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: Jul 30, 2022
To: "Vivian W. Sung" [redacted]
From: "The Green Journal" em@greenjournal.org
Subject: Your Submission ONG-22-1120

RE: Manuscript Number ONG-22-1120

Non-operative Management of Pelvic Organ Prolapse

Dear Dr. Sung:

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 Aug 20, 2022, we will assume you wish to withdraw the manuscript from further consideration.

REVIEWER COMMENTS:

Reviewer #1: Summary: This is a Clinical Expert Series discussing the non-operative management of pelvic organ prolapse. The authors give a comprehensive review of the evaluation and non-operative management of prolapse, focusing on pessary use.

Epidemiology
- Lines 68-71: "Annual cross-sectional data from National Health and Nutrition Examination Surveys… feeling a vaginal bulge." This is repeated from lines 59-62.
- Line 71: Consider using "anterior, posterior, and apical prolapse" as the authors themselves point out that "cystocele, enterocele, or rectocele" "have fallen out of favor" (lines 233-234).
- Line 77: There has been cost-effectiveness research investigating ambulatory treatment of prolapse (PMID: 21360216; PMID: 27504918).

Pathophysiology and risk factors
- Lines 110-112: Consider citing the proposed etiology for mechanical stress on prolapse and "positive effect on tissue"

Diagnosis and Evaluation of Pelvic Organ Prolapse
- Lines 295-304: Consider discussing the role of renal ultrasound to evaluate for hydronephrosis in the setting of patients with advanced prolapse who elect for conservative management

Nonsurgical Treatment of Pelvic Organ Prolapse
- Lines 350-356: Would add a line describing typical removal process following the description about placement here.
- Lines 366-368: Again would add a line about removal of Gellhorn, especially since the breaking of suction and use of a ring forceps can be helpful and are different from removal of ring pessaries.
- Lines 428-442: Would add to the discussion of vaginal estrogen use in the setting of pessary that this may not prevent erosions (Level I evidence, PMID: 33501563).

Conclusion
- Consider mentioning pelvic floor physical therapy as this was discussed as part of this paper and is considered an

option for non-operative management of prolapse

Reviewer #2:

Abstract:
concise and well written

Introduction:
line 36; can omit mentioning ICS and IUGA, sufficient to just provide citation

Epidemiology:
71-72: person-years is sometimes too abstract for these types of articles, I would recommend just providing the incidence of each type of prolapse

77-79: this seems to be a little out of place, and does not contribute significantly to a generalist understanding of POP

Pathophysiology:
line 82-91: If the authors have access to a figure demonstrating the levels of support that would serve as a useful adjunct to this paragraph

line 100-107: I would also add 1-2 sentences about the fact that while Cesarean Delivery is associated with a lower risk of POP compared to SVD or OVD, it is not protective

Figure 2 is a bit fuzzy and it is hard to make out the anatomic details

line 298-300: recommend adding something about defects noted only defecography but no apparent defect on exam may not lead to resolution of defecatory symptoms

line 300-304: I would add that US may be obtained if there is concern about possible bladder outlet obstruction (either due to high PVR, acute increase in Cr/decrease in GFR)

line 360-367: would add that ring/support pessaries tend to be less successful than space-occupying pessaries for stage 3 and 4 prolapse

Reviewer #3: Re: Non-operative Management of Pelvic Organ Prolapse

This manuscript is a review of non-operative management of pelvic organ prolapse. It includes an overview of the definition, epidemiology, pathophysiology, evaluation, and diagnosis of pelvic organ prolapse in addition to non-operative management of the condition including pelvic floor muscle training and pessary use. The review highlights previously published research findings relevant to the topics listed above and strives to provide recommendations based on established guidelines and other original research.

My main critique is that the article strives to cover many topics related to pelvic organ prolapse (e.g. epidemiology, pathophysiology, evaluation, diagnosis, etc.) at the expense of offering a more focused and thorough review of non-operative management of pelvic organ prolapse.

General questions:
If the focus of the article is on non-operative management of pelvic organ prolapse, why is the majority of the article discussing the definition, epidemiology, pathophysiology, evaluation, and diagnosis of pelvic organ prolapse?

There are many other reviews of pelvic organ prolapse that include a review of non-operative management of prolapse. Is there new data or additional information about non-operative management that you would like to highlight or expand upon through this article?

1. P1, L22 Given the paper is focused on non-operative management of pelvic organ prolapse, recommend concentrating on non-surgical treatments in the abstract. Currently, non-surgical management is mentioned once in the abstract only in reference to pessary use. There is no mention of pelvic floor muscle therapy, which is discussed later in the article as the other option for non-surgical management.

2. P2, L40-41 What is your source for these symptoms in relation to prolapse (specifically low backache)? Jevlosek et al. published a review of pelvic organ prolapse (Jelovsek JE, Maher C, Barber MD. Pelvic organ prolapse. Lancet. 2007;369(9566):1027-38) that does an excellent job reviewing symptoms of pelvic organ prolapse based on the literature reviewed. Some references from that review may enhance your presentation of the information listed here if you decided to expand on this.

3. P3, L61 and L70 You mention a cross-sectional study that found 2-5% of non-pregnant patients reported symptoms of vaginal bulge. Does this affect overall epidemiology of the disease? Are you highlighting that only 2-5% of patients have symptoms of vaginal bulge, compared to the 40-50% that have prolapse on exam?
4. P6, L140 Consider including sources for statement about obesity possibly being protective. What data or source suggests this?

5. P12, L 287 Consider including this paragraph regarding additional testing under the next subject heading titled "Additional testing."

6. P13, L295 Given your audience for this article is Ob/Gyn providers, consider using technical terms rather than lay terms such as "bladder scan." Your audience should know what you mean by using an ultrasound to evaluate postvoid residual.

7. P14, L340 What source did you use for this list of recommended contraindications to pessary?

8. P16, L371-372 Interesting finding. What source supports the statement that the cube and the donut pessary "result in more vaginal discharge compared to other pessary types"?

9. P17, L414 and P18 L 419 Here you discuss timing of pessary removal and pessary check. Consider reviewing Thys et al. (Thys SD, Hakvoort RA, Asseler J, Milani AL, Vollebregt A, Roovers JP. Effect of pessary cleaning and optimal time interval for follow-up: a prospective cohort study. Int Urogynecol J. 2020;31(8):1567-1574) as an additional source on this topic.

10. P18, L438 Here you review timing of pessary holiday in patients with vaginal erosion. Is there data on the optimal or recommended time to leave the pessary out in setting of vaginal erosion? If so, please site the source here.

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. 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."

4. 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."

5. 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.

6. 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.

7. 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.

8. 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.

9. Figures 1-7: Please upload as figures files on Editorial Manager.
Figures 2-6: Are these images original to the manuscript, or is permission needed?

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

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

***

If you choose 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 Aug 20, 2022, we will assume you wish to withdraw the manuscript from further consideration.

Sincerely,

The Editors of Obstetrics & Gynecology

RE: Manuscript Number ONG-22-1120

Non-operative Management of Pelvic Organ Prolapse

Dear Editors,

Thank you for the opportunity to submit a revised version of our manuscript.
We have addressed editor and reviewer requests.

Thank you for your consideration.

Vivian Sung, on behalf of all authors.

REVIEWER COMMENTS:

Reviewer #1: Summary: This is a Clinical Expert Series discussing the non-operative management of pelvic organ prolapse. The authors give a comprehensive review of the evaluation and non-operative management of prolapse, focusing on pessary use.

Epidemiology
1. Lines 68-71: "Annual cross-sectional data from National Health and Nutrition Examination Surveys… feeling a vaginal bulge." This is repeated from lines 59-62.

Thank you – we have deleted this.

2. Line 71: Consider using "anterior, posterior, and apical prolapse" as the authors themselves point out that "cystocele, enterocele, or rectocele" "have fallen out of favor" (lines 233-234).

Thank you for catching this – we have modified.

3. Line 77: There has been cost-effectiveness research investigating ambulatory treatment of prolapse (PMID: 21360216; PMID: 27504918).

Lines 325-328: We have added this reference later in the paper under Pelvic Floor Muscle Therapy:

In another randomized trial of 162 women comparing PFMT to pessary of Stage 2 or greater prolapse, there was no difference between treatments for reducing pelvic floor symptoms, but pessary was more cost-effective compared to PFMT. Greater than 70% of women in this trial had Stage 2 prolapse.

Pathophysiology and risk factors
4. Lines 110-112: Consider citing the proposed etiology for mechanical stress on prolapse and "positive effect on tissue"

Lines 112-117: We have revised this to say:
One of many possible reasons is compounded years of mechanical stress on the muscles and connective tissue, but since there may be a certain amount of force needed to maintain tissue strength, the threshold where this mechanical stress becomes a negative influence on pelvic organ

support is unclear.

Diagnosis and Evaluation of Pelvic Organ Prolapse
5. Lines 295-304: Consider discussing the role of renal ultrasound to evaluate for hydronephrosis in the setting of patients with advanced prolapse who elect for conservative management

Lines 293-296: This has been added:

For women who have an elevated post-void residual, renal ultrasound can be considered to evaluate for hydronephrosis. For example if hydronephrosis is present, treatment should be considered as opposed to observation

Nonsurgical Treatment of Pelvic Organ Prolapse
6. Lines 350-356: Would add a line describing typical removal process following the description about placement here.

Lines 356-359: This has been added:
Removal includes inserting an index finger into the vagina and finding the rim of the pessary. The patient or clinician can then hook their finger under the rim and pull the pessary down and out of the vagina.

7. Lines 366-368: Again would add a line about removal of Gellhorn, especially since the breaking of suction and use of a ring forceps can be helpful and are different from removal of ring pessaries.

Lines 372-379: This has been added:

Since there is a small degree of suction when the pessary is in place, it is important to release the suction between the pessary and the vaginal apex before extracting it. This is why self-management is not an ideal option with these types of pessaries. Removal can be assisted by using a ring forceps or Kelly clamp to grasp the stem of the Gellhorn pessary for stabilization. Then with a bit of traction on the clamp, the clinician can break the suction by hooking a finger behind the base of the pessary and then remove it with downward traction.

8. Lines 428-442: Would add to the discussion of vaginal estrogen use in the setting of pessary that this may not prevent erosions (Level I evidence, PMID: 33501563).

Lines 434-435: This point and reference have been added to the same line:

Vaginal estrogen may be helpful to manage this, and can decrease the risk of vaginal discharge and pessary discontinuation, although may not prevent erosions.

Conclusion
9. Consider mentioning pelvic floor physical therapy as this was discussed as part of this paper and is considered an option for non-operative management of prolapse

Line 478: We have added this:

Depending on patient goals and degree of prolapse, pelvic floor physical therapy can be offered.

Reviewer #2:

Abstract:
concise and well written

Introduction:
1. line 36; can omit mentioning ICS and IUGA, sufficient to just provide citation

We have removed these.

Epidemiology:
2. 71-72: person-years is sometimes too abstract for these types of articles, I would recommend just providing the incidence of each type of prolapse

Line 64-65: We have revised this statement:

In a study of postmenopausal women, 31.8% were found to have pelvic organ prolapse.

3. 77-79: this seems to be a little out of place, and does not contribute significantly to a generalist understanding of POP

We have removed this.

Pathophysiology:
4. line 82-91: If the authors have access to a figure demonstrating the levels of support that would serve as a useful adjunct to this paragraph

Editors: not sure if this is needed, since Reviewer 2 critiqued that we should have less about epidemiology and pathophysiology and more focus on non-surgical options.

If the editors feel this should be added, there is an image in reference:
Huebner M, DeLancey JOL. Levels of pelvic floor support: what do they look like on magnetic resonance imaging? Int Urogynecol J. 2019 Sep;30(9):1593-1595. doi: 10.1007/s00192-019-03986-x. Epub 2019 May 29. PMID: 31143979; PMCID: PMC6707880.

We did search ONG for a similar image for ease of permisisons, but did not find one.

5. line 100-107: I would also add 1-2 sentences about the fact that while Cesarean Delivery is associated with a lower risk of POP compared to SVD or OVD, it is not protective

Lines 102-103: We have included this point:
Vaginal delivery is strongly associated with persistent symptomatic prolapse, although cesarean delivery has not been demonstrated to be definitively protective.

6. Figure 2 is a bit fuzzy and it is hard to make out the anatomic details

We have included another figure 2 illustrating the same anatomy. We hope this is more clear.

7. line 298-300: recommend adding something about defects noted only defecography but no apparent defect on exam may not lead to resolution of defecatory symptoms

Lines 302-303: We have added:

However, findings on defecography without defect on examination may not warrant intervention.

8. line 300-304: I would add that US may be obtained if there is concern about possible bladder outlet obstruction (either due to high PVR, acute increase in Cr/decrease in GFR)

Thank you – this has been added per Reviewer 2's comments as well. Lines 293-296.

9. line 360-367: would add that ring/support pessaries tend to be less successful than space-occupying pessaries for stage 3 and 4 prolapse

Lines 361-362: We have added:
Ring pessaries may be less effective for more advanced stage 3-4 prolapse due to expulsion.

Reviewer #3: Re: Non-operative Management of Pelvic Organ Prolapse

This manuscript is a review of non-operative management of pelvic organ prolapse. It includes an overview of the definition, epidemiology, pathophysiology, evaluation, and diagnosis of pelvic organ prolapse in addition to non-operative management of the condition including pelvic floor muscle training and pessary use. The review highlights previously published research findings relevant to the topics listed above and strives to provide recommendations based on established guidelines and other original research.

My main critique is that the article strives to cover many topics related to pelvic organ prolapse (e.g. epidemiology, pathophysiology, evaluation, diagnosis, etc.) at the expense of offering a more focused and thorough review of non-operative management of pelvic organ prolapse.

General questions:
If the focus of the article is on non-operative management of pelvic organ prolapse, why is the majority of the article discussing the definition, epidemiology, pathophysiology, evaluation, and diagnosis of pelvic organ prolapse?

There are many other reviews of pelvic organ prolapse that include a review of non-operative management of prolapse. Is there new data or additional information about non-operative management that you would like to highlight or expand upon through this article?

We removed some content and are open to removing more, should the Editors feel these sections do not belong in this review.

1. P1, L22 Given the paper is focused on non-operative management of pelvic organ prolapse, recommend concentrating on non-surgical treatments in the abstract. Currently, non-surgical management is mentioned once in the abstract only in reference to pessary use. There is no mention of pelvic floor muscle therapy, which is discussed later in the article as the other option for non-surgical management.

Line 22: We have added pelvic floor physical therapy to the abstract:

Although surgical options exist, all patients who are symptomatic and desire treatment should be offered non-surgical treatment first, including pelvic floor physical therapy or a pessary trial.

2. P2, L40-41 What is your source for these symptoms in relation to prolapse (specifically low backache)? Jevlosek et al. published a review of pelvic organ prolapse (Jelovsek JE, Maher C, Barber MD. Pelvic organ prolapse. Lancet. 2007;369(9566):1027-38) that does an excellent job reviewing symptoms of pelvic organ

prolapse based on the literature reviewed. Some references from that review may enhance your presentation of the information listed here if you decided to expand on this.

We have included the suggested reference.

3. P3, L61 and L70 You mention a cross-sectional study that found 2-5% of non-pregnant patients reported symptoms of vaginal bulge. Does this affect overall epidemiology of the disease? Are you highlighting that only 2-5% of patients have symptoms of vaginal bulge, compared to the 40-50% that have prolapse on exam?

We agree that statement is confusing and have removed it.

4. P6, L140 Consider including sources for statement about obesity possibly being protective. What data or source suggests this?

In consideration of the critique that there is too much epidemiologic information, and the weak data regarding this issue, we have removed this paragraph entirely.

5. P12, L 287 Consider including this paragraph regarding additional testing under the next subject heading titled "Additional testing."

We have revised this.

6. P13, L295 Given your audience for this article is Ob/Gyn providers, consider using technical terms rather than lay terms such as "bladder scan." Your audience should know what you mean by using an ultrasound to evaluate postvoid residual.

We agree and have removed this.

7. P14, L340 What source did you use for this list of recommended contraindications to pessary?

Lines 342-343: We have softened the language to say:
Special considerations about appropriateness of pessary insertion include local infection, noncompliance for follow-up, unexplained genital tract bleeding, and potentially mesh exposure.

8. P16, L371-372 Interesting finding. What source supports the statement that the cube and the donut pessary "result in more vaginal discharge compared to other pessary types"?

This is based on the authors' experience. Since there are no randomized trials assessing this as a primary outcome, we have revised the statement:

Lines 380-382: Clinically there may be more vaginal discharge compared to a ring pessary.

9. P17, L414 and P18 L 419 Here you discuss timing of pessary removal and pessary check. Consider reviewing Thys et al. (Thys SD, Hakvoort RA, Asseler J, Milani AL, Vollebregt A, Roovers JP. Effect of pessary cleaning and optimal time interval for follow-up: a prospective cohort study. Int Urogynecol J. 2020;31(8):1567-1574) as an additional source on this topic.

This reference mentioned by this reviewer is a small cohort of 123 women evaluating cleaning of pessary at 3 versus 9 month intervals, and included both women who self-manage and those who do not. Almost have of the women self-managed the pessary. The study showed no difference between

groups who had cleaning 3 versus 9 months, did not include a sample size analysis, and does not change our statement that interval recommendations are inconclusive ranging from 3-12 months. Furthermore, this particular paragraph in the paper is referring to women who do not self manage and thus the applicability of such a small sample size is unclear. We have already included a randomized trial as well as the UK Clinical Guideline for Best Practice in the use of Vaginal Pessaries as our references in this section.

Therefore, we do not feel this reference enhances or changes our paper and thus we have not included it.

10. P18, L438 Here you review timing of pessary holiday in patients with vaginal erosion. Is there data on the optimal or recommended time to leave the pessary out in setting of vaginal erosion? If so, please site the source here.

There are no trials evaluating timing of pessary holiday with erosion. Recommendations are based on existing guidelines and clinical practice, as included in this section.

In addition:
1. References: We have cleaned up the references – there was a software error leading to mis-numbering.

Figures:
2. Figures 2-3 are original and no permission is needed.

3. Figures 4-6 are from a prior article from this journal Obstetrics and Gynecology and do require permission.
4. Figure 7 was provided by Reia LLC with permission, if it is to be included.

Thank you – Vivian

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. 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."

4. 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."

5. 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.

6. 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.

7. 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.

8. 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.

9. Figures 1-7: Please upload as figures files on Editorial Manager.
Figures 2-6: Are these images original to the manuscript, or is permission needed?

10. 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.