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-19-731

The association of labor with neonatal respiratory outcomes at 36-40 weeks gestation

Dear Dr. Plunkett:

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 28, 2019, we will assume you wish to withdraw the manuscript from further consideration.

REVIEWER COMMENTS:

Reviewer #1: The Association of Labor with Neonatal Respiratory Outcomes at 36 to 40 weeks Gestation, is a retrospective study of the APEX study examining composite neonatal respiratory morbidity in women who were exposed to labor and those were not exposed to labor. The authors also look at the association between labor and maternal diabetic status and labor and gestational age. This paper does not compare actual route of delivery.

Abstract is well written with clear objectives, methods and results.

Introduction is clear. Objectives and hypothesis are clearly stated.

Materials and Methods

1- Lines 154: why was this definition of labor used? ACOG’s reVITALize definition is: Uterine contractions resulting in cervical change (dilation and/or effacement). Was cervical change information available? This would significantly add to the paper as one of the main limitations is length of labor exposure (see discussion comments below)

2- Line 155: Why was TTN not included in the composite neonatal respiratory morbidity?

3- Lines 220: For the women with diabetes, how many women were treated with insulin therapy? Is there an association between labor and neonatal resp morbidity who were pregestational DM (these women would be more likely to have increased risk of neonatal morbidity/adverse pregnancy outcomes compared to women with GDM, specifically those without insulin).

Discussion

4- Lines 278: While the authors state the limitation that length of labor as related to neonatal respiratory morbidity is not available, this is a major flaw in the study. For example, based on the author’s definition of labor, a woman may have been induced with cytotec with painful contractions for 1 hour and then had a CD while other women may have presented with SROM and progressed in labor without augmentation resulting in 18 hours of labor and NSVD. These women, in this study would be considered both being exposed to labor however these "labors" are extremely different. It would be helpful if the author's were able to use ACOG reVITALize definition of labor to confirm cervical change.

5- Lines 291: the author's conclude this study will assist with route of delivery counseling, however it is not applicable to study. Would omit this and state trial of labor.
Reviewer #2: A secondary analysis of women in the Assessment of Perinatal Excellence obstetric cohort who delivered across 25 US hospitals over a 3-year period. Objective is to evaluate whether labor between 36-40 weeks is associated with a lower odds of respiratory morbidity and to assess if the association with labor varies by gestational age and by maternal diabetes. Singleton deliveries from 36 - 40 weeks gestation were included in the analysis. Interactions between labor and diabetes mellitus and labor and gestational age were tested.

Objective is well stated and consistent: a composite respiratory morbidity

Causes for respiratory distress at term look different than preterm: Transient tachypnoea of the newborn, Respiratory distress syndrome, Meconium aspiration, Primary or secondary persistent pulmonary hypertension of the newborn, Pneumonia, Pneumothorax. I'm certain there are more diagnosis. These are all reasons for the need for Oxygen or CPAP or ventilation. Also a a depressed baby with acidosis. This is not an exclusion criteria and yet I see no mention of APGARS or PH or HIE or any other diagnosis that could be the cause of ventilation or CPAP. Some of these babies were likely on a cooling protocol? Can you comment on this?

Did the reason for delivery each week look different?

Can you describe reasons for delivery/ labor at 36, 37, 38 weeks? Were the infants different weights at 36,37,38 between groups. Example you state why ALL women had a cesarean in those that started with Labor but there is no information by week.

Maternal and neonatal characteristics are clearly different between the Labor and No Labor groups. I think a table much like Table 3 with more detail about maternal and neonatal characteristics by gestational age week. Example was IUGR and placental cord abnormalities more prevalent at 36,37 weeks and those that were more severe delivered by cesarean? Please comment.

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1. Introduction - very clear introduction and study objective - clinically relevant question and appropriate hypothesis

2. Line 237-240 - I appreciate the authors pointing out that the absolute difference in their primary composite outcome was only 1%.

3. Line 279-282 - I was left wondering how much further study is actually needed regarding the mechanistic underpinnings for the 1% difference that was found and how providers will incorporate the small difference in a composite measure into their patient counseling (Line290-293).

4. Figure 1 - APEX population - would replace "N" with "n" to be consistent with the rest of the figure

5. Figure 1 - The first exclusion box 0 would replace "Exclusion" with "Exclusions" given there are multiple things listed and to be consistent with your 3rd and 4th exclusion box

STATISTICAL EDITOR'S COMMENTS:

1. lines 91-93 and 96-97: Wouldn't it be less confusing to change line 91-93 to something like "each one week decrease in GA from 40 weeks was associated with a 17% (insert CIs) decrease in odds of adverse respiratory outcome, when comparing labor to non-labor". That would seem more consistent with Fig 2 which shows NS difference in labor vs non-labor at 40 wks, but a step-wise decrease in adverse respiratory outcome comparing labor to non-labor as the GA decreases. As presently written, the lowest aOR is at 36 weeks and progressively increases to approach non-random difference at 40 weeks. The increase from a low level may be confusing to some readers, rather than stating the change with respect to a referent at 40 weeks, where there was apparently no significant difference in outcomes for labor vs non-labor.

2. lines 83-84 and 97-98: See later comments re: power analysis for interaction with DM status.

3. lines 138-139: Since the deliveries were over a three year period, were there any women who had more than one delivery? If so, how was the analysis adjusted? Those instances would have some correlation of outcomes and would have to either be randomly selected to just one event per woman or adjusted for correlation, thus lowering the actual or effective sample sizes.
4. lines 177-178 and Table 2: Since the inference threshold was $p < .05$, rather than $p \leq .05$, should indicate in Table 2 whether the hypothesis was rejected or accepted for the difference in duration of ventilatory support. The NS differences in ventilator support (as a binary variable) or in neonatal deaths cannot be generalized due to low counts and low stats power.

5. lines 173-176, Table 3 and Fig 2: Should either expand Table 3 or include another table with both crude and adjusted ORs. The counts of adverse events for 40 week cohort is too few to allow for multiple adjustment with 7 adjustors. Likewise, for that GA stratum, there is low power to discern interaction terms. Should provide (could be in supplemental), the breakdown of DM vs non DM by GA, labor vs non-labor and composite outcome. There may be insufficient power to evaluate interaction terms of DM vs labor status and composite outcome for some of the other GAs, as well. Also, was parity included as potential adjustor in the multivariable model? The difference in frequency of nulliparous is striking.

6. Suggest including sensitivity analysis for the subset of labor cohort who then underwent CD. Were there differences in composite adverse respiratory risk for that group compared to labor without CD? Could be in supplemental if not contributory.

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 tasks 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. Responsible reporting of research studies, which includes a complete, transparent, accurate and timely account of what was done and what was found during a research study, is an integral part of good research and publication practice and not an optional extra. Obstetrics & Gynecology supports initiatives aimed at improving the reporting of health research, and we ask authors to follow specific guidelines for reporting randomized controlled trials (ie, CONSORT), observational studies (ie, STROBE), meta-analyses and systematic reviews of randomized controlled trials (ie, PRISMA), harms in systematic reviews (ie, PRISMA for harms), studies of diagnostic accuracy (ie, STARD), meta-analyses and systematic reviews of observational studies (ie, MOOSE), economic evaluations of health interventions (ie, CHEERS), quality improvement in health care studies (ie, SQUIRE 2.0), and studies reporting results of Internet e-surveys (CHERRIES). Include the appropriate checklist for your manuscript type upon submission. Please write or insert the page numbers where each item appears in the margin of the checklist. Further information and links to the checklists are available at http://ong.editorialmanager.com. In your cover letter, be sure to indicate that you have followed the CONSORT, MOOSE, PRISMA, PRISMA for harms, STAR, STROBE, CHEERS, SQUIRE 2.0, or CHERRIES guidelines, as appropriate.

4. 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.

5. 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.

6. 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).

7. 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.

8. 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.

9. 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.

10. 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.

11. The Journal's Production Editor has the following comments on the figures in your manuscript:

"Figures need to be uploaded as separate files into Editorial Manager with your revision (Figures 1 and 2)"

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.

12. 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 http://edmgr.ovid.com/acd/accounts/ifauth.htm.

Please note that if your article is accepted, you will receive an email from the editorial office asking you to choose a publication route (traditional or open access). Please keep an eye out for that future email and be sure to respond to it promptly.

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If you choose to revise your manuscript, please submit your revision 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 28, 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 if you have any questions.
May 23, 2019

Dear Editors:

Thank you for the thoughtful review of our manuscript. Please find our responses to each of the reviewer comments detailed below in italics. STROBE guidelines were followed for this observational cohort study. The checklist is attached below. Page numbers listed within the checklist refer to those found in the version of the manuscript without track-changes (“clean copy”).

Sincerely,

The Authors

REVIEWER COMMENTS:

Reviewer #1: The Association of Labor with Neonatal Respiratory Outcomes at 36 to 40 weeks Gestation, is a retrospective study of the APEX study examining composite neonatal respiratory morbidity in women who were exposed to labor and those were not exposed to labor. The authors also look at the association between labor and maternal diabetic status and labor and gestational age. This paper does not compare actual route of delivery.

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1- Lines 154: why was this definition of labor used? ACOG’s reVITALize definition is: Uterine contractions resulting in cervical change (dilation and/or effacement). Was cervical change information available? This would significantly add to the paper as one of the main limitations is length of labor exposure (see discussion comments below)

Thank you for your comment. Unfortunately, cervical change information is not available for all women who presented with painful uterine contractions. APEX data were collected between 2008 and 2011, prior to the 2014 to posting of the reVITALize definitions. The methods were clarified accordingly to read, “Labor was defined in the original APEX data set as painful regular uterine contractions.” (Lines 153-4).

2- Line 155: Why was TTN not included in the composite neonatal respiratory morbidity?

We had 2 reasons for not including TTN. 1.) We opted to focus on more severe morbidities (those that required respiratory support) and 2)In the original data set the diagnosis criteria for TTN included “possible TTN” and we did not feel these criteria were sufficiently robust to include in our analysis.

3- Lines 220: For the women with diabetes, how many women were treated with insulin therapy? Is there an association between labor and neonatal resp morbidity who were
pregestational DM (these women would be more likely to have increased risk of neonatal morbidity/adverse pregnancy outcomes compared to women with GDM, specifically those without insulin).

Unfortunately, we do not have additional information on diabetic women. The original data set did not include data regarding the medical management or glycemic control for these women. We added this point in the limitations section as follows: “Similarly, we do not have additional data regarding glycemic control in women with gestational or pregestational diabetes and could not assess the association between diabetic management and neonatal respiratory outcomes.”

Discussion

4- Lines 278: While the authors state the limitation that length of labor as related to neonatal respiratory morbidity is not available, this is a major flaw in the study. For example, based on the author's definition of labor, a woman may have been induced with cytotec with painful contractions for 1 hour and then had a CD while other women may have presented with SROM and progressed in labor without augmentation resulting in 18 hours of labor and NSVD. These women, in this study would be considered both being exposed to labor however these "labors" are extremely different. It would be helpful if the author's were able to use ACOG reVITALize definition of labor to confirm cervical change.

Thank you for your thoughtful comment. Please see response to 1 above. As noted by the reviewer, the limitation is acknowledged. Although a separate sub-group analysis to evaluate whether there is an association between duration of labor and neonatal respiratory outcome is certainly of interest, its absence does not detract from the conclusions of the study that the results of this analysis can contribute to the discussion of the potential benefits of a trial of labor.

5- Lines 291: the author's conclude this study will assist with route of delivery counseling, however it is not applicable to study. Would omit this and state trial of labor.

Thank you. The edit has been made.

Reviewer #2: A secondary analysis of women in the Assessment of Perinatal Excellence obstetric cohort who delivered across 25 US hospitals over a 3-year period. Objective is to evaluate whether labor between 36-40 weeks is associated with a lower odds of respiratory morbidity and to assess if the association with labor varies by gestational age and by maternal diabetes. Singletons delivered from 36 - 40 weeks gestation were included in the analysis. Interactions between labor and diabetes mellitus and labor and gestational age were tested

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diagnosis that could be the cause of ventilation or CPAP. Some of these babies were likely on a cooling protocol? Can you comment on this?

Thank you for your thoughtful comment. We agree that there are additional clinical circumstances (low APGARS, low pH, HI, cooling protocol) that may impact neonatal respiratory outcomes. However, since these factors are along the causal pathway for poor respiratory outcomes we are unable to statistically adjust for these events. They cannot be included in the model.

Did the reason for delivery each week look different?

Yes. We have included a frequency table by indication for cesarean delivery in those women who experienced labor as compared to those who did not. We submit this table for consideration for inclusion as a supplemental table.

Can you describe reasons for delivery/ labor at 36, 37, 38 weeks? Were the infants different weights at 36,37,38 between groups.(You just give an overall weight). Example you state why ALL women had a cesarean in those that started with Labor but there is no information by week.

See previous response regarding the first comment. We have also submitted a table with birth weight by gestational age that could also be considered for inclusion as a supplemental table.

Maternal and neonatal characteristics are clearly different between the Labor and No Labor groups. I think a table much like Table 3 with more detail about maternal and neonatal characteristics by gestational age week. Example was IUGR and placental cord abnormalities more prevalent at 36,37 weeks and those that were more severe delivered by cesarean? Please comment.

Thank you for your comment. We believe detailing the clinical characteristics by week is interesting but becomes cumbersome when all possible maternal and fetal/neonatal characteristics are included. As suggested above, we have compiled a frequency table of indications for cesarean delivery from which much of the above information can be inferred.

Reviewer #3: Plunkett et al provide us with a secondary analysis of the Assessment of Perinatal Excellence obstetric cohort to evaluate if labor is associated with lower odds of respiratory morbidity among neonates born between 36 and 40 weeks. The data was collected from over 25 hospitals over a 3-year period and included 63,187 women who underwent labor and 10,629 who did not. The study objective was very clear and they were able to answer their objective with the database though a limitation, as the authors point out, is not having information related to the length of labor.

1. Introduction - very clear introduction and study objective - clinically relevant question and appropriate hypothesis

2. Line 237-240 - I appreciate the authors pointing out that the absolute difference in their primary composite outcome was only 1%.

3. Line 279-282 - I was left wondering how much further study is actually needed regarding the mechanistic underpinnings for the 1% difference that was found and how providers will incorporate the small difference in a composite measure into their patient counseling (Line290-293).
Thank you for your comment. Although the absolute risk reduction is indeed small (1%), the lower odds of neonatal respiratory morbidity remain significant and could be incorporated into patient counseling accordingly.

4. Figure 1 - APEX population - would replace "N" with "n" to be consistent with the rest of the figure.

Thank you. The edit has been made.

5. Figure 1 - The first exclusion box 0 would replace "Exclusion" with "Exclusions" given there are multiple things listed and to be consistent with your 3rd and 4th exclusion box.

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STATISTICAL EDITOR'S COMMENTS:

1. lines 91-93 and 96-97: Wouldn't it be less confusing to change line 91-93 to something like "each one week decrease in GA from 40 weeks was associated with a 17% (insert CIs) decrease in odds of adverse respiratory outcome, when comparing labor to non-labor". That would seem more consistent with Fig 2 which shows NS difference in labor vs non-labor at 40 wks, but a step-wise decrease in adverse respiratory outcome comparing labor to non-labor as the GA decreases. As presently written, the lowest aOR is at 36 weeks and progressively increases to approach non-random difference at 40 weeks. The increase from a low level may be confusing to some readers, rather than stating the change with respect to a referent at 40 weeks, where there was apparently no significant difference in outcomes for labor vs non-labor.

Thank you for your thoughtful comments. We respectfully disagree and believe that the readership (primarily individuals who practice obstetrics) will be accustomed to evaluating pregnancy as a progression from earlier to later gestational age and that the current phrasing will be more readily understood.

2. lines 83-84 and 97-98: See later comments re: power analysis for interaction with DM status.

3. lines 138-139: Since the deliveries were over a three year period, were there any women who had more than one delivery? If so, how was the analysis adjusted? Those instances would have some correlation of outcomes and would have to either be randomly selected to just one event per woman or adjusted for correlation, thus lowering the actual or effective sample sizes.

Thank you for your comment. Unfortunately, the original data set did not include this information. I suspect the likelihood that a multiparous patient delivered on one of the randomly selected days in which data abstraction occurred over a 3-year period is low, however, we do not have the data available to confirm.

4. lines 177-178 and Table 2: Since the inference threshold was p < .05, rather than p ≤ .05, should indicate in Table 2 whether the hypothesis was rejected or accepted for the difference in duration of ventilatory support. The NS differences in ventilator support
as a binary variable) or in neonatal deaths cannot be generalized due to low counts and low stats power.

Thank you for your comment. The statistical significance is stated in the methods as <0.05 thus the P-value of 0.05 was not considered statistically significant. Please see Line 215-218 which states, “Neonates of women who labored and who did not labor were similar with regard to the need for ventilator support (0.5% versus 0.6%, P=0.10) and the duration of ventilator support for those neonates who required mechanical ventilation (median: 1 day versus 2 days, P=0.05).”

5. lines 173-176, Table 3 and Fig 2: Should either expand Table 3 or include another table with both crude and adjusted ORs. The counts of adverse events for 40 week cohort is too few to allow for multiple adjustment with 7 adjustors. Likewise, for that GA stratum, there is low power to discern interaction terms. Should provide (could be in supplemental), the breakdown of DM vs non DM by GA, labor vs non-labor and composite outcome. There may be insufficient power to evaluate interaction terms of DM vs labor status and composite outcome for some of the other GAs, as well. Also, was parity included as potential adjustor in the multivariable model? The difference in frequency of nulliparous is striking.

Thank you for your comment. Table 3 has been edited as suggested. We have created frequency tables by gestational age and diabetic status that could be considered for inclusion as supplemental tables. Regarding power, since categorical variables provide less power, our analysis included GA at delivery as a continuous variable and the interaction between GA (as a continuous value) and labor was assessed. The trend in the odds ratios over increasing GA is consistent with decreasing strength of association and an association towards the null at 40 weeks. Additionally, covariates in our model were all significant and (as shown in the updated Table) the unadjusted and adjusted estimates of the odds ratio were similar. Parity was not included in the model. The covariates in the model were selected a priori to adjust for potential confounders. Parity is different in the groups because only women with prior children have repeat cesarean delivery. Neither parity itself (nor prior cesarean delivery), however, should affect a potential association between labor and neonatal respiratory outcomes and as such was not included in the model.

6. Suggest including sensitivity analysis for the subset of labor cohort who then underwent CD. Were there differences in composite adverse respiratory risk for that group compared to labor without CD? Could be in supplemental if not contributory.

Thank you for your comment. We respectfully disagree with the reviewer. The objective of this analysis is to determine whether labor has an independent association with the neonatal respiratory outcomes. Please see Lines 268-271. Unfortunately, it is not possible to adjust for route of delivery or stratify by route of delivery as it falls along the causal pathway between our exposure (labor) and outcome (neonatal respiratory morbidity).

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. 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. Responsible reporting of research studies, which includes a complete, transparent, accurate and timely account of what was done and what was found during a research study, is an integral part of good research and publication practice and not an optional extra. Obstetrics & Gynecology supports initiatives aimed at improving the reporting of health research, and we ask authors to follow specific guidelines for reporting randomized controlled trials (ie, CONSORT), observational studies (ie, STROBE), meta-analyses and systematic reviews of randomized controlled trials (ie, PRISMA), harms in systematic reviews (ie, PRISMA for harms), studies of diagnostic accuracy (ie, STARD), meta-analyses and systematic reviews of observational studies (ie, MOOSE), economic evaluations of health interventions (ie, CHEERS), quality improvement in health care studies (ie, SQUIRE 2.0), and studies reporting results of Internet e-surveys (CHERRIES). Include the appropriate checklist for your manuscript type upon submission. Please write or insert the page numbers where each item appears in the margin of the checklist. Further information and links to the checklists are available at http://ong.editorialmanager.com. In your cover letter, be sure to indicate that you have followed the CONSORT, MOOSE, PRISMA, PRISMA for harms, STARD, STROBE, CHEERS, SQUIRE 2.0, or CHERRIES guidelines, as appropriate.

4. 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.

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6. Specific rules govern the use of acknowledgments in the journal. Please note the following guidelines:
* All financial support of the study must be acknowledged.
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