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

*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.
RE: Manuscript Number ONG-20-813

Vaginal delivery with a previous cesarean after external cephalic version: A systematic review and meta-analysis

Dear Dr. Turrentine:

Your manuscript has been reviewed by the Editorial Board and by special expert referees. Although it is judged not acceptable for publication in Obstetrics & Gynecology in its present form, we would be willing to give further consideration to a revised version.

If you wish to consider revising your manuscript, you will first need to study carefully the enclosed reports submitted by the referees and editors. Each point raised requires a response, by either revising your manuscript or making a clear and convincing argument as to why no revision is needed. To facilitate our review, we prefer that the cover letter include the comments made by the reviewers and the editor followed by your response. The revised manuscript should indicate the position of all changes made. We suggest that you use the “track changes” feature in your word processing software to do so (rather than strikethrough or underline formatting).

***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 Jul 11, 2020, we will assume you wish to withdraw the manuscript from further consideration.***

REVIEWER COMMENTS:

Reviewer #1: Authors performed a systematic review of the literature and pooled analysis to estimate the rate of successful external cephalic version in women with a prior history of cesarean delivery and determine the rate of successful vaginal delivery following ECV compared to women without a history of cesarean birth. Authors did not find a difference in overall successful rates of ECV in women with or without prior CS; the overall rate of vaginal delivery was lower in women with cesarean scar versus women without.

Overall authors performed a good systematic review and meta-analysis, however, there are a couple of issues that threaten the internal validity and generalizability of their findings.

1. While it is entirely appropriate to compare rates of successful ECV in patients with prior CS versus women without a scar, their primary finding of not observing a difference in success rates conflicts with the results of the largest study on this subject from the US that combined 2 national databases (McLaren et al 2018 citation #9) and reported lower rates of successful ECV in women with prior CS; 80% vs. 86%, p<0.001 in a cohort of >10,000 patients. That authors failed to find differences in their pooled analysis likely due to a beta error.

2. Comparing successful vaginal rates between women with prior CS and without CS ignores the impact that a history of CS has on likelihood of vaginal delivery. It is not surprising that in that comparison, women with a history of prior CS had lower successful vaginal rates. The most appropriate control group are women with prior CS undergoing TOLAC without ECV; indeed, McLaren et al had such a comparison and not surprisingly reported no difference in rates of successful vaginal delivery in TOLAC+ECV group vs. TOLAC (75% vs 74%). In their analysis, authors could have done more in pointing out that ECV in the setting of CS scar reduces rates of cesarean delivery from 95% (prior CS, breech, no ECV) versus 25% as McLaren et al reported.

3. In a couple of their analyses, I2 was >75%, pointing to high heterogeneity; studies spanned wide time periods from 1980s (Flamm, 1991) including a European retrospective study that spanned 16 years and some spanned several continents: performance of ECV and management of TOLAC have evolved so much over the last decade that the results shown (minus McLaren's) will have little relevance to contemporary practice. Critical variables that affect successful outcomes including tocolysis (incomplete data), amniotic fluid index, nulligravid status, use of regional anesthesia, fetal monitoring etc. are not consistently documented across the studies. These limit generalizability.

4. Lack of meaningful safety maternal and neonatal outcomes data is problematic; these are important concerns in considering ECV for patients contemplating TOLAC; McLaren et al, in their large series reported increased relative risks (albeit low absolute risks) of blood transfusion, unplanned hysterectomy and low Apgar scores (<7) at 5 minutes.
Reviewer #2: This manuscript adds important information to the literature and helps to inform clinical practice. A few thoughts for consideration are as follows:

1. The title might be clearer with the word order adjusted as follows: "Vaginal delivery after external cephalic version with a previous cesarean section: A systematic review and meta-analysis." A similar change would be clearer in the Abstract Objective.

2. Some of your sentences can be simplified and will be clearer as a result. For example this sentence: "Yet, a paucity of data proposes that external cephalic version for breech presentation is not contraindicated in women with a prior low-transverse uterine incision who are candidates for a trial of labor after cesarean." ... Perhaps something like this: "The available data indicates a prior low transverse cesarean section is not a contraindication for external cephalic version."

3. Line 66: This sentence needs clarified.

4. Line 75: Why is the registration number not written here?

5. I am surprised that the other two trial authors did not respond. Surely, you could elicit responses using your available networks?

6. Numbers under 10 should be written out and numerals not utilized (ie "two" not 2).

7. It would be helpful to analyze multiparous people who in both the case and control groups have a prior vaginal delivery. That would be very interesting, although it is likely that there are very limited numbers of people with a vaginal delivery followed by a cesarean section who then had a successful external cephalic version.

8. An important component of this analysis is the adverse events at the time of external cephalic version, as this, in addition to the likelihood of successful vaginal delivery, likely influences provider willingness to offer external cephalic version in the context of breech presentation in a person with a prior cesarean section. It would be useful to further explore this with additional analyses.

9. Delete "However, the potential limitations of our study must be considered as well."

10. It would be helpful if Figure 1 included more sub-categories per usual systematic review flow diagrams.

Reviewer #3: The authors present a meta-analysis of 8 studies addressing successful external cephalic version and successful vaginal delivery in patients with and without history of prior cesarean delivery. They found similar rates of ECV but lower rates of successful vaginal delivery in patients with previous cesarean birth compared to patients without previous cesarean delivery.

Please address the following specific comments and questions.

1. Page 6-7, lines 98-100: Please clarify whether studies were limited to patients with 1 prior cesarean delivery or whether 2 or more prior cesarean deliveries were included.

2. Page 7, lines 108-110: The primary outcome listed here is one sided and does not include comparison to women without previous cesarean births. Please clarify.

3. Page 8, lines 123-125: Please clarify the purpose for the subgroup analysis. If evaluating parity, it seems that the time of parous events in the c-section group should be clarified. Were patients with history of cesarean delivery and prior vaginal delivery included (rather than just one prior cesarean delivery with no prior vaginal deliveries)? Successful ECV and VBAC in multiparous patients that either did or did not have prior vaginal delivery are likely to be different when each are compared to multiparous patients without history of cesarean delivery.

4. Page 9, lines 155-157 and line 167: Please clarify specifically what was visualized on the funnel plots that did not suggest publication bias.

5. Page 10, lines 170-175: Please see #3 above. If possible, please provide more information on the parity of the patient’s included in the sub-group analysis.

6. With the studies included, is it possible to provide baseline demographics or any information on the indications for
primary or repeat cesareans?

7. Page 11-13: Overall the discussion is well written. Are the authors able to speculate as to why patients with prior cesarean delivery and successful ECV might have lower success rates of vaginal delivery?

STATISTICAL EDITOR COMMENTS:

The Statistical Editor makes the following points that need to be addressed:

lines 155-157, 167-169: Should include the funnel plots in supplemental material.

Table 1: Some of the groups had N < 100, so the corresponding %s should be rounded to nearest integer %, not cited to 0.1% precision level.

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.

55. Could you provide the breech presentation rate at 37 weeks and beyond instead of all births? That’s more relevant as one wouldn’t do an ECV prior to 37 weeks.

75. Of course, we’ll need the registration number.

93. One of your reviewers I think commented on the lack of responsiveness by the authors of the 2 trials being something you could overcome if you tried harder. That does not require a response from you—some authors just don’t respond!

Results: If you have the information, neonatal outcome data would be a terrific addition as noted by one of your reviewers.

200. While the rate of vaginal birth is lower for the women who had an ECV, don’t you think its important to emphasize that a 75% success rate for TOLAC is consistent with or better than overall TOLAC rates? The way you tee this up in the discussion, abstract and precis it sounds like we should be counseling women that their chance for vaginal birth is lower so perhaps more caution is warranted. In fact, given TOLAC success rates generally quoted in the 60-70% rate, for the woman standing in front of you considering the options, an ECV sounds pretty good compared to other women considering TOLAC w/o a breech presentation to complicate the situation. Offering a patient w/ a CS an ECV is managing 2 separate risks for CS: by avoiding the breech presentation, the patient is still left w/ her risks from prior CS.

EDITORIAL OFFICE COMMENTS:

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

3. Authors of systematic reviews are encouraged to prospectively register their study in PROSPERO (https://www.crd.york.ac.uk/PROSPERO/), an international database of prospectively registered systematic reviews. If you already have a PROSPERO registration number, please note it in your submitted cover letter and include it at the end of the abstract.

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 data definitions at https://www.acog.org/practice-management/health-it-and-clinical-informatics/revitalize-obstetrics-data-definitions and the gynecology data definitions at https://www.acog.org/practice-management/health-it-and-clinical-informatics/revitalize-gynecology-data-definitions. 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: Review articles should not exceed 25 typed, double-spaced pages (6,250 words). Stated page limits include all numbered pages in a manuscript (i.e., title page, précis, abstract, text, references, tables, boxes, figure legends, and print appendixes) but exclude references.

6. 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).

7. 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 (i.e., 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."

8. 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 Reviews is 300 words. Please provide a word count.

9. 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.

10. 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.

11. Line 141: 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.

12. In your Abstract, manuscript Results sections, and tables, the preferred citation should be in terms of an effect size, such as odds ratio or relative risk or the mean difference of a variable between two groups, expressed with appropriate confidence intervals. When such syntax is used, the P value has only secondary importance and often can be omitted or noted as footnotes in a Table format. Putting the results in the form of an effect size makes the result of the statistical test more clinically relevant and gives better context than citing P values alone.

   If appropriate, please include number needed to treat for benefits (NNTb) or harm (NNTh). When comparing two
procedures, please express the outcome of the comparison in U.S. dollar amounts.

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

13. Please review the journal’s Table Checklist to make sure that your tables conform to journal style. The Table Checklist is available online here: http://edmgr.ovid.com/ong/accounts/table_checklist.pdf.

14. 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 at the Clinical Guidance page at https://www.acog.org/clinical (click on "Clinical Guidance" at the top).

15. Figures:

Figure 1: This file can be resubmitted with the revision.

Figure 2: There is something going on with the headers across the top. Please upload a new version.

Figure 3: This file can be resubmitted with the revision.

16. 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 Jul 11, 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.
June 15, 2020

Editor
Obstetrics & Gynecology
RE: Manuscript ID ONG-20-813

Dear Editor,

We wish to thank the Editor and Reviewers for their comments. We also want to thank you for the opportunity to do the revisions. The suggestions were terrific, and the manuscript is stronger from them. We will address each comment individually. We have attached a manuscript version with the Track Changes as well as a “clean version” with the Track Changes accepted for ease of readability. The line numbers refer to the revised Track Changes version. The PROSPERO registration number is CRD42020160145. Each author has approved the final form of the revision, and the agreement form signed by each author and submitted with the initial version remains valid. Regarding the inquiry of transparency around peer-review, yes, please publish our point-by-point response letter (OPT-IN). This letter serves as confirmation we have read the Instructions for Authors for this article type (i.e. Original Research). Finally, we have followed in the document the MOOSE guideline for meta-analyses of observational studies in epidemiology.

Best regards,

Mark Turrentine, MD

REVIEWER COMMENTS:

Reviewer #1:

Authors performed a systematic review of the literature and pooled analysis to estimate the rate of successful external cephalic version in women with a prior history of cesarean delivery and determine the rate of successful vaginal delivery following ECV compared to women without a history of cesarean birth. Authors did not find a difference in overall successful rates of ECV in women with or without prior CS; the overall rate of vaginal delivery was lower in women with cesarean scar versus women without.

Overall authors performed a good systematic review and meta-analysis, however, there are a couple of issues that threaten the internal validity and generalizability of their findings.

1. While it is entirely appropriate to compare rates of successful ECV in patients with prior CS versus women without a scar, their primary finding of not observing a difference in success rates conflicts with the results of the largest study on this subject from the US that combined 2 national databases (McLaren et al 2018 citation #9) and reported lower rates of successful ECV in women with prior CS; 80% vs. 86%, p<0.001 in a cohort of >10,000 patients. That authors failed to find differences in their pooled analysis likely due to a beta error.
We agree this is very likely and thus why in the Discussion (Lines 261 to 266) under our limitations we state a “major constraint is that insufficient power may have accounted for the absence of detectable difference in rates of successful external cephalic version.” If changing the phrase from “insufficient power” to a “beta error” would clarify this, we are willing to adjust the wording. Further, this is the strength of a meta-analysis in that it pools evidence so larger numbers are available to assess outcomes. One always has to keep in mind it may be possible that the McLaren study has a type I error (granted it would be a low probability)?

2. Comparing successful vaginal rates between women with prior CS and without CS ignores the impact that a history of CS has on likelihood of vaginal delivery. It is not surprising that in that comparison, women with a history of prior CS had lower successful vaginal rates. The most appropriate control group are women with prior CS undergoing TOLAC without ECV; indeed, McLaren et al had such a comparison and not surprisingly reported no difference in rates of successful vaginal delivery in TOLAC+ECV group vs. TOLAC (75% vs 74%). In their analysis, authors could have done more in pointing out that ECV in the setting of CS scar reduces rates of cesarean delivery from 95% (prior CS, breech, no ECV) versus 25% as McLaren et al reported.

We do not agree we ignored the impact a history of cesarean delivery has on a vaginal delivery. On the contrary, our intent was to answer the clinical question faced by the obstetric health care professional, “How do I counsel the patient with a previous cesarean who is discovered to have a breech presentation at term in the office?” Our first goal was, “What is the chance of a successful ECV? and then “How likely would the patient have a successful VBAC? We have a large amount of information to counsel the patient undergoing a TOLAC with a cephalic presentation. We point out in the Discussion (Lines 235 to 236) the median rate of a successful vaginal birth after cesarean was in the range from published series of women attempting a trial of labor after cesarean. We thank the reviewer for suggesting for us to point out that ECV in the setting of a previous cesarean is still a better clinical option than a scheduled cesarean delivery. We have added lines 237 to 244 to reflect this.

3. In a couple of their analyses, $I^2$ was >75%, pointing to high heterogeneity; studies spanned wide time periods from 1980s (Flamm, 1991) including a European retrospective study that spanned 16 years and some spanned several continents: performance of ECV and management of TOLAC have evolved so much over the last decade that the results shown (minus McLaren's) will have little relevance to contemporary practice. Critical variables that affect successful outcomes including tocolysis (incomplete data), amniotic fluid index, nulligravid status, use of regional anesthesia, fetal monitoring etc. are not consistently documented across the studies. These limit generalizability.

We agree that important factors not provided in publications could have affected both the rate of ECV and successful VBAC. We have modified lines 268 to 270 to further reflect this point.

4. Lack of meaningful safety maternal and neonatal outcomes data is problematic; these are important concerns in considering ECV for patients contemplating TOLAC; McLaren et al, in their large series reported increased relative risks (albeit low absolute risks) of blood transfusion, unplanned hysterectomy and low Apgar scores (<7) at 5 minutes.
We agree that the lack of safety data for both maternal and neonatal outcomes is challenging. Unfortunately, this is what is currently available in the published medical literature. We did add lines 208 to 215 of neonatal data. We also added lines 251 to 259 to stress this point further.

**Reviewer #2:**

This manuscript adds important information to the literature and helps to inform clinical practice. A few thoughts for consideration are as follows:

1. The title might be clearer with the word order adjusted as follows: "Vaginal delivery after external cephalic version with a pervious cesarean section: A systematic review and meta-analysis." A similar change would be clearer in the Abstract Objective.

   Thank you, we have made this suggested edit.

2. Some of your sentences can be simplified and will be clearer as a result. For example this sentence: "Yet, a paucity of data proposes that external cephalic version for breech presentation is not contraindicated in women with a prior low-transverse uterine incision who are candidates for a trial of labor after cesarean." . . . Perhaps something like this: "The available data indicates a prior low transverse cesarean section is not a contraindication for external cephalic version."

   Thank you, this clarification has been made as suggested.

3. Line 66: This sentence needs clarified.

   The line has been clarified (lines 69 to 73).

4. Line 75: Why is the registration number not written here?

   We registered our planned meta-analysis on November 26, 2109. I suspect due to the COVID-19 pandemic, evaluations were delayed. We did obtain our registration number on May 4, 2020 and this has been added to the manuscript.

5. I am surprised that the other two trial authors did not respond. Surely, you could elicit responses using your available networks?

   We are just as disappointed by the lack of response from the two trial authors as is Reviewer #2. We sent emails to the corresponding authors (one from Canada and the other from Spain) that were listed in the journal articles. We sent emails to the departments of the institution where the work was performed. Finally, we went through Linkedin, found the corresponding authors and sent a message as well. Unfortunately, we never obtained a return reply.

6. Numbers under 10 should be written out and numerals not utilized (ie "two" not 2).

   Thank you for this clarification. Numbers under 10 have been spelled out.

7. It would be helpful to analyze multiparous people who in both the case and control groups have a prior vaginal delivery. That would be very interesting, although it is likely that there are
very limited numbers of people with a vaginal delivery followed by a cesarean section who then had a successful external cephalic version.

We agree this would be an important variable to have evaluated. While the studies reported parity, it was not specified if the individuals had a prior vaginal delivery or not. We did add this limitation in lines 269.

8. An important component of this analysis is the adverse events at the time of external cephalic version, as this, in addition to the likelihood of successful vaginal delivery, likely influences provider willingness to offer external cephalic version in the context of breech presentation in a person with a prior cesarean section. It would be useful to further explore this with additional analyses.

We agree that the analysis of adverse events at the time of ECV is an important component of this review and those are described in lines 200 to 208. Due to the rarity of adverse events in the available study population (n = 1 and n = 3) too few frequencies of adverse events are available to do any further analysis.

9. Delete "However, the potential limitations of our study must be considered as well."

We believe that some type of transition sentence is needed to describe the limitations. We did edit this sentence (lines 260 to 261)

10. It would be helpful if Figure 1 included more sub-categories per usual systematic review flow diagrams.

We added an explanation of why the three studies were excluded.

Reviewer #3:

The authors present a meta-analysis of 8 studies addressing successful external cephalic version and successful vaginal delivery in patients with and without history of prior cesarean delivery. They found similar rates of ECV but lower rates of successful vaginal delivery in patients with previous cesarean birth compared to patients without previous cesarean delivery.

Please address the following specific comments and questions.

1. Page 6-7, lines 98-100: Please clarify whether studies were limited to patients with 1 prior cesarean delivery or whether 2 or more prior cesarean deliveries were included.

This is an excellent point. We have added in the results (lines 149 to 151) the proportion of women with one previous cesarean (99%).

2. Page 7, lines 108-110: The primary outcome listed here is one sided and does not include comparison to women without previous cesarean births. Please clarify.

Thank you for catching this. The suggested edit has been made.
3. Page 8, lines 123-125: Please clarify the purpose for the subgroup analysis. If evaluating parity, it seems that the time of parous events in the c-section group should be clarified. Were patients with history of cesarean delivery and prior vaginal delivery included (rather than just one prior cesarean delivery with no prior vaginal deliveries)? Successful ECV and VBAC in multiparous patients that either did or did not have prior vaginal delivery are likely to be different when each are compared to multiparous patients without history of cesarean delivery.

We have edited the sentence (lines 133 to 134) to clarify the purpose of the subgroup analysis. We agree that knowing if a prior vaginal delivery had occurred would be an important variable to have evaluated. While the studies reported parity, it was not specified if the individuals had a prior vaginal delivery or not. We did add this limitation in line 269.

4. Page 9, lines 155-157 and line 167: Please clarify specifically what was visualized on the funnel plots that did not suggest publication bias.

We added the phrase “the funnel plot noted symmetry” to clarify.

5. Page 10, lines 170-175: Please see #3 above. If possible, please provide more information on the parity of the patient's included in the sub-group analysis.

We added the language of “parity 1 or greater” to help clarify. Unfortunately the articles do not have the granularity of the data to comment with more specificity.

6. With the studies included, is it possible to provide baseline demographics or any information on the indications for primary or repeat cesareans?

Unfortunately only two studies (Flamm et al 1991, n = 56 and Keepanasseril 2017, n = 38) provided information on the reason for the primary cesarean delivery. Further, only two studies provided general reasons for a repeat cesarean in women with a successful ECV either malpresentation or “emergency” [Weill 2017 (n = 1) and Impey 2018 (n = 15)]. Thus, the numbers would most likely be too small for any meaningful interpretation.

7. Page 11-13: Overall the discussion is well written. Are the authors able to speculate as to why patients with prior cesarean delivery and successful ECV might have lower success rates of vaginal delivery?

It would be difficult from this type of pooled data to speculate why the outcomes were obtained. However, we have added to the limitations (lines 268 to 270) what may have affected these findings.

STATISTICAL EDITOR COMMENTS:

lines 155-157, 167-169: Should include the funnel plots in supplemental material.

The funnel plots have been included in the supplemental material.

Table 1: Some of the groups had N < 100, so the corresponding %s should be rounded to nearest integer %, not cited to 0.1% precision level.

Table 1 has been modified to reflect this.
EDITOR 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. We have reviewed the Instructions to the Authors and confirmed compliance. We noted a reference was omitted in the Reference section and this has been added. The superscript numbers in the manuscript were correct.

Numbers below refer to line numbers.

55. Could you provide the breech presentation rate at 37 weeks and beyond instead of all births? That’s more relevant as one wouldn’t do an ECV prior to 37 weeks.

While most of the studies did not provide the gestational age that ECV were performed, the inclusion criteria were listed. The gestational age that studies included women has been added to Table 1.

75. Of course, we’ll need the registration number.

Fortunately, PROSPERO finally issued a number (it took 6 months!) and this has been added to the manuscript.

93. One of your reviewers I think commented on the lack of responsiveness by the authors of the 2 trials being something you could overcome if you tried harder. That does not require a response from you—some authors just don’t respond!

Believe me I tried (as noted above).

Results: If you have the information, neonatal outcome data would be a terrific addition as noted by one of your reviewers.

Limited data is available, but lines 208 to 215 were added. Definitely improves, thanks.

200. While the rate of vaginal birth is lower for the women who had an ECV, don’t you think its important to emphasize that that a 75% success rate for TOLAC is consistent with or better than overall TOLAC rates? The way you tee this up in the discussion, abstract and precis it sounds like we should be counseling women that their chance for vaginal birth is lower so perhaps more caution is warranted. In fact, given TOLAC success rates generally quoted in the 60-70% rate, for the woman standing in front of you considering the options, an ECV sounds pretty good compared to other women considering TOLAC w/o a breech presentation to complicate the situation. Offering a patient w/ a CS an ECV is managing 2 separate risks for CS: by avoiding the breech presentation, the patient is still left w/ her risks from prior CS.

Thank you for pointing this out. I have gone back and emphasized the higher rate of successful vaginal delivery. The Précis was too limited to change (but I’m open to suggestions).
EDITORIAL OFFICE COMMENTS:

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

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 disclosures remain the same.

3. Authors of systematic reviews are encouraged to prospectively register their study in PROSPERO (https://www.crd.york.ac.uk/PROSPERO/), an international database of prospectively registered systematic reviews. If you already have a PROSPERO registration number, please note it in your submitted cover letter and include it at the end of the abstract.

We have noted the PROSPERO registration number in our cover letter and at the end of the Abstract.

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 data definitions at https://www.acog.org/practice-management/health-it-and-clinical-informatics/revitalize-obstetrics-data-definitions and the gynecology data definitions at https://www.acog.org/practice-management/health-it-and-clinical-informatics/revitalize-gynecology-data-definitions. If use of the reVITALize definitions is problematic, please discuss this in your point-by-point response to this letter.

We are compliant with current terminology.

5. Because of space limitations, it is important that your revised manuscript adhere to the following length restrictions by manuscript type: Review articles should not exceed 25 typed, double-spaced pages (6,250 words). Stated page limits include all numbered pages in a
We are compliant with the stated limits.

6. Specific rules govern the use of acknowledgments in the journal. Please note the following guidelines: These guidelines have been noted and complied with.

* 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).

7. 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."

The Précis is consistent with this recommendation.

8. 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.

The Abstract and manuscript are consistent.

In addition, the abstract length should follow journal guidelines. The word limit for Reviews is 300 words. Please provide a word count.

This has been done.

9. 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.

Only standard abbreviations have been used.

10. 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.

We have confirmed we did not use the virgule symbol in sentences with words.

11. Line 141: 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 was the only location this was done, we have corrected this.

12. In your Abstract, manuscript Results sections, and tables, the preferred citation should be in terms of an effect size, such as odds ratio or relative risk or the mean difference of a variable between two groups, expressed with appropriate confidence intervals. When such syntax is used, the P value has only secondary importance and often can be omitted or noted as footnotes in a Table format. Putting the results in the form of an effect size makes the result of the statistical test more clinically relevant and gives better context than citing P values alone.

We have expressed our findings as an effect size.

If appropriate, please include number needed to treat for benefits (NNTb) or harm (NNTh). When comparing two procedures, please express the outcome of the comparison in U.S. dollar amounts.

This is included (NNTb).

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

We have confirmed this is standardized. However, the Forest Plots are generated from RevMan and the P-value for Heterogeneity is unable to be modified to not exceed three decimal places.

13. Please review the journal's Table Checklist to make sure that your tables conform to journal style. The Table Checklist is available online here: http://edmgr.ovid.com/ong/accounts/table_checklist.pdf.

We have confirmed this is in the journal’s style. Please note we needed to “split” the table between two pages due to its width; however, on the second page the column of “Study” can be deleted once this table is on one page only with publication.

14. 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 at the Clinical Guidance page at https://www.acog.org/clinical (click on "Clinical Guidance" at the top).

We have confirmed we are using the most current version of the Practice Bulletin cited.

15. Figures: We have resubmitted all figures with this revision.

Figure 1: This file can be resubmitted with the revision.

Figure 2: There is something going on with the headers across the top. Please upload a new version.

Figure 3: This file can be resubmitted with the revision.

16. 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.