

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.*

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: Oct 19, 2018
To: "Sean C Dowdy" [REDACTED]
From: "The Green Journal" em@greenjournal.org
Subject: Your Submission ONG-18-1794

RE: Manuscript Number ONG-18-1794

Optimizing Pre-Anesthesia Care for the GYN Patient

Dear Dr. Dowdy:

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 09, 2018, we will assume you wish to withdraw the manuscript from further consideration.

REVIEWER COMMENTS:

REVIEWER #1:

This is a nicely written overview of preoperative optimization of patient baseline status to improve postoperative outcomes including use of opiates.

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REVIEWER #3:

The authors summarize current recommendations for pre-operative optimization of women undergoing gynecologic procedures.

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2. A running foot (short title) is missing.
3. The precis is appropriate. Consider switching the voice to active voice, i.e. "Optimizing pre-anesthesia care improves outcomes for women undergoing gynecologic surgery."
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18. The references are not formatted per Obstetrics & Gynecology guidelines. Please find the guidelines online and revise.

EDITORIAL OFFICE COMMENTS:

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

2. Each author on this manuscript must submit a completed copy of our revised author agreement form (updated in the January 2018 issue). 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>):

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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.

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3. 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.

4. Tables, figures, and supplemental digital content should be original. The use of borrowed material (eg, lengthy direct quotations, tables, figures, or videos) is discouraged, but should it be considered essential, written permission of the copyright holder must be obtained. Permission is also required for material that has been adapted or modified from another source. Both print and electronic (online) rights must be obtained from the holder of the copyright (often the publisher, not the author), and credit to the original source must be included in your manuscript. Many publishers now have online systems for submitting permissions request; please consult the publisher directly for more information. In addition, you must list any material included in your submission that is not original or that you are not able to transfer copyright for in the space provided under I.B on the first page of the author agreement form.

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 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>.

6. Because of space limitations, it is important that your revised manuscript adhere to the following length restrictions by manuscript type: Clinical Expert Series articles should not exceed 25 typed, double-spaced pages (6,250 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.

7. 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).

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

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 Expert Series, 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. The American College of Obstetricians and Gynecologists' (College) documents are frequently updated. These documents may be withdrawn and replaced with newer, revised versions. If you cite College documents in your manuscript, be sure the reference you are citing is still current and available. If the reference you are citing has been updated (ie, replaced by a newer version), please ensure that the new version supports whatever statement you are making in your manuscript and then update your reference list accordingly. If the reference you are citing has been

withdrawn with no clear replacement, please contact the editorial office for assistance (obgyn@greenjournal.org). In most cases, if a College document has been withdrawn, it should not be referenced in your manuscript (exceptions could include manuscripts that address items of historical interest). All College documents (eg, Committee Opinions and Practice Bulletins) may be found via the Resources and Publications page at <http://www.acog.org/Resources-And-Publications>.

13. The Journal's Production Editor had the following to say about the figures in your manuscript:

"Figure 1: Please upload original file type (high res eps, tiff, jpeg) to Editorial Manager, items pasted into Word often lose resolution and do not print well. Additionally, is this figure original to this manuscript?"

Figure 2: Please upload original file type (high res eps, tiff, jpeg) to Editorial Manager, items pasted into Word often lose resolution and do not print well. Additionally, is this figure original to this manuscript?"

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

When you submit your revision, art saved in a digital format should accompany it. Please upload each figure as a separate file to Editorial Manager (do not embed the figure in your manuscript file).

If the figures were created using a statistical program (eg, STATA, SPSS, SAS), please submit PDF or EPS files generated directly from the statistical program.

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

Figures should be no smaller than the journal column size of 3 1/4 inches. Art that is low resolution, digitized, adapted from slides, or downloaded from the Internet may not reproduce. Refer to the journal printer's web site (<http://cjs.cadmus.com/da/index.asp>) for more direction on digital art preparation.

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 09, 2018, we will assume you wish to withdraw the manuscript from further consideration.

Sincerely,

The Editors of Obstetrics & Gynecology

2017 IMPACT FACTOR: 4.982

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

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

November 19, 2018

Nancy Cheescheir, MD, Editor-in-Chief
Obstetrics and Gynecology

Dear Dr. Chescheir,

Please find attached revisions to our manuscript, entitled “Optimizing Pre-Anesthesia Care for the GYN Patient.”

We have addressed concerns from the reviewers in a point-by-point fashion in *italics*, referencing corresponding line numbers with changes or explanations.

High-resolution figures have been provided. Figure 1 is original, while we have now obtained permission to use Figure 2. We have also added a running title, abstract word count, and the required statements, below. In addition, a reference that was previously in press, is now in print and has been added to the Reference section. Note that the combined length of the abstract, introduction, and conclusion is 212 words under the limit to provide more space for the actual review. However, our subject is quite broad, and the manuscript now runs at 29 pages. For this reason we chose not to comply with a few of the reviewers’ requests in order to avoid adding significantly to the length of the manuscript, and because we had intentionally omitted these subjects previously. In addition, we have been very strict about separating pre-anesthesia care from intra- and post-operative care (the subject of many queries), which is not within the scope of our assignment. If the editors feel we have not addressed the comments satisfactorily, we are happy to add more text and references (in particular queries 11 and 16 from reviewer #3).

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

I affirm 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 have been explained.

Thank you for your consideration.

Sincerely,

Sean C. Dowdy, M.D.



REVIEWER COMMENTS:

REVIEWER #1:

This is a nicely written overview of preoperative optimization of patient baseline status to improve postoperative outcomes including use of opiates.

Overall, your manuscript needs to be reduced in length by at least 20% in areas where this is data (antibiotics and DVT prophylaxis) but particularly in areas with no evidence.

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5. Line 152, "studies are awaited" sounds odd. Maybe, "we are waiting on studies", "the literature is sparse" or other

Done

6. Line 253, what does "options" refer to, change to "options for these patients include"

I believe the intended line was 215. If so, this has been corrected.

7. Line 291, add the word "when" before "to use".

Done

8. Line 356 and 362, isn't the bowel prep before the surgery not "following"?

Yes, thank you – this has been corrected.

9. Line 393 reducing the overall incidence of what? Add the word "clot" or something similar after "incidence"

Done

10. Line 441, you need to define Type 2 incisions

Done

11. Line 453, insert the word "a" before "penicillin"

Done

12. Line 505, a second meta-analysis of what, presumably preoperative steroids but please clarify?

We have made this change, but please note that the word “dexamethasone” now appears 5 times in that paragraph.

REVIEWER #2:

This is a thorough review of perioperative considerations, following a surgical pathway approach.

- 1) Pre-op Counseling and Information: How should pre-operative visits be considered, either for surgeon, anesthesiologist, or both? Consents signed in office, in pre-op?

We are unable to determine what this reviewer intended by, “how should preop visits be considered.” We did not include a discussion of regulatory requirements such as informed consent, site marking, surgical time-out, etc, due to space considerations, as well as our opinion that this is more appropriately categorized under safety rather than preoperative optimization.

- 2) Prehabilitation: The authors suggest that prehabilitation is limited by the timescale required to achieve a beneficial effect. As the audience of this paper is Gynecologists, this might still be achievable as fibroid and prolapse surgery may both be considered elective. For oncology providers, might this be a good strategy to consider for patients undergoing neoadjuvant chemotherapy for ovarian cancer?

Generally patients’ functional status improves markedly during NAC, but there may still be incremental improvement with the use of prehab. This has yet to be reported on. Speculated benefits have been added (line 127).

- 3) Carbohydrate loading: Anecdotally, we have noted significant hyperglycemia from carbohydrate loading. The authors might consider a dilute version of the carbohydrate loading beverage.

Please see line 156 in which carbohydrate loading in diabetics is discussed. To our knowledge there is no evidence to recommend a dilute version of carbohydrate loading.

- 4) Diabetes: Can the authors please include comment on when they would consider pre-admitting patients for immediate pre-operative glycemic control. Another consideration would be to schedule diabetic patients as first case of the day, especially when patients are on insulin at home.

Absent acute effects associated with profound hyperglycemia (ie diabetic ketoacidosis), preadmission is not necessary as hyperglycemia may be controlled with an insulin drip started in the preoperative area and continued during surgery.

- 5) Obesity: When should these patients be considered for concomitant bariatric surgery or panniculectomy?

Determining when morbidly obese patients require bariatric surgery or panniculectomy is an important question and a situation that is commonly encountered. However, weighing risks and benefits is complex, requires individualization, is often dependent on insurance coverage, and we feel is beyond the scope of this review.

- 6) Pre-op VTE prophylaxis: Please include commentary regarding timing of VTE prophylaxis. If an epidural is to be considered, dosing should be after the catheter is placed.

This has been added to line 464.

7) Antibiotics prophylaxis: Line 441, please define type II incision, or just describe and avoid the term. There are also studies suggesting the benefit of metronidazole to hysterectomy prophylaxis, if the authors would like to include. Also, if bowel surgery is planned, additional antibiotics should be given preoperatively as well.

Reference to type II incisions has been addressed in query 10 of the first reviewer. As far as the addition of metronidazole, to our knowledge there is no level I evidence supporting its use in addition to cephalosporins (ex: the data from the Michigan Surgical Quality Collaborative is retrospective). We have added a sentence to this effect (line 458), and hesitate to make more definitive recommendations given the potential impact on cost and potential complications (such as C. Diff).

REVIEWER #3:

The authors summarize current recommendations for pre-operative optimization of women undergoing gynecologic procedures.

1. The title is appropriate.

Thank you

2. A running foot (short title) is missing.

This has been added

3. The precis is appropriate. Consider switching the voice to active voice, i.e. "Optimizing pre-anesthesia care improves outcomes for women undergoing gynecologic surgery."

Done

4. Abstract:

a. There are several grammatical errors making the abstract difficult to read quickly.

Please provide line numbers as we were unable to identify grammatical errors in the abstract.

b. The abstract should be revised to include the conclusive recommendations from the manuscript rather than be a copy of the introduction section.

Please see lines 43-47 which includes conclusive recommendations. Other recommendations are more nuanced and cannot be distilled within the confines of an abstract given length constraints.

5. The first paragraph of the introduction should be shortened to be more focused on the topic at hand. Careful revision of the introduction should focus on grammatical errors as well.

Please provide line numbers as we were unable to identify grammatical errors in this section. The first paragraph of the introduction has been shortened as requested.

6. Line 81: Based on the rest of the manuscript, the patient's engagement in the pre-operative and post-operative aspects is important, not just in "recovery." Consider changing the wording here.

The word "recovery" has been deleted.

7. Lines 93-95: Are there specific diaries recommended? Are any diaries to improve outcomes? *Literature on this subject is sparse and we cannot recommend any specific diaries be used. To our knowledge, no study has shown that use of a specific diary improves outcomes, but we do recommend this as part of best practice within the broader subject of patient education and engagement.*

8. Prehabilitation: Is there any evidence for prehabilitation in overweight or obese women with sedentary lifestyles?

For this review we interpreted "pre-anesthesia care" to represent relatively short-term interventions. For this reason, we considered weight loss to be beyond the scope of this review since it is a longer-term optimization. Difficulties with the time scale for recovery are included on line 149. Otherwise, even obese women can be frail and/or malnourished and would presumably benefit from prehab. Also, please see lines 371-372.

9. Alcohol Abuse: Please define "modest intake" and "excessive intake" of alcohol.

The definition of modest intake has been added as per the provided reference.

10. Opioid Dependence with a special consideration of buprenorphine:

a. In these patients, it is difficult to know how much opioids to give them for their post-recovery. Any suggestions or evidence-based theories would be helpful here.

This is an excellent question and to our knowledge there is no literature to guide opioid dosing outside of trial and error. Also please note that this review does not include a discussion of postoperative care, but rather optimization of pre-anesthesia care.

b. Patient education regarding NSAID usage rather than strict opioid usage should be mentioned. *This has been added to line 230.*

c. Patient education regarding proper discarding of opioids is also important. This is to restrict usage by family/friends after surgical pain has subsided. *Most patients will require no home-going opioids after surgery and so education on proper disposal is not always necessary, particularly in the pre-anesthesia phase when patients are overwhelmed with information of higher priority. While we are well aware of the problem of diversion, we have intentionally not addressed this topic because there is some disagreement on best practices. The FDA recommends flushing remaining opioids (which may not be ideal for the environment), while others recommend pulverizing them and mixing them with coffee grounds or kitty litter. There are opioid return facilities in many cities, and kits are being created to make opioids unusable so they can be safely disposed. Thus, this is not a short topic, and we feel this would be more appropriately discussed in a review focusing on postoperative care.*

11. Preoperative Anemia: The roles of oral iron to improve anemia and hormones/tranexamic acid/Lupron/UAE to stop menstrual bleeding pre-operatively should be discussed as they are important in benign gynecologic elective procedures.

The subject of this review is optimization of preanesthesia care. We considered discussion of treatment options for abnormal uterine bleeding to be longer-term management and out of scope. In the preoperative anemia section we do discuss the use of IV iron since results are achieved short term, and provide evidence to demonstrate improvements are much less dramatic for oral, compared to IV iron. We also consider the use of tranexamic acid to be more of an intraoperative than preoperative intervention. Furthermore tranexamic acid does not treat anemia, but rather reduces the risk of bleeding during surgery. For this reason we have elected to not include a discussion of tranexamic acid, although this could be added as an additional paragraph if the editors consider it of great enough import (our group has published on this subject in your journal; we reduced the incidence of blood transfusion by over 50%).

12. Obesity: obesity can cause difficulty with completing laparoscopic/robotic procedures increasing the risk of laparotomy and its associated risks.

This has been added to line 364.

13. Bowel Preparation: Does bowel prep change the risk of bowel resection versus primary repair in the case of accidental bowel injury, for example during endometriosis surgery?

No. Not using bowel preps should not influence the decision to perform primary repair, resection, or diversion. We have not used bowel preps in our oncologic practice for over 7 years.

14. Preoperative antibiotics prophylaxis: Please discuss the roles of pre-operative showers and chlorhexidine gluconate wipes.

An additional short paragraph has been added describing the use of bundled interventions to reduce surgical site infection, including the use of chlorhexidine on line 519.

15. Pharmacologic adjuncts:

a. There are several medications not included in the discussion. Please consider discussing them: Zofran, Celecoxib, Tylenol, Toradol.

This section includes brief mention of both Celocoxib (we assume what this reviewer intended, not Celecoxib) and Tylenol as preemptive medications. Toradol is generally started prior to extubation for post-surgical pain, and therefore not discussed here. Similarly, anti-emetics are generally used intraoperatively rather than as part of preoperative optimization.

b. Discuss age-based limitations/adjustments in medication doses.

The only drug requiring dose adjustment is celecoxib, now added to line 544.

16. The recommendations presented in this manuscript can be summarized in one table/box to be a quick guide to readers.

We remain concerned about the length of this broad review. If the editors feel this suggestion is important we are happy to add an additional table, but do not think this would justify deleting a half to full page of text.

17. Discuss the role of pre-operative clinics that are specifically designed to optimize patients. How useful are these? Do they improve outcomes?

This concept is included under the broader topic of prehabilitation. While we have utilized a dedicated preoperative clinic for over a decade, we cannot advocate for this based on available literature. The more important issue is managing existing medical conditions, which is discussed elsewhere in the text.

18. The references are not formatted per Obstetrics & Gynecology guidelines. Please find the guidelines online and revise.

Done.

EDITORIAL OFFICE COMMENTS:

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

2. Each author on this manuscript must submit a completed copy of our revised author agreement form (updated in the January 2018 issue). 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.

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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 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>.

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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:

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2. LINE 3: Please add any academic degrees to the byline for each author you would like to include (no more than two per person).
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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 **Tuesday, January 29th**.

Sincerely,

-Daniel Mosier

Daniel Mosier
Editorial Assistant
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The American College of Obstetricians and Gynecologists
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