

# OBSTETRICS & GYNECOLOGY



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- Comments from the reviewers and editors (email to author requesting revisions)
- Response from the author (cover letter submitted with revised manuscript)\*
- Email correspondence between the editorial office and the authors\*

*\*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](mailto:obgyn@greenjournal.org).

**Date:** Feb 15, 2019  
**To:** "Emanuel C Trabuco" [REDACTED]  
**From:** "The Green Journal" em@greenjournal.org  
**Subject:** Your Submission ONG-19-120

RE: Manuscript Number ONG-19-120

Reoperation for urinary incontinence after retropubic and transobturator sling

Dear Dr. Trabuco:

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 Mar 08, 2019, we will assume you wish to withdraw the manuscript from further consideration.

#### REVIEWER COMMENTS:

Reviewer #1: The authors present a retrospective work comparing reoperation rates for SUI between retropubic sling and TOT. This is an important topic given that reoperation rates increase global health care costs and are associated with increased morbidity. This work is overall well done with a clear and cogent hypothesis that answers a critical clinical question

- 1) Abstract- please include P values for the two comparator groups
- 2) Lines 106-110; Was patient symptom the only rubric used to diagnose SUI? What specific urodynamic testing was used to confirm the diagnosis?
- 3) Line 155- Why did you use 100 minus the Kaplan Meier Limit estimate?
- 4) Line 211 please report the number of enterotomies by type of sling
- 5) Did you account for complications (bladder perforation etc) based on number of years in practice of the surgeon? Did these decrease with time? These should be included in your analysis and discussion.
- 6) The discussion is well written and not over reaching.

Reviewer #2: Thank you for inviting me to review this manuscript. The authors identified patients having either a TVT or TOT at a single institution from 2002-2012, retrospectively collected data, and matched them with respect to age, BMI, isolated vs. combined procedure and preoperative diagnosis. The rationale for the study is sound and the topic important. The methodology is flawed as would be expected with a retrospective study design. The chance of uncontrolled systematic bias remains.

#### Comments:

In general it is advised that your key words match what is emphasized in the abstract. Please either delete mesh exposure from the key words or add mention of this as it pertains to the study in the abstract, if possible.

How was stress predominant UI defined and/or assessed? How were symptoms assessed? Were any questionnaires used?

Was urethral hypermobility assessed? If not, why not?

Line 99- please list all neurologic diseases excluded rather than use "etcetera". At this point you have listed most of the diseases and it is doubtful that many more would comprise this list.

The median time to reoperation for recurrent SUI was short in both groups. I would make this point again in the discussion section when addressing the duration of follow up in your patients.

When was this data pulled and analyzed (please place this info into the manuscript)? It is unclear what was the duration of follow up for these patients. For example, do the 2012 patients have 5-year follow up and the 2002 patients 15+ years? If 85% had 1-year follow then what happened to them afterward? If patients without reoperation had 3-4 year follow up then what happened with patients who did have reoperations?

The authors should display a Figure 4: Cumulative incidence of reoperation for recurrent SUI following the primary anti-incontinence procedure by type of sling among women in the FULL cohort with (A) an isolated procedure or (B) combined procedures. The TOT may function well when performed as an isolated procedure compared to the TVT. TVT being performed as an isolated procedure goes from 49.8% to 83% when the matching rubric is applied. Do the authors believe they have adequately controlled for this? Bottom line: combined vs. isolated seems to matter from these data yet the authors focus on complications rather than efficacy with respect to this variable and their methodology significantly increases the representation of TVT/isolated in the matched sample where they found TOT/combined has a higher recurrence rate compared to TOT/isolated.

Reviewer #3: "Reoperation for urinary incontinence after retropubic and transobturator sling" is a single center retrospective cohort study done out of Mayo Clinic in Rochester, MN. The authors reviewed a surgical database over a 10 year time frame to find patients fitting the inclusion/exclusion criteria. Information on 1881 patients was collected and analyzed with 1551 having a retropubic sling and 330 having a transobturator sling. The primary outcome was reoperation for SUI with defined procedures listed. Secondary outcomes were intraoperative and mesh related complications.

#### Abstract

Lines 47-48, recommend listing % with retropubic and transobturator instead of using respectively, it's much easier to follow this way.

#### Introduction:

Concise and relevant. No significant extraneous information.

Line 75 there is redundancy with "achieve have" when discussing continence and complication rates. Pick one or the other.

Line 79 the comma after SUI is not needed so should be deleted. The mention of matching for known confounders when analyzing the data is an added strength of this study so good that it is mentioned in the intro.

#### Methods:

Clear description of the methods used. Clearly discussed the inclusion and exclusion criteria. Both criteria were reasonable, though unsure why age 21 was used as a cutoff for age inclusion. Very unlikely that they had any patients under that age though that would have been eligible for the study.

Clear description of definitions for incontinence that are reasonable and taken from reliable source (ICS). Listed the different kinds of slings that were used which illustrates a large variety of different slings.

The groups analyzed were separated into isolated procedures vs combined procedures and the data between retropubic and transobturator slings were compared separately. This is an important distinction and very useful information for surgeons to have when considering what kind of sling will be placed in certain circumstances so this separate analysis is excellent.

Also very important was the attempt to match for known confounders. The authors used a greedy algorithm, an optimization algorithm, to match patients. They state a goal of a 2 to 1 match. Statistical analysis plan all appear appropriate.

#### Results:

Table 1 clear format and easy to read. Parity listed as one of the baseline characteristics. POPQ score, specifically Aa would be more useful information to list. If that information is available, would recommend listing that instead of parity.

Table 1 illustrates that matching for confounders eliminated the difference between the groups again highlighting its impact on the quality of the final data presented.

Lines 191-194, consider listing the types of repeat procedures in a table instead of text.

Line 196 consider new paragraph with data on risk of reoperation. Since it is the crux of the paper, it will stand out more as its own paragraph.

Figure 2 gives a clear visual of the data presented in the text and the survival curve clearly highlights the information that will be most useful for clinicians. Excellent job.

Figure 3 also very clear. Would recommend switching the order of the graphs in figure 3 to match the text, or switching the text, as the combined procedure group is mentioned first in the text on line 204.

Table 2 also clear and easy to read.

#### Discussion:

Line 239-240, comment on number of reoperations that would be avoided if all procedures were converted to retropubic route needs to also address that if that were done there would also be increase in reoperation for urinary retention. Overall the total number of reoperations may still be lower but one should not be mentioned without the other since the data also clearly shows an increased risk of reoperation for retention in the retropubic group.

Agree with listed strengths of the study. This study does fill a void in knowledge with regard to long term efficacy of two different mid-urethral slings. Rates of complications that were discussed were consistent with other rates reported in the literature specifically for reoperation for urinary retention and for mesh exposure.

Agree also with weaknesses. Good that lack of information on ISD may have affected results. That information would have been useful to have for a better analysis but most patients with SUI do not require complex urodynamics so not having that information really increases the generalizability (external validity) of the data.

Potential for not capturing all patients who had reoperation also is a weakness but that was not specific to one group or the other and as was mentioned in the paper 85% of the cohort had follow-up beyond 1 year which was the median time to recurrence. Also median duration of follow-up for those without reoperation was 4-5 years after the sling placement.

Given that the Uretex and Align slings comprised the bulk of the retropubic slings placed in patients during the study and are no longer on the market from what I can tell, a brief sentence stating that they are no different than products currently on the market or if there are differences mentioning those may be helpful as well.

Reviewer #4: The current study aimed to compare the rate of SUI recurrence defined as reoperation for SUI between retropubic (RP) vs. TO in a historical cohort of women undergoing a primary midurethral sling (MUS) placement between 2002 - 2012 at a single institution.

There is an increasing demand for long-term MUS data, both efficacy and safety, especially with the recent medico-legal controversies related to synthetic (polypropylene) sling products. The authors appropriately established the rationale for the study given a paucity of long-term data specific to MUS procedures. As stated as one of the study strengths, what distinguishes from existing incontinence surgery studies is that the current study included detailed demographics and surgical data, which allowed to account for potential confounders as well as only include synthetic sling procedures in their analysis.

My comments/suggestions include the following.

#### Methods:

Ln 117: Pelvilace is a porcine dermis xenograft, Sabre® is a bioabsorbable product. These have different characteristics compared to polypropylene sling products, thus the efficacy and safety differs compared to polypropylene slings.

Especially, one of the secondary outcomes is "mesh exposure" which is unique to permanent synthetic slings, such as polypropylene products, and "highlights the safety of retropubic macroporous polypropylene slings" (Ln 267), I would suggest excluding non-polypropylene products from the analysis.

Ln 119: In this study, 108 and 204 women had RP and TO Aris (Table 1) - according to the manufacturer website, Aris is only available as a TO sling. Is RP Aris commercially available?

#### Results:

Ln 200-: The cumulative incidence rates at 5 and 8 years were 4.1 and 5.2%, respectively, for RP, 9.2 and 11.2% for TO. However, the median f/u was 4.9 yrs for RP and 3.7 yrs for TO among non-recurrent patients. 1) Because of the high number of right censored subjects (follow-up duration < 5 yrs for the majority of patients), these cumulative incidence rates could be underestimated. 2) Given the difference in the follow-up duration between RP and TO, this could affect the difference in cumulative incidence rates. These points should be addressed in the discussion section.

Ln 215-: In addition to the cumulative incidence rate of sling revision for retention, rates of mesh exposure/erosion should be included (not just the HR between groups) - useful information especially for patient counseling.

#### Discussion:

Ln 236: The "cumulative incidence of a reoperation by 8 years rates appears small" - possibly underestimated as mentioned above. The primary outcome was defined as reoperation for recurrent SUI, which was lower in the RP sling group. As treatment management for recurrent SUI includes non-surgical options, which some studies have shown considerable # of patients choosing non-surgical management for recurrence, especially in short- and mid-term follow up studies. Not capturing the population undergoing non-surgical treatment for recurrent SUI would potentially underestimate the rate of recurrence. It would be helpful to see the "overall recurrence" requiring either non-surgical or surgical treatment, or no treatment, especially the authors had access to the entire patient records, or alternatively, this should be mentioned as a weakness of the study.

#### STATISTICAL EDITOR COMMENTS:

The Statistical Editor makes the following points that need to be addressed:

Table 2: Should include (could be on-line supplemental material) the counts for subsequent surgery for urinary retention incidence rates and subsequent surgery of mesh exposure incidence rates.

Fig 2, 3: Need to include along the x-axes at the indicated time points the number remaining at risk in each cohort.

#### EDITOR COMMENTS:

1. Thank you for your submission to Obstetrics & Gynecology. In addition to the comments from the reviewers above, you are being sent a notated PDF that contains the Editor's specific comments. Please review and consider the comments in this file prior to submitting your revised manuscript. These comments should be included in your point-by-point response cover letter.

\*\*\*The notated PDF is uploaded to this submission's record in Editorial Manager. If you cannot locate the file, contact Randi Zung and she will send it by email - rzung@greenjournal.org.\*\*\*

- Please consult the Instructions for Authors regarding the use of abbreviations, and what constitutes an acceptable abbreviation. Please spell out all abbreviations and abstract on first use. It is reasonable to not use abbreviations for words that are seldom used in the paper.

- Thank you very much. This paper was a joy to read. Your writing style is very clear, you've read the instructions to authors (yeah!!!) and you not over stepped your data.

- are you saying here that current procedures have lower efficacy than before? Or do you mean that if a woman requires reoperation, the 2nd procedure is less efficacious? Please write this more clearly

- This last line (86-87) really belongs in the methods section. You might want to instead state your primary and any secondary outcomes here in the introduction and move 86-87 to the methods.

- please state who did the reviews. and if there was some way of checking a portion of the data for mistakes. Were these all electronic or a mixture? How were patients identified? By CPT code? If so, in the Supplemental Digital Content or in a box, please list the codes searched for.

- Since you had a 10 year window, and as you note, the type of surgery being done was changing over time, did you see a shift in the procedure type over time?

- please provide units for age.

- I am confused here. Based on the methods section, you study population had either SUI or stresspredominant mixed incontinence. How could 30-50% of the population in your study NOT have a preop dx of SUI?

- your study time frame was 2002-2012, correct? Doesn't seem much different than 2000-2009. Please comment.

2. 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. 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.

4. Our journal requires that all evidence-based research submissions be accompanied by a transparency declaration statement from the manuscript's lead author. The statement is as follows: "The lead author\* affirms that this manuscript is an honest, accurate, and transparent account of the study being reported; that no important aspects of the study have been omitted; and that any discrepancies from the study as planned (and, if relevant, registered) have been explained."

\*The manuscript's guarantor.

If you are the lead author, please include this statement in your cover letter. If the lead author is a different person, please ask him/her to submit the signed transparency declaration to you. This document may be uploaded with your submission in Editorial Manager.

5. 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.

6. 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.

7. 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 26 typed, double-spaced pages (6,500 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.

8. 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).

9. 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.

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 commercial name (with the generic name in parentheses) may be used once in the body of the manuscript. Use the generic name at each mention thereafter. Commercial names should not be used in the title, précis, or abstract.

12. 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.

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](http://edmgr.ovid.com/ong/accounts/table_checklist.pdf).

14. Figures: Please upload the figures as separate figure files in Editorial Manager for the revision stage.

- Figure 1: Okay as-is.
- Figure 2: Upload the original file instead of copying and pasting the image.
- Figure 3: Upload the original file instead of copying and pasting the image.

15. 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/ifaauth.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.

16. 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 Mar 08, 2019, we will assume you wish to withdraw the manuscript from further consideration.

Sincerely,

Nancy C. Chescheir, MD  
Editor-in-Chief

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

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In compliance with data protection regulations, please contact the publication office if you would like to have your personal information removed from the database.

March 1, 2019

Nancy C. Chescheir, MD  
Editor in Chief  
Obstetrics and Gynecology

RE: Manuscript Number ONG-16-386

Dear Dr. Chescheir,

We are submitting here our revised manuscript, “Reoperation for urinary incontinence after retropubic and transobturator sling” to be considered for publication in *Obstetrics and Gynecology* which has been revised based on the reviewers’ critiques we received. We have responded to the consultants’ comments in a point-by-point fashion below to explain where their recommended changes were included in the text of the paper.

Each of the authors has made a substantial contribution to the material submitted here, and has read and approved the final manuscript. None of the authors have any direct or indirect commercial financial incentive associated with publishing the article. No extra-institutional funding for the project has been provided. This manuscript is not under consideration by another journal or electronic publication, nor has it been previously published.

Thank you again for reviewing our work. Please let us know if we can provide anything further to facilitate publication of our manuscript in *Obstetrics and Gynecology*.

Respectfully,

Emanuel Trabuco



We appreciate the Reviewer’s thoughtful comments on how to improve the manuscript. Specific responses below:

#### REVIEWER COMMENTS:

Reviewer #1: The authors present a retrospective work comparing reoperation rates for SUI between retropubic sling and TOT. This is an important topic given that reoperation rates increase global health care costs and are associated with increased morbidity. This work is overall well done with a clear and cogent hypothesis that answers a critical clinical question

- 1) Abstract- please include P values for the two comparator groups.

*We have added the p-value for the HR.*



2) Lines 106-110; Was patient symptom the only rubric used to diagnose SUI? What specific urodynamic testing was used to confirm the diagnosis?

*Yes, symptoms were the only criteria used based on review of the consult note prior to the procedure. Urodynamics stress incontinence was not required.*

3) Line 155- Why did you use 100 minus the Kaplan Meier Limit estimate?

*The Kaplan-Meier estimate takes into account the varying follow-up for each patient and is an estimate of the survival-free of the event. Because the "survival" terminology is sometimes confusing to readers when the event isn't death, we have instead reported the estimates as 100 minus the Kaplan-Meier estimates and referred to them as cumulative incidence estimates.*

4) Line 211 please report the number of enterotomies by type of sling

*Enterotomies were all related to concomitant procedures performed during the sling and not due to the sling procedure.*

5) Did you account for complications (bladder perforation etc) based on number of years in practice of the surgeon? Did these decrease with time? These should be included in your analysis and discussion.

*We did not evaluate that and feel that it is beyond the scope of this paper. All surgeons were fellowship trained, high volume sling implanters and most of the perforations were from trainees passing the trocar.*

6) The discussion is well written and not over reaching.

Reviewer #2: Thank you for inviting me to review this manuscript. The authors identified patients having either a TVT or TOT at a single institution from 2002-2012, retrospectively collected data, and matched them with respect to age, BMI, isolated vs. combined procedure and preoperative diagnosis. The rationale for the study is sound and the topic important. The methodology is flawed as would be expected with a retrospective study design. The chance of uncontrolled systematic bias remains.

Comments:

In general it is advised that your key words match what is emphasized in the abstract. Please either delete mesh exposure from the key words or add mention of this as it pertains to the study in the abstract, if possible.

How was stress predominant UI defined and/or assessed? How were symptoms assessed? Were any questionnaires used?

*Symptoms were assessed based on review of the consult note information available prior to the index procedure. Questionnaires were not available for use.*

Was urethral hypermobility assessed? If not, why not?

*This was not documented in the EMR.*

Line 99- please list all neurologic diseases excluded rather than use "etcetera". At this point you have listed most of the diseases and it is doubtful that many more would comprise this list.

*"Etcetera" was deleted.*

The median time to reoperation for recurrent SUI was short in both groups. I would make this point again in the discussion section when addressing the duration of follow up in your patients.

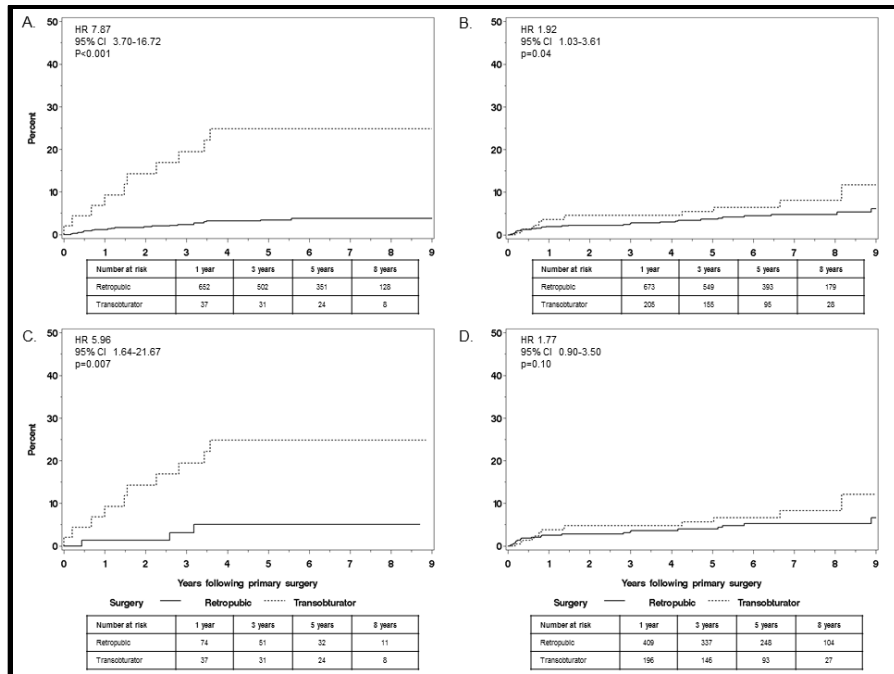
A statement has been added to the limitations section of the Discussion to acknowledge that our cumulative incidence estimates beyond 5 years could be underestimated.

When was this data pulled and analyzed (please place this info into the manuscript)? It is unclear what was the duration of follow up for these patients. For example, do the 2012 patients have 5-year follow up and the 2002 patients 15+ years? If 85% had 1-year follow then what happened to them afterward? If patients without reoperation had 3-4 year follow up then what happened with patients who did have reoperations?

*The data was abstracted in 2014; this information has been added to the methods (line 107). The duration of follow-up was originally reported in the Results Section of the paper. Since this is a retrospective study of patients seen at a tertiary center the duration of follow-up per patient is variable. However, in the time-to-event methods used in the statistical analysis, each patient contributes to the estimation of the cumulative incidence for as long as they have follow-up.*

The authors should display a Figure 4: Cumulative incidence of reoperation for recurrent SUI following the primary anti-incontinence procedure by type of sling among women in the FULL cohort with (A) an isolated procedure or (B) combined procedures. The TOT may function well when performed as an isolated procedure compared to the TVT. TVT being performed as an isolated procedure goes from 49.8% to 83% when the matching rubric is applied. Do the authors believe they have adequately controlled for this? Bottom line: combined vs. isolated seems to matter from these data yet the authors focus on complications rather than efficacy with respect to this variable and their methodology significantly increases the representation of TVT/isolated in the matched sample where they found TOT/combined has a higher recurrence rate compared to TOT/isolated.

We feel it is important to focus on the results controlling for baseline differences between the groups and therefore we prefer to only present the results for the covariate-matched cohort in the paper and to not add an additional figure. The figure below (which we are not including in the paper) depicts the cumulative incidence of reoperation for recurrent SUI following the primary anti-incontinence procedure by type of sling among women in the full cohort (A. women with combined procedures; B. women with isolated procedures) and women in the covariate-matched cohort (C. women with combined procedures; D. women with isolated procedures). The results for the performance of TOT (compared to TVT) when performed as an isolated procedure were similar regardless of whether evaluated in the full cohort (panel B, HR 1.92) or the covariate-matched cohort (panel D, HR 1.77).



Reviewer #3: "Reoperation for urinary incontinence after retropubic and transobturator sling" is a single center retrospective cohort study done out of Mayo Clinic in Rochester, MN. The authors reviewed a surgical database over a 10 year time frame to find patients fitting the inclusion/exclusion criteria. Information on 1881 patients was collected and analyzed with 1551 having a retropubic sling and 330 having a transobturator sling. The primary outcome was reoperation for SUI with defined procedures listed. Secondary outcomes were intraoperative and mesh related complications.

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*Change has been made.*

#### Introduction:

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*Deleted "achieve."*

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*Deleted the comma.*

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*I agree but unfortunately that information was not abstracted.*

Table 1 illustrates that matching for confounders eliminated the difference between the groups again highlighting its impact on the quality of the final data presented.

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*For space constraints will keep as text.*

Line 196 consider new paragraph with data on risk of reoperation. Since it is the crux of the paper, it will stand out more as its own paragraph.

*Made the information a new paragraph.*

Figure 2 gives a clear visual of the data presented in the text and the survival curve clearly highlights the information that will be most useful for clinicians. Excellent job.

Figure 3 also very clear. Would recommend switching the order of the graphs in figure 3 to match the text, or switching the text, as the combined procedure group is mentioned first in the text on line 204.

*The order of the curves has been changed and the figure title has been modified accordingly.*

Table 2 also clear and easy to read.

Discussion:

Line 239-240, comment on number of reoperations that would be avoided if all procedures were converted to retropubic route needs to also address that if that were done there would also be increase in reoperation for urinary retention. Overall the total number of reoperations may still be lower but one should not be mentioned without the other since the data also clearly shows an increased risk of reoperation for retention in the retropubic group.

*Yes, however we are reporting on the number of reoperation for SUI only not total reoperation. Given that sling revision would predisposed to recurrence this would be captured in the reoperation rates reported.*

Agree with listed strengths of the study. This study does fill a void in knowledge with regard to long term efficacy of two different mid-urethral slings. Rates of complications that were discussed were consistent with other rates reported in the literature specifically for reoperation for urinary retention and for mesh exposure.

Agree also with weaknesses. Good that lack of information on ISD may have affected results. That information would have been useful to have for a better analysis but most patients with SUI do not require complex urodynamics so not having that information really increases the generalizability (external validity) of the data.

Potential for not capturing all patients who had reoperation also is a weakness but that was not specific to one group or the other and as was mentioned in the paper 85% of the cohort had follow-up beyond 1 year which was the median time to recurrence. Also median duration of follow-up for those without reoperation was 4-5 years after the sling placement.

Given that the Uretex and Align slings comprised the bulk of the retropubic slings placed in patients during the study and are no longer on the market from what I can tell, a brief sentence stating that they are no different than products currently on the market or if there are differences mentioning those may be helpful as well.

*Agree but because of space constraints cannot add to the discussion.*

Reviewer #4: The current study aimed to compare the rate of SUI recurrence defined as reoperation for SUI between retropubic (RP) vs. TO in a historical cohort of women undergoing a primary midurethral sling (MUS) placement between 2002 - 2012 at a single institution.

There is an increasing demand for long-term MUS data, both efficacy and safety, especially with the recent medico-legal controversies related to synthetic (polypropylene) sling products. The authors appropriately established the rationale for the study given a paucity of long-term data specific to MUS procedures. As stated as one of the study strengths, what distinguishes from existing incontinence surgery studies is that the current study included detailed demographics and surgical data, which allowed to account for potential confounders as well as only include synthetic sling procedures in their analysis.

My comments/suggestions include the following.

Methods:

Ln 117: Pelvilace is a porcine dermis xenograft, Sabre® is a bioabsorbable product. These have different characteristics compared to polypropylene sling products, thus the efficacy and safety differs compared to polypropylene slings. Especially, one of the secondary outcomes is "mesh exposure" which is unique to permanent synthetic slings, such as polypropylene products, and "highlights the safety of retropubic macroporous polypropylene slings" (Ln 267), I would suggest excluding non-polypropylene products from the analysis.

*I agree that the certain characteristics may affect performance. The goal was to compare overall the efficacy of the two approaches and inclusion better allows for generalizability. In addition, the material was used in both approaches. Lastly, as the numbers of these are low they are unlikely to drive overall. As a result, we would prefer to include them.*

Ln 119: In this study, 108 and 204 women had RP and TO Aris (Table 1) - according to the manufacturer website, Aris is only available as a TO sling. Is RP Aris commercially available?

*This was the Supris device. The correct name has been made to Table 1.*

#### Results:

Ln 200:- The cumulative incidence rates at 5 and 8 years were 4.1 and 5.2%, respectively, for RP, 9.2 and 11.2% for TO. However, the median f/u was 4.9 yrs for RP and 3.7 yrs for TO among non-recurrent patients. 1) Because of the high number of right censored subjects (follow-up duration < 5 yrs for the majority of patients), these cumulative incidence rates could be underestimated. 2) Given the difference in the follow-up duration between RP and TO, this could affect the difference in cumulative incidence rates. These points should be addressed in the discussion section.

*We have added a statement to the Discussion Section acknowledging that the the rates for the cumulative incidence of a reoperation for recurrent SUI beyond 5 years may be underestimated.*

Ln 215:- In addition to the cumulative incidence rate of sling revision for retention, rates of mesh exposure/erosion should be included (not just the HR between groups) - useful information especially for patient counseling.

These rates were originally included in Table 2, however due to space limitations we have not repeated them in the text of the paper.

#### Discussion:

Ln 236: The "cumulative incidence of a reoperation by 8 years rates appears small" - possibly underestimated as mentioned above. The primary outcome was defined as reoperation for recurrent SUI, which was lower in the RP sling group. As treatment management for recurrent SUI includes non-surgical options, which some studies have shown considerable # of patients choosing non-surgical management for recurrence, especially in short- and mid-term follow up studies. Not capturing the population undergoing non-surgical treatment for recurrent SUI would potentially underestimate the rate of recurrence. It would be helpful to see the "overall recurrence" requiring either non-surgical or surgical treatment, or no treatment, especially the authors had access to the entire patient records, or alternatively, this should be mentioned as a weakness of the study.

*Agree, unfortunately beyond the scope of the study to contact all 1800 women to assess for recurrence requiring non-surgical treatment.*

#### STATISTICAL EDITOR COMMENTS:

The Statistical Editor makes the following points that need to be addressed:

Table 2: Should include (could be on-line supplemental material) the counts for subsequent surgery for urinary retention incidence rates and subsequent surgery of mesh exposure incidence rates.

*The counts have been added to Table 2.*

Fig 2, 3: Need to include along the x-axes at the indicated time points the number remaining at risk in each cohort.

*The number at risk have been added below each figure.*

#### EDITOR COMMENTS:

1. Thank you for your submission to Obstetrics & Gynecology. In addition to the comments from the reviewers above, you are being sent a notated PDF that contains the Editor's specific comments. Please review and consider the comments in this file prior to submitting your revised manuscript. These comments should be included in your point-by-point response cover letter.

\*\*\*The notated PDF is uploaded to this submission's record in Editorial Manager. If you cannot locate the file, contact Randi Zung and she will send it by email - [rzung@greenjournal.org](mailto:rzung@greenjournal.org).\*\*\*

- Please consult the Instructions for Authors regarding the use of abbreviations, and what constitutes an acceptable abbreviation. Please spell out all abbreviations and abstract on first use. It is reasonable to not use abbreviations for words that are seldom used in the paper.

- Thank you very much. This paper was a joy to read. Your writing style is very clear, you've read the instructions to authors (yeah!!!) and you not over stepped your data.

- are you saying here that current procedures have lower efficacy than before? Or do you mean that if a woman requires reoperation, the 2nd procedure is less efficacious? Please write this more clearly

*The later, a change has been made to hopefully add clarity.*

- This last line (86-87) really belongs in the methods section. You might want to instead state your primary and any secondary outcomes here in the introduction and move 86-87 to the methods.

*Changes have been made.*

- please state who did the reviews. and if there was some way of checking a portion of the data for mistakes.

*Daniel Carranza did reviews of the EMR. Data clean up and resolution of unclear data was done by independent review by Emanuel Trabuco.*

Were these all electronic or a mixture? How were patients identified? By CPT code? If so, in the Supplemental Digital Content or in a box, please list the codes searched for.

*Patients were identified using an Institutional Surgical database. This information is provided in line 94-95*

- Since you had a 10 year window, and as you note, the type of surgery being done was changing over time, did you see a shift in the procedure type over time?

*No, one group performed primarily the transobturator sling and another the retropubic approach. This likely minimized selection bias.*

- please provide units for age.

*Units added.*

- I am confused here. Based on the methods section, you study population had either SUI or stresspredominant mixed incontinence. How could 30-50% of the population in your study NOT have a preop dx of SUI?

*Our study also included patient with occult incontinence. This has been clarified in methods (line 97-98). Also, that line refers to the diagnosis of SUI and a significant proportion had MUI (40.2 and 28.8%)*

- your study time frame was 2002-2012, correct? Doesn't seem much different than 2000-2009. Please comment.

*Yes and no. Although similar study time frames the other included a heterogenous group of SUI procedures that had not been completely phased over to slings. Our study, though similar time frames made provide a homogenous population of primarily treated slings.*

2. 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. 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.

4. Our journal requires that all evidence-based research submissions be accompanied by a transparency declaration statement from the manuscript's lead author. The statement is as follows: "The lead author\* affirms that this manuscript is an honest, accurate, and transparent account of the study being reported; that no important aspects of the study have been omitted; and that any discrepancies from the study as planned (and, if relevant, registered) have been explained." \*The manuscript's guarantor.

If you are the lead author, please include this statement in your cover letter. If the lead author is a different person, please ask him/her to submit the signed transparency declaration to you. This document may be uploaded with your submission in Editorial Manager.

5. 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.

6. 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.

7. 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 26 typed, double-spaced pages (6,500 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.

8. 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).

9. 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.

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 commercial name (with the generic name in parentheses) may be used once in the body of the manuscript. Use the generic name at each mention thereafter. Commercial names should not be used in the title, précis, or abstract.

12. 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.

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](http://edmgr.ovid.com/ong/accounts/table_checklist.pdf).

14. Figures: Please upload the figures as separate figure files in Editorial Manager for the revision stage.

- Figure 1: Okay as-is.
- Figure 2: Upload the original file instead of copying and pasting the image.
- Figure 3: Upload the original file instead of copying and pasting the image.

15. 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/ifaauth.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.

16. 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 Mar 08, 2019, we will assume you wish to withdraw the manuscript from further consideration.

Sincerely,

Nancy C. Chescheir, MD  
Editor-in-Chief

2017 IMPACT FACTOR: 4.982

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

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In compliance with data protection regulations, please contact the publication office if you would like to have your personal information removed from the database.

**From:** [REDACTED]  
**To:** [Randi Zung](#)  
**Subject:** FW: Reoperation Paper  
**Date:** Wednesday, April 24, 2019 9:28:31 AM  
**Attachments:** [19-120R1 ms \(4-17-19v4\) edits.docx](#)

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Attached is the paper with the changes requested.

Thanks

---

**From:** Weaver, Amy L., M.S.  
**Sent:** Tuesday, April 23, 2019 11:51 AM  
**To:** Trabuco, Emanuel C., M.D.; Mc Gree, Michaela E.  
**Subject:** RE: Reoperation Paper

Dr. Trabuco,

Attached is the paper with our changes in the abstract and results – highlighted in turquoise.

Our responses are inserted below.

1. Line 105: Please see the Editor's changes to the text here. Please confirm that they are still reflective of the study period.  
**>>Reply: yes, This is reflective of the time period for the index procedure.**
2. Line 178 (Abstract-Results and Results sections): In both the abstract and the body text, please provide absolute numbers as well as whichever effect size you are reporting (if appropriate) + Confidence intervals. P values may be omitted for space concerns. We strongly prefer CI's as they give more information about strength of association than do P values. By absolute values, I mean something like: xx (outcome in exposed)/yy (outcome in unexposed) (zz%) (Effect size= ; 95% CI= ). An example might be: Outcome 1 was more common in the exposed than the unexposed 60%/20% (Effect size=3;95% CI 2.6-3.4).  
**>>Reply: For the outcomes that are standard percentages, we have now added the difference in the group percentages along with a 95% CI for this difference. For all other outcome measures in the text we had already reported 95% CIs.**
3. Line 193-200: Please replace these p-values with CIs throughout this section.  
**>>Reply: The first paragraph of the results is comparing baseline characteristics between the groups. We would prefer not to add 95% CIs to this paragraph, but instead to just report the 95% CIs for the comparisons of the outcomes between groups . We have also not added (x/N) in the text of the manuscript when we report crude percentages since those details are sufficiently provided in the tables.**

~Amy

---

**From:** Trabuco, Emanuel C., M.D.  
**Sent:** Monday, April 22, 2019 8:29 AM  
**To:** Weaver, Amy L., M.S.; Mc Gree, Michaela E.  
**Subject:** FW: Reoperation Paper

Hi Amy,

They want on last change. Please see below and note that the deadline to reply is April 23<sup>rd</sup>.  
Thanks

---

**From:** Randi Zung [mailto:RZung@greenjournal.org]  
**Sent:** Thursday, April 18, 2019 2:02 PM  
**To:** Trabuco, Emanuel C., M.D.  
**Subject:** [EXTERNAL] RE: Reoperation Paper

Dear Dr. Trabuco:

Dr. Chescheir has reviewed your latest version. She has a few additional comments for you to address. In the attached file (v4), the new comments are highlighted in blue, and they are listed below:

1. Line 105: Please see the Editor's changes to the text here. Please confirm that they are still reflective of the study period.
2. Line 178 (Abstract-Results and Results sections): In both the abstract and the body text, please provide absolute numbers as well as whichever effect size you are reporting (if appropriate) + Confidence intervals. P values may be omitted for space concerns. We strongly prefer CI's as they give more information about strength of association than do P values. By absolute values, I mean something like: xx (outcome in exposed)/yy (outcome in unexposed) (zz%) (Effect size= ; 95% CI= ). An example might be: Outcome 1 was more common in the exposed than the unexposed 60%/20% (Effect size=3;95% CI 2.6-3.4).
3. Line 193-200: Please replace these p-values with CIs throughout this section.

This will be the final opportunity to make changes to the manuscript text. Please send your final version back to me when you are finished. In order to make the deadline for the next available issue, we will need your file by April 23.

Thank you,  
Randi

---

**From:** Trabuco, Emanuel C., M.D. [REDACTED]  
**Sent:** Wednesday, April 10, 2019 5:07 PM  
**To:** Randi Zung <RZung@greenjournal.org>  
**Subject:** FW: Reoperation Paper

Hi

I have made the correction/clarifications in the appropriate areas of the included paper. Please also note that we have made a few edits to the figures to accommodate one of the request. Lastly please confirm that Dr. Carranza has provided the copy right transfer. Thank you for considering our work. Please let me know if you have further questions.

Emanuel

---

**From:** Weaver, Amy L., M.S.  
**Sent:** Tuesday, April 09, 2019 12:03 PM

**To:** Trabuco, Emanuel C., M.D.  
**Cc:** Mc Gree, Michaela E.  
**Subject:** RE: Reoperation Paper

Dr. Trabuco,

Attached are the documents with our changes which are outlined below . Please pass along these changes and the reasons below to the journal.

- 1) Figure 1: See the edits in red. The changes made by the journal did not account for all of the 1591 patients who were excluded
- 2) Figure 2: See the edits in red. We changed the y-axis label for “Percentage” to “Percent” which is the standard labeling that we use for Kaplan-Meier/Cumulative incidence curves.
- 3) Figure 3: We have replaced the original 2-panel figure with the attached 4-panel figure and have updated the text of the manuscript and legend accordingly.  
We still need for the folks at the journal to make the following changes to match the layout of Figure 2: a) change ‘Years following primary surgery’ to ‘Years after primary surgery’ and b) remove ‘surgery’ from the legend.
- 4) Legends: See edits highlighted in yellow.
- 5) Manuscript: Additional changes from Amy Weaver (pages 11-13) are denoted using track changes.

Amy & Michaela

**From:** Randi Zung [<mailto:RZung@greenjournal.org>]  
**Sent:** Tuesday, April 02, 2019 12:52 PM  
**To:** Trabuco, Emanuel C., M.D.  
**Cc:** Sci Pubs  
**Subject:** [EXTERNAL] Your Revised Manuscript 19-120R1

Dear Dr. Trabuco:

Your revised manuscript is being reviewed by the Editors. Before a final decision can be made, we need you to address the following queries. Please make the requested changes to the latest version of your manuscript that is attached to this email. **Please track your changes and leave the ones made by the Editorial Office.** Please also note your responses to the author queries in your email message back to me.

1. General: The Manuscript Editor and Dr. Chescheir have made edits to the manuscript using track changes. Please review them to make sure they are correct.
2. Our journal requires that all evidence-based research submissions be accompanied by a transparency declaration statement from the manuscript’s lead author. The statement is as follows: “The lead author\* affirms that this manuscript is an honest, accurate, and transparent account of the study being reported; that no important aspects of the study have been omitted; and that any discrepancies from the study as planned (and, if relevant, registered) have been explained.” \*The manuscript’s guarantor.

Please provide a signed version of this statement. A blank version is attached.

3. Please provide a completed STROBE checklist. The checklist is available at <http://ong.editorialmanager.com>

4. Daniel Carranza will need to complete our electronic Copyright Transfer Agreement, which was sent to them through Editorial Manager ([EM@greenjournal.org](mailto:EM@greenjournal.org))

5. Line 39: Note this addition to the Abstract-Objective. Is that acceptable?

6. Line 99 and elsewhere: When you write that a study occurred between date 1 and date 2, it literally excludes those boundary dates. For instance, "This study was performed between Feb 2018 and Jan 2019" would mean it was performed from March 2018 to Dec 2018. Do you instead mean that the study was performed from date 1 to date 2? If so, please edit.

7. Line 173-174: It is not necessary to repeat dates again since they appear in the Methods. You may want to reword this sentence.

8. Line 180: The Journal style doesn't not use the virgule (/) except in numeric expressions. Please edit here and in all instances. Should this be "and" or "or"?

9. Line 187: I remain confused here. If this many did not have a preoperative diagnosis of SUI, how could you include them since your primary endpoint is for RECURRENT SUI?

10. Line 238: Please include the figure 4 from your response to the reviewers' comments. If you wish it could go into supplemental digital content. Please cite it in the text here and include a figure legend description on Page 25. If you want it here in the text, it would be Figure 4. If it is going as SDC, please cite it as Appendix 1.

11. Line 242: This again emphasizes why I'm confused about how any, much less almost half, of your patients did not have a preoperative diagnosis of SUI.

12. Line 265: Why is this in quotes? You didn't include that above.

To facilitate the review process, we would appreciate receiving a response within 48 hours.

Best,  
Randi Zung

--

**Randi Zung (Ms.)**

Editorial Administrator | *Obstetrics & Gynecology*  
American College of Obstetricians and Gynecologists  
409 12th Street, SW  
Washington, DC 20024-2188  
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**From:** [REDACTED]  
**To:** [Denise Shields](#)  
**Subject:** RE: figures in your Green Journal manuscript (19-120)  
**Date:** Friday, April 5, 2019 2:06:23 PM

---

Hi

I have reviewed and agree with the changes and have no further edits.

Thanks

---

**From:** Denise Shields [mailto:DS Shields@greenjournal.org]  
**Sent:** Tuesday, April 02, 2019 2:01 PM  
**To:** Trabuco, Emanuel C., M.D.  
**Subject:** [EXTERNAL] figures in your Green Journal manuscript (19-120)

Dear Dr. Trabuco,

Your figures and legend have been edited and they are attached for your review. Please review the attachments CAREFULLY for any mistakes.

PLEASE NOTE: Any changes to the figures 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, 4/5. Thank you for your help.

Best,  
Denise

Denise Shields  
Senior Manuscript Editor  
*Obstetrics & Gynecology*  
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**From:** [REDACTED]  
**To:** [Denise Shields](#)  
**Subject:** RE: figures in your Green Journal manuscript (19-120)  
**Date:** Wednesday, April 17, 2019 5:47:00 PM  
**Attachments:** [19-120R1 legend with edits.docx](#)

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Hi

The figures looks good. The last version of the figure we sent had the HR and pvalue in the upper left hand corner of each survival curve. If this will delay publication I am OK with the HR being the legend.

Enclosed is the legend in which I noticed a minor typo.

Thanks

---

**From:** Denise Shields [mailto:[DS Shields@greenjournal.org](mailto:DS Shields@greenjournal.org)]  
**Sent:** Wednesday, April 17, 2019 2:41 PM  
**To:** Trabuco, Emanuel C., M.D.  
**Subject:** [EXTERNAL] FW: figures in your Green Journal manuscript (19-120)

Dear Dr. Trabuco,

Randi Zung forwarded me the edits you made to your figures. Attached are the latest versions for your review. Please let me know if it's okay to proceed.

Regards,  
Denise

---

**From:** Denise Shields  
**Sent:** Tuesday, April 2, 2019 3:01 PM  
**To:** [REDACTED]  
**Subject:** figures in your Green Journal manuscript (19-120)

Dear Dr. Trabuco,

Your figures and legend have been edited and they are attached for your review. Please review the attachments CAREFULLY for any mistakes.

PLEASE NOTE: Any changes to the figures 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, 4/5. Thank you for your help.

Best,  
Denise

Denise Shields

Senior Manuscript Editor

*Obstetrics & Gynecology*

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