

OBSTETRICS & GYNECOLOGY



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

- Comments from the reviewers and editors (email to author requesting revisions)
- Response from the author (cover letter submitted with revised manuscript)*

**The corresponding author has opted to make this information publicly available.*

Personal or nonessential information may be redacted at the editor's discretion.

Questions about these materials may be directed to the *Obstetrics & Gynecology* editorial office:
obgyn@greenjournal.org.

Date: Apr 17, 2020
To: "Luis D. Pacheco" [REDACTED]
From: "The Green Journal" em@greenjournal.org
Subject: Your Submission ONG-20-892

RE: Manuscript Number ONG-20-892

Early acute respiratory support for the COVID-19 pregnant patient

Dear Dr. Pacheco:

Your manuscript has been rapidly reviewed by the Editors. We would like to pursue fast-track publication. If you can address the comments below and submit your revision quickly, the Editorial Office will start working on it as soon as possible. I am setting the due date to April 20, but we will start working on it whenever you can submit.

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).

REVIEWER COMMENTS:

Reviewer #1: This is an important manuscript and generally well done. I have the following questions and suggestions, some minor, others more substantive.

- 1) Line 44: Reverse the order of "expert" and "personnel";
- 2) Line 45: Add "an" before "anesthesiologist";
- 3) Line 46: I don't know what "awake self-prone position" is so this should be clarified in text; is the improvement in oxygenation true for pregnancy? Will pregnant women lie prone?
- 4) Line 56-57-What do you mean by oxygen desaturation? These recommendations seem a little loose. What do you mean by maintenance? Not really practical in many cases to completely fluid restrict pregnant patients;
- 5) Line 63: Need a "who" before "do not";
- 6) Line 72: Don't need "may";
- 7) Lines 74-82, since they sum up the 3 modalities, should come after all 3 modalities have been discussed;
- 8) But as I read on, seems like you dismiss NIPPV yet don't really definitively say don't use it. Why-are there situations where HFNC will fail but NIPPV will avoid mechanical ventilation? If yes, please say so. If no, why not just say don't use (and I notice it is not in your flow diagram);
- 9) "The Fetal Monitoring and Delivery Considerations" section is the most problematic.
 - a) Some (not I) will quibble with no intervention before 24 weeks, so might so prior to 23-24 weeks gestation instead of prior to 24 weeks;
 - b) If a patient is already intubated, the risk to the mother of a cesarean is low (I just did one the other day and the patient is going home) and because the patient is not aerosolizing virus, the risk to healthcare providers is not high either;
 - c) The daily NST recommendation seems too all encompassing and should be made on an individualized basis;
 - d) Lines 120-128 are overbroad. Would we really write off a 27 weeker if it were growth restricted? What does maternal body habitus have to do with it? We section obese women all the time. If a patient is already intubated, are her "airway characteristics" then really relevant?
- 10) Why steroids only before 34 weeks?
- 11) Table 1 does not seem to align very well with the methods discussed in the text. Where is high flow nasal canula? You list four face masks. Why? Are they relevant to your overall recommendations?

12) Table 1 also makes me wonder: Should oxygen delivery in COVID boil down to 2 methods-nasal flow (high flow if necessary) and mechanical ventilation? Figure 2 would seem to suggest this.

Reviewer #2: The authors have submitted a timely, well-written and concise piece on respiratory support of the pregnant patient.

1 - Figure 1 is helpful (I for one not being familiar with the appearance of it)

2 - Many interesting points and helpful tidbits are provided (ie, line 83, 104, 117) that are highly relevant

EDITORIAL OFFICE COMMENTS:

1. George Saade will need to complete our electronic Copyright Transfer Agreement, which was sent to them through Editorial Manager. Once the form is complete, please add their disclosures to the "Financial Disclosure" section.

2. ACOG is moving toward discontinuing the use of "provider." Please replace "provider" throughout your paper with either a specific term that defines the group to which are referring (for example, "physicians," "nurses," etc.), or use "health care professional" if a specific term is not applicable.

3. 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. 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:

A. OPT-IN: Yes, please publish my point-by-point response letter.

B. OPT-OUT: No, please do not publish my point-by-point response letter.

4. As of December 17, 2018, Obstetrics & Gynecology has implemented an "electronic Copyright Transfer Agreement" (eCTA) and will no longer be collecting author agreement forms. When you are ready to revise your manuscript, you will be prompted in Editorial Manager (EM) to click on "Revise Submission." Doing so will launch the resubmission process, and you will be walked through the various questions that comprise the eCTA. Each of your coauthors will receive an email from the system requesting that they review and electronically sign the eCTA.

Please check with your coauthors to confirm that the disclosures listed in their eCTA forms are correctly disclosed on the manuscript's title page.

5. Figure 1: This appears to be from the manufacturer. Do you have permission to use this image in print and online? If not, you may want to take your own picture of the product.

6. Standard obstetric and gynecology data definitions have been developed through the reVITALize initiative, which was convened by the American College of Obstetricians and Gynecologists and the members of the Women's Health Registry Alliance. Obstetrics & Gynecology has adopted the use of the reVITALize definitions. Please access the obstetric and gynecology data definitions at <https://www.acog.org/About-ACOG/ACOG-Departments/Patient-Safety-and-Quality-Improvement/reVITALize>. If use of the reVITALize definitions is problematic, please discuss this in your point-by-point response to this letter.

7. Because of space limitations, it is important that your revised manuscript adhere to the following length restrictions by manuscript type: Current Commentary articles should not exceed 12 typed, double-spaced pages (3,000 words). Stated page limits include all numbered pages in a manuscript (i.e., title page, précis, abstract, text, references, tables, boxes, figure legends, and print appendixes) but exclude references.

8. Specific rules govern the use of acknowledgments in the journal. Please note 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 response in the journal's electronic author form verifies that permission has been obtained from all named persons.

* If all or part of the paper was presented at the Annual Clinical and Scientific Meeting of the American College of Obstetricians and Gynecologists or at any other organizational meeting, that presentation should be noted (include the exact dates and location of the meeting).

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: Current Commentary articles, 250 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 standardize the presentation of your data throughout the manuscript submission. For P values, do not exceed three decimal places (for example, "P = .001"). For percentages, do not exceed one decimal place (for example, 11.1%).

13. 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.

14. Authors whose manuscripts have been accepted for publication have the option to pay an article processing charge and publish open access. With this choice, articles are made freely available online immediately upon publication. An information sheet is available at <http://links.lww.com/LWW-ES/A48>. The cost for publishing an article as open access can be found at <http://edmgr.ovid.com/acd/accounts/ifauth.htm>.

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

If you choose to revise your manuscript, please submit your revision through Editorial Manager at <http://ong.editorialmanager.com>. Your manuscript should be uploaded in a word processing format such as Microsoft Word. Your revision's cover letter should include the following:

- * A confirmation that you have read the Instructions for Authors (<http://edmgr.ovid.com/ong/accounts/authors.pdf>), and
- * A point-by-point response to each of the received comments in this letter.

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

Sincerely,

Nancy C. Chescheir, MD
Editor-in-Chief

2018 IMPACT FACTOR: 4.965
2018 IMPACT FACTOR RANKING: 7th out of 83 ob/gyn journals

In compliance with data protection regulations, you may request that we remove your personal registration details at any time. (Use the following URL: <https://www.editorialmanager.com/ong/login.asp?a=r>). Please contact the publication office if you have any questions.



April 20, 2020

Obstetrics & Gynecology
409 12th Street, SW,
Washington, DC 20024-2188

Dear Editors:

Please find attached our revised clinical practice manuscript entitled “Early acute respiratory support for the COVID-19 pregnant patient.”

We provide responses to the reviewer comments on the following pages.

This article has not been previously published and is not currently under consideration for publication by any other journal. The authors will not submit it to another journal unless a final negative decision is made by the editors of *Obstetrics & Gynecology*. Each of the authors made substantial contributions to the drafting of the manuscript, and each has confirmed they have no conflicts of interest.

We confirm that one person who provided editing services but made no other contribution to the work has given written permission to be named in the Acknowledgment section.

For questions concerning this manuscript, please feel free to contact me.

Sincerely,

A handwritten signature in black ink, appearing to read 'Luis D. Pacheco'.

Luis D. Pacheco, MD
Departments of Obstetrics & Gynecology and Anesthesiology
The University of Texas Medical Branch at Galveston

Reviewer #1: This is an important manuscript and generally well done. I have the following questions and suggestions, some minor, others more substantive.

- 1) Line 44: Reverse the order of "expert" and "personnel";
R/ Done, order of words reversed.
- 2) Line 45: Add "an" before "anesthesiologist";
R/ Done. Word added.
- 3) Line 46: I don't know what "awake self-prone position" is so this should be clarified in text; is the improvement in oxygenation true for pregnancy? Will pregnant women lie prone?
R/ Sentence added in text to clarify. We specify that this position may be an option for pregnant women at less than 20 weeks.
- 4) Line 56-57-What do you mean by oxygen desaturation? These recommendations seem a little loose. What do you mean by maintenance? Not really practical in many cases to completely fluid restrict pregnant patients;
R/ Sentence added to clarify "oxygen desaturation". We strongly believe that maintenance fluids are not indicated in any patient with acute hypoxemic respiratory failure.
- 5) Line 63: Need a "who" before "do not";
R/ Word "who" was added.
- 6) Line 72: Don't need "may";
R/ Corrected
- 7) Lines 74-82, since they sum up the 3 modalities, should come after all 3 modalities have been discussed;
R/ We believe the way it is written provides adequate flow to the reader.
- 8) But as I read on, seems like you dismiss NIPPV yet don't really definitively say don't use it. Why-are there situations where HFNC will fail but NIPPV will avoid mechanical ventilation? If yes, please say so. If no, why not just say don't use (and I notice it is not in your flow diagram);
R/ We discuss both HFNC and NIPPV, however we clearly favor HFNC as NIPPV may increase transmission of the virus. We clearly state that in areas where HFNC is not available, NIPPV may be used.
- 9) "The Fetal Monitoring and Delivery Considerations" section is the most problematic.
 - a) Some (not I) will quibble with no intervention before 24 weeks, so might so prior to 23-24 weeks gestation instead of prior to 24 weeks;
R/ Agree, text has been changed. We corrected gestational age to 23-24 weeks.
 - b) If a patient is already intubated, the risk to the mother of a cesarean is low (I just did one the other day and the patient is going home) and because the patient is not aerosolizing virus, the risk to healthcare providers is not high either;
R/ We do not agree with this statement. We have also performed multiple c sections in the ICU, just because one case was uneventful does not mean it is a low risk procedure. Risks of infection, bleeding, inadequate exposure, limited neonatal equipment availability, etc.. are significant.

c) The daily NST recommendation seems too all encompassing and should be made on an individualized basis;

R/ Agree, that is why we mention “suggest” as opposed to recommend.

d) Lines 120-128 are overbroad. Would we really write off a 27 weeker if it were growth restricted? What does maternal body habitus have to do with it? We section obese women all the time. If a patient is already intubated, are her "airway characteristics" then really relevant?

R/ We understand we section obese women all the time, but not obese women with severe ARDS who may desaturate dramatically with any change in position and who are carriers of a highly contagious disease. Again, we use term “individualize” in this statement. Some may opt not to monitor a fetus at 27 weeks with an EFW of 350 gr in a 500-pound woman.

We agree with the diminished importance of the airway anatomy once intubated; the sentence has been removed from the text.

10) Why steroids only before 34 weeks?

R/ Agree with observation, we have removed 34 weeks as a limiting factor from the text.

11) Table 1 does not seem to align very well with the methods discussed in the text. Where is high flow nasal canula? You list four face masks. Why? Are they relevant to your overall recommendations?

R/ We describe the different methods to deliver oxygen as most MFM and obstetricians are not clear in the specific characteristics of these devices. It is an opportunity to understand the different fractions of oxygen delivered with each modality. HFNC is described in detail in another section as it is not a conventional oxygen delivery device.

12) Table 1 also makes me wonder: Should oxygen delivery in COVID boil down to 2 methods- nasal flow (high flow if necessary) and mechanical ventilation? Figure 2 would seem to suggest this.

R/ We disagree. Just to give an example, if a patient is an mouth breather, nasal cannulas are not that effective. Placing a face mask will be indicated.

Reviewer #2: The authors have submitted a timely, well-written and concise piece on respiratory support of the pregnant patient.

13) Figure 1 is helpful (I for one not being familiar with the appearance of it)

R/Agree

14) Many interesting points and helpful tidbits are provided (ie, line 83, 104, 117) that are highly relevant

R/Agree

15) **The Editorial Office** had a concern about permission to reuse Figure 1. The authors have decided to replace Figure 1 with their own original image.