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 22, 2021
To: "Lauren Caldwell" [redacted]
From: "The Green Journal" em@greenjournal.org
Subject: Your Submission ONG-21-583

RE: Manuscript Number ONG-21-583

Women's Experience of Their First Sexual Encounter After Pelvic Reconstructive Surgery

Dear Dr. Caldwell:

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 13, 2021, we will assume you wish to withdraw the manuscript from further consideration.

REVIEWER COMMENTS:

Reviewer #1:

This is a high-quality, qualitative data set regarding women describing their first sexual encounter following pelvic reconstructive surgery.

Strengths:
* Despite the fact that study after study finds that women care ENORMOUSLY about sexual function before and after surgery, this topic is under-studied and under-published in our field, a field that should care deeply about it.
* This is a topic on which the women's voice needs to be heard, and qualitative methods are ideal for exploring this topic. This applies to all doctors who perform surgery on female parts and all patients thinking of undergoing surgery, so it is incredibly relevant to our field and how we counsel.
* The qualitative methods are sound and excellent, rich data were obtained.

Limitations:
* As this is only among women having pelvic reconstructive surgery, we cannot externalize it to all women having gynecologic surgery and other special populations, such as oncologic patients, that may have different concerns.
* There are few quantitative outcomes measured here, so statements like "self-image generally improved after surgery" have to be taken in context of the fact that we are talking about a gestalt of qualitative information.

Comments for authors by section:

Introduction:
* Clear and concise, with a transparent statement of the study purpose and methods.

Methods:
* Line 131-132: It is not clear from these methods how this quantitative data from the PISQ-12 was used in the study, or if it was used other than to determine if women self-reported as sexually active. I would suggest adding some sentences here to clarify how this was utilized in the present study.
* Line 132: Were any additional patient characteristic data points or other quantitative data points specifically collected for this study? What data points from the parent RCT are analyzed and reported here?
* Line 157: Was any quantitative information analyzed in this study? If so, how? For example, when women reported the timing of sexual intercourse in the study, was this quantified and analyzed in any way?

Results:

* Line 164-165: As mentioned above, it should be discussed in the methods what patient characteristic information was collected for this study, and how/when it was collected. I assume it was collected as part of the parent RCT, but this should be fleshed out in the Methods section.
* The quotes selected are rich and relevant, and keep the themes organized in the reader's mind.
* Tables and word cloud are interesting and informative.
* The data may be a little more interesting if you dichotomized women into better or worse PISQ-12 scores and analyzed if different themes emerged in each. Just an interesting idea.

Discussion:
* Line 332-334: This is really the thrust of the whole study. I would put in a teaser here if you are doing future research exploring interventions to address this gap in provider counseling, as I imagine your group may be doing based on these results.
* Authors acknowledge limitations well and discuss them adequately.

Reviewer #2:

Thank you for conducting such a thoughtful and well needed study. Reading about patients' fears and anxieties in real life is so elucidating.
Introduction: well written and great explanation about this study being an ancillary study to TIPPS

Methods: line 134 please expand on your comment of "routine counseling." What is typically said to patients--nothing in vagina for 4 weeks? When does a postmenopausal woman start local estrogen? Is oral sex ok to do? when can insertional activity occur, including use of sex toys and battery operated devices?

Line 145: Can you describe rev.com a little more for readers not familiar with this technology used in qualitative research?

The interview questions are excellent and open-ended leaving lots of space for patients to discuss a variety of concerns and topics. Bravo to the team for formulating these questions.

Results: The sample size is low but the comments provided are rich and very insightful. Word cloud confirms the robust comments.
Can you reanalyze based on surgery type: Half of the patients (45%) underwent sling alone. These patients heal faster and there is a small incision. Patient undergoing sacrocolpopexy procedures also may heal faster if there are no vaginal incisions and mesh is applied laparoscopically or robotically. The group that may heal the slowest and be most concerned (with partners expressing concern about undissolved suture knots) are those undergoing hysterectomy with apical suspension for prolapse using delayed absorbable sutures that have a half life of 90 days. Heterosexual partners may feel those knots and lead to hispareunia and patient discomfort.

Knowing about menopausal status and use of estrogen would also be very important because healing may be faster with better lubrication. Please add this information.

Discussion: the authors do an excellent job describing the limitations of the study but further information on non-penetrative sexual activity beyond masturbation (eg cunnilingus, fingering, anal sex, use of sex toys) would be helpful.

Broadening out to multiple sites and more diverse populations would be interesting.

Reviewer #3:

Comments to the Author:
This is a qualitative study consisting of semi-structured interviews with patients who are 2-4 months postop from either pelvic organ prolapse or urinary incontinence surgery. The purpose of the interview is to gain information about women's first sexual experience following pelvic reconstructive surgery. Authors showed that timing of return to first sexual activity is driven more by partner and provider's recommendation rather than personal desire, there was fear surrounding damage

of surgical repair and hope for improvement in sexual function.

Major Comments:
1. The message of the paper was muddied by the quotes throughout the piece. It would be helpful to organize the quotes from patients into a table organized by theme, rather that within the body of the document. This will allow for more fluid reading of the document.
2. Grounded theory methodology is the most accepted way of analyzing this kind of interview data and is most commonly used in this type of study. Was grounded theory used in this study and if not why?
3. In the Roos et al 2013 article referenced in this paper, the qualitative questionnaire responses are organized into positive effects on sexual function and negative effects on sexual function and then further subcategorized into themes relating to positive or negative effects. This made themes very clear and was an effective way of communicating responses. They also commented on how many women out of the total women interviewed shared the same sentiment which was helpful. This paper would benefit from more clear organization of themes and reporting of how frequent each theme is. The grouping of themes in this paper made it difficult to discern meaningful findings from the paper.
4. The results left a lot of unanswered questions. If the interview included answers to the following questions it would be helpful if it was included. Did patients feel like they returned to sexual activity too soon? Was the first sexual experience more or less uncomfortable than anticipated? What further information do patients wish they received from their provider?

Minor Comments:
1. You state "surgeries include native tissue repair with or without sling, mesh augmented repair and sling alone" line 168. It would be helpful to know who underwent hysterectomy and who did not because the presence or absence of a vaginal cuff factors into patient's responses. Also, can you further clarify what a mesh augmented repair is? Is this transvaginal mesh or sacrocolpopexy? Is there a difference in patients who had abdominal surgery? Was it open or minimally invasive and how does this affect the outcomes?
2. Of the 16% of patients that did not resume intercourse within 4-8 weeks, what did the patients site as the reason for not returning to sexual activity?
3. The standard deviation in age of 13.3 years suggests potentially a bimodal distribution of patient's age. Was there a difference in responses in the pre and postmenopausal women?
4. I suggest cutting down on the number of quotes and only selecting truly illustrative quotes because I felt some did not add much value and diluted the effect of the quotes.
5. The word cloud (figure 1) does not add much value to the paper, would consider omitting this
6. Who conducted the interviews with patients?

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

2. Obstetrics & Gynecology uses an "electronic Copyright Transfer Agreement" (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. Each of your coauthors received an email from the system, titled "Please verify your authorship for a submission to Obstetrics & Gynecology." Each author should complete the eCTA if they have no yet done so.

3. For studies that report on the topic of race or include it as a variable, authors must provide an explanation in the manuscript of who classified individuals' race, ethnicity, or both, the classifications used, and whether the options were defined by the investigator or the participant. In addition, the reasons that race/ethnicity were assessed in the study also should be described (eg, in the Methods section and/or in table footnotes). Race/ethnicity must have been collected in a formal or validated way. If it was not, it should be omitted. Authors must enumerate all missing data regarding race and ethnicity as in some cases, missing data may comprise a high enough proportion that it compromises statistical precision

and bias of analyses by race.

Use "Black" and "White" (capitalized) when used to refer to racial categories. The nonspecific category of "Other" is a convenience grouping/label that should be avoided, unless it was a prespecified formal category in a database or research instrument. If you use "Other" in your study, please add detail to the manuscript to describe which patients were included in that category.

4. 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), observational studies using ICD-10 data (ie, RECORD), 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, RECORD, CHEERS, SQUIRE 2.0, or CHERRIES guidelines, as appropriate.

5. 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.

6. 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.

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).
* If your manuscript was uploaded to a preprint server prior to submitting your manuscript to Obstetrics & Gynecology, add the following statement to your title page: "Before submission to Obstetrics & Gynecology, this article was posted to a preprint server at: [URL]."

8. 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 limit for Original Research articles is 300 words; Reviews is 300 words; Case Reports is 125 words; Current Commentary articles is 250 words; Executive Summaries, Consensus Statements, and Guidelines are 250 words; Clinical Practice and Quality is 300 words; Procedures and Instruments is 200 words. Please provide a word count.

9. 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.

10. 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.

11. 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.

12. In your Abstract, manuscript Results sections, and tables, the preferred citation should be in terms of an effect size, such as odds ratio or relative risk or the mean difference of a variable between two groups, expressed with appropriate confidence intervals. When such syntax is used, the P value has only secondary importance and often can be omitted or noted as footnotes in a Table format. Putting the results in the form of an effect size makes the result of the statistical test more clinically relevant and gives better context than citing P values alone.

If appropriate, please include number needed to treat for benefits (NNTb) or harm (NNTh). When comparing two procedures, please express the outcome of the comparison in U.S. dollar amounts.

Please standardize the presentation of your data throughout the manuscript submission. For P values, do not exceed three decimal places (for example, "P = .001"). For percentages, do not exceed one decimal place (for example, 11.1%").

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.

14. Please review examples of our current reference style at http://ong.editorialmanager.com (click on the Home button in the Menu bar and then "Reference Formatting Instructions" document under "Files and Resources). Include the digital object identifier (DOI) with any journal article references and an accessed date with website references. Unpublished data, in-press items, personal communications, letters to the editor, theses, package inserts, submissions, meeting presentations, and abstracts may be included in the text but not in the reference list.

In addition, 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). 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 at the Clinical Guidance page at https://www.acog.org/clinical (click on "Clinical Guidance" at the top).

15. Figure 1: Please upload as a high-res figure file on Editorial Manager.

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.

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16. 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 https://wkauthorservices.editage.com/open-access/hybrid.html.

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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. Do not omit your responses to the Editorial Office or Editors' comments.

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 13, 2021, we will assume you wish to withdraw the manuscript from further consideration.

Sincerely,

John O. Schorge, MD
Associate Editor, Gynecology

2019 IMPACT FACTOR: 5.524
2019 IMPACT FACTOR RANKING: 6th out of 82 ob/gyn journals

[redacted]

May 13, 2021

To the Editors of Obstetrics & Gynecology,

Thank you for your careful consideration of our manuscript, “Women’s Experience of Their First Sexual Encounter After Pelvic Reconstructive Surgery”. We are pleased to address the thoughtful reviewer comments and have included a revised manuscript with this submission. Please find our responses to both Reviewer and Editorial Office comments below. The authors have reviewed the “Instructions for Authors – January 2021” document.

REVIEWER COMMENTS:

Reviewer #1:

This is a high-quality, qualitative data set regarding women describing their first sexual encounter following pelvic reconstructive surgery.

Strengths:
* Despite the fact that study after study finds that women care ENORMOUSLY about sexual function before and after surgery, this topic is under-studied and under-published in our field, a field that should care deeply about it.
* This is a topic on which the women's voice needs to be heard, and qualitative methods are ideal for exploring this topic. This applies to all doctors who perform surgery on female parts and all patients thinking of undergoing surgery, so it is incredibly relevant to our field and how we counsel.
* The qualitative methods are sound and excellent, rich data were obtained.

Limitations:
* As this is only among women having pelvic reconstructive surgery, we cannot externalize it to all women having gynecologic surgery and other special populations, such as oncologic patients, that may have different concerns.
* There are few quantitative outcomes measured here, so statements like "self-image generally improved after surgery" have to be taken in context of the fact that we are talking about a gestalt of qualitative information.

Comments for authors by section:

Introduction:

* Clear and concise, with a transparent statement of the study purpose and methods.
Response: Thank you for your careful review and kind comment.

Methods:
* Line 131-132: It is not clear from these methods how this quantitative data from the PISQ-12 was used in the study, or if it was used other than to determine if women self-reported as sexually active. I would suggest adding some sentences here to clarify how this was utilized in the present study.
Response: Thank you for this thoughtful comment. The PISQ-12 was administered to study participants in order to describe the baseline sexual function of our population prior to surgery. Lines 143-151 have been revised with a clarifying sentence which reads: "These PISQ-12 scores were used to describe the study population's pre-operative sexual function and were not repeated post-operatively."

* Line 132: Were any additional patient characteristic data points or other quantitative data points specifically collected for this study? What data points from the parent RCT are analyzed and reported here?
Response: Thank you for this comment. We have added clarification of baseline characteristics data collected in lines 151-153, "Baseline characteristics including age, insurance, and patient-defined race, ethnicity, partner status and education level were collected at the time of enrollment to further describe the patient population."

* Line 157: Was any quantitative information analyzed in this study? If so, how? For example, when women reported the timing of sexual intercourse in the study, was this quantified and analyzed in any way?
Response: Thank you for this question. Our primary goal was to describe the first sexual encounter after surgery using a qualitative methodology. Our study population of 20 patients allowed us to reach thematic saturation and produce robust qualitative data. This sample size was not powered to meaningfully analyze quantitative data. We have added this clarification in lines 153-154, "Additional data collected in the TIPPS randomized controlled trial was not analyzed for this study."
Patients' report of their timing of return to sexual activity was assigned a unique code during data analysis and allowed for a description of the most common timing for the return to sexual activity, which was 4-8 weeks.

Results:
* Line 164-165: As mentioned above, it should be discussed in the methods what patient characteristic information was collected for this study, and how/when it was collected. I assume it was collected as part of the parent RCT, but this should be fleshed out in the Methods section.

Response: Thank you for this comment. We have added clarification of baseline characteristics data collected in lines 151-154, “Baseline characteristics including age, insurance, and patient-defined race, ethnicity, partner status and education level were collected at the time of enrollment to further describe the patient population. Additional data collected in the TIPPS randomized controlled trial was not analyzed for this study.”

* The quotes selected are rich and relevant, and keep the themes organized in the reader's mind.
Response: Thank you for this kind comment.

* Tables and word cloud are interesting and informative.
Response: Thank you for this feedback.

* The data may be a little more interesting if you dichotomized women into better or worse PISQ-12 scores and analyzed if different themes emerged in each. Just an interesting idea.
Response: Thank you for this thoughtful suggestion. The authors agree the description of any differences in themes among women with different baseline sexual function would provide valuable insights. Our study population at baseline had, on average, good sexual function. Further exploration of differences between patients with varying pre-operative sexual function would require additional patient recruitment to ensure thematic saturation within each group.

To more thoroughly address this point, we explored our three patients with the highest PISQ-12 scores (>40), and the three patients with the lowest PISQ-12 scores (<25) at baseline. The themes of Conflicting Emotions (including Fear and Concern, Hope and Optimism, Curiosity, and Disappointment and Regret), Outside Influences (including Partner and Physician), Physical Changes, Emotional Changes, Unchanged Experience, Uncertainty, and Self-Image were all shared between patients in these two groups.

Discussion:
* Line 332-334: This is really the thrust of the whole study. I would put in a teaser here if you are doing future research exploring interventions to address this gap in provider counseling, as I imagine your group may be doing based on these results.
Response: Thank you for making this point. We have included in lines 470-471, “Future studies exploring physician counseling methods and their influence on the patient experience are needed.”

* Authors acknowledge limitations well and discuss them adequately.
Response: Thank you for taking the time to offer a thorough review of our work.

Reviewer #2:

Thank you for conducting such a thoughtful and well needed study. Reading about patients' fears and anxieties in real life is so elucidating.
Introduction: well written and great explanation about this study being an ancillary study to TIPPS
Response: Thank you for your thoughtful review and comments.

Methods: line 134 please expand on your comment of "routine counseling." What is typically said to patients--nothing in vagina for 4 weeks? When does a postmenopausal woman start local estrogen? Is oral sex ok to do? when can insertional activity occur, including use of sex toys and battery operated devices?
Response: Thank you for this excellent point. Our standard instructions include nothing per vagina prior to a standard 4 to 6-week postoperative visit, including vaginal estrogen for postmenopausal patients, tampons, douching, or penetrative intercourse. Oral sex is not typically discussed.
We have clarified post-operative instructions in lines 155-156, “Following surgery, patients were instructed to avoid placing anything in the vagina including tampons, douching, topical estrogen or penetrative intercourse.”

Line 145: Can you describe rev.com a little more for readers not familiar with this technology used in qualitative research?
Response: We have included additional description of the services provided by Rev in lines 170-175, “This mobile application was used to record the entirety of each telephone interview following verbal consent from the patient. Precise transcripts of these interviews were then produced by Rev transcriptionists.”

The interview questions are excellent and open-ended leaving lots of space for patients to discuss a variety of concerns and topics. Bravo to the team for formulating these questions.
Response: Thank you for kind comment.

Results: The sample size is low but the comments provided are rich and very insightful. Word cloud confirms the robust comments.
Response: Thank you for this insightful comment. We also feel confident that meaningful data were obtained as thematic saturation was reached in our interviews.

Can you reanalyze based on surgery type: Half of the patients (45%) underwent sling alone. These patients heal faster and there is a small incision. Patient undergoing sacrocolpopexy procedures also may heal faster if there are no vaginal incisions and mesh is applied laparoscopically or robotically. The group that may heal the slowest and be most concerned (with partners expressing concern about

undissolved suture knots) are those undergoing hysterectomy with apical suspension for prolapse using delayed absorbable sutures that have a half life of 90 days. Heterosexual partners may feel those knots and lead to hispareunia and patient discomfort.
Response: Thank you for raising this interesting question. We have clarified in lines 204-205, “Seven patients (35%) underwent a hysterectomy at the time of their POP or UI surgery.”

Interestingly, Fear and Concern (subcategory of “Conflicting Emotions” theme), and specifically fear of damage to the surgical repair, was expressed by patients undergoing all types of surgery including with or without hysterectomy, and with or without use of mesh. We have included this detail in lines 247-250, “Although this fear was often related to the use of mesh in the surgical repair, it was also expressed by patients who had undergone native tissue repairs, and by those who had surgery both with and without a hysterectomy.”

Similarly, the themes of concern for the partner experience and partner concern for causing damage to the surgical repair (both included under “Partner” subcategory of “Outside Influences” theme) were also consistent in patients with or without hysterectomy. We have included this in lines 220-221, “Women often expressed concern for the partners’ experience, regardless of the type or route of surgery.”

Knowing about menopausal status and use of estrogen would also be very important because healing may be faster with better lubrication. Please add this information.
Response: Thank you for making this point. We have added this information in lines 201-202, “Half of our patients were post-menopausal, of which 40% were prescribed vaginal estrogen and 20% were taking oral estrogen.”

Discussion: the authors do an excellent job describing the limitations of the study but further information on non-penetrative sexual activity beyond masturbation (eg cunnilingus, fingering, anal sex, use of sex toys) would be helpful.
Response: Thank you for raising this interesting point. We have included in the Results section lines 209-211, “Three patients (15%) described an initial return to sexual activity without penetrative vaginal intercourse, including anal sex, oral sex, and manual stimulation.” We have also added this detail in lines 341-342, “Three patients disclosed that their first sexual encounter after surgery did not include penetrative vaginal intercourse.” Our interview questions did not specifically ask about various types of sexual activity, although this may be an interesting area for further research.

Broadening out to multiple sites and more diverse populations would be interesting.
Response: Thank you for raising this point. The authors agree that further investigation of this component of the patient surgical experience would be valuable.

Reviewer #3:

Comments to the Author:
This is a qualitative study consisting of semi-structured interviews with patients who are 2-4 months postop from either pelvic organ prolapse or urinary incontinence surgery. The purpose of the interview is to gain information about women's first sexual experience following pelvic reconstructive surgery. Authors showed that timing of return to first sexual activity is driven more by partner and provider's recommendation rather than personal desire, there was fear surrounding damage of surgical repair and hope for improvement in sexual function.

Major Comments:
1. The message of the paper was muddied by the quotes throughout the piece. It would be helpful to organize the quotes from patients into a table organized by theme, rather that within the body of the document. This will allow for more fluid reading of the document.
Response: Thank you for your thorough review and suggestions for improvement. We have reorganized the vast majority of the patient quotes into Table 3, which is now retitled “Major Themes, Subcategories and Illustrative Quotes”. This change in the table is clarified in lines 214-215. We have retained a small number of quotes within the body of the manuscript where they were felt by the authors to be most salient.

2. Grounded theory methodology is the most accepted way of analyzing this kind of interview data and is most commonly used in this type of study. Was grounded theory used in this study and if not why?
Response: Thank you for raising this point. Yes, grounded theory methodology was used in this study. Our qualitative data (in the form of interview transcripts) was first coded to create preliminary themes. As additional transcripts underwent coding and new concepts emerged, codes were further grouped to ultimately create the major themes presented in our Results. We had previously described this in our Methods section using the term focus group methodology, however the work cited for this focus group methodology (Krueger R) employs grounded theory methodology for analysis of focus group data. To avoid this confusion, we have edited lines 177-178 and included an additional citation: “New codes were developed and assigned as novel concepts arose using grounded theory methodology[12,13].”

3. In the Roos et al 2013 article referenced in this paper, the qualitative questionnaire responses are organized into positive effects on sexual function and negative effects on sexual function and then further subcategorized into themes relating to positive or negative effects. This made themes very clear and was an effective way of communicating responses. They also commented on how many

women out of the total women interviewed shared the same sentiment which was helpful. This paper would benefit from more clear organization of themes and reporting of how frequent each theme is. The grouping of themes in this paper made it difficult to discern meaningful findings from the paper.
Response: Thank you for raising this point. We have reorganized the major themes, subcategories and illustrative quotes together in Table 3 with the goal of improved clarity of important themes. While we agree that major themes may be organized and presented in a variety of ways, we chose not to separate into positive and negative effects as many themes were overlapping and interconnected. For example, patients who reported fear of damage to their surgical repair also disclosed an ultimately unchanged sexual experience, and some who were hopeful and optimistic also discussed disappointment. The authors feel that further separation of our major themes would dilute their multifaceted nature which we aim to convey.

We have also intentionally not included quantitative data as part of our major themes, as the qualitative data is not intended for such an analysis. The word cloud illustrated in Figure 1 may offer some additional insight into the frequency of codes. We have clarified this application of the word cloud in lines 215-216, “Codes applied are demonstrated in Figure 1, where the relative size within the word cloud reflects the frequency of code application.”

4. The results left a lot of unanswered questions. If the interview included answers to the following questions it would be helpful if it was included. Did patients feel like they returned to sexual activity too soon? Was the first sexual experience more or less uncomfortable than anticipated? What further information do patients wish they received from their provider?
Response: Thank you for raising these interesting questions. The answers are varied between patients; in other words, some patients reported they returned to sexual activity too soon, while others felt confident in the timing of their sexual activity. The report that the return to intercourse was too soon was often tied to the theme of Disappointment. We have included this observation in lines 256-257, “This sentiment was often connected to the timing of return to sexual activity, particularly that intercourse was resumed too soon.”

Similarly, many patients reported changes in their sexual experience (grouped within the theme “Sexual Changes and Stability”) which included discomfort during the initial encounter. Others reported their experience was unchanged or even improved (also included in the theme “Sexual Changes and Stability”).

We have included topics of interest for physician counseling in lines 468-471, “Women expressed interest in information from their physician on sexual activity not involving vaginal penetration, sexual positions, and use of lubricants.”

Minor Comments:
1. You state "surgeries include native tissue repair with or without sling, mesh

augmented repair and sling alone" line 168. It would be helpful to know who underwent hysterectomy and who did not because the presence or absence of a vaginal cuff factors into patient's responses. Also, can you further clarify what a mesh augmented repair is? Is this transvaginal mesh or sacrocolpopexy? Is there a difference in patients who had abdominal surgery? Was it open or minimally invasive and how does this affect the outcomes?
Response: Thank you for raising this point. We have clarified in lines 200-202 that all mesh-augmented repairs in our cohort were minimally invasive sacrocolpopexies, and all native tissue repairs were performed by vaginal approach. We have also included the requested data on hysterectomy in lines 202-203, “Seven patients (35%) underwent a hysterectomy at the time of their POP or UI surgery.” All major themes were reported by women who underwent surgery both with and without a hysterectomy.

2. Of the 16% of patients that did not resume intercourse within 4-8 weeks, what did the patients site as the reason for not returning to sexual activity?
Response: Thank you for this question. We have clarified in lines 207-209 that while the majority of our 20 patients resumed intercourse within 4-8 weeks, some resumed 8-12 weeks postoperatively. Only one patient did not resume intercourse by the time of her interview due to an exacerbation of a chronic health condition which was unrelated to her surgery. The clarification now reads, “The majority (80%) resumed intercourse within 4-8 weeks, while 15% resumed 8-12 weeks postoperatively. One patient had not resumed intercourse at the time of her interview due to an exacerbation of a chronic health condition.”

3. The standard deviation in age of 13.3 years suggests potentially a bimodal distribution of patient's age. Was there a difference in responses in the pre and postmenopausal women?
Response: Thank you for this interesting question. We have clarified in lines 201-202 that our patient population was evenly split between pre- and post-menopausal women, “Half of our patients were post-menopausal, of which 40% were prescribed vaginal estrogen and 20% were taking oral estrogen.” All major themes were reported by both pre- and post-menopausal women.

4. I suggest cutting down on the number of quotes and only selecting truly illustrative quotes because I felt some did not add much value and diluted the effect of the quotes.
Response: Thank you for this suggestion. We have reorganized the vast majority of the patient quotes into Table 3, which is now retitled “Major Themes, Subcategories and Illustrative Quotes”. This change in the table is clarified in lines 214-215. We have retained a small number of quotes within the body of the manuscript where they were felt to be most salient.

5. The word cloud (figure 1) does not add much value to the paper, would consider omitting this

Response: Thank you for this feedback. We acknowledge that this method of data presentation is less traditional, particularly in comparison with quantitative studies. We feel that the greatest value in the figure is the relative frequency of various codes, which is reflected in the size within the word cloud. We have clarified this in lines 215-216, “Codes applied are demonstrated in Figure 1, where the relative size within the word cloud reflects the frequency of code application.” Finally, reviewers #1 and 2 responded more positively to the word cloud figure, suggesting that some readers may find the figure helpful in their review of the paper.

6. Who conducted the interviews with patients?

Response: All interviews were conducted by the primary author. This has been clarified in lines 164-165, “All interviews were conducted by the primary author.”

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.

Response: A. OPT-IN

2. Obstetrics & Gynecology uses an "electronic Copyright Transfer Agreement" (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. Each of your coauthors received an email from the system, titled "Please verify your authorship for a submission to Obstetrics & Gynecology." Each author should complete the eCTA if they have no yet done so.

Response: All disclosures listed in the eCTA forms are correctly disclosed on the manuscript’s title page. All coauthors have completed the eCTA.

3. For studies that report on the topic of race or include it as a variable, authors must provide an explanation in the manuscript of who classified individuals' race, ethnicity, or both, the classifications used, and whether the options were defined by the

investigator or the participant. In addition, the reasons that race/ethnicity were assessed in the study also should be described (eg, in the Methods section and/or in table footnotes). Race/ethnicity must have been collected in a formal or validated way. If it was not, it should be omitted. Authors must enumerate all missing data regarding race and ethnicity as in some cases, missing data may comprise a high enough proportion that it compromises statistical precision and bias of analyses by race.

Use "Black" and "White" (capitalized) when used to refer to racial categories. The nonspecific category of "Other" is a convenience grouping/label that should be avoided, unless it was a prespecified formal category in a database or research instrument. If you use "Other" in your study, please add detail to the manuscript to describe which patients were included in that category.
Response: We have included clarification within the Methods section, lines 151-153, “Baseline characteristics including age, insurance, and patient-defined race, ethnicity, partner status and education level were collected at the time of enrollment to further describe the patient population.”

4. 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), observational studies using ICD-10 data (ie, RECORD), 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 https://clicktime.symantec.com/3VFowyMQd3e3c58GziLFUdB7Vc?u=http%3A%2F%2Fong.editorialmanager.com. In your cover letter, be sure to indicate that you have followed the CONSORT, MOOSE, PRISMA, PRISMA for harms, STARD, STROBE, RECORD, CHEERS, SQUIRE 2.0, or CHERRIES guidelines, as appropriate.
Response: Data presented in this manuscript was collected as part of a qualitative study in which a rigorous qualitative methodology was utilized. None of the above guidelines are applicable to qualitative work.

5. 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://clicktime.symantec.com/3BpP5pBqmhmZw8YctesGDYB7Vc?u=https%3A%2F%2Fwww.acog.org%2Fpractice-management%2Fhealth-it-and-clinical-informatics%2Frevitalize-obstetrics-data-definitions and the gynecology data definitions at https://clicktime.symantec.com/379z8XSHMDogotcQ6Ys8rR57Vc?u=https%3A%2F%2Fwww.acog.org%2Fpractice-management%2Fhealth-it-and-clinical-informatics%2Frevitalize-gynecology-data-definitions. If use of the reVITALize definitions is problematic, please discuss this in your point-by-point response to this letter.
Response: The reVITALize definitions have been utilized throughout the manuscript.

6. 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.
Response: Our manuscript does not exceed 5,500 words. Excluding References, the total number of pages is 23 typed, double-spaced pages; however one of these pages is one line for Figure 1 legend.

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).
* If your manuscript was uploaded to a preprint server prior to submitting your manuscript to Obstetrics & Gynecology, add the following statement to your title page: "Before submission to Obstetrics & Gynecology, this article was posted to a preprint server at: [URL]."
Response: Acknowledgements are included on our title page as follows: “The authors wish to thank the University of Texas at Austin Dell Medical School Department of Women’s Health for their financial support of this work.
Presented at Pelvic Floor Disorders Week, American Urogynecologic Society, Virtual Meeting, October 8-10th, 2020, and Duke Multidisciplinary Benign Urology Research Symposium, Virtual Meeting, April 29-30th, 2021.” Of note the presentation at the Duke Multidisciplinary Benign Urology Research Symposium occurred after original submission of this manuscript and has been added with these revisions.

8. 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 limit for Original Research articles is 300 words; Reviews is 300 words; Case Reports is 125 words; Current Commentary articles is 250 words; Executive Summaries, Consensus Statements, and Guidelines are 250 words; Clinical Practice and Quality is 300 words; Procedures and Instruments is 200 words. Please provide a word count.
Response: Abstract word count: 297

9. Only standard abbreviations and acronyms are allowed. A selected list is available online
at https://clicktime.symantec.com/3SZdRTVgtEdCEPV5QEpaeGE7Vc?u=http%3A%2F%2Fedmgr.ovid.com%2Fong%2Faccounts%2Fabbreviations.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.
Response: All abbreviations are spelled out the first they are used, and are not used in the title or précis.

10. 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.

Response: We have replaced the virgule symbol (/) throughout the text and tables. We have retained this symbol in describing the Pelvic Organ Prolapse/Incontinence Sexual Questionnaire (PISQ) in order to accurately reflect the originally published questionnaire title. We have also retained this symbol in the references when used in the originally published article.

11. 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.
Response: “Provider” has been replaced throughout the manuscript with a specific term or “health care professional” where appropriate. We have retained “provider” in Table 1 as this was the terminology used during patient interviews.

12. In your Abstract, manuscript Results sections, and tables, the preferred citation should be in terms of an effect size, such as odds ratio or relative risk or the mean difference of a variable between two groups, expressed with appropriate confidence intervals. When such syntax is used, the P value has only secondary importance and often can be omitted or noted as footnotes in a Table format. Putting the results in the form of an effect size makes the result of the statistical test more clinically relevant and gives better context than citing P values alone.

If appropriate, please include number needed to treat for benefits (NNTb) or harm (NNTh). When comparing two procedures, please express the outcome of the comparison in U.S. dollar amounts.

Please standardize the presentation of your data throughout the manuscript submission. For P values, do not exceed three decimal places (for example, "P = .001"). For percentages, do not exceed one decimal place (for example, 11.1%").
Response: Our presented qualitative data is descriptive only.

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: https://clicktime.symantec.com/3MsbeRc7bw3gz7c2xhqDWZw7Vc?u=http%3A%2F%2Fedmgr.ovid.com%2Fong%2Faccounts%2Ftable_checklist.pdf.
Response: The Table Checklist has been reviewed to ensure that all tables conform to journal style.

14. Please review examples of our current reference style at https://clicktime.symantec.com/3VFowyMQd3e3c58GziLFUdB7Vc?u=http%3A%2F%2Fong.editorialmanager.com (click on the Home button in the Menu bar and then "Reference Formatting Instructions" document under "Files and Resources). Include the digital object identifier (DOI) with any journal article references and an accessed

date with website references. Unpublished data, in-press items, personal communications, letters to the editor, theses, package inserts, submissions, meeting presentations, and abstracts may be included in the text but not in the reference list.

In addition, 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). 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 at the Clinical Guidance page at https://clicktime.symantec.com/3BcWFtAYFR6Xc42MepHSrGP7Vc?u=https%3A%2F%2Fwww.acog.org%2Fclinical (click on "Clinical Guidance" at the top).
Response: The Reference Formatting Instructions have been reviewed to ensure that all references conform to journal style.

15. Figure 1: Please upload as a high-res figure file on Editorial Manager.

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.

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

Response: A high-resolution TIFF file of Figure 1 will be uploaded on Editorial Manager. The figure has been removed from the manuscript in Microsoft Word.

16. 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 https://clicktime.symantec.com/3QZ5KFkJj1MzNTZrNT6DSyi7Vc?u=http%3A%2F%2Flinks.lww.com%2FLWW-ES%2FA48. The cost for publishing an article as open access can be found at https://clicktime.symantec.com/3RVeQE8oc2Roicz5vp6CUsf7Vc?u=https%3A%2F%2Fwkauthorservices.editage.com%2Fopen-access%2Fhybrid.html.

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Response: The corresponding author will promptly respond to all emails from the editorial office.

Thank you again for your consideration of our revised manuscript.

Best,

Lauren Caldwell, MD