

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.*

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Questions about these materials may be directed to the *Obstetrics & Gynecology* editorial office:
obgyn@greenjournal.org.

Date: Oct 07, 2019
To: "Anne M. Stachowicz" [REDACTED]
From: "The Green Journal" em@greenjournal.org
Subject: Your Submission ONG-19-1630

RE: Manuscript Number ONG-19-1630

Topical Hemostats in Benign Gynecologic Surgery

Dear Dr. Stachowicz:

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

REVIEWER COMMENTS:

REVIEWER #1:

Overall:

This paper is a current commentary that reviews the use of hemostats in benign gynecology.

OTHER:

Disclosures: Financial disclosures provided.

Human subjects: not applicable

Abstract:

1. The abstract is succinct and representative of the manuscript.

Introduction:

2. The brief introduction defines hemostats and identifies the need to define their role in benign gynecologic surgery.
3. The subsequent sections describe hemostat categories, review existing evidence for their use, discusses risks, cost estimates and trends in use.
4. Line 227: Please define "surgeon identity".

Conclusions:

5. The discussion is brief and relevant.

References:

6. The authors exceed the limit for references (41 instead of 24) for a current commentary but this seems justified as the manuscript is in large part a review paper.

FIGURE:

7. The figure legend states that this table was adapted from Spotnitz et al. There are 3 Spotnitz papers noted in the references. It might be useful to specify which Spotnitz paper the table was adapted from.

REVIEWER #2:

Very nice review of hemostatic agents. i have a few questions:

1. Is there any further comparative data among the various brands that have been listed within the categories of agents?
2. Is there any evidence available in the urologic or colorectal literature that could be brought in to this review that is pertinent to the gynecologic surgical anatomy? If so, I would like to see that reviewed/mentioned here as well.

REVIEWER #3:

OVERALL

1-The authors may consider changing "hemostats" to "hemostatic agents" as the latter is used more often in the literature and the OR (in my experience), and Hemostat is also the name of a surgical instrument, and therefore may be confusing to readers.

2-The authors should comment on whether the hemostatic use or evidence differs between open versus minimally invasive surgery. This is not currently mentioned at all, yet the increasing use of these agents has increased over the same time period as the use of MIS.

3-The authors should make the article more clinically relevant by commenting on use of agents in particular circumstances. Are there agents that cannot be used for various religious patients (e.g. Jehovah Witness) or vegetarians or without functioning clotting factors?

4-Any recommendations on how gynecologists should select which agent to use if multiple agents are available? This is alluded to in the review of the different categories and could lend itself to a flow chart.

INTRODUCTION

5-The authors are making a distinction in this commentary about the use of these agents in benign gynecologic surgery. Can they therefore comment on whether the evidence exists and/or is better in other surgical specialties? General surgery? Trauma? OB? This could be done in the introduction or prior to the Specific Evidence or Use in Benign Gynecology. The introduction would also benefit from a brief outline of the commentary structure so the reader knows what will be discussed.

HEMOSTAT CATEGORIES

6-Lines 59-61: Given that the examples are in the table, they can be removed from these lines, where they are only distracting.

7-Line 62: Change Figure 1 to Table 1.

SPECIFIC EVIDENCE FOR USE IN BENIGN GYNECOLOGY

8-As above, it is worth mentioning whether the amount of evidence for use in benign gynecology is comparable to the evidence in other fields. Also, given that this is a commentary with the possibility of opinions, it would be interesting to know what the authors tend to do in their practice for each of the procedure types.

9-Lines 104-105: Is there only evidence for these two procedures because there is no evidence for other procedures (i.e. studies do not exist) or because the evidence does not favor usage?

10-Line 139-143: What is the mode of hysterectomy in these studies?

11-Line 147: Cesarean section is not a gynecological procedure

12-Lines 145-151: This paragraph could be incorporated into the start of this section to provide a better context for how the authors settled on these procedures to focus on and to reduce redundancy.

RISKS OF HEMOSTAT USE

13-The authors do a good job of reviewing specific studies in this section. However, many of these risks are documented for one specific type of agent, rather than any or all of the agents. The authors should make this more clear. They could consider adding this to the table or creating a different table with risks for specific agents.

POST-PROCEDURAL INFECTIOUS COMPLICATIONS

14-Lines 160-166: Is there any evidence for increased risk of post-op abscess in other procedures or with other agents?

15-Line 162: what was the mode of surgery?

16-Line 167: This seems like a very broad recommendation based on one agent type

17-Lines 170-182: Is there any literature about the mimicry leading to unnecessary procedures or treatment? Are any of the other agents associated with this mimicry?

18-Lines 200-202: Which agents are these for? Again, this may be well-represented in a table.

COST OF HEMOSTAT USE

19-The cost of the different agents should be added to the Table. Is there any evidence to whether or how much these are contributing to healthcare spending? An agent may also be expensive but its use may be cheaper than the alternative (e.g. longer OR time, blood transfusion, etc.). Before focusing on how to reduce spending on hemostats, the authors should establish whether we know whether they are cost-effective. Overall, this section could be shortened by cutting lines 208-215.

CURRENT TRENDS IN USE

20-This paragraph should either be incorporated into the introduction or should be moved to the beginning of the Commentary.

FIGURE 1

21-Rename as table

22-Add cost of each agent

23-Add known risks of appropriate agents

24-Add type of surgery used for (open versus minimally invasive)

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. 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:

- A. OPT-IN: Yes, please publish my point-by-point response letter.
- B. OPT-OUT: No, please do not publish my point-by-point response letter.

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.

Please check with your coauthors to confirm that the disclosures listed in their eCTA forms are correctly disclosed on the manuscript's title page.

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: Current Commentary articles should not exceed 12 typed, double-spaced pages (3,000 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: Current Commentary articles, 250 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. The Journal's production editor had the following to say about the figures in your manuscript:

"Figure 1: Please recategorize this as a table."

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.

10. 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.

If you choose to revise your manuscript, please submit your revision through Editorial Manager at <http://ong.editorialmanager.com>. Your manuscript should be uploaded in a word processing format such as Microsoft Word. Your revision's cover letter should include the following:

* A confirmation that you have read the Instructions for Authors (<http://edmgr.ovid.com/ong/accounts/authors.pdf>), and

* A point-by-point response to each of the received comments in this letter.

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

Sincerely,

The Editors of Obstetrics & Gynecology

2018 IMPACT FACTOR: 4.965

2018 IMPACT FACTOR RANKING: 7th out of 83 ob/gyn journals

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

October 22, 2019

Re: Revision of Submission ONG-19-1630, "Topical Hemostatic Agents in Benign Gynecologic Surgery"

The Editors
Obstetrics & Gynecology
409 12th Street, SW
Washington, DC 20024-2188
Phone: 202-314-2317
Fax: 202-479-0830
Email: obgyn@greenjournal.org

Dear Editors:

On behalf of my co-author, I am pleased to re-submit our manuscript, "Topical Hemostatic Agents in Benign Gynecologic Surgery," for consideration for publication as Clinical Commentary in *Obstetrics & Gynecology*. Each author actively participated in drafting sections of the manuscript, editing, revising, and approving the final, submitted version. James L. Whiteside received money paid to him from Coloplast, the International Academy of Pelvic Surgery, and Legal reviews. He received teaching honoraria from AUGS. I have no potential conflicts of interest to report. The manuscript has not been previously presented, published or submitted to another journal for publication. Our manuscript discusses our opinion there is limited specialty-specific evidence demonstrating that routine, preferential use of these agents confers any patient-care benefit, and the use of these products is not without risk and can add unwarranted costs to the healthcare system. Below you will find the reviewers' comments followed by our response in red. We look forward to your comments and critique of the manuscript. If you have any questions about the manuscript, I will be serving as the corresponding author. Thank you for your consideration.

REVIEWER COMMENTS:

REVIEWER #1:

Overall:

This paper is a current commentary that reviews the use of hemostats in benign gynecology.

OTHER:

Disclosures: Financial disclosures provided.

Human subjects: not applicable

Abstract:

1. The abstract is succinct and representative of the manuscript.

Introduction:

2. The brief introduction defines hemostats and identifies the need to define their role in benign gynecologic surgery.

3. The subsequent sections describe hemostat categories, review existing evidence for their use, discusses risks, cost estimates and trends in use.

4. Please define "surgeon identity".

Line 70: Surgeon identity was further defined as follows, "surgeon identity, i.e. an individual surgeon's practice habits,".

5. The discussion is brief and relevant.

References:

6. The authors exceed the limit for references (41 instead of 24) for a current commentary but this seems justified as the manuscript is in large part a review paper.

FIGURE:

7. The figure legend states that this table was adapted from Spotnitz et al. There are 3 Spotnitz papers noted in the references. It might be useful to specify which Spotnitz paper the table was adapted from.

Citation inserted into Table 1. Title "Adapted from Spotnitz et al."⁵

REVIEWER #2:

1. Is there any further comparative data among the various brands that have been listed within the categories of agents?

Thank you for this question. Unfortunately, within the scope of benign gynecology, the few comparative studies only analyzed hemostatic agents versus controls (e.g. saline rinse or electrocautery).

2. Is there any evidence available in the urologic or colorectal literature that could be brought in to this review that is pertinent to the gynecologic surgical anatomy? If so, I would like to see that reviewed/mentioned here as well.

The urologic body of literature regarding hemostatic agents pertains to use in extra- and retroperitoneal dissection beds (e.g. radical nephrectomy, pelvic lymphadenopathy, extraperitoneal prostatectomy). Similarly, the colorectal body of literature discusses hemostatic agent use in liver parenchymal bleeding, gastrectomy, and for prevention of bowel anastomotic leaks. As this review is focused towards the primary readership of *Obstetrics and Gynecology*, the generalist OB/GYN, we feel that a discussion of hemostatic agent use in such circumstances is beyond the scope of this review.

REVIEWER #3:

OVERALL

1-The authors may consider changing "hemostats" to "hemostatic agents" as the latter is used more often in the literature and the OR (in my experience), and Hemostat is also the name of a surgical instrument, and therefore may be confusing to readers.

Please see in text that all occurrences of "hemostat" has been replaced with "hemostatic agent".

2-The authors should comment on whether the hemostatic use or evidence differs between open versus minimally invasive surgery. This is not currently mentioned at all, yet the increasing use of these agents has increased over the same time period as the use of MIS.

As there is a lack of literature comparing the efficacy of hemostatic agents in open versus minimally invasive surgical approaches, there is nothing we can add to the manuscript on this topic. Additionally, there is no available evidence evaluating trends in hemostat use as minimally invasive procedures have increased in demand. It is our suspicion that use of hemostatic agents, particularly in prophylactic circumstances has increased as more minimally invasive procedures are being performed, however, these suspicions are not currently supported by literature.

3-The authors should make the article more clinically relevant by commenting on use of agents in particular

circumstances. Are there agents that cannot be used for various religious patients (e.g. Jehovah Witness) or vegetarians or without functioning clotting factors?

A statement regarding patient religious and animal rights beliefs has been added under “Immunologic Risks” section (see lines 196-198). Statements regarding use of mechanical hemostatic products in setting of heparinized patients as well as their limited efficacy in the setting of thrombocytopenia has been added (lines 33-35). Additionally, these topics are mentioned in Figure 1.

4-Any recommendations on how gynecologists should select which agent to use if multiple agents are available? This is alluded to in the review of the different categories and could lend itself to a flow chart.

A flow chart (Figure 1) has been added and cited in the manuscript on line 80. Additionally a figure legend and preliminary image of the figure has been added to the end of the manuscript.

INTRODUCTION

5-The authors are making a distinction in this commentary about the use of these agents in benign gynecologic surgery. Can they therefore comment on whether the evidence exists and/or is better in other surgical specialties? General surgery? Trauma? OB? This could be done in the introduction or prior to the Specific Evidence or Use in Benign Gynecology. The introduction would also benefit from a brief outline of the commentary structure so the reader knows what will be discussed.

A statement has been added to the manuscript introduction pertaining to the smaller body of literature regarding hemostatic agents in benign gynecology as opposed to other specialties, and that evidence supporting use has been borrowed from other specialties such as orthopedics (lines 6-8). As the scope of this review pertains to benign gynecology, we feel that adding commentary beyond this may be distracting to the purpose of this manuscript.

Lines 5-10 of the introduction paragraph as well as the section headings gives readers the opportunity to scan and identify which topics this commentary will cover.

HEMOSTAT CATEGORIES

6-Lines 59-61: Given that the examples are in the table, they can be removed from these lines, where they are only distracting.

Completed, please see manuscript (line 15).

7-Line 62: Change Figure 1 to Table 1.

All instances of Figure 1 have been changed to Table 1 as requested.

SPECIFIC EVIDENCE FOR USE IN BENIGN GYNECOLOGY

8-As above, it is worth mentioning whether the amount of evidence for use in benign gynecology is comparable to the evidence in other fields. Also, given that this is a commentary with the possibility of opinions, it would be interesting to know what the authors tend to do in their practice for each of the procedure types.

Please see our response to this reviewer's question #5 above.

9-Lines 104-105: Is there only evidence for these two procedures because there is no evidence for other procedures (i.e. studies do not exist) or because the evidence does not favor usage?

To the best of our knowledge these two procedures are the only two for which there are comparative studies, for the other procedures there is either no existing studies or only small, single arm assessments. This limitation in knowledge has been added to the manuscript (Line 81).

10-Line 139-143: What is the mode of hysterectomy in these studies?

These studies both included all surgical routes, however, it should have been noted and we have since clarified in the manuscript (lines 86-88, 123), that increased rates of postoperative complications were only associated with hemostat use in setting of minimally invasive surgical approach.

11-Line 147: Cesarean section is not a gynecological procedure

Cesarean section has been removed from the mentioned list (lines 82-85).

12-Lines 145-151: This paragraph could be incorporated into the start of this section to provide a better context for how the authors settled on these procedures to focus on and to reduce redundancy.

Completed, please see manuscript.

RISKS OF HEMOSTAT USE

13-The authors do a good job of reviewing specific studies in this section. However, many of these risks are documented for one specific type of agent, rather than any or all of the agents. The authors should make this more clear. They could consider adding this to the table or creating a different table with risks for specific agents.

An explanation has been added to the manuscript that studies pertaining to risks only focus on individual products and may not be applicable to all hemostatic agents (lines 136-139). That being said, surgeons are encouraged to review the IFU for education on specific pertinent product risks. As IFU for each product includes extensive lists of theoretical risks, we do not feel it is feasible to add a column to the table for the risks of specific agents.

Specific risks pertaining to categories of hemostatic agents have been added as superscript numbers with explanations under the table (Please see table 1). Instead of footnotes, we additionally tried creating a separate "Risk" Column, however as many risks pertain to multiple but not all products we felt there was too much repetition. We feel the cleanest presentation of the data is represented in Table 1 currently.

POST-PROCEDURAL INFECTIOUS COMPLICATIONS

14-Lines 160-166: Is there any evidence for increased risk of post-op abscess in other procedures or with other agents?

This review of post-operative abscess encompasses all studies pertaining to benign gynecology and hemostatic agents.

15-Line 162: what was the mode of surgery?

The study by Anderson included benign and malignancy-related hysterectomy of all routes with exception to vaginal (line 144).

16-Line 167: This seems like a very broad recommendation based on one agent type.

Hemostatic agent in this sentence has been changed to gelatin-thrombin matrix to emphasize this concern pertains to this particular hemostatic agent (line 150).

17-Lines 170-182: Is there any literature about the mimicry leading to unnecessary procedures or treatment? Are any of the other agents associated with this mimicry?

This study is the only of its kind reported in the literature of gynecologic surgery. Frati et al report that despite initial CT report not exclusively describing concern for abscess, six of eight patients undergoing CT for post-operative fever were treated with antibiotic while the remaining two underwent necessary reoperation. There are reports of mechanical hemostats (porcine gelatin) as well as fibrin sealants mimicking abscess or recurrent tumor on MRI in neurosurgical, cardiothoracic, and hepatic surgery contexts as well.

18-Lines 200-202: Which agents are these for? Again, this may be well-represented in a table.

"(Please see Table 1 for which hemostatic agent categories these risk pertain to)" has been added to the end of the "Case Based Reported Complications" section (line 205-6).

COST OF HEMOSTAT USE

19-The cost of the different agents should be added to the Table. Is there any evidence to whether or how much these are contributing to healthcare spending? An agent may also be expensive but its use may be cheaper than the alternative (e.g. longer OR time, blood transfusion, etc.). Before focusing on how to reduce spending on hemostats, the authors should establish whether we know whether they are cost-effective. Overall, this section could be shortened by cutting lines 208-215.

Reporting exact costs associated each individual agent is difficult nor would be accurate as costs of agents vary significantly. A statement advising physicians to investigate local costs has been added (lines 213-214). There are no available comparative cost analyses (line 214-215). The suggested lines have been removed.

CURRENT TRENDS IN USE

20-This paragraph should either be incorporated into the introduction or should be moved to the beginning of the Commentary.

The "Current Trends in Use" section has been moved to earlier in the manuscript just after the description of various hemostatic agents and before the discussion of benign gynecologic evidence.

FIGURE 1

21-Rename as table.

Completed, please see manuscript.

22-Add cost of each agent

Reporting exact costs associated each individual agent is difficult nor would be accurate as costs of agents vary significantly. A statement advising physicians to investigate local costs has been added to the manuscript text (line 213-214).

23-Add known risks of appropriate agents.

Completed, please see Table 1

24-Add type of surgery used for (open versus minimally invasive).

These products can be adapted for use in multiple different modes of gynecologic surgery. Therefore, we cannot distinguish which product is used for which type of surgery.

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. 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:

A. OPT-IN: Yes, please publish my point-by-point response letter.

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Please check with your coauthors to confirm that the disclosures listed in their eCTA forms are correctly disclosed on the manuscript's title page.

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.

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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.

The abstract has been carefully reviewed and the authors feel it meets the above criteria.

In addition, the abstract length should follow journal guidelines. The word limits for different article types are as follows: Current Commentary articles, 250 words. Please provide a word count.

Added word count at end of abstract

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 list of acceptable abbreviations has been reviewed. Use of average wholesale pricing (AWP) and odds ratio (OR) has been eliminated as those terms were only used once. The following abbreviations used in the manuscript are not on the accepted list: Food and Drug Administration (FDA), Oxidized Regenerated Cellulose (ORC), Anti-mullerian Hormone (AMH), Antral Follicle Count (AFC), Information for Use (IFU), Computed Tomography Scan (CT), and US dollar (USD). The authors feel that expansion of these abbreviations throughout the manuscript would detract from its readability. All abbreviations have been defined at initial use.

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.

All uses of the virgule symbol (/) in sentences with words have been replaced. The only remaining use of this symbol is to either express data or in web-addresses in the references.

9. The Journal's production editor had the following to say about the figures in your manuscript:

"Figure 1: Please recategorize this as a table."

Recategorized as requested.

Sincerely,

Anne M. Stachowicz, MD