Dear Dr. Tuuli:

Thank you for sending us your work for consideration for publication in Obstetrics & Gynecology. Your manuscript has been reviewed by the Editorial Board and by special expert referees. The Editors would like to invite you to submit a revised version for further consideration.

If you wish to revise your manuscript, please read the following comments submitted by the reviewers and Editors. Each point raised requires a response, by either revising your manuscript or making a clear argument as to why no revision is needed in the cover letter.

To facilitate our review, we prefer that the cover letter you submit with your revised manuscript include each reviewer and Editor comment below, followed by your response. That is, a point-by-point response is required to each of the EDITOR COMMENTS (if applicable), REVIEWER COMMENTS, STATISTICAL EDITOR COMMENTS (if applicable), and EDITORIAL OFFICE COMMENTS below. Your manuscript will be returned to you if a point-by-point response to each of these sections is not included.

The revised manuscript should indicate the position of all changes made. Please use the "track changes" feature in your document (do not use strikethrough or underline formatting).

Your submission will be maintained in active status for 21 days from the date of this letter. If we have not heard from you by Sep 30, 2022, we will assume you wish to withdraw the manuscript from further consideration.

REVIEWER COMMENTS:

Reviewer #1:

The authors present the results of their study examining the effects of timing of the second stage of labor pushing on postpartum pelvic floor morbidity among nulliparous women with neuraxial anesthesia. This was a planned secondary analysis of a previous published paper examining the effects timing of the second stage on labor outcomes. They found that there was no difference in perineal lacerations, pelvic organ prolapse measures or patient reported pelvic floor symptoms at 6 weeks and 6 months postpartum. Please address the following questions.

RESULTS

1) Lines 135-36: The authors report that there the change in the FISI score from baseline was statistically higher in the immediate pushing group (2.9 +5.7 vs. 2.0 +4.5). I acknowledge that this is statistically important, but is it clinically important? Given the number of participants in the study this is only a difference of 3-4 patients. Additionally, there was a difference in the baseline FISI scores, with the immediate pushing group having a higher score. Finally, was there an association between 3rd/4th degree lacerations, which were also higher among the immediate pushing group, and higher FISI scores.

2) I realize that this is probably reported in the original paper, but would the authors comment on the time of second stage for each group. Additionally, how many patients in the delayed group were able to delay pushing for the entire 60 minutes? Please include data on length of the entire second stage for both groups, and actual time spend pushing in each group.

TABLE 1

3) What were the indications for both operative vaginal delivery and cesarean delivery in each group? Was there a difference among patients with arrest of descent or fetal indications?

TABLE 2
4) How many of the 3rd/4th lacerations were associated with an operative vaginal delivery?

Reviewer #2:
This is a planned secondary analysis of a multi-site RCT evaluating delayed versus immediate pushing on pelvic floor morbidity assessed through POP-Q stage, extent of perineal lacerations, and validated pelvic floor questionnaires.

This is a very large study and despite only approximately 40% recruitment, the researchers recruited over their required sample size (also may want to address this in their manuscript).

This study is limited by not having baseline objective prolapse data (POP-Q) pre-delivery and only short-term 6 months follow-up, but adds to the literature on delivery and pelvic floor disorders.

1. General comments—Was breastfeeding evaluated in this patient population? This would be an interesting addition to the demographics to see if there were any significant difference between groups as we know this can affect tissue quality, etc.

2. Introduction, Page 4, Line 53-54: "current" Cochrane review would change to the year so that this manuscript will be pertinent in the future (want to make it readable in the future)

3. Methods, Page 5, Line 87: POP-Q (add dash)

4. Methods, Page 6, Line 95: don't understand the subjective "baseline" measurements after the subject has already had the trauma of the delivery. Were they specifically instructed to consider how they felt pre-delivery? If so, this should be stated in the methods and further described (more than already in the manuscript) in the limitations for possible bias.

5. Methods, Page 6, Line 99: use the term intention to treat analysis if this is what you did

6. Methods, Page 6, Line 113: please provide citation

7. Results, Page 7, Line 116: suggestion to add "; however, below the MCD of 4."

8. Discussion, Page 8, Lines 146-152: would be careful citing "ONLY" other paper. Would just cite the paper you are referencing directly (leave off the Cochrane comment) and describe what they found/studied. I would also add in discussion regarding other studies in literature that aren't RCTs but still have discussed the second stage of labor and pelvic floor morbidity. Example: Prospective cohort study by Jin et al in IUJ 2022 (PMID: 35267059) that addresses 2nd stage of labor on pelvic floor dysfunction, or a few studies out of Israel by Pardo et al (PMID: 33455478) to be more inclusive of the literature surrounding your topic. The discussion would benefit from a thorough literature search with addition of pertinent studies.

9. Discussion, Page 8, Line 154: would add in short-term follow-up or something similar to not overstate your findings.

10. Discussion, Page 8, Line 159: may consider add a strength is this is a large randomized trial...and leave off the largest to our knowledge (again not to "date" your manuscript for the future)

11. Discussion, Page 8, Line 175: again would expand on how the baseline data was collected and why this can affect your results

12. Conclusion, Page 9, Line 184: would add after pelvic morbidity "in the short term" or something to this effect to again not overstate your findings

13. Table 1, Page 13, Line 282: P-values here are unnecessary in well randomized controlled trial

14. Table 3, Page 15, Line 321: Row Stage 0, column immediate pushing, missing a parenthesis

Reviewer #3:
In this secondary analysis of a previously published randomized controlled trial, the authors determined whether immediate pushing or delayed pushing in the second stage results in higher risk of pelvic floor morbidity at 6 weeks and 6 months post-partum, and concluded that among nulliparous women in the second stage of labor with neuraxial anesthesia, immediate pushing, compared with delayed pushing, did not increase perineal lacerations, pelvic-organ prolapse measures, or patient-reported pelvic floor symptoms at 6 weeks and 6 months post-partum. Overall, the manuscript was well written, but there are some issues that need to be addressed by the authors prior to publication.
Introduction:
The introductory section of this manuscript is well written and captures the key points around this topic, including what is currently known about this topic, research gaps based on prior studies, and the study objectives. However, there are a few things that could make the introductory section of this manuscript stronger:

1. Please discuss that the development of pelvic floor morbidities is a complex process and could result from a multifactorial etiology.

2. Please discuss how the postpartum period offers a window of opportunity for early symptom recognition and the provision of health promotion activities, hence decreasing the emergence of pelvic floor morbidities and its implications.

3. It is important to discuss that due to women's acceptance of urogenital symptoms as a normal result of delivery, which may delay the identification and treatment of pelvic floor dysfunction, the precocious perception of these symptoms in puerperium depends on factors including access to and the quality of care they receive.

4. Please briefly discuss questionnaires and their utility in diagnosis and management of pelvic floor dysfunction. Questionnaires are used as a parameter in the assessment of progression of pelvic floor disorders and are used to identify urogenital symptoms, quantify the intensity and severity of symptoms, assess the impact on women's quality of life, and identify urogenital symptoms. Additionally, they are inexpensive and non-invasive aspects in medical research, which aids in the method's reproducibility.

Methods:
Lines 67-78: Please state the exclusion criteria for the study. This is important because risk factors like overweight, obesity, lifestyle choices (e.g., smoking, sedentarism), maternal age, maternal parity are additional factors that could impact the incidence and development of pelvic floor dysfunction.

Lines 85-94: While the PFDI-20 and PFIQ-7 are great tools to assess pelvic floor dysfunction and/or quality of life, they both have some questions that address vaginal symptoms, but without emphasis on sexual factors. How did the authors assess changes in sexual function from pelvic floor dysfunction?

Discussion:
In addition to the discussed issues in the discussion section, the authors should discuss these additional issues:

1. Was labor managed with antenatal perineal massage and the application of warm compresses to the perineum during the second stage of labor? If yes, was the practice uniform at all participating centers? This is critically important because antenatal perineal massage and the application of warm perineal compress packs to the perineum during the second stage of labor have been shown to reduce the incidence of perineal tears at first delivery, but there is no evidence to demonstrate that this reduces the incidence of pelvic organ prolapse.

2. Patients with pelvic organ prolapse can be completely asymptomatic and if they are aware of the prolapse, it may not necessarily bother them. Were they patients like this in the cohort? Patient symptoms may bear no relation to extent of prolapse. Some patients may have significant symptoms with minimal degrees of prolapse whereas others may have bothersome symptoms despite having severe degrees of pelvic organ prolapse. Were they patients that had pelvic organ prolapse without symptoms?

STATISTICAL EDITOR COMMENTS:

lines 111-113: The sample size/power calculation is correct for comparison of ≥ 2nd degree perineal lacerations. The calculation is incorrect for fecal incontinence, those rates have much lower absolute rates and the power for a 40% relative difference has ~ 50% power. It is unclear what criteria were used for discerning a 40% difference in pelvic organ prolapse. Also, the power/sample size did not account for comparisons at several time points, that would have required adjustment for multiple hypothesis testing. So, the Authors can state that the study had sufficient power to generalize the NS difference in proportion of ≥ 2nd degree perineal lacerations, but not for the others and not for multiple time points. The others would have to be considered as secondary outcomes. Also, the primary outcome is a composite, the subsets of it are not primary outcomes.

Table 1: Some entries are described in characteristics as formatted by n (%) or mean (SD), but are actually shown as n ± % or mean ± SD. Need to clarify and apply consistently. Some of the row entries have low counts, their comparisons are NS, but there is low power and therefore the NS comparison cannot be generalized from these data.

Table 2: Need to clearly separate the primary from its subsets, since they are secondary outcomes.

Table 3: How were these data tested to evaluate whether a 40% relative difference in proportion with pelvic prolapse had occurred?
Table 4: By inspection the relationship of means to SD for most entries have significant right skewing. That is, they are not normally distributed. Should apply non-parametric stats test to verify whether the FISI changes from baseline retain statistical significance.

EDITORIAL OFFICE COMMENTS:

1. If your article is accepted, the journal will publish a copy of this revision letter and your point-by-point responses as supplemental digital content to the published article online. You may opt out by writing separately to the Editorial Office at em@greenjournal.org, and only the revision letter will be posted.

2. When you submit your revised manuscript, please make the following edits to ensure your submission contains the required information that was previously omitted for the initial double-blind peer review:
   * Funding information (ie, grant numbers or industry support statements) should be disclosed on the title page and at the end of the abstract. For industry-sponsored studies, describe on the title page how the funder was or was not involved in the study.
   * Include clinical trial registration numbers, PROSPERO registration numbers, or URLs at the end of the abstract (if applicable).
   * Name the IRB or Ethics Committee institution in the Methods section (if applicable).
   * Add any information about the specific location of the study (ie, city, state, or country), if necessary for context.

3. Obstetrics & Gynecology's Copyright Transfer Agreement (CTA) must be completed by all authors. When you uploaded your manuscript, each coauthor received an email with the subject, "Please verify your authorship for a submission to Obstetrics & Gynecology." Please ask your coauthor(s) to complete this form, and confirm the disclosures listed in their CTA are included on the manuscript's title page. If they did not receive the email, they should check their spam/junk folder. Requests to resend the CTA may be sent to em@greenjournal.org.

4. 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, describe the reasons that race and ethnicity were assessed in the Methods section and/or in table footnotes. Race and 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.

List racial and ethnic categories in tables in alphabetic order. Do not use "Other" as a category; use "None of the above" instead.

Please refer to "Reporting Race and Ethnicity in Obstetrics & Gynecology" at https://edmgr.ovid.com/ong/accounts/Race_and_Ethnicity.pdf.

5. ACOG uses person-first language. Please review your submission to make sure to center the person before anything else. Examples include: "People with disabilities" or "women with disabilities" instead of "disabled people" or "disabled women"; "patients with HIV" or "women with HIV" instead of "HIV-positive patients" or "HIV-positive women"; and "people who are blind" or "women who are blind" instead of "blind people" or "blind women."

6. The journal follows ACOG's Statement of Policy on Inclusive Language (https://www.acog.org/clinical-information/policy-and-position-statements/statements-of-policy/2022/inclusive-language). When possible, please avoid using gendered descriptors in your manuscript. Instead of "women" and "females," consider using the following: "individuals;" "patients;" "participants;" "people" (not "persons"); "women and transgender men;" "women and gender-expansive patients;" or "women and all those seeking gynecologic care."

7. Clinical trials must include a data sharing statement. Please add the following questions and your answers to the end of the manuscript after the References section:

Authors' Data Sharing Statement

Will individual participant data be available (including data dictionaries)? No.
What data in particular will be shared? Not available.
What other documents will be available? Not available.
When will data be available (start and end dates)? Not applicable.
By what access criteria will data be shared (including with whom, for what types of analyses, and by what mechanism)? Not applicable.
8. Please add whether you received IRB or Ethics Committee approval or exemption to your Methods. Include the name of the IRB or Ethics Committee. If you received an exemption, explain why in this section.


10. 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.

11. Make sure your manuscript meets the following word limit. The word limit includes the manuscript body text only (for example, the Introduction through the Discussion in Original Research manuscripts), and excludes the title page, précis, abstract, tables, boxes, and figure legends, reference list, and supplemental digital content. Figures are not included in the word count.

Original Research: 3,000 words

12. Specific rules govern the use of acknowledgments in the journal. Please review the following guidelines and edit your title page as needed:

* 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 or indicate whether the meeting was held virtually).
* 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]."
* Do not use only authors' initials in the acknowledgement or Financial Disclosure; spell out their names the way they appear in the byline.

13. Provide a short title of no more than 45 characters, including spaces, for use as a running foot. Do not start the running title with an abbreviation.

14. Be sure that each statement and any data in the abstract are also stated in the body of your manuscript, tables, or figures. Statements and data that appear in the abstract must also appear in the body text for consistency. Make 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 manuscript.

In addition, the abstract length should follow journal guidelines.

Original Research: 300 words

15. Abstracts for clinical trials should be structured according to the journal's standard format. The Methods section should include the primary outcome and sample size justification. The Results section should begin with the dates of enrollment to the study, a description of demographics, and the primary outcome analysis. Please review the sample abstract that is located online at http://edmgr.ovid.com/ong/accounts/sampleabstract_RCT.pdf and edit your abstract as needed.

16. 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.

17. The journal does not use the virgule symbol (/) in sentences with words, except with ratios. 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.

18. ACOG avoids using "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.
19. 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.

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

Express all percentages to one decimal place (for example, 11.1"). Do not use whole numbers for percentages.

20. Line 159: Your manuscript contains a priority claim, which means you state your study is the first of its kind or the largest study to date. We discourage such claims, since they are often difficult to prove. If this is based on a systematic search of the literature, that search should be described in the text (search engine name, search terms, date range of search, and languages encompassed by the search). If it is not based on a systematic search but only on your level of awareness, please delete or rephrase this statement.

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

22. Please review examples of our current reference style at https://edmgr.ovid.com/ong/accounts/ifa_suppl_refstyle.pdf. 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 formal reference list. Please cite them on the line in parentheses.

If you cite ACOG documents in your manuscript, be sure the references you are citing are still current and available. Check the Clinical Guidance page at https://www.acog.org/clinical (click on "Clinical Guidance" at the top). If the reference is still available on the site and isn't listed as "Withdrawn," it's still a current document. In most cases, if an ACOG document has been withdrawn, it should not be referenced in your manuscript.

Please make sure your references are numbered in order of appearance in the text.

23. Figure 1: Please check or explain n values for the delayed pushing arm (489-53=436). Please upload as a figure file on Editorial Manager.

24. 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.

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 as a Microsoft Word document. Your revision's cover letter should include a point-by-point response to each of the received comments in this letter. Do not omit your responses to the EDITOR COMMENTS (if applicable), the REVIEWER COMMENTS, the STATISTICAL EDITOR COMMENTS (if applicable), or the EDITORIAL OFFICE COMMENTS.

If you submit a revision, we will assume that it has been developed in consultation with your coauthors and that each author has given approval to the final form of the revision.

Again, your manuscript will be maintained in active status for 21 days from the date of this letter. If we have not heard from you by Sep 30, 2022, we will assume you wish to withdraw the manuscript from further consideration.

Sincerely,
Torri D. Metz, MD, MS
Associate Editor, Obstetrics

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.
September 20, 2022

Dear Dr Editors,

On behalf of my co-authors, please accept this revised manuscript entitled, “Effect of Second Stage Pushing Timing on Postpartum Pelvic Floor Morbidity: a Multicenter Randomized Controlled Trial” for consideration as a publication in the Obstetrics and Gynecology.

We have revised the manuscript in response to the reviewers’ comments below and we believe this has made the manuscript even stronger.

**REVIEWER COMMENTS**

**Reviewer #1:**
The authors present the results of their study examining the effects of timing of the second stage of labor pushing on postpartum pelvic floor morbidity among nulliparous women with neuraxial anesthesia. This was a planned secondary analysis of a previous published paper examining the effects timing of the second stage on labor outcomes. They found that there was no difference in perineal lacerations, pelvic organ prolapse measures or patient reported pelvic floor symptoms at 6 weeks and 6 months postpartum. Please address the following questions.

**RESULTS**

1) Lines 135-36: The authors report that there the change in the FSI score from baseline was statistically higher in the immediate pushing group (2.9 +5.7 vs. 2.0 +4.5). I acknowledge that this is statistically important, but is it clinically important? Given the number of participants in the study this is only a difference of 2-4 patients. Additionally, there was a difference in the baseline FSI scores, with the immediate pushing group having a higher score. Finally, was there an association between 3rd/4th degree lacerations, which were also higher among the immediate pushing group, and higher FSI scores.
   - **RESPONSE:** Although statistically significant the difference of 0.9 is less than the minimal clinically significant difference for FSI.
   - **CHANGE:** We have included this in the results and discussion. Lines 77, 227- 228, 236- 237

2) I realize that this is probably reported in the original paper, but would the authors comment on the time of second stage for each group. Please include data on length of the entire second stage for both groups, and actual time spend pushing in each group.
   - **RESPONSE:** Duration of the second stage was significantly longer in the delayed pushing group (94.2 ± 78.6 versus 132.6 ± 79.8 min, P<0.01), but active pushing duration was not significantly different between (77.98 ± 77.0 versus 73.03 ± 75.3 min, P=0.32).
   - **CHANGE:** We have now included the total duration of the second stage and duration of active pushing in each group: Lines 213 – 215 and Table 1
Additionally, how many patients in the delayed group were able to delay pushing for the entire 60 minutes?
  - RESPONSE: 360/489 (73.6%) delayed pushing 60 minutes or more

TABLE 1
3) What were the indications for both operative vaginal delivery and cesarean delivery in each group? Was there a difference among patients with arrest of descent or fetal indications?
  - RESPONSE: Indications for cesarean (Non-reassuring fetal status, Maternal exhaustion, Inadequate expulsive efforts, Arrest of descent, Failed vacuum or forceps delivery) and operative vaginal delivery (Non-reassuring fetal status, Maternal exhaustion, Inadequate expulsive efforts, Arrest of descent) were not significantly different between groups.
  - CHANGE: We have now included indications for cesarean and operative vaginal delivery: Table 1

TABLE 2
4) How many of the 3rd/4th lacerations were associated with an operative vaginal delivery?
  - RESPONSE: 43 patients had 3rd or 4th degree perineal lacerations, of which 5 (11.6%) were in the setting of operative vaginal deliveries. Conversely, 5 (10%) of the 50 patients who had operative vaginal deliveries were diagnosed with a 3rd or 4th degree lacerations.
  - CHANGE: None

Reviewer #2:
This is a planned secondary analysis of a multi-site RCT evaluating delayed versus immediate pushing on pelvic floor morbidity assessed through POP-Q stage, extent of perineal lacerations, and validated pelvic floor questionnaires.

This is a very large study and despite only approximately 40% recruitment, the researchers recruited over their required sample size (also may want to address this in their manuscript).
  - RESPONSE: We did recruit more patients than our planned sample size.
  - CHANGE: We have now included this in the Results: Line 204 - 206

This study is limited by not having baseline objective prolapse data (POP-Q) pre-delivery and only short-term 6 months follow-up, but adds to the literature on delivery and pelvic floor disorders.
  - Thank you

1. General comments—Was breastfeeding evaluated in this patient population? This would be an interesting addition to the demographics to see if there were any significant difference between groups as we know this can affect tissue quality, etc.
  - RESPONSE: Breast feeding was not evaluated in this trial
  - CHANGE: None

2. Introduction, Page 4, Line53-54: "current" Cochrane review would change to the year so that this manuscript will be pertinent in the future (want to make it readable in the future)
  - RESPONSE: We have changed “current” Cochrane review to the 2017 Cochrane review.
  - CHANGE: Page 6, Line 220 - 221

3. Methods, Page 5, Line 87: POP-Q (add dash)
  - Done: Line 160
4. Methods, Page 6, Line 95: don't understand the subjective "baseline" measurements after the subject has already had the trauma of the delivery. Were they specifically instructed to consider how they felt pre-delivery? If so, this should be stated in the methods and further described (more than already in the manuscript) in the limitations for possible bias.
   - RESPONSE: We acknowledge that assessment of subjective baseline symptoms after the subject has already had the trauma of the delivery is a limitation. However, subjects were specifically instructed to consider how they felt pre-delivery.
   - CHANGE: We have clarified this in the Methods and we have highlighted the approach as a limitation in the Discussion. Line 170 – 172 and 293 - 300

5. Methods, Page 6, Line 99: use the term intention to treat analysis if this is what you did
   - RESPONSE: We performed intention to treat analysis in which participants were analyzed in the group they were randomized whether or not they followed the assigned intervention.
   - CHANGE: We have indicated this in the Method: Line 180

6. Methods, Page 6, Line 113: please provide citation
   - CHANGE: We have included a citation: Line 193, reference 14

7. Results, Page 7, Line 116: suggestion to add "; however, below the MCD of 4." 
   - CHANGE: Done. Line 227 - 228

8. Discussion, Page 8, Lines 146-152: would be careful citing "ONLY" other paper. Would just cite the paper you are referencing directly (leave off the Cochrane comment) and describe what they found/studied.
   - RESPONSE: We have removed “ONLY”, removed the reference to the Cochrane review, and just cited the paper and the findings.
   - CHANGE: Line 237 - 240

   I would also add in discussion regarding other studies in literature that aren’t RCTs but still have discussed the second stage of labor and pelvic floor morbidity. Example: Prospective cohort study by Jin et al in IUI 2022 (PMID: 35267059) that addresses 2nd stage of labor on pelvic floor dysfunction, or a few studies out of Israel by Pardo et al (PMID: 33455478) to be more inclusive of the literature surrounding your topic. The discussion would benefit from a thorough literature search with addition of pertinent studies.
   - RESPONSE: We have now included other studies assessing different aspects different aspects of the second stage and the risk of pelvic floor dysfunction
   - CHANGE: Line 242 - 256

9. Discussion, Page 8, Line 154: would add in short-term follow-up or something similar to not overstate your findings.
   - CHANGE: Short term has been added. Line 257 - 258

10. Discussion, Page 8, Line 159: may consider add a strength is this is a large, randomized trial…and leave off the largest to our knowledge (again not to "date" your manuscript for the future)
    - CHANGE: Thank you. These changes have been made. Line 273

11. Discussion, Page 8, Line 175: again would expand on how the baseline data was collected and why this can affect your results
    - CHANGE: We have added information on how the baseline data were collected could have affected the results Line 293 - 299
12. Conclusion, Page 9, Line 184: would add after pelvic morbidity "in the short term" or something to this effect to again not overstate your findings
   - CHANGE: Short term has been added. Line 279

13. Table 1, Page 13, Line 282: P-values here are unnecessary in well randomized controlled trial
   - RESPONSE: We included P-values because the cohort included in the pelvic floor assessments is a subset of the original randomized participants. Therefore, we deemed it necessary to formal test if baseline characteristics remain similar between groups.
   - CHANGE: No change is made, but we will be happy to remove the p-values if the Editor wants us to.

14. Table 3, Page 15, Line 321: Row Stage 0, column immediate pushing, missing a parenthesis
   - CHANGE: The missing parenthesis had been added. Table 3.

Reviewer #3:
In this secondary analysis of a previously published randomized controlled trial, the authors determined whether immediate pushing or delayed pushing in the second stage results in higher risk of pelvic floor morbidity at 6 weeks and 6 months post-partum, and concluded that among nulliparous women in the second stage of labor with neuraxial anesthesia, immediate pushing, compared with delayed pushing, did not increase perineal lacerations, pelvic-organ prolapse measures, or patient-reported pelvic floor symptoms at 6 weeks and 6 months post-partum. Overall, the manuscript was well written, but there are some issues that need to be addressed by the authors prior to publication.

Introduction:
The introductory section of this manuscript is well written and captures the key points around this topic, including what is currently known about this topic, research gaps based on prior studies, and the study objectives. However, there are a few things that could make the introductory section of this manuscript stronger:

1. Please discuss that the development of pelvic floor morbidities is a complex process and could result from a multifactorial etiology.
   - CHANGE: We have added this to the introduction. Line 109 - 111

2. Please discuss how the postpartum period offers a window of opportunity for early symptom recognition and the provision of health promotion activities, hence decreasing the emergence of pelvic floor morbidities and its implications.
   - CHANGE: We have added this to the Discussion. Line 262 - 265

3. It is important to discuss that due to women’s acceptance of urogenital symptoms as a normal result of delivery, which may delay the identification and treatment of pelvic floor dysfunction, the precocious perception of these symptoms in puerperium depends on factors including access to and the quality of care they receive.
   - CHANGE: We have added this to the introduction. Line 265 - 272

4. Please briefly discuss questionnaires and their utility in diagnosis and management of pelvic floor dysfunction. Questionnaires are used as a parameter in the assessment of progression of pelvic floor disorders and are used to identify urogenital symptoms, quantify the intensity and severity of symptoms, assess the impact on women’s quality of life, and identify urogenital symptoms. Additionally, they are inexpensive and non-invasive aspects in medical research, which aids in the method’s reproducibility.
   - CHANGE: We have added this to the introduction. Line 269 - 272
Methods:
Lines 67-78: Please state the exclusion criteria for the study. This is important because risk factors like overweight, obesity, lifestyle choices (e.g. smoking, sedentarism), maternal age, maternal parity are additional factors that could impact the incidence and development of pelvic floor dysfunction.

- **CHANGE**: We have added exclusion criteria to the Methods section. Line 137 - 138

Lines 85-94: While the PFDI-20 and PFIQ-7 are great tools to assess pelvic floor dysfunction and/or quality of life, they both have some questions that address vaginal symptoms, but without emphasis on sexual factors. How did the authors assess changes in sexual function from pelvic floor dysfunction?

- **RESPONSE**: We did not assess sexual function from pelvic floor dysfunction in this study
- **CHANGE**: We have added this as a limitation in the discussion. Line 290 - 292

Discussion:
In addition to the discussed issues in the discussion section, the authors should discuss these additional issues:

1. Was labor managed with antenatal perineal massage and the application of warm compresses to the perineum during the second stage of labor? If yes, was the practice uniform at all participating centers? This is critically important because antenatal perineal massage and the application of warm perineal compress packs to the perineum during the second stage of labor have been shown to reduce the incidence of perineal tears at first delivery, but there is no evidence to demonstrate that this reduces the incidence of pelvic organ prolapse.

- **RESPONSE**: There was no clinical protocol at any of the sites during the study for the use of perineal massage and the application of warm compresses to the perineum during the second stage of labor. While it is plausible that some obstetric care providers used these techniques, it is likely that randomization resulted in balance in the proportion of participants in the immediately and delayed pushing groups who received antenatal perineal massage and warm perineal compresses.
- **CHANGE**: No change made

2. Patients with pelvic organ prolapse can be completely asymptomatic and if they are aware of the prolapse, it may not necessarily bother them. Were they patients like this in the cohort? Patient symptoms may bear no relation to extent of prolapse. Some patients may have significant symptoms with minimal degrees of prolapse whereas others may have no bothersome symptoms despite having severe degrees of pelvic organ prolapse. Were they patients that had pelvic organ prolapse without symptoms?

- **RESPONSE**: We agree that pelvic floor symptoms may not be proportional to the degree of prolapse, but we did not specifically relate symptoms to prolapse quantification in this study.
- **CHANGE**: No change made

**STATISTICAL EDITOR COMMENTS**

lines 111-113: The sample size/power calculation is correct for comparison of ≥ 2nd degree perineal lacerations. The calculation is incorrect for fecal incontinence, those rates have much lower absolute rates and the power for a 40% relative difference has ~ 50% power. It is unclear what criteria were used for discerning a 40% difference in pelvic organ prolapse. Also, the power/sample size did not account for comparisons at several time points, that would have required adjustment for multiple hypothesis testing. So, the Authors can state that the study had sufficient power to generalize
the NS difference in proportion of ≥ 2nd degree perineal lacerations, but not for the others and not for multiple time points. The others would have to be considered as secondary outcomes. Also, the primary outcome is a composite, the subsets of it are not primary outcomes.

- **CHANGES:**
  - We have corrected the power analysis for pelvic organ prolapse and removed that for FISI. Line 191 - 197
  - We have also indicated the potential for insufficient power for the other analysis and for the multiple time points. Line 285 - 288
  - We have also clarified the subsets of the primary outcomes are not primary outcomes. Table 2

**Table 1:** Some entries are described in characteristics as formatted by n (%) or mean (SD), but are actually shown as n ± % or mean ± SD. Need to clarify and apply consistently. Some of the row entries have low counts, their comparisons are NS, but there is low power and therefore the NS comparison cannot be generalized from these data.

- **CHANGE:** We have applied consistent formatting of the data. Table 1

**Table 2:** Need to clearly separate the primary from its subsets, since they are secondary outcomes.

- **CHANGE:** We have clearly separated the primary outcome from its subsets as secondary outcomes. Table 2

**Table 3:** How were these data tested to evaluate whether a 40% relative difference in proportion with pelvic prolapse had occurred?

- **CHANGE:** We have included the relative risks for stage 2 or greater pelvic organ prolapse with immediate compared with delayed pushing at 6 weeks and 6 days. Line 220 - 222

**Table 4:** By inspection the relationship of means to SD for most entries have significant right skewing. That is, they are not normally distributed. Should apply non-parametric stats test to verify whether the FISI changes from baseline retain statistical significance.

- **RESPONSE:** We used non-parametric statistical tests for all the comparisons in Table 4, which produced the statistical significance in the FISI change from baseline at 6 months.

**EDITORIAL OFFICE COMMENTS**

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  - Running Foot: Pushing Timing and Postpartum Pelvic Floor Morbidity

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23. Figure 1: Please check or explain n values for the delayed pushing arm (489-53=436). Please upload as a figure file on Editorial Manager

- We have double checked and corrected a typographical error in the n value for the delayed pushing group in Figure 1

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