OBSTETRICS & GYNECOLOGY

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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.

Date: Nov 20, 2020
To: "Marielle E Meurice" [redacted]
From: "The Green Journal" em@greenjournal.org
Subject: Your Submission ONG-20-2763

RE: Manuscript Number ONG-20-2763

Contraception choice among those seeking abortion for fetal indication or managing pregnancy loss

Dear Dr. Meurice:

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).

Your paper will be maintained in active status for 21 days from the date of this letter. If we have not heard from you by Dec 11, 2020, we will assume you wish to withdraw the manuscript from further consideration.

REVIEWER COMMENTS:

Reviewer #1:

The presented manuscript is a retrospective cross-sectional study describing the contraceptive choices of women after abortion for fetal indication or pregnancy loss and to compare to those undergoing abortion for non-fetal indications. Pregnancies up to 24 weeks were included. The primary outcome was whether or not a contraceptive method was chosen.

1. Abstract - Recommend re-writing lines 60-62 for clarity by moving the "n" to a denominator in the parentheses (68/134, 50.7%...). Would include the denominator for line 62. Line 67: consider changing to "Greater than half of women seeking abortion for fetal indication…"

2. Methods - Lines 89-91: Is there a standard counseling template used at your facility? How is it known that each patient in the study received reproductive planning and contraception counseling?

3. Results - Lines 118-122: The authors indicate that it was after data collection and comparison of the pregnancy loss and fetal anomaly groups that the decision was made to combine these two groups into one. However, the methods indicate that prior to data collection, a power calculation was performed "using the hypothesis that those seeking pregnancy options for fetal indications or pregnancy loss were approximately 50% less likely to desire contraception…" (lines 92-94). So was the decision to group made before or after? Line 125: it should be stated that a minority of ALL patients chose induction of labor.

4. Discussion - Would consider potentially pointing out that patients who desired the pregnancy or conceived after IVF had very low rates of choosing contraception. It would very interesting to know the same information for patients with infertility. In limitations, I would also recommend commenting that these are women who chose to pursue abortion (as opposed to expectant management) and may represent a slightly different patient cohort.

Reviewer #2:

Thank you for your thoughtful review regarding choice of contraception for women undergoing abortion related to loss or fetal indication as compared to non-fetal indications. Please see the following suggestions:

Precis: The authors cannot make a conclusion about counseling benefits from this study. Can only conclude what data shows about contraceptive choice when everyone is counseled about all options (if that is indeed what was done).

Methods: Lines90-91: Please comment on the standard for contraceptive counseling. Is this based on a questionnaire every patient receives outlining the same options? Does every provider counsel the same way? How many providers were involved in the care for these patients?

Lines 101: No need for this definition as not included in results

Lines 107-109: Further define your primary and secondary outcomes. Were these documented as chosen by the patient based on initial intake or by provider after counseling and if so-within what time period?

Results: Lines 126-7-If writing "of those" with respect to LARC then the percent would be 34% (16/47). Same for line 128. Just remove"of those" and then you can leave percentages as is.

Discussion: Would add more information with respect to primary outcome. If patients answered their choice for contraception on initial intake this is different than if the provider counsels a patient and then documents choice of contraception. If the provider counseling is what influenced choice of contraception for patients, is the shared-decision-making model used or something else? (lines 141-44)

145-155-would shorten this section to what is applicable from your study findings related to pregnancy loss and abortion for fetal indication with respect to LARC use

156-163-Less applicable specific to your study findings unless you feel timing of counseling for your patients may have impacted their contraceptive choice-if so, would tie that in.

Reviewer #3:

SUMMARY
Retrospective cohort (not cross-sectional) study comparing contraceptive choice for people ending a pregnancy for fetal loss or anomaly to those ending it for other reasons prior to 24 weeks gestation.

PRECIS
The Précis should really focus on findings… the group of interest (patients with loss or fetal anomaly) chooses contraception half the time albeit less than those without loss or anomaly. "may benefit from comprehensive contraception counseling" is too vague here. Comparison group must be stated explicitly in the Précis for clarity.

ABSTRACT
To simplify objective, focus on your primary outcome and change to "To compare contraception choice of people…"
Leave significance out of the abstract (last sentence)
Line 66 needs a period at the end.

MANUSCRIPT OVERALL
Important investigation into contraceptive choice when counseling consistently offered for people ending pregnancy for fetal anomaly or pregnancy loss! Thank you for your work to characterize this population.
Much use of "women". To be more inclusive, consider changing to "people" or "pregnant people".
Since you are underpowered based on your assumption (50% of people ending a pregnancy for fetal loss or anomaly choose a contraception method), suggest adding additional data (2019?) to provide a more robust analysis.
Suggest limiting (and re-running) analysis to include only people who selected surgical management (D&C/D&E) given that is the vast majority of your sample you present, especially because I'm guessing a person ending a pregnancy for a non-fetal indication in the second trimester would not be offered IOL?

INTRODUCTION
Clear, concise.

METHODS

The methods of this study are described as a "cross-sectional" study but really is a retrospective cohort study comparing those who end a pregnancy for anomaly or IUFD to those who have a D&E for other reasons.
Line 91: where did you obtain IRB approval?
Line 92-3: some of the language is somewhat clunky because of the heterogeneity of your sample (including people who

chose medical and surgical management) that could be simpler if you limit analysis to surgical management only.
Line 98: You should present your inclusion criteria before you describe what information you collected from the EMR for those included. Was gestational age your only inclusion criterion? Were there any exclusion criteria?
The data you present are of people who largely chose surgical management. Suggest limiting this manuscript to analysis to patients who had a D&C or D&E. People's options for contraception (IUD in particular) would require two visits for someone who chose medical management and this may affect contraception choice. Suggest omitting those who had an IOL (n=15) and those who chose medical management for a fetal indication (n=18) and the n=20 people who did not have a fetal indication for ending their pregnancy.

RESULTS
You collapsed Race and Ethnicity into one variable. Why? Were race categories pre-defined by investigators?

TABLES
The tables as presented are VERY busy/wordy and thus difficult to read.
Table 1. Why are you presenting data comparing those with fetal loss/missed ab/IUFD to those with a fetal anomaly? This demographic data (absolute n and %) may be interesting to know about the sample, but are statistical comparisons between these groups valuable? ("Among fetal indication" section).
Table 1. Remove "desired pregnancy"... you essentially have too much "missing data" (labeled here as "not specified") unevenly distributed between groups driving your "significant" difference.
Tables 2 and 3. To make these tables more readable, suggest limiting this table to your primary outcome (and describing secondary outcome in text alone in the manuscript).

STATISTICS EDITOR COMMENTS:

Table 1: The columns for fetal loss (n = 35) and for fetal anomalies (n = 99), are too few to format the %s to nearest 0.1%, should round to nearest integer % precision level.

Table 2: Same issue for the columns with N = 82 and n = 97 as totals. Should round the %s to nearest integer %.

Table 3: Need to include the unadjusted ORs in separate columns for context. Since CIs are given, the columns of p-values are redundant and should be omitted. Need to include as a footnote a list of variables retained in the final aOR model. Given the samples, counts choosing contraception (esp LARC) vs the number of baseline differences (and adjustors required), should corroborate the multivariable model's conclusions with a matching algorithm, e.g., propensity score matching.

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. For studies that report on the topic of race or include it as a variable, authors must provide an explanation in the manuscript of who classified individuals' race, ethnicity, or both, the classifications used, and whether the options were defined by the investigator or the participant. In addition, the reasons that race/ethnicity were assessed in the study also should be described (eg, in the Methods section and/or in table footnotes). Race/ethnicity must have been collected in a formal or validated way. If it was not, it should be omitted. Authors must enumerate all missing data regarding race and ethnicity as in some cases, missing data may comprise a high enough proportion that it compromises statistical precision and bias of analyses by race.

Use "Black" and "White" (capitalized) when used to refer to racial categories. The nonspecific category of "Other" is a convenience grouping/label that should be avoided, unless it was a prespecified formal category in a database or research instrument. If you use "Other" in your study, please add detail to the manuscript to describe which patients were included in that category.

4. 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), observational studies using ICD-10 data (ie, RECORD), 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, RECORD, CHEERS, SQUIRE 2.0, or CHERRIES guidelines, as appropriate.

Use of ICD-10 Codes - Search manuscript to see if author's study uses ICD-10 codes.

5. 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.

6. Because of space limitations, it is important that your revised manuscript adhere to the following length restrictions by manuscript type: Original Research reports 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.

7. Specific rules govern the use of acknowledgments in the journal. Please note the following guidelines:

* All financial support of the study must be acknowledged.
* Any and all manuscript preparation assistance, including but not limited to topic development, data collection, analysis, writing, or editorial assistance, must be disclosed in the acknowledgments. Such acknowledgments must identify the entities that provided and paid for this assistance, whether directly or indirectly.
* All persons who contributed to the work reported in the manuscript, but not sufficiently to be authors, must be acknowledged. Written permission must be obtained from all individuals named in the acknowledgments, as readers may infer their endorsement of the data and conclusions. Please note that your response in the journal's electronic author form verifies that permission has been obtained from all named persons.
* If all or part of the paper was presented at the Annual Clinical and Scientific Meeting of the American College of Obstetricians and Gynecologists or at any other organizational meeting, that presentation should be noted (include the exact dates and location of the meeting).

8. 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 Original Research articles is 300 words; Reviews is 300 words; Case Reports is 125 words; Current Commentary articles is 250 words; Executive Summaries, Consensus Statements, and Guidelines are 250 words; Clinical Practice and Quality is 300 words; Procedures and Instruments is 200 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. 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. Please review examples of our current reference style at http://ong.editorialmanager.com (click on the Home button in the Menu bar and then "Reference Formatting Instructions" document under "Files and Resources). Include the digital object identifier (DOI) with any journal article references and an accessed date with website references. Unpublished data, in-press items, personal communications, letters to the editor, theses, package inserts, submissions, meeting presentations, and abstracts may be included in the text but not in the reference list.

In addition, 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).

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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. Do not omit your responses to the Editorial Office or Editors' comments.

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 21 days from the date of this letter. If we have not heard from you by Dec 11, 2020, we will assume you wish to withdraw the manuscript from further consideration.

Sincerely,
John O. Schorge, MD
Associate Editor, Gynecology

2019 IMPACT FACTOR: 5.524
2019 IMPACT FACTOR RANKING: 6th out of 82 ob/gyn journals

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Revision Letter
Manuscript ONG-20-2763
Contraception choice among those seeking abortion for fetal indication or management of pregnancy loss

Dear Dr. John O. Schorge,

Thank you for your consideration of our manuscript, “Contraception choice among those seeking abortion for fetal indication or management of pregnancy loss”. We have addressed all comments below and have submitted a revised manuscript using track changes. We confirm that we have read the “Instructions for Authors” document prior to resubmission and our manuscript complies with all of the requirements.

Sincerely,

Marielle E. Meurice, MD

Reviewer #1:

The presented manuscript is a retrospective cross-sectional study describing the contraceptive choices of women after abortion for fetal indication or pregnancy loss and to compare to those undergoing abortion for non-fetal indications. Pregnancies up to 24 weeks were included. The primary outcome was whether or not a contraceptive method was chosen.

1. Abstract - Recommend re-writing lines 60-62 for clarity by moving the "n" to a denominator in the parentheses (68/134, 50.7%...). Would include the denominator for line 62. Line 67: consider changing to "Greater than half of women seeking abortion for fetal indication…"

The denominator was added to the parentheses for both recommendations.

Revised text: Those with fetal indication were less likely to choose contraception than those with non-fetal indication (68/134, 50.7% vs 142/158, 89.9%, $p<0.001$), and less likely to choose long acting reversible contraception (LARC) (19/68, 27.9% vs 94/142, 66.2%, $p<0.001$.)
Line number: 67-69

The next sentence was revised as below.

Revised text: Greater than half of those seeking abortion for fetal indication or management of pregnancy loss are interested in contraception and offering contraception may be beneficial in this setting.
Line number: 73-75

2. Methods - Lines 89-91: Is there a standard counseling template used at your facility? How is it

known that each patient in the study received reproductive planning and contraception counseling?

There is a standardized template that the physician uses to guide their visit, which includes contraception choice for all patients. Both attending providers use shared-decision making contraception counseling with their patients. This was added to the manuscript.

Revised text: Obstetrics and gynecology residents and two family planning specialist attendings addressed reproductive planning and offered contraception to all patients during the study period using a shared-decision making model and documenting the contraception choice using standardized templates.
Line number: 105-108

3. Results - Lines 118-122: The authors indicate that it was after data collection and comparison of the pregnancy loss and fetal anomaly groups that the decision was made to combine these two groups into one. However, the methods indicate that prior to data collection, a power calculation was performed "using the hypothesis that those seeking pregnancy options for fetal indications or pregnancy loss were approximately 50% less likely to desire contraception…" (lines 92-94). So was the decision to group made before or after? Line 125: it should be stated that a minority of ALL patients chose induction of labor.

The fetal anomaly and pregnancy loss group were initially combined before the study for the power calculation because our observations in clinic suggested these two groups shared similarities in their contraception choices and reproductive planning. After data analysis it was confirmed that these groups were similar and could be combined for the final analysis. This was clarified in the results section.

Revised text: Pregnancy loss and fetal anomaly groups were compared with respect to demographics and primary outcome and these two groups were combined into a “fetal indication” group. They did not significantly differ on the primary and secondary outcome and were similar in every demographic variable except gestational age (12 6/7 vs. 18 4/7 weeks, p <0.001) (Table 1).
Line number: 160-163

Those undergoing labor induction was clarified.

Revised text: A minority of all patients chose induction of labor, with only 11% (15) of those with fetal indications choosing induction of labor.
Line number: 166-178

4. Discussion - Would consider potentially pointing out that patients who desired the pregnancy or conceived after IVF had very low rates of choosing contraception. It would very interesting to know the same information for patients with infertility. In limitations, I would also recommend

commenting that these are women who chose to pursue abortion (as opposed to expectant management) and may represent a slightly different patient cohort.

We added a line about those planning for future pregnancies and IVF-ET pregnancies being less likely to choose contraception.

Revised text: Those who were planning future pregnancies or conceived by in vitro fertilization embryo transfer (IVF-ET) had lower rates of choosing contraception.
Line number: 247-249

We also added a comment in the limitations regarding those seeking abortion for miscarriage and fetal anomalies not being necessarily representative of this patient population as a whole.

Revised text: Finally, this study queries those seeking abortion or medical intervention rather than expectant management, which may not represent all patients with pregnancy loss or fetal anomalies.
Line number: 295-302

Reviewer #2:

Thank you for your thoughtful review regarding choice of contraception for women undergoing abortion related to loss or fetal indication as compared to non-fetal indications. Please see the following suggestions:

Precis: The authors cannot make a conclusion about counseling benefits from this study. Can only conclude what data shows about contraceptive choice when everyone is counseled about all options (if that is indeed what was done).

We revised the precis to include only what the data shows. The revised Precis incorporates feedback from Reviewer #3 as well regarding phrasing.

Revised text: Those seeking care for pregnancy loss or abortion for fetal indication are half as likely to choose contraception versus those with non-fetal indication after counseling.
Line number: 50-51

Methods: Lines90-91: Please comment on the standard for contraceptive counseling. Is this based on a questionnaire every patient receives outlining the same options? Does every provider counsel the same way? How many providers were involved in the care for these patients?

A standardized template is used to collect the contraception choice for all patients and the counseling is overseen by two family planning attendings, which was clarified in the methods section. The study is retrospective, so a standard script was not used but both providers provide similar counseling that involves shared-decision making.

Revised text: Obstetrics and gynecology residents and two family planning specialist attendings addressed reproductive planning and offered contraception to all patients during the study period using a shared-decision making model and documenting the contraception choice using standardized templates.
Line number:105-108

The counseling may slightly differ between providers and patients, but information is gathered in a standardized way. This was added to the limitations.

Revised text: Limitations include that analysis was of intent rather than actual uptake of method and although all patients were asked about contraception, the counseling may have differed slightly.
Line number: 291-293

Lines 101: No need for this definition as not included in results

This was deleted.

Line number: 129

Lines 107-109: Further define your primary and secondary outcomes. Were these documented as chosen by the patient based on initial intake or by provider after counseling and if so-within what time period?

These were further defined in the manuscript and reported in standardized template during initial consultation and/or the two-week post-operative visit.

Revised text: The primary outcome was whether any contraception method was chosen at the time of abortion or management of pregnancy loss, which was noted either at initial consultation or at the two-week post-procedure visit using a standardized template.
Line number: 135-137

Results: Lines 126-7-If writing "of those" with respect to LARC then the percent would be 34% (16/47). Same for line 128. Just remove "of those" and then you can leave percentages as is.

The phrase "of those" was removed in both sentences.

Line number: 179-181

Discussion: Would add more information with respect to primary outcome. If patients answered their choice for contraception on initial intake this is different than if the provider counsels a

patient and then documents choice of contraception. If the provider counseling is what influenced choice of contraception for patients, is the shared-decision-making model used or something else? (lines 141-44)

The methods section was revised to give more information regarding contraception counseling.

Revised text: Obstetrics and gynecology residents and two family planning specialist attendings addressed reproductive planning and offered contraception to all patients during the study period using a shared-decision making model and documenting the contraception choice using standardized templates.
Line number: 105-108

Revised text: The primary outcome was whether any contraception method was chosen at the time of abortion or management of pregnancy loss, which was noted either at initial consultation or at the two-week post-procedure visit using a standardized template.
Line number: 135-137

This was updated in the discussion section as well.

Revised text: The majority of these people were interested in contraception after shared-decision-making contraception counseling, but less interested in contraception than those seeking abortion for non-fetal indications.
Line number: 198-240

145-155-would shorten this section to what is applicable from your study findings related to pregnancy loss and abortion for fetal indication with respect to LARC use

This section was shortened and a phrase was added to regarding how interest in LARC is poorly understood in this patient population.

Revised text: The fact that fewer people in our fetal indication group were interested in LARC may reflect interest in becoming pregnant sooner, but interest in LARC in this patient population is poorly understood.
Line number: 245-247

156-163-Less applicable specific to your study findings unless you feel timing of counseling for your patients may have impacted their contraceptive choice-if so, would tie that in.

We included this because we find that providers may be uncomfortable discussing contraception when someone is grieving the index pregnancy loss. Our study finds that many women choose contraception if offered at the initial consultation and/or two-week follow up visit, but more study is needed to find the optimal timing. We feel that this is an important future direction.

Reviewer #3:

SUMMARY
Retrospective cohort (not cross-sectional) study comparing contraceptive choice for people ending a pregnancy for fetal loss or anomaly to those ending it for other reasons prior to 24 weeks gestation.

We feel that our study meets the definition of cross-sectional better than retrospective cohort because groups were not followed over time. However, we would be glad to change the study type if the reviewer feels that retrospective cohort is more appropriate.

PRECIS
The Précis should really focus on findings… the group of interest (patients with loss or fetal anomaly) chooses contraception half the time albeit less than those without loss or anomaly. "may benefit from comprehensive contraception counseling" is too vague here. Comparison group must be stated explicitly in the Précis for clarity.

We rewrote the precis based on your comments and Reviewer #1, focusing more on the findings and clearly indicating the comparison group.

Revised text: Those seeking care for pregnancy loss or abortion for fetal indication are half as likely to choose contraception versus those with non-fetal indication after counseling.
Line number: 50-51

ABSTRACT

To simplify objective, focus on your primary outcome and change to "To compare contraception choice of people…"

This change was made in the abstract introduction.

Revised text: To compare contraception choices of those undergoing procedures for fetal indications to those having abortions for non-fetal indications
Line number: 59-60

Leave significance out of the abstract (last sentence)

The last sentence of the methods section in the abstract was deleted.

Line number: 66

Line 66 needs a period at the end.

This was added.

Line number: 72

MANUSCRIPT OVERALL
Important investigation into contraceptive choice when counseling consistently offered for people ending pregnancy for fetal anomaly or pregnancy loss! Thank you for your work to characterize this population.

Much use of "women". To be more inclusive, consider changing to "people" or "pregnant people".

Changes were made throughout the manuscript to remove gendered language and replace with "people" or "those".

Since you are underpowered based on your assumption (50% of people ending a pregnancy for fetal loss or anomaly choose a contraception method), suggest adding additional data (2019?) to provide a more robust analysis.

We apologize if our power calculation was not clear, but we believe we are powered to answer our clinical question. Based on provider experience, we hypothesized those seeking abortion for fetal indication or management of pregnancy loss were 50% less likely compared with those seeking abortion for other indications to plan to use contraception. We estimated that our sample size would need to be ~150 in each group for 80% power to detect a difference. Our final sample size is 134 fetal indication and 158 in the non-fetal indication.

Suggest limiting (and re-running) analysis to include only people who selected surgical management (D&C/D&E) given that is the vast majority of your sample you present, especially because I'm guessing a person ending a pregnancy for a non-fetal indication in the second trimester would not be offered IOL?

We included the whole population because we do not think that choice of medical versus surgical management affects contraception choice at time of abortion for fetal anomaly or pregnancy loss. We do agree that it could affect who actually receives LARC, but we collected intent and not placement of devices Additionally, we offer immediate postpartum LARC for induction of labor, so this is an option for those undergoing this mode of management. Although IOL is available for any patient presenting for abortion at our institution, it is rarely chosen by women with non-fetal indications.

We preformed sensitivity analysis using the subset of study population who had surgical abortion (n=254). Results from multivariate logistic regression model for contraception use are listed below. The difference between results from main analysis and sensitivity analysis are minimal. Adjusted OR for fetal indication from the main analysis and sensitivity analysis are the same: 0.11 (0.05-0.23). We also ran the recommended

propensity score per Statistics Editor. We added this analysis to the manuscript. If the reviewer feels strongly about the exclusion of medical management after reviewing the revised manuscript, we are willing to re-run the original analyses and omit medical management.

	Adjusted odds ratios and 95% C.I.
Age (years)	*0.96 (0.91-1.02)*
Gestational age in weeks	*0.97 (0.91-1.04)*
Race/ethnicity	
Non-Hispanic White	*Referent*
Non-Hispanic Black	*1.49 (0.40-5.52)*
Hispanic	*1.56 (0.68-3.61)*
Asian/Pacific Islander	*0.62 (0.22-1.74)*
Other/unknown	*1.47 (0.44-4.88)*
Parity	
0	*Referent*
1	*1.34 (0.62-2.91)*
2+	*1.67 (0.70-3.97)*
Medical problems	
None	*Referent*
One or more	*0.28 (0.13-0.59)*
Procedure indication	
Non-fetal indication	*Referent*
Fetal indication	*0.12 (0.05-0.27)*

Revised Text: We performed a sensitivity analysis using a subset of 254 patients who underwent surgical abortion. We also tried propensity score matching approach to evaluate the correlation of fetal indication and contraception choice. A multivariate logistic model predicting fetal indication was fitted using age in years, gestation age in weeks, race/ethnicity, parity and comorbid condition (model C statistics=0.85). Propensity score is the predicted probability that the patient will be in fetal indication group from the multivariate logistic model. Using a matching algorithm with a caliper of 0.1, we created a sample of n=67 non-fetal indication and n=67 fetal indication patients (1:1) with similar distribution of the characteristics using patient's propensity score. Characteristics were well-balanced in the matched cohort. Using the matched sample, we compared odds of choosing contraception for fetal indication group versus non fetal indication group in a univariate logistic regression model.
Line number: 146-156

Revised Text: Both sensitivity analysis and propensity matching approach analysis showed similar results as the main analysis. Odds ratio for choosing contraception for fetal indication group comparing to non-fetal indication group

are 0.11 (95 C.I. 0.05-0.23) and 0.18 (95% C.I. 0.08-0.40) respectively in the two analyses.
Line Number: 190-193

INTRODUCTION
Clear, concise.

METHODS

The methods of this study are described as a "cross-sectional" study but really is a retrospective cohort study comparing those who end a pregnancy for anomaly or IUFD to those who have a D&E for other reasons.

We feel that our study meets the definition of cross-sectional better than retrospective cohort because groups were not followed over time. However, we would be glad to change the study type if the reviewer feels that retrospective cohort is more appropriate.

Line 91: where did you obtain IRB approval?

This was added to the manuscript.

Revised text: We obtained IRB approval from the University of California, Irvine.
Line number: 108-109

Line 92-3: some of the language is somewhat clunky because of the heterogeneity of your sample (including people who chose medical and surgical management) that could be simpler if you limit analysis to surgical management only.

We chose to include both surgical and medical management, as the focus of the study was centered on fetal anomaly and pregnancy loss, rather than on the procedure chosen and our primary outcome is contraception intent. If the reviewer feels strongly about the exclusion of medical management after reviewing the revised manuscript, we are willing to re-run the analyses. See sensitivity analysis above.

Line 98: You should present your inclusion criteria before you describe what information you collected from the EMR for those included. Was gestational age your only inclusion criterion? Were there any exclusion criteria?

This was made more explicit in the revised manuscript. Inclusion criteria was anyone seeking pregnancy termination or management of pregnancy loss. There were no exclusion criteria.

Revised text: Inclusion criteria were any individual seeking pregnancy termination or management of pregnancy loss. There were no exclusion criteria.

Line number: 122-124

The data you present are of people who largely chose surgical management. Suggest limiting this manuscript to analysis to patients who had a D&C or D&E. People's options for contraception (IUD in particular) would require two visits for someone who chose medical management and this may affect contraception choice. Suggest omitting those who had an IOL (n=15) and those who chose medical management for a fetal indication (n=18) and the n=20 people who did not have a fetal indication for ending their pregnancy.

Please see comments above regarding decision to include medical management and sensitivity analysis.

RESULTS
You collapsed Race and Ethnicity into one variable. Why? Were race categories pre-defined by investigators?

We collected two variables regarding race and ethnicity, ethnicity (Hispanic or Latino/ non-Hispanic), race (AIAN/Asian/Native Hawaiian or other pacific Islander/Black/White/More than one race/Unknown). This is part of patient intake and the patient self-identified their race and identify, which is then input into the electronic medical record using a standardized form. In order to limit the covariates in the analysis, we created a combination of race/ethnicity variable (Non-Hispanic White/Non-Hispanic Black/Hispanic/Asian or Pacific Islander/Others or unknown). To clarify, we added how we collected and derived race/ethnicity variable in the revised manuscript in the methods section. We also changed the variable name to race/ethnicity and updated the name of the categories in the tables.

Revised Text: We collected information on patients' demographics, including age, race and ethnicity. Self-reported race/ethnicity was combined into five categories, Non-Hispanic White, Non-Hispanic Black, Hispanic, Asian or Pacific Islander, Others (including American Indian/Alaska Native or more than one race) or unknown.
Line Number: 126-129

TABLES
The tables as presented are VERY busy/wordy and thus difficult to read.

We hope the changes below have improved the table readability.

Table 1. Why are you presenting data comparing those with fetal loss/missed ab/IUFD to those with a fetal anomaly? This demographic data (absolute n and %) may be interesting to know about the sample, but are statistical comparisons between these groups valuable? ("Among fetal indication" section).

We compared fetal loss and fetal anomaly in this table to prove to the reader that these groups can be combined as they are similar. This is why we initially showed the p-values, but we have deleted this to make the table more readable.

Table 1. Remove "desired pregnancy"… you essentially have too much "missing data" (labeled here as "not specified") unevenly distributed between groups driving your "significant" difference.

This was removed from Table 1 and Table 2.

Tables 2 and 3. To make these tables more readable, suggest limiting this table to your primary outcome (and describing secondary outcome in text alone in the manuscript).

The secondary outcome was deleted from Table 2 and 3 and is only described in the text.

Statistics Editor Comments:

Table 1: The columns for fetal loss (n = 35) and for fetal anomalies (n = 99), are too few to format the %s to nearest 0.1%, should round to nearest integer % precision level.

This was updated in Table 1 and in the manuscript in the results section.

Table 2: Same issue for the columns with N = 82 and n = 97 as totals. Should round the %s to nearest integer %.

This was updated in Table 2. There were no edits needed in the manuscript with respect to these changes.

Table 3: Need to include the unadjusted ORs in separate columns for context. Since CIs are given, the columns of p-values are redundant and should be omitted. Need to include as a footnote a list of variables retained in the final aOR model. Given the samples, counts choosing contraception (esp LARC) vs the number of baseline differences (and adjustors required), should corroborate the multivariable model's conclusions with a matching algorithm, e.g., propensity score matching.

Unadjusted OR was added in a separate column and p-values were deleted. A foot note was added with final variables used in the aOR.

Thank you for your suggestion regarding another approach to evaluate the correlation of fetal indication of abortion and contraception choice. Below we describe the propensity score matching. In response to Reviewer #3, we also performed a sensitivity analysis, which is described in the manuscript methods and results.

A multivariate logistic model predicting fetal indication was fitted using age in years, gestation age in weeks, race/ethnicity, parity and comorbid condition (model C statistics=0.85). Propensity score is the predicted probability of the patient will be in fetal indication group from the multivariate logistic model. Using a matching algorithm with a caliper of 0.1, we created a sample of n=67 non-fetal indication and n=67 fetal indication patients (1:1) with similar distribution of the characteristics using patient's propensity score. Characteristics were well balanced in the matched cohort as shown in the table below. Using the matched sample, odds ratio for choosing contraception use for fetal indication group is 0.18 (0.08, 0.40) p<0.0001

Characteristics	*Non-fetal indication n=67*		*Fetal indication n=67*		*p-value*
	mean ± SD		*mean ± SD*		
Age (years)	*32.2 ± 6.2*		*31.9 ± 5.9*		*0.7868*
Gestational age (weeks)	*16.3 ± 5.6*		*16.0 ± 4.7*		*0.7272*
	n	*%*	*n*	*%*	
Race					*0.8996*
White	*27*	*40.3%*	*24*	*35.8%*	
Black	*2*	*3.0%*	*3*	*4.5%*	
Hispanic	*25*	*37.3%*	*23*	*34.3%*	
Asian	*7*	*10.4%*	*10*	*14.9%*	
Other/unknown	*6*	*9.0%*	*7*	*10.4%*	
Parity					*0.8636*
0	*20*	*29.9%*	*21*	*31.3%*	
1	*18*	*26.9%*	*20*	*29.9%*	
≥2	*29*	*43.3%*	*26*	*38.8%*	
History of comorbid conditions					*0.4836*
No	*26*	*38.8%*	*30*	*44.8%*	
Yes	*41*	*61.2%*	*37*	*55.2%*	

Revised Text: We performed a sensitivity analysis using a subset of 254 patients who underwent surgical abortion. We also tried propensity score matching approach to evaluate the correlation of fetal indication and contraception choice. A multivariate logistic model predicting fetal indication was fitted using age in years, gestation age in weeks, race/ethnicity, parity and comorbid condition (model C statistics=0.85). Propensity score is the predicted probability that the patient will be in fetal indication group from the multivariate logistic model. Using a matching algorithm with a caliper of 0.1, we created a sample of n=67 non-fetal indication and n=67 fetal indication patients (1:1) with similar distribution of the characteristics using patient's propensity score. Characteristics were well-balanced in the matched cohort. Using the matched sample, we compared odds of choosing contraception for fetal indication group versus non fetal indication group in a univariate logistic regression model.
Line number: 146-156

Revised Text: Both sensitivity analysis and propensity matching approach analysis showed similar results as the main analysis. Odds ratio for choosing contraception for fetal indication group comparing to non-fetal indication group are 0.11 (95 C.I. 0.05-0.23) and 0.18 (95% C.I. 0.08-0.40) respectively in the two analyses.
Line Number: 190-193

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:

OPT-IN: Yes, please 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.

All disclosures are listed.

3. For studies that report on the topic of race or include it as a variable, authors must provide an explanation in the manuscript of who classified individuals' race, ethnicity, or both, the classifications used, and whether the options were defined by the investigator or the participant. In addition, the reasons that race/ethnicity were assessed in the study also should be described (eg, in the Methods section and/or in table footnotes). Race/ethnicity must have been collected in a formal or validated way. If it was not, it should be omitted. Authors must enumerate all missing data regarding race and ethnicity as in some cases, missing data may comprise a high enough proportion that it compromises statistical precision and bias of analyses by race.

Use "Black" and "White" (capitalized) when used to refer to racial categories. The nonspecific category of "Other" is a convenience grouping/label that should be avoided, unless it was a prespecified formal category in a database or research instrument. If you use "Other" in your study, please add detail to the manuscript to describe which patients were included in that category.

Please see response to Reviewer #3. The participant self-identified race. Race and ethnicity were included as part of patient demographics. It was collected through our electronic medical record in a validated way through a form that all patients fill out. Other or unknown makes up a small percentage of the data. Other was prespecified in the form.

4. 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), observational studies using ICD-10 data (ie, RECORD), 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, RECORD, CHEERS, SQUIRE 2.0, or CHERRIES guidelines, as appropriate.

Use of ICD-10 Codes - Search manuscript to see if author's study uses ICD-10 codes.

Not applicable

5. 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.

Not applicable.

6. Because of space limitations, it is important that your revised manuscript adhere to the following length restrictions by manuscript type: Original Research reports 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.

We have confirmed that the revised manuscript adheres to the length restrictions.
Pages: 10
Words: 2104

7. Specific rules govern the use of acknowledgments in the journal. Please note the following guidelines:

* All financial support of the study must be acknowledged.
* Any and all manuscript preparation assistance, including but not limited to topic development, data collection, analysis, writing, or editorial assistance, must be disclosed in the acknowledgments. Such acknowledgments must identify the entities that provided and paid for this assistance, whether directly or indirectly.
* All persons who contributed to the work reported in the manuscript, but not sufficiently to be authors, must be acknowledged. Written permission must be obtained from all individuals named in the acknowledgments, as readers may infer their endorsement of the data and conclusions. Please note that your response in the journal's electronic author form verifies that permission has been obtained from all named persons.
* If all or part of the paper was presented at the Annual Clinical and Scientific Meeting of the American College of Obstetricians and Gynecologists or at any other organizational meeting, that presentation should be noted (include the exact dates and location of the meeting).

These are all addressed in the manuscript.

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 Original Research articles is 300 words; Reviews is 300 words; Case Reports is 125 words; Current Commentary articles is 250 words; Executive Summaries, Consensus Statements, and Guidelines are 250 words; Clinical Practice and Quality is 300 words; Procedures and Instruments is 200 words. Please provide a word count.

The abstract was reviewed at the conclusion of our revisions and revised to ensure accuracy. The length of the abstract is 188 words, which complies with journal's requirements.

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.

Two acronyms are used in this manuscript – LARC and IVF-ET. Both are spelled out the first time they appear in abstract and manuscript. They are not used in the title or precis.

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.

All virgules were taken out of the manuscript and tables, unless related to data or measurements.

11. 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.

All "providers" were removed and replaced with "health care professional".

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%").

Redundant p-values were removed from abstract and manuscript related to statistics describing multivariate modeling where confidence intervals were used. Tables 1-3 were updated with using only 3 decimal places for p-values.

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.

This was revised and the tables conform to all criteria.

14. Please review examples of our current reference style at http://ong.editorialmanager.com (click on the Home button in the Menu bar and then "Reference Formatting Instructions" document under "Files and Resources). Include the digital object identifier (DOI) with any journal article references and an accessed date with website references. Unpublished data, in-press items, personal communications, letters to the editor, theses, package inserts, submissions, meeting presentations, and abstracts may be included in the text but not in the reference list.

In addition, 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).

References were reviewed and DOI is used for all references. No websites were used. No ACOG documents are used as references.

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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.

Noted, we will promptly respond.