

# OBSTETRICS & GYNECOLOGY



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- Comments from the reviewers and editors (email to author requesting revisions)
- Response from the author (cover letter submitted with revised manuscript)\*
- Email correspondence between the editorial office and the authors\*

*\*The corresponding author has opted to make this information publicly available.*

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Questions about these materials may be directed to the *Obstetrics & Gynecology* editorial office:

[obgyn@greenjournal.org](mailto:obgyn@greenjournal.org).

**Date:** Feb 08, 2019  
**To:** "Erin A Brennand" [REDACTED]  
**From:** "The Green Journal" em@greenjournal.org  
**Subject:** Your Submission ONG-19-18

RE: Manuscript Number ONG-19-18

Revision after mesh midurethral sling: impact of physician specialty, annual operative volume and surgical facility

Dear Dr. Brennand:

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

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

Your paper will be maintained in active status for 21 days from the date of this letter. If we have not heard from you by Mar 01, 2019, we will assume you wish to withdraw the manuscript from further consideration.

#### REVIEWER COMMENTS:

Reviewer #1: General comments: This is a large administrative database study. The objective of this study was to estimate rates of revision surgery for mesh mid-urethral slings, secondary objectives were to explore if physician specialty, operative volume or hospital type affect revision surgery. The authors utilized data from Alberta Health Services over 13 years. The authors discovered a revision surgery rate of 3.36% at 5 years and 4.57% at 10 years. Revision rates declined if a surgeon had >50 cases per year. Concomitant prolapse repair was associated with increased rates of revision. This well-designed and written study, which provides valuable information that is timely as the global debate on mesh, intensifies.

#### Specific comments:

1. This study utilizes very complex statistical techniques and must be reviewed by a statistician.
2. It would be helpful if the authors could discuss more about the similarities and differences between the other studies that used NHS and other sources of data (ref 6, 7, 8)
3. The authors note there was not a difference seen between hospital types. It seems less likely that rural doctors are performing >50 cases of slings per year. How many rural hospitals operate at that volume?

Reviewer #2: This is a well written and comprehensive study evaluating risk factors for revision of mesh midurethral slings in one province in Canada. The authors have anticipated and answered many methodological questions I would have had. I have the following comments/questions.

1. Methods: Was the annual number of procedures performed calculated as the 12 months prior to the index procedure vs. Jan-Dec. etc. Please clarify.
2. Methods: What about some sort of measure of total procedures performed by each surgeon during the study period as that would seem to impact experience as well as annual procedures. Also, is there any way to categorize the surgeons by years out of postgraduate training? Someone who has done 100s of procedures and then one year happens to do 40 (maybe because of an illness or something) would then be classified as a lower volume surgeon despite their extensive experience.
3. Results: I'd like to know more about the surgeons, first how many surgeons are included in the study? What proportion

would you consider low vs. high volume (so we can compare with other studies), I am trying to get a sense of whether there are surgeons who maybe do a few procedures a year vs. the "high volume" surgeons, are these people who do these procedures 2-3x per week? The cohort median MUS per surgeon (IQR) is reported but I would like to know what proportion of surgeons fall into low vs. mid vs. high volume. Also, how many urologists and how many ob/gyns were there?

4. Results: Table 2: do you mean "cumulative rates" rather than "accumulative"?

5. Results: Figure 1: I love this figure!

6. Discussion: Less than 50 procedures per year is about 4 per month...I suspect most general ob/gyns do less than 4 per month, if that, compared to urogynecologists who do more....is there any literature out there reporting the average volume of a general ob/gyn vs. urogynecologist vs. urologist?

Reviewer #3: This is a cohort study looking at risk of revision surgery following midurethral sling. I applaud the authors on their use of very complete and comprehensive databases and a large population of women captured. My concerns/questions are as follows:

1) The research question is an interesting one but I'm not sure how this is different from previous publications. The Welk article cited includes association of revision with the number of procedures per surgeon. As the authors mention, previous work evaluates the number of surgeries in terms of dichotomized outcomes or quartiles and the aim here was to look for a linear relationship, however, in the end there were similar cutoffs determined, 25, 50 and 110 cases. Table 3 then uses these cut-off showing categorized data.

The Johnsson Funk article covers the association of concomitant surgery.

2) Outcomes were various revision surgeries. I would be interested in hearing more about why the revision was done. Did this include revisions for mesh erosion, urinary retention, pain, etc. Or if the data is not available, a mention of why not (info not captured in the database, for example)

3) Line 185 - should this be "did not contribute to the 5-year cumulative risk"?

4) Line 296 - I agree with the "additional experience" but what do you mean by "additional training". I don't believe that information was captured/presented here.

#### STATISTICAL EDITOR'S COMMENTS:

1. lines 217-221: Should put this information and expand on it in a Table. That is, the final model explained x% of the variance, leaving (100-x)% unexplained. Then cite all the contributing factors to the explained variance in order. lines 220-221: Is this individual surgeon factor separate from surgeon's annual MUS volume? Need to clarify.

2. Table 1: Should cite whether there were statistically significant changes over time for age, concomitant POP surgery, median MUS per surgeon and proportion urology.

3. Table 2: Since the mean follow-up was ~ 6 years and the study was from 2004 to 2016, need to include for each "interval of time" how many were lost to follow-up as a separate column from those remaining at risk "N in cohort". Also, should include a column of the number with mesh complications at each time interval.

4. Table 3: Need more clarity re: referents. For example, the patient age appears to be per year, the annual volume of MUS for the 51-110 volume appears to be (lines 227-229) that the odds of mesh complication declined at 0.991 per additional case, but that is not evident from the Table. Were the 1-50 cases and the 110+ cases groups also per additional case? Also, the Table states the mid category is 51-110, as apparently does fig 1, but lines 227-229 state the range was 51-100 MUS per year. Need to clarify. Also, since the odds per case would be multiplicative over the range 51-110 and 0.991 per case is such a small increment, suggest re-stating the difference as the declining odds per increment of 10 cases per year (which would be OR ~ 0.90, with appropriate CIs). Also, to put these differences in more concrete examples, suggest citing the mesh complication rate for suitable intervals of MUS per year in Table format. For example, in categories of 1-10, 11-20 etc to 191-200, cite the corresponding rates of mesh complications. Also should cite whether there was any differential loss of follow-up for low volume vs high volume data that alternatively could have contributed to the difference in mesh complication rates.

#### EDITORIAL OFFICE COMMENTS

1. The Editors of Obstetrics & Gynecology are seeking to increase transparency around its peer-review process, in line with efforts to do so in international biomedical peer review publishing. If your article is accepted, we will be posting this revision letter as supplemental digital content to the published article online. Additionally, unless you choose to opt out, we

will also be including your point-by-point response to the revision letter, as well as subsequent author queries. If you opt out of including your response, only the revision letter will be posted. Please reply to this letter with one of two responses:

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

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

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

3. In order for an administrative database study to be considered for publication in Obstetrics & Gynecology, the database used must be shown to be reliable and validated. In your response, please tell us who entered the data and how the accuracy of the database was validated. This same information should be included in the Materials and Methods section of the manuscript.

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

5. Because of space limitations, it is important that your revised manuscript adhere to the following length restrictions by manuscript type: Original Research reports should not exceed 26 typed, double-spaced pages (6,500 words). Stated page limits include all numbered pages in a manuscript (i.e., title page, précis, abstract, text, references, tables, boxes, figure legends, and print appendixes) but exclude references.

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

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

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

8. The most common deficiency in revised manuscripts involves the abstract. Be sure there are no inconsistencies between the Abstract and the manuscript, and that the Abstract has a clear conclusion statement based on the results found in the paper. Make sure that the abstract does not contain information that does not appear in the body text. If you submit a revision, please check the abstract carefully.

In addition, the abstract length should follow journal guidelines. The word limits for different article types are as follows: Original Research articles, 300 words. Please provide a word count.

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

12. Please review the journal's Table Checklist to make sure that your tables conform to journal style. The Table Checklist is available online here: [http://edmgr.ovid.com/ong/accounts/table\\_checklist.pdf](http://edmgr.ovid.com/ong/accounts/table_checklist.pdf).

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

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

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

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

Again, your paper will be maintained in active status for 21 days from the date of this letter. If we have not heard from you by Mar 01, 2019, we will assume you wish to withdraw the manuscript from further consideration.

Sincerely,

The Editors of Obstetrics & Gynecology

2017 IMPACT FACTOR: 4.982

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

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In compliance with data protection regulations, please contact the publication office if you would like to have your personal information removed from the database.

February 26, 2019

Dear Editor(s),

Thank you for inviting us to revise our paper, "**Revision after mesh midurethral sling: impact of physician specialty, annual operative volume and surgical facility**", taking into account the reviewers' comments. We appreciate the time and careful attention the reviewers have shown our paper. By addressing their comments through revisions, we hope our manuscript will become acceptable for publication in Obstetrics & Gynecology. Our responses to individual comments follow, and changes to the manuscript have completed using "Track Changes".

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### Reviewer #1

1. This study utilizes very complex statistical techniques and must be reviewed by a statistician.

Response: Our responses and changes based on the suggestion of the Statistcal Editor follow later in this document.

2. It would be helpful if the authors could discuss more about the similarities and differences between the other studies that used NHS and other sources of data (ref 6, 7, 8)

Response: A paragraph has been added to the Discussion section.

3. The authors note there was not a difference seen between hospital types. It seems less likely that rural doctors are performing >50 cases of slings per year. How many rural hospitals operate at that volume?

Response: Of the 20 rural hospitals with MUS procedures performed at them, 4 consistently had annual volumes of >50 MUS/year. In contrast, of the 12 urban & academic hospitals performing MUS procedures, 8 of 12 had volumes of >50 MUS/year.

### Reviewer #2

1. Methods: Was the annual number of procedures performed calculated as the 12 months prior to the index procedure vs. Jan-Dec. etc. Please clarify.

Response: The number of procedures performed was calculated as the number of MUS performed in the calendar year prior. This window of time lined up to way the administrative data is reported and was pulled for this study. It ensured that an entire 12 months of data was used to determine the inserting surgeon's volume. If we had used a rolling definition of 1 year prior to each individual case (where each reference "year" was an interval specific to the case), in some cases we would have had <12 months of preceding interval data to determine surgeon's volume. We have clarified this on lines 167-168.

To give an example for clarity, if a surgery was conducted on February 10, 2016 the reference period was January 1-December 31, 2015.

2. Methods: What about some sort of measure of total procedures performed by each surgeon during the study period as that would seem to impact experience as well as annual procedures. Also, is there any way to categorize the surgeons by years out of postgraduate training? Someone who has done 100s of procedures and then one year happens to do 40 (maybe because of an illness or something) would then be classified as a lower volume surgeon despite their extensive experience.

Response: 230 unique surgeons are captured in this model. The range of procedures performed by each surgeon is 1 to 1,437. While many surgeons are clustered in the range of 100-400 cases in this window of time, including a detailed description about surgical volume in this paper could potentially identify those individual surgeons who performed only 1 MUS in this window and those performing >1000 MUS. While international readers likely have no interest in surgeon identity, this paper will likely be read by some of the Gynecologists captured by this dataset and many in the Canadian Gynecologic community who figure out the low vs. high volume surgeons with ease.

This dataset does not capture years of postgraduate training. This would require linkage to the College of Physicians and Surgeons of Alberta database, which is generally not easily obtained. Even if linkage was performed, it is expected that data for analysis would not be available for >12 months.

3. Results: I'd like to know more about the surgeons, first how many surgeons are included in the study? What proportion would you consider low vs. high volume (so we can compare with other studies), I am trying to get a sense of whether there are surgeons who maybe do a few procedures a year vs. the "high volume" surgeons, are these people who do these procedures 2-3x per week? The cohort median MUS per surgeon (IQR) is reported but I would like to know what proportion of surgeons fall into low vs. mid vs. high volume. Also, how many urologists and how many ob/gyns were there?

Response: 230 unique surgeons were included, 190 were Gynecologists and 40 were Urologists. Of these, 97 contributed minimally to the dataset meaning they performed these procedures for 2 year or less with a volume of 10 or less cases contributed to the dataset over this time. It is felt the most likely explanation for these cases is that they reflect surgeons who were preceptored to learn MUS, but ultimately chose not to offer it in their practice. Anticipating that this reviewer would be interested in knowing if the model changed by removing these very low volume surgeons, we ran an analysis without them. No change occurs in the model, and we have added the results to the tables submitted for on-line supplemental content.

Of the 133 surgeons who contributed significantly to the model, 104 of these surgeons were Gynecologists and 29 were Urologists. 31 surgeons were considered high volume (>50 cases/year). Both specialties were represented in the high-volume surgeon group.

This information and additional analysis have been updated on lines 196 & 236 in the manuscript.

4. Results: Table 2: do you mean "cumulative rates" rather than "accumulative"?



Response: This has been changed as suggested.

5. Results: Figure 1: I love this figure!

Response: The authors are also enthusiastic about this figure, as we feel it allows intuitive understanding of the results.

6. Discussion: Less than 50 procedures per year is about 4 per month...I suspect most general ob/gyns do less than 4 per month, if that, compared to urogynecologists who do more....is there any literature out there reporting the average volume of a general ob/gyn vs. urogynecologist vs. urologist?

Response: A study investigating the impact of the Health Canada warning regarding use of mesh on the volume of MUS procedures in Calgary, Alberta reported the mean number MUS procedures prior to the warning was 47.2/surgeon per year vs 35.0/surgeon per year after, although the change was not statistically significant<sup>1</sup>. The authors did not break down these volumes by core specialty (Gynecology vs Urology) as this cannot be done without breaking the anonymity of the data source.

1. Carlson K, et al. Case distribution and complications of mid-urethral sling surgery in a Canadian city before and after the Health Canada advisory on pelvic floor mesh. *Int Urogynecol J*. DOI 10.1007/s00192-017-3354-z

### Reviewer #3

1) The research question is an interesting one but I'm not sure how this is different from previous publications. The Welk article cited includes association of revision with the number of procedures per surgeon. As the authors mention, previous work evaluates the number of surgeries in terms of dichotomized outcomes or quartiles and the aim here was to look for a linear relationship, however, in the end there were similar cutoffs determined, 25, 50 and 110 cases. Table 3 then uses these cut-off showing categorized data.

The Jonsson Funk article covers the association of concomitant surgery.

Response: Our paper supports the previous findings by Jonsson-Funk and Welk and adds to the body of evidence that suggest surgeon volume and decision regarding performance of concomitant prolapse surgery are modifiable health system factors that may hold promise for improvement of MUS risk. By performing a study with similar goals and examining a different data set with different statistical techniques, we have shown that these associations are reproducible and consistent across different health care systems.

Additionally, by graphically representing our model we provide an easily interpretable display for readers. Clinicians without statistical training often struggle with the interpretation of data presented as Odds and Hazard Ratios, however by converting our logistic models out of odds and into probabilities we put significant effort into generating a paper that is interpretable by a wide audience.

2) Outcomes were various revision surgeries. I would be interested in hearing more about why the revision was done. Did this include revisions for mesh erosion, urinary retention, pain, etc. Or if the data is not available, a mention of why not (info not captured in the database, for example)



Response: The authors did not feel it was appropriate to use the ICD-10-CA diagnostic codes associated with the surgical visit to determine the true reason for revision surgery. This is because most of the ICD-10-CA codes associated with the revision surgery generally reflected generic ICD codes that function as “catch-all” for mesh complications. Additionally, it has been shown that Urinary Retention is a diagnosis that is often under coded in these administrative data sources<sup>1</sup>. Additional work is required to evaluate the level of diagnostic detail captured in Canadian administrative data regarding mesh complications before it can be utilized.

1. Juurlink D, Preyra C, Croxford R, Chong A, Austin P, Tu J, Laupacis A. Canadian Institute for Health Information Discharge Abstract Database: A Validation Study. Toronto: Institute for Clinical Evaluative Sciences; 2006.

3) Line 185 - should this be "did not contribute to the 5-year cumulative risk"?

Response: This has been corrected.

4) Line 296 - I agree with the "additional experience" but what do you mean by "additional training". I don't believe that information was captured/presented here.

Response: We have updated this phrasing (now line 323). Certainly, the paper supports that experience is related to outcome. Including the word “training” was meant to reflect that experience is generally obtained through additional training, particularly in the post-mesh warning medico-legal climate.

## STATISTICAL EDITOR'S COMMENTS:

1. lines 217-221: Should put this information and expand on it in a Table. That is, the final model explained x% of the variance, leaving (100-x)% unexplained. Then cite all the contributing factors to the explained variance in order. lines 220-221: Is this individual surgeon factor separate from surgeon's annual MUS volume? Need to clarify.

Response: Yes, the individual surgeon factor is separate from the annual MUS volume. This has been clarified on line 220.

Our description of variance for the inclusion of unique surgeon ID and hospital ID random intercepts was included to explain the criteria of how the model was reduced to the most parsimonious model, not to explain component variance. In this manner, a random intercept was removed because it did not improve fit. The Statistical Editor has made an excellent suggestion to include a statistical measure of the model's goodness of fit and the authors have updated the paper as suggested to include the pseudo- $R^2$ . Unlike OLS/linear regression where the  $R^2$  can directly be interpreted as explained variance, the McFadden  $R^2$  analogue in logistic regression is not as directly interpretable. Some would describe the value of McFadden's  $R^2$  as explaining a percentage of variance, while others would disagree with this interpretation and instead interpret it only as a measure of goodness of fit. We feel most comfortable with using it in this latter manner and have updated the text, and made the language surrounding this statistic more consistent to reflect that the model was evaluated for goodness of fit (rather than explained variance).

1. Smith TJ, McKenna CM. A Comparison of Logistic Regression Pseudo  $R^2$  Indices. Multiple Linear Regression Viewpoints, 2013, Vol. 39(2)

2. McFadden, D. (1974) "Conditional logit analysis of qualitative choice behavior." P. Zarembka (ed.), Frontiers in Econometrics. Academic Press

2. Table 1: Should cite whether there were statistically significant changes over time for age, concomitant POP surgery, median MUS per surgeon and proportion urology.

Response: This has been completed as requested.

3. Table 2: Since the mean follow-up was ~ 6 years and the study was from 2004 to 2016, need to include for each "interval of time" how many were lost to follow-up as a separate column from those remaining at risk "N in cohort". Also, should include a column of the number with mesh complications at each time interval.

Response: This has been completed as requested.

4. Table 3: Need more clarity re: referents. For example, the patient age appears to be per year, the annual volume of MUS for the 51-110 volume appears to be (lines 227-229) that the odds of mesh complication declined at 0.991 per additional case, but that is not evident from the Table. Were the 1-50 cases and the 110+ cases groups also per additional case? Also, the Table states the mid category is 51-110, as apparently does fig 1, but lines 227-229 state the range was 51-100 MUS per year. Need to clarify. Also, since the odds per case would be multiplicative over the range 51-110 and 0.991 per case is such a small increment, suggest re-stating the difference as the declining odds per increment of 10 cases per year (which would be OR ~ 0.90, with appropriate CIs). Also, to put these differences in more concrete examples, suggest citing the mesh complication rate for suitable intervals of MUS per year in Table format. For example, in categories of 1-10, 11-20 etc to 191-200, cite the corresponding rates of mesh complications. Also should cite whether there was any differential loss of follow-up for low volume vs high volume data that alternatively could have contributed to the difference in mesh complication rates

Response: We have updated the error on line 227 and changed "100" to "110".

There was no differential loss to follow-up between the high & low volume surgeons, and this has been added to line 242.

The 1-50 and 110+ groups were also per additional case. As per the Statistical Editor's suggestions, we have changed the units from per case to increments of 10 cases in Table 3 and agree this makes the findings more interpretable. We have updated the ORs and CIs accordingly, and explained Table 3 on line 234.

Regarding the suggested table of mesh complication rates per 10 unit interval, we have completed this table of proportions and 95% CIs as suggested. However, in the range of 110+ annual cases the group of surgeons represented is a small number. For this reason, we are not able to separate this range out into smaller groups of 10. This is because separating the small group further could possibly facilitate identification of certain surgeons annual surgical volume data can be accessed by those with administrative positions in Alberta's healthcare system. The range of 1-50 annual

cases per year does contain a much larger number of surgeons, and allowed separation into groups without this risk. However we did determine through the model that no significant difference in risk occurred over this range, so if the Editor(s) would like us to collapse this range for the table we would be agreeable to edit the table further.

#### **EDITORIAL OFFICE COMMENTS requiring response:**

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

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

Response: Yes, we **Opt-In** to including our responses.

3. In order for an administrative database study to be considered for publication in Obstetrics & Gynecology, the database used must be shown to be reliable and validated. In your response, please tell us who entered the data and how the accuracy of the database was validated. This same information should be included in the Materials and Methods section of the manuscript.

Response: The administrative database included in this paper is a national mandatory reporting system for all of English speaking Canada. Information is entered by trained Health Information Coders employed by Alberta Health Services. References 14-16 provide support for the validation and accuracy.

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 limits for different article types are as follows: Original Research articles, 300 words. Please provide a word count.

Response: Abstract has been updated based on these recommendations, and an updated word count provided.

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.

Response: The standard list of abbreviations does not include a category that encompasses both tension free vaginal tapes (TVT) and transobturator tapes (TVT-O). For this reason, the authors have used “mid urethral sling” as an anatomically correct description of the surgeries performed as they can not be separated in this dataset. This term is widely accepted in the Urogynecology literature. We request permission to use “MUS” as an abbreviation throughout the text for brevity and have defined it at first use in the paper.

12. Please review the journal's Table Checklist to make sure that your tables conform to journal style. The Table Checklist is available online here: [http://edmgr.ovid.com/ong/accounts/table\\_checklist.pdf](http://edmgr.ovid.com/ong/accounts/table_checklist.pdf).

Response: We have checked to ensure our tables conform, including use of footnote symbols.

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We recognize the reviewers' and editor's comments pointed out several areas where we were able to strengthen our paper. Thanks to their thorough reviews, our paper is much improved. Please let us know if there are further areas where additional work is needed.

Sincerely,



**Erin Brennand MD, FRCSC**



## Daniel Mosier

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**From:** Erin Alexandra Brennand [REDACTED]  
**Sent:** Tuesday, March 19, 2019 11:02 PM  
**To:** Daniel Mosier  
**Cc:** [REDACTED]  
**Subject:** Re: Manuscript Revisions: ONG-19-18R1  
**Attachments:** 19-18R1 ms (3-19-19v2) EB edits.docx

Dear Mr. Mosier,

Thank you for the opportunity to continue to revise my manuscript, with the goal that it becomes acceptable for publication in Obstetrics and Gynecology. Here are my responses to the highlighted issues:

1. Please note the minor edits and deletions throughout. Please let us know if you disagree with any of these changes.

Response: The majority of changes and deletions are great. A few minor changes have been made on my part throughout the abstract and paper in response to the edits/suggestions that were returned to me. A large conclusion paragraph was removed during the editorial process. I've added a two line sentence similar to what I have seen in recent articles in the Green Journal, as I think the paper reads better this way.

2. LINE 1: We avoid using "impact" other than to mean "to strike." Therefore, your title was reworded. Do you approve the edits?

Response: I've tried to come up with a title that conveys some of the analysis that showed a non significant association as well, as these findings are quite interesting as well.

How about: "Evaluation of surgeon's annual operative volume and specialty on likelihood of revision after mesh midurethral sling"

From an editorial perspective, is it better to use "risk" instead of "likelihood" given that findings are presented as rate/risk (eg. in probabilities)?

3. LINE 3: Hude Quan will need to complete our electronic Copyright Transfer Agreement, which was sent to them through Editorial Manager.

Response: I believe this was completed today. If not, would it be possible to resend the link to him?

4. LINE 17: Provide a running title of about 45 characters.

Response: Completed.

5. LINE 31: Please be sure this is stated in the body text, preferably in the Methods.

Response: This is stated in lines 332-333 and Table 5. I think it's best stated in this area as it's related to results of the analysis.

6. LINE 41: Please be sure this is stated in the body of your paper, tables, or figures. Statements and data that appear in the Abstract must also appear in the body text for consistency.

Response: I have updated line 147 to be clearer about the nature of the cohort, and in turn, I updated lines 40-41 to be more precise in the abstract.

7. LINE 42: Please be sure this is stated in the body of your paper, tables, or figures. Statements and data that appear in the Abstract must also appear in the body text for consistency.

Response: I believe this was for line 52. Line 311 expresses the rate per individual case, and as per one of the reviewers the odds per 10 cases is shown in Table 5.

8. LINE 170: Please use either e.g. or i.e. but be consistent throughout the paper

Response: I have selected "e.g.", as I feel it the more appropriate abbreviation for the majority of instances.

9. TABLES: Your "eTables" may be left in print, since your manuscript isn't overly long. The tables have been renumbered according to how they are first cited in the body text.

Response: Thank you.

10. TABLE 4: This table was not cited in the body text. Please add the in-text citation and number in the order with the other tables.

Response: This has been cited and updated as Table 6. The prior Table 6 has been renumbered to 7, and references in the text body updated as well.

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

Response: These have been reviewed, and small updates to the titles of tables was performed to differentiate 4 from 6. I've renumbered but not repositioned them within the text. There are no changes to the figure.

I have attached the manuscript, with track changes highlighted as requested. If you require further edits or changes on my part, please let me know.

Thank you very much for your time and assistance. They are greatly appreciated.

Yours sincerely,

Erin Brennand

On Tue, 19 Mar 2019 at 10:11, Daniel Mosier <[dmosier@greenjournal.org](mailto:dmosier@greenjournal.org)> wrote:

Dear Dr. Brennand,

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

1. Please note the minor edits and deletions throughout. Please let us know if you disagree with any of these changes.
2. LINE 1: We avoid using "impact" other than to mean "to strike." Therefore, your title was reworded. Do you approve the edits?
3. LINE 3: Hude Quan will need to complete our electronic Copyright Transfer Agreement, which was sent to them through Editorial Manager.
4. LINE 17: Provide a running title of about 45 characters.
5. LINE 31: Please be sure this is stated in the body text, preferably in the Methods.
6. LINE 41: Please be sure this is stated in the body of your paper, tables, or figures. Statements and data that appear in the Abstract must also appear in the body text for consistency.
7. LINE 42: Please be sure this is stated in the body of your paper, tables, or figures. Statements and data that appear in the Abstract must also appear in the body text for consistency.
8. LINE 170: Please use either e.g. or i.e. but be consistent throughout the paper
9. TABLES: Your "eTables" may be left in print, since your manuscript isn't overly long. The tables have been renumbered according to how they are first cited in the body text.

10. TABLE 4: This table was not cited in the body text. Please add the in-text citation and number in the order with the other tables.
11. FIGURE: Your figures and legend have been edited and they have been attached for your review. Please review the attachments CAREFULLY for any mistakes.

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

Please let me know if you have any questions. Your prompt response to these queries will be appreciated; please respond no later than COB on **Thursday, March 21st**.

Sincerely,

-Daniel Mosier

**Daniel Mosier**

Editorial Assistant

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## Eileen Chang (Temp)

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**From:** Erin Alexandra Brennand [REDACTED]  
**Sent:** Tuesday, March 12, 2019 3:31 PM  
**To:** Eileen Chang (Temp)  
**Cc:** [REDACTED]  
**Subject:** Re: O&G Figure Revision: 19-18

Hello Eileen,

Thank you for the opportunity to review the figure. I approve the edits.

Thank you,

Erin Brennand

On Tue, 12 Mar 2019 at 12:54, Eileen Chang (Temp) <[echang@greenjournal.org](mailto:echang@greenjournal.org)> wrote:

Good Afternoon,

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

PLEASE NOTE: Any changes to the figure or legend must be made now. Changes made at later stages are expensive and time-consuming and may result in the delay of your article's publication.

To avoid a delay, I would appreciate a reply no later than Thursday, 3/14. Thank you for your help.

Best,

Eileen