

# 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)\*
- Email correspondence between the editorial office and the authors\*

*\*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](mailto:obgyn@greenjournal.org).

**Date:** Nov 09, 2018  
**To:** "Tetsuya Kawakita" [REDACTED]  
**From:** "The Green Journal" em@greenjournal.org  
**Subject:** Your Submission ONG-18-2005

RE: Manuscript Number ONG-18-2005

Reducing Cesarean Surgical Site Infections: A Resident-Driven Quality Initiative

Dear Dr. Kawakita:

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).

Your paper will be maintained in active status for 21 days from the date of this letter. If we have not heard from you by Nov 30, 2018, we will assume you wish to withdraw the manuscript from further consideration.

#### REVIEWER COMMENTS:

Reviewer #1:

Overall Comments:

The authors present a study of the implementation of an evidence-based surgical bundle and its effect on Cesarean surgical site infections. They performed a pre/post intervention design (not retrospective cohort) looking at surgical site infections pre-intervention and comparing them post-intervention. They did attempt to match patients in these two different groups with the use of Coarsened Exact Matching with k-to-k solution. This was a reasonable way in which to minimize confounding in overall characteristics between the groups and is a strength of this study. The authors describe the specific components of this surgical bundle adequately and provide the rationale for these inclusions. They further describe the patient groups succinctly. Further, the authors showed that matching the subjects did impact potential confounding of the patients clinical and demographic characteristics.

Specific Comments:

Title: Good

Short title: OK

Précis: Good

Abstract, Methods Section: This was actually a quasi-experimental, pre/post intervention study, not a retrospective cohort study; otherwise, a nice summary of the study.

Introduction: Explains the rationale for the study. Please see line 76 for the spelling of "bundale." It was of interest that this study was performed under the purview of a patient safety and quality improvement initiative by the residents.

Materials and Methods: I would not state that this was a retrospective cohort study, it was a pre/post intervention study. The rest of the Methods were well described.

Results: The identification of the subjects pre/post intervention and the use of CEM matching was well described and provided in the figure and table. All of the tables were helpful. Did the authors seek to determine whether compliance had any effect on outcomes?

Discussion: With respect to weaknesses outlined, a couple of others should at least be noted. Specifically that the lack of randomization can effect the implication of causality and secondly, that results may reflect regression to the mean with the results due to chance. A third potential weakness is the confounding by patient characteristics, however, CEM matching proactively addressed this issue. Were there any other potential changes in secular trends that may need to be have accounted for?

Reviewer #2: The authors have submitted an analysis of a resident-implemented quality improvement project with the goal of reducing surgical site infections after cesarean delivery. There are often many barriers to changing hospital culture. I commend their team for implementing this project.

Abstract:

Although it makes the abstract longer, I would suggest keeping lines 42-47 for those readers who unfortunately read only abstracts.

Line 57: It is unclear that the rate of surgical site infections that are described first are from the unmatched patient cohort. It would be helpful to note this to make it easier to understand.

Introduction:

Lines 73-77. The part after "small sample size" needs rewording for clarity. Otherwise concise and easy to follow.

Material and Methods

Lines 91 and 123: The authors report that an emergency cesarean delivery was an exclusion criterion, but on line 123 mention that some bundle elements may not have been performed during emergency cesarean deliveries. Please explain this apparent contradiction.

Lines 137-146: Most of this can be attributed to Table 2 to save space. For example, "Maternal demographics are listed in Table 2."

Results:

Concise and well-written.

Discussion:

Table 1 shows compliance rates prior to and after implementation of the project. Although compliance improved after implementation, almost 30% of patients did not undergo vaginal cleansing or placental removal by cord traction. Why do the authors think compliance was lower for these elements? Also, in the materials and methods section (line 127) the authors mention monthly compliance reviews. Did they find that compliance increased over the course of the study period? If so, this would be worth mentioning in the discussion as another method of helping others implement similar projects.

Line 237: note typo.

Line 239: The authors comment that some women may have sought postpartum care outside of the system. They should be able to provide data for how many patients were lost to follow up.

Tables and Figures:

Appropriate for manuscript.

References:

Contemporaneous and appropriate for manuscript. I advise rechecking the formatting. Errors are common in the reference section and I noted some typos and formatting issues.

Reviewer #3: Reducing cesarean surgical site infections: a resident-driven quality initiative

The authors implemented a quality care surgical bundle, and compare the incidence of surgical site infection to a retrospective cohort

1. The authors should be congratulated on this effort.
2. Lines 102-4 are repetitive.
3. The surgical bundle (Box 1) includes processes that were not tracked. This includes clippers instead of razor, closure

of subcutaneous tissue, dressing removal, and daily chlorhexidine shower. Please explain why they were included, how this may have affected results, and resulting limitations.

4. Line 249. According to Table 3, only the addition of azithromycin and vaginal cleaning were entirely new. The authors state that azithromycin may be the sole cause of SSI reduction, but the same may be true for vaginal cleansing or the combination of both.
5. Figure 1 might not be needed.
6. An examination of the data reveals that the addition of the matched-cohort did not really change the results when compared to the unmatched cohort. Table 2 demonstrates that there is really no difference in patient demographics before and after matching, and if there is, the difference is very small. Why do the authors feel it is important to include the results of both the unmatched and matched cohorts? Would it not be enough to simply state that matching did not change the results?
7. Has this surgical bundle be adopted by all practitioners at your institution? If not, why not? What are the obstacles?
8. Are there cesarean deliveries that were not associated with residents? If so, do you have data on their incidence of SSI?

#### STATISTICAL EDITOR COMMENTS:

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

lines 163-164: Why were those 6 factors chosen for matching? From Table 2, it appears that only maternal age, race/ethnicity and pregnancy associated HTN were different pre and post implementation?

Table 2: Should include units for GA at delivery

#### EDITOR COMMENTS:

1. Thank you for your submission. The Editors would welcome a revision, but under the Clinical Practice and Quality article type.

A Clinical Practice and Quality study article is a full-length report of the implementation of research findings into clinical practice, assessment of a change in clinical practice methods on outcomes, discussion of cost-conscious care, or a focused description of a quality improvement or a quality assessment program. Quality improvement and quality assessment studies are initiatives within a clinical unit or health care system that are designed to improve health care in terms of one or more of the aims for the health care system put forth by the Health and Medicine Division of the National Academies of Sciences, Engineering, and Medicine (formerly the Institute of Medicine): safe, effective, patient-centered, timely, efficient, and equitable.

The article's length should not exceed 5,500 words (approximately 22 manuscript pages). The Introduction and Discussion should not exceed 250 words and 750 words, respectively.

If the IRB at your institution does not require approval of quality improvement studies for either the performance or reporting of the results, please submit a copy of this decision by your IRB. Otherwise, please provide the name of the IRB that approved your study and include it in the methods section. For quality studies, the SQUIRE 2.0 reporting guideline is recommended (<http://www.equator-network.org/wp-content/uploads/2012/12/SQUIRE-2.0-checklist.pdf>), and a completed checklist should be submitted.

#### Clinical Practice

1) Abstract: Articles that focus on clinical practice should have a structured abstract of no more than 300 words, using the following headings:

**Objective:** A single phrase stating the primary objective, question or hypothesis starting with, for example, "To evaluate" or "To estimate."

**Methods:** Describes the clinical setting, the intervention(s) or practice pattern(s) studied, study design and power calculations if appropriate, participants, and outcome measures.

**Results:** Reports observed associations between the interventions and relevant contextual elements and the primary

outcome(s), and important secondary outcomes when appropriate. Provides measurements expressed in absolute numbers and percentages and when appropriate indicates relative risks or odds ratios with confidence intervals and level of statistical certainty. Any results contained in the abstract should be also be presented in the body, tables, or figures of the manuscript.

Conclusion: Describes key findings or conclusions. Is directly supported by the data. Provides clinical implications when appropriate.

2) Headings: Clinical practice study reports should be organized in a manner similar to the structured abstract.

Introduction: Orients the reader to the clinical setting and research finding(s) implemented into practice or the clinical practice method being assessed. Ends with a clearly stated primary outcome or hypothesis, followed by secondary outcomes if appropriate. Avoid a detailed literature review in this section.

Materials and Methods: States the type and time-frame of study of the study and describes the research methodology in sufficient detail so that others could duplicate or adapt the work to their settings. This section should state that an appropriate IRB approved the work or determined the work to be exempt. If it was exempt from IRB approval, state the reason why. In all cases, the institutional affiliation of the IRB should be provided. Identify methods of statistical analysis and when appropriate, state the bases (including alpha and beta error estimates) for their selection. Cite any statistical software programs used in the text. In most cases, express P values to no more than three decimal places. Where appropriate, indicate the study's intended power to detect statistical differences in the primary outcome, and pre-specified key secondary outcomes. For studies that include data obtained from administrative database, identify who entered the study and how the accuracy of the database was validated.

Results: Presents the findings in appropriate detail. Tables and figures may be used and should be able to be understood on their own; duplication between these and the text should be minimized. Actual numbers and percentages should be given in addition to odds ratios or relative risks. When appropriate, number needed to treat for benefit (NNTb) or harm (NNT<sub>h</sub>) should be supplied.

Discussion: Begins with a description of, without detailed repetition of, what the submitted study found in relation to the study's primary outcomes first, followed by any secondary outcomes. Describes, but does not repeat, the results. Describes how the research implementation or clinical practice change affected care, costs, workflow, or satisfaction for patients, providers, or the health care system(s). The discussion should compare the study's findings with those of previous relevant studies, with explanations in cases where they differ; avoiding a complete review of the literature. Primacy claims indicating that the study is the "first" or "largest" should be avoided, unless supported by a description of the search strategy to support the claim. A final summary is not necessary.

#### Quality Improvement and Assessment

1) Abstract: Articles describing quality improvement and quality assessment should have a structured abstract of no more than 300 words, with the following headings:

Objective: Describes the nature and significance of the local problem and the purpose of the project and this report (in no more than two sentences).

Methods: Describes the clinical setting, intervention(s), approach chosen, measures for reporting the processes and results, and analytic methods.

Results: Reports observed associations between the interventions and relevant contextual elements and the primary outcome(s), and important secondary outcomes when appropriate. Provides measurements expressed in absolute numbers and percentages and when appropriate indicates relative risks or odds ratios with confidence intervals and level of statistical certainty. Any results contained in the abstract should be also be presented in the body, tables, or figures of the manuscript.

Discussion: Describes key findings or conclusions. Is directly supported by the data. Provides clinical implications when appropriate.

2) Headings: Quality improvement and quality assessment studies should be organized in a manner similar to the structured abstract and should use elements found in the SQUIRE 2.0 reporting guideline.<sup>23</sup> A completed checklist should be submitted.

Introduction: Describes why the study was performed and includes the nature and significance of the local problem, the framework used to explain the problem, and the assumptions used to develop the intervention. This should be one page or less and should end a clearly stated purpose of the project with a clearly stated primary outcome or hypothesis. Avoid a detailed literature review in this section.

Materials and Methods: Describes the contextual elements such as the clinical setting (eg, inpatient versus outpatient, size of unit, purpose of the clinical setting, number and type of staff and patients, hospital vs non-hospital setting), and time-frame of study. Describes the intervention in sufficient detail so that others could adapt the work to their settings, and describes the specifics of the team involved. Describes the measures for studying the processes and outcomes, data collection, and analytic methods. Identifies methods of statistical analysis and when appropriate, states the bases (including alpha and beta error estimates) for their selection. Cite any statistical software programs used in the text. In most cases, express P values to no more than three decimal places. Where appropriate, indicate the study's intended power to detect statistical differences in the primary outcome, and pre-specified key secondary outcomes. For studies that include data obtained from administrative database, identify who entered the study and how the accuracy of the database was validated. This section should state that an appropriate IRB approved the work or determined the work to be exempt.

If it was exempt from IRB approval, state the reason why. In all cases the institutional affiliation of the IRB should be provided in the manuscript.

**Results:** Reports the initial steps of the intervention and their evolution over time; details of the process measures and outcomes in appropriate detail. Tables and figures may be used and should be able to be understood on their own; duplication between these and the text should be minimized. Actual numbers and percentages should be given in addition to odds ratios or relative risks. When appropriate, number needed to treat for benefit (NNTb) or harm (NNTh) should be supplied. The report should include information regarding unintended outcomes and details about missing data. Finally, address racially equitable outcomes.<sup>28</sup>

**Discussion:** Describes the key findings, relevance to the rationale and specific aims of the study and particular strengths of the study. Describes the associations between the intervention and the outcomes and considers the approach used to establish whether or not a cause-effect relationship was established. The discussion should compare the study's findings with those of previous relevant studies with explanations in cases where they differ; avoiding a complete review of the literature. Primacy claims indicating that the study is the "first" or "largest" should be avoided, unless supported by a description of the search strategy to support the claim. Considers outcomes in terms of the framework for quality assessment from the Health and Medicine Division of the National Academies of Sciences, Engineering, and Medicine (formerly the Institute of Medicine). Considers the costs and strategic trade-offs involved in the intervention and the limitations of study, including generalizability, and how the achieved gains can be sustained or spread to other contexts in the current or other settings. Includes ethical aspects of the work and how these were addressed. A final summary may suggest next steps if appropriate.

2. 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, as well as subsequent author queries. 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:

1. OPT-IN: Yes, please publish my response letter and subsequent email correspondence related to author queries.
2. OPT-OUT: No, please do not publish my response letter and subsequent email correspondence related to author queries.

3. Author Agreement Forms: Please note the following issues with your forms. Updated or corrected forms should be submitted with the revision.

Helain J. Landy, MD - Did not approve of the final version or agree to be accountable for the Work.

Melissa Fries, MD - Did not agree to be accountable for the Work.

Please note:

a) Any material included in your submission that is not original or that you are not able to transfer copyright for must be listed under I.B on the first page of the author agreement form.

b) All authors must disclose any financial involvement that could represent potential conflicts of interest in an attachment to the author agreement form.

c) All authors must indicate their contributions to the submission by checking the applicable boxes on the author agreement form.

d) The role of authorship in Obstetrics & Gynecology is reserved for those individuals who meet the criteria recommended by the International Committee of Medical Journal Editors (ICMJE; <http://www.icmje.org>):

\* Substantial contributions to the conception or design of the work;

OR

the acquisition, analysis, or interpretation of data for the work;

AND

\* Drafting the work or revising it critically for important intellectual content;

AND

\* Final approval of the version to be published;

AND

\* Agreement to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

The author agreement form is available online at <http://edmgr.ovid.com/ong/accounts/agreementform.pdf>. Signed forms should be scanned and uploaded into Editorial Manager with your other manuscript files. Any forms collected after your revision is submitted may be e-mailed to [obgyn@greenjournal.org](mailto:obgyn@greenjournal.org).

4. Our journal requires that all evidence-based research submissions be accompanied by a transparency declaration statement from the manuscript's lead author. The statement is as follows: "The lead author\* affirms that this manuscript is an honest, accurate, and transparent account of the study being reported; that no important aspects of the study have

been omitted; and that any discrepancies from the study as planned (and, if relevant, registered) have been explained."  
\*The manuscript's guarantor.

If you are the lead author, please include this statement in your cover letter. If the lead author is a different person, please ask him/her to submit the signed transparency declaration to you. This document may be uploaded with your submission in Editorial Manager.

5. Please submit a completed STROBE guideline with your revision.

Responsible reporting of research studies, which includes a complete, transparent, accurate and timely account of what was done and what was found during a research study, is an integral part of good research and publication practice and not an optional extra. Obstetrics & Gynecology supports initiatives aimed at improving the reporting of health research, and we ask authors to follow specific guidelines for reporting randomized controlled trials (ie, CONSORT), observational studies (ie, STROBE), meta-analyses and systematic reviews of randomized controlled trials (ie, PRISMA), harms in systematic reviews (ie, PRISMA for harms), studies of diagnostic accuracy (ie, STARD), meta-analyses and systematic reviews of observational studies (ie, MOOSE), economic evaluations of health interventions (ie, CHEERS), and quality improvement in health care (ie, SQUIRE 2.0). Include the appropriate checklist for your manuscript type upon submission. Please write or insert the page numbers where each item appears in the margin of the checklist. Further information and links to the checklists are available at <http://ong.editorialmanager.com>. In your cover letter, be sure to indicate that you have followed the CONSORT, MOOSE, PRISMA, PRISMA for harms, STARD, STROBE, CHEERS, or SQUIRE 2.0 guidelines, as appropriate.

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 will be transitioning as much as possible to use of the reVITALize definitions, and we encourage authors to familiarize themselves with them. The obstetric data definitions are available at <http://links.lww.com/AOG/A515>, and the gynecology data definitions are available at <http://links.lww.com/AOG/A935>.

7. Because of space limitations, it is important that your revised manuscript adhere to the following length restrictions by manuscript type: Clinical Practice and Quality articles 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 appendixes).

Please limit your Introduction to 250 words and your Discussion to 750 words.

8. Specific rules govern the use of acknowledgments in the journal. Please edit your acknowledgments or provide more information in accordance with 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 signature on the journal's author agreement 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).

9. 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 limits for different article types are as follows: Clinical Practice and Quality, 300 words. Please provide a word count.

10. 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.

11. The journal does not use the virgule symbol (/) in sentences with words. 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.

12. 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](http://edmgr.ovid.com/ong/accounts/table_checklist.pdf).

### 13. Figures

Figure 1: Please resubmit as-is.

Please upload Box 1 as a separate file on Editorial Manager.

14. If you choose to revise your manuscript, please submit your revision via Editorial Manager for Obstetrics & Gynecology at <http://ong.editorialmanager.com>. It is essential that your cover letter list point-by-point the changes made in response to each criticism. Also, please save and submit your manuscript in a word processing format such as Microsoft Word.

If you submit a revision, we will assume that it has been developed in consultation with your co-authors, that each author has given approval to the final form of the revision, and that the agreement form signed by each author and submitted with the initial version remains valid.

Again, your paper will be maintained in active status for 21 days from the date of this letter. If we have not heard from you by Nov 30, 2018, we will assume you wish to withdraw the manuscript from further consideration.

Sincerely,

Dwight J. Rouse, MD  
Associate Editor for Obstetrics

2017 IMPACT FACTOR: 4.982  
2017 IMPACT FACTOR RANKING: 5th out of 82 ob/gyn journals

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In compliance with data protection regulations, please contact the publication office if you would like to have your personal information removed from the database.

We would like to thank all reviewers and editors for their comments and critique of the manuscript that are very helpful to improve our manuscript. Please see the detailed response to comments below.

### **Reviewer #1:**

#### Overall Comments:

The authors present a study of the implementation of an evidence-based surgical bundle and its effect on Cesarean surgical site infections. They performed a pre/post intervention design (not retrospective cohort) looking at surgical site infections pre-intervention and comparing them post-intervention. They did attempt to match patients in these two different groups with the use of Coarsened Exact Matching with k-to-k solution. This was a reasonable way in which to minimize confounding in overall characteristics between the groups and is a strength of this study. The authors describe the specific components of this surgical bundle adequately and provide the rationale for these inclusions. They further describe the patient groups succinctly. Further, the authors showed that matching the subjects did impact potential confounding of the patients clinical and demographic characteristics.

#### Specific Comments:

Title: Good

Short title: OK

Précis: Good

#### **Reviewer #1 Comment #1**

Abstract, Methods Section: This was actually a quasi-experimental, pre/post intervention study, not a retrospective cohort study; otherwise, a nice summary of the study.

#### **Reviewer #1 Response #1**

Thank you for your suggestion. We have updated the study design.

Line 39

“This was a quasi-experimental, pre/post intervention study of women...”

#### **Reviewer #1 Comment #2**

Introduction: Explains the rationale for the study. Please see line 76 for the spelling of "bundale." It was of interest that this study was performed under the purview of a patient safety and quality improvement initiative by the residents.

#### **Reviewer #1 Response #2**

We have corrected the typo.

**Reviewer #1 Comment #3**

Materials and Methods: I would not state that this was a retrospective cohort study, it was a pre/post intervention study. The rest of the Methods were well described.

**Reviewer #1 Response #3**

Thank you for your suggestion. We have updated the study design.

Line 89

“This was a quasi-experimental, pre/post intervention study of women...”

**Reviewer #1 Comment #4**

Results: The identification of the subjects pre/post intervention and the use of CEM matching was well described and provided in the figure and table. All of the tables were helpful. Did the authors seek to determine whether compliance had any effect on outcomes?

**Reviewer #1 Response #4**

Thank you for your suggestion. We considered examining if compliance had effects on the rate of surgical site infections. However, our sample size was not large enough to perform a further stratified analysis.

**Reviewer #1 Comment #5**

Discussion: With respect to weaknesses outlined, a couple of others should at least be noted. Specifically that the lack of randomization can affect the implication of causality and secondly, that results may reflect regression to the mean with the results due to chance. A third potential weakness is the confounding by patient characteristics, however, CEM matching proactively addressed this issue. Were there any other potential changes in secular trends that may need to be accounted for?

**Reviewer #1 Response #5**

We agree that due to the study design we can only infer correlation but not causation. We have noted this in the discussion.

Line 261

“Because our study was not a randomized controlled trial, we can only infer correlation but not causation.”

Regarding the second suggestion, we agree that there may be some concerns regarding issues with regression to the mean. However, our baseline surgical site infection rates were 5.5%, 6.5%, and 5.2% in 2013, 2014, and 2015, respectively ( $P = .38$ ), suggesting surgical site infection rates were stable before study. We are happy to include this information in the paper. However, due to word limitation of 750 words, we would like to defer to editor’s decision.

Regarding the third suggestion, CEM would have addressed the issues with confounders and we have discussed this in the strengths.

Line 250

“In addition, Coarsened Exact Matching was used to account for potential demographic change due to the closure of two local hospitals.”

There was no change in our clinical practice other than the surgical bundle.

**Reviewer #2:**

The authors have submitted an analysis of a resident-implemented quality improvement project with the goal of reducing surgical site infections after cesarean delivery. There are often many barriers to changing hospital culture. I commend their team for implementing this project.

**Reviewer #2 Comment #1**

Abstract:

Although it makes the abstract longer, I would suggest keeping lines 42-47 for those readers who unfortunately read only abstracts.

**Reviewer #2 Response #1**

We agree that lines 42-47 are important for readers.

**Reviewer #2 Comment #2**

Line 57: It is unclear that the rate of surgical site infections that are described first are from the unmatched patient cohort. It would be helpful to note this to make it easier to understand.

**Reviewer #2 Response #2**

Thank you for your suggestion. We have now made it clear in the abstract.

Line 57

“The rate of surgical site infections in the unmatched cohort was...”

**Reviewer #2 Comment #3**

Introduction:

Lines 73-77. The part after "small sample size" needs rewording for clarity. Otherwise concise and easy to follow.

**Reviewer #2 Response #3**

We have reworded the sentence to clarify.

Line 76-78

“as previous studies were limited by small sample size, a meta-analysis of a variety of surgical bundles, or secondary analysis of a clinical trial for a different purpose.”

**Reviewer #2 Comment #4**

Material and Methods

Lines 91 and 123: The authors report that an emergency cesarean delivery was an exclusion criterion, but on line 123 mention that some bundle elements may not have been performed

during emergency cesarean deliveries. Please explain this apparent contradiction.

#### **Reviewer #2 Response #4**

Thank you for your careful review. In case of urgent cesarean delivery (not emergency cesarean delivery), attending physicians may opt out to perform vaginal preparation. However, this sentence is confusing, so we have deleted the sentence.

Line 124

#### **Reviewer #2 Comment #5**

Lines 137-146: Most of this can be attributed to Table 2 to save space. For example, "Maternal demographics are listed in Table 2."

#### **Reviewer #2 Response #5**

We listed variables so that we could define some of the variables in this paragraph. For example, we defined diabetes, pregnancy-associated hypertensive disease, and labor. We are happy to remove the list of demographics if editors would like us.

#### **Reviewer #2 Comment #6**

Results:

Concise and well-written.

Discussion:

Table 1 shows compliance rates prior to and after implementation of the project. Although compliance improved after implementation, almost 30% of patients did not undergo vaginal cleansing or placental removal by cord traction. Why do the authors think compliance was lower for these elements? Also, in the materials and methods section (line 127) the authors mention monthly compliance reviews. Did they find that compliance increased over the course of the study period? If so, this would be worth mentioning in the discussion as another method of helping others implement similar projects.

Line 237: note typo.

#### **Reviewer #2 Response #6**

Although we excluded emergent cesarean delivery, urgent cesarean delivery was not excluded. In case of urgent cesarean delivery, attending physicians may have opted out of vaginal cleansing or decide to perform manual removal of placenta, which may explain lower rates of vaginal cleansing or placenta removal by cord traction. We have discussed this in the discussion section.

#### **Line 269-274**

“Approximately 30% of women in the post-implementation period did not have vaginal cleansing or placenta removal by cord traction. Although we excluded emergent cesarean

delivery, urgent cesarean delivery was not excluded. In case of urgent cesarean delivery, attending physicians may have opted out of vaginal cleansing or decide to perform manual removal of placenta, which may explain lower rates of vaginal cleansing or placenta removal by cord traction.”

Regarding the compliance over the course of the post-implementation period, the use of intravenous azithromycin, chlorhexidine alcohol skin preparation, vaginal preparation, and placenta delivery by cord traction increased over time ( $P < .01$ ). We have added a figure as well as discussed in the discussion.

Line 274-278

“We observed improving compliance on vaginal cleansing and placenta removal by cord traction during the post-implementation period.”

The typo has been corrected.

Line 267-272

**Reviewer #2 Comment #7**

Line 239: The authors comment that some women may have sought postpartum care outside of the system. They should be able to provide data for how many patients were lost to follow up.

**Reviewer #2 Response #7**

Unfortunately, we did not have information regarding loss of follow up. We have added this to the limitation.

Line 255

“Information regarding loss of follow-up was not available in our data.”

**Reviewer #2 Comment #8**

Tables and Figures:

Appropriate for manuscript.

References:

Contemporaneous and appropriate for manuscript. I advise rechecking the formatting. Errors are common in the reference section and I noted some typos and formatting issues.

**Reviewer #2 Response #8**

We have reviewed the reference and made the appropriate change.

**Reviewer #3: Reducing cesarean surgical site infections: a resident-driven quality initiative**

The authors implemented a quality care surgical bundle and compare the incidence of surgical site infection to a retrospective cohort

**Reviewer #3 Comment #1**

1. The authors should be congratulated on this effort.

**Reviewer #3 Response #1**

Thank you.

**Reviewer #3 Comment #2**

2. Lines 102-4 are repetitive.

**Reviewer #3 Response #2**

The repetitive sentence was removed.

**Reviewer #3 Comment #3**

3. The surgical bundle (Box 1) includes processes that were not tracked. This includes clippers instead of razor, closure of subcutaneous tissue, dressing removal, and daily chlorhexidine shower. Please explain why they were included, how this may have affected results, and resulting limitations.

**Reviewer #3 Response #3**

Compliance on use of clippers instead of a razor, suture closure of subcutaneous tissue, dressing removal between 24 and 48 hours, and chlorhexidine shower was not consistently documented in the chart. However, our hypothesis was that the quality initiative would reduce the rate of surgical site infections, so our results and conclusion would not change due to lack of compliance information of some of the elements. We discussed in the paper why only 6 elements were examined.

Line 132-135

“Compliance on the other elements (use of clippers instead of a razor, suture closure of subcutaneous tissue, dressing removal between 24 and 48 hours, and chlorhexidine shower) was not consistently documented in the chart. Therefore, these elements were not tracked.”

**Reviewer #3 Comment #4**

4. Line 249. According to Table 3, only the addition of azithromycin and vaginal cleaning were entirely new. The authors state that azithromycin may be the sole cause of SSI reduction, but the same may be true for vaginal cleansing or the combination of both.

**Reviewer #3 Response #4**

We agree with Reviewer #3. It is possible that only the addition of preoperative azithromycin and/or vaginal cleansing is responsible for the reduced rate of surgical site infections. We have updated the discussion.

Line 264

“It is possible that only the addition of preoperative azithromycin and/or vaginal cleansing is responsible for the reduced rate of surgical site infections.”

**Reviewer #3 Comment #5**

5. Figure 1 might not be needed.

**Reviewer #3 Response #5**

We are happy to remove Figure 1 if editors would like us to. However, we thought this Figure provided important information.

**Reviewer #3 Comment #6**

6. An examination of the data reveals that the addition of the matched-cohort did not really change the results when compared to the unmatched cohort. Table 2 demonstrates that there is really no difference in patient demographics before and after matching, and if there is, the difference is very small. Why do the authors feel it is important to include the results of both the unmatched and matched cohorts? Would it not be enough to simply state that matching did not change the results?

**Reviewer #3 Response #6**

We agree that CEM matching did not change our results significantly. However, we felt it was important to present results of matched cohort because of the closure of obstetric units at two local hospitals during the post-implementation period, which may have resulted in a change of our patient demographics.

**Reviewer #3 Comment #7**

7. Has this surgical bundle be adopted by all practitioners at your institution? If not, why not? What are the obstacles?

**Reviewer #3 Response #7**

The surgical bundle was adopted by all practitioners at our institution.

**Reviewer #3 Comment #8**

8. Are there cesarean deliveries that were not associated with residents? If so, do you have data on their incidence of SSI?

**Reviewer #3 Response #8**

All of the cesarean deliveries were covered by residents. We have updated the paper to clarify.

Line 91-92

“All cesarean deliveries were covered by residents.”

**STATISTICAL EDITOR COMMENTS:**

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

**Statistical editor Comment #1**

lines 163-164: Why were those 6 factors chosen for matching? From Table 2, it appears that only maternal age, race/ethnicity and pregnancy associated HTN were different pre and post implementation?

**Statistical editor Response #1**

Factors used for CEM was chosen a priori because these were risk factors for surgical site infections. We have clarified this in the paper.

Line 171-173

“To account for the potential demographic change, we performed Coarsened Exact Matching (CEM) with k-to-k solution based on predefined factors including age, race/ethnicity, body mass index ( $\text{kg}/\text{m}^2$ ), rupture of membranes, and labor.<sup>27</sup> These factors were chosen because these were known risk factors for surgical site infections.<sup>10, 28”</sup>

**Statistical editor Comment #2**

Table 2: Should include units for GA at delivery

**Statistical editor Response #2**

We have updated Table 2.

**EDITOR COMMENTS:****Editor Comment #1**

1. Thank you for your submission. The Editors would welcome a revision, but under the Clinical Practice and Quality article type.

A Clinical Practice and Quality study article is a full-length report of the implementation of research findings into clinical practice, assessment of a change in clinical practice methods on outcomes, discussion of cost-conscious care, or a focused description of a quality improvement or a quality assessment program. Quality improvement and quality assessment studies are initiatives within a clinical unit or health care system that are designed to improve health care in terms of one or more of the aims for the health care system put forth by the Health and Medicine Division of the National Academies of Sciences, Engineering, and Medicine (formerly the Institute of Medicine): safe, effective, patient-centered, timely, efficient, and equitable.

The article's length should not exceed 5,500 words (approximately 22 manuscript pages). The Introduction and Discussion should not exceed 250 words and 750 words, respectively.

If the IRB at your institution does not require approval of quality improvement studies for either the performance or reporting of the results, please submit a copy of this decision by your IRB. Otherwise, please provide the name of the IRB that approved your study and include it in the methods section. For quality studies, the SQUIRE 2.0 reporting guideline is recommended

(<http://www.equator-network.org/wp-content/uploads/2012/12/SQUIRE-2.0-checklist.pdf>), and a completed checklist should be submitted.

### **Editor Response #1**

Our paper is compliant with these requirements. We have submitted SQUIRE 2.0 checklist.

### **Editor Comment #2**

Clinical Practice

1) Abstract: Articles that focus on clinical practice should have a structured abstract of no more than 300 words, using the following headings:

**Objective:** A single phrase stating the primary objective, question or hypothesis starting with, for example, "To evaluate" or "To estimate."

**Methods:** Describes the clinical setting, the intervention(s) or practice pattern(s) studied, study design and power calculations if appropriate, participants, and outcome measures.

**Results:** Reports observed associations between the interventions and relevant contextual elements and the primary outcome(s), and important secondary outcomes when appropriate. Provides measurements expressed in absolute numbers and percentages and when appropriate indicates relative risks or odds ratios with confidence intervals and level of statistical certainty. Any results contained in the abstract should be also be presented in the body, tables, or figures of the manuscript.

**Conclusion:** Describes key findings or conclusions. Is directly supported by the data. Provides clinical implications when appropriate.

2) Headings: Clinical practice study reports should be organized in a manner similar to the structured abstract.

**Introduction:** Orients the reader to the clinical setting and research finding(s) implemented into practice or the clinical practice method being assessed. Ends with a clearly stated primary outcome or hypothesis, followed by secondary outcomes if appropriate. Avoid a detailed literature review in this section.

**Materials and Methods:** States the type and time-frame of study of the study and describes the research methodology in sufficient detail so that others could duplicate or adapt the work to their settings. This section should state that an appropriate IRB approved the work or determined the work to be exempt. If it was exempt from IRB approval, state the reason why. In all cases, the institutional affiliation of the IRB should be provided. Identify methods of statistical analysis and when appropriate, state the bases (including alpha and beta error estimates) for their selection. Cite any statistical software programs used in the text. In most cases, express P values to no more than three decimal places. Where appropriate, indicate the study's intended power to detect statistical differences in the primary outcome, and pre-specified key secondary outcomes. For studies that include data obtained from administrative database, identify who entered the study and how the accuracy of the database was validated.

**Results:** Presents the findings in appropriate detail. Tables and figures may be used and should be able to be understood on their own; duplication between these and the text should be

minimized. Actual numbers and percentages should be given in addition to odds ratios or relative risks. When appropriate, number needed to treat for benefit (NNTb) or harm (NNTh) should be supplied.

**Discussion:** Begins with a description of, without detailed repetition of, what the submitted study found in relation to the study's primary outcomes first, followed by any secondary outcomes. Describes, but does not repeat, the results. Describes how the research implementation or clinical practice change affected care, costs, workflow, or satisfaction for patients, providers, or the health care system(s). The discussion should compare the study's findings with those of previous relevant studies, with explanations in cases where they differ; avoiding a complete review of the literature. Primacy claims indicating that the study is the "first" or "largest" should be avoided, unless supported by a description of the search strategy to support the claim. A final summary is not necessary.

## Quality Improvement and Assessment

1) **Abstract:** Articles describing quality improvement and quality assessment should have a structured abstract of no more than 300 words, with the following headings:

**Objective:** Describes the nature and significance of the local problem and the purpose of the project and this report (in no more than two sentences).

**Methods:** Describes the clinical setting, intervention(s), approach chosen, measures for reporting the processes and results, and analytic methods.

**Results:** Reports observed associations between the interventions and relevant contextual elements and the primary outcome(s), and important secondary outcomes when appropriate. Provides measurements expressed in absolute numbers and percentages and when appropriate indicates relative risks or odds ratios with confidence intervals and level of statistical certainty. Any results contained in the abstract should be also be presented in the body, tables, or figures of the manuscript.

**Discussion:** Describes key findings or conclusions. Is directly supported by the data. Provides clinical implications when appropriate.

2) **Headings:** Quality improvement and quality assessment studies should be organized in a manner similar to the structured abstract and should use elements found in the SQUIRE 2.0 reporting guideline.<sup>23</sup> A completed checklist should be submitted.

**Introduction:** Describes why the study was performed and includes the nature and significance of the local problem, the framework used to explain the problem, and the assumptions used to develop the intervention. This should be one page or less and should end a clearly stated purpose of the project with a clearly stated primary outcome or hypothesis. Avoid a detailed literature review in this section.

**Materials and Methods:** Describes the contextual elements such as the clinical setting (eg, inpatient versus outpatient, size of unit, purpose of the clinical setting, number and type of staff and patients, hospital vs non-hospital setting), and time-frame of study. Describes the intervention in sufficient detail so that others could adapt the work to their settings, and describes the specifics of the team involved. Describes the measures for studying the processes and

outcomes, data collection, and analytic methods. Identifies methods of statistical analysis and when appropriate, states the bases (including alpha and beta error estimates) for their selection. Cite any statistical software programs used in the text. In most cases, express P values to no more than three decimal places. Where appropriate, indicate the study's intended power to detect statistical differences in the primary outcome, and pre-specified key secondary outcomes. For studies that include data

obtained from administrative database, identify who entered the study and how the accuracy of the database was validated. This section should state that an appropriate IRB approved the work or determined the work to be exempt. If it was exempt from IRB approval, state the reason why. In all cases the institutional affiliation of the IRB should be provided in the manuscript.

**Results:** Reports the initial steps of the intervention and their evolution over time; details of the process measures and outcomes in appropriate detail. Tables and figures may be used and should be able to be understood on their own; duplication between these and the text should be minimized. Actual numbers and percentages should be given in addition to odds ratios or relative risks. When appropriate, number needed to treat for benefit (NNTb) or harm (NNT<sub>h</sub>) should be supplied. The report should include information regarding unintended outcomes and details about missing data. Finally, address racially equitable outcomes.<sup>28</sup>

**Discussion:** Describes the key findings, relevance to the rationale and specific aims of the study and particular strengths of the study. Describes the associations between the intervention and the outcomes and considers the approach used to establish whether or not a cause-effect relationship was established. The discussion should compare the study's findings with those of previous relevant studies with explanations in cases where they differ; avoiding a complete review of the literature. Primacy claims indicating that the study is the "first" or "largest" should be avoided, unless supported by a description of the search strategy to support the claim. Considers outcomes in terms of the framework for quality assessment from the Health and Medicine Division of the National Academies of Sciences, Engineering, and Medicine (formerly the Institute of Medicine). Considers the costs and strategic trade-offs involved in the intervention and the limitations of study, including generalizability, and how the achieved gains can be sustained or spread to other contexts in the current or other settings. Includes ethical aspects of the work and how these were addressed. A final summary may suggest next steps if appropriate.

### **Editor Response #2**

Our paper is compliant with these requirements.

### **Editor Comment #3**

2. 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, as well as subsequent author queries. 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:

1. OPT-IN: Yes, please publish my response letter and subsequent email correspondence related to author queries.
2. OPT-OUT: No, please do not publish my response letter and subsequent email

correspondence related to author queries.

### **Editor Response #3**

Yes, please publish my response letter and subsequent email correspondence related to author queries.

### **Editor Comment #4**

3. Author Agreement Forms: Please note the following issues with your forms. Updated or corrected forms should be submitted with the revision.

Helain J. Landy, MD - Did not approve of the final version or agree to be accountable for the Work.

Melissa Fries, MD - Did not agree to be accountable for the Work.

Please note:

a) Any material included in your submission that is not original or that you are not able to transfer copyright for must be listed under I.B on the first page of the author agreement form.

b) All authors must disclose any financial involvement that could represent potential conflicts of interest in an attachment to the author agreement form.

c) All authors must indicate their contributions to the submission by checking the applicable boxes on the author agreement form.

d) The role of authorship in Obstetrics & Gynecology is reserved for those individuals who meet the criteria recommended by the International Committee of Medical Journal Editors (ICMJE; <http://www.icmje.org>):

\* Substantial contributions to the conception or design of the work;

OR

the acquisition, analysis, or interpretation of data for the work;

AND

\* Drafting the work or revising it critically for important intellectual content;

AND

\* Final approval of the version to be published;

AND

\* Agreement to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

The author agreement form is available online

at <http://edmgr.ovid.com/ong/accounts/agreementform.pdf>. Signed forms should be scanned and uploaded into Editorial Manager with your other manuscript files. Any forms collected after your

revision is submitted may be e-mailed to [obgyn@greenjournal.org](mailto:obgyn@greenjournal.org).

#### **Editor Response #4**

We have updated author agreement forms.

#### **Editor Comment #5**

4. Our journal requires that all evidence-based research submissions be accompanied by a transparency declaration statement from the manuscript's lead author. The statement is as follows: "The lead author\* affirms that this manuscript is an honest, accurate, and transparent account of the study being reported; that no important aspects of the study have been omitted; and that any discrepancies from the study as planned (and, if relevant, registered) have been explained." \*The manuscript's guarantor.

If you are the lead author, please include this statement in your cover letter. If the lead author is a different person, please ask him/her to submit the signed transparency declaration to you. This document may be uploaded with your submission in Editorial Manager.

#### **Editor Response #5**

We have added the following sentence in the cover letter.

“The lead author affirms that this manuscript is an honest, accurate, and transparent account of the study being reported; that no important aspects of the study have been omitted; and that any discrepancies from the study as planned (and, if relevant, registered) have been explained.”

#### **Editor Comment #6**

5. Please submit a completed STROBE guideline with your revision.

Responsible reporting of research studies, which includes a complete, transparent, accurate and timely account of what was done and what was found during a research study, is an integral part of good research and publication practice and not an optional extra. Obstetrics & Gynecology supports initiatives aimed at improving the reporting of health research, and we ask authors to follow specific guidelines for reporting randomized controlled trials (ie, CONSORT), observational studies (ie, STROBE), meta-analyses and systematic reviews of randomized controlled trials (ie, PRISMA), harms in systematic reviews (ie, PRISMA for harms), studies of diagnostic accuracy (ie, STARD), meta-analyses and systematic reviews of observational studies (ie, MOOSE), economic evaluations of health interventions (ie, CHEERS), and quality improvement in health care (ie, SQUIRE 2.0). Include the appropriate checklist for your manuscript type upon submission. Please write or insert the page numbers where each item appears in the margin of the checklist. Further information and links to the checklists are available at <http://ong.editorialmanager.com>. In your cover letter, be sure to indicate that you have followed the CONSORT, MOOSE, PRISMA, PRISMA for harms, STARD, STROBE, CHEERS, or SQUIRE 2.0 guidelines, as appropriate.

#### **Editor Response #6**

We have submitted STROBE checklist.

**Editor Comment #7**

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 will be transitioning as much as possible to use of the reVITALize definitions, and we encourage authors to familiarize themselves with them. The obstetric data definitions are available at <http://links.lww.com/AOG/A515>, and the gynecology data definitions are available at <http://links.lww.com/AOG/A935>.

**Editor Response #7**

We have reviewed revitalize definitions and made sure definitions were according the the initiative.

**Editor Comment #8**

7. Because of space limitations, it is important that your revised manuscript adhere to the following length restrictions by manuscript type: Clinical Practice and Quality articles 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 appendixes).

Please limit your Introduction to 250 words and your Discussion to 750 words.

8. Specific rules govern the use of acknowledgments in the journal. Please edit your acknowledgments or provide more information in accordance with 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 signature on the journal's author agreement 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).

**Editor Response #8**

Our paper is compliant with these requirements.

**Editor Comment #9**

9. 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 limits for different article types are as follows: Clinical Practice and Quality, 300 words. Please provide a word count.

**Editor Response #9**

We have updated the abstract according to main text change.

**Editor Comment #10**

10. 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.

11. The journal does not use the virgule symbol (/) in sentences with words. 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.

**Editor Response #10**

Our paper is compliant with these requirements.

**Editor Comment #11**

12. 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](http://edmgr.ovid.com/ong/accounts/table_checklist.pdf).

**Editor Response #11**

We have submitted the journal's Table Checklist.

**Editor Comment #12**

13. Figures

Figure 1: Please resubmit as-is.

Please upload Box 1 as a separate file on Editorial Manager.

**Editor Comment #12**

We have uploaded Figure 1 and Box 1 separately.

## Daniel Mosier

---

**From:** Tetsuya Kawakita [REDACTED]  
**Sent:** Tuesday, November 20, 2018 1:50 PM  
**To:** Daniel Mosier  
**Subject:** Re: Manuscript Revisions: ONG-18-2005R1  
**Attachments:** Response revise 2.docx; 18-2005R1 ms (11-19-18v2)TK.docx

Thank you for your careful review. I have revised the paper and answered questions. Please see attached manuscript and response.

I am looking forward to hearing from you!

Tetsuya

On Mon, Nov 19, 2018 at 3:05 PM Daniel Mosier <[dmosier@greenjournal.org](mailto:dmosier@greenjournal.org)> wrote:

Dear Dr. Kawakita,

Thank you for submitting your revised manuscript. It has been reviewed by the editor, and there are a few issues that must be addressed before we can consider your manuscript further:

1. Please note the minor edits and deletions throughout. Please let us know if you disagree with any of these changes.
2. LINE 3: Please ask the following authors to respond to the authorship confirmation email we sent. We sent an email from [em@greenjournal.org](mailto:em@greenjournal.org). The message contains a link that needs to be clicked on. We emailed the authors at the email addresses below– are these the correct addresses?

- Sara N. Iqbal: [REDACTED]
- Jim C Huang: [REDACTED]
- Melissa Fries: [REDACTED]

3. LINE 54: The journal avoids using the virgule (“/”) with text. Is using “and” here correct? This was also changed on lines 154, 161, and 204.
4. LINE 134: Is “and” correct?
5. LINE 141: Is “and” correct?
6. LINE 182: Is “and” correct?
7. LINE 199: The meaning of this sentence is unclear
8. Line 228: Please revise "and/or" to mean either "and" or "or." Be sure this is done throughout your paper.
9. LINE 236: How do you define "urgent" and "emergent"?

Please let me know if you have any questions. Your prompt response to these queries will be appreciated; please respond no later than COB on **Monday, November 26<sup>th</sup>**.

Sincerely,

-Daniel Mosier

**Daniel Mosier**

Editorial Assistant

*Obstetrics & Gynecology*

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**From:** [REDACTED]  
**To:** [Stephanie Casway](mailto:Stephanie.Casway)  
**Subject:** Re: O&G Figure Revision: 18-2005  
**Date:** Monday, November 26, 2018 3:39:51 PM

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Stephanie,

Thank you for the figures. I have reviewed all attachments and agree with edits.

Tetsuya

On Mon, Nov 26, 2018 at 3:23 PM Stephanie Casway <[SCasway@greenjournal.org](mailto:SCasway@greenjournal.org)> wrote:

Good Afternoon Dr. Kawakita,

Your figures and legend have been edited, and PDFs of the figures and legend are attached for your review. Please review the figures CAREFULLY for any mistakes.

PLEASE NOTE: Any changes to the figures must be made now. Changes at later stages are expensive and time-consuming and may result in the delay of your article's publication.

To avoid a delay, I would be grateful to receive a reply no later than Wednesday, 11/28. Thank you for your help.

Best wishes,

Stephanie Casway, MA  
Production Editor

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