

# 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:** Mar 08, 2019  
**To:** "Stephanie Jillian Handler" [REDACTED]  
**From:** "The Green Journal" em@greenjournal.org  
**Subject:** Your Submission ONG-19-184

RE: Manuscript Number ONG-19-184

"Referral Patterns for the Evaluation of Asymptomatic Microscopic Hematuria in Women in a Single Healthcare System: Room for Improvement"

Dear Dr. Handler:

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 29, 2019, we will assume you wish to withdraw the manuscript from further consideration.

#### REVIEWER COMMENTS:

Reviewer #1: Abstract - The American Urological Association has defined asymptomatic hematuria (AMH) and this study is to evaluate the appropriateness of referrals to women's pelvic medicine and the patterns of care for women diagnosed with AMH and the cost of unindicated evaluation

Methods - 100 women with AMH were identified retrospectively referred by either ob/gyns or primary care providers  
Results - of the 100 women, 54 did not meet the definition - 33 were identified by dipstick alone, 11 by urinalysis but with < 3 RBCs / HPF, and 10 had a concurrent benign condition

Conclusions - less than half of the referrals for AMH were appropriate, and education of primary care providers for referral for AMH is necessary

Introduction - Urinary dipstick has a high incidence of known false positive testing for AMH. Referral should be confirmed by microscopy and the cost of unindicated evaluation was reviewed.

Methods - IRB approval was obtained, referrals by OB/gyn and primary care were evaluated and the indication for referral and the economic burden were reviewed

Results - 100 women were evaluated - 54 referrals for AMH were inappropriate and only 8 (15%) of these inappropriate referrals subsequently met the criteria. Of the referrals by Internal Medicine, 44% did not meet guidelines and of those made by ob/gyns, 75% did not meet guidelines. This led to unnecessary testing in 46 patients totaling \$62,000 or \$1349 per patient.

Discussion - AMH should be confirmed by microscopy before referral. 54 of 100 did not meet the referral criteria which led to unindicated care. Lack of compliance to guidelines leads to increased risk and cost. More education is needed regarding the AMH guidelines.

Comments - This is a simple study but impactful. It is quite clear that despite well established guidelines, inappropriate referral is being undertaken. This leads to a waste of time, money, and can increase potential risk. This is a good study revealing a great educational opportunity.

Reviewer #2: This is a well timed observational study highlighting the issue of unnecessary referrals for hematuria.

Conclusions are well supported but the clarity of your findings could be improved for more clarification, i.e. it does seem urine microscopy at times is called urinalysis. Being very clear on the type of urine test being described would be helpful in the reading of the manuscript.

Reviewer #3: This was a retrospective cohort of women referred to an FPMRS practice for workup of asymptomatic microhematuria (AMH) within a single hospital system. The authors reviewed 100 consecutive referrals and determined that most of these were inappropriate and unnecessary. The authors further went on to extrapolate the additional costs associated with AMH workup, such as imaging or cystourethroscopy. It is unclear why these costs would be incurred, as the consulting physician would recognize the referral as unindicated and not initiate further workup.

The finding that many referrals to FPMRS by primary care and OB/Gyn are not indicated is not novel. Whereas FPMRS specialists see some referrals for AMH, the majority of gross and MH referrals go to urologists. The study would have been significantly stronger had referrals to the Urology practice also been evaluated.

The authors suggest providing more education to PCP and women's health physicians about AMH, however the discussion passed on the opportunity to educate. Given the audience of The Obstetrics & Gynecology journal, the authors could have included a review of the sensitivity and negative predictive value of a positive urine dipstick for blood vs RBCs on urine microscopy. They could further go on to review the epidemiology of bladder cancer, especially relative to women.

#### STATISTICAL EDITOR'S COMMENTS:

1. Abstract: the proportion 46/100 should have CIs added.
2. Pg 7: Should compare the fractions 30/68 vs 24/32 to determine whether the difference is statistically different, rather than just a numerical difference. Few fixable
3. Fig 1: Should expand the flow diagram to include the breakdown of the 46 which met AMH criteria and the reasons that the 54 did not
4. Table 2 should be expanded to contrast the costs incurred by the 46 with AMH vs the 54 without AMH (total and per patient).
5. Also, what is the cost of the work-up to prior to referral for AMH? That is, the cost of microscopic urinalysis and ruling out a benign cause if RBC > 3 for those that are not referred?
6. What were the costs (total and per patient) for those women who "insisted on having an evaluation for AMH despite being counseled to the contrary?"

#### EDITORIAL OFFICE COMMENTS:

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

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

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

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

3. Responsible reporting of research studies, which includes a complete, transparent, accurate and timely account of what was done and what was found during a research study, is an integral part of good research and publication practice and not an optional extra. Obstetrics & Gynecology supports initiatives aimed at improving the reporting of health research, and we ask authors to follow specific guidelines for reporting randomized controlled trials (ie, CONSORT), observational studies (ie, STROBE), meta-analyses and systematic reviews of randomized controlled trials (ie, PRISMA), harms in systematic reviews (ie, PRISMA for harms), studies of diagnostic accuracy (ie, STARD), meta-analyses and systematic reviews of observational studies (ie, MOOSE), economic evaluations of health interventions (ie, CHEERS), quality

improvement in health care studies (ie, SQUIRE 2.0), and studies reporting results of Internet e-surveys (CHERRIES). Include the appropriate checklist for your manuscript type upon submission. Please write or insert the page numbers where each item appears in the margin of the checklist. Further information and links to the checklists are available at <http://ong.editorialmanager.com>. In your cover letter, be sure to indicate that you have followed the CONSORT, MOOSE, PRISMA, PRISMA for harms, STARD, STROBE, CHEERS, SQUIRE 2.0, or CHERRIES guidelines, as appropriate.

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

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

6. Titles in Obstetrics & Gynecology are limited to 100 characters (including spaces). Do not structure the title as a declarative statement or a question. Introductory phrases such as "A study of..." or "Comprehensive investigations into..." or "A discussion of..." should be avoided in titles. Abbreviations, jargon, trade names, formulas, and obsolete terminology also should not be used in the title. Titles should include "A Randomized Controlled Trial," "A Meta-Analysis," or "A Systematic Review," as appropriate, in a subtitle. Otherwise, do not specify the type of manuscript in the title.

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

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

8. Provide a short title of no more than 45 characters (40 characters for case reports), including spaces, for use as a running foot.

9. Provide a précis on the second page, for use in the Table of Contents. The précis is a single sentence of no more than 25 words that states the conclusion(s) of the report (ie, the bottom line). The précis should be similar to the abstract's conclusion. Do not use commercial names, abbreviations, or acronyms in the précis. Please avoid phrases like "This paper presents" or "This case presents."

10. 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.

11. 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.

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. The American College of Obstetricians and Gynecologists' (ACOG) documents are frequently updated. These documents may be withdrawn and replaced with newer, revised versions. If you cite ACOG documents in your manuscript, be sure the reference you are citing is still current and available. If the reference you are citing has been updated (ie,

replaced by a newer version), please ensure that the new version supports whatever statement you are making in your manuscript and then update your reference list accordingly (exceptions could include manuscripts that address items of historical interest). If the reference you are citing has been withdrawn with no clear replacement, please contact the editorial office for assistance ([obgyn@greenjournal.org](mailto:obgyn@greenjournal.org)). In most cases, if an ACOG document has been withdrawn, it should not be referenced in your manuscript (exceptions could include manuscripts that address items of historical interest). All ACOG documents (eg, Committee Opinions and Practice Bulletins) may be found via the Clinical Guidance & Publications page at <https://www.acog.org/Clinical-Guidance-and-Publications/Search-Clinical-Guidance>.

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

"FIGURE 2: Please provide us with the original file (i.e. the original PPT or Excel file)."

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

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

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

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

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

17. 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.

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

If you submit a revision, we will assume that it has been developed in consultation with your co-authors and that each author has given approval to the final form of the revision.

Again, your paper will be maintained in active status for 21 days from the date of this letter. If we have not heard from you by Mar 29, 2019, we will assume you wish to withdraw the manuscript from further consideration.

Sincerely,

The Editors of Obstetrics & Gynecology

2017 IMPACT FACTOR: 4.982

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

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

March 29, 2019

Re: Resubmission of the manuscript *Referral Patterns for the Evaluation of Asymptomatic Microscopic Hematuria in Women in a Single Healthcare System: Room for Improvement*, ONG-19-184

The Editors

*Obstetrics & Gynecology*

409 12<sup>th</sup> Street, SW

Washington, DC 20024-2188

Dear Editors:

We appreciate the careful review and constructive suggestions to our manuscript, *Referral Patterns for the Evaluation of Asymptomatic Microscopic Hematuria in Women in a Single Healthcare System: Room for Improvement*. Thank you for the opportunity to revise it. We believe that the manuscript is significantly improved after making the suggested changes.

Below this letter are the reviewers' and editor's comments followed by our responses in italics. Changes in the manuscript are designated using the track changes feature. All revisions have been developed in consultation with all co-authors. Each author has given approval to the final form of this revision.

Thank you again for your consideration.

Sincerely,

Stephanie Handler, MD

REVIEWER COMMENTS:

**Reviewer #1:**

Abstract - The American Urological Association has defined asymptomatic hematuria (AMH) and this study is to evaluate the appropriateness of referrals to women's pelvic medicine and the patterns of care for women diagnosed with AMH and the cost of unindicated evaluation

Methods - 100 women with AMH were identified retrospectively referred by either ob/gyns or primary care providers

Results - of the 100 women, 54 did not meet the definition - 33 were identified by dipstick alone, 11 by urinalysis but with < 3 RBCs / HPF, and 10 had a concurrent benign condition

Conclusions - less than half of the referrals for AMH were appropriate, and education of primary care providers for referral for AMH is necessary

Introduction - Urinary dipstick has a high incidence of known false positive testing for AMH. Referral should be confirmed by microscopy and the cost of unindicated evaluation was reviewed.

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Discussion - AMH should be confirmed by microscopy before referral. 54 of 100 did not meet the referral criteria which led to unindicated care. Lack of compliance to guidelines leads to increased risk and cost. More education is needed regarding the AMH guidelines.

Comments - This is a simple study but impactful. It is quite clear that despite well established guidelines, inappropriate referral is being undertaken. This leads to a waste of time, money, and can increase potential risk.

This is a good study revealing a great educational opportunity.

*Thank you.*

**Reviewer #2:**

This is a well-timed observational study highlighting the issue of unnecessary referrals for hematuria.

Conclusions are well supported but the clarity of your findings could be improved for more

clarification, i.e. it does seem urine microscopy at times is called urinalysis. Being very clear on the type of urine test being described would be helpful in the reading of the manuscript.

*We agree with the reviewer, and have edited the manuscript to more clearly reflect the type of urine test being described. We refer to urine microscopy as either “urine microscopy” or “microscopic urinalysis.” Changes have been throughout the abstract and manuscript. Figure 1 was also changed.*

### **Reviewer #3:**

This was a retrospective cohort of women referred to an FPMRS practice for workup of asymptomatic microhematuria (AMH) within a single hospital system. The authors reviewed 100 consecutive referrals and determined that most of these were inappropriate and unnecessary. The authors further went on to extrapolate the additional costs associated with AMH workup, such as imaging or cystourethroscopy. It is unclear why these costs would be incurred, as the consulting physician would recognize the referral as unindicated and not initiate further workup.

*We agree with the reviewer that this point should be clarified, so we developed our explanation in the results section: “Despite this, many were subject to evaluation ordered either by the referring provider or the specialist. Interestingly, some patients pressed for further testing due to concerns that a malignancy or other serious pathology would be missed, regardless of documented counseling by the specialist that their microscopic urinalyses were negative for AMH and the AUA did not recommend subsequent testing. In other cases, the microhematuria workup was initiated by the specialist under the assumption that the diagnosis of AMH was correct.”*

The finding that many referrals to FPMRS by primary care and OB/Gyn are not indicated is not novel. Whereas FPMRS specialists see some referrals for AMH, the majority of gross and MH referrals go to urologists. The study would have been significantly stronger had referrals to the Urology practice also been evaluated.

*This is an excellent point. The group studied in our work is actually a practice of female Urologists, or Urology-trained FPMRS. We identified this in the methods section of the manuscript. To further clarify this point, we revised the abstract and discussion to specify that the specialists in this work are in “a Urology-based FPMRS (Female Pelvic Medicine and Reconstructive Surgery) practice.” We also revised Figure 1 to specify that the practice is a “Urology-based FPMRS practice.”*

The authors suggest providing more education to PCP and women's health physicians about AMH, however the discussion passed on the opportunity to educate. Given the audience of The Obstetrics & Gynecology journal, the authors could have included a review of the sensitivity and negative predictive value of a positive urine dipstick for blood vs RBCs on urine microscopy. They could further go on to review the epidemiology of bladder cancer, especially relative to women.

*Thank you for this suggestion. In the introduction section, we have expanded our review on the*

*sensitivity, specificity, positive predictive value, and negative predictive value of the urine dipstick for blood: “While the data on the sensitivity and specificity of the urine dipstick for microscopic hematuria are scarce, debatable and variable among manufacturers, the false negative and false positive rates are estimated to be 91-100% and 65-99.6%, respectively. Naturally, the negative predictive value of the urine dipstick for microhematuria is 100%, and the positive predictive value is only 80%.” We also added the following in the discussion section: “Confirming the diagnosis of AMH with microscopic urinalysis is especially important in the female population considering that the positive predictive value may be as low as 80%.”*

*Additionally, in the discussion section we included a brief review of bladder cancer in women: “Bladder cancer is not a common diagnosis in women. In the United States, it is the ninth most common cancer. Risk factors for the disease include age (the average age at diagnosis in women is 71), cigarette smoking, chronic infection, and exposure to environmental hazards. Bladder cancer usually presents with microscopic or gross hematuria but can sometimes be accompanied with irritative voiding symptoms such as urinary frequency, urinary urgency, and dysuria. While bladder cancer is less common in women, it is more often diagnosed at a later stage; some hypothesize this delay in diagnosis occurs because the symptoms of early bladder cancer are similar to symptoms of benign genitourinary pathology such as urinary tract infection or nephrolithiasis, and are therefore overlooked. This delay in diagnosis translates to poorer survival rates in women. Still, bladder cancer is uncommon in women, with only 18,810 new diagnoses every year.*

#### STATISTICAL EDITOR'S COMMENTS:

1. Abstract: the proportion 46/100 should have CIs added.

*We agree with the reviewer, and have added CI in the abstract: “We found that 46% (95% CI 36%, 56%) of the referrals for AMH were appropriate.” We also added the following to the manuscript in the methods section: “A Chi-square test was used to test for statistical differences in proportion.” We also added the following to the results section: “our study demonstrated that 54% (95% CI 44%, 64%) of 100 patients referred to a Urology-based FPMRS practice for AMH did not meet the AUA’s diagnostic criteria.”*

2. Pg 7: Should compare the fractions 30/68 vs 24/32 to determine whether the difference is statistically different, rather than just a numerical difference. Few fixable.

*We agree with the reviewer, and have developed the results section as follows: “In comparison, referrals by Obstetrician-Gynecologists were statistically less likely to be AUA-compliant ( $p=0.04$ ).”*

3. Fig 1: Should expand the flow diagram to include the breakdown of the 46 which met AMH criteria and the reasons that the 54 did not

*We have expanded Figure 1 to include the breakdown of the 100 patients included in the study.*

4. Table 2 should be expanded to contrast the costs incurred by the 46 with AMH vs the 54 without AMH (total and per patient).

*We have expanded Table 2 to include the cost of workup of both AUA-indicated and unindicated referrals for AMH.*

5. Also, what is the cost of the work-up to prior to referral for AMH? That is, the cost of microscopic urinalysis and ruling out a benign cause if RBC > 3 for those that are not referred?

*We have added this value (\$13.80) in Table 2.*

6. What were the costs (total and per patient) for those women who "insisted on having an evaluation for AMH despite being counseled to the contrary?"

*Thank you for drawing attention to the point. Unfortunately, the medical records do not indicate which patients specifically requested a workup. Sometimes, the microhematuria workup was performed by the specialist under the assumption that the diagnosis of AMH was correct. Other times, the patient requested the unindicated workup. For these reasons, we could not make the requested cost calculation. We have added in the limitations section of the manuscript: "Third, our cost analysis is limited by the fact that we were unable to differentiate which specialty-initiated unindicated evaluations were patient-driven versus provider-driven."*

## Daniel Mosier

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**From:** Stephanie Handler [REDACTED]  
**Sent:** Thursday, April 18, 2019 9:53 PM  
**To:** Daniel Mosier  
**Subject:** Re: Manuscript Revisions: ONG-19-184R1  
**Attachments:** AMH revision 04.17.19.docx; Authorship Ackerman.pdf; Authorship Anger.pdf; Authorship Bresee.PDF; Authorship Eilber.pdf; Authorship Handler.pdf

Dear Mr Mosier,

Thank you for your continued consideration and thoughtful edits. I appreciate your help in improving this manuscript! I agree with your revisions, and made all the requested changes. Additionally, attached please find the signed authorship change forms from all authors except Parisa Samimi - I believe she sent you her form separately.

Again, thank you very much.

Sincerely,  
Stephanie Handler

On Tue, Apr 16, 2019 at 12:14 PM Daniel Mosier <[dmosier@greenjournal.org](mailto:dmosier@greenjournal.org)> wrote:

Dear Dr. Handler,

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

1. Please note the minor edits and deletions throughout. Please let us know if you disagree with any of these changes.
2. When an author is added to the byline, we require an acknowledgment from all authors. Please see the attached form, which needs to be completed by every author (including Dr. Bresee).
3. LINE 3: Please spell out the first name of each author.
4. LINE 82: Please reduce the length of your Introduction to about 250 words.
5. LINE 86: Please rewrite in a way that is more readable for the typical OBGYN. You have too much emphasis on specifics here. Also, it is not clear why 'Naturally' the NPV is 100% and PPV 'only' 80%. Too much detail to be able to follow – please simplify
6. LINE 176: Please reduce the length of your Discussion to about 750 words.
7. LINE 200: This paragraph is the main finding and should begin the Discussion

8. TABLE 1 (ORIGINAL): This Table can be deleted as it is entirely stated in the text
9. TABLE 1 (NEW): Please simplify the numbers by restricting to whole integers. It is not necessary (or accurate) when estimating costs to carry it out to decimals.

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

Please let me know if you have any questions. Your prompt response to these queries will be appreciated; please respond no later than COB on **Thursday, April 18th**.

Sincerely,

-Daniel Mosier

**Daniel Mosier**

Editorial Assistant

*Obstetrics & Gynecology*

The American College of Obstetricians and Gynecologists

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Washington, DC 20024

Tel: 202-314-2342

Fax: 202-479-0830

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Web: <http://www.greenjournal.org>

--

Stephanie Handler

**From:** [REDACTED]  
**To:** [Denise Shields](#)  
**Subject:** Re: figures in your Green Journal manuscript (19-184)  
**Date:** Monday, April 8, 2019 11:16:13 AM

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Dear Denise,

The figures look great. Thank you so much for making the changes.

Best,  
Stephanie

Stephanie Handler, MD  
Fellow, Female Pelvic Medicine and Reconstructive Surgery  
Harbor-UCLA Medical Center

---

**From:** Denise Shields <DShields@greenjournal.org>  
**Sent:** Monday, April 8, 2019 7:34:12 AM  
**To:** Stephanie Handler  
**Subject:** RE: figures in your Green Journal manuscript (19-184)

Dear Stephanie,

Attached are edited versions of the figures with the requested edits. Do these look okay?

Thank you for sending the permission for figure 1.

Regards,  
Denise

---

**From:** Stephanie Handler [REDACTED]  
**Sent:** Thursday, April 4, 2019 3:23 PM  
**To:** Denise Shields <DShields@greenjournal.org>  
**Subject:** Re: figures in your Green Journal manuscript (19-184)

Dear Denise,

Thank you for editing the figures.

- Figure 1 is original: I designed it and my husband, who is a professional art director, made the figure for me on Photoshop
- The n= in the first box should be 206 (also in the second box), not 56
- In Figure 2, would it be possible to change "urinalysis" to microscopic urinalysis"? One of the suggestions by the reviewers was to be more specific when discussing type of urine test

Please let me know if I can help with this in any way.

Best,  
Stephanie

Stephanie Handler, MD  
Fellow, Female Pelvic Medicine and Reconstructive Surgery  
Harbor-UCLA Medical Center

---

**From:** Denise Shields <[DShields@greenjournal.org](mailto:DShields@greenjournal.org)>  
**Sent:** Tuesday, April 2, 2019 12:34:39 PM  
**To:** Stephanie Handler  
**Subject:** figures in your Green Journal manuscript (19-184)

Dear Dr. Handler,

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

The following queries are in the figure legends:

1. AQ: Figure 1 appears to be modified from another source. If it is, please provide permission for print and online use from the publisher to include it in your article. Please be sure to get permission to modify the original figure.
2. AQ: The first box doesn't indicate an n, but it appears to be 56 based on data in your manuscript. Please confirm whether this is correct.

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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