NOTICE: This document contains correspondence generated during peer review and subsequent revisions but before transmittal to production for composition and copyediting:

- 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: 02/17/2023
To: "Mindy Marie Sampson" [redacted]
From: "The Green Journal" em@greenjournal.org
Subject: Your Submission ONG-23-312

RE: Manuscript Number ONG-23-312

A Case and Review of Mpox Infection During Pregnancy

Dear Dr. Sampson:

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, and STATISTICAL EDITOR COMMENTS (if applicable) below.

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).

*** The Editors would like to fast track your manuscript. Your submission will be maintained in active status for 7 days from the date of this letter. If we have not heard from you by 02/24/2023, we will assume you wish to withdraw the manuscript from further consideration.

EDITOR COMMENTS:

1. If you opt to submit a revision for consideration, please add more information in the abstract about the case (eg presentation, diagnosis and treatment).

2. The details of the delivery such as fetal head position and presence of a nuchal cord are not relevant to the case report and can be deleted.

3. The last paragraph of the case describing the infant’s nasolacrimal duct obstruction should also be deleted as it is not relevant to the case.

4. Please note the following:

* Help us reduce the number of queries we add to your manuscript after it is revised by reading the Revision Checklist at https://journals.lww.com/greenjournal/Documents/RevisionChecklist_Authors.pdf and making the applicable edits to your manuscript.

REVIEWER COMMENTS:

Reviewer #1:

The authors present a case of an mpox infection occurring at 31 weeks gestation which resulted in an uncomplicated induction at 39 weeks and 2 days of pregnancy.

The following are my questions and comments:

1. The opening line of the conclusion in the abstract (Transplacental transmission of mpox is possible). does not follow with any granularity from the case synopsis immediately preceding or the teaching point immediately following?

2. Can the authors elaborate a little more for the reader regarding the patient counseling undertaken around perinatal mpox infection?

3. The authors reference the AJOG review article. The article states that cesarean delivery is recommended (unless vaginal and anorectal lesions are absent AND vaginal and rectal MPXV-PCR swabs are negative). Can the authors confirm that the swabs were negative prior to induction?

Reviewer #2:

The authors describe a case of mpox infection during pregnancy treated with tecovirimat at 31 weeks, which resulted in a health delivery at term.

Some additional details about the patient's hospital and post-discharge course would be helpful.

MAJOR

* Please further describe "the outbreak is due to clade IIb."

* Paragraph starting on line 53: What was the reason for admission at 31 weeks (working diagnosis)? More info on the decision to admit given the symptoms described would be helpful.

* What was the working differential of the patient's skin lesions prior to day 6 of her hospitalization, when she disclosed her mpox exposure?

* Why was the patient induced at 39 weeks?

* Was the neonate isolated from the mother following delivery?

* What do the authors think caused the neonate's skin lesion that was noted a birth?

* I would consider re-framing "without evidence of fetal infection" as the neonate was IgG positive.

MINOR

* Recommend use of person-centric language (pregnant people or individuals rather than pregnant women)

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Sincerely,

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

The Editors of Obstetrics & Gynecology

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February 20, 2023

Editor in Chief:

Jason D. Wright, MD

Obstetrics & Gynecology

Dear Dr. Wright,

Please find enclosed a revised manuscript titled “A Case and Review of Mpox Infection During Pregnancy” for your consideration for publication as a Case Report in *Obstetrics & Gynecology*. The authors include Mindy M. Sampson, Gray Magee, Evan Schrader, Keerti Dantuluri, Areej Bukhari, Catherine Passaretti, Lorene Temming, Michael Leonard, Jennifer Philips and David Weinrib. The revisions you and the reviewers suggested have been addressed and are shown in the track changes.

This manuscript has not been previously published and is not under consideration for publication elsewhere. To the best of my knowledge, no conflict of interest, financial or other, exists. All authors have contributed significantly to the work and have seen and approved the manuscript. This case was discussed with our institutional review board (IRB) at Wake Forest University, given this is a case report IRB approval was not required. A signed consent was obtained from the patient in this case report to utilize her clinical images. Thank you for considering our manuscript for publication in your journal.

Thank you for your thoughtful consideration of our revised manuscript, we hope that you will find it suitable for publication in *Obstetrics & Gynecology*.

Sincerely,

Mindy M Sampson, DO

1225 Harding Pl. Ste 2100, Charlotte, NC 28204

Charlotte, NC 28204

[redacted]

Response to Editor:
Thank you for your thoughtful review and feedback on our letter. We appreciated your recommendations and have made some additions to address your suggestions.

Comment 1:
If you opt to submit a revision for consideration, please add more information in the abstract about the case (eg presentation, diagnosis and treatment).

Response:
We added additional text in lines 33-37 of the abstract for provide more details about the case.

Comment 2:
*The details of the delivery such as fetal head position and presence of a nuchal cord are not relevant to the case report and can be deleted.

Response:
We deleted this text.

Comment 3:
*The last paragraph of the case describing the infant's nasolacrimal duct obstruction should also be deleted as it is not relevant to the case.

Response:
We deleted this text.

Response to Reviewer #1:

Thank you for taking the time to read our manuscript, we appreciated your meaningful feedback to help to improve this text.

Comment 1:
*The opening line of the conclusion in the abstract (Transplacental transmission of mpox is possible). does not follow with any granularity from the case synopsis immediately preceding or the teaching point immediately following?

Response:
We appreciate this comment and added text in line 38-39 and 44-46, which we think makes the abstract and teaching points more cohesive.

Comment 2:
*Can the authors elaborate a little more for the reader regarding the patient counseling undertaken around perinatal mpox infection?

Response:
We added further details regarding the counseling that occurred with the patient in lines 76-78.

Comment 3:
*The authors reference the AJOG review article. The article states that cesarean delivery is recommended (unless vaginal and anorectal lesions are absent AND vaginal and rectal MPXV-PCR swabs are negative). Can the authors confirm that the swabs were negative prior to induction?

Response:
These recommendations were not published at the time our patient was cared for. However, we do agree this is an important teaching point. Therefore, we have added text in lines 129-132 to further address this.

Response to Reviewer #2:

Thank you for taking the time to review our manuscript and give us detailed feedback to improve this case report. We appreciate the detailed recommendations.

Comment 1:
*Some additional details about the patient's hospital and post-discharge course would be helpful.

Response:
We have added text in lines 96-97 and lines 101-102 to provide further details regarding the infant's hospital course and post-discharge follow-up. Due to word limits we attempted to provide the most relevant details of the clinical history.

Comment 2:
*Please further describe "the outbreak is due to clade IIb."

Response:
We choose to remove the text related to the genomic clades. We felt this would take more extensive text to describe the genomic differences between the clades. Given the word limitations we choose to remove this given we felt this was less relevant to this case and the audience of this journal.

Comment 3:
*Paragraph starting on line 53: What was the reason for admission at 31 weeks (working diagnosis)? More info on the decision to admit given the symptoms described would be helpful.

Response:
We have added text in line 58 to explain the reason for admission.

Comment 4:
*What was the working differential of the patient's skin lesions prior to day 6 of her hospitalization, when she disclosed her mpox exposure?

Response:

We have added text to line 66 to explain that this was previously thought to be related to herpes simplex.

Comment 5:
*Why was the patient induced at 39 weeks?

Response:
We added text in lines 85-89 to address this question. We discuss induction options routinely with patients at 39 weeks of gestation without any risk factors for adverse pregnancy outcomes, per the ARRIVE trial.

Comment 6:
*Was the neonate isolated from the mother following delivery?

Response:
There is text included in the manuscript in lines 88-90 stating the infant was isolated after delivery until pediatric evaluation per our institutional policy.

Comment 7:
*What do the authors think caused the neonate's skin lesion that was noted a birth?

Response:
We added clarification in line 94-95 to explain that the scalp lesion was attributed to occiput posterior positioning during delivery.

Comment 8:
* I would consider re-framing "without evidence of fetal infection" as the neonate was IgG positive.

Response:
Thank you for pointing out this opportunity to clarify our message. We adjusted the wording in line 133-134 to note that clinical exam was not suggestive of mpox infection.

Comment 9:
* Recommend use of person-centric language (pregnant people or individuals rather than pregnant women)

Response:
We appreciate this suggestion. We have updated the text and choose to use the “pregnant individuals”