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 20, 2020
To: "Stephanie L Gaw" [redacted]
From: "The Green Journal" em@greenjournal.org
Subject: Your Submission ONG-20-910

RE: Manuscript Number ONG-20-910

Acute Respiratory Distress Syndrome in a Preterm Pregnant Patient with Coronavirus Disease 2019

Dear Dr. Gaw:

Your manuscript has been reviewed by the Editorial Board and by special expert referees. The Editors would like to receive your revised manuscript as soon as possible for potential fast-track publication. Your due date has been tentatively set to April 22, but this can be adjusted as needed. The standard revision letter follows.

***

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: Overall, this is a very well done case report about an important topical issue. I have the following comments and suggestions.

1) You use language such as "necessitated" and "required" throughout. I think you should avoid this. Your team made a judgment call (and probably the right one) but it can't be said that the if the patient had remained pregnant she would not have pulled through without needing to be delivered;

2) To point 1 above, to a primarily obstetric audience it may not be clear why you deemed this patient to have reached the end of her respiratory rope before delivery. pO2?, FiO2, little to no room to go up on vent? Please explain to readers who will not have much familiarity with the nuances of respiratory support why you felt you were up against the wall;

3) Point 2 notwithstanding, I think you could make all of your points in a manuscript that is 1/3 shorter;

4) The Precis is awkwardly worded. After the comma, I think you could say something like "whose deteriorating respiratory condition prompted delivery and whose respiratory status improved post-partum;

5) The Background of the Abstract seems off-point and only tangentially related to your case;

6) Teaching point #2 is overbroad as respiratory failure will not be an indication for delivery in all pregnant patients;

7) Teaching point #3 not really appropriate as it is not a clinical teaching point per se;

8) Please say cesarean "delivery" rather than "section" throughout;

9) Line 89 and 90: the Doppler duplex and echocardiogram don't seem indicated and with an eye to shortening could be left unementioned;

10) As written, lines 95-96 make it seem as though all meds were given to promote fetal lung maturity.

11) Discussion: If it does not, please make clear that not all patients who are placed on mechanical ventilation for COVID pneumonia should be delivered for that reason alone.

Reviewer #2: Eye-opening and timely submission on antepartum pt with COVID-19 induced ARDS & teaching Points very well done

1 - Line 91 it would be helpful to (briefly) know when the naso swab test was performed, how long it took to get the result and what sort of exposure precautions were undertaken

2 - Table 1 has a lot of unneeded maternal and neonatal data points that do not measurably add value to the case - this could easily be transitioned to Supplemental Data

3 - Curious that hydroxychloroquine was used (line 95) - one wonders who (ID?) recommended this, and based on what - it would be helpful to understand whether this is what is happening in San Fran, or everywhere. Also azith and ceftri were started empirically for (?) CAP

4 - Presumably the patient was switched from non-rebreather to HFNC as this is the preferred route for Covid(?), or was there some other reason. The verbage about pre-ox through SpO2 nadir seems unneeded (line 109-113)

5 - Hopefully the remdesivir (line 116) gets attention in the Discussion, as the authors (line 117) are assuming the readership knows the nuances of indications (if any) for these (off-label) agents in this setting

6 - This reader not familiar with 'driving pressure' (line 121) and much of the ventilator setting lingo is written for intensivists (rather than obgyn audience)

7 - Though provided in the Supp, it would be easy to mention within the case text that pt was taken to the designated COVID OR

EDITOR'S COMMENTS:

We no longer require that authors adhere to the Green Journal format with the first submission of their papers. However, any revisions must do so. I strongly encourage you to read the instructions for authors (the general bits as well as those specific to the feature-type you are submitting). The instructions provide guidance regarding formatting, word and reference limits, authorship issues and other relevant topics. Adherence to these requirements with your revision will avoid delays during the revision process by avoiding re-revisions on your part in order to comply with formatting.

Numbers below refer to line numbers.

31. The précis is a single sentence of no more than 25 words, written in the present tense and stating the conclusion(s) of the report (ie, the bottom line). The précis should be similar to the abstract's conclusion. Do not use commercial names, abbreviations, or acronyms in the précis. Precis should be the "hook" for people who scan the Table of Contents to see what to read. It shouldn't not include statements like "in this study" or "we found". Just state what you found.

I agree with recommendations by the other 2 reviewers with the following exceptions:
1. Point 9 of reviewer 1: I would mention the work up for PE that was done. It's important, in my opinion, to remind people that pregnant women in Spring 2020 still can get other disorders besides COVID. It does not add much work wise but reinforces the need to remember the broader differential.

160: Rather than “at this time” please state the age of the neonate.

209: You did not give mag sulfate; why did you decide against it?

EDITOR 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. 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.

2. 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.

3. Please do the following regarding your supplemental files:
a. Remove the Table of Contents at the beginning of your supplemental files.
b. Rename any parts of the manuscript that are "supplemental" an "Appendix," whether the appendix is text, a figure, or a table.
c. Order the appendixes in the order they are cited in the text. Renumber/reorder your appendixes as needed.
d. Make sure the supplemental material is cited in the body text as “Appendix [number].” Each appendix should be cited in order at first mention.

4. Expand “P/F” to read “PaO2/FiO2 ratio.”

5. 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.

6. Anne L. Donovan and Mary Prahl included disclosures on the electronic Copyright Transfer Agreement. Is this disclosure worded correctly? Please add this to the title page:
“Anne L. Donovan disclosed that funding was provided to her institution from the Network for the Investigation of Delirium: Unifying Scientists (Pilot Grant Funding). Money was paid to her from the Agency for Healthcare Research and Quality (paid consultancy). Mary Prahl disclosed that in the article, the case involves a pregnant women who received compassionate-use Remdesivir. Her spouse is employed at the company that makes Remdesivir. Her role in this case was solely confined to the management of the neonate, and she had no involvement or influence in management of women who received the compassionate-use drug. The other authors did not disclose any potential conflicts of interest.”

7. 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.

8. Because of space limitations, it is important that your revised manuscript adhere to the following length restrictions by manuscript type: Case Reports should not exceed 8 typed, double-spaced pages (2,000 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.

9. 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).

10. Provide a précis on the second page, for use in the Table of Contents. The précis is a single sentence of no more than 25 words that states the conclusion(s) of the report (ie, the bottom line). The précis should be similar to the abstract's conclusion. Do not use commercial names, abbreviations, or acronyms in the précis. Please avoid phrases like "This paper presents" or "This case presents."

11. 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: Case Reports, 125 words; Current Commentary articles, 250 words. Please provide a word count.

12. 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.

13. 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.

14. 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.

15. The American College of Obstetricians and Gynecologists' (ACOG) documents are frequently updated. These documents may be withdrawn and replaced with newer, revised versions. If you cite ACOG 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 (exceptions could include manuscripts that address items of historical interest). 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 an ACOG document has been withdrawn, it should not be referenced in your manuscript (exceptions could include manuscripts that address items of historical interest). All ACOG documents (eg, Committee Opinions and Practice Bulletins) may be found via the Clinical Guidance & Publications page at https://www.acog.org/Clinical-Guidance-and-Publications/Search-Clinical-Guidance.

16. Figures

Figure 1: Please upload as a figure file on Editorial Manager.

Figure 2: Please cite within the manuscript and upload as a figure file on Editorial Manager.

17. 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.

18. 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

_____

University of California
San Francisco

Department of Obstetrics, Gynecology & Reproductive Sciences
Division of Maternal Fetal Medicine
Center for Reproductive Sciences

[redacted]

Stephanie L. Gaw, MD PhD
Assistant Professor

April 29, 2020

Nancy C. Chescheir, MD
Editor-in-Chief
Obstetrics & Gynecology

RE: Manuscript Number ONG-20-910

Dear Dr. Chescheir:

We respectfully submit our revised manuscript entitled “Acute Respiratory Distress Syndrome in a Preterm Pregnant Patient with Coronavirus Disease 2019” for publication in *Obstetrics & Gynecology*.

We have read the Instructions for Authors. We have also addressed each item and comment from the editor and the reviewers (detailed below) and hope that you find our revised manuscript satisfactory to merit publication in your journal.

We thank you in advance for your consideration and look forward to your response.

Sincerely,

Stephanie L. Gaw, MD PhD

EDITOR'S SPECIFIC COMMENTS:

1. The précis is a single sentence of no more than 25 words, written in the present tense and stating the conclusion(s) of the report (ie, the bottom line). The précis should be similar to the abstract's conclusion. Do not use commercial names, abbreviations, or acronyms in the précis. Precis should be the "hook" for people who scan the Table of Contents to see what to read. It shouldn't not include statements like "in this study" or "we found". Just state what you found.

   We have added the following précis: A pregnant patient at 28 weeks developed respiratory failure from coronavirus disease 2019 and after multidisciplinary consideration underwent urgent delivery.

2. I agree with recommendations by the other 2 reviewers with the following exceptions: Point 9 of reviewer 1: I would mention the work up for PE that was done. It's important, in my opinion, to remind people that pregnant women in Spring 2020 still can get other disorders besides COVID. It does not add much work wise but reinforces the need to remember the broader differential.

   We thank the editor for this thoughtful comment. We agree and have kept these points in the manuscript (Page 4, lines 84-85).

3. Rather than "at this time" please state the age of the neonate.

   This has been modified to "the 16-day-old infant" (Page 6, Lines 137-138).

4. You did not give mag sulfate; why did you decide against it?

   The patient was started on magnesium for fetal neuroprotection prior to delivery (Page 5, Line 114).

REVIEWER COMMENTS:

Reviewer #1

1. You use language such as "necessitated" and "required" throughout. I think you should avoid this. Your team made a judgment call (and probably the right one) but it can't be said that the if the patient had remained pregnant she would not have pulled through without needing to be delivered.

   This is an excellent suggestion by the reviewer, and we have adjusted our language accordingly throughout the manuscript.

2. To point 1 above, to a primarily obstetric audience it may not be clear why you deemed this patient to have reached the end of her respiratory rope before delivery. pO2?, FiO2, little to no room to go up on vent? Please explain to readers who will not have much familiarity with the nuances of respiratory support why you felt you were up against the wall.

We thank the reviewer for this thoughtful comment. We have expanded on our rationale for early delivery in the discussion section (Page 7, Lines 164-168): "Rationale for early delivery in our case included: 1) the patient's rapid deterioration over less than 24 hours, 2) the lack of improvement in oxygenation on 80-100% FiO_2 despite optimization of ventilator settings and supportive therapies, 3) the opportunity to safely transport the patient to the operating room, and 4) the understanding that delivery may decrease maternal oxygen consumption and improve lung mechanics."

3. Point 2 notwithstanding, I think you could make all of your points in a manuscript that is 1/3 shorter.

   We recognize the need to be concise and have attempted to shortened the text without losing important content.

4. The Precis is awkwardly worded. After the comma, I think you could say something like "whose deteriorating respiratory condition prompted delivery and whose respiratory status improved post-partum.

   We have modified the précis to read: "A pregnant patient at 28 weeks developed respiratory failure from coronavirus disease 2019 and after multidisciplinary consideration underwent urgent delivery."

5. The Background of the Abstract seems off-point and only tangentially related to your case.

   We thank the reviewer for this thoughtful comment. We have modified the background section to more closely match the pertinent points from the case and discussion (Page 3, Lines 45-48): "Data suggest pregnant women are not at elevated risk of acquiring SARS-CoV-2 infection or developing severe disease than non-pregnant patients. However, management of pregnant patients who are critically ill with coronavirus disease 2019 (COVID-19) is complicated by physiologic changes and other pregnancy considerations, and requires balancing maternal and fetal well-being."

6. Teaching point #2 is overbroad as respiratory failure will not be an indication for delivery in all pregnant patients

   This has been changed to reflect that not all patients with respiratory failure should be delivered for that indication alone (Page 3, Lines 59-61): "In pregnant patients with moderate-to-severe ARDS requiring positive-pressure ventilation, early delivery can decrease maternal oxygen requirements and improve respiratory mechanics, which may improve maternal outcomes under the appropriate clinical circumstances."

7. Teaching point #3 not really appropriate as it is not a clinical teaching point per se.

   We have modified this teaching point as follows (Page 3, Lines 62-64): "Preterm infants may be at particular risk of perinatal COVID-19 infection due to the fetal environment and immature passive immunity and skin integrity, and additional testing and isolation measures may be warranted in the exposed premature infant requiring ongoing hospitalization."

8. Please say cesarean "delivery" rather than "section" throughout.

This has been changed throughout the manuscript.

9. Line 89 and 90: the Doppler duplex and echocardiogram don't seem indicated and with an eye to shortening could be left unmementioned.

   We thank the reviewer for this thoughtful comment. These lines have been left in the manuscript per the request of the editor.

10. As written, lines 95-96 make it seem as though all meds were given to promote fetal lung maturity.

    We thank the reviewer for the careful reading of the manuscript and have edited the text to clarify that the other medications were not given for fetal lung maturity (Page 4, Lines 90-95).

11. Discussion: If it does not, please make clear that not all patients who are placed on mechanical ventilation for COVID pneumonia should be delivered for that reason alone.

    We have attempted to make this clear in the discussion section, and we advise that "Little information exists on ARDS in pregnancy, particularly from COVID-19, and the risks and benefits of early delivery should be individualized in each case, prioritizing maternal stability over acute fetal status." (Page 7, Lines 171-173)

Reviewer #2

1. Line 91 it would be helpful to (briefly) know when the naso swab test was performed, how long it took to get the result and what sort of exposure precautions were undertaken

   We thank the reviewer for this request for clarification. The nasopharyngeal swab was performed at the patient's local hospital, with results available in approximately 24 hours. We are unsure of the exposure precautions undertaken by the healthcare professionals at the local hospital, but we have expanded the appendix to include our institution's protocols for protecting healthcare professionals against SARS-CoV-2 exposure during oral and nasopharyngeal testing (Appendix 1, Page 3, Lines 79-82). At our institution, nasopharyngeal and oropharyngeal swabs are considered an aerosolizing procedure. Thus the healthcare professional collecting the swab must wear novel respiratory personal protective equipment (PPE), including an N95 respirator plus face shield or a powered-air-purifying respirator (PAPR) as well as gown and gloves. Patients should also be in an isolated room, though it does not need to be a negative pressure room.

2. Table 1 has a lot of unneeded maternal and neonatal data points that do not measurably add value to the case - this could easily be transitioned to Supplemental Data.

   We thank the reviewer for this excellent suggestion. We have moved the neonatology laboratory results to the appendix. We have respectfully kept the maternal data points as previously listed, given available data showing worse outcomes in patients with COVID-19 with lymphopenia, elevated liver enzymes, acute kidney injury, elevated lactate dehydrogenase, elevated

inflammatory markers (C-reactive protein, ferritin, D-dimer), elevated prothrombin time, and elevated troponin.

3. Curious that hydroxychloroquine was used (line 95) - one wonders who (ID?) recommended this, and based on what - it would be helpful to understand whether this is what is happening in San Fran, or everywhere. Also azith and ceftri were started empirically for (?) CAP

   We thank the reviewer for this request for clarification. Our patient was initially started on ceftriaxone and azithromycin at the local hospital for treatment of presumed community-acquired pneumonia. She was then started on hydroxychloroquine when her nasopharyngeal swab resulted positive for COVID-19. Upon transfer of care to our institution, antimicrobials were discontinued due to low suspicion for bacterial pneumonia. Hydroxychloroquine was also discontinued due to QTc prolongation on initial EKG and access to compassionate use remdesivir.

   Our institution's division of infectious diseases recommends first-line treatment of hospitalized COVID-19 patients with enrollment in the Adaptive COVID-19 Treatment Trial (ClinicalTrials.gov number, NCT04280705), which randomizes patients to receive remdesivir or placebo. In patients excluded from this trial (including pregnant patients), compassionate use remdesivir may be obtained. If access to compassionate use drug is not permitted, then our institution recommends considering treatment with hydroxychloroquine with close monitoring for adverse effects particularly cardiotoxicity.

   We have edited the manuscript to reflect that empiric antibiotics were discontinued upon admission to our institution (Page 5, Lines 105-106). We also note that hydroxychloroquine was discontinued due to QTc prolongation and access to compassionate use remdesivir (Page 5, Lines 104-105).

4. Presumably the patient was switched from non-rebreather to HFNC as this is the preferred route for Covid(?), or was there some other reason. The verbage about pre-ox through SpO2 nadir seems unneeded (line 109-113).

   Because the non-rebreather mask cannot reliably provide more than 15L/min of oxygen, she was transitioned to high-flow nasal cannula, which can provide up to 50L/min of oxygen at our institution. We have edited and expanded the text as follows (Page 4, Lines 98-99): "She was transitioned to high-flow nasal cannula, which can provide up to 50L/min of oxygen, and was uptitrated to 30L/min with FiO_2 100% with no improvement in her saturation or work of breathing." We have also removed the lines regarding preoxygenation at the time of intubation.

5. Hopefully the remdesivir (line 116) gets attention in the Discussion, as the authors (line 117) are assuming the readership knows the nuances of indications (if any) for these (off-label) agents in this setting.

   We thank the reviewer for this comment and believe we have expanded sufficiently on the indications for compassionate use remdesivir in pregnant patients (Pages 7-8, Lines 181-185): "The most effective treatment for COVID-19 is unknown. At our institution, hospitalized adults with COVID-19 are enrolled in the Adaptive COVID-19 Treatment Trial (ClinicalTrials.gov,

NCT04280705), however pregnant patients are excluded. Therefore, we obtained and administered compassionate use remdesivir for this patient after reviewing internal data shared by Gilead Sciences on safety of remdesivir in pregnancy."

6. This reader not familiar with 'driving pressure' (line 121) and much of the ventilator setting lingo is written for intensivists (rather than obgyn audience)

   We thank the reviewer for this thoughtful critique and agree that portions of the manuscript are directed at an intensive care audience rather than an OB/GYN audience. We have edited the language in the manuscript throughout to address this concern.

   We have also provided definitions of lung compliance and dead space (Page 5, Lines 102-103) and normal ranges for PaO_2/FiO_2 ratio, static compliance, and calculated dead space (Page 6, Lines 146-149) to help provide context for the OB/GYN audience.

7. Though provided in the Supp, it would be easy to mention within the case text that pt was taken to the designated COVID OR.

   This has been included in the case report (Page 5, Line 119).

EDITORIAL REQUIREMENTS

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. 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.

2. 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.

   We have confirmed with our co-authors that the disclosures listed in their eCTA forms are correctly disclosed on the manuscript's title page.

3. Please do the following regarding your supplemental files:
   a. Remove the Table of Contents at the beginning of your supplemental files.
   b. Rename any parts of the manuscript that are "supplemental" an "Appendix," whether the

appendix is text, a figure, or a table.

c. Order the appendixes in the order they are cited in the text. Renumber/reorder your appendixes as needed.

d. Make sure the supplemental material is cited in the body text as “Appendix [number].” Each appendix should be cited in order at first mention.

Done.

4. Expand “P/F” to read “PaO2/FiO2 ratio.”

   Done.

5. 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.

   This has been changed throughout.

6. Anne L. Donovan and Mary Prahl included disclosures on the electronic Copyright Transfer Agreement. Is this disclosure worded correctly? Please add this to the title page:

   “Anne L. Donovan disclosed that funding was provided to her institution from the Network for the Investigation of Delirium: Unifying Scientists (Pilot Grant Funding). Money was paid to her from the Agency for Healthcare Research and Quality (paid consultancy). Mary Prahl disclosed that in the article, the case involves a pregnant women who received compassionate-use Remdesivir. Her spouse is employed at the company that makes Remdesivir. Her role in this case was solely confined to the management of the neonate, and she had no involvement or influence in management of women who received the compassionate-use drug. The other authors did not disclose any potential conflicts of interest.”

   Done.

7. 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://urldefense.proofpoint.com/v2/url?u=https-3A__www.acog.org_About-2DACOG_ACOG-2DDepartments_Patient-2DSafety-2Dand-2DQuality-2DImprovement_reVITALize&d=DwIGaQ&c=iORugZls2LlYyCAZRB3XLg&r=X5TKSJvVKlYLTOjAcBVfnf6ZNS7HppVns1SyOG-QQuI&m=g8k22xJG941kmlBbNr2OI_g1ZVxpzOvBEf9JHZ2Y-5M&s=TP-2PcfwhlHI6G9maoQcvSYbDwRM4tTe9Q0Ib4BstcI&e= . If use of the reVITALize definitions is problematic, please discuss this in your point-by-point response to this letter.

   We have reviewed the reVITALize definitions and have not identified any discrepancies with intended definitions used in our manuscript.

8. Because of space limitations, it is important that your revised manuscript adhere to the following length restrictions by manuscript type: Case Reports should not exceed 8 typed, double-spaced pages (2,000

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.

We recognize the need to be concise and have attempted to shortened the text without losing important content. The current word count of the manuscript from the introduction through the conclusion, including tables and figure legends, is 1940 words and 8 double-spaced pages. The abstract is 123 words long, and the precis is 20 words long.

9. 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.
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    We have no acknowledgments to include with our submission.

10. Provide a précis on the second page, for use in the Table of Contents. The précis is a single sentence of no more than 25 words that states the conclusion(s) of the report (ie, the bottom line). The précis should be similar to the abstract's conclusion. Do not use commercial names, abbreviations, or acronyms in the précis. Please avoid phrases like "This paper presents" or "This case presents."

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    We have reviewed our abstract and teaching points, and we do not believe there are inconsistencies between the abstract and the manuscript. The abstract is 123 words long.

12. Only standard abbreviations and acronyms are allowed. A selected list is available online at https://urldefense.proofpoint.com/v2/url?u=http-3A__edmgr.ovid.com_ong_accounts_abbreviations.pdf&d=DwIGaQ&c=iORugZls2LlYyCAZRB3XLg&r=X5TKSJvVKlYLTOjAcBVfnf6ZNS7HppVns1SyOG-QQuI&m=g8k22xJG941kmlBbNr2OI_g1ZVxpzOvBEf9JHZ2Y-5M&s=_hdYH7-L1yiHQFAtTYpZgYlnMkMU4Yy4LDJ_x9CAmBM&e= . 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.

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    Areas where the virgule symbol were previously used have been edited accordingly.

14. Please review the journal's Table Checklist to make sure that your tables conform to journal style. The Table Checklist is available online here: https://urldefense.proofpoint.com/v2/url?u=http-3A__edmgr.ovid.com_ong_accounts_table-5Fchecklist.pdf&d=DwIGaQ&c=iORugZls2LlYyCAZRB3XLg&r=X5TKSJvVKlYLTOjAcBVfnf6ZNS7HppVns1SyOG-QQuI&m=g8k22xJG941kmlBbNr2OI_g1ZVxpzOvBEf9JHZ2Y-5M&s=aE-djy4Av-aXD0M6n0TTrUoNrd0oCCCV3ixgGS78lgg&e= .

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    Done.

16. Figures
    Figure 1: Please upload as a figure file on Editorial Manager.
    Figure 2: Please cite within the manuscript and upload as a figure file on Editorial Manager.

We have submitted Figure 1 as both an Excel file and a PDF.
We have submitted Figure 2 (which includes two chest radiography images) as separate JPEG files.

17. 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 https://urldefense.proofpoint.com/v2/url?u=http-3A__links.lww.com_LWW-2DES_A48&d=DwIGaQ&c=iORugZls2LlYyCAZRB3XLg&r=X5TKSJvVKlYLTOjAcBVfnf6ZNS7HppVns1SyOG-QQuI&m=g8k22xJG941kmlBbNr2OI_g1ZVxpzOvBEf9JHZ2Y-5M&s=5DnyNDAmZ-fS9qbG0Hp0hkeI6XtYh0awrcx_ossVWts&e= . The cost for publishing an article as open access can be found at https://urldefense.proofpoint.com/v2/url?u=http-3A__edmgr.ovid.com_acd_accounts_ifauth.htm&d=DwIGaQ&c=iORugZls2LlYyCAZRB3XLg&r=X5TKSJvVKlYLTOjAcBVfnf6ZNS7HppVns1SyOG-QQuI&m=g8k22xJG941kmlBbNr2OI_g1ZVxpzOvBEf9JHZ2Y-5M&s=XTNZAh2S0w_pY67ElaLUSfCE4gl4ZEZ4FSBxaQkUQMk&e= .

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    * A point-by-point response to each of the received comments in this letter.

Done.