NOTICE: This document contains correspondence generated during peer review and subsequent revisions but before transmittal to production for composition and copyediting:

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

*The corresponding author has opted to make this information publicly available.

Personal or nonessential information may be redacted at the editor’s discretion.

Questions about these materials may be directed to the Obstetrics & Gynecology editorial office: obgyn@greenjournal.org.
RE: Manuscript Number ONG-23-2049

Postpartum necrotizing myositis with endometrial prolapse: a case report

Dear Dr. Peng:

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, and STATISTICAL EDITOR COMMENTS (if applicable) below. 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). Upload the tracked-changes version when you submit your revised manuscript.

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 01/16/2024, we will assume you wish to withdraw the manuscript from further consideration.

EDITOR COMMENTS:

Please note the following:

* This was mentioned by one of the reviewers, but this point needs emphasis. Please de-identify all images, specifically Figure 2.

* Please have the manuscript reviewed and edited by a native English speaker if possible. There are some awkward phrases that do not flow well and are difficult to understand.

* Help us reduce the number of queries we add to your manuscript after it is revised by reading the Revision Checklist at https://journals.lww.com/greenjournal/Documents/RevisionChecklist_Authors.pdf and making the applicable edits to your manuscript.

* As of January 2024, only certain article types will appear in the print version of the journal. Case Reports, specifically, will only publish online. All accepted articles will continue to publish online. All articles will be indexed in PubMed as an official article of Obstetrics & Gynecology. Additional information is available in the Instructions for Authors (https://journals.lww.com/greenjournal/Pages/InformationforAuthors.aspx#II).

* Figures 1-4: Please upload as individual figure files on Editorial Manager.

REVIEWER COMMENTS:

Reviewer #1: Interesting case report about a complex and unique postpartum complication

Overall: This is a case report regarding a postpartum case of necrotizing myositis. The manuscript is well written and clear, offering clinical insights on a rare but potentially emergent postpartum condition. The condition is demonstrated clearly
and aided by the patient photographs.

The title is appropriate and specifically describes the case. The introduction provides a nice background review of the literature on this topic that has been previously published. As for the management as described in this case, I am not sure it is generalizable to the U.S. or broader global population. I was surprised to see that the postpartum hemorrhage was only described as 1.5 L; and the pharmacologic management strategies were not outlined prior to surgical intervention. In the U.S. it is rare to proceed with surgical management and B-Lynch suture placement after SVD with 1.5 L blood loss and would typically have a trial of many pharmacologic and non-surgical tamponade strategies (i.e. placement of Bakri Ballon, Jada device) prior to transabdominal operative management, as was performed in this case.

The photographs do support the descriptions of this case well. The limitations are the generalizability of this management approach to postpartum hemorrhage. I do think the authors could support their work with further details on the patient course, and there were notable omissions in the type of antibiotics given, including length and timing and patient response. The references appear to be complete and up to date on the subject.

Specifically:

Background:
Line 4-6: Does not really adequately define the condition or tie together that myositis can cause or causes a systemic infection. Would add one more sentence to address the progression of the illness and necessity for prompt recognition.

Line 8-17 Case:
The fact that there was a bag like vaginal prolapse seemed to be essential to diagnosis. Is that necessary or was there a delay in diagnosis that led to this prolapse of the "abscess?"

Line 56- Bleeding of 1500 ml does not seem as severe to lead to a B-Lynch procedure. What other measures were tried, Hb/Hct obtained, is this routine in China, as it is less so in US.

Line 60- what pharmacologic treatment. Can you write out or describe the series of antibiotics that were prescribed?

Line 68: What is Pelvic B-ultrasound? Please address.

Line 85- what is a subtotal hysterectomy (supracervical?) Need to address why this was chosen, vs total hysterectomy?

Line 86- why J tube implantation-was there ureteral injury? If not, would consider adding prophylactic J tube ureteral implantation

Line 91-92- be specific about course of antibiotic treatment and duration. Did she remain afebrile? WBC elevated or followed (what were the results)?

Line 95- Again, what is pelvic B ultrasound?

Line 103- clarify that the pelvis and abdomen was irrigated, but the patient was treated intravenously with imipenem

Question-were there any cultures available with targeted sensitivities?

Line 104-line 111- the series of events are unclear. Can you describe the situation and when was this performed in relation to the pelvic cavity irrigation?

Would expand on:
Duration of antibiotic therapy- IV and Po
How frequently was the mass monitored?
How long did it take the patient to defervesce and symptomatically feel better?

Line 133: GDM and other descriptors should be brought up in the case before discussion

Line 139- how do you rule out or evaluate for myositis early?

Line 143- Covid issue sounds like an unexpected confounder. Should be addressed through her case care earlier on. How did that impact her care, decisions, delay? Again, were there cultures and sensitivities? This often guides understanding of source and targeting antibiotic management (optimizing antibiotic stewardship)

Figure 4: "Pus moss" I am not familiar with this term, and would need that to be further described as it is a rare medical term.
Reviewer #2: This case report describes a patient with severe infectious complications several weeks postpartum. There are impressive images of the uterine lining "cast" prolapsing.

I recommend expanding the case presentation information in the body of the text. Several details of the patient's case are first and only mentioned in the discussion including length of membrane rupture (line 134), diabetes status (line 133) and COVID diagnosis (line 142). Additionally, I would recommend further elaboration on course and attempted (if any) interventions during the 78 days between birth and presenting with prolapsed infection. For example, in lines 59-61, the authors describe frequent visits and poor response to treatments, however, how often were these presentations for care, were any imaging or cultures obtained (as suggested is best practice in discussion), and what pharmacologic treatments were attempted (i.e. antibiotics, pain medications, etc.)? Some wording is confusing and would benefit from review from an English-speaker, perhaps from another region. For example, as a provider in the US, I am not certain what the authors are indicating with phrase "B-ultrasound." Another example that may need clarifying is line 154-155; I believe the authors are referring to possibility of residual products of conception as using pregnancy here makes me think of fetal/embryonic tissue.

Images must be de-identified; Figure 2 MRI images still have patient name and DOB visible.

--
Sincerely,
Mengyang Sun, MD, MS
Editorial Fellow

The Editors of Obstetrics & Gynecology

In compliance with data protection regulations, you may request that we remove your personal registration details at any time. (Use the following URL: https://www.editorialmanager.com/ong/login.asp?a=r). Please contact the publication office if you have any questions.
Dear editor and reviewer:
Thank you for your precious comments and advice. Those comments are all valuable and very helpful for revising and improving our paper, as well as the important guiding significance to our work. We have studied comments carefully and have made correction which we hope meet with approval. The main corrections in the paper and the responds to the reviewer’s comments are as following:

EDITOR COMMENTS:

Please note the following:

* This was mentioned by one of the reviewers, but this point needs emphasis. Please de-identify all images, specifically Figure 2.
  **Authors’ Response:** Thanks for your kind suggestions, we have changed and re-uploaded the picture.

* Please have the manuscript reviewed and edited by a native English speaker if possible. There are some awkward phrases that do not flow well and are difficult to understand.
  **Authors’ Response:** Thank you. We have meticulously examined the manuscript and made corresponding revisions, including addressing typographical errors, grammatical mistakes, and overly long sentences.

* Help us reduce the number of queries we add to your manuscript after it is revised by reading the Revision Checklist at https://journals.lww.com/greenjournal/Documents/RevisionChecklist_Authors.pdf and making the applicable edits to your manuscript.
  **Authors’ Response:** Alright, we have meticulously examined the list.

* As of January 2024, only certain article types will appear in the print version of the journal. Case Reports, specifically, will only publish online. All accepted articles will continue to publish online. All articles will be indexed in PubMed as an official article of Obstetrics & Gynecology. Additional information is available in the Instructions for Authors (https://journals.lww.com/greenjournal/Pages/InformationforAuthors.aspx#II).
  **Authors’ Response:** Thanks, we have got it.

* Figures 1-4: Please upload as individual figure files on Editorial Manager.
  **Authors’ Response:** Thank you. We have understood and dealt with it as you said.

REVIEWER COMMENTS:
Reviewer #1:

Background:
Line 4-6: Does not really adequately define the condition or tie together that myositis
can cause or causes a systemic infection. Would add one more sentence to address the progression of the illness and necessity for prompt recognition.

**Authors' Response:** Thanks for your careful checks. We are sorry for our carelessness. We have rewritten these contents, please see page 1, line 6-9.

Line 8 -17 Case:
The fact that there was a bag like vaginal prolapse seemed to be essential to diagnosis.
Is that necessary or was there a delay in diagnosis that led to this prolapse of the "abscess?"

**Authors' Response:** The patient had been consulting with other medical institutions, as the uncommon condition might have led to a delay in treatment. Consequently, upon arrival at our hospital, the patient's condition had significantly deteriorated. Upon initial diagnosis at our hospital, we observed the pictured accumulation of exudate.

Line 56- Bleeding of 1500 ml does not seem as severe to lead to a B-Lynch procedure. What other measures were tried, Hb/Hct obtained, is this routine in China, as it is less so in US.

**Authors' Response:** The patient experienced weak intrapartum contractions, and uterine massage, hysterotomy medications, and hemostatic agents proved ineffective. Profound bleeding of 1500ml ensued, accompanied by persistent heavy bleeding, BP 107/70mmHg, HR 126 bpm, and hemoglobin 72g/L, indicating anemia. Given the initial diagnosis of refractory postpartum hemorrhage, hemorrhagic shock, and early disseminated intravascular coagulation (DIC), an operation was promptly performed. We have rewritten these contents, please see page 3, line 61-62.

Line 60- what pharmacologic treatment. Can you write out or describe the series of antibiotics that were prescribed?

**Authors' Response:** Other medical institutions obstetrical outpatient application: oral erythromycin enteric-coated capsule 0.5g, twice a day. Oral cefdinir capsule 0.1g, three times a day, its digestive department recommended oral alprazole enteric-coated tablet 5mg, three times a day.

Line 68: What is Pelvic B-ultrasound? Please address.

**Authors' Response:** It's mean pelvic ultrasound.


Line 85- what is a subtotal hysterectomy (supracervical?) Need to address why this was chosen, vs total hysterectomy?

**Authors' Response:** Subtotal hysterectomy is a surgical procedure that involves removing the uterus while keeping the cervix intact. The patient in this case is a 35-year-old woman who leads an active sexual life and has a strong desire to preserve her cervix. Keeping the cervix intact can have both physical and mental health benefits for women, including enhancing the quality of their sexual lives. During the surgery, it was discovered that the pelvic floor abscess was widespread, the wound was large, and the para-uterine structures were not clearly visible. By preserving the cervix, the risk of a pelvic floor wound may be reduced.

Line 86- why J tube implantation—was there ureteral injury? If not, would consider adding prophylactic J tube ureteral implantation

**Authors' Response:** During the intraoperative exploration, it was discovered that the patient had extensive dense adhesions within the pelvic cavity, as well as dense adhesions between the anterior wall of the lower uterine segment and the bladder. The tissue was found to be brittle. During the separation process, the bladder revealed a cleft with a diameter of approximately 1 cm. During the surgery, the ureter and its associated vessels were either damaged or not affected, resulting in the prophylactic placement of a double J tube.

Line 91-92- be specific about course of antibiotic treatment and duration. Did she remain afebrile? WBC elevated or followed (what were the results)?

**Authors' Response:** The patients received a two-week course of intravenous cefoperazone sulbactam and metronidazole following their operation. The patient's white blood cell count was 21.43 * 10^9 / L on the second day post-op. They experienced a fever on the first day post-op, reaching a maximum temperature of 38.6 degrees Celsius. Prior to discharge, the patient's white blood cell count had decreased to 10.18 * 10^9 / L, and they no longer had a fever.

Line 95- Again, what is pelvic B ultrasound?

**Authors' Response:** It's mean pelvic ultrasound.


Line 103- clarify that the pelvis and abdomen was irrigated, but the patient was treated intravenously with imipenem

Question—were there any cultures available with targeted sensitivities?

**Authors' Response:** The infected tissue in the patient's pelvic region underwent a bacterial culture and drug susceptibility test, revealing that the Escherichia coli present was sensitive to imipenem.

Line 104-line 111- the series of events are unclear. Can you describe the situation and when was this performed in relation to the pelvic cavity irrigation?

**Authors’ Response:** The pelvic drainage tube is equipped with a dedicated flushing tube. Gentamicin is injected into the pelvic cavity and subsequently extracted through an additional tube.

Would expand on:

Duration of antibiotic therapy- IV and Po

How frequently was the mass monitored?
How long did it take the patient to defervesce and symptomatically feel better?

**Authors' Response:** Amipenem was administered intravenously for a duration of 20 days, and pelvic ultrasound was utilized to monitor the changes in the pelvic mass approximately 7 days later. The patient's symptoms began to improve 1 week following the initiation of antibiotic treatment.

Line 133: GDM and other descriptors should be brought up in the case before discussion

**Authors' Response:** Thanks, we have been added in the latest article.

Line 139- how do you rule out or evaluate for myositis early?

**Authors' Response:** Early-stage myositis is often challenging to diagnose in clinical settings. Therefore, healthcare professionals should be more vigilant when encountering similar cases, and promptly obtain a pathology diagnosis. Appropriate antibiotic treatment should be administered in a timely manner. The objective of this case report is to draw greater attention to the significance of this disease.

Line 143- Covid issue sounds like an unexpected confounder. Should be addressed through her case care earlier on. How did that impact her care, decisions, delay? Again, were there cultures and sensitivities? This often guides understanding of source and targeting antibiotic management (optimizing antibiotic stewardship)

**Authors’ Response:** Coinfection with COVID-19 during the development of myositis, when COVID-19 is prevalent nationwide, could lead healthcare professionals to overlook the presence of myositis and focus solely on treating the symptoms caused by COVID-19. This oversight may potentially influence the progression of myositis in such patients.

Figure 4: "Pus moss" I am not familiar with this term, and would need that to be further described as it is a rare medical term.

**Authors’ Response:** The article is to describe the myometrial necrosis, which may be inappropriate and has been changed in the text. Thank you for reminding.

Reviewer #2: This case report describes a patient with severe infectious complications several weeks postpartum. There are impressive images of the uterine lining "cast" prolapsing. I recommend expanding the case presentation information in the body of the text. Several details of the patient's case are first and only mentioned in the discussion including length of membrane rupture (line 134), diabetes status (line 133) and COVID diagnosis (line 142).

**Authors’ Response:** Ok, thanks for your guidance. We have rewritten these contents, please see page3, line 58-60.

Additionally, I would recommend further elaboration on course and attempted (if any) interventions during the 78 days between birth and presenting with prolapsed infection. For example, in lines 59-61, the authors describe frequent visits and poor response to treatments, however, how often were these presentations for care, were any imaging or cultures obtained (as suggested is best practice in discussion), and what pharmacologic treatments were attempted (i.e. antibiotics, pain medications,
etc.)?

Authors' Response: Thanks for your guidance, We have rewritten these contents, please see page3, line 64-83.

Some wording is confusing and would benefit from review from an English-speaker, perhaps from another region. For example, as a provider in the US, I am not certain what the authors are indicating with phrase "B-ultrasound."

Authors' Response: It's mean pelvic ultrasound.


Another example that may need clarifying is line 154-155; I believe the authors are referring to possibility of residual products of conception as using pregnancy here makes me think of fetal/embryonic tissue.

Authors' Response: Yes, it's mean residual products of conception. Please see page 7, line 180-181.

Images must be de-identified; Figure 2 MRI images still have patient name and DOB visible.

Authors' Response: Thanks, we already know and have changed it.