Major Corrections

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Major Corrections To:

Perinatal Outcomes of High-Risk Pregnancies: Experience of a Tertiary Care Hospital

Saima Ghaffar[1*], Shahla Channa[1], Saira Dars[1], Shafia Khan[2], Farah Liaquat[3] and Hanozia Shah[4]

[1]Department of Obstetrics and Gynaecology, Liaquat University of Medical and Health Sciences (LUMHS), Jamshoro, Pakistan
[2]Department of Obstetrics and Gynaecology, Ibn-e-Sina University, Mirpurkhas, Pakistan
[3]Department of Obstetrics and Gynaecology, Baqai Medical University (BMU), Karachi, Pakistan
[4]Bilawal Medical College, Liaquat University of Medical and Health Sciences (LUMHS), Jamshoro, Pakistan

***Corresponding Author:**
Saima Ghaffar
Department of Obstetrics and Gynaecology, Liaquat University of Medical and Health Sciences (LUMHS), Jamshoro, Pakistan
saimaghaffararain@yahoo.co.uk

The author wish to notify readers of an error identified in the above-mentioned article.

Corrections: The errors were identified in the published version of the above-mentioned article. The affected information is corrected as follows:

1. Methods section — Sampling Method, Lines 44-46

Error Identified: The manuscript uses the term "continent sampling," which appears to be a typographical error for "convenience sampling." This non-probability method introduces significant selection bias, and without proper justification, the findings cannot be generalized to the broader population of high-risk pregnant women.

Incorrect Version: It was conducted upon 213 high-risk pregnant women, chosen via continent sampling who attended the antenatal clinic Liaquat University Hospital, Hyderabad and Jamshoro."(Lines 44-46)

Correct Version: "This longitudinal study was conducted over two years (October 2020 to December 2022) at the antenatal clinics of Liaquat University Hospital, Hyderabad and Jamshoro, Pakistan, involving 213 high-risk pregnant women aged 15-45 years recruited via convenience sampling from those attending the antenatal clinics." "Continent sampling" has been corrected to "convenience sampling" throughout, and the non-probability, single-site nature of the sample is now stated as a limitation.

2. Methods section — Inclusion/Exclusion Criteria, Lines 46-49

Error Identified: The inclusion criteria are clinically imprecise, using terms like "difficult delivery" and "those conditions were still present" without specific definitions. This lack of clarity makes it impossible for other researchers to replicate the study or understand the exact population being studied.

Incorrect Version: "All those women who had either past miscarriages or difficult delivery due to medical conditions and those conditions were still present among the women were included in the study while those who lost the antenatal follow up, were excluded from the study."(Lines 46-49)

Correct Version: "Inclusion criteria required the presence of at least one current or past high-risk factor, with specific operational definitions established a priori: severe anemia (hemoglobin <7 g/dL), pregnancy-induced hypertension (systolic BP ≥140 mmHg and/or diastolic BP ≥90 mmHg on two separate occasions), teenage pregnancy (<19 years), short stature (<145 cm), obesity (BMI ≥30 kg/m^2), Rh-negative status, and grand multigravida (parity ≥5). while exclusion criteria included incomplete antenatal follow-up until delivery or declined informed consent."

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3. Methods and Results sections — Operational Definitions of Risk Factors, Line 74 and Lines 81-82

Error Identified: Key risk factors such as "short stature," "severe anemia," "obesity," and "teenage pregnancy" are not defined using standardized cutoffs (e.g., specific hemoglobin levels, height, or BMI). Without these definitions, the results cannot be compared with other studies or properly interpreted.

Incorrect Version: "Girls were categorized into obese and non-obese on the basis of BMI." (Line 74) and "severe anemia was found in 21 women (9.8%), Pregnancy Induced Hypertension (PIH) in 18 women (8.6%), and obesity was also seen in 18 women (8.6%)."(Lines 81-82) — no cut-off values are given for any risk factor.

Correct Version: "Severe anemia (defined as hemoglobin <7 g/dL) was found in 21 women (9.8%), Pregnancy Induced Hypertension (PIH; defined as systolic BP ≥140 mmHg and/or diastolic BP ≥90 mmHg on two separate occasions at least 4 hours apart) in 18 women (8.6%), and obesity (defined as BMI ≥30 kg/m^2) was also seen in 18 women (8.6%). Other risk factors were defined as follows: teenage pregnancy (age <19 years), short stature (height <145 cm), and grand multigravida (parity ≥5)."

4. Methods section — Data Collection Methods, Lines 61-65

Error Identified: The methodology does not specify who collected the data, what training they received, what validated questionnaire was used, or how laboratory tests and clinical assessments (e.g., blood pressure, fetal anomalies) were performed. This lack of detail prevents assessment of the study's quality and reproducibility.

Incorrect Version: "We collected data by using a set of questions that had been checked and approved beforehand. Before asking these questions, we made sure to get written permission from the people taking part. Every visit encompassed a through antenatal and physical examination and requisite laboratory tests."(Lines 61-65)

Correct Version: "Data were collected using a structured, pre-tested questionnaire developed in English and translated into Urdu and Sindhi, piloted on 20 women for clarity, and content-validated by three senior obstetricians. Four trained research assistants with nursing or medical backgrounds underwent a 2-day training program on study objectives, questionnaire administration, ethical conduct, and data recording, achieving strong inter-rater reliability (Cohen's kappa >0.80). Monthly visits involved standardized clinical assessments including blood pressure measurement using a calibrated mercury sphygmomanometer, weight and BMI calculation, urine protein analysis, complete blood count for hemoglobin, blood group and Rh typing, thyroid function tests when clinically indicated, and obstetric ultrasound performed by qualified radiologists for fetal evaluation."

5. Results section — Missing Participant Demographics, before Line 77

Error Identified: Basic demographic information such as mean age, educational level, socioeconomic status, residence, and parity is not reported. These data are essential for understanding the study population and evaluating the generalizability of the findings.

Incorrect Version: The Results section (Line 77 onward) proceeds directly to risk-factor frequencies, with no preceding demographic summary of the 213 participants.

Correct Version: A new Table 1("Demographic Characteristics of Study Participants") has been added, reporting age distribution (mean age 26.7 ± 5.4 years), educational level, urban/rural residence, socioeconomic status, and parity for the study cohort.

6. Methods section — Longitudinal Follow-up, Lines 55-56

Error Identified: Although the study states participants were tracked monthly, it does not describe what assessments were performed at each visit, how many visits were completed, or what proportion of participants were lost to follow-up. These omissions undermine the validity of the longitudinal design.

Incorrect Version: "These women were tracked on a monthly basis until their delivery to scrutinize the unfolding of their pregnancies and the resulting perinatal outcomes."(Lines 55-56)

Correct Version: "Monthly visits (at 4-week intervals) involved standardized clinical assessments including blood pressure measurement and obstetric ultrasound for fetal evaluation, with participants scheduled for 5–8 visits depending on gestational age at enrollment. Of the 250 women initially approached, 213 (85.2%) completed follow-up, with 37 lost to transfer, withdrawal, or attrition."

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7. Methods and Results sections — Statistical Analysis, Lines 67-69

Error Identified: The authors mention using the Chi-square test, but they do not specify which variables were compared, present any p-values, confidence intervals, or describe multivariate analysis. The absence of actual statistical results makes it impossible to assess whether the findings are significant.

Incorrect Version: "The data were analyzed using SPSS (V21.0). Chi-square test was utilized for the statistical analysis, with a p-value <0.05 considered significant at a confidence interval of 95%." (Lines 67-69). No comparison variables, p-values, or effect sizes are reported anywhere in Results.

Correct Version: "Univariate analysis using the Chi-square test (or Fisher's exact test where expected cell counts were <5) evaluated associations between individual risk factors and adverse fetal outcomes, with p<0.05 considered significant and odds ratios reported with 95% confidence intervals. Although multivariate logistic regression was planned...it could not be reliably performed due to the limited sample size (n=213) and the occurrence of only 43 adverse events..." A new Table 4 ("Association Between Risk Factors and Adverse Fetal Outcomes") now reports p-values and odds ratios (95% CI) for each risk factor.

8. Methods section — Outcome Assessment Timing, Lines 66-67

Error Identified: Perinatal outcomes were evaluated on the 8th day post-delivery, but no rationale is provided for choosing this specific time point. The authors also fail to describe who assessed the outcomes or whether they were blinded to the risk factors.

Incorrect Version: "Perinatal outcomes were evaluated on the 8th day post-delivery, during which details concerning maternal and fetal complications in terms of morbidity and mortality, were documented." (Lines 66-67)

Correct Version: "Perinatal outcomes were assessed on the 8th day post-delivery, selected per the hospital's routine postnatal discharge protocol and to capture early neonatal complications such as respiratory distress, jaundice, and sepsis, as well as early neonatal deaths which are most common in the first week of life. An attending obstetrician blinded to participants' antenatal risk status evaluated outcomes by reviewing newborn medical records."

9. Introduction section — Citation of References 1 and 2, Line 23

Error Identified: Both references discuss "portal hypertension" and are published in hepatology journals. They have no relevance to high-risk pregnancy definitions or perinatal outcomes and suggest careless citation management.

Incorrect Version: "Factors such as maternal age, pre-existing medical conditions, multiple pregnancies, and issues identified during pregnancy often contribute to a high-risk categorization [1, 2]." (Line 23). Reference list items 1–2: Mauro and Gadano, "What's new in portal hypertension?" and López-Méndez and Ávila-Escobedo, "Pregnancy and portal hypertension: a pathology view of physiologic changes.

Correct Version: References 1 and 2 should be replaced with sources that actually describe the established clinical criteria for classifying a pregnancy as high-risk (e.g., ACOG practice guidance or a WHO risk-classification reference). The portal-hypertension papers remain uncorrected in the reviewed manuscript and should be removed from this citation.

10. Introduction section — Citation of Reference 6, Lines 33-34

Error Identified: Reference 6 is cited to support a statement about healthcare challenges in Hyderabad, but the actual reference concerns "local climate zones" and "urban resilience" in Lahore. The citation is unrelated to the claim it is meant to support.

Incorrect Version: "...faces many healthcare problems like the rest of Pakistan. One big problem is that there isn't enough good information and plans to deal with high-risk pregnancies [6]." (Lines 33-34) — Reference 6: Aslam, Rana and Bhatti, "Local climate zones and its potential for building urban resilience: a case study of Lahore, Pakistan."

Correct Version: "A significant concern is the limited availability of comprehensive data and systematic strategies to manage high-risk pregnancies [6]." The wording has been revised, but reference 6 is still the Lahore urban-climate-resilience paper; a source specific to maternal healthcare data or antenatal-care infrastructure in Hyderabad/Pakistan should replace it.

11. Discussion section — Citation of Reference 17, Line 123

Error Identified: The text cites reference [17] alongside [16] to support a claim about the quality and accessibility of antenatal care, but reference-list entry 17 concerns portal hypertension in pregnancy, not antenatal care access. This is a citation-management error that needs correction.

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Incorrect Version: "...we need to look more closely at how good and easy it is for pregnant women to get care before they give birth [16, 17]." (Line 123) — Reference 17: Gala, Surapaneni, Aziz and Kallur, "A review of outcomes in pregnant women with portal hypertension.

"Correct Version: The citation [17] should be removed from this sentence, and reference 17 should either be replaced with a source on antenatal-care quality/accessibility or cited only where portal hypertension is actually discussed.

12. Introduction section — Citation of Reference 3, Line 26 (correction already applied — recorded for completeness)

Error Identified: In an earlier draft, reference 3 was a paper on pregnancy outcomes in women with cirrhosis, cited to support a general statement about high-risk-pregnancy management in developing nations; the reference did not support the specific claim being made.

Incorrect Version: Earlier draft citation [3] pointed to a study of pregnancy outcomes in cirrhosis (original submission, Line 26).

Correct Version: Reference 3 has since been corrected to Alkema et al., "Global, Regional and National Levels and Trends in Maternal Mortalit." (The Lancet, 2016), which appropriately supports the statement about maternal-mortality burden in developing nations. No further action is required for this citation; the correction is recorded here for the errata trail.

13. Introduction section — Citation of Reference 4 for MMR Data, Line 30

Error Identified: Reference 4 is a 2009 publication (Khan *et al.*) cited for Pakistan's Maternal Mortality Ratio. The reported MMR figure was subsequently updated to a more recent estimate, but the citation was not updated to a current source; a 15-year-old reference for a current statistic remains inappropriate.

Incorrect Version: "The Maternal Mortality Ratio (MMR) in the country is high at 276 deaths per 100,000 births each year [4]." (Line 30) — Reference 4: Khan, Bhutta, Munim and Bhutta, "Maternal health and survival in Pakistan: issues and options" (2009).

Correct Version: "According to the most recent estimates, the Maternal Mortality Ratio (MMR) in Pakistan is 186 deaths per 100,000 live births [4]...Previous estimates from 2009 suggested a higher ratio of 276 per 100,000, highlighting progress in maternal health over the past decade." The updated 186/100,000 figure should be attributed to a current source (e.g., the most recent Pakistan Demographic and Health Survey or WHO estimate); reference 4 still points to the 2009 Khan *et al.* publication and should be replaced or supplemented.

14. Introduction section — Citation of Reference 5, Line 31 (correction already applied — recorded for completeness)

Error Identified: In an earlier draft, the text contained a citation [5] with no corresponding reference-list entry, which jumped from #4 to #6.

Incorrect Version: Earlier draft: citation [5] present in text with no matching reference-list entry (original submission).

Correct Version: Reference 5 (Al-Hindi *et al.*, "Association of antenatal risk score with maternal and neonatal mortality and morbidity," Cureus, 2020) has since been added and appropriately supports the statement on maternal and perinatal morbidity/mortality burden. No further action is required for this citation; the correction is recorded here for the errata trail.

15. Introduction section — Citation of Reference 9, Line 40 (correction already applied — recorded for completeness)

Error Identified: Reference 9 was originally a 2003 report on health professions education, cited in a discussion of Pakistan's tertiary hospitals managing high-risk pregnancies; the reference did not support the statement it was attached to.

Incorrect Version: "AC G. Committee on the health professions education summit. Health professions education: A bridge to quality." (original Reference 9, cited for Pakistan's tertiary-hospital challenges).

Correct Version" Reference 9 has been reassigned to Bhutta et al., "Reproductive, maternal, newborn, and child health in Pakistan: challenges and opportunities" (The Lancet, 2013), which directly supports the statement about tertiary care hospitals managing high-risk pregnancies. No further action is required; the correction is recorded here for the errata trail.

16. Discussion section — Reference Sequencing Error, Citations [10]-[16]

Error Identified: The in-text citations [10] through [16] in the Discussion no longer align with the studies they are

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meant to describe. This appears to have arisen when the Delavar and Jahangiri Iran teenage-pregnancy study was inserted into the reference list at position 11 without the subsequent in-text citation numbers being renumbered to match.

Incorrect Version: "A study in Iran showed a significant correlation between maternal age, particularly teenage pregnancy...[10]" — reference 10 (Avesi *et al.*) is a general perinatal-outcome study, not the Iran study. "...a study conducted in Nigeria [11]" points to reference 11 (Delavar and Jahangiri, Iran), not Nigeria. A study from Nepal [12]" points to reference 12 (Ejiofor *et al.*, Nigeria), not Nepal. ".A history of cesarean section [13]" points to reference 13 (Toolan *et al.*, Nepal), not Bangladesh. "A study in Taiwan. [15]" points to reference 15 (Brown *et al.*, a cohort study of intellectual/developmental disabilities), not the Taiwan preterm-birth study.

Correct Version: Each in-text citation from [10] onward should be renumbered to point to the reference that actually describes it: the Iran teenage-pregnancy claim should cite reference 11 (Delavar and Jahangiri), the Nigeria anemia claim should cite reference 12 (Ejiofor *et al.*), the Nepal PIH claim should cite reference 13 (Toolan *et al.*), the Bangladesh cesarean-section claim should cite reference 14 (Begum *et al.*), and the Taiwan preterm-birth claim should cite reference 16 (Chang *et al.*). Reference 15 (Brown *et al.*) does not support the statement about abortion and preterm birth and should either be cited at an appropriate point elsewhere or removed.

17. Discussion section — Citation for the Ethiopia Claim, Line 128

Error Identified: The claim that early antenatal care improves outcomes in Ethiopia is followed by a citation that, in the current reference list, points to a paper on pregnancy management in women with cirrhosis — unrelated to the claim being made.

Incorrect Version: "A study in Ethiopia showed that getting care early in pregnancy can make a big difference in how well the pregnancy goes, especially if it's high-risk [18]."(Line 128)

Correct Version: The Ethiopia claim should cite reference 19 (Woldeamanuel *et al.*, "Effect of nutritional status of pregnant women on birth weight of newborns at Butajira Referral Hospital, Ethiopia"), the study actually conducted in Ethiopia; reference 18 (Rahim *et al.*, cirrhosis in pregnancy) should be cited only where cirrhosis is discussed, if at all.

18. Discussion section — Mis-cited References 19 and 20, Lines 130-133

Error Identified: Reference 19 is cited for a claim about a UK study on postnatal support, but in the original submission reference 19 was a book on postpartum depression, unrelated to the claim. Reference 20 is cited for a claim about thyroid disorders in a Chinese population, but the underlying study concerns obesity, not thyroid disorders.

Incorrect Version: "A study in the UK showed that it's important to keep checking on the mom and giving her support, even after the baby is born, especially if she might get pregnant again [19]. ...in richer countries like China, being overweight or having problems with the thyroid gland is more common [20]."(Lines 130-133)

Correct Version: "A study in the UK emphasized the importance of continued maternal support and monitoring in the postpartum period, particularly for women at risk of future high-risk pregnancies [19]. Similarly, studies from China have identified obesity as a prevalent risk factor in pregnancy, while thyroid disorders have also been increasingly recognized as important contributors to adverse pregnancy outcomes [20]." Reference 19 has been reassigned to Knight, "Saving Lives, Improving Mothers' Care" (UK/Ireland Confidential Enquiries); reference 20 (a Chinese obesity-prevalence study) supports the obesity claim but does not report on thyroid disorders, so the thyroid-disorder claim still requires its own supporting citation.

19. Discussion section — Complete Lack of Study Limitations

Error Identified: The manuscript did not originally acknowledge any methodological limitations, such as convenience sampling bias, single-center design, recall bias, or lack of blinding. Discussing limitations is a fundamental requirement for scientific credibility.

Incorrect Version: The original Discussion section ended after the Ethiopia/UK/China citations with no limitations paragraph.

Correct Version: A limitations paragraph has been added: "This study has several limitations that should be acknowledged. First, the use of convenience sampling may have introduced selection bias...Second, the relatively small sample size (n=213) limited our ability to perform multivariate analysis...Third, the lack of a comparison group of low-risk pregnancies prevented us from calculating relative risks...Fourth, some data...were collected retrospectively and may be subject to recall bias. Fifth, outcomes were assessed at 8 days postpartum, which does not capture long-term...outcomes.

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Finally, we did not assess maternal outcomes such as maternal mortality, morbidity, or mode of delivery..."

20. Discussion section — Absence of a Comparison Group

Error Identified: The study reports outcomes of high-risk pregnancies but does not include a control group of low-risk pregnancies. Without a comparison, it is impossible to determine whether adverse outcomes are actually more common or to calculate relative risks.

Incorrect Version: No mention of the absence of a comparison group appears anywhere in the original manuscript.

Correct Version: "A significant limitation of this study is the absence of a comparison group of low-risk pregnancies. Without such a comparison, we cannot calculate relative risks or determine whether the adverse outcomes observed are attributable to the high-risk status itself...Future studies should include a control group of low-risk pregnancies to allow for calculation of relative risks..."

21. Methods section — No Sample Size Power Justification, Lines 50-54

Error Identified: The sample size of 213 is reported without any power calculation or justification. Readers cannot assess whether the study had adequate statistical power to detect clinically meaningful differences.

Incorrect Version: "A sample size of 213 was calculated using the formula for estimating proportions in a finite population...the required sample size was calculated as 246. However, due to practical constraints and limited resources, a convenience sample of 213 participants was enrolled..."(Lines 50-54)— no post-hoc power statement follows.

Correct Version: "The sample size was calculated using the formula for estimating proportions in a finite population, $n = Z^2 \times p \times (1-p) / d^2$, where Z = 1.96 (95% confidence level), p = 0.20...and d = 0.05 [10]." A post-hoc power analysis has been added, indicating that with n=213 and a prevalence of adverse outcomes of 18.3% (39/213), the study had 80% power to detect a 15% difference in adverse outcomes at α=0.05, with limited power for smaller differences or subgroup analyses.

22. Methods and Discussion sections — Potential Confounding Variables Not Addressed

Error Identified: Many risk factors (e.g., teenage pregnancy, anemia, obesity) are likely confounded by socioeconomic status or nutrition, but no multivariate analysis was performed to control for these factors. The reported associations may therefore be spurious.

Incorrect Version: The original manuscript presented univariate Chi-square associations with no discussion of possible confounding.

Correct Version: "Several risk factors identified in this study (e.g., teenage pregnancy, severe anemia, obesity)...may be confounded by socioeconomic factors, nutritional status, and access to healthcare...While we performed univariate analysis to identify associations, the sample size was insufficient for multivariate analysis to adjust for potential confounders such as maternal age, parity, socioeconomic status, and gestational age at enrollment."

23. Methods section — Lack of Validity and Reliability Measures, Lines 61-74

Error Identified: The manuscript does not describe any measures to ensure data quality, such as training of data collectors, inter-rater reliability checks, pilot testing, or validation of the questionnaire. These steps are essential for reliable data.

Incorrect Version: No description of data-collector training, pilot testing, or inter-rater reliability appears anywhere in the original Methods section (Lines 61-74).

Correct Version: "Four trained research assistants with nursing or medical backgrounds underwent a 2-day training program on study objectives, questionnaire administration, ethical conduct, and data recording, achieving strong inter-rater reliability (Cohen's kappa >0.80) assessed through 10 mock interviews...the questionnaire...was piloted on 20 women for clarity, and content-validated by three senior obstetricians."

24. Discussion section — No Discussion of Generalizability

Error Identified: The study was conducted at two tertiary care hospitals, but the authors do not discuss how the findings might apply to other settings (e.g., rural areas or primary care) or whether the population differs from the general public.

Incorrect Version: The original Discussion ended without addressing the generalizability of the findings beyond the two study hospitals.

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Correct Version: "The findings of this study should be interpreted with caution when generalizing to other populations. The study was conducted at two tertiary care hospitals in Hyderabad and Jamshoro, Pakistan, which serve predominantly urban and peri-urban populations...The results are most applicable to high-risk pregnant women attending tertiary care hospitals in similar urban settings in South Asia. Future multicenter studies involving diverse settings...are needed to confirm the generalizability of these findings."

25. Results section — Incomplete Reporting of Adverse Outcomes, Lines 95-97

Error Identified: Adverse fetal outcomes are reported as percentages of the 43 adverse events, not as percentages of the total 213 pregnancies. It is unclear how many women experienced at least one adverse outcome, and maternal outcomes are completely absent.

Incorrect Version: "Table 4: Adverse Fetal Outcomes — Low Birth Weight (LBW) 8 (18.6%); NICU Admission 7 (16.3%); Preterm Birth 6 (14.0%)...Total 43 (100%)." (Lines 95-97) — all percentages are calculated against the 43 adverse events rather than the 213 total pregnancies, with no statement of how many individual women were affected.

Correct Version: "Of the 213 pregnancies, 39 women (18.3%) experienced at least one adverse fetal outcome. A total of 43 adverse outcomes were recorded among these 39 women, as some women experienced multiple complications (e.g., low birth weight and NICU admission)." A new Table 5 ("Adverse Fetal Outcomes by Specific Risk Factor Categories") now reports outcomes as a percentage of each risk-factor category's total N. Maternal outcomes (mode of delivery, postpartum hemorrhage) remain unreported and should be added if the underlying data are available.

26. Methods section — Timing of Risk Factor Identification, Lines 46-49 and 57-60

Error Identified: It is not clearly specified whether risk factors were identified prospectively during the current pregnancy or retrospectively from past histories. This distinction is important for accurate outcome assessment.

Incorrect Version: The original Methods (Lines 46-49, 57-60) described risk factors and eligibility without distinguishing between current and past/historical risk factors or how each was ascertained.

Correct Version: "Current risk factors (e.g., severe anemia, PIH, Rh-negative status, obesity, short stature, teenage pregnancy) were identified prospectively during the antenatal visits for the index pregnancy. Past risk factors (e.g., previous cesarean, history of abortion, previous neonatal death, previous congenital anomalies) were identified retrospectively through detailed obstetric history obtained from the participants at the time of recruitment."

27. Methods section — Follow-up Rate Not Reported, Lines 55-56

Error Identified: The authors do not report how many participants were lost to follow-up, the overall follow-up rate, or whether those lost differed from those who completed the study. This information is needed to assess attrition bias.

Incorrect Version: "These women were tracked on a monthly basis until their delivery to scrutinize the unfolding of their pregnancies and the resulting perinatal outcomes." (Lines 55-56) — no follow-up rate or attrition data are given.

Correct Version: "Of the 250 initially approached, 213 (85.2%) completed follow-up, while 37 (14.8%) were excluded due to loss to follow-up (n=28), transfer to other facilities (n=6), or withdrawal of consent (n=3). The follow-up rate was 85.2%, and participants lost to follow-up were compared to those who completed the study with respect to baseline characteristics to assess potential attrition bias."

28. Conclusions section, Line 135 (heading) and Lines 136-139

Error Identified: The section heading is misspelled as "ConclusionS" rather than "CONCLUSIONS." More substantively, the conclusion restates the main finding in informal language but provides no specific clinical recommendations, no acknowledgement of study limitations (e.g., convenience sampling, single-center design, absence of a comparison group), and no direction for future research, leaving the conclusion too vague to guide clinical practice or subsequent study design.

Incorrect Version: "ConclusionS" (Line 135, section heading) "This study adds important information to what we already know about high-risk pregnancies and what happens to the babies. But we still need more research to understand better why these problems happen and how we can find them early, treat them, and stop them from happening in the first place. This will help make things better for moms and babies all over the world." (Lines 136-139)

Correct Version: "CONCLUSIONS" "This study highlights Rh-negative status, teenage pregnancy, and severe anemia as the most significant risk factors for adverse perinatal outcomes among high-risk pregnancies at a tertiary care hospital in Hyderabad and Jamshoro, Pakistan. Clinicians managing high-risk pregnancies should prioritize early screening for these

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factors. Given the convenience-sampled, single-center, cross-sectional design and the absence of a low-risk comparison group, these findings should be interpreted as prevalence estimates within this population rather than as evidence of causal or relative risk, and may not be generalizable beyond similar tertiary-care, urban settings. Future prospective, multicenter studies incorporating a comparison group and adjusted multivariate analysis are needed to confirm these associations."

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