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: Apr 23, 2021
To: "Henry Naftali Lesser" [redacted]
From: "The Green Journal" em@greenjournal.org
Subject: Your Submission ONG-21-632

RE: Manuscript Number ONG-21-632

The association between attempted vaginal delivery of monochorionic twin pregnancies and delivery outcomes.

Dear Dr. Lesser:

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 May 14, 2021, we will assume you wish to withdraw the manuscript from further consideration.

REVIEWER COMMENTS:

Reviewer #1: The authors have a natural history database of twin pregnancies at a single institution spanning nearly 15 years. That said, mode of delivery is driven by many factors, so reporting on the frequency of vaginal delivery by chorionicity at a single institution is not particularly informative or generalizable. I would drop that from this paper, and rather focus on vaginal vs cesarean among monochorionic twins as the title of the paper states. And then decide a priori on a composite neonatal outcomes for monochorionic twins based on a consensus statement, make sure you are powered, and present both a multivariable logistic regression model adjusting for confounding as well as a propensity score based analysis. Indications for delivery should also be presented and analyzed.

My major concerns are the following:
1. Ultimately this is a descriptive clinical study at a single institution, with limited generalizability.
2. Confounding by indication is a problem here, and they will need to consider propensity score based approaches when comparing mode of delivery and its association with neonatal outcomes. The authors do not even use multivariable logistic regression which itself would be inadequate. Either IPTW or propensity score approach would also need to be presented.
3. We need to know the indications for delivery. Without that, simply comparing ultimate mode of delivery is not nearly as informative for clinicians.
4. The abstract is confusing as the paper first compares MD to DD twins, the interesting clinical question here is with regards to MD twins so stick with that.
5. What is THE primary outcome? To focus on neonatal outcomes, may want to consider a composite measure, one may exist for twins from COMETT or another consensus statement, and then the authors need to make sure they are statistically powered to assess the outcome of interest.

Minor stylistic concerns:
1. The introduction should really focus on monochorionic twins and mode of delivery.
2. The methods includes a lot of generic content about management of twins in labor which is essentially ACOG guidelines, these can be shortened and the references citated.
3. Discussion first para concisely state the results of your study.

Reviewer #2: Only last week I encountered in consult a patient whose obstetrician had recommended cesarean delivery for monochorionicity. I guess reiterating an older caveat may still be useful for some.

The report by Lesser et al is well conceived and well written. The number of monochorionic diamniotic pregnancies is only one third of such pregnancies included in the Twin Birth Study, but still a decent number.

To be realistic, the study has only limited external validity. We can only dream that similar provisions for twin deliveries would universally be in place ("…our practice has a structured protocol that allows for senior personnel trained in the multifaceted approaches in a twin delivery to always be present at the time of delivery"). The authors recognize this in the Discussion.

There is a contradiction on page 7. The decision to include only MD twins 34 weeks or greater is justified on lines 141-142 :"…in order to reduce outcome bias from prematurity". Later, on line 160-161, the justification is: "…our cohort was not large enough to adequately control for gestational age for outcomes expected to be rare". The first one would have been the wrong reason. The second one is acceptable if the low event numbers would have been insufficient for meaningful comparisons per strata.

Line 235: place reference 20 there.

Line 257: it is Barrett JF, not Barrett FR.

Reviewer #3: Overall Comments: A review of the literature notes that delivery of twins is recommended for dichorionic pregnancies around 38 weeks, at 36 weeks for monochorionic (without confounding complications) and at 32-34 weeks in cases of single amniotic twin pregnancy. The main risk associated with vaginal delivery is the possibility of anoxia of the second twin along with uterine atony, postpartum hemorrhage and difficult delivery. However, a cesarean delivery performed by non-cephalic presentation of the second twin is noted to be associated with increased maternal morbidity without improved neonatal outcome. The most important factors in the decision of the delivery mode include the presentation of the fetus, gestational age, and weight or the weight difference between the fetuses. The authors present data from a retrospective cohort study looking primarily at mode delivery outcomes (vaginal delivery (VD) both twins, cesarean delivery (CD) both twins or vaginal delivery twin A and CD twin B) in monochorionic-diamniotic vs dichorionic-diamniotic twin births. It was noted that chorionicity was not associated with differences in delivery mode and among pregnancies that were monochorionic, there were no differences in neonatal outcomes between those undergoing CD vs VD. Please see specific comments below
Specific Comments:
Title: This reviewer would suggest phrasing the title a bit differently to be more specific, "The association of chorionicity on diamnionic delivery outcomes"
Short title: ok
Précis: ok
Abstract: Provides an effective summary of the study and its results.
Introduction: Provides rationale for the study.
Materials and Methods: Nicely presented.
Results: Efficiently presented; did not refer to Table 4 in the text, would consider combining Tables 4 and 5.
Discussion: It seems that other than a bit earlier delivery based on diamniotic and chorionicity, the delivery is mode is driven by the usual low risk single delivery indications along with established twin indications ie non-vertex presenting twin, nonvertex second twin with increased fetal weight compared to first twin, nonvertex second twin with EFW <1500g as well as typical contraindications to labor-how are these data new or novel for OBGYNs in practice in the US? Is this a clinical question that could be addressed by a randomized controlled trial? Please be specific with what new data this study provides and how it is applicable to current clinical care? Agree with the need for experienced OB trained in the multi-faceted approaches to twin delivery.
Tables/Figures: see above

STATISTICAL EDITOR COMMENTS:

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

Table 1: From the prior delivery modes, it seems that both groups had a large proportion of nulliparous women. Should include parity among the baseline characteristics, in the "All" and subset categories.

Table 2: Should include CIs for the proportions of delivery mode, esp "Any cesarean delivery". For the component subsets, the CD rates are very similar, but the smaller samples have less power to generalize the NS comparisons. Should include this in limitations. In the last group with n = 79 and n = 337 the components do not sum to the totals, in that 31+17=48, not 79 and 177+78+2=257, not 337. Need to clarify the sums and the proportions.

Table 5: While it is true that comparisons of neonatal outcomes were all NS, in most cases the counts were very low, thus there is very little power to generalize the NS findings. Also, the relationship of mean to SD for LOS shows a right skewing of the LOS and very likely non-normal distribution. Should format as median (range or IQR) and test non-parametrically.

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. Our journal requires that all evidence-based research submissions be accompanied by a transparency declaration statement from the manuscript's lead author. The statement is as follows: "The lead author* affirms that this manuscript is an honest, accurate, and transparent account of the study being reported; that no important aspects of the study have been omitted; and that any discrepancies from the study as planned (and, if relevant, registered) have been explained." *The manuscript's guarantor.

If you are the lead author, please include this statement in your cover letter. If the lead author is a different person, please ask him/her to submit the signed transparency declaration to you. This document may be uploaded with your submission in Editorial Manager.

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 avoid using "Caucasian."

4. Please add the name of the IRB to line 101.

5. 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.

6. 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.

7. 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 5,500 words. Stated word limits include the title page, précis, abstract, text, tables, boxes, and figure legends, but exclude references.

8. 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).
* If your manuscript was uploaded to a preprint server prior to submitting your manuscript to Obstetrics & Gynecology, add the following statement to your title page: "Before submission to Obstetrics & Gynecology, this article was posted to a preprint server at: [URL]."

9. Provide a short title of no more than 45 characters (40 characters for case reports), including spaces, for use as a running foot. Currently, your running title appears to be too long.

10. 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. Please provide a word count.

11. 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 spell out "MD" and "DD" with an en dash ("monochorionic--diamniotic" and "dichorionic--diamniotic"). There are no restrictions on abbreviations in figures and tables.

12. 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.

13. 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%").

14. 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.

15. 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).

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

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.

You will be receiving an Open Access Publication Charge letter from the Journal's Publisher, Wolters Kluwer, and instructions on how to submit any open access charges. The email will be from publicationservices@copyright.com with the subject line 'Please Submit Your Open Access Article Publication Charge(s)'. Please complete payment of the Open Access charges within 48 hours of receipt.

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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 May 14, 2021, 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

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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.

REVIEWER COMMENTS and AUTHOR RESPONSES:

Reviewer #1: The authors have a natural history database of twin pregnancies at a single institution spanning nearly 15 years. That said, mode of delivery is driven by many factors, so reporting on the frequency of vaginal delivery by chorionicity at a single institution is not particularly informative or generalizable. I would drop that from this paper, and rather focus on vaginal vs cesarean among monochorionic twins as the title of the paper states. And then decide a priori on a composite neonatal outcomes for monochorionic twins based on a consensus statement, make sure you are powered, and present both a multivariable logistic regression model adjusting for confounding as well as a propensity score based analysis. Indications for delivery should also be presented and analyzed.

Comment 1: My major concerns are the following: Ultimately this is a descriptive clinical study at a single institution, with limited generalizability:
Response 1: **Thank you for pointing this out. This is addressed in our revised edition of the manuscript by adding generalizability as a limitation in the discussion.**
Comment 2: Confounding by indication is a problem here, and they will need to consider propensity score based approaches when comparing mode of delivery and its association with neonatal outcomes. The authors do not even use multivariable logistic regression which itself would be inadequate. Either IPTW or propensity score approach would also need to be presented.
Response 2: It is well known that MD and DD twins differ. The purpose of the first analysis of this paper was simply to show that modes of delivery are not different between the groups. Therefore we did not intend to control for the many differences between the 2 groups.
Comment 3: We need to know the indications for delivery. Without that, simply comparing ultimate mode of delivery is not nearly as informative for clinicians.
Response 3: Indications for delivery are complex and not particularly relevant to the analysis we did. The most relevant factor would be parity, which is why we did a subanalysis of nulliparous women (Table 2).
Comment 4: The abstract is confusing as the paper first compares MD to DD twins, the interesting clinical question here is with regards to MD twins so stick with that.
Response 4: It is hard to know what aspect of the paper each reader would prefer. We chose to include both parts of the analysis.
Comment 5: What is THE primary outcome? To focus on neonatal outcomes, may want to consider a composite measure, one may exist for twins from COMETT or another consensus statement, and then the authors need to make sure they are statistically powered to assess the outcome of interest.
Response 5: The neonatal outcomes were all rare, aside from NICU and mechanical ventilation. However, we would then have to control for differences in maternal characteristics and our regression would be over-fitted. We added to the discussion that we were underpowered for this analysis.

Minor stylistic concerns:
Comment 6: The introduction should really focus on monochorionic twins and mode of delivery.
Response 6: We believe it is important to provide background information on both MD and DD gestations prior to focusing on MD.

Comment 7: The methods includes a lot of generic content about management of twins in labor which is essentially ACOG guidelines, these can be shortened and the references cited.
Response 7: Thank you for pointing this out. This has been addressed.
Comment 8: Discussion first paragraph concisely state the results of your study.
Response 8: Thank you for pointing this out. This has been addressed.

Reviewer #2: Only last week I encountered in consult a patient whose obstetrician had recommended cesarean delivery for monochorionicity. I guess reiterating an older caveat may still be useful for some.

The report by Lesser et al is well conceived and well written. The number of monochorionic diamniotic pregnancies is only one third of such pregnancies included in the Twin Birth Study, but still a decent number. To be realistic, the study has only limited external validity. We can only dream that similar provisions for twin deliveries would universally be in place ("…our practice has a structured protocol that allows for senior personnel trained in the multifaceted approaches in a twin delivery to always be present at the time of delivery"). The authors recognize this in the Discussion.

Comment 1: There is a contradiction on page 7. The decision to include only MD twins 34 weeks or greater is justified on lines 141-142 :"…in order to reduce outcome bias from prematurity". Later, on line 160-161, the justification is: "…our cohort was not large enough to adequately control for gestational age for outcomes expected to be rare". The first one would have been the wrong reason. The second one is acceptable if the low event numbers would have been insufficient for meaningful comparisons per strata.
Response 1: We agree with this comment. This is addressed by removing the "…in order to reduce outcome bias from prematurity". See line 141.

Comment 2: Line 235: place reference 20 there.
Response 2: Thank you for pointing this out. This has been addressed.

Comment 3: Line 257: it is Barrett JF, not Barrett FR.
Response 3: Thank you bringing this to our attention, this has been addressed.

Reviewer #3: Overall Comments: A review of the literature notes that delivery of twins is recommended for dichorionic pregnancies around 38 weeks, at 36 weeks for monochorionic (without confounding complications) and at 32-34 weeks in cases of single amniotic twin pregnancy. The main risk associated with vaginal delivery is the possibility of anoxia of the second twin along with uterine atony, postpartum hemorrhage and difficult delivery. However, a cesarean delivery performed by non-cephalic presentation of the second twin is noted to be associated with increased maternal morbidity without improved neonatal outcome. The most important factors in the decision of the delivery mode include the presentation of the fetus, gestational age, and weight or the weight difference between the fetuses. The authors present data from a retrospective cohort study looking primarily at mode delivery outcomes (vaginal delivery (VD) both twins, cesarean delivery (CD) both twins or vaginal
delivery twin A and CD twin B) in monochorionic-diamniotic vs dichorionic-diamniotic twin births. It was noted that chorionicity was not associated with differences in delivery mode and among pregnancies that were monochorionic, there were no differences in neonatal outcomes

between those undergoing CD vs VD. Please see specific comments below

Specific Comments:
Title: This reviewer would suggest phrasing the title a bit differently to be more specific, "The association of chorionicity on diamnionic delivery outcomes"
Response: We used this for the running header / short title.
Short title: ok
Précis: ok
Abstract: Provides an effective summary of the study and its results.
Introduction: Provides rationale for the study.
Materials and Methods: Nicely presented.
Results: Efficiently presented; did not refer to Table 4 in the text, would consider combining Tables 4 and 5.
Response: This is addressed, see Line 162. However, we prefer to maintain separate Tables for maternal demographic information and neonatal outcomes.
Discussion: It seems that other than a bit earlier delivery based on diamniotic and chorionicity, the delivery is mode is driven by the usual low risk single delivery indications along with established twin indications ie non-vertex presenting twin, nonvertex second twin with increased fetal weight compared to first twin, nonvertex second twin with EFW <1500g as well as typical contraindications to labor-how are these data new or novel for OBGYNs in practice in the US? Is this a clinical question that could be addressed by a randomized controlled trial? Please be specific with what new data this study provides and how it is applicable to current clinical care? Agree with the need for experienced OB trained in the multi-faceted approaches to twin delivery.
Response: This could potentially be addressed with a very large RCT in monochorionic-diamniotic twins only, but we do not think this is likely to be undertaken. Therefore, our data, albeit limited, might be worthwhile to providers who care for MD twins

Tables/Figures: see above.

STATISTICAL EDITOR COMMENTS:

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

Table 1: From the prior delivery modes, it seems that both groups had a large proportion of nulliparous women. Should include parity among the baseline characteristics, in the "All" and subset categories.
Response: This was added, as suggested.

Table 2: Should include CIs for the proportions of delivery mode, esp "Any cesarean delivery". For the component subsets, the CD rates are very similar, but the smaller samples have less power to generalize the NS comparisons. Should include this in limitations. In the last group with n = 79 and n = 337 the components do not sum to the totals, in that 31+17=48, not 79 and 177+78+2=257, not 337. Need to clarify the sums and the proportions.
Response: Thank you for bringing this to our attention. This has been addressed; there was a typo in the original draft of this manuscript which is now fixed.

Table 5: While it is true that comparisons of neonatal outcomes were all NS, in most cases the counts were very low, thus there is very little power to generalize the NS findings. Also, the

relationship of mean to SD for LOS shows a right skewing of the LOS and very likely non-normal distribution. Should format as median (range or IQR) and test non-parametrically.
Response: This was added, as suggested.

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.
Response: OPT-IN

2. Our journal requires that all evidence-based research submissions be accompanied by a transparency declaration statement from the manuscript's lead author. The statement is as follows: "The lead author* affirms that this manuscript is an honest, accurate, and transparent account of the study being reported; that no important aspects of the study have been omitted; and that any discrepancies from the study as planned (and, if relevant, registered) have been explained." *The manuscript's guarantor.

If you are the lead author, please include this statement in your cover letter. If the lead author is a different person, please ask him/her to submit the signed transparency declaration to you. This document may be uploaded with your submission in Editorial Manager.
Response: This has been addressed.

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 avoid using "Caucasian."
Response: This was done as suggested.

4. Please add the name of the IRB to line 101.

Response: This was done as suggested.

5. 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.
Response: Given that this is a retrospective cohort study, we followed STROBE specific guidelines for reporting our data. The checklist is attached separately.

6. 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.

7. 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 5,500 words. Stated word limits include the title page, précis, abstract, text, tables, boxes, and figure legends, but exclude references.

8. 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).
* If your manuscript was uploaded to a preprint server prior to submitting your manuscript to Obstetrics & Gynecology, add the following statement to your title page: "Before submission to Obstetrics & Gynecology, this article was posted to a preprint server at: [URL]."

9. Provide a short title of no more than 45 characters (40 characters for case reports), including spaces, for use as a running foot. Currently, your running title appears to be too long.
Response: This has been addressed.

10. 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. Please provide a word count.
Response: This has been addressed and the abstract has a word count of 274.

11. 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 spell out "MD" and "DD" with an en dash ("monochorionic--diamniotic" and "dichorionic--diamniotic"). There are no restrictions on abbreviations in figures and tables.
Response: This is addressed.

12. 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.
Response: This is addressed.

13. 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%").

14. 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.

15. 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).

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

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You will be receiving an Open Access Publication Charge letter from the Journal's Publisher, Wolters Kluwer, and instructions on how to submit any open access charges. The email will be from publicationservices@copyright.com with the subject line 'Please Submit Your Open Access Article Publication Charge(s)'. Please complete payment of the Open Access charges within 48 hours of receipt.

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 May 14, 2021, 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