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)*

**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.

Date: Apr 18, 2019
To: "Anousheh Shafa" [redacted]
From: "The Green Journal" em@greenjournal.org
Subject: Your Submission ONG-19-369

RE: Manuscript Number ONG-19-369

Minimally invasive hysterectomy and bariatric surgery to improve endometrial cancer survivorship

Dear Dr. Shafa:

Your manuscript has been reviewed by the Editorial Board and by special expert referees. Although it is judged not acceptable for publication in Obstetrics & Gynecology in its present form, we would be willing to give further consideration to a revised version.

If you wish to consider revising your manuscript, you will first need to study carefully the enclosed reports submitted by the referees and editors. Each point raised requires a response, by either revising your manuscript or making a clear and convincing argument as to why no revision is needed. To facilitate our review, we prefer that the cover letter include the comments made by the reviewers and the editor followed by your response. The revised manuscript should indicate the position of all changes made. We suggest that you use the "track changes" feature in your word processing software to do so (rather than strikethrough or underline formatting).

Your paper will be maintained in active status for 21 days from the date of this letter. If we have not heard from you by May 09, 2019, we will assume you wish to withdraw the manuscript from further consideration.

REVIEWER COMMENTS:

Reviewer #1: The authors present a case of a patient who underwent gastric bypass surgery at the time of her surgery for early stage endometrial cancer. While this is an interesting concept, it is by no means novel and has occurred on many occasions in high volume centers. There is a balance between correcting her obesity and managing her endometrial cancer in a high risk morbidly obese patient which can certainly be done. My main question is, in this high risk patient, if her IUD seemed to be working, why did you offer surgery at all? There is decent evidence that high dose progestational therapy may work in this subset of patients.

Reviewer #2: The authors present an interesting combined surgery for the treatment of obesity and uterine cancer. While there are many concerns regarding combined surgical procedures (increased operative time, complications, LOS, etc), their safety has also been reported. Given the complex preparation and multidisciplinary team required for bariatric surgery, it is very unlikely that obese patients diagnosed with uterine cancer would be able to complete such a process prior to definitive surgery for uterine cancer. In this case, the patient had already started the process and surgery was only delayed by 2 months. Thus, the authors were able to offer a combined procedure.

While this is a vary rare circumstance, it is a useful teaching case to highlight the inter-relationship between obesity and endometrial cancer.

The only reservation with the article is the description of the patient population: "specific group of motivated patients." Because this was a fortunate coincidence, I do not think the authors can define the specific group (unless it is patients undergoing evaluation for bariatric surgery who happen to get diagnosed with uterine cancer). Would avoid the language above since the "specific group" is not defined. This is really a specific patient.

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. 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.

4. Because of space limitations, it is important that your revised manuscript adhere to the following length restrictions by manuscript type: Case Reports should not exceed 8 typed, double-spaced pages (2,000 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.

5. 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).

6. 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: Case Reports, 125 words. Please provide a word count.

7. 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.

8. 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.

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

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

11. Authors whose manuscripts have been accepted for publication have the option to pay an article processing charge and publish open access. With this choice, articles are made freely available online immediately upon publication. An information sheet is available at http://links.lww.com/LWW-ES/A48. The cost for publishing an article as open access can be found at http://edmgr.ovid.com/acd/accounts/ifauth.htm.

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

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

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

Again, your paper will be maintained in active status for 21 days from the date of this letter. If we have not heard from you by May 09, 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.

April 30, 2019

Re: Submission of manuscript, “Minimally invasive hysterectomy and bariatric surgery to improve endometrial cancer survivorship”

The Editors
Obstetrics & Gynecology
409 12th Street, SW
Washington, DC 20024-2188

Dear Reviewers and Editors:

On behalf of my co-authors, I am pleased to resubmit our manuscript, “Minimally invasive hysterectomy and bariatric surgery to improve endometrial cancer survivorship,” for consideration for publication as a case report in *Obstetrics & Gynecology.* Each of the comments by the reviewers and the editor are included below with our responses, which are italicized. These changes can also be viewed in the manuscript through the track changes feature.

REVIEWER COMMENTS:

Reviewer #1: The authors present a case of a patient who underwent gastric bypass surgery at the time of her surgery for early stage endometrial cancer. While this is an interesting concept, it is by no means novel and has occurred on many occasions in high volume centers. There is a balance between correcting her obesity and managing her endometrial cancer in a high risk morbidly obese patient which can certainly be done. My main question is, in this high risk patient, if her IUD seemed to be working, why did you offer surgery at all? There is decent evidence that high dose progestational therapy may work in this subset of patients.

We appreciate your comments and critiques. At the 3 month follow-up gynecologic oncology appointment, the patient was counseled on her treatment options. Her options were to continue progesterone therapy with close surveillance included every 3 to 6 month endometrial biopsy versus surgical treatment with a hysterectomy and bilateral salpingo-oophorectomy. The patient desired definitive surgical management.

In response to your comment, the phrase “first report” has been removed from the manuscript. While this dual surgery may have certainly been performed at other institutions that can provide both surgeries, the current literature does not have information regarding such cases especially with information regarding measurable outcomes up to six months after combined surgery.

Reviewer #2: The authors present an interesting combined surgery for the treatment of obesity and uterine cancer. While there are many concerns regarding combined surgical procedures (increased operative time, complications, LOS, etc), their safety has also been reported. Given

the complex preparation and multidisciplinary team required for bariatric surgery, it is very unlikely that obese patients diagnosed with uterine cancer would be able to complete such a process prior to definitive surgery for uterine cancer. In this case, the patient had already started the process and surgery was only delayed by 2 months. Thus, the authors were able to offer a combined procedure.

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The only reservation with the article is the description of the patient population: "specific group of motivated patients." Because this was a fortunate coincidence, I do not think the authors can define the specific group (unless it is patients undergoing evaluation for bariatric surgery who happen to get diagnosed with uterine cancer). Would avoid the language above since the "specific group" is not defined. This is really a specific patient.

Thank you for acknowledging this opportunity to provide patient education regarding the association between obesity and endometrial cancer, as well as the importance of treating obesity-related comorbidities in order to improve cancer survivorship. We do realize this case is unique in that our patient had already begun the bariatric surgery evaluation. We have therefore removed the language of "specific group" from the manuscript. However, at our institution, we are also fortunate to be able to identify such patients. For example, patients who are diagnosed with endometrial cancer and are good candidates for bariatric surgery can be evaluated by our bariatric surgery colleagues often within only a few days after referral. The reverse is also true for patients who are undergoing evaluation for bariatric surgery and have symptoms suspicious for endometrial cancer.

EDITORIAL OFFICE COMMENTS:

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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.

OPT-IN: Yes, please publish my response letter and subsequent email correspondence related to author queries.

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I will notify the co-authors to expect an email from the system and that they should review and electronically sign the eCTA.

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The use of the reVITALize definitions is not problematic and the manuscript has been revised to include the appropriate terminology, including atypical endometrial hyperplasia and postmenopausal bleeding.

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Word count for this case report is 1765 words, including the title page, precis, abstract, teaching points, text, table, and section headings.

5. 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).
There are no necessary changes in acknowledgements.

6. 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.
The abstract has been carefully reviewed.

In addition, the abstract length should follow journal guidelines. The word limits for different article types are as follows: Case Reports, 125 words. Please provide a word count.
Word count for case repot abstract is 124 words, not including the three section headers (Background, Case, and Conclusion).

7. 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.
The manuscript has been reviewed to ensure that only standard abbreviations and acronyms are used. All abbreviations and acronyms have been spelled out the first time they are used in the abstract and again the body of the manuscript before using the appropriate abbreviation and acronym.

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The virgule symbol is only used to express data or a measurement, including kg/m^2 and insulin units/day.

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

10. Please review the journal's Table Checklist to make sure that your tables conform to journal style. The Table Checklist is available online here:
http://edmgr.ovid.com/ong/accounts/table_checklist.pdf.
The Table Checklist has been reviewed and our table is within the guidelines.

11. Authors whose manuscripts have been accepted for publication have the option to pay an article processing charge and publish open access. With this choice, articles are made freely available online immediately upon publication. An information sheet is available at http://links.lww.com/LWW-ES/A48. The cost for publishing an article as open access can be found at http://edmgr.ovid.com/acd/accounts/ifauth.htm.
If accepted for publication, we do not wish to proceed with open access.

Each author participated actively in care of the patient, drafting sections of the manuscript, editing, and approving the final, submitted version. None of the authors have any financial or other conflict of interest.

This case report complies with HIPAA regulations. The patient involved in the case report has provided a signed authorization form for use of her medical information for research. This form will be filed with our records. This case report has not been previously published or submitted to another journal for publication.

This case report demonstrates the safe and effective use of dual surgery including minimally invasive hysterectomy and gastric bypass surgery to treat an obese patient with endometrioid endometrial adenocarcinoma and several obesity-related comorbidities. This case report also highlights the importance of patient education and a collaborative team model in order to improve cancer survivorship.

We look forward to your response. If you have any questions about the manuscript, I will be serving as the corresponding author. Thank you for your consideration.

Sincerely,

Anousheh Shafa, MD
[redacted]