

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: Jul 02, 2020
To: "Elizabeth Suh-Burgmann" [REDACTED]
From: "The Green Journal" em@greenjournal.org
Subject: Your Submission ONG-20-1662

RE: Manuscript Number ONG-20-1662

Impact of the COVID-19 Pandemic on Endometrial Cancer Detection

Dear Dr. Suh-Burgmann:

Your manuscript has been rapidly reviewed by the Editors. We would like to pursue fast-track publication. If you can address the comments below and submit your revision quickly, the Editorial Office will start working on it as soon as possible. I am setting the due date to July 6th, but we will start working on it whenever you can submit.

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).

REVIEWER COMMENTS:

Reviewer #1: The purpose of this manuscript was to evaluate COVID-19's "impact on the diagnosis of endometrial cancer, which affects over 65,000 women in the US annually and is usually detected by biopsy following complaints of abnormal bleeding (4)." This was a retrospective review of electronic databases.

1. The authors note that data was assessed from electronic databases. How were the subjects identified in the databases? What type of databases were used for this study; administrative, research or other type of database? How reliable and valid is the data in these databases?
2. Who assessed the data in the databases? Was the data recorded on a piloted form? Was the data transferred to an electronic database? What was done to ensure accuracy of data recording and transfer? What was done if there was missing data?
3. The authors note that "all outpatient women's health clinics remained open and providers continued to perform indicated biopsies." After the SIP order were only emergency or urgent patients seen in their clinics? Did the call center have a list of patient complaints, like menopausal vaginal bleeding, that were considered urgent and needed immediate attention? Was gyn ultrasound available during this time frame? Or did they continue to provide routine care, like Pap smears, mammograms, etc? How was telemedicine used in their clinics? Were patients dissuaded from coming to the clinic unless they had an urgent condition?
4. Why did the authors select "four weeks preceding March 4" for both 2020 and 2019? Why not evaluate data from Jan 1, 2020 to March 4, 2020 as pre-COVID group? Why not label as the pre-COVID group (4 weeks before March 4th) and the COVID-19 group?
5. What were the total number of female person-weeks covered by Kaiser Permanente Northern California during the time frames of this study? Could the authors write the incidence rates as whole number diagnoses per 100,000 person years?
6. In the results section please re-write " In 2020, the incidence rate decreased from 1.0 (95% CI:0.8-1.3) from February 26-March 3 to 0.58 (95% CI, 0.48-0.69) compared to 2019 (incidence rate ratio, 0.59, 95% CI:0.44-0.78, P<.001)." Instead of "February 26-March 3", should it be February 6-March 3? Should it be "to 0.58 (95% CI, 0.48-0.69) for March 4-May 26, compared to 2019..."?

Reviewer #2: Suh-Burgmann and colleagues examined the incidence rates of endometrial cancer in California during the COVID-19 pandemic. Overall this is very well written and interesting. Comments for the authors:

1. Are person-weeks limited to female members of the health system?

2. Assume that the incidence rate reported in the Results is based on diagnoses per 100,000 person weeks? This should somehow be clarified in the Results.

Reviewer #3: Table 1: The p-values should all be rounded to nearest 0.01, since all were NS and the size of the samples does not warrant precision to nearest 0.0001. The comparison in South Bay area is (1) actually NS, so there is no trend and (2) it is only one of 6 subset by geography and there is no adjustment for multiple hypothesis testing, so should just cite the overall test, which had $p = 0.32$. Also, for some of the subsets, the counts were modest, so there is likely low stats power to have observed differences based on age, BMI etc for these cohorts.

Fig 1: Should include a larger sample prior to March 4 for both years, since there appears to be a drop in weekly case in Feb in both 2019 and 2020, so a longer comparison might more convincingly show the difference in 2020 vs 2019.

Fig 1 and lines 41-43: From the graph itself, the rates for Feb 3-March 4 do not appear that different for 2019 vs 2020, so why use only one week from 2019 vs 2020. Line 32 suggests that the comparison was to have been the 4 weeks prior to March 4, not just Feb 26-March 3. The 4 weeks before Feb 26-Mar 3 appear to have for rates 2019 vs 2020: (1) rate higher in 2020, (2) ~ equal in 2020 and 2019, (3) higher in 2020, then (4) lower in 2020. Need to examine a longer time frame to assure that the differences are associated with Covid-19, rather than just seasonal or weekly variation.

Reviewer #4: Thank you for submitting your work to the Journal. It is important to be seeing data regarding non-obstetric consequences of the COVID-19 pandemic. You've used the research letter format very well; your paper is clearly written, succinct and focused.

It is an idiosyncratic fact that at the Journal we tend to avoid the use of the word impact to imply the result of a change, preferring to limit "impact" to mean a physical blow. Please use "effect" or "affect" instead.

Line 26: Since your paper is about endometrial cancer diagnoses rates in KPNC, could you give a range of annual rates for diagnoses in your system over the last 5 years for context?

Line 32: Why not just say from Feb 4 to May 26, 2020 and to the same period in 2019? It isn't clear why you did this and whether there is a reason to have done so.

Line 39: This would be "From March 4 to...." rather than "between" as that would technical exclude March 4 and May 26.

I'm unclear on line 39-43 why you are reporting the rates for March 4-May 26 separately from 2/26-3/3. Provide units for incidence (eg, 0.88/100,000 person-weeks)

Please limit p values to 3 decimals.

44. Is this the overall call rate to the KPNC call center?

46. We do not allow authors to describe variables or outcomes in terms that imply a difference (such as the terms "trend" or "tendency" or "marginally different") unless there is a statistical difference. Please edit here and throughout to indicate that there is no difference. Since the South Bay Area is significant due to nature of local pandemic, in the discussion you could mention the difference and the lack of significance perhaps due to power.

51. This is of course a well informed speculation. Other possible explanations may be over all anxiety, adjustment to stay at home orders and changes in routines with minimization of symptoms.

54. Disproportionately affected by what? Fear of COVID 19? COVID 19 itself?

Table 1 can go to supplemental digital content; none of the findings are different from year to year and the data reported here are not that relevant to this research letter objective or result. The data should be available but isn't critical in the manuscript itself.

It looks like the rate of endometrial Ca diagnoses were already falling from Feb 4 to March 4, preceding the rapid rise in cases in California and the State at home order. This may be temporal, given a similar pattern in 2019. Please comment.

EDITOR 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. Obstetrics & Gynecology uses an "electronic Copyright Transfer Agreement" (eCTA). 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 data definitions at <https://www.acog.org/practice-management/health-it-and-clinical-informatics/revitalize-obstetrics-data-definitions> and the gynecology data definitions at <https://www.acog.org/practice-management/health-it-and-clinical-informatics/revitalize-gynecology-data-definitions>. 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: Research Letters articles should not exceed 2.5 pages (600 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. 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."

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.

Please spell out "SIP."

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. ACOG is moving toward discontinuing the use of "provider." Please replace "provider" throughout your paper with either a specific term that defines the group to which are referring (for example, "physicians," "nurses," etc.), or use "health care professional" if a specific term is not applicable.

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. Each supplemental file in your manuscript should be named an "Appendix," numbered, and ordered in the way they are first cited in the text. Do not order and number supplemental tables, figures, and text separately. References cited in appendixes should be added to a separate References list in the appendixes file.

12. 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>.

13. 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.

Sincerely,

The Editors of Obstetrics & Gynecology

2019 IMPACT FACTOR: 5.524

2019 IMPACT FACTOR RANKING: 6th out of 82 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.

July 3, 2020

Dear Editors,

Thank you for the response to our submission, "Impact of the COVID-19 pandemic on detection of endometrial cancer" which we have retitled "Effect of the COVID-19 pandemic on detection of endometrial cancer."

Our point-by-point response to the Reviewer comments, which were very helpful, is detailed below.

Based on the comments, it was apparent that the presentation of the rate comparisons was somewhat confusing, which we attribute to our attempt to adhere to the prescribed word count as well as to an unfortunate typo in dates which we have corrected. We have rewritten the Results section to present the comparisons more clearly. Although we have tried to keep the revision succinct, these and other changes made to address the reviewer comments have increased the word count from 600 to 670. We are unable to identify additional edits to streamline the paper without compromising clarity but are open to suggested changes.

We confirm that we have read the Instructions for Authors.

Thank you again,

Elizabeth Suh-Burgmann, MD

Mubarika Alavi, MD

Julie Schmittiel, Ph D

REVIEWER COMMENTS:

Reviewer #1: The purpose of this manuscript was to evaluate COVID-19's "impact on the diagnosis of endometrial cancer, which affects over 65,000 women in the US annually and is usually detected by biopsy following complaints of abnormal bleeding (4)." This was a retrospective review of electronic databases.

1. The authors note that data was assessed from electronic databases. How were the subjects identified in the databases? What type of databases were used for this study; administrative, research or other type of database? How reliable and valid is the data in these databases?

The data was extracted using a database that pulls data directly from the electronic medical record, organizing it into formats that can more efficiently be searched. The database is used for both research and operational purposes. The accuracy of the information in the database reflects the accuracy of the information in the medical record itself. Within this database, it is possible to search separate datasets for pathology, pharmacy, outpatient visits, call center encounters, hospitalizations, etc. We used the pathology dataset to identify subjects by searching for the keywords "endometrial adenocarcinoma" on endometrial biopsy or D&C specimens obtained during the respective time periods. The PI manually reviewed reports for confirmation and histology. The number of women identified in 2019 is consistent with the expected number for that time interval based on the typical annual number of endometrial

cancer diagnoses in the health system. Furthermore, we used the same methodology for all analyses so a deficiency in the data extraction algorithms would be expected to apply equally to all time periods and would be unlikely to compromise the overall comparisons.

We have revised the sentence in the Methods describing data collection to read: **“Cancers were identified by pathology reports, confirmed by manual review, and patient characteristics assessed using electronic databases linked to medical records.”**

2. Who assessed the data in the databases?

Extraction of data from these databases requires search algorithms to be written using SAS code. This was performed by Mubarika Alavi, an analyst at the KPNC Division of Research trained to do this type of work. Pathology reports were manually reviewed by the PI as described above.

Was the data recorded on a piloted form? Was the data transferred to an electronic database? What was done to ensure accuracy of data recording and transfer?

Data from the medical record is automatically transferred to the electronic database. Data used for the study was extracted from database searches into SAS and Excel research files for analysis.

What was done if there was missing data?

Because of the closed, integrated nature of the health system, it is unlikely that cancer diagnoses among health plan members occurred outside of the system.

Missing patient characteristic data was very limited and is noted as “unknown” in Table 1.

3. The authors note that "all outpatient women's health clinics remained open and providers continued to perform indicated biopsies." After the SIP order were only emergency or urgent patients seen in their clinics? Did the call center have a list of patient complaints, like menopausal vaginal bleeding, that were considered urgent and needed immediate attention? Was gyn ultrasound available during this time frame? Or did they continue to provide routine care, like Pap smears, mammograms, etc? How was telemedicine used in their clinics? Were patients dissuaded from coming to the clinic unless they had an urgent condition?

Routine screening visits were deferred shortly after the SIP order. Physicians and nurse practitioners were asked to convert their in-person appointments that did not require physical exam to video or phone appointments. At no time was there a policy to defer visits for women with bleeding who required biopsy (had this been the case, there would have been essentially no new diagnoses made during this time). However, patients may have cancelled or delayed visits. The call center has numerous protocols for different complaints. The protocol for abnormal vaginal bleeding directs women with severe bleeding or other worrisome symptoms to the emergency department. Otherwise, an appointment is scheduled with a gynecologist, typically within 2-3 days. After the SIP order, these initial appointments were scheduled as telephone or video visits. While this would be expected to result in a short delay in diagnosis, the proportion of endometrial cancer diagnoses preceded by a call center call for abnormal bleeding did not change during the pandemic compared to the same period in 2019 (35% in 2019, 41% in 2020) which suggests that failure to follow-up calls with biopsy was not a significant contributor of decreased diagnoses. GYN ultrasound continued to be available during this time unless the ordering physician indicated it should be deferred.

Given space considerations we have not added these details to the manuscript, and instead summarize the situation as **“In response to the SIP order, routine screening visits were deferred and some complaints of bleeding were initially evaluated by phone or video, but all outpatient women’s health**

clinics remained open and providers continued to perform biopsies." However, if the Editors feel that additional information should be included, we would be happy to do so.

4. Why did the authors select "four weeks preceding March 4" for both 2020 and 2019?

We selected 4 weeks pre- pandemic as we felt that 4 weeks was adequate to assess the pre-COVID rate.

Why not evaluate data from Jan 1, 2020 to March 4, 2020 as pre-COVID group?

We limited the pre-COVID analysis to 4 weeks due to time constraints.

Why not label as the pre-COVID group (4 weeks before March 4th) and the COVID-19 group?

On the figure, we have added a vertical line with a label at March 4 to visually separate the pre-pandemic and pandemic time periods for clarity.

5. What were the total number of female person-weeks covered by Kaiser Permanente Northern California during the time frames of this study?

The total number of person-weeks based on the population of females aged 18 or older was 21,250,387 in 2019 and 21,820,111 in 2020.

Could the authors write the incidence rates as whole number diagnoses per 100,000 person years?

Using crude conversion, the average weekly incidence rate from March 4-May 26, 2019 of 0.88 cases/100,000 person-weeks converts to 46 cases/100,000 person-years and for 2020, the rate of 0.58 cases/100,000 person-weeks converts to 30 cases/100,000 person-years. Although we appreciate that whole numbers are more readable, we feel it is more appropriate to present the incidence rates as diagnoses per 100,000 person-weeks because the rates presented are the average of weekly incidence rates during the respective time periods and because the overall time period of the study is only 16 weeks.

6. In the results section please re-write " In 2020, the incidence rate decreased from 1.0 (95% CI:0.8-1.3) from February 26-March 3 to 0.58 (95% CI, 0.48-0.69) compared to 2019 (incidence rate ratio, 0.59, 95% CI:0.44-0.78, P<.001)." Instead of "February 26-March 3", should it be February 6-March 3? Should it be "to 0.58 (95% CI, 0.48-0.69) for March 4-May 26, compared to 2019..."?

We apologize for this typo of the date Feb 26. It should have been Feb 4. We have corrected this. Based on this and other reviewer comments, we have rewritten the Results section to try to present the comparisons more clearly.

Reviewer #2: Suh-Burgmann and colleagues examined the incidence rates of endometrial cancer in California during the COVID-19 pandemic. Overall this is very well written and interesting. Comments for the authors:

1. Are person-weeks limited to female members of the health system?

Yes, person weeks were calculated based on health plan membership of females aged 18 and older during the respective time periods.

2. Assume that the incidence rate reported in the Results is based on diagnoses per 100,000 person weeks? This should somehow be clarified in the Results.

Yes, the incidence rate reported is based on diagnoses per 100,000 person-weeks based on the population of female health plan members aged 18 and older. We have revised a sentence in the

Methods to read: **“All rates were based on the population of female health plan members aged 18 or older at the time and compared using incidence rate ratios.”**

We have also added a footnote to the figure: **“Incidence rate calculated as diagnosis per 100,000 person-weeks based on the population of female health plan members aged 18 or older at the time.”**

Reviewer #3: Table 1: The p-values should all be rounded to nearest 0.01, since all were NS and the size of the samples does not warrant precision to nearest 0.0001. The comparison in South Bay area is (1) actually NS, so there is no trend and (2) it is only one of 6 subset by geography and there is no adjustment for multiple hypothesis testing, so should just cite the overall test, which had $p = 0.32$. Also, for some of the subsets, the counts were modest, so there is likely low stats power to have observed differences based on age, BMI etc for these cohorts.

We have rounded the P values to the nearest 0.01 and removed the footnote regarding the South bay.

1. Fig 1: Should include a larger sample prior to March 4 for both years, since there appears to be a drop in weekly case in Feb in both 2019 and 2020, so a longer comparison might more convincingly show the difference in 2020 vs 2019.

When the pre-pandemic period of Feb 4-March 3 is compared between 2019 and 2020, the rates are similar (0.94 (95% CI:0.74-1.19) in 2019 vs 1.0 (95% CI:0.79-1.26) in 2020). We have rewritten the Results section to try to present these comparisons more clearly. While we agree that adding data from a longer pre-pandemic time interval going back to Jan 1 would add to the comparison between pre-pandemic and pandemic rates, extracting this additional data and recalculating rates will require approximately 2-3 weeks to complete. In the interest of time, we respectfully request to forego this additional analysis.

2. Fig 1 and lines 41-43: From the graph itself, the rates for Feb 3-March 4 do not appear that different for 2019 vs 2020, so why use only one week from 2019 vs 2020.

The rates between Feb 4-March 3 were similar. We have corrected the typo of Feb 26 instead of Feb 4.

3. Line 32 suggests that the comparison was to have been the 4 weeks prior to March 4, not just Feb 26-March 3.

Please see response to the Reviewer #1, question 6. Again, we regret the typo and have corrected this.

4. The 4 weeks before Feb 26-Mar 3 appear to have for rates 2019 vs 2020: (1) rate higher in 2020, (2)~ equal in 2020 and 2019, (3) higher in 2020, then (4) lower in 2020. Need to examine a longer time frame to assure that the differences are associated with Covid-19, rather than just seasonal or weekly variation.

We have revised the Results section to state: “From Feb 4-March 3, the average weekly endometrial cancer incidence rate in 2020 (1.0, 95% CI:0.79-1.26) was similar to the rate observed in 2019 (0.94, 95% CI:0.74-1.19). “

We feel that weekly or seasonal variation is unlikely to account for the findings given that the rates during the pre-pandemic weeks were similar in 2019 and 2020, the rates during the pandemic were assessed over 12 weeks, the magnitude of the decline observed in 2020 relative to pre-pandemic levels is large and is similar to the magnitude of decline relative to the identical time period in 2019.

Reviewer #4: Thank you for submitting your work to the Journal. It is important to be seeing data regarding non-obstetric consequences of the COVID-19 pandemic. You've used the research letter format very well; your paper is clearly written, succinct and focused.

1. It is an idiosyncratic fact that at the Journal we tend to avoid the use of the word impact to imply the result of a change, preferring to limit "impact" to mean a physical blow. Please use "effect" or "affect" instead.

We have changed the title to “Effect of the COVID-19 pandemic on endometrial cancer detection” and removed the word “impact” from the introductory paragraph.

2. Line 26: Since your paper is about endometrial cancer diagnoses rates in KPNC, could you give a range of annual rates for diagnoses in your system over the last 5 years for context?

Based on the institution’s cancer registry, the annual number of endometrial cancer diagnoses from 2014 to 2017 ranged from 722 to 845. The numbers for 2018 and 2019 are not yet finalized but based on membership we would expect them to be in this same range.

3. Line 32: Why not just say from Feb 4 to May 26, 2020 and to the same period in 2019? It isn't clear why you did this and whether there is a reason to have done so.

We compare rates pre-pandemic (Feb 4-March 3) to those observed during the pandemic (March 4-May 26) in 2020. In order to assess if a decline was attributable to seasonal variation, we also compared the pandemic period (March 4-May 26) in 2020 to the same period in 2019. We have rewritten the Results section to try to present these comparisons more clearly.

4. Line 39: This would be "From March 4 to...." rather than "between" as that would technical exclude March 4 and May 26.

We have made this correction.

5. I'm unclear on line 39-43 why you are reporting the rates for March 4-May 26 separately from 2/26-3/3.

Provide units for incidence (eg, 0.88/100,000 person-weeks)

As per our response to Reviewer #1, question 6, we regret the typo of Feb 26 instead of Feb 4. We have corrected this in the Results section.

We had previously stated in the Methods that the incidence rate represented diagnoses/100,000 person-weeks. In response to Reviewer #2, question 1, we have added a sentence in the Methods to clarify that the rates are based on the population of female health plan members aged 18 or older at the time. We have not reiterated “diagnoses per 100,000 person-weeks among females aged 18 or older” when presenting the rates in the Results for space considerations but would be happy to do so if deemed necessary by the Editors.

6. Please limit p values to 3 decimals.

We have corrected this in the table.

7. Is this the overall call rate to the KPNC call center?

We have clarified what we mean by call rate by changing the sentence to “However, the **volume of calls about abnormal vaginal bleeding** during the pandemic was 33% lower in 2020...”

8. We do not allow authors to describe variables or outcomes in terms that imply a difference (such as the terms "trend" or "tendency" or "marginally different") unless there is a statistical difference. Please edit here and throughout to indicate that there is no difference. Since the South Bay Area is significant

due to nature of local pandemic, in the discussion you could mention the difference and the lack of significance perhaps due to power.

We have revised our discussion of this finding as suggested to read: **“Although the greatest relative drop in diagnoses was observed in the South Bay, which was an early COVID-19 hot spot(4), the difference was not statistically significant, possibly due to insufficient power.”**

9. This is of course a well informed speculation. Other possible explanations may be over all anxiety, adjustment to stay at home orders and changes in routines with minimization of symptoms. Disproportionately affected by what? Fear of COVID 19? COVID 19 itself?

We have changed “...likely due to fear of COVID-19,...” to **“potentially due to fear of COVID-19 exposure,...”**

We have changed this sentence to read “There was no indication that women at higher risk based on age or comorbidities were **less likely to be diagnosed during the pandemic.**”

10. Table 1 can go to supplemental digital content; none of the findings are different from year to year and the data reported here are not that relevant to this research letter objective or result. The data should be available but isn't critical in the manuscript itself.

We have changed reference to the table to refer to the Appendix.

11. It looks like the rate of endometrial Ca diagnoses were already falling from Feb 4 to March 4, preceding the rapid rise in cases in California and the State at home order. This may be temporal, given a similar pattern in 2019. Please comment.

Please see response to Reviewer #3, question 1 and 4.