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.
RE: Manuscript Number ONG-20-585

A framework proposal for quality and safety measurement in gynecological emergency care

Dear Dr. Fauconnier:

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.

The editor would like for you to resubmit your article as a Clinical Practice and Quality article. Please see the comment from the Associate Editor below. When you submit your revision, be sure to change the article type.

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 May 24, 2020, we will assume you wish to withdraw the manuscript from further consideration.***

REVIEWER COMMENTS:

Reviewer #2: The authors identify the conditions constituting the G-PLEs and a NM in the field of gynecological emergencies care and established the magnitude of the problem and the relation between G-PLEs and NM cases. In my opinion, the objective of this work is not clear. The methodology used to prove that their proposed scheme for identification of high risk cases and near miss cases among women with pelvic pain again is not clear. English language is misleading. They fail at the introduction section and at the discussion to convince me with the importance of the extensive effort they have done. Results section well analyzed. Conclusion does not represent to my opinion a real add to scientific knowledge.

Reviewer #3: Using mixed-methods, authors identified a list of 11 life-threatening gynecologic diagnoses in women who presented with acute pelvic pain and corresponding criteria of near-miss including clinical, laboratory tests and care management parameters and determined the prevalence of these diagnoses in a network of hospitals in France. Gynecologic life-threatening conditions were diagnosed in 3.5% of women who presented with APP to GYN emergency units; near miss conditions were more frequently diagnosed in this population compared to control groups of hospitalized and randomly selected group outpatients. Authors propose using this framework in improving quality and safety in GYN emergency care.

1. Abstract; line 94, consider replacing "measure" with prevalence
2. Introduction; line 131: isn't this true of ALL countries?
Lines 148-151 should be moved to methods section or removed.
3. Design; lines 153-8; please include data showing % representation of all hospitals/GYN emergencies this network constitutes. Important for context.
Lines 163-165; need to expand definition of Near-Miss and include criteria detailed in Appendix 1
Lines 170-172: need to define APP and CPP? Why use cut-off of 15 weeks gestation?

Line 187; is this published or was it a pilot study?

4. Discussion; line 258-264: this is equally applicable to settings where most patients use general ED for triage; there is often delays in GYN emergency diagnosis and unnecessary diagnostic tests that add to delays and costs.

5. Appendix 1; Why was acute pyelonephritis in pregnancy included and not other life-threatening medical diagnoses, e.g. viral pneumonia, cardia events etc.
For near misses; how about unplanned surgical procedures (e.g., bowel resection/re-anastomosis), unplanned return to operating room?

Reviewer #4: fig 2: Either as part of the figures or in separate Table, should list the n/N for each center that led to the rate calculations by individual center. Difficult to interpret the figure on NMs, since the frequencies are so small and seven centers had none. Probably could include the figure on NMs in supplemental material and just describe in main text.

Table 1: Would it be possible to construct a flow diagram summarizing the outcomes or error rates for the various groups? I think it amy be informative. The non-hospitalized group has n=381 as the entry for those admitted to operating room, should be zero, correct?

Table 2: For the column of NM, the total = 32, so all %s should be rounded to nearest integer %, not to nearest 0.1% precision.

ASSOCIATE EDITOR
We request the authors restructure the paper as a Clinical Practice and Quality submission. The Instructions for Authors (available at https://www.editorialmanager.com/ong/default.aspx) states that these articles should be structured like Original Research, and the same length restrictions apply.

Quality Improvement and Assessment
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> Objective: Describes the nature and significance of the local problem and the purpose of the project and this report.

> Methods: Describes the clinical setting, intervention(s), approach chosen, measures for reporting the processes and results, and analytic methods.

> Results: Reports observed associations between the interventions and relevant contextual elements and the primary outcome(s), and important secondary outcomes when appropriate.

Quality improvement and quality assessment manuscripts should be organized in a manner similar to the structured abstract and should use elements found in the SQUIRE 2.0 reporting guideline. A completed checklist should be submitted. The content of the text differs from Original Research as follows:

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> Results: Reports the initial steps of the intervention and their evolution over time; details the process measures and outcomes. Includes information regarding unintended outcomes and details about missing data. Addresses racially equitable outcomes.

> Discussion: Describes the key findings, relevance to the rationale and specific aims of the study, and particular strengths of the study. Describes the associations between the intervention and the outcomes and considers the approach used to establish whether or not a cause–effect relationship was established. Considers outcomes in terms of the framework for quality assessment from the Health and Medicine Division of the National Academies of Sciences, Engineering, and Medicine (formerly the Institute of Medicine). Considers the costs and strategic trade-offs involved in the intervention and the limitations of study, including generalizability, and how the achieved gains can be sustained or spread to other contexts in the current or other settings. Includes ethical aspects of the work and how these were addressed. A final summary may
suggest next steps if appropriate.

MANUSCRIPT EDITOR COMMENTS:

1. 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 you are referring (for example, "physicians," "nurses," etc.), or use "health care professional" if a specific term is not applicable.

EDITOR COMMENTS:

1. The Editors of Obstetrics & Gynecology are seeking to increase transparency around its peer-review process, in line with efforts to do so in international biomedical peer review publishing. If your article is accepted, we will be posting this revision letter as supplemental digital content to the published article online. Additionally, unless you choose to opt out, we will also be including your point-by-point response to the revision letter. If you opt out of including your response, only the revision letter will be posted. Please reply to this letter with one of two responses:
   A. OPT-IN: Yes, please publish my point-by-point response letter.
   B. OPT-OUT: No, please do not publish my point-by-point response letter.

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

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

3. Responsible reporting of research studies, which includes a complete, transparent, accurate and timely account of what was done and what was found during a research study, is an integral part of good research and publication practice and not an optional extra. Obstetrics & Gynecology supports initiatives aimed at improving the reporting of health research, and we ask authors to follow specific guidelines for reporting randomized controlled trials (ie, CONSORT), observational studies (ie, STROBE), meta-analyses and systematic reviews of randomized controlled trials (ie, PRISMA), harms in systematic reviews (ie, PRISMA for harms), studies of diagnostic accuracy (ie, STARD), meta-analyses and systematic reviews of observational studies (ie, MOOSE), economic evaluations of health interventions (ie, CHEERS), quality improvement in health care studies (ie, SQUIRE 2.0), and studies reporting results of Internet e-surveys (CHERRIES). Include the appropriate checklist for your manuscript type upon submission. Please write or insert the page numbers where each item appears in the margin of the checklist. Further information and links to the checklists are available at http://ong.editorialmanager.com. In your cover letter, be sure to indicate that you have followed the CONSORT, MOOSE, PRISMA, PRISMA for harms, STARD, STROBE, CHEERS, SQUIRE 2.0, or CHERRIES guidelines, as appropriate.

Please provide the SQUIRE checklist with your revised submission.

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

5. Because of space limitations, it is important that your revised manuscript adhere to the following length restrictions by manuscript type: Clinical Practice and Quality articles should not exceed 22 typed, double-spaced pages (5,500 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
7. The most common deficiency in revised manuscripts involves the abstract. Be sure there are no inconsistencies between the Abstract and the manuscript, and that the Abstract has a clear conclusion statement based on the results found in the paper. Make sure that the abstract does not contain information that does not appear in the body text. If you submit a revision, please check the abstract carefully.

In addition, the abstract length should follow journal guidelines. The word limits for Clinical Practice and Quality is 300 words. Please provide a word count.

8. 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.

Please expand the following abbreviations: "APP," "G-EDs," and "NM."

9. 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").

10. 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.

11. The American College of Obstetricians and Gynecologists’ (ACOG) documents are frequently updated. These documents may be withdrawn and replaced with newer, revised versions. If you cite ACOG documents in your manuscript, be sure the reference you are citing is still current and available. If the reference you are citing has been updated (ie, replaced by a newer version), please ensure that the new version supports whatever statement you are making in your manuscript and then update your reference list accordingly (exceptions could include manuscripts that address items of historical interest). If the reference you are citing has been withdrawn with no clear replacement, please contact the editorial office for assistance (obgyn@greenjournal.org). In most cases, if an ACOG document has been withdrawn, it should not be referenced in your manuscript (exceptions could include manuscripts that address items of historical interest). All ACOG documents (eg, Committee Opinions and Practice Bulletins) may be found via the Clinical Guidance & Publications page at https://www.acog.org/Clinical-Guidance-and-Publications/Search-Clinical-Guidance.

12. When you submit your revision, art saved in a digital format should accompany it. If your figure was created in Microsoft Word, Microsoft Excel, or Microsoft PowerPoint formats, please submit your original source file. Image files should not be copied and pasted into Microsoft Word or Microsoft PowerPoint.

When you submit your revision, art saved in a digital format should accompany it. Please upload each figure as a separate file to Editorial Manager (do not embed the figure in your manuscript file).

Figures should be saved as high-resolution TIFF files. The minimum requirements for resolution are 300 dpi for color or black and white photographs, and 600 dpi for images containing a photograph with text labeling or thin lines.

Figure 2: Please upload a high resolution version of this figure (should be crisp when you zoom in).

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

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

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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 24, 2020, we will assume you wish to withdraw the manuscript from further consideration.***

Sincerely,

The Editors of Obstetrics & Gynecology

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.
Dear editors,

Please find a point-by-point response to each of the received comments (original manuscript Number ONG-20-585). I confirm that I have read the Instructions for Authors. Please see my responses to the comments as underlined text. Please also look at the version of the manuscript with changes highlighted.

A framework proposal for quality and safety measurement in gynecological emergency care

Dear Dr. Fauconnier:

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REVIEWER COMMENTS:
Reviewer #2: The authors identify the conditions constituting the G-PLEs and a NM in the field of gynecological emergencies care and established the magnitude of the problem and the relation between G-PLEs and NM cases.

1. In my opinion, the objective of this work is not clear.
We have rewritten the abstract, and the introduction section to try to make it clearer (lines 105-110, 159-163 and 169-170 see also throughout the discussion).

2. The methodology used to prove that their proposed scheme for identification of high risk cases and near miss cases among women with pelvic pain again is not clear.
We have added additional details to the methods section and hope that the reviewer finds it clearer.

3. English language is misleading.
Most of the original manuscript and this revision were edited by a native American-English speaking professional biomedical translator. Neither she nor we understand what the reviewer means by “misleading”: we are certainly not trying to lead readers astray or create a wrong impression by deliberate deceit, nor do we think we have done so inadvertently. We would be happy to correct further any specific sentences that the reviewer finds misleading or unclear.

4. They fail at the introduction section and at the discussion to convince me with the importance of the extensive effort they have done.
The discussion has been completely rewritten to clarify the importance of our work (i.e. line 317-320,330-331,386-389).

5. Results section well analyzed.

6. Conclusion does not represent to my opinion a real add to scientific knowledge.
To be honest, we can only disagree and hope that the reviewer finds the revised discussion more convincing. We think nonetheless that it make sense to present the manuscript as a Clinical Practice and Quality article, rather than an Original Research one.

Reviewer #3: Using mixed-methods, authors identified a list of 11 life-threatening gynecologic diagnoses in women who presented with acute pelvic pain and corresponding criteria of near-miss including clinical, laboratory tests and care management parameters and determined the prevalence of these diagnoses in a network of hospitals in France. Gynecologic life-threatening conditions were diagnosed in 3.5% of women who presented with APP to GYN emergency units; near miss conditions were more frequently diagnosed in this population compared to control groups of hospitalized and randomly selected group outpatients. Authors propose using this framework in improving quality and safety in GYN emergency care.
1. Abstract; line 94, consider replacing "measure" with prevalence
Done accordingly (abstract line 107).
2. Introduction; line 131: isn't this true of ALL countries?
Yes, we agree and have removed this (line 153).
Lines 148-151 should be moved to methods section or removed.
We have moved these sentences to the methods section, as suggested (now line to 183-187)
3. Design; lines 153-8; please include data showing % representation of all hospitals/GYN emergencies
   this network constitutes. Important for context.
   This suggestion is obviously sound! Unfortunately, the number of women admitted in gynecologic emergency department is not available in France and in Belgium. However, in this two countries the gynecologic emergencies are admitted primarily at dedicated gynecologic emergency departments which are component of maternity service (see lines 344-350). Based on the number of annual births we can roughly estimate the representation of these centers (about 12 % all public hospitals with gynecologic emergencies, see lines 195-197).
Lines 163-165; need to expand definition of Near-Miss and include criteria detailed in Appendix 1
The definition was expanded and now include example of criteria (lines to 202-206)
Lines 170-172; need to define APP
APP are now defined precisely (lines 210-213).
Idem (line 216-217), a reference was added.
Why use cut-off of 15 weeks gestation?
Early pregnancy complication are part of gynecologic emergencies, (see ReVitalize!). As in most maternity wards, we chose to use the cutoff of 15 weeks' gestation, which corresponds to the start of the second trimester. Acute medical problems in the second and third trimesters are different in terms of quality and safety (and substantially more data about them are already available, see line 152-154). Moreover, in most hospitals, different staff members are responsible for obstetrics compared with gynecologic emergencies.
Line 187; is this published or was it a pilot study?
Yes, a reference was added (line 253).
4. Discussion; line 258-264: this is equally applicable to settings where most patients use general ED for triage; there is often delays in GYN emergency diagnosis and unnecessary diagnostic tests that add to delays and costs.
Thanks for this comment, we agree and have added the remark in the discussion (lines 342-343).
5. Appendix 1: Why was acute pyelonephritis in pregnancy included and not other life-threatening medical diagnoses, e.g. viral pneumonia, cardiia events etc.

We have defined the G-PLEs as “pelvic” conditions in the sense of anatomical and physiological pathways responsible for acute pelvic painful symptoms (see lines 369-370). The aim was to take into account the diagnosis most frequently encountered in G-EDs, that is, those relevant to acute gynecologic (or early pregnancy) conditions and those mimicking them. Another aim in defining what a GPLE is, was to include condition at risk of progression to severe complications in the absence of timely appropriate management (see 159-160, 392-394). Acute pyelonephrite during pregnancy was in that sense included in the DELPHI process as it was thought to meet these criteria by the experts. Retrospectively it did not correspond to a G-PLE condition as it was infrequently encountered and did not rely to NM (see Table 2). On the other hand other life-threatening medical diagnoses, e.g. viral pneumonia, cardiia events etc. are not encountered in G-EDs as they do not manifest as gynecologic symptoms (pelvic pain, or bleeding), and are seen in priority at general EDs. We have tried to explain this better throughout the introduction and discussion section. We have also added a paragraph to explain this point briefly (lines 368-374).

For near misses; how about unplanned surgical procedures (e.g., bowel resection/re-anastomosis), unplanned return to operating room?

Yes, a very interesting question that calls for a substantive response! Unplanned surgical procedures were included in the Delphi process, for example unplanned adnexectomy (see discussion lines 361-367) or salpingectomy but they were not retained. In this way it would have make sense to include bowel resection/re-anastomosis as it is the counterpart of missing a bowel occlusion. Unfortunately, we did not include this statement in the first-round Delphi questionnaire, and none of the participants wanted to add it.

Unplanned return to the operating room has indeed been proposed as a trigger for quality assessment in surgery because it may indicate the possibility of an adverse event caused by medical care. This unplanned return thus offers a simpler outcome than our system when assessing safety and quality of planned surgery (for example, hysterectomy). The significance of this indicator in gynecologic emergencies appears to be more problematic to interpret, however, between the consequences of the surgical procedure itself (including the fact that not all women would have surgery) and the other elements of the care pathways of emergency management (diagnostic errors, therapeutic delays, and so on).

Finally, our system (which is mainly dedicated to predictive analysis of risk) does not preclude the reporting of adverse situations or malfunctions, such as unplanned return to the operative room, return visits, or re-hospitalization: all of these may be the subject of retrospective internal analysis, as in morbidity-mortality conferences. We tried to make this important point clearer throughout the introduction and discussion section.
Reviewer #4: fig 2: Either as part of the figures or in separate Table, should list the n/N for each center that led to the rate calculations by individual center. Difficult to interpret the figure on NM, since the frequencies are so small and seven centers had none. Probably could include the figure on NM in supplemental material and just describe in main text.

We provide a new table reporting the detail of n/N for each center, as it is long we propose it as supplementary material, not for print. We have also deleted the portion of the figure concerning near-misses in the figure and left the remainder of Figure 2 with GPLEs and hospitalization rate as part of the manuscript.

Table 1: Would it be possible to construct a flow diagram summarizing the outcomes or error rates for the various groups? I think it may be informative. The non-hospitalized group has n=381 as the entry for those admitted to operating room, should be zero, correct?

The reviewer is right, it is interesting information. In the Table 1 we provide the outcomes of diagnostic error in terms of return visits and OR admission rates for the three groups. We have also provided some new results regarding diagnostic errors (see results section line 293-295, 299-300, 305-306).

Table 2: For the column of NM, the total = 32, so all %s should be rounded to nearest integer %, not to nearest 0.1% precision.

The change was done in the table 2 as suggested.

ASSOCIATE EDITOR

We request the authors restructure the paper as a Clinical Practice and Quality submission. The Instructions for Authors (available at https://www.editorialmanager.com/ong/default.aspx) states that these articles should be structured like Original Research, and the same length restrictions apply.

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Methods: Describes the clinical setting, intervention(s), approach chosen, measures for reporting the processes and results, and analytic methods.

Results: Reports observed associations between the interventions and relevant contextual elements and the primary outcome(s), and important secondary outcomes when appropriate.

We have edited the abstract accordingly, the word count is presently 279.

Quality improvement and quality assessment manuscripts should be organized in a manner similar to the structured abstract and should use elements found in the SQUIRE 2.0 reporting guideline. A completed checklist should be submitted. The content of the text differs from Original Research as follows:

Introduction: Describes why the study was performed and includes the nature and significance of the local problem, the framework used to explain the problem, and the assumptions used to develop the intervention.

The introduction was rewritten accordingly.

Methods: Describes the contextual elements such as the clinical setting (e.g., inpatient versus outpatient, size of unit, purpose of the clinical setting, number and type of staff and patients, hospital vs non-hospital setting) and timeframe of study. Describes the intervention in sufficient detail so that others could adapt the work to their settings and describes the specifics of the team involved. Describes the measures for studying the processes and outcomes, data collection, and analytic methods.

Results: Reports the initial steps of the intervention and their evolution over time; details the process measures and outcomes. Includes information regarding unintended outcomes and details about missing data. Addresses racially equitable outcomes.

Discussion: Describes the key findings, relevance to the rationale and specific aims of the study, and particular strengths of the study. Describes the associations between the intervention and the outcomes and considers the approach used to establish whether or not a cause–effect relationship was established. Considers outcomes in terms of the framework for quality assessment from the Health and Medicine Division of the National Academies of Sciences, Engineering, and Medicine (formerly the Institute of Medicine). Considers the costs and strategic trade-offs involved in the intervention and the limitations of study, including generalizability, and how the achieved gains can be sustained or spread to other contexts in the current or other settings. Includes ethical aspects of the work and how these were addressed. A final summary may suggest next steps if appropriate.
The discussion was completely rewritten accordingly. It does now follow the requested sequences. We have also provide the type of study in the title and added a new paragraphe to the discussion according to squire check-list recommendations (see line 1-2 and 386-390).

MANUSCRIPT EDITOR COMMENTS:

1. 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.

The term “provider” was replaced throughout the paper.

EDITOR COMMENTS:

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

Please reply to this letter with one of two responses:

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

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

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

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

According to their printed author agreement forms none of my coauthors reported disclosures related to the present study.
3. Responsible reporting of research studies, which includes a complete, transparent, accurate and timely account of what was done and what was found during a research study, is an integral part of good research and publication practice and not an optional extra. Obstetrics & Gynecology supports initiatives aimed at improving the reporting of health research, and we ask authors to follow specific guidelines for reporting randomized controlled trials (ie, CONSORT), observational studies (ie, STROBE), meta-analyses and systematic reviews of randomized controlled trials (ie, PRISMA), harms in systematic reviews (ie, PRISMA for harms), studies of diagnostic accuracy (ie, STARD), meta-analyses and systematic reviews of observational studies (ie, MOOSE), economic evaluations of health interventions (ie, CHEERS), quality improvement in health care studies (ie, SQUIRE 2.0), and studies reporting results of Internet e-surveys (CHERRIES). Include the appropriate checklist for your manuscript type upon submission. Please write or insert the page numbers where each item appears in the margin of the checklist. Further information and links to the checklists are available at http://ong.editorialmanager.com. In your cover letter, be sure to indicate that you have followed the CONSORT, MOOSE, PRISMA, PRISMA for harms, STARD, STROBE, CHEERS, SQUIRE 2.0, or CHERRIES guidelines, as appropriate.

Please provide the SQUIRE checklist with your revised submission.

We provide the SQUIRE checklist.

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

The Standard obstetric and gynecology data definitions were checked and have been modified where necessary, except for “vaginal bleeding”. The term vaginal bleeding is intended as a symptom that lead a women to consult, so it is not possible to use the proposed term of abnormal uterine bleeding that necessitate an examination. We propose to leave the term as “abnormal vaginal bleeding”

5. Because of space limitations, it is important that your revised manuscript adhere to the following length restrictions by manuscript type: Clinical Practice and Quality articles should not exceed 22 typed, double-spaced pages (5,500 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.
The previous version of our manuscript adhered strictly to these length restrictions. The revised manuscript, due to the numerous requested modifications over crowds these restriction (number of printed pages = 20, total manuscript word count = 6117). We propose therefore to delete the Appendix 1, from the printed version and have it as internet-only material (manuscript word count: =5879, total number of printed pages = 19). Nonetheless, if you want me to strictly adhere to these restrictions, it possible to put the Box 1 as internet-only material (total word count = 5200). However, I found this box very appealing for the readers and also useful to understand the methods used, so I would be very thankful if you accept to let it in the printed version.

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.

Ok, done

* 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.

All named person have receive the present manuscript and give approval with the manuscript in its present form

* 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).

The preliminary results of the present study were presented at the 40th journées nationales du Collège National des Gynécologues-Obstétriciens Français (CNGOF;) Décembre 2016; Montpellier; France. The presentation received the Prize for best communication for safety in Obstetrics & Gynecology.

7. 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 has been carefully checked.

In addition, the abstract length should follow journal guidelines. The word limits for Clinical Practice and Quality is 300 words. Please provide a word count.

The word count is now 279

8. 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.

Please expand the following abbreviations: "APP," "G-EDs," and "NM."

The following abbreviations were expanded throughout the manuscript.

9. 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.

OK.

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\%).

Done.
10. 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. 
Done.

11. The American College of Obstetricians and Gynecologists’ (ACOG) documents are frequently updated. These documents may be withdrawn and replaced with newer, revised versions. If you cite ACOG documents in your manuscript, be sure the reference you are citing is still current and available. If the reference you are citing has been updated (ie, replaced by a newer version), please ensure that the new version supports whatever statement you are making in your manuscript and then update your reference list accordingly (exceptions could include manuscripts that address items of historical interest). If the reference you are citing has been withdrawn with no clear replacement, please contact the editorial office for assistance (obgyn@greenjournal.org). In most cases, if an ACOG document has been withdrawn, it should not be referenced in your manuscript (exceptions could include manuscripts that address items of historical interest). All ACOG documents (eg, Committee Opinions and Practice Bulletins) may be found via the Clinical Guidance & Publications page at https://www.acog.org/Clinical-Guidance-and-Publications/Search-Clinical-Guidance.

12. When you submit your revision, art saved in a digital format should accompany it. If your figure was created in Microsoft Word, Microsoft Excel, or Microsoft PowerPoint formats, please submit your original source file. Image files should not be copied and pasted into Microsoft Word or Microsoft PowerPoint.

When you submit your revision, art saved in a digital format should accompany it. Please upload each figure as a separate file to Editorial Manager (do not embed the figure in your manuscript file).

Figures should be saved as high-resolution TIFF files. The minimum requirements for resolution are 300 dpi for color or black and white photographs, and 600 dpi for images containing a photograph with text labeling or thin lines.

Figure 2: Please upload a high resolution version of this figure (should be crisp when you zoom in).
Done, the figure is in its native resolution embedded in a power-point file. If you need I can provide you other format at Your convenience.

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

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

***

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 24, 2020, we will assume you wish to withdraw the manuscript from further consideration.***

Sincerely,

The Editors of Obstetrics & Gynecology

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.
RE: Manuscript Number ONG-20-585R1

A framework proposal for quality and safety measurement in gynecologic emergency care: a mixed-methods study

Dear Dr. Fauconnier:

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 second revised version.

Each of the following points 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.

IMPORTANT: The latest version of your manuscript and appendixes file is attached. Please use these versions for editing, leave track changes on, and do not accept all the changes before editing.

***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 20, 2020, we will assume you wish to withdraw the manuscript from further consideration.***

EDITOR AND MANUSCRIPT EDITOR COMMENTS:

1. 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 at the end of page 2.

Are the email addresses with each author’s name correct?

Isabelle LE CREFF: ilecreff@hotmail.com
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Marie-Hélène BOUVIER-COLLE: bouvier-colle.marie-helenee@orange.fr

2. Our journal doesn’t use the abbreviations « G-PLEs » and « G-PLE. » We have expanded these to read, « gynecologic emergencies » and « gynecologic emergency, » respectively, throughout the abstract and body text. I did not use the full explanation, « potentially life-threatening gynecologic emergencies. » Is this okay?

3. On line 125, should "case-cohort" read, "case-control"?

4. On line 136, the editor says, "Please insert the data (n = ; %) here." He is referring to "ectopic pregnancies with severe bleeding."

5. On line 138, the editor would like to know how severe appendicitis is considered a gynecologic emergency.

6. Lines 139-140: Add the statistical result of the statement, " Diagnostic errors occurred more frequently among women with gynecologic emergencies than controls."

7. On page 9, the editor made changes to the paragraph starting with, "The objectives of this study..." Do you agree with
his edits?


9. Lines 193-194: Please clarify the sentence, "Based on the number of annual births we estimate the activity of these centers accounted for about 12% all public hospitals with gynecologic emergencies."

10. Please clarify the sentence on lines 207-209, and spell out "and/or" to mean either "and" or "or." "Acute pelvic pain was defined as lower abdominal pain, interesting the hypogastrium and/or the right iliac fossa and/or the left iliac fossa, for less than a month..."

11. Line 220: Please clarify the sentence, "Women admitted to other hospitals were also followed up."

12. Line 223: Please revise "and/or" to mean either "and" or "or." Be sure this is done throughout your paper.

13. Line 240-243: Please reword so that have the words "gynecologic emergency" do not repeat three times in the same sentence.

14. Where is Table 2 cited in the text? The editor would like to change Table 2 to an appendix. Please cite it in your body text and add the table to your appendixes file.

15. Line 320: How can severe appendicitis be considered gynecologic emergency?

16. Lines 321-322: Please clarify the phrase, "they are treated in large numbers and are homogeneous relative to the outcomes studied."

17. Lines 322-323: Please clarify, "The figures of gynecologic emergencies we measured in the participating emergency departments."

18. Lines 328-329: Please clarify, "These three features suggest their criticality in the sense of risk analysis."

19. Lines 337-338: Please clarify, "...diagnostic errors not uncommonly lead to the initial management of these cases in gynecology which can constitute a loss of chance."

20. Lines 334: What do you mean by "Commonwealth"?

21. Line 354: Clarify "Secondly, not all G-PLEgynecologic emergency conditions have the same weight."

22. Line 366: The editor commented, "Somewhere here the part about including appendicitis needs to be clarified."

23. On line 378, is "9+6" referring to references 9 and 6? If so, please put these numbers in parentheses with a comma between them.

24. What is the source of Box 1? That is, how was it created? Is it original to your manuscript?

25. Please reduce the amount of information in Table 1 to show only the most relevant data. You may include an additional table as an appendix to show the data you excluded from table 1. Please see #27 below if you decide to include a new appendix to supplement Table 1.

26. The editor would like to change figures 2 and 3 to appendixes. They are now appendixes 3 and 5, respectively.

27. Please note the following about appendixes in the Green Journal: 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.

***

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 20, 2020, we will assume you wish to withdraw the manuscript from further consideration.***

Sincerely,

The Editors of Obstetrics & Gynecology

2019 IMPACT FACTOR: 5.524
2019 IMPACT FACTOR RANKING: 6th out of 82 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.
Response to the EDITOR’s AND MANUSCRIPT EDITOR’s COMMENTS:

Dear editors

Please find enclosed the detailed responses to the editors’ comments. We also have made the corrections requested in the text of the file you sent to us. We hope these answers will satisfy you. Please note that a professional native American-English speaker (Jo-Ann Cahn) has thoroughly corrected the ms for spell, typo and grammatical errors.

I would like to thank the editor for the remarkable editing work done on the ms. I think it has gained substantially in clarity and readability.

1. 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 at the end of page 2.

Are the email addresses with each author’s name correct?

Isabelle LE CREFF: ilecreff@hotmail.com
Yes

Rym BOULKEDID: rym.boukedid.rdb@gmail.com

The old email is no longer functional, but Rym BOULKEDID can be reached at: aym81@yahoo.fr

Muriel DORET-DION: muriel.doret-dion@chu-lyon.fr
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Romain JACOBS: romain.jacobs@chiv.fr

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Solen CARVALHO: Solenn.CARVALHO@chu-nantes.fr
Yes

Chérif AKLADIOS: Cherif.youssef2@wanadoo.fr
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Michelle NISOLLE: Michelle.Nisolle@uliege.be
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Corinne ALBERTI: corinne.alberti@inserm.fr
Yes, and can also be reached at corinne.alberti@aphp.fr

Marie-Hélène BOUVIER-COLLE: bouvier-colle.marie-helenee@orange.fr
She has retired, but can be reached at:
mamanours2@yahoo.fr

I have personally emailed each of these authors and all have agreed to complete the electronic Copyright Transfer Agreement.

2. Our journal doesn’t use the abbreviations « G-PLEs » and « G-PLE. » We have expanded these to read, « gynecologic emergencies » and « gynecologic emergency, » respectively, throughout the abstract and body text. I did not use the full explanation, « potentially life-threatening gynecologic emergencies. » Is this okay?

We think that the term "gynecologic emergency" is likely to be confusing, for G-PLE (which we must admit was an awkward choice) does not represent all conditions that are currently termed gynecologic emergencies but only those who have the potential to progress toward severe complications. Most gynecologic emergencies have a benign course (for example, uncomplicated miscarriage or ruptured corpus luteum) and were not considered potentially life-threatening emergencies. Your proposed change would therefore call them “non-gynecologic emergencies”. My preferred solution would be to use the full explanation, "potentially life-threatening gynecologic emergencies" at the first occurrence in the text and then use "potentially life-threatening emergencies" and “not potentially life-threatening emergencies” (or "emergencies not potentially life-threatening or other variations). I have made this modification throughout the manuscript and think that it works well. I hope you agree.

Please note that it will be necessary to modify the figure 1 accordingly (see the last pdf file you send to me).

3. On line 125, should "case-cohort" read, "case-control"?

The exact design was a nested case-cohort study within a prospective data collection phase among women consulting for acute pelvic pain. Case-cohort study designs have been proposed as an alternative to nested case-control study designs. A case-cohort study requires only the selection of a random sample, called a subcohort, and all cases. Compared to the nested case-control studies, a major advantage of the case-cohort design is the ability to study several disease outcomes using the same subcohort, as we sought to do here, collecting all potentially life-threatening emergencies and all cases with near-misses at the same time to assess their relations. We propose to add a
sentence (line ) and a reference explaining this point in the method section [Prentice RL. A case-cohort design for epidemiologic cohort studies and disease prevention trials. Biometrika. 1986;73:1-11]. Please note that the Endnote CWW does not function when track change of MS Word is activated. So, my proposal is to give the number 33 to the newly added reference (last one). Then You will be able to change it easily for the last round or I will do myself for the definitiv manuscript.

4. On line 136, the editor says, "Please insert the data (n = ; %) here." He is referring to "ectopic pregnancies with severe bleeding."

We have added these data.

5. On line 138, the editor would like to know how severe appendicitis is considered a gynecologic emergency.

I do understand the editor's question. From the point of view of both pathology and the organization of care, appendicitis has nothing to do with a gynecologic emergency. However, the presenting symptom, acute pelvic pain, is shared with other acute gynecologic or early pregnancy conditions. Women with appendicitis have symptoms that frequently mimic gynecologic diagnoses. This can lead women to initially seek gynecologic care, which can result in the loss of opportunity for earlier treatment and even in harm to her. From this point of view, appendicitis may be considered as potentially life-threatening and a gynecologic emergency because it is first seen in the gynecologic emergency department. From the perspective of risk management, it must be considered among gynecologic emergencies, and our study was undertaken to improve risk management in gynecology.

We explained this in the introduction (line 158), and added a new paragraph to the discussion: "The symptoms of women with appendicitis frequently mimic those of acute gynecologic conditions. When a woman comes for emergency care for acute pain, neither she nor the doctor who sees her knows if it is appendicitis or another condition. Appendicitis may thus be considered a potentially life-threatening emergency from the perspective of risk management. Certainly, severe appendicitis was a not uncommon diagnosis in our study. (line 398-403).

6. Lines 139-140: Add the statistical result of the statement, "Diagnostic errors occurred more frequently among women with gynecologic emergencies than controls."

We have added the statistical results that support this statement.
7. On page 9, the editor made changes to the paragraph starting with, "The objectives of this study..." Do you agree with his edits?

Yes


URGO is the name of the project, see https://clinicaltrials.gov/ct2/show/NCT02274441?titles=URGO&draw=2&rank=2*. It is technically a sort of amusing acronym for (URgences Gynécologiques et Obstétricales, that is, Ob-Gyn emergency department). We have modified the sentence as follows: "were asked to participate in the project URGO (URgences Gynécologiques et Obstétricales, that is, Ob-Gyn emergency department), a sentinel network for gynecologic emergencies."

9. Lines 193-194: Please clarify the sentence, "Based on the number of annual births we estimate the activity of these centers accounted for about 12% all public hospitals with gynecologic emergencies."

The number of women admitted in gynecologic emergency departments is not available for France or Belgium. However, in both countries the gynecologic emergencies are admitted primarily at dedicated gynecologic emergency departments, a component of maternity units (see lines 344-350). These hospitals account for about 12% of all births in France. We think it is logical to assume that they provide care for a similar percentage of women at gynecologic emergency departments (see lines 195-197). We have changed the sentence to read: "Around 12% of all French births take place in the participating hospitals. We therefore estimated that a similar percentage of French women seek care in the gynecologic emergency departments of the participating centers."

10: Please clarify the sentence on lines 207-209, and spell out "and/or" to mean either "and" or "or." "Acute pelvic pain was defined as lower abdominal pain, interesting the hypogastrium and/or the right iliac fossa and/or the left iliac fossa, for less than a month..."

This sentence has been modified as requested, line 182-183: "as lower abdominal pain affecting the hypogastrium or right or left iliac fossa or any combination of them, for less than a month,..."

11. Line 220: Please clarify the sentence, "Women admitted to other hospitals were also followed up."

This sentence has been modified to read: "When women were transferred or subsequently admitted to another hospital, we retrieved the complete report of her care at the receiving
establishment and all necessary information for reaching a final diagnosis.”

12. Line 223: Please revise "and/or" to mean either "and" or "or." Be sure this is done throughout your paper.

We have revised this formulation throughout the paper.

13. Line 240-243: Please reword so that have the words "gynecologic emergency" do not repeat three times in the same sentence.

We have revised the sentence as follows: "To assess the relation between potentially life-threatening emergencies and near-misses, we compared the rate of near-misses among the group of women diagnosed with such life-threatening conditions and those who were not."

14. Where is Table 2 cited in the text? The editor would like to change Table 2 to an appendix. Please cite it in your body text and add the table to your appendixes file.

We made an error and referred to Table 2 as Table 3 in the last version. We have now corrected this.

We think it would be unfortunate to convert Table 2 to an appendix (which means that it is not displayed in the pdf of the manuscript), especially as I have removed the final diagnoses from Table 1. No final list of the diagnoses studied and their frequencies thus appears in the paper or pdf versions, although we strongly feel that this absence is harmful to the manuscript. I would suggest keeping Table 2 in the main text, but we leave the final decision to you.

15. Line 320: How can severe appendicitis be considered gynecologic emergency?

We have discussed this point above in the response to comment #5.

16. Lines 321-322: Please clarify the phrase, "they are treated in large numbers and are homogeneous relative to the outcomes studied."

The sentence has now been modified to say: "they are conditions commonly seen in gynecologic emergency departments and are homogenous relative to quality of care and safety outcomes."

We hope you find it clearer.

17. Lines 322-323: Please clarify, "The figures of gynecologic emergencies we measured in the participating emergency departments."

"Figures" was meant to say numbers or rates. The sentence has been revised to say: The prevalence of the potentially life-
threatening gynecologic emergencies we measured in the participating gynecologic emergency departments, as well as the risk of near misses associated with them, underlines their importance for patient safety.

18. Lines 328-329: Please clarify, "These three features suggest their criticality in the sense of risk analysis."

In operations research, engineering, and risk/failure analysis, a criticality matrix is a representation (often graphical) of failure modes along with their probabilities and severities. The term criticality came first from nuclear physics, moved into nuclear plant operations, and extended outwards, even here to gynecology. By analogy, a potentially life-threatening emergency reaches criticality or becomes critical when it will lead inevitably to disaster unless interrupted and dealt with appropriately. The concept of criticality is thus used to prioritize the study of ways to interrupt the common situations that can, albeit rarely, have disastrous outcomes. Criticality analysis is an essential tool in error prevention in these situations.

We have thus modified the sentence to read:

"These three features suggest their criticality (23), as understood in the field of risk analysis engineering, that is, their combined probability and severity. This is essential information for identifying the situations it is most important to learn how to prevent."

19. Lines 337-338: Please clarify, "... diagnostic errors not uncommonly lead to the initial management of these cases in gynecology which can constitute a loss of chance."

We have modified this sentence as follows: "... diagnostic errors not uncommonly lead to initial gynecologic management of these cases, which represents the loss of an opportunity to resolve or treat them as early as possible, before they become critical."

20. Lines 334: What do you mean by "Commonwealth"?

We have modified the term to the UK and Australia, The reference is to an Australian study but Acute Gynecology and early pregnancy units were primarily developed in the UK.

21. Line 354: Clarify "Secondly, not all G-PLEgynecologic emergency conditions have the same weight."

We have modified the sentence as follows: "The criticality of these potentially life-threatening emergency conditions varies."
22. Line 366: The editor commented, "Somewhere here the part about including appendicitis needs to be clarified."

We have added the following paragraph:
"The symptoms of women with appendicitis frequently mimic those of acute gynecologic conditions. When a woman comes for emergency care for acute pain, neither she nor the doctor who sees her knows if it is appendicitis or another condition. Appendicitis may thus be considered a potentially life-threatening emergency from the perspective of risk management. Certainly, severe appendicitis was a not uncommon diagnosis in our study.

23. On line 378, is "9+6" referring to references 9 and 6? If so, please put these numbers in parentheses with a comma between them.

It was a typing error, and we have removed it.

24. What is the source of Box 1? That is, how was it created? Is it original to your manuscript?

Box 1 is original to our manuscript; it was created to expand all the definitions used for both parts of the study (i.e., the Delphi procedure and the data collection phase of the study). We think it helps the reader to be able to refer to these definitions while reading the study. It may be used to conduct further studies according to the same definitions.

25. Please reduce the amount of information in Table 1 to show only the most relevant data. You may include an additional table as an appendix to show the data you excluded from Table 1. Please see #27 below if you decide to include a new appendix to supplement Table 1.

Done. We have decided not to include the removed information in a new appendix.

26. The editor would like to change figures 2 and 3 to appendixes. They are now appendixes 3 and 5, respectively.

Ok

27. Please note the following about appendixes in the Green Journal:
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.

We checked the appendix file, all are fine. We have changed one citation (see line 299)

***
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.

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***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 20, 2020, we will assume you wish to withdraw the manuscript from further consideration.***

Sincerely,

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