Date: Apr 11, 2019
To: "Lena Braginsky" [redacted]
From: "The Green Journal" em@greenjournal.org
Subject: Your Submission ONG-19-462

RE: Manuscript Number ONG-19-462

A randomized controlled trial of tissue adhesive compared to sterile strips after cesarean delivery

Dear Dr. Braginsky:

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 02, 2019, we will assume you wish to withdraw the manuscript from further consideration.

REVIEWER COMMENTS:

Reviewer #1: In this multicenter randomized controlled trial, women undergoing cesarean delivery (both scheduled and in labor) via Pfannenstiel skin incision were randomized to receive tissue adhesive (2 octyl cyanoacrylate) versus sterile strips after closure of the skin incision. Three different clinical sights, The primary outcome was a composite of wound complications (drainage, cellulitis, abscess, seroma, hematoma or isolated wound separation) within 8 weeks of delivery. Secondary outcomes included operative time, readmission, office or emergency department visits or antibiotic use for wound complications, and patient satisfaction with the cesarean scar. Had standardized protocols in place for preps and closure and antibiotics

Abstract succinct and well written

Objective is well defined

Introduction: You simply state that tissue adhesive has been shown to have some antibacterial properties. Since this is the mechanism you are basing your study to decrease wound infection can you expound on this data from the two references. What is the proposed mechanism, how good is the data? you might also use this mechanism again in your discussion since you didn' t see any difference

Materials and Methods are well defined: Was a dressing placed on top of the tissue adhesive after it dried or was it left open or perhaps at the discretion of the attending? Please describe.

Results:
Many more women were eligible than entered and you had very few exclusion criteria. What was the primary reason>1814 women were eligible and 1310 were excluded? Was this because they were non english speaking? was this because you only had a research nurse at different times? Please explain.

There are two known main factors that effect post cesarean infection of wounds BMI < 30, 30-39.9. >40 which you nicely define in demographic table and in your Materials and Methods section. The second factor is Labor/ROM and chorioamnionitis.

I think you can condense Tables 1 and 2 Outcomes both Primary and secondary

So I think one more table Table 3 looking at sub analysis of primary and secondary outcomes by maternal weight and by labor and PROM and chorioamnionitis would be valuable

line 227 you refer to wound drainage as a secondary outcome and from my read this is simply a subset of the primary composite outcome: please clarify

Discussion: A paragraph about cost would be great, sterile strips vs adhesive and how this might contribute to VALUE

Reviewer #2: Braginsky and colleagues present findings from a well-executed multicenter randomized controlled trial comparing tissue adhesive to sterile strips after cesarean delivery. I have included a few comments/questions for clarification.

1. Introduction lines 107-108: One type of adhesive is mentioned in the introduction. It was not clear in the materials and methods if this was the adhesive used on all the study patients.

2. Results: Did you consider stratifying your results between the classes of BMI? Would there be a difference in the outcomes?

Reviewer #3:

1. This study has been adequately summarised in the abstract.

2. The only significant exclusion criterion was the planned use of staples for skin closure. Primary and repeat caesarean sections were included and all patients had to be treated with an initial proscribed skin cleansing agent and were to be given preoperative antibiotics, although the choice was determined by the individual institutions. The type of subcuticular skin suture, whether absorbable or non-absorbable was left to the discretion of the surgeon as were other aspects of post-operative care.

3. The study was discontinued when an interim analysis concluded there were no demonstrable differences between the two approaches.

4. The rationale for these approaches has been explained in the study by Westcott et al (reference 17), quoting encouraging results from a retrospective survey. That study highlighted the potential impact of the siting of the abdominal skin incision, the numbers of previous caesarean sections and the use of anticoagulation.

5. Since the authors of the present report were aware of this retrospective study by Westcott et al (2017) in which a difference in wound separation but not infection was observed in patients given anticoagulants, it is a pity there is no mention of anticoagulant use in the present study; this association had previously been reported by others. With an average age around 33 years and an average BMI around 34 for both groups, it is possible a significant percentage of patients in both groups would have been given an anticoagulant at some stage. It also appears from the Westcott et al (2017) study a previous caesarean section had an impact.

6. The Daykan study (reference 31) to which reference has been made had compared glue versus subcuticular suture to close the wound, which is a different concept and it is difficult to see what relevance the conclusion reached in that report has to the present study.

7. The failure to consider the issues identified in the Westcott et al (2017) paper challenges the validity of the conclusions reached in the present study and the premature termination.

STATISTICAL EDITOR'S COMMENTS:

1. lines 72-80: Should state what proportion of original sample size was achieved. Also, would be helpful for the reader to include CIs for the wound complication rates. The incident rate ratio = 0.96, but with CIs 0.48-1.93. By that metric, the lower boundary was 50% of the control rate. Therefore the conclusion of a negative study, although likely valid, was not corroborated using the original sample sizes (nor power), so a more nuanced conclusion should be stated in Abstract and precis.

2. Table 1: Were blood loss, BMI and maternal age all normally distributed? If not, should cite as median(range or IQR). Blood loss, specifically, is often skewed. No need to cite statistical comparisons, since the cohorts were randomized, any statistical difference should be due to random chance. Many of the characteristics were infrequent, so there also would have been little power to discern a difference.

3. Table 2: Although it is stated in Fig 1 and in the Methods, should explicitly state that the cohorts were ITT.

4. Table 3: Was operative time normally distributed? If not, should cites as median(IQR or range) and test non-

parametrically. Since there were 10 items tested, should use a stricter inference threshold than p < .05. Findings also limited by missing data for Patient Scar Assessment Scale. Also, insufficient power to discern difference in readmission rates, visit for wound complication or antibiotic Rx rates.

EDITORIAL OFFICE COMMENTS:

1. The Editors of Obstetrics & Gynecology are seeking to increase transparency around its peer-review process, in line with efforts to do so in international biomedical peer review publishing. If your article is accepted, we will be posting this revision letter as supplemental digital content to the published article online. Additionally, unless you choose to opt out, we will also be including your point-by-point response to the revision letter, as well as subsequent author queries. 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:
1. OPT-IN: Yes, please publish my response letter and subsequent email correspondence related to author queries.
2. OPT-OUT: No, please do not publish my response letter and subsequent email correspondence related to author queries.

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

Any author agreement forms previously submitted will be superseded by the eCTA. During the resubmission process, you are welcome to remove these PDFs from EM. However, if you prefer, we can remove them for you after submission.

3. Clinical trials submitted to the journal as of July 1, 2018, must include a data sharing statement. The statement should indicate 1) whether individual deidentified participant data (including data dictionaries) will be shared; 2) what data in particular will be shared; 3) whether additional, related documents will be available (eg, study protocol, statistical analysis plan, etc.); 4) when the data will become available and for how long; and 5) by what access criteria data will be shared (including with whom, for what types of analyses, and by what mechanism). Responses to the five bullet points should be provided in a box at the end of the Methods section.

4. In order for an administrative database study to be considered for publication in Obstetrics & Gynecology, the database used must be shown to be reliable and validated. In your response, please tell us who entered the data and how the accuracy of the database was validated. This same information should be included in the Materials and Methods section of the manuscript.

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

6. Because of space limitations, it is important that your revised manuscript adhere to the following length restrictions by manuscript type: Original Research reports should not exceed 22 typed, double-spaced pages (5,500 words). Stated page limits include all numbered pages in a manuscript (i.e., title page, précis, abstract, text, references, tables, boxes, figure legends, and print appendixes) but exclude references.

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

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

8. The most common deficiency in revised manuscripts involves the abstract. Be sure there are no inconsistencies between the Abstract and the manuscript, and that the Abstract has a clear conclusion statement based on the results found in the paper. Make sure that the abstract does not contain information that does not appear in the body text. If you submit a revision, please check the abstract carefully.

In addition, the abstract length should follow journal guidelines. The word limits for different article types are as follows: Original Research articles, 300 words. Please provide a word count.

9. Abstracts for all randomized, controlled 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 here: http://edmgr.ovid.com/ong/accounts/sampleabstract_RCT.pdf. Please edit your abstract as needed.

10. 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.

11. The journal does not use the virgule symbol (/) in sentences with words. Please rephrase your text to avoid using "and/or," or similar constructions throughout the text. You may retain this symbol if you are using it to express data or a measurement.

12. We discourage claims of first reports since they are often difficult to prove. How do you know this is the first report? If this is based on a systematic search of the literature, that search should be described in the text (search engine, search terms, date range of search, and languages encompassed by the search). If on the other hand, it is not based on a systematic search but only on your level of awareness, it is not a claim we permit.

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

14. The Journal's Production Editor had the following to say about the figures in your manuscript:

"Figure 1: need to upload into Editorial Manager as a separate file; also, please add a figure legend to your manuscript."

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

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

If the figures were created using a statistical program (eg, STATA, SPSS, SAS), please submit PDF or EPS files generated directly from the statistical program.

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

Art that is low resolution, digitized, adapted from slides, or downloaded from the Internet may not reproduce.

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If you choose to revise your manuscript, please submit your revision via Editorial Manager for Obstetrics & Gynecology at http://ong.editorialmanager.com. It is essential that your cover letter list point-by-point the changes made in response to each criticism. Also, please save and submit your manuscript in a word processing format such as Microsoft Word.

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 02, 2019, we will assume you wish to withdraw the manuscript from further consideration.

Sincerely,

The Editors of Obstetrics & Gynecology

2017 IMPACT FACTOR: 4.982
2017 IMPACT FACTOR RANKING: 5th out of 82 ob/gyn journals

_____
In compliance with data protection regulations, you may request that we remove your personal registration details at any time. (Use the following URL: https://www.editorialmanager.com/ong/login.asp?a=r) Please contact the publication office

[redacted]

Dr. Nancy C. Chescheir

Editor-in-chief

Obstetrics and Gynecology

Dear Dr. -Chescheir and Journal Reviewers,

Thank you for your consideration of our original manuscript entitled “A randomized controlled trial of tissue adhesive compared to sterile strips after cesarean delivery” for publication in *Obstetrics & Gynecology*. We were delighted to receive your feedback and have adjusted the manuscript in response to your comments. Below is a list of the reviewer questions with specific responses to each point outlined in red:

Reviewer #1

Introduction: You simply state that tissue adhesive has been shown to have some antibacterial properties. Since this is the mechanism you are basing your study to decrease wound infection can you expound on this data from the two references. What is the proposed mechanism, how good is the data? you might also use this mechanism again in your discussion since you didn' t see any difference.

Thank you for your comment. We have added clarification to this point in lines 109-112 of the manuscript. We also make an effort of re-visit this point in this discussion section, lines 276-287.

Materials and Methods are well defined: Was a dressing placed on top of the tissue adhesive after it dried or was it left open or perhaps at the discretion of the attending? Please describe.

The decision to place a dressing on top of tissue adhesive was left at the discretion of the provider, and no dressing was placed until the tissue adhesive was completely dry. Only 2/252 patients had a dressing placed over the tissue adhesive. We have changed the text in the methods and results to reflect this in lines 152-153 and lines 213-214.

Results:
Many more women were eligible than entered and you had very few exclusion criteria. What was the primary reason>1814 women were eligible and 1310 were excluded? Was this because they were non english speaking? was this because you only had a research nurse at different times? Please explain.

The majority of the women screened were ineligible due to the study personnel not being available to accomplish consent and randomization of the participant. However, we unfortunately we were unable to track the exact number of women who delivered when study personnel were unavailable, compared to exclusion for other reasons. We list the unavailability of study personnel during the consent and randomization process as an exclusion criteria (lines 137-138).

There are two known main factors that effect post cesarean infection of wounds BMI < 30, 30-39.9. >40 which you nicely define in demographic table and in your Materials and Methods section. The second factor is Labor/ROM and chorioamnionitis.

Yes, we agree that labor, ruptured membranes and chorioamnionitis are risk factors for post cesarean wound infections. We collected data on these factors, in addition to other risk factors which may be associated with post cesarean wound complications (Table 1). We were pleased to find that there were no differences in the frequency of any of these risk factors between intervention groups. As such, we would not expect to find different results in any of these subgroups.

I think you can condense Tables 1 and 2 Outcomes both Primary and secondary

Thank you very much for your suggestion. We have combined the primary and secondary outcome tables into a single table for all outcomes, Table 2.

So I think one more table Table 3 looking at sub analysis of primary and secondary outcomes by maternal weight and by labor and PROM and chorioamnionitis would be valuable

We appreciate the reviewer's feedback and respectfully disagree. Our randomization strategy allowed for clinical factors that could potentially impact the primary outcome (such as labor and chorioamnionitis) to be randomly distributed across the comparison groups. As such, we did not include pre-specified sub-group analyses in our analytic plan. Our study is not adequately powered to perform sub-group analyses.

line 227 you refer to wound drainage as a secondary outcome and from my read this is simply a subset of the primary composite outcome: please clarify

Thank you for calling attention to this point. As stated in the methods " The primary outcome was a composite of wound complications, which was defined as one or more of the following: wound drainage, cellulitis, abscess, hematoma, seroma, or isolated wound separation within 8 weeks of delivery. Pre-specified secondary outcomes included individual components of the primary outcome, operative time, readmission for wound complication, office or emergency room visit or antibiotics prescribed for wound complication, and patient satisfaction with the scar".

In order to avoid confusion, we have changed lines 235-236 in the results section to read "With regard to individual components of the primary outcome, wound drainage was the most frequently reported wound complication…". We are happy to adjust this further if advisable.

Discussion: A paragraph about cost would be great, sterile strips vs adhesive and how this might contribute to VALUE

Thank you for your suggestion – we have adjusted our discussion to address cost of each intervention (lines 310-313).

Reviewer #2: Braginsky and colleagues present findings from a well-executed multicenter randomized controlled trial comparing tissue adhesive to sterile strips after cesarean delivery. I have included a few comments/questions for clarification.

1. Introduction lines 107-108: One type of adhesive is mentioned in the introduction. It was not clear in the materials and methods if this was the adhesive used on all the study patients.

We used only one type of tissue adhesive – 2-octyl cyanoacrylate. We have adjusted our methods to make this point more clear (line 139).

2. Results: Did you consider stratifying your results between the classes of BMI? Would there be a difference in the outcomes?

Thank you for your comment. See answer to Reviewer #2's question about regarding subgroup analyses.

Reviewer #3:

1. This study has been adequately summarised in the abstract.

2. The only significant exclusion criterion was the planned use of staples for skin closure. Primary and repeat caesarean sections were included and all patients had to be treated with an initial proscribed skin cleansing agent and were to be given preoperative antibiotics, although the choice was determined by the individual institutions. The type of subcuticular skin suture, whether absorbable or non-absorbable was left to the discretion of the surgeon as were other aspects of post-operative care.

3. The study was discontinued when an interim analysis concluded there were no demonstrable differences between the two approaches.

4. The rationale for these approaches has been explained in the . study by Westcott et al (reference 17), quoting encouraging results from a retrospective survey. That study highlighted the potential impact of the siting of the abdominal skin incision, the numbers of previous caesarean sections and the use of anticoagulation.

5. Since the authors of the present report were aware of this retrospective study by Westcott et al (2017) in which a difference in wound separation but not infection was observed in patients given anticoagulants, it is a pity there is no mention of anticoagulant use in the present study; this association had previously been reported by others. With an average age around 33 years and an average BMI around 34 for both groups, it is possible a significant percentage of patients in both groups would have been given an anticoagulant at some stage. It also appears from the Westcott et al (2017) study a previous caesarean section had an impact.

Thank you so much for your thoughtful feedback. Our study started prior to the publication by Westcott et al, and unfortunately the authors did not recognize anticoagulation as a significant risk factor for the development of wound complications. However, as a randomized controlled trial, we expect the number of women on anticoagulation to be equally distributed between groups and should not impact the validity of our results or our conclusion.

6. The Daykan study (reference 31) to which reference has been made had compared glue versus subcuticular suture to close the wound, which is a different concept and it is difficult to see what relevance the conclusion reached in that report has to the present study.

Thank you for your comment. We agree that the findings of the Daykan et al study may not be directly relevant to our trial due to the difference in study design. We reference this study as it was the only prior randomized trial to compare tissue adhesive to sterile strips after cesarean delivery. We have modified the text to clarify this point in lines 290-296.

7. The failure to consider the issues identified in the Westcott et al (2017) paper

challenges the validity of the conclusions reached in the present study and the premature termination.

Please see above reply to question #5.

STATISTICAL EDITOR'S COMMENTS:

1. lines 72-80: Should state what proportion of original sample size was achieved. Also, would be helpful for the reader to include CIs for the wound complication rates. The incident rate ratio = 0.96, but with CIs 0.48-1.93. By that metric, the lower boundary was 50% of the control rate. Therefore the conclusion of a negative study, although likely valid, was not corroborated using the original sample sizes (nor power), so a more nuanced conclusion should be stated in Abstract and precis.

We greatly appreciate your suggestions and have performed additional analyses to include odds ratio with 95% confidence intervals where appropriate. We have edited our methods accordingly. We have also adjusted our precis and abstract to more accurately reflect the findings of our analysis. Please see lines 38-40 (precis), 74 (abstract), 81-88 (abstract), 193-198 (methods), 229-230 (results), 246-251 (results), and Table 2.

2. Table 1: Were blood loss, BMI and maternal age all normally distributed? If not, should cite as median(range or IQR). Blood loss, specifically, is often skewed. No need to cite statistical comparisons, since the cohorts were randomized, any statistical difference should be due to random chance. Many of the characteristics were infrequent, so there also would have been little power to discern a difference.

Thank you so much for your feedback. Blood loss, maternal BMI and maternal age were not normally distributed by the Kolmogorov-Smirnov test. We have edited our methods accordingly and adjusted our analysis/results using the appropriate non parametric tests (Mann-Whitney U test). Please see changes in lines 193-198, Table 1 and Table 2.

3. Table 2: Although it is stated in Fig 1 and in the Methods, should explicitly state that the cohorts were ITT.

We have adjusted the footnote in Table 2 to reflect the intention-to-treat approach (line 444).

4. Table 3: Was operative time normally distributed? If not, should cites as median(IQR or range) and test non-parametrically. Since there were 10 items tested, should use a stricter inference threshold than $p < .05$. Findings also limited by missing data for Patient Scar Assessment Scale. Also, insufficient power to discern difference in readmission rates, visit for wound complication or antibiotic Rx rates.

Thank you again for your insights. Operative time and patient satisfactions scores were not normally distributed. We have edited our methods and have adjusted our analysis using the appropriate statistical tests. Our analytic plan did not include adjustment for

multiple comparisons thus these results should be interpreted with caution. We have adjusted the methods and results to reflect these changes and to address the above mentioned limitations (line 193-200, 246-251, 306-310, Table 2).

EDITORIAL OFFICE COMMENTS:

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

1. OPT-IN: Yes, please publish my response letter and subsequent email correspondence related to author queries. -
2. OPT-OUT: No, please do not publish my response letter and subsequent email correspondence related to author queries.

3. Clinical trials submitted to the journal as of July 1, 2018, must include a data sharing statement. The statement should indicate 1) whether individual deidentified participant data (including data dictionaries) will be shared; 2) what data in particular will be shared; 3) whether additional, related documents will be available (eg, study protocol, statistical analysis plan, etc.); 4) when the data will become available and for how long; and 5) by what access criteria data will be shared (including with whom, for what types of analyses, and by what mechanism). Responses to the five bullet points should be provided in a box at the end of the Methods section.

See box between line 203-204.

6. Because of space limitations, it is important that your revised manuscript adhere to the following length restrictions by manuscript type: Original Research reports should not exceed 22 typed, double-spaced pages (5,500 words). Stated page limits include all numbered pages in a manuscript (i.e., title page, précis, abstract, text, references, tables, boxes, figure legends, and print appendixes) but exclude references.

We have confirmed that our revised manuscript meets the word limit requirements.

8. The most common deficiency in revised manuscripts involves the abstract. Be sure there are no inconsistencies between the Abstract and the manuscript, and that the Abstract has a clear conclusion statement based on the results found in the paper. Make sure that the abstract does not contain information that does not appear in the body text. If you submit a revision, please check the abstract carefully.

In addition, the abstract length should follow journal guidelines. The word limits for different article types are as follows: Original Research articles, 300 words. Please provide a word count. Our abstract word count currently is 296.

14. The Journal's Production Editor had the following to say about the figures in your manuscript:

"Figure 1: need to upload into Editorial Manager as a separate file; also, please add a figure legend to your manuscript." Thank you. We have added a figure legend to lines 465-466 and will upload a separate file for the figure.

We thank you again for your thoughtful insights into our manuscript, and sincerely hope that you will find the revised version acceptable for publication. We would be thrilled to share our findings in Obstetrics *& Gynecology*.

Sincerely,

Lena Braginsky, MD
NorthShore University HealthSystem, an academic affiliate of the University of Chicago
Maternal-Fetal Medicine Fellow

Daniel Mosier

From: Lena B [redacted]
Sent: Sunday, May 5, 2019 2:50 PM
To: Daniel Mosier
Subject: Re: Manuscript Revisions: ONG-19-462R1
Attachments: 19-462R1 ms (5-1-19v2).docx

Hi Daniel,

Thank you so much for your work and attention on our manuscript. Attached are the requested edits with tracked changes (I did not rename the file). Below are also the responses to your questions.

1. Please note the minor edits and deletions throughout. Please let us know if you disagree with any of these changes.
   - Looks great, thank you!
2. Is the email address on the title page correct? According to our records, we have your address as [redacted]
   - I have changed the contact email in the paper to [redacted] since I will be leaving NorthShore at the completion of my fellowship this June. We can keep my journal account email as [redacted] if that's okay.
3. LINE 72: This statement is not consistent with the wording on page 11: "we estimated that 864 participants would be required." Please edit as needed
   - Thank you for pointing this out, we have adjusted accordingly
4. LINE 74: Please explain decision to stop here and not in Results
   - Done
5. LINE 78: Please RRs and 95 % CIs instead of P values here and throughout. Also, why ORs instead of relative risks?
   - We have changed the analysis to include RR instead of OR and have removed P values where RR is reported
6. LINE 221: Same comment as in Abstract
7. LINE 243: Although apparently statistically significantly different, they don't seem clinically so
8. LINE 259: Since these are non-obstetric studies, please shorten by half and use causal language to describe only randomized studies
   - Adjustments made. Only one non-obstetric RCT compared tissue adhesive on top of sutures for skin versus standard surgical dressing (others were prospective non randomized studies or retrospective design). The rest of the RCTs in the non obstetric population involve the use of glue instead of sutures, which is not as relevant to our study.

Please let me know if there is anything else that needs to be addressed, and thank you again!

Lena

On Thu, May 2, 2019 at 1:58 PM Daniel Mosier <dmosier@greenjournal.org> wrote:

> Dear Dr. Braginsky,

Thank you for submitting your revised manuscript. It has been reviewed by the editor, and there are a few issues that must be addressed before we can consider your manuscript further:

1. Please note the minor edits and deletions throughout. Please let us know if you disagree with any of these changes.

2. Is the email address on the title page correct? According to our records, we have your address as [redacted]

3. LINE 72: This statement is not consistent with the wording on page 11: “we estimated that 864 participants would be required.” Please edit as needed.

4. LINE 74: Please explain decision to stop here and not in Results

5. LINE 78: Please RRs and 95 % CIs instead of P values here and throughout. Also, why ORs instead of relative risks?

6. LINE 221: Same comment as in Abstract

7. LINE 243: Although apparently statistically significantly different, they don't seem clinically so

8. LINE 259: Since these are non-obstetric studies, please shorten by half and use causal language to describe only randomized studies

When revising, use the attached version of the manuscript. Leave the track changes on, and do not use the “Accept all Changes”

Please let me know if you have any questions. Your prompt response to these queries will be appreciated; please respond no later than COB on **Monday, May 6th.**

Sincerely,

-Daniel Mosier

Daniel Mosier

Editorial Assistant

Obstetrics & Gynecology

From: [redacted]
To: Denise Shields
Subject: Re: figure in your Green Journal manuscript (19-462R1)
Date: Wednesday, May 1, 2019 2:55:15 PM

Hi Denise,

Huge thank you to you for editing this figure for me - I think it looks great! All of the numbers are accurate and it is good to go.

Very much appreciate your work on this!

Lena

On Wed, May 1, 2019 at 11:40 AM Denise Shields <DShields@greenjournal.org> wrote:

> Re: “Tissue Adhesive Compared With Sterile Strips After Cesarean Delivery: A Randomized Controlled Trial”
>
> Dear Dr. Braginsky,
>
> Your figure has been edited and is attached for your review. Please review the attachments CAREFULLY for any mistakes.
>
> PLEASE NOTE: Any changes to the figure must be made now. Changes made at later stages are expensive and time-consuming and may result in the delay of your article’s publication.
>
> To avoid a delay, I would appreciate a reply no later than Friday, 5/3. Thank you for your help.
>
> Best,
>
> Denise
>
> Denise Shields
>
> Senior Manuscript Editor

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