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 13, 2020
To: "Chidi Ochu Uzoma Esike"
From: "The Green Journal" em@greenjournal.org
Subject: Your Submission ONG-20-547

RE: Manuscript Number ONG-20-547

ESIKE'S TECHNIQUE - A NOVEL UTERUS-PRESERVING TREATMENT FOR UNCONTROLLABLE POSTPARTUM HEMORRHAGE

Dear Dr. Esike:

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 referees 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).

***Due to the COVID-19 pandemic, your paper will be maintained in active status for 30 days from the date of this letter. If we have not heard from you by May 13, 2020, we will assume you wish to withdraw the manuscript from further consideration.***

REVIEWER COMMENTS:

Reviewer #1: This article describes an alternative method of uterine compression suture method for hemostasis. The authors propose this method as a simpler technique than the already studied B lynch. Their main claim of advantage is that you do not have to enter the uterus and that you do not need a different suture type or size to accomplish.

Abstract - line 81-28, it would be more correct to say where more fatal cases are due to PPH occur. Since PPH is the leading cause of maternal morbidity (though not mortality) in the developed world

Introduction -line 113 instead of "I write to present" a more formal wording is needed such as "in this report we describe the Esike's technique...." or something along those lines

Esike's technique
line 124 instead of "good bite" more formal wording such as 3 3-4 centimeter anchoring stitch are placed X( not sure what number you want to put here) centimeters apart in the lower uterine segment above the bladder reflection anteriorly and repeat the placement of 3 stitches on the posterior aspect of the lower uterine segment(then continue with the wording about removing the needle etc)

Picture 12,3, are not useful
remove the term "healthy bite"

Figure 5 is the most useful figure and maybe all you need to show suture placement in addition to the description provided
pix 4 5, 6 may be helpful but are not essential
line 275 typo - compressing ( not compressing)

there is no picture 8 - it goes from 6->8, needs relabeling

experience: lines 338-339 describing the patient's profession can be removed. That information is generally not needed in this type of presentation
Reviewer #2: The author describes a compression suture technique of the uterus to be used following postpartum hemorrhage (PPH). It is, fundamentally, little different from the Hayman brace suture described in the Green Journal in 2002. The author describes an uncontrolled case series of 18 women with PPH who underwent the procedure in Nigeria; only two women underwent hysterectomy. This work would have had more merit if the author had been able to point to (1) theoretical advantages of this technique over existing compression techniques and (2) evidence from clinical studies of actual benefits. Such detail is not included in the paper. Uncontrolled case series of course carry substantial risk of bias.

Reviewer #3: Author presented a novel eponymous uterine compression technique for retractable post partum hemorrhage in a low-resource setting.

It would appear this is a simple and differentiated technique compared to existing techniques.

1. Lines 83-84; need to temper impact of lack of hysterectomy and how this technique will save lives; readers need to know what alternative medical therapies are employed in this setting, for example misoprostol is cheap and readily available.

2. Lines 108-109; as above, in addition, how about uterine packing methods? How about other compression methods? B-Lynch or Pereira? And why are they not appropriate for use in this setting?

3. Too many pictures and figures; suggest keeping only picture #6, figures #1 & 7

4. Lines 331-340; create a table showing demographics, relevant obstetric and surgical parameters including estimated blood loss, hemoglobin pre & post, blood transfusions, route & type of delivery, obstetric complications, multiple gestations (if any) etc

5. Further, enumerate initial medical remedies for PPH in this setting- oxytocic, misoprostol, methergine, etc

6. Lines 349-352 would seem unnecessary

7. Discussion can be shortened.

EDITOR NOTES
Dr. Esike:

Thank you for this submission. There are some issues with writing style for your paper that I am addressing in my comments below. Please make sure that my suggestions for changes do not alter your meaning or intended emphasis.
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 ad 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.

80: Loss of the uterus is not a complication of a hysterectomy, it is the goal. I think your background should really focus on the disproportionate rate of postpartum hemorrhage as the cause of death in developing countries and the work force in many places being unable to perform potentially life-saving hysterectomy. If medical management fails, an effective alternative surgical approach that can be performed by doctors able to perform a cesarean delivery (but not a hysterectomy) can be lifesaving.

85: In the technique section, briefly describe the technique itself. Something like "Esike's technique is a uterine compression method which does not require hysterotomy. Six sutures are placed in the lower uterine segment, three anteriorly and three posteriorly. Starting with the middle one, the sutures are tied at the fundus, with the help of an assistant to provide uterine compression. The more laterally placed sutures are then tied similarly, resulting in uterine compression".

95: Not really possible to talk about safety given the small N as complications, which may be rare, may occur and you don’t have follow up. You can conclude. "This technique uses readily available sutures and easily taught technique that can be incorporated in limited-resource obstetrical settings."

I recommend a similar refocus of the introduction of your paper as suggested for the abstract.

103: delete hyphen.

Lines 106-107: It may be useful here to introduce to readers the concept of the medical officer who can perform cesarean births, but not hysterectomy, as the primary physician at most hospitals and birthing facilities. I would avoid the term "sentences". Perhaps something similar to what I suggested for the abstract "Without the ability to perform a hysterectomy, a physician faced with intractable hemorrhage from uterine atony needs alternatives. Uterine compression sutures, a mechanical method of compressing the uterus and closing the arterial beds to reduce bleeding have been developed to treat PPH and avoid hysterectomy and thus preserve fertility in these patients. However, these compression sutures, such as the B-Lynch suture, require hysterotomy, which may be beyond the surgical competence of an individual medical officer. We developed an alternative compression suture method that does not require hysterotomy and uses suture materials available in birthing facilities."

Line 117- 355: Please tell us if the patient is in lithotomy position. You make the point several times that one of the problems with current methods are the need for hysterotomy but ½ the patients had had a cesarean, so a hysterotomy was already done. In the description of the technique, please tell us if the hysterotomy for the CS has already been closed when you start the Esike technique. I assume but you need to state if the suture line anteriorly goes fundal to or below the hysterotomy. Please note that I’m recommending a significant edit of your manuscript and a reduction in the number of figures. This is primarily to conform with Journal style. Only your current Figure 1 and 7 are needed. In my revisions, Figure 2= your current figure 7). If the patient delivered vaginally, a laparotomy is performed and the uterus exteriorized.

Place two rows of three sutures, either polyglactin #2 or chromic #2 suture, in the lower uterine segment, one anteriorly and one posteriorly. Place the first row anteriorly just above the bladder reflection, but at slightly different distances from the bladder reflection. The suture should be placed deep into the myometrium but avoiding the endometrial cavity and each should run about 3-4 cm parallel to the bladder reflection. Tie the suture twice in the middle, leaving two long tails and secure them to the drape with a hemostat or mosquito artery forcep. Repeat for each suture.

Posteriorly, place three sutures at various levels in the lower 1/5 of the uterus, oriented in the same direction as those anteriorly. One should be in the midline, while the other two placed laterally, ending about 2 cms from the lateral edge of the uterus. Figure 1 demonstrates the suture placement and numbering. Begin with the two middle sutures, labeled as Suture 2 and 5 in Figure 1. The assistant slowly, firmly and continuously compresses the uterus as the surgeon ties the 2 sutures at the fundus until it cannot be further compressed. This is then repeated for the 2 lateral pairs of sutures (Suture 1 and 4 tied together and suture 3 and 6) The lateral sutures should be tied about 4 cm from the lateral edge of the uterus. As the uterus is compressed, slack should be taken up by the sutures prior to tying. Figure 2 illustrates the appearance of the uterus with all three compressions sutures tied.

Observe for vaginal bleeding for some minutes prior to replacing the uterus into the abdominal cavity and closing the abdomen.

Experience
Esike’s uterine compression suture was used in 18 women from 2009 to 2019 in the former Ebonyi State University Teaching Hospital and Alex Ekwueme Federal University Teaching Hospital in [name of city], Nigeria. Each woman had
severe postpartum hemorrhage due to uterine atony and had undergone the local protocols for management to no avail. The age of the patients ranged from 22-38 years. Three were primigravida, seven had 1-4 prior births and eight had 5 or more. Eleven had had no prenatal care. One woman had had a prior myomectomy and nine were delivered by cesarean birth. [NOTE: I’ve omitted their work history as it seems irrelevant to the presentation. Given the small N percentages are also not relevant.]

The uterine compression suture resulted in control of the hemorrhage in 16/18 women: two required hysterectomy. Suture placement required 11-25 minutes. All women were discharged within 7 days without complication. “ [NOTE: Please clarify: Since ½ the women had had vaginal birth, does this 11-25 minute range only include time once laparotomy was performed and presumably with the surgical field set up for possible hysterectomy? When you say all women were discharged in 7 days, does this include the 2 who had hysterectomy?]

You write about this being easy to learn, but have not provided us any information about teaching others. Can you include anything about that in your experience section?

361-364: This technique does not prevent uterine atony; rather, it is a treatment for it. I recommend instead that the first paragraph of your discussion include a brief introduction to the effect that health centers and hospitals in low-resource settings usually lack easy access to large quantities of blood or surgeons capable of performing hysterectomy or complex surgical procedures. As such, alternative, rapidly performed and easily taught surgical approaches are necessary when medical management of uterine atony fails.

Paragraph 2 should point out the differences between your technique and B-Lynch. (Suture type, length, needle type may be appropriate to include). After that, you concluding paragraph is all that is really needed.

EDITOR 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. 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. To prevent confusion among our readers and reviewers, manuscripts submitted to the journal must be written in grammatically correct formal English.

The journal's publisher, Wolters Kluwer, in partnership with Editage, offers editorial services to help authors prepare a submission-ready manuscript. These editorial services range from a complete language, grammar, and terminology check to intensive language and structural editing of academic papers. They also include translation with editing, plagiarism check, and artwork preparation. For more information regarding Wolters Kluwer Author Services, please visit http://wkauthorservices.editage.com.

Listed below are other companies that provide language and copyediting services.

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* Boston BioEdit: http://www.bostonbioedit.com
* Charlesworth Author Services: http://cwauthors.com/author_services_main
* Editorial Rx: http://www.editorialrx.com
* Enago: http://www.enago.com
* ScienceDocs: http://www.sciencedocs.com
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* Textcheck: http://www.textcheck.com
Note that appearance in this list of vendors does not represent endorsement by the publisher or journal. Authors are encouraged to investigate each service on their own, as well as seek out additional vendors offering similar services. Costs for these services are the responsibility of the author.

4. 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.

5. Because of space limitations, it is important that your revised manuscript adhere to the following length restrictions by manuscript type: Procedures and Instruments articles 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.

6. Titles in Obstetrics & Gynecology are limited to 100 characters (including spaces). Do not structure the title as a declarative statement or a question. Introductory phrases such as "A study of..." or "Comprehensive investigations into..." or "A discussion of..." should be avoided in titles. Abbreviations, jargon, trade names, formulas, and obsolete terminology also should not be used in the title. Titles should include "A Randomized Controlled Trial," "A Meta-Analysis," or "A Systematic Review," as appropriate, in a subtitle. Otherwise, do not specify the type of manuscript in the title.

7. 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).

8. Provide a short title of no more than 45 characters, 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: Procedures and Instruments, 200 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. Figures: All figures should be cited within the manuscript and uploaded as figure files on Editorial Manager. Also, please rename all pictures as figures. The number of the figure should reflect the order in which they are cited within the manuscript. Note that some of the drawings have a figure number written on them that does not match the figure number associated with them.

13. 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.
14. 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.

***Again, your paper will be maintained in active status for 30 days from the date of this letter. If we have not heard from you by May 13, 2020, we will assume you wish to withdraw the manuscript from further consideration.***

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.
The Editor-in-Chief

Obstetrics and Gynecology

Dear sir,

**REVISION OF ESIKE’S TECHNIQUE – A NOVEL UTERUS-PRESERVING TREATMENT FOR UNCONTROLLABLE POSTPARTUM HEMORRHAGE**

I thank you for the thorough work you and your team did by extensively reviewing this paper and making useful suggestions that will make it a much better paper.

I have painstakingly implemented the revisions and answered the questions raised in this letter to you and I am sending you the revised copy. I do hope it will meet your esteemed expectation.

Sir I think that adding pictures three that illustrates an insertion of the suture and picture five showing an assistant compressing the uterus while the two sutures (2 and 5) are being tied will make this technique real and more understandable to readers and indeed less abstract as inclusion of only the illustrations are bound to make the technique look. If it will not distort anything, I do not know if this can be given some consideration in the event of this manuscript being considered for publication.
Response to Reviewers Questions

Reviewer One

Comment

Line 83 -84, need to temper impact of lack of hysterectomy and how this technique will save lives. Readers need to know what alternative medical therapies are employed in this setting, for example misoprostol is cheap and readily available.

Response

Hysterectomy is the last resort in the treatment of PPH. It is very effective but unfortunately in low resources countries, general duty doctors with just first degree in medicine with experience in performing just caesarean sections man majority health centers and district hospitals that carter for women. Most of these doctors can perform cesarean sections but cannot perform hysterectomy. The implication is that any woman who had PPH and needed hysterectomy dies in these places. Moreover, blood is needed even where a doctor can perform hysterectomy. The lack of blood and blood products in these resource constrained countries can prevent even the obstetricians and other doctors with the skills of hysterectomy from performing it hence leading to avoidable deaths of such PPH patients.

But the Esike’s technique which is simple, effective and easily learnt will prevent such deaths because these doctors who can do caesarean section but cannot do hysterectomy or more complicated compression suture techniques can equally perform Esike’s technique without the need for any additional instruments or
equipment. It can also be done without the need for additional blood if there is no blood or blood products.

In resource poor settings, the protocol for presenting PPH starts with active management of labour where 10iu of intramuscular oxytocin is given to the woman after delivery of the baby. If this does not prevent bleeding various protocols for each unit is employed which in our center include giving 0.5mg of intravenous ergometorie, inserting 600-800 microgram of misoprostol per rectum, setting up 2 intravenous lines with wide-bore canula, rapidly infusing normal saline in one hand and high dose oxytocin in the other catheterizing the bladder giving prostaglandins, checking for genital tract trauma, uterine evacuation, uterine packing either with gauze or balloon for tamponading the uterus etc. When all these fail, the patients is taken to the theatre. With laparotomy done, those that know the B-Lynch compression suture or any other can do it, but those dose that cannot do it or does it and the woman is still bleeding proceed to hysterectomy. The B-lynch procedure is popular theoretically in some special centers in developing countries but few doctors especially among the general duty doctors can actually carry it out.

However with the Esike’s technique that is easy to learn, those that can do B-lynch or hysterectomy can always carry out the much simpler, easily learnt and equally effective Esike’s technique and also spare the woman’s uterus at the same time.

2. Comment

Lines 108-109; as above, in addition, how about uterine packing methods? How about other compression methods? B-lynch or Pereira? And why are they not appropriate for these settings.
Response

The issue of out of stock syndrome where the most basic of drugs hospital consumables etc are lacking in health faculties in resources poor countries are so serious that anybody who has not practiced in any of these developing countries cannot understand it. The front line doctors in the vast first and second tier health facilities in developing countries that look after the vast majority of our pregnant women most often receive no further training after their MBBS and learn their caesarean section skills mainly from other over worked senior colleagues who themselves may not have received any further training from even workshops and conferences after graduation. So for them, the most popular compression suture method, the B lynch suture may have been a name crammed during fifth MBBS exam for controlling PPH. They may not have even seen it performed not to talk of practicing it. They may not have heard less popular methods like Hayman’s, Pereira methods not to talk of practicing them.

Moreover, a review of the literature had shown that some of these methods eg B-Lynch require special large curved needles, longer sutures etc which are not available in most developing countries’ health facilities. This limits their use by even the few obstetricians who know how to use them. This is where Esike’s technique has an advantage. Apart from its being simple, effective and easy carry to learn, it does not require any special materials, just the suture that is used for cesarean section.

Comments

3. Too many pictures and figures, suggest keeping only picture and figures 1 and 7

Answer: This is ok by me but I would have thought that at least adding the picture clearly illustrating the insertion of suture (picture three) and that illustrating the assistant compressing the uterus while the surgeon is tying the sutures (picture five)
would have helped the readers understanding more and show them that this procedure is real and practicable and not abstract as the two illustrations chosen may make the procedure to look.

4. Comment

Line 331-340, create a table showing demographics, relevant obstetric and surgical parameters including estimated blood loss, hemoglobin, pre and post, blood transfusion, route and type of delivery, obstetric complications, multiple gestation (if any) etc.

**Answer:** I have these information but they were removed because of space and cord count constraints. If advised to do otherwise, they will be included.

5. Comment

Further enumerate initial medical remedies for PPH in this setting-oxytocic misoprostol, methergin etc.

**Response**

I will add them. I removed specifics and captured this by saying after all the departmental protocols for preventing PPH failed. I will now add, ‘after all the departmental protocol for managing PPH like intramuscular 10iu of oxytocin after delivery of the baby, 600-800microgramm of rectal misoprostol after delivery of the baby, 0.5mg of intravenous ergometrin, prostaglandin etc.


**Response** Looking at these lines in my downloaded work, 149 talked about route of delivery which I think is important and 351 and 352 talked about the success rates of the technique which I consider needed in the paper unless otherwise advised.
7. **Comment**: Discussion can be shortened.

**Response**: I will work on it.

**EDITORS NOTE**

1. **Comment**: Line 117 – 435 please tell us if the patient is in lithotomy position.

**Response**: No. To carry out this technique, the patients are in supine position.

2. **Comment**: Line 117 – 335 you make the point several times that one of the problems with current methods are the need for hysterotomy but half of your patients had cesarean section, so hysterotomy was already done

**Response**: No. Esike’s technique does not involve hysterotomy. In the cesarean patients, the surgery had been done and they were found to have uncontrollable PPH. Esike’s technique was applied without removing the stitches that were used to suture the uterine incision of the cesarean section. The sutures were applied below the line of the incision anteriorly.

**Comment**: I assume, but you need to state if the suture line anteriority goes fundal to or below the hysterotomy.

**Response**: The sutures are inserted below the repaired hystorotomy and go fundally when they are being tied.

**Comment**: In the description of the technique, please tell us if the hysterotomy for the c/s has already been closed when you start the Esike’s technique.

**Answer**: Yes, the hysterectomy is closed before starting the Esike’s technique. One of the drawbacks pointed out about the methods that involve hysterotomy is that the uterus needs to be completely repaired for it to contract fully so in cases involving hysterotomy, the uterus does not contract maximally till the hysterotomy is repaired. This leads to more loss of blood.
Comment: Please note that I’m recommending a significant edit of your manuscript and reduction in the numbers of pictures.

Answer: Please do anything that will bring the manuscript to international standard and in line with the journal’s policy. However, if my plea to add pictures three and five in addition to the ones chosen for the reasons I adduced earlier, I will appreciate it.

Thank you and God bless.

Yours faithfully,

Dr. Esike Chidi O.U