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: May 15, 2020
To: "Mary Catherine Tolcher" [redacted]
From: "The Green Journal" em@greenjournal.org
Subject: Your Submission ONG-20-1208

RE: Manuscript Number ONG-20-1208

Prone Positioning for Hypoxemia in Pregnant Women with COVID-19

Dear Dr. Tolcher:

Your manuscript has been reviewed by the Editorial Board and by special expert referees. Dr. Chescheir is interested in potentially publishing your revised manuscript in a timely manner. In order to have this considered quickly, we need to have your revision documents submitted to us as soon as you are able. I am tentatively setting your due date to May 18, 2020, but please let me know if you need additional time.

The standard revision letter text 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: The authors present a Current Commentary describing their experience with prone positioning for pregnant women with CODID-19 related respiratory distress. I have several questions / comments for the authors

1. The beginning of the article is a fairly lengthy review of respiratory physiology and management of respiratory failure in pregnant women. The review is good but not really the focus of this short submission. If this is meant to be a thorough review of respiratory complications in pregnancy, the paper should be redone that way. Since it seems to be just a focus on prone positioning, would probably shorten the intro portion to a paragraph or two and jump right into the role of prone positioning.

2. the authors should spend a paragraph or two detailing how they came up with this protocol. did they use other reports of this, did they convene a committee, did one person write this up and then it got approved? One wouldn't expect there to be much data behind it, but it would still be good to understand how these protocols and recommendations came to be.

3. do the authors have any clinical experience with using this prone position for pregnant patients with COVID-19 (or any other pregnant patients)? or, is this just a plan for if it is ever needed. if they do have any experience the authors should probably describe a case or two for illustration.

4. the videos are very good. nicely done!!

5. i think this would be better suited to be a "Procedures and Instruments" article type, as it is not really a "Commentary". would suggest revising the format to match that article type.

Reviewer #2:

Abstract
- This section presents the clinical background and goal of this work succinctly as well as admirably.

Body
- The discussion of the physiological changes of pregnancy and how they may affect ventilation is a well done summary

of this topic.

- It may be helpful for the readers who are less familiar with some of the terms to briefly explain them, such as with the mention of plateau pressure in line 92, driving pressures in line 116, -capnia (as related to hypo and hyper as stated in lines 115 and 117), low-tidal volume ventilation in line 118, transmural pressures in line 125.

- The statement in line 110 that "the risk of failed intubation in pregnant women is 8-10 times higher than in non-pregnant patients" should be referenced.

- In lines 111-12, the statement that "an emergency surgical airway should be considered early" is too strong of an endorsement in my opinion. It is true that pregnant patients are generally classified as a "difficult airway", however I would suggest that several advanced airway options and/or adjuncts could be employed prior to the often morbid emergent surgical airway. These other options include video assisted laryngoscopy, blind nasal intubation, use of a Bougie device, etc. I would suggest presentation of these as additional options prior to proceeding with an emergent surgical airway.

- What he "additional caution" is/are that is advocated for in patients "≥34 weeks of gestation" in line 147 should be specifically stated.

- Suggest rephrasing "in the videos" in line 157 to "in the accompanying supplementary videos", as the current wording may be misinterpreted by readers to lead them elsewhere for such videos.

- In addition to simulation training, rightly stated in line 158, a strong emphasis on collaboration and care planning discussions, ideally at the time of admission of a pregnant patient to an ICU as well as ongoing, should be emphasized. This may be done following this sentence regarding simulation training in addition to the concluding message of the manuscript.

- Although true that shorter prone positioning may be considered, most institutions typically employ 16 hours per day for intubated patients, in accordance with trial data (current 4th reference already: Guerin C, et al. Prone positioning in severe acute respiratory distress syndrome). I would advocate that pregnant patients that require such interventions should not be treated as if their lung pathology would not also benefit from similar durations. For those with mild or moderate ARDS (which should by defined by Berlin criteria here for the benefit of common understanding and communication between teams), I would suggest wording to promote discussion with the treating Critical Care team regarding shortened duration of prone positioning, "passive" proning, and even if it is felt to be indicated for mild or moderate ARDS in each individual patient. I believe that if the Ob./MFM team is advocating for deviations from high level data in our patients to our Intensivist colleagues, that may strain credibility and collaboration, thus should be avoided.

- The concluding sentence is excellently written, especially in regards to promoting collaboration and ongoing discussion of care with our colleagues.

Figures and Tables

- These present a tremendous amount of information effectively.

- The pictures and videos are a superbly beneficial, well done!

- The decision algorithm is overall very informative and thorough, though there are some points that may benefit from amendment and/or clarification, as follows (with rationale for each with them):

o Remove

Indications: failed pre-discharge ambulatory oxygenation test - (a patient that would necessitate prone positioning should not be managed as an outpatient)

Indications: suspected or confirmed COVID-19 (may consider for other etiologies of ARDS) - (disease etiology is less important than the presence of ARDS itself; inclusion of this indication may confuse readers into thinking that COVID itself is an indication for prone positioning).

Absolute contraindications: hemodynamic instability (requiring vasopressors)… - (many patients that may benefit from prone positioning will be on vasopressors, and if a pregnant patient is, neither intervention should be withheld from them).

Absolute contraindications: non-reassuring fetal status - (as this may be due to hypoxemia, prone positioning may improve this; alternatively if this is kept in the manuscript, I would advise specifying category III tracing as an absolute contraindication only).

Absolute contraindications: Recent tracheal, thoracoabdominal surgery or trauma, or Cesarean delivery within last 48 hours. - (such patients may have prone positioning if indicated, therefore this is not an absolute contraindication).

Absolute contraindications: Severe respiratory distress (respiratory rate >30/min, $PaCO_2$ >50, pH <7.35, accessory muscle use) (*awake only) - (these are common accompanying signs and/or symptoms for patients with severe ARDS who may therefore benefit from prone positioning)

Anticipated airway issues or need for intubation (*awake only) - (this is not necessary to state, and may confuse some regarding if intubation is actually a contraindication for prone positioning).

For an intubated patient requiring prone positioning, it is true that ideally they will have enteral nutrition help for >1 hour prior to prone positioning, this is not absolutely required.

RASS, with the level of -4, should be explained in a footnote for this figure.
BIS should be explained in a footnote for this figure.
Final box in bottom right: Discontinue prone positioning for respiratory rate ≥30, fatigued, using accessory muscles (*awake only) - (these are often accompanying signs and symptoms of severe ARDS, for which prone positioning may benefit patients; a patient may need to be monitored for longer to have the benefits of this position lead to diminishment of these signs and symptoms).

References
- A thorough and insightful resource for the interested reader.

EDITOR'S COMMENTS:

Thank you very much for this important submission. One of your reviewers recommended changing this to a Procedures and Instruments feature; I am comfortable with you keeping this as a Current Commentary-it could fit either. On your revision, please note that we don't use the "and/or" convention so please edit that out.

Nice video!

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. Obstetrics & Gynecology uses an "electronic Copyright Transfer Agreement" (eCTA). 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.

The following co-authors will need to complete our electronic Copyright Transfer Agreement, which was sent to them by email through Editorial Manager. Once the form is complete, please add their disclosures to the “Financial Disclosure” section: Kalpalatha K Guntupalli and Joseph L Nates.

3. 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.

4. 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.

5. 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).

6. 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 limit for Current Commentary articles is 250 words. Please provide a word count.

7. 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.

8. 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.

9. 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.

10. Figures and Video:

Figure 1: Current figure file can be resubmitted as-is.

Figure 2: Please break this figure into Figures 2 and 3. Note that we will need to collect image release forms from anyone identifiable in these images.

Videos: Please be sure to cite Video 1 and Video 2 within the manuscript text. We will also need images releases from anyone identifiable in the videos. If someone appears in both, we just need one form from them.

The image release form is uploaded to your submission's record in your Author account, but email the Editorial Office if you cannot locate it.

11. Each supplemental file in your manuscript should be named an "Appendix," numbered, and ordered in the way they are first cited in the text. Do not order and number supplemental tables, figures, and text separately. References cited in appendixes should be added to a separate References list in the appendixes file.

12. 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.

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 18, 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.

May 18, 2020

Nancy C. Chescheir, MD
Editor-in-Chief
Obstetrics & Gynecology
409 12th Street, SW
Washington, DC 20024-2188

Manuscript No: ONG-20-1208
Title: "Prone Positioning for Hypoxemia in Pregnant Women with COVID-19"

Dear Dr. Chescheir,

Attached please find our revised manuscript. We have carefully reviewed the comments and suggestions made by the Reviewers, and we have enclosed our point-by-point responses below. I attest that I have read the Authors Instructions.

We thank you for your consideration of our work, and we look forward to your review of the revised manuscript. If I can provide any further clarifications, please do not hesitate to contact me.

Thank you for your consideration.

Sincerely,

Mary Catherine Tolcher, MD, MSc
Baylor College of Medicine
Division of Maternal-Fetal Medicine, Ben Taub Hospital

Responses to Reviewer Comments

REVIEWER COMMENTS:

Reviewer #1: The authors present a Current Commentary describing their experience with prone positioning for pregnant women with CODID-19 related respiratory distress. I have several questions / comments for the authors

1. The beginning of the article is a fairly lengthy review of respiratory physiology and management of respiratory failure in pregnant women. The review is good but not really the focus of this short submission. If this is meant to be a thorough review of respiratory complications in pregnancy, the paper should be redone that way. Since it seems to be just a focus on prone positioning, would probably shorten the intro portion to a paragraph or two and jump right into the role of prone positioning.

***Authors' reply*: The authors considered shortening the review of respiratory physiology based on the Reviewer #1's comment. However, since we had room in the word counts and Reviewer #2 appreciated the longer review, we did not shorten the intro portion. Additionally, we have found that this brief review of pertinent physiology has helped our OB/MFM team better collaborate with the ICU team regarding ventilator management in pregnant women and complex decisions on timing of delivery.**

2. the authors should spend a paragraph or two detailing how they came up with this protocol. did they use other reports of this, did they convene a committee, did one person write this up and then it got approved? One wouldn't expect there to be much data behind it, but it would still be good to understand how these protocols and recommendations came to be.

***Authors' reply*: We have added several sentences outlining how the algorithm was developed.**
Page: 8
Lines: 186-195

3. do the authors have any clinical experience with using this prone position for pregnant patients with COVID-19 (or any other pregnant patients)? or, is this just a plan for if it is ever needed. if they do have any experience the authors should probably describe a case or two for illustration.

***Authors' reply*: The authors have experience with a series of cases in which prone positioning was utilized for pregnant and postpartum patients. Our earliest experiences helped shape the algorithm. We currently have a research protocol submitted to the IRB to review this case series. The IRB is pending approval. We want physicians to be able to institute prone positioning therapy for their patients with COVID-19 as soon as possible, and we are not able to properly detail the**

cases and obtain informed consent from the patients as soon as we would like, and we anticipate accumulating more cases in the coming few weeks. However, we would be very interested in submitting a separate case series detailing the clinical course of these patients.

4. the videos are very good. nicely done!!

Authors' reply**: Thank you.**

5. i think this would be better suited to be a "Procedures and Instruments" article type, as it is not really a "Commentary". would suggest revising the format to match that article type.

Authors' reply**: Since the Editor thinks this manuscript is suited for either category, we have left this as a Current Commentary.**

Reviewer #2:

Abstract

- This section presents the clinical background and goal of this work succinctly as well as admirably.

Authors' reply**: Thank you.**

Body

- The discussion of the physiological changes of pregnancy and how they may affect ventilation is a well done summary of this topic.

Authors' reply**: Thank you.**

- It may be helpful for the readers who are less familiar with some of the terms to briefly explain them, such as with the mention of plateau pressure in line 92, driving pressures in line 116, -capnia (as related to hypo and hyper as stated in lines 115 and 117), low-tidal volume ventilation in line 118, transmural pressures in line 125.

Authors' reply**: We have defined plateau pressure (pages 4-5, lines 94-96), deleted driving pressure (complicated concept that is not a necessary for the topic and target audience; page 6, line 130), defined hypo- and hypercapnia (page 6, lines 129 and 132), low tidal volume ventilation (page 6, line 133), and expanded upon and defined transmural pressure (now termed "transpulmonary pressure", which is the same thing; page 6, lines 140-142).**

- The statement in line 110 that "the risk of failed intubation in pregnant women is 8-10 times higher than in non-pregnant patients" should be referenced.

***Authors' reply*: We thank the Reviewer for this comment. We have taken the time to further review the literature on the incidence of both difficult and failed intubation in the obstetric population (a fascinating topic as the data has changed over the last few decades making this point debatable). We have reworded and expanded a brief section on difficult or failed intubation.**
Pages: 5-6
Lines: 113-126
Reference numbers: 4-8

- In lines 111-12, the statement that "an emergency surgical airway should be considered early" is too strong of an endorsement in my opinion. It is true that pregnant patients are generally classified as a "difficult airway", however I would suggest that several advanced airway options and/or adjuncts could be employed prior to the often morbid emergent surgical airway. These other options include video assisted laryngoscopy, blind nasal intubation, use of a Bougie device, etc. I would suggest presentation of these as additional options prior to proceeding with an emergent surgical airway.

***Authors' reply*: As above, the authors appreciate this insightful suggestion, and upon further review, we agree that this statement was too strong. We have reworded and added additional details and suggested references for a difficult airway algorithm in obstetric patients.**
Pages: 5-6
Lines: 113-126
Reference numbers: 4-8

- What he "additional caution" is/are that is advocated for in patients "≥34 weeks of gestation" in line 147 should be specifically stated.

***Authors' reply*: We have reworded this sentence and expanded on our rationale for "additional cautions" post cesarean and ≥34 weeks of gestation.**
Page: 7
Lines: 170-174

- Suggest rephrasing "in the videos" in line 157 to "in the accompanying supplementary videos", as the current wording may be misinterpreted by readers to lead them elsewhere for such videos.

***Authors' reply*: This has been rephrased and we have cited Video 1 and Video 2 in the manuscript text.**
Page: 8
Lines: 198-199

- In addition to simulation training, rightly stated in line 158, a strong emphasis on collaboration and care planning discussions, ideally at the time of admission of a

pregnant patient to an ICU as well as ongoing, should be emphasized. This may be done following this sentence regarding simulation training in addition to the concluding message of the manuscript.

***<u>Authors' reply</u>*: The authors agree and have added a statement about collaboration and care planning.**
Pages: 9
Lines: 205-209

- Although true that shorter prone positioning may be considered, most institutions typically employ 16 hours per day for intubated patients, in accordance with trial data (current 4th reference already: Guerin C, et al. Prone positioning in severe acute respiratory distress syndrome). I would advocate that pregnant patients that require such interventions should not be treated as if their lung pathology would not also benefit from similar durations. For those with mild or moderate ARDS (which should by defined by Berlin criteria here for the benefit of common understanding and communication between teams), I would suggest wording to promote discussion with the treating Critical Care team regarding shortened duration of prone positioning, "passive" proning, and even if it is felt to be indicated for mild or moderate ARDS in each individual patient. I believe that if the Ob./MFM team is advocating for deviations from high level data in our patients to our Intensivist colleagues, that may strain credibility and collaboration, thus should be avoided.

***<u>Authors' reply</u>*: The authors agree and have edited this sentence to reflect shorter durations of proning for awake pregnant patients where the data is less clear and the prone position may be less comfortable and poorlytolerated for prolonged periods.**
Page: 9
Lines: 214-217

- The concluding sentence is excellently written, especially in regards to promoting collaboration and ongoing discussion of care with our colleagues.

***<u>Authors' reply</u>*: Thank you.**

Figures and Tables

- These present a tremendous amount of information effectively.

- The pictures and videos are a superbly beneficial, well done!

***<u>Authors' reply</u>*: Thank you.**

- The decision algorithm is overall very informative and thorough, though there are some points that may benefit from amendment and/or clarification, as follows (with rationale for each with them):

o Remove

Indications: failed pre-discharge ambulatory oxygenation test - (a patient that would necessitate prone positioning should not be managed as an outpatient)

***Authors' reply*: The authors agree and have removed this from the algorithm.**

Indications: suspected or confirmed COVID-19 (may consider for other etiologies of ARDS) - (disease etiology is less important than the presence of ARDS itself; inclusion of this indication may confuse readers into thinking that COVID itself is an indication for prone positioning).

***Authors' reply*: The authors understand and initially included this to encourage consideration in our institution for our most acute respiratory patients (at the time of submission, primarily related to COVID). We have edited to state "Suspected or confirmed ARDS" only.**

Absolute contraindications: hemodynamic instability (requiring vasopressors)… - (many patients that may benefit from prone positioning will be on vasopressors, and if a pregnant patient is, neither intervention should be withheld from them).

***Authors' reply*: The authors agree with this and have edited to read "hemodynamic instability or life-threatening arrhythmias", to ensure the patient is not acutely decompensating at the time of prone positioning.**

Absolute contraindications: non-reassuring fetal status - (as this may be due to hypoxemia, prone positioning may improve this; alternatively if this is kept in the manuscript, I would advise specifying category III tracing as an absolute contraindication only).

***Authors' reply*: The authors agree and have edited the algorithm specifying "Non-reassuring fetal status requiring immediate delivery".**

Absolute contraindications: Recent tracheal, thoracoabdominal surgery or trauma, or Cesarean delivery within last 48 hours. - (such patients may have prone positioning if indicated, therefore this is not an absolute contraindication).

***Authors' reply*: The authors are concerned about causing excessive pain or increased incisional complications due to the prone position; however, as you note this is not an absolute contraindication, so has been moved to "relative contraindications" section of the algorithm.**

Absolute contraindications: Severe respiratory distress (respiratory rate >30/min, PaCO2 >50, pH <7.35, accessory muscle use) (*awake only) - (these are common accompanying signs and/or symptoms for patients with severe ARDS who may therefore benefit from prone positioning)

***Authors' reply*: The authors agree and have removed this statement from algorithm.**

Anticipated airway issues or need for intubation (*awake only) - (this is not necessary to state, and may confuse some regarding if intubation is actually a contraindication for prone positioning).

***Authors' reply*: The authors agree and have removed this statement from algorithm. However, the authors feel that it is important to caution against prone positioning for an acutely decompensating awake non-intubated patient due to possible delay in obtaining airway with need to reposition patient, so the following was added to the absolute contraindication section: "Concern for acute respiratory decompensation requiring intubation (*awake only)".**

For an intubated patient requiring prone positioning, it is true that ideally they will have enteral nutrition help for >1 hour prior to prone positioning, this is not absolutely required.

***Authors' reply*: The authors agree and have revised statement to include "If possible, stop enteral feeds at least 1 hour".**

RASS, with the level of -4, should be explained in a footnote for this figure.

***Authors' reply*: The authors agree and have revised the Figure 1 Legend.**
Page: 12
Lines: 282-283

BIS should be explained in a footnote for this figure.

***Authors' reply*: The authors agree and have revised the Figure 1 Legend.**
Page: 12
Lines: 284

Final box in bottom right: Discontinue prone positioning for respiratory rate ≥30, fatigued, using accessory muscles (*awake only) - (these are often accompanying signs and symptoms of severe ARDS, for which prone positioning may benefit patients; a patient may need to be monitored for longer to have the benefits of this position lead to diminishment of these signs and symptoms).

***Authors' reply*: The authors agree and have removed this statement from algorithm. However, the authors feel that it is important to caution against prone positioning for an acutely decompensating awake non-intubated patient due to possible delay in obtaining airway with need to re-position patient, so the following was added to the Discontinue prone positioning section: "Concern for acute respiratory decompensation requiring intubation (*awake only)".**

References
- A thorough and insightful resource for the interested reader.

***<u>Authors' reply</u>*: Thank you.**

EDITOR'S COMMENTS:

Thank you very much for this important submission. One of your reviewers recommended changing this to a Procedures and Instruments feature; I am comfortable with you keeping this as a Current Commentary-it could fit either. On your revision, please note that we don't use the "and/or" convention so please edit that out.

Nice video!

***<u>Authors' reply</u>*: Thank you.**

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.

***<u>Authors' reply</u>*: OPT-IN**

2. Obstetrics & Gynecology uses an "electronic Copyright Transfer Agreement" (eCTA). 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.

***<u>Authors' reply</u>*: Noted.**

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

***<u>Authors' reply</u>*: This has been completed.**

The following co-authors will need to complete our electronic Copyright Transfer Agreement, which was sent to them by email through Editorial Manager. Once the form

is complete, please add their disclosures to the “Financial Disclosure” section: Kalpalatha K Guntupalli and Joseph L Nates.

Authors' reply: **Drs Guntupalli and Nates have assured me that they have submitted the eCTA. They also both stated they have no financial disclosures.**

3. 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=ZQs-KZ8oxEw0p81sqgiaRA&r=zF-ahl4SsE_jCrntQ2_UhQ&m=L7-2sZYmZUOJy-NrAo9XWiUdbZeWx0WvWc5aA8quObA&s=HKd7WY1cm9cKWz9jbf_aFxz06ZfGX5d0IsKcD5R3h7k&e= . If use of the reVITALize definitions is problematic, please discuss this in your point-by-point response to this letter.

Authors' reply: **Think link provided did not work (perhaps due to ACOG website updates?), but we were able to locate the definitions and review.**

4. 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.

Authors' reply: **Noted.**

5. 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).

***Authors' reply*: Noted.**

6. 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 limit for Current Commentary articles is 250 words. Please provide a word count.

***Authors' reply*: Noted. We have provided an abstract word count on the title page.**

7. 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=ZQs-KZ8oxEw0p81sqgiaRA&r=zF-ahl4SsE_jCrntQ2_UhQ&m=L7-2sZYmZUOJy-NrAo9XWiUdbZeWx0WvWc5aA8quObA&s=ecHXPS78Jt9PqPxWpf9a3D7MjG_U93s9GPjB958dO3I&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.

***Authors' reply*: Noted.**

8. 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.

***Authors' reply*: We have removed the virgule symbol from the manuscript.**

9. 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.

***Authors' reply*: We have replaced the term "provider" with "physician or respiratory therapist".**
Page: 12
Lines: 295-296

10. Figures and Video:

Figure 1: Current figure file can be resubmitted as-is.

***Authors' reply*: Completed.**

Figure 2: Please break this figure into Figures 2 and 3. Note that we will need to collect image release forms from anyone identifiable in these images.

***Authors' reply*: We have uploaded image release forms from all people in the images and videos.**

Videos: Please be sure to cite Video 1 and Video 2 within the manuscript text. We will also need images releases from anyone identifiable in the videos. If someone appears in both, we just need one form from them.

The image release form is uploaded to your submission's record in your Author account, but email the Editorial Office if you cannot locate it.

***Authors' reply*: We have now specifically cited Video 1 and Video 2 in the manuscript text.**
Page 8
Lines 198-199

11. Each supplemental file in your manuscript should be named an "Appendix," numbered, and ordered in the way they are first cited in the text. Do not order and number supplemental tables, figures, and text separately. References cited in appendixes should be added to a separate References list in the appendixes file.

12. 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=ZQs-KZ8oxEw0p81sqgiaRA&r=zF-ahl4SsE_jCrntQ2_UhQ&m=L7-2sZYmZUOJy-NrAo9XWiUdbZeWx0WvWc5aA8quObA&s=ftbbv0au3GrsSXnm2I3drSvaUQFIP8CkaIDZ4rvQI78&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=ZQs-KZ8oxEw0p81sqgiaRA&r=zF-ahl4SsE_jCrntQ2_UhQ&m=L7-2sZYmZUOJy-NrAo9XWiUdbZeWx0WvWc5aA8quObA&s=tvzV03ICcI-ySKQhA_8ioG-K-e87p99-iSBFG5doOqc&e= .

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.

***Authors' reply*: Thank you.**

***

If you choose to revise your manuscript, please submit your revision through Editorial Manager at https://urldefense.proofpoint.com/v2/url?u=http-3A__ong.editorialmanager.com&d=DwIGaQ&c=ZQs-KZ8oxEw0p81sqgiaRA&r=zF-ahl4SsE_jCrntQ2_UhQ&m=L7-2sZYmZUOJy-NrAo9XWiUdbZeWx0WvWc5aA8quObA&s=AxMvFZDZhVbUjX5r0KqTzjVNKAygbZi3fkAvNMWab-o&e= . 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 (https://urldefense.proofpoint.com/v2/url?u=http-3A__edmgr.ovid.com_ong_accounts_authors.pdf&d=DwIGaQ&c=ZQs-KZ8oxEw0p81sqgiaRA&r=zF-ahl4SsE_jCrntQ2_UhQ&m=L7-2sZYmZUOJy-NrAo9XWiUdbZeWx0WvWc5aA8quObA&s=5QllDNIrNHQHXRW2vtFn3xJg7qcPLf0CLCHnyZtqFQM&e=), 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 18, 2020, we will assume you wish to withdraw the manuscript from further consideration..

Sincerely,

Nancy C. Chescheir, MD
Editor-in-Chief