoid gendered descriptions.

6. Standard obstetric and gynecology data definitions have been developed through the reVITALize initiative, which was convened by the American College of Obstetricians and Gynecologists and the members of the Women's Health Registry Alliance. Obstetrics & Gynecology has adopted the use of the reVITALize definitions. Please access the obstetric data definitions at https://www.acog.org/practice-management/health-it-and-clinical-informatics/revitalize-obstetrics-data-definitions and the gynecology data definitions at https://www.acog.org/practice-management/health-it-and-clinical-informatics/revitalize-gynecology-data-definitions. If use of the reVITALize definitions is problematic, please discuss this in your point-by-point response to this letter.
Response: Thank you for this information.

7. 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.
Response: The acknowledgements follow the above specifications.

8. 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.
Response: This has been included.

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1. TMA – thrombotic microangiopathies
2. TTP – thrombotic thrombocytopenic purpura
3. CM-HUS – complement-mediated hemolytic uremic syndrome
4. aHUS – atypical hemolytic uremic syndrome
5. CAPS – catastrophic antiphospholipid syndrome
6. AFLP – acute fatty liver of pregnancy
7. ADAMTS13 - a disintegrin and metalloprotease with thrombospondin type 1 motif, member 13
8. LDH – lactate dehydrogenase
9. APS – antiphospholipid syndrome
10. aPL – antiphospholipid
11. CBC – complete blood count
12. CMP – comprehensive metabolic panel
13. sFLT1 - soluble fms-like tyrosine kinase 1
14. PIGF – placental growth factor
15. TPE – therapeutic plasma exchange
16. FFP – fresh frozen plasma
17. LMWH – low molecular weight heparin

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